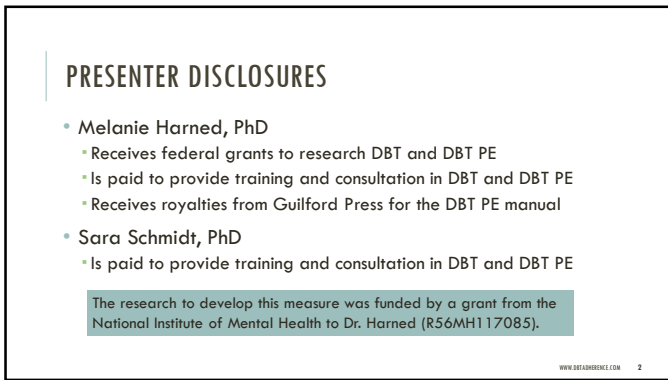
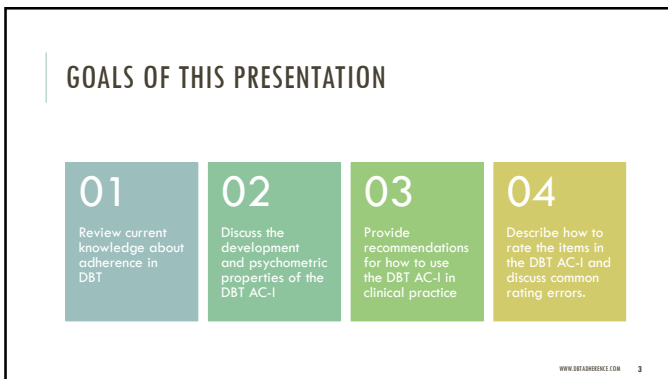


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OVERVIEW OF DBT ADHERENCE

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DBT ADHERENCE: WHAT DOES IT REALLY MEAN?

- The extent to which treatment was delivered in accord with the DBT manual in a single session
 - The therapist used the prescribed strategies and did not use the proscribed strategies of DBT
- Not a quality of a therapist
 - No such thing as an “adherent” DBT therapist (or program)
- Not (entirely) a measure of competence
 - Can be adherent and not highly competent






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DBT ADHERENCE: DOES IT MATTER?

Higher therapist adherence predicts better client outcomes and retention.

 Fewer Suicide Attempts 20% decrease in subsequent suicide attempts per SD increase in adherence	 Lower Risk of Dropout 22% decrease in treatment dropout per SD increase in adherence	 Fewer Hospitalizations 41% decrease in subsequent hospitalizations per SD increase in adherence among community therapists
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Harned, Schmidt, Korslund, & Gallop, under review

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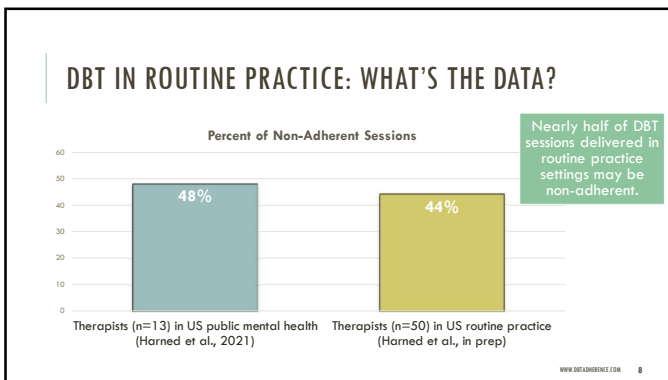
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OTHER REASONS TO STRIVE FOR ADHERENCE

- ★★★ Quality assurance for administrators, programs, therapists, and consumers
- 🏠 Required for DBT-LBC clinician certification
- 💰 Potential for enhanced reimbursement rates

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Efforts to improve the quality of DBT services in routine practice settings have been hampered by the lack of a pragmatic measure to evaluate therapist adherence.

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THE CHALLENGE OF ADHERENCE MEASUREMENT

Efficient
(feasible to use)

Effective
(reliable and valid)

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THE DBT ADHERENCE CODING SCALE (DBT ACS; LINEHAN & KORSLUND, 2003)

- Has been the only validated measure of DBT adherence (the "gold standard")
- Observational measure used to rate DBT individual & group sessions
- Includes 66 items across 12 subscales
- Uses a 0-5 rating scale, where 4.0 and higher is adherent
- Current uses:
 - Clinical trials research
 - DBT-LBC Clinician Certification

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PROS AND CONS OF THE DBT ACS


- ✓ Comprehensive measure of all DBT strategies and protocols
- ✓ Excellent psychometric properties
- ✓ Established procedures for training coders
- ✗ Long and complex
- ✗ Requires observation of recorded sessions
- ✗ Restricted to use by trained coders
- ✗ Not free or publicly available

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PROJECT AIMS

- To develop a measure that:
 - Assesses therapist strategies critical to the adherent delivery of DBT
 - Is brief and easy to use
 - Can be used for multiple purposes (e.g., quality improvement, supervision, research)
 - Can be completed by therapists (self-report) and observers
 - Has good psychometric properties
 - Is freely available



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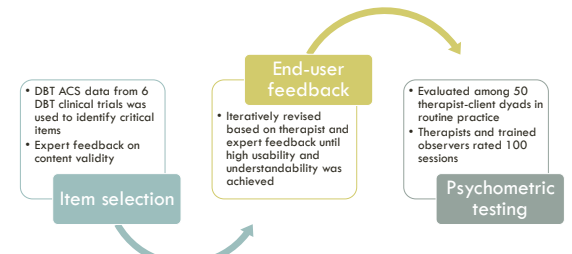
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THE DEVELOPMENT OF THE DBT AC-I

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THE MEASURE DEVELOPMENT PROCESS



```
graph LR; A[Item selection] --> B[End-user feedback]; B --> C[Psychometric testing];
```

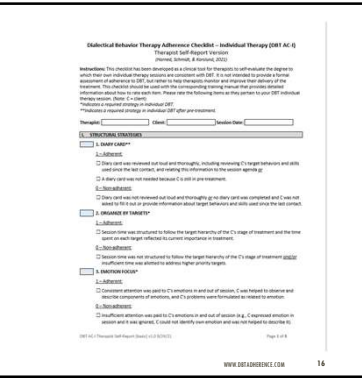
- Item selection**
 - DBT ACS data from 6 DBT clinical trials was used to identify critical items
 - Expert feedback on content validity
- End-user feedback**
 - Iteratively revised based on therapist and expert feedback until high usability and understandability was achieved
- Psychometric testing**
 - Evaluated among 50 therapist-client dyads in routine practice
 - Therapists and trained observers rated 100 sessions

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THE DBT ADHERENCE CHECKLIST FOR INDIVIDUAL THERAPY (DBT AC-I; HARNED, SCHMIDT & KORSLUND, 2021)

- 26 items that draw from all 12 subscales of the DBT ACS.
- Each item is rated on a binary (0/1) scale with behavioral anchors defining adherent vs. non-adherent delivery.
- Therapist self-report and observer-rated versions are available.
- Includes an accompanying training manual.



The image shows a thumbnail of the DBT Adherence Checklist for Individual Therapy (DBT AC-I) form. The form is titled "Behavioral Behavior Therapy Adherence Checklist - Individual Therapy (DBT AC-I)" and includes a section for "PSYCHOMETRIC INDICES". The form is designed to be filled out by a therapist or observer to assess adherence to DBT principles during individual therapy sessions.

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A BRIEF REVIEW OF KEY PSYCHOMETRIC INDICES

RELIABILITY: DOES IT YIELD ACCURATE AND CONSISTENT SCORES?

- **Inter-rater reliability:** the degree of agreement between raters

VALIDITY: DOES IT MEASURE ADHERENCE TO DBT?

- **Convergent validity:** the degree to which it is correlated with the gold standard measure of adherence
- **Criterion validity:** the degree to which it correctly identifies adherent vs. non-adherent sessions according to the gold standard measure of adherence

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PSYCHOMETRICS: OBSERVER-RATED VERSION

- ✓ Excellent inter-rater reliability between trained observers and the gold standard rater (ICC = 0.93).
- ✓ The observer-rated DBT AC-I score was highly correlated with the DBT ACS score ($r = 0.90, p < .001$).
- ✓ The observer-rated DBT AC-I score correctly identified 91% of adherent and 80% of non-adherent sessions as defined by the DBT ACS.

Inter-rater Reliability **Convergent Validity** **Criterion Validity**

The DBT AC-I offers an efficient and effective alternative to the DBT ACS when rated by trained observers.

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MH3

PSYCHOMETRICS: THERAPIST SELF-REPORT VERSION

Inter-rater Reliability

Inter-rater reliability between therapists and trained observers was poor (ICC=0.09).
 • Average item-level agreement = 84.2% (range = 63 – 98%).

Convergent Validity

Therapists' self-rated DBT AC-I score was not correlated with the DBT ACS score ($r = 0.05, p = .63$).

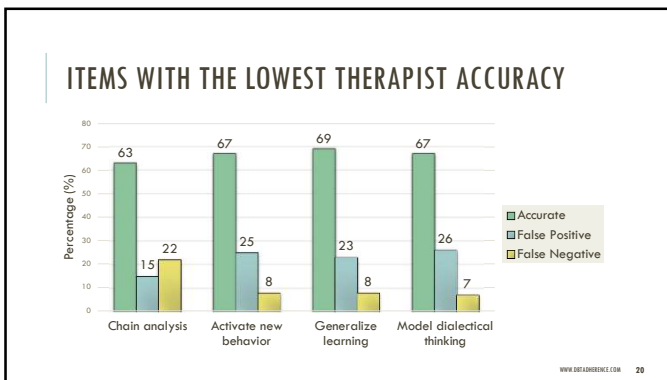
Criterion Validity

Therapists' self-rated DBT AC-I score did not significantly predict adherent versus non-adherent sessions according to the DBT ACS.

Therapists' self-rated adherence on the DBT AC-I should not be assumed to reflect their actual adherence to DBT.


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PREDICTORS OF THERAPIST ACCURACY



GREATER OBSERVER-RATED ADHERENCE



MORE DBT KNOWLEDGE



MORE SUICIDAL CLIENTS

Therapists who were more adherent, knowledgeable, and whose sessions were with clients with more severe suicidal ideation were more accurate in rating their own adherence.

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MH3 Confirm ICC

Melanie Harned, 10/5/2021

RECOMMENDED USES OF THE DBT AC-I

Potential Use	Description	Therapist Self-Report	Untrained Observers*	Trained Observers*
Quality Monitoring	Use to monitor the quality of DBT that is being delivered by a therapist or in a program.	✓	✓	✓
Quality Improvement	Use the evaluation results to help therapists modify and improve their delivery of DBT when needed.	✓	✓	✓
Supervision and Training	Use to inform supervision and identify additional therapist training needs.	✓	✓	✓
Team Consultation	Use to obtain/provide consultation during DBT team meetings.	✓	✓	✓
Formal Assessment of Adherence	Use to make reliable and valid determinations of the degree to which sessions were adherent to DBT.	✗	✗	✓
High Stakes Decisions	Use in situations in which the evaluation results could have serious negative impacts on the therapist or program being rated (e.g., decisions related to salary and promotion, service contract loss, certification).	✗	✗	✓

* Observers who have not been trained to reliability in the gold standard DBT Adherence Coding Scale.
 * Observers who have been trained to reliability in the gold standard DBT Adherence Coding Scale.

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DBT AC-I THERAPIST STRATEGIES

26 Items

Structural Strategies	(3 Items)
Problem Assessment	(2 Items)
Problem Solving	(6 Items)
Contingency Management	(2 Items)
Exposure	(1 Item)
Cognitive Modification	(1 Item)
Validation	(3 Items)
Reciprocal Communication	(2 Items)
Irreverent Communication	(2 Items)
Dialectical Strategies	(2 Items)
Case Management	(1 Item)
Protocols	(1 Item)

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Category	# of Items	Individual Items
Structural Strategies	3	Diary card, Organize by targets, Emotion focus
Problem Assessment	2	Define specifically, Chain analysis
Problem Solving	6	Teach new information, Generate solutions, Activate new behavior, Provide coaching, Generalize new learning, Commitment and troubleshooting
Contingency Management	2	Reinforcement, aversive contingencies
Exposure	1	Informal exposure
Cognitive Modification	1	Challenge cognitions
Validation	3	V4, V5, V6
Reciprocal Communication	2	Warm engagement, Self-disclosure
Irreverent Communication	2	Direct confrontation, Unorthodox irreverence
Dialectical Strategies	2	Balanced style and strategies, Model dialectical thinking
Case Management	1	Consultation to the client
Protocols	1	Suicidal behaviors protocol

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TYPES OF ITEMS

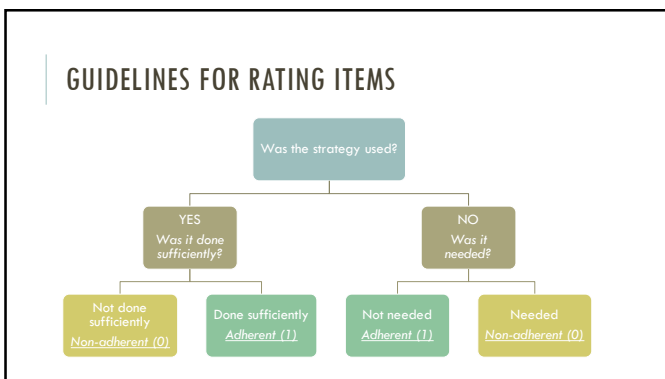
Required (n=13)

- Strategies that must be used in every session.
- Examples: emotion focus, generate solutions

Context-dependent (n=13)

- Strategies that are required only if certain conditions are met.
- Examples: chain analysis, suicidal behaviors protocol

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Slide 25

MH7 Not sure whether to leave this one in here or not

Melanie Harned, 10/13/2021

OUR GOALS

- To briefly describe how to rate each item.
- To highlight common rating errors for the items with the lowest agreement rates.
- To provide information about additional training options.

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**AN INTRODUCTION TO RATING
THE DBT AC-I**

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STRUCTURAL STRATEGIES


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Required
(except pre-tx)


1. DIARY CARD

T reviews and conveys the importance of the diary card and C's progress.



Adherent diary card review:

- Talks about it out loud
- Comments on presence/absence of important targets
- Reviews and reinforces skills use
- Uses it to inform the session agenda



If diary card is not complete:

- Asks client to complete it in session
- or
- Verbally reviews important targets and skills use


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Required

2. ORGANIZE BY TARGETS

T structures the session time in accord with the target hierarchy.



- Overall session time was organized to follow the target hierarchy (not necessarily sequentially).
- If LTB occurs or urges increase by 3+ points, it must be targeted.
- TIB and QOL may or may not be targeted depending on time and presence of higher-priority targets.


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Required

3. EMOTION FOCUS


T focuses on the C's emotions throughout the session.



PAYS ATTENTION TO C'S EMOTIONS



HELPS C TO OBSERVE AND DESCRIBE EMOTIONS



FORMULATES PROBLEMS AS EMOTION-RELATED

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PROBLEM ASSESSMENT STRATEGIES |

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4. DESCRIBE SPECIFICALLY Required

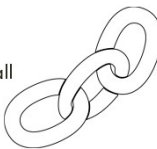
 T uses, and facilitates the C to use, behaviorally specific language.

- Consistently uses behaviorally specific language to describe emotions, behaviors, and thoughts.
- Describes problems clearly and precisely.
 - Frequency, duration, intensity, topography
- Avoids using:
 - Vague descriptions and terms (e.g., “upset”)
 - Judgments (e.g., bad/good, “jerk”)
- Coaches client to describe specifically and restate judgments.

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5. CHAIN ANALYSIS Context-dependent

 T conducts a chain analysis when needed to understand the function of a problem behavior and the barriers to effective behaviors.

- Chain analysis is needed when a primary target behavior or high urges occurred and
 - Controlling variables are not known and/or
 - Prior solutions have not been effective
- An adherent chain analysis must attend to small units of behavior and clearly identify:
 - The function of the problem behavior
 - The barriers to effective behavior

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CHAIN ANALYSIS: COMMON RATING ERRORS

False Positives (15%)

- Chain was not done when it was needed (e.g., 3+ increase in suicide urges)
- Chain was done that was overly vague and did not result in:
 - Specifically defined problems
 - Clearly hypothesized controlling variables
 - A complete picture of the event (beginning, middle, end)

False Negatives (22%)

- A chain was not done and it was not needed, but therapists thought it was required (e.g., in every session)
- A chain was done that was detailed enough to meet the functions/be adherent, but therapists thought more details were needed

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PROBLEM SOLVING STRATEGIES

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TEACH NEW INFORMATION

Context-dependent

 T taught the C new behaviors or skills and/or provided psychoeducation on relevant topics.

- This strategy is needed if the client:
 - Displays inaccurate understanding of a skill, or
 - Is clearly lacking knowledge about a relevant topic
- New information can be taught:
 - Using skill acquisition procedures (e.g., instructing the C in a skill, modeling how to use a skill)
 - By providing psychoeducation (e.g., about the biosocial model, behavioral theory, or evidence-based treatments)




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7. GENERATE SOLUTIONS

Required

T helps the C generate and evaluate new solutions to problems.



- Solutions may include DBT skills and general problem-solving strategies
- Potential solutions should be:
 - Well-matched and adequate to address the main problems
 - Well-matched to the client's current abilities
 - Adaptive, realistic, and feasible to implement
- An effort should be made to get the client active in generating solutions

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8. ACTIVATE NEW BEHAVIOR IN SESSION

Required

T compels an active, new response from the C in session.


- Goal is to get the C to do something differently in session, not just talk about doing something differently.
- Examples may include having the client:



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ACTIVATE NEW BEHAVIOR: COMMON RATING ERRORS




False Positives (25%)


- Therapists often (mis)rated themselves as activating new behavior when they asked the client to do something new outside of session (e.g., practice a skill)
- To count, the new behavior must occur in session
- This does not include talking about new behavior, must actually do new behavior

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9. PROVIDE COACHING FEEDBACK Context-dependent

 T gives behaviorally specific feedback to shape, refine, and increase C's skillful behaviors.



- This strategy is needed if the C used a specific skill or generally engaged in skillful behavior that was not fully effective.
- Involves giving behaviorally specific feedback to:
 - Clarify effective behavior (what worked) and
 - Shape more skillful behavior (what could be improved)

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10. GENERALIZE NEW LEARNING Required
(except pre-tx)

 T actively works to transfer new learning from therapy to the C's real-world environment.





- Must give at least one behavioral assignment to practice or review new learning from session in relevant contexts in the client's life.
- Examples may include:
 - Practice a specific skill (e.g., paced breathing when anxious)
 - Implement solutions generated in session (e.g., dispose of lethal means)
 - Review new learning (e.g., listen to a recording of the session)

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GENERALIZE NEW LEARNING: COMMON RATING ERRORS



False Positives (23%)

- Therapists often (mis)rated themselves as generalizing learning when they:
 - Discussed skills or solutions the client could use (e.g., during solution analysis), but did not specifically assign them to do anything
 - Gave overly vague assignments (e.g., "practice mindfulness this week")

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Context-dependent

11. COMMITMENT AND TROUBLESHOOTING

T attempts to get a commitment from C when needed and troubleshoots barriers to doing what they agree to do.

An attempt to get a commitment is needed when:

- C is in pre-treatment
 - Commitment to work on targets and engage in DBT
- C is suicidal or has engaged in LTB
 - Commitment to not kill/harm self
- T & C have decided on solutions to implement
 - Commitment to complete behavioral assignments

If a commitment is obtained, it must be troubleshooted:

- "What might get in the way?"
- "What can you do about that if it happens?"

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CONTINGENCY MANAGEMENT STRATEGIES

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Required

12. REINFORCEMENT

T reinforces the C's adaptive behaviors.

- Reinforcement must be used to increase target-relevant adaptive behaviors.
 - Includes reinforcing small steps toward desired behavior (shaping)
- Reinforcers vary by client but often include:
 - Praise
 - Attention/contact
 - Increasing warmth
 - Expressing approval



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Context-dependent

13. AVERSIVE CONTINGENCIES

T applies aversive consequences/punishment to decrease the likelihood of maladaptive behaviors.

What are aversive contingencies?	When are aversives needed?	What counts?
<ul style="list-style-type: none">Removing a positive (e.g., withdrawing warmth)Applying a negative (e.g., expressing disapproval)	<ul style="list-style-type: none">Maladaptive behavior is being reinforced by consequences out of the T's control, andThere is no adaptive behavior to reinforce.	<ul style="list-style-type: none">Must clearly use an aversive to punish a specific maladaptive behaviorDoes not include generally engaging in behavior the client finds aversive (e.g., interrupting, chain analysis)

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EXPOSURE STRATEGIES

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Context-dependent

14. INFORMAL EXPOSURE

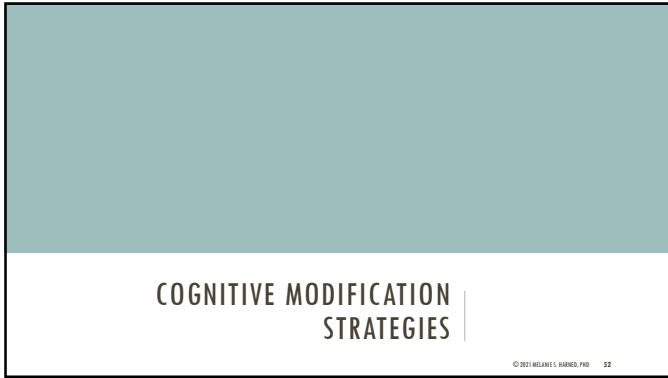
T uses exposure procedures to treat extreme emotional responses or block emotional avoidance.

* Informal exposure is needed if (1) emotional avoidance is a high priority target, and (2) it is obvious that the client is avoiding emotions in session.

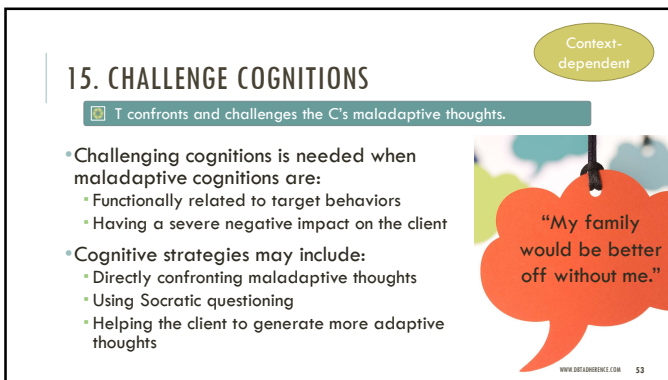
1 Notice and confront efforts to avoid emotion.	2 Identify the emotion and redirect back to the cue.	3 Coach to experience the emotion without avoiding.	4 Block problematic action and expressive tendencies.	5 Continue exposure until new learning occurs.
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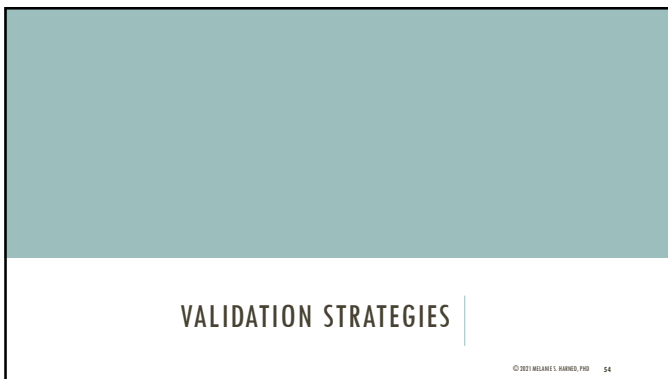
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* Required

VALIDATION STRATEGIES

- 16. V4 Learning History/Biology
 - T conveys that C's reactions make sense in the context of the C's learning history or biology.
- 17. V5 Current Events*
 - T conveys that C's reactions make sense in the current context.
- 18. V6 Radical Genuineness*
 - T interacts with the C in an ordinary and natural manner that conveys that the C is a person of equal status.

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RECIPROCAL COMMUNICATION STRATEGIES

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* Required
** Context-dependent

RECIPROCAL COMMUNICATION STRATEGIES

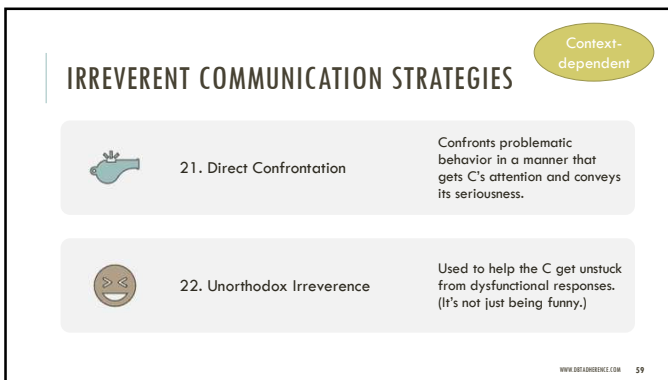
-  19. Warm Engagement*
Communicates warmth and caring verbally and/or non-verbally.
-  20. Self-Disclosure**
Shares information about self and/or their reactions to the client (e.g., "When you do X, I feel Y").

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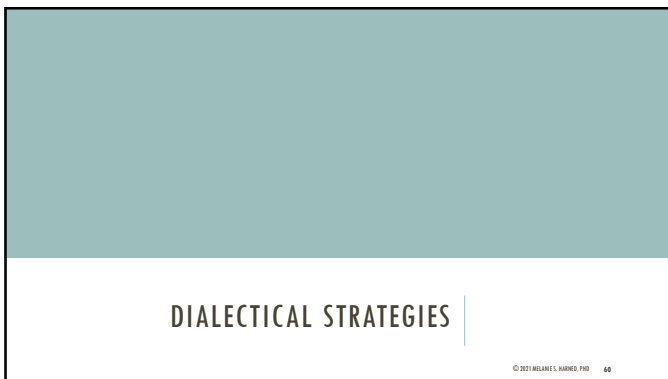
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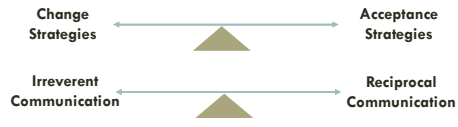
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23. BALANCED STYLE AND STRATEGIES Required

 T balances acceptance- and change-oriented strategies and communication styles.

• Goal is to use therapist style and strategies that are balanced in terms of acceptance and change across the course of the session.

Change
Strategies



Acceptance
Strategies


Irreverent
Communication

Reciprocal
Communication

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24. MODEL DIALECTICAL THINKING Required

 T models dialectical thinking and works to find a synthesis when polarization occurs.

• Goal is for T to adopt and model a dialectical world view by highlighting polarities and working towards synthesis.

• Ways to model dialectical thinking:


- Use "both-and" statements
- Actively work to find synthesis by searching for a middle path
- Highlight transaction and natural change



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MODEL DIALECTICAL THINKING: COMMON RATING ERRORS



False Positives (26%)

- Common ways that therapists thought they modeled dialectical thinking when they did not:
 - By putting "and" between two statements that are not actually related or opposed.
 - e.g., "You're feeling sad and you're feeling afraid."
 - By making both validation and change statements about a problem.
 - e.g., first validating (e.g., "It's understandable that you cut yourself") and later pushing for change (e.g., "You need to stop cutting yourself")

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CASE MANAGEMENT STRATEGIES

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25. CONSULTATION TO THE CLIENT

Context-dependent

T consults to the C about how to interact effectively with their environment rather than intervening on the C's behalf.

- Goal is to help the client to act as their own agent in managing their environment.
- This strategy is only relevant to other professionals and key people in the client's life with whom it may be typical for a therapist to have direct contact.
 - Common examples: skills group leaders, parents, prescribers
 - Does not apply to coaching a client to interact with people who are not involved in their treatment (e.g., friends, coworkers, neighbors)



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PROTOCOLS

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26. SUICIDAL BEHAVIORS PROTOCOL Context-dependent

 T uses the suicidal behavior protocol (assessment, problem-solving, commitment, and troubleshooting) when needed.

* The suicidal behaviors protocol is required if the client:

- Attempted suicide or engaged in non-suicidal self-injury
- Reported a 3+ point increase in urges for these behaviors

1	2	3	4
Assess Chain analysis or other methods	Problem Solve Generate and evaluate solutions	Commitment To not kill/harm self To implement solutions	Troubleshoot What might get in the way?

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TRAINING OPTIONS

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DBT ADHERENCE WEBSITE (WWW.DBTADHERENCE.COM)

		
DOWNLOAD THE MEASURE AND THE TRAINING MANUAL	PRACTICE RATING THE MOCK SESSIONS	REVIEW CLIPS OF SPECIFIC STRATEGIES

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