DBT Skills Training as a Stand-Alone or Adjunctive Treatment: Efficacy and Clinical Applications

Visit www.behavioraltech.org for all training details.

Moderator Introduction

Alexis Karlson, MSSW
Director of Business Operations
How to Submit Questions

• Submit your questions by typing your question into the Q&A box and clicking “Send.”
• If you don’t see a Q&A box, click the icon with a “?” to toggle the display of the Q&A section.

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DBT Skills Training as a Stand-Alone or Adjunctive Treatment: Efficacy and Clinical Applications

Live Webinar | July 7, 2016

Yevgeny Botanov, PhD

Visit www.behavioraltech.org for all training details.

Trainer Introduction

Yevgeny Botanov, PhD
Post Doctoral Fellow
Behavioral Tech, LLC
DBT was designed for the severe and chronic, multi-diagnostic, difficult-to-treat individuals.

Solution Was to Apply A Dialectical Approach by Balancing:

- Change Strategies
- Acceptance Strategies

Dialectics
**PROBLEMS TO SOLVE**

**Problem**

*Low distress tolerance* made focusing on one problem area (one part of a problem, one disorder, or one therapy topic) impossible, with frequent crises overtaking any ability for sustained work on change.

---

**PROBLEMS TO SOLVE**

**Problem**

An ever-changing clinical presentation, together with frequent crises, resulted in confused therapists and a chaotic therapy.
Solution Was to Provide a Dialectical Balance

Target-based Agenda

Protocol-based Agenda

Dialectics

Solution Teach clients skills!

Distress Tolerance

Emotion Regulation

Interpersonal Effectiveness

Mindfulness
Teach Skillful Behavior to Replace Problem Behavior

<table>
<thead>
<tr>
<th>Behaviors to Increase</th>
<th>Behaviors to Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mindfulness Skills</td>
<td>• Identity confusion</td>
</tr>
<tr>
<td></td>
<td>• Emptiness</td>
</tr>
<tr>
<td></td>
<td>• Cognitive dysregulation</td>
</tr>
<tr>
<td></td>
<td>• Absence of flexibility, difficulties with change</td>
</tr>
<tr>
<td>Interpersonal Skills</td>
<td>• Interpersonal chaos</td>
</tr>
<tr>
<td></td>
<td>• Fears of abandonment</td>
</tr>
<tr>
<td>Emotion Regulation Skills</td>
<td>• Labile affect</td>
</tr>
<tr>
<td></td>
<td>• Excessive anger</td>
</tr>
<tr>
<td>Distress Tolerance Skills</td>
<td>• Impulsive behaviors</td>
</tr>
<tr>
<td></td>
<td>• Suicidal behaviors</td>
</tr>
</tbody>
</table>

DBT Modes

- Individual DBT
- Out-of-Session Coaching
- Team Consultation
- DBT Skills Training

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How much data is there?

**DBT Randomized Controlled Trials**

35 Randomized Controlled Trials at 26 Independent Sites in 10 Different Countries with 12 Distinct Patient Populations

- Linehan
- Turner
- Koons
- Safer
- Craighead
- Verheul
- Lynch
- Clarkin
- McMann
- Carter
- Courbasson
- Feigenbaum
- Piazzello
- Priebe
- Bohus
- Harned
- Mehlum
- Goldstein
- Telch
- Safer
- Bradley
- Harley
- Soler
- Safer
- Hill
- Hirvikoski
- Van Dijk
- Neacsiu
- Fleming
- Uliazek
- Andreasson
- Klein

http://www.linehaninstitute.org/research/data-to-date.php

“In sum, DBT and related treatments provide the most solid...evidence of efficacy relative to all treatments [for BPD] that have been investigated in RCTs so far.” (p. 73, Cochrane Review, 2012)

DBT is designated as having “Strong Research Support” for BPD.
## 15 RCTs of DBT Skills Interventions

<table>
<thead>
<tr>
<th>Population</th>
<th># of RCTs</th>
<th>Adjunctive Treatments?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disordered Eating</td>
<td>5</td>
<td>Some</td>
</tr>
<tr>
<td>Major Depressive Disorder</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>ADHD</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Prison &amp; Childhood Abuse</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>BPD</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>BPD - Suicidal</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>High Emotion Dysregulation (anxious and/or depressed; non-BPD)</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>College students + Significant Psychopathology</td>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### RCTs for Disordered Eating

<table>
<thead>
<tr>
<th>Population &amp; Problem Behaviors Investigated</th>
<th>Treatments/N</th>
<th>Length</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female, binge eating disorder</td>
<td>DBT Skills (n = 22) &amp; WL (n = 22)</td>
<td>20 weeks</td>
<td>Telch, Agras, &amp; Linehan, 2001</td>
</tr>
<tr>
<td>Female, at least one binge/purge episode per week</td>
<td>DBT Skills (n = 14) &amp; WL (n = 15)</td>
<td>20 weeks</td>
<td>Safer, Telch, &amp; Agras, 2001</td>
</tr>
<tr>
<td>Binge eating disorder</td>
<td>DBT Skills (n = 50) &amp; Active Comparison Group Therapy (n = 81)</td>
<td>20 weeks</td>
<td>Safer, Robinson, &amp; Jo, 2010</td>
</tr>
<tr>
<td>Female, subthreshold bulimia nervosa</td>
<td>DBT Skills (n = 18) &amp; 6-week WL (n = 14)</td>
<td>12 weeks</td>
<td>Hill, Craighead, &amp; Safer, 2011</td>
</tr>
<tr>
<td>Female, full- or sub-threshold variants of either BED or BN</td>
<td>DBT (n = 12) &amp; Self-Guided DBT Diary Cards (n = 13)</td>
<td>15 weeks</td>
<td>Klein, Skinner, &amp; Hawley, 2013</td>
</tr>
</tbody>
</table>
### RCTs for Disordered Eating

<table>
<thead>
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<td>Safer, Telch, &amp; Agras, 2001</td>
</tr>
<tr>
<td>Binge eating disorder</td>
<td>DBT Skills (n = 50) &amp; Active Comparison Group Therapy (n = 51)</td>
<td>20 weeks</td>
<td>Safer, Robinson, &amp; Jo, 2010</td>
</tr>
<tr>
<td>Female, subthreshold bulimia nervosa</td>
<td>DBT Skills (n = 18) &amp; 6-week WL (n = 14)</td>
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</tr>
</tbody>
</table>
Dialectical Behavior Therapy for Binge Eating and Bulimia

Debra L. Safer
Christy F. Telch
Eunice Y. Chen

Foreword by
Marsha M. Linehan
Disordered Eating

- Three RCTs
- Uncontrolled pilot trial – Telch et al., 2000
- Exclusion criteria:
  - BMI<17.5; current suicidality, psychosis, substance abuse; concurrent psychotherapy or weigh lose treatment
  - Antidepressant or mood stabilizer (Telch et al., 2001); less than 3 months of use (Safer et al, 2010)
- Diary cards used

<table>
<thead>
<tr>
<th>Study</th>
<th>Adherence Ratings</th>
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<th>Team</th>
<th>Out-of-Session Coaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safer et al., 2001; Telch et al., 2001</td>
<td>No</td>
<td>Not described</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Safer et al., 2010</td>
<td>✓</td>
<td>✓</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
</tbody>
</table>

Subthreshold Bulimia Nervosa

- One RCT (Hill et al., 2011)
- Adapted from Safer
  - 12 sessions, session time extended
  - Incorporates The Appetite Awareness Workbook
  - Two additional eating disorder skills
    - appetite awareness (avoid getting too hungry)
    - antideprivation eating (choosing to eat treats to prevent feelings of deprivation)
- Modules:
  - (1) appetite awareness and mindfulness, (2) distress tolerance, and (3) emotion regulation

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Hill et al., 2011</td>
<td>No</td>
<td>Weekly</td>
<td>✓</td>
<td>Not reported</td>
</tr>
</tbody>
</table>
Additional Findings

- DBT skills vs. individually supported self-monitoring using adapted DBT diary cards
  - 15 sessions of DBT skills training
  - Both treatments showed large and significant improvements in binge eating, bulimic symptoms, and interoceptive awareness.
  - DBT superior in reducing binge eating, binge eating abstinence in final 4 weeks, moving from full- to sub-threshold binge eating levels

<table>
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</thead>
<tbody>
<tr>
<td>Klein et al., 2013</td>
<td>No</td>
<td>Weekly</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>

Overall Findings

- DBT skills training more effective at reducing binge eating or binge/purge behaviors compared to waitlist controls, self-guided treatment, and an active group therapy
- DBT skills training superior to active and non-active controls in reducing other types of eating-related pathology
  - appetite awareness  - eating restraint
  - weight-related concerns - eating concerns
  - urges to eat when angry - preoccupation with food
- DBT vs. Active Comparison Group Therapy (ACGT)
  - DBT < ACGT in treatment dropout (4% vs. 33%)
  - DBT = ACGT in abstinence and reducing binge eating (64% in DBT & 36% in ACGT)
  - DBT > ACGT in increasing eating restraint and reducing eating concerns
**RCTs for Mood Disorders**

<table>
<thead>
<tr>
<th>Population &amp; Problem Behaviors Investigated</th>
<th>Treatments/N</th>
<th>Length</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 60 or older, current major depressive disorder</td>
<td>DBT + Medication (n = 17) &amp; Medication (n = 17)</td>
<td>28 weeks</td>
<td>Lynch et al., 2003</td>
</tr>
<tr>
<td>Major depressive disorder, on stable medication</td>
<td>DBT (n = 13) &amp; WL (n = 11)</td>
<td>16 weeks</td>
<td>Harley et al., 2008</td>
</tr>
<tr>
<td>Bipolar I or II</td>
<td>DBT (n = 13) &amp; WL (n = 13)</td>
<td>12 weeks</td>
<td>Van Dijk, Jeffrey, &amp; Katz, 2013</td>
</tr>
</tbody>
</table>

**Major Depressive Disorder**

- Lynch et al., 2003
  - 28 weekly 2-hour skills groups
  - 30 minute scheduled phone contact
  - Diary card review
- Harley et al., 2008
  - Review of HW completed at end of treatment
  - Participants allowed concurrent mental health treatment

<table>
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<tr>
<th>Study</th>
<th>Adherence Ratings</th>
<th>Supervision</th>
<th>Team</th>
<th>Out-of-Session Coaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lynch et al., 2003</td>
<td>No</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Harley et al., 2008</td>
<td>No, Not reported</td>
<td></td>
<td>✓</td>
<td>Not reported</td>
</tr>
</tbody>
</table>
# DBT Skills Training as a Stand-Alone or Adjunctive Treatment: Efficacy and Clinical Applications

**Live Webinar | July 7, 2016**

Yevgeny Botanov, PhD

## Session Module Content

<table>
<thead>
<tr>
<th>Session</th>
<th>Module</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Psychoeducation and Core Mindfulness</td>
<td>Psychoeducation on depression, teaching core mindfulness concepts and practices, and encouraging participants to develop a daily mindfulness practice</td>
</tr>
<tr>
<td>2</td>
<td>Distress Tolerance</td>
<td>Targeting suicidal ideation; strong negative emotions; distressing memories; and stressful situations</td>
</tr>
<tr>
<td>3</td>
<td>Emotion Regulation</td>
<td>How to identify and label emotions, understand their functions, determine when to accept an emotion and when to attempt to change it, and strategies for changing emotions</td>
</tr>
<tr>
<td>5</td>
<td>Interpersonal Effectiveness</td>
<td>Interpersonal effectiveness skills aimed at helping participants make requests or say no to requests from others while maintaining or improving their relationships and self-respect.</td>
</tr>
</tbody>
</table>

### 14-week cycle X 2

---

**TABLE 1.** A Session-by-Session Treatment Outline for the DBT for Depression Skills Group

<table>
<thead>
<tr>
<th>Session</th>
<th>Mindfulness Exercise</th>
<th>Session Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1</td>
<td>Raisin</td>
<td>Intro to group, mindfulness, handouts (1 and 2)</td>
</tr>
<tr>
<td>M2</td>
<td>Body scan</td>
<td>Review handout (2), teach handout (3)</td>
</tr>
<tr>
<td>IE1</td>
<td>Mindfulness of breath</td>
<td>IE handouts (1–3)</td>
</tr>
<tr>
<td>IE2</td>
<td>3-min breathing space</td>
<td>DEARMAN handout (8)</td>
</tr>
<tr>
<td>IE3</td>
<td>Mindfulness of relationships</td>
<td>GIVE, FAST handouts (9 and 19)</td>
</tr>
<tr>
<td>IE4</td>
<td>Observing initial reactions to IE scenarios</td>
<td>Skills practice session using example IE scenarios and members’ real-life situations</td>
</tr>
<tr>
<td>ReO</td>
<td>Raisin</td>
<td>Intro to group, dialectics, and mindfulness</td>
</tr>
<tr>
<td>ER1</td>
<td>Mindfulness of sounds and thoughts</td>
<td>ER handouts (1 and 2)</td>
</tr>
<tr>
<td>ER2</td>
<td>Mindfulness of facial expression and emotion</td>
<td>ER handouts (5 and 6)</td>
</tr>
<tr>
<td>ER3</td>
<td>Mindfulness of positive experiences</td>
<td>ER handouts (7 and begin (9)</td>
</tr>
<tr>
<td>ER4</td>
<td>Mindfulness about letting go</td>
<td>Finish ER handout (9), teach handout (10)</td>
</tr>
<tr>
<td>ReO</td>
<td>Raisin</td>
<td>Intro to group, dialectics, and mindfulness</td>
</tr>
<tr>
<td>DT1</td>
<td>Guided imagery visualization</td>
<td>DT handout (1)</td>
</tr>
<tr>
<td>DT2</td>
<td>3-min breathing space for distress tolerance</td>
<td>DT handouts (2–4)</td>
</tr>
<tr>
<td>DT3</td>
<td>Tasting a lemon</td>
<td>DT handout (5)</td>
</tr>
<tr>
<td>DT4</td>
<td>Self-soothing show and tell</td>
<td>Finish handout (5) and discuss how to keep skills practice active postgroup</td>
</tr>
</tbody>
</table>

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Lynch et al., 2003

Harley et al., 2008

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**Bipolar Disorder**

- **Sample**
  - **Age:** $M = 42.3$, 75% female
  - **Range of hospitalizations:** 0-12
    - 75% of sample hospitalized 2.3 times
  - **Diagnoses:**
    - 58% Bipolar II
    - 50% comorbid
    - 75% moderate/severe depression
  - All taking psychotropic medication

<table>
<thead>
<tr>
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<th>Team</th>
<th>Out-of-Session Coaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van Dijk et al., 2003</td>
<td>No</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Table 1**

<table>
<thead>
<tr>
<th>Week</th>
<th>Skills taught</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>Psychoeducation about BD: facts about depression, mania/hypomania and psychosis, introduction to mindfulness</td>
</tr>
<tr>
<td>Two</td>
<td>Psychoeducation about BD: what is BD, causes of BD, DBT skill: states of mind</td>
</tr>
<tr>
<td>Three</td>
<td>Psychiatrist presentation on medications for BD</td>
</tr>
<tr>
<td>Four</td>
<td>DBT skill: reducing vulnerability to emotions: balancing eating, sleeping, exercise, eliminating drugs and alcohol, treating physical illness and taking medications, and building mastery</td>
</tr>
<tr>
<td>Five</td>
<td>DBT skill: nonjudgmental stance</td>
</tr>
<tr>
<td>Six</td>
<td>DBT skill: radical acceptance</td>
</tr>
<tr>
<td>Seven</td>
<td>DBT skills: distracting, self-soothing, pro's and con's, urge management</td>
</tr>
<tr>
<td>Eight</td>
<td>Facts about emotions</td>
</tr>
<tr>
<td>Nine</td>
<td>DBT skill: self-validation</td>
</tr>
<tr>
<td>Ten</td>
<td>Looking at relationships</td>
</tr>
<tr>
<td>Eleven</td>
<td>DBT skill: balancing enjoyable activities with responsibilities</td>
</tr>
<tr>
<td>Twelve</td>
<td>Presentation of resources to continue with treatment of BD, completion of post-assignments</td>
</tr>
</tbody>
</table>

Van Dijk et al., 2012
Mood Disorders

- DBT skills > WL in treatment-resistant depression
- DBT skills + Medication = Medication for older adults
  - Treatments were comparably effective in reducing depression at end of treatment (28 weeks)
  - Significant differences in favor of DBT skills training emerging at 6-month follow-up on clinician rated depression remission rates
- DBT skills vs. wait list controls - nonsignificant trends favoring DBT in reducing depression for bipolar I or II
  - Twelve of 13 study participants completed the full intervention and 86% of group sessions were attended
  - End of treatment results
    - Mild or minimal depression: DBT (92%) vs. WL (42%)
    - BDI-II reduction: DBT (16.7) vs. WL (10.3)
    - Increase in mindfulness and aspects of affect control greater for DBT

Mood Effects in Other Trials

- DBT skills training interventions on depression severity in samples selected for other primary problems
  - DBT superior to:
    - Active comparative treatment for BPD
    - Wait list controls for subthreshold bulimia
  - DBT equivalent to:
    - Active comparative treatment for high levels of emotion dysregulation
    - Active comparative treatment for binge eating disorder
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Yevgeny Botanov, PhD*

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**RCTs for ADHD**

<table>
<thead>
<tr>
<th>Population &amp; Problem</th>
<th>Treatments/N</th>
<th>Length</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults, ADHD</td>
<td>DBT (n = 26) &amp; Semi-Structured Discussion Group (n = 25)</td>
<td>12 weeks</td>
<td>Hirvikoski et al., 2011</td>
</tr>
<tr>
<td>College students, ADHD</td>
<td>DBT (n = 17) &amp; Self-study (n = 16)</td>
<td>8 weeks</td>
<td>Fleming et al., 2015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study</th>
<th>Adherence Ratings</th>
<th>Supervision</th>
<th>Team</th>
<th>Out-of-Session Coaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hirvikoski et al., 2011</td>
<td>No</td>
<td>Bimonthly</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Fleming et al., 2015</td>
<td>No</td>
<td>Weekly</td>
<td>✔️</td>
<td>Not reported</td>
</tr>
</tbody>
</table>

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The themes and contents of the sessions in the order employed in the current study:

1. Clarifications: After a general introduction, the participants were educated about the symptoms of ADHD. The overall goal of the group therapy was defined according to the manual/worksheet to control ADHD rather than to be controlled by ADHD. The participants got a list of literature and internet sites for self-studies.

2. Neurobiology and Mindfulness: The neurobiology of ADHD and the consequent cognitive dysfunctions were discussed. Subsequently, the participants were familiarized with mindfulness training (Cahn, 2012). The first of the three “how skills” (observing, describing, participating) were introduced together with the first of the three “what skills” (taking a nonjudgmental stance, focusing on one thing at a time; being effective) (Linehan, 1993b).

3. A session aims for mindfulness training was given. Following this session, mindfulness training was a central part of the sessions as well as homework.

4. Homework and Mindfulness: To generalize the learned skills into everyday life, the importance of homework was emphasized. Possible obstacles in completing homework were discussed, together with strategies that facilitate carrying out the assignments. A written rationale for the homework was also given to the participants. Mindfulness training was continued during the second part of the sessions.

5. Mindfulness & Mindfulness training continued, and the dialectic balance between acceptance and change was elaborated on.

6. Dysfunctional behavior/behavior analysis: In addition to mindfulness, “an acceptance tool” behavioral analysis, “an acceptance tool” was presented and practiced during all following sessions. Dysfunctional behavior was defined as the kind of behavior the participant wanted to change. The participants learned to describe problems as behaviors, in a nonjudgmental way, i.e., to perform an analysis of “S-R-C” (stimulus–response–component behavior) and consequences of behavior in a certain time as well as long-term. Alternative strategies as well as new to correct problems that have already come up were also discussed.

7. Emotion Regulation: A brief theory of emotions was presented (primary emotions, signal and communicative aspects of emotions, relationship between cognition and emotion, especially in adults with ADHD). The exercises in both mindfulness and behavioral analysis were limited to emotional regulation.

8. Depression reduction in ADHD: A questionnaire from the Neuropsychiatric Unit was administered in the participants about the pharmacological treatment of ADHD. Symptoms of depression and psychological treatment of depression were also described. The participants had the opportunity to discuss their expectations or experiences of medical treatment. The homework (both mindfulness exercises and behavioral analysis) was related to emotional regulation.

9. Impulse Control: Different aspects of impulsivity were discussed. The participants learned how to use mindfulness and behavioral analysis as strategies for improved impulse control. Positive aspects of impulsivity (e.g., spontaneity, creativity) were discussed.

10. Stress Management: A theoretical model for stressors and stress reactions was presented (Hersen et al., 2006; Kazret & Thoren, 1990). The relationship between stress and performance was explained, and strategies for stress management were trained.

11. Change and Control: Difficulties with organization and planning are closely related to stress in adults with ADHD. During this session, disorganization behavior was discussed and organizational strategies presented and trained as homework.

12. Dependency: Information on symptoms of substance abuse as well as on dependency clinics was presented. Other risk behaviors and corresponding activities, such as internet abuse, were discussed.

13. ADHD and Relationship/Interpersonal issues: The impact of ADHD on self-esteem and relationships was elaborated. The participants and their significant others were offered an individual session with one of the group leaders. The significant others received information on ADHD and the content and objectives of the current group therapy.

14. Retrospect and Outlook: The attained individual goals were discussed, as well as strategies for achieving the remaining ones. Possibility of attending an existing self-help group or of transforming the current group into a self-help group were discussed.

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Linehan Institute | Behavioral Tech, LLC | 1107 NE 45th Street, Suite 230, Seattle, WA 98105 | Ph. (206) 675-8588 | Fax 1+(206) 675-8590 | www.behavioraltc.org
ADHD Findings

- Adults
  - Completers of treatment that maintained a stable medication regimen showed significant reductions in ADHD symptoms for the DBT group but not control

- College Sample
  - Inattentive symptoms were significantly improved in the DBT group by the end of follow-up.
  - Mindfulness and quality of life improvements were evident at end of treatment but only improvement in mindfulness persisted through the follow-up period

Fleming et al., 2015
Varying Populations

<table>
<thead>
<tr>
<th>Population &amp; Problem Behaviors Investigated</th>
<th>Treatments/N</th>
<th>Length</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>High emotion dysregulation with anxiety and depressive disorder</td>
<td>DBT (n = 24) &amp; Activity-based support grp (n = 24)</td>
<td>12 weeks</td>
<td>Neacsiu et al., 2014</td>
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<tr>
<td>College students, severe psychopathology</td>
<td>DBT (n = 27) &amp; Positive Psychotherapy (n = 27)</td>
<td>12 weeks</td>
<td>Uliaszek et al., 2016</td>
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</table>

<table>
<thead>
<tr>
<th>Study</th>
<th>Adherence Ratings</th>
<th>Supervision</th>
<th>Team</th>
<th>Out-of-Session Coaching</th>
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<tbody>
<tr>
<td>Neacsiu et al., 2014</td>
<td>✓</td>
<td>Weekly</td>
<td>✓</td>
<td>Not reported</td>
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<tr>
<td>Uliaszek et al., 2016</td>
<td>No</td>
<td>Weekly</td>
<td>Not reported</td>
<td>Not reported</td>
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Session Module

<table>
<thead>
<tr>
<th>Session</th>
<th>Module</th>
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<tbody>
<tr>
<td>1</td>
<td>Mindfulness</td>
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<td>2</td>
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<td>3</td>
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<td>4</td>
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<tr>
<td>5</td>
<td>Emotion Regulation</td>
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<td>8</td>
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<tr>
<td>9</td>
<td>Mindfulness</td>
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<td>10</td>
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<td>11</td>
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<td>12</td>
<td>Distress Tolerance</td>
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<td>13</td>
<td></td>
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<tr>
<td>14</td>
<td>Interpersonal Effectiveness</td>
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<td>15</td>
<td></td>
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<tr>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>

Neacsiu et al., 2014
Session | Module
--- | ---
1 | Orientation to DBT and Mindfulness
2 | Distress Tolerance
3 | Mindfulness
4 | Emotion Regulation
5 | Mindfulness
6 | Interpersonal Effectiveness

Ulíaszek et al., 2016

Findings

• Activity-based support group (ASG)
  – DBT skills > ASG in reducing emotion dysregulation and anxiety, increasing skills use
  – DBT skills = ASG in treatment acceptability and reducing depression

• Positive Psychotherapy (PPT)
  – DBT skills = PPT in improvement of primary clinical outcomes
  – DBT skills group demonstrated nearly all medium to large effect sizes while the PPT showed mostly small to medium effect sizes.
  – DBT skills < PPT attrition rates
  – DBT skills > PPT attendance and overall therapeutic alliance
Corrections/Forensics

- One RCT\(^1\)
  - Incarcerated females with history of childhood abuse with significant trauma and depression
  - No treatment control group
  - Emotion Regulation and Distress Tolerance
    - 9 sessions of 18-session treatment
- Three uncontrolled studies
  - Forensic individuals with intellectual disability\(^2\)
    - 13 weeks
  - Incarcerated male adolescents\(^3\)
    - Twice weekly for 16 weeks
  - Inmates deemed by officers difficult to manage\(^4\)
    - Twice weekly for 16 weeks

Corrections/Forensics Findings

- DBT > No treatment in reducing depression, interpersonal problems, and trauma symptoms
- DBT reduces
  - Disciplinary violations
  - Impulsive behavior
  - Distancing as a coping mechanism
- DBT improves
  - Psychiatric ratings
  - Aggression
  - Anger
  - Global functioning
Anxiety

• No studies evaluating DBT skills training interventions for primarily anxiety disorder

• DBT skills training more effective than active treatment controls in reducing anxiety severity among:
  – Individuals with BPD\textsuperscript{1}
  – High levels of emotion dysregulation\textsuperscript{2}
  – DBT interventions that included a skills training component more effective than those without skills training in improving anxiety among suicidal and self-injuring individuals with BPD\textsuperscript{3}

Uncontrolled Trials

• DBT skills for adolescents with ODD\textsuperscript{1}
  – 16 weeks
  – Parent report
    • Decrease in negative behaviors and increase in positive behaviors
  – Self-report
    • Decrease in depression and externalizing and internalizing behaviors

• Caregivers of adults with dementia\textsuperscript{2}
  – 8 weeks
  – Significant improvements:
    • Problem-focused coping, emotional well-being, and energy level
BPD

• BPD with a moderate to severe level of illness
• Not recruited for elevated suicidality
• Results
  – Superiority of DBT skills training in reducing:
    • Treatment dropout, depression, anxiety, general psychiatric symptoms, anger, feelings of emptiness, and emotional instability
    • No difference on global BPD severity, suicide attempts, NSSI, or emergency room visits

<table>
<thead>
<tr>
<th>Population &amp; Problem Behaviors Investigated</th>
<th>Treatments/N</th>
<th>Length</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPD</td>
<td>DBT (n = 29) &amp; Standard Group Therapy (n = 30)</td>
<td>13 weeks</td>
<td>Soler et al., 2009</td>
</tr>
</tbody>
</table>

DBT Skills Training for Individuals that are Suicidal?
DBT Component Analysis
(Linehan et al., 2015)

DBT Interventions with Skills Training

Standard DBT (DBT individual + DBT skills group)

DBT Skills Group + Intensive case management

DBT without Skills Training

DBT Individual (no skills) + Activities group

§ DBT interventions with skills training were superior to DBT without skills training in improving:
  – Frequency of non-suicidal self-injury
  – Depression
  – Anxiety

§ No significant differences between Standard DBT and DBT Skills Group + Intensive case management.

(Linehan et al., 2015)
A Common Misunderstanding

• Many have (mis)interpreted this study to mean DBT Skills Only is as effective as Standard DBT

  **BUT**

• DBT skills condition was not “skills only”
  – Included manualized case management + LRAMP

• The study was not powered to test equivalence

• Clinically significant findings favored Standard DBT over DBT Skills condition in follow-up year
  – Standard DBT clients were 2.0-2.4x less likely to attempt suicide, be psychiatrically hospitalized, or go to an ED

  *(Linehan et al., 2015)*

---

Is DBT *skills training* a key component in DBT treatment?

**Yes.**
Summary of DBT Skills RCTs

- DBT skills training interventions improve:
  - Emotion dysregulation
  - Binge eating and binge/purge episodes
  - Eating and weight-related concerns
  - Depression
  - Anxiety
  - ADHD behaviors
  - General distress

- DBT skills interventions are more effective than waitlists, standard group therapy, support groups, self-guided treatment, and medication-only

Is DBT skills training as effective as standard DBT?

We don’t know.
(No study has directly compared standard DBT to DBT Skills alone)
WHY DO SKILLS WORK?

DBT Skills Use as a Mediator

• Use of DBT skills fully or partially explains improvements in:
  – Suicide attempts
  – Non-suicidal self-injury
  – Depression
  – Anxiety
  – Anger control
  – Emotion regulation
  – Interpersonal problems

(Neacsiu et al., 2010; Neacsiu et al., 2014)
Is *skills* use a mechanism of change in DBT?

Yes!

Choosing a Skills Curriculum
Six Month Treatment Cycle

- Interpersonal Effectiveness (6 weeks)
- Mindfulness (2 weeks)
- Mindfulness (2 weeks)
- Distress Tolerance (6 weeks)
- Emotion Regulation (6 weeks)
- Mindfulness (2 weeks)

Standard DBT Skills Training Class Format
(Length: 2.5 hours)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting started</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Homework Review</td>
<td>60 minutes</td>
</tr>
<tr>
<td>Break</td>
<td>10-15 minutes</td>
</tr>
<tr>
<td>Didactic/New Teaching</td>
<td>60 minutes</td>
</tr>
<tr>
<td>Wind-Down</td>
<td>10-15 minutes</td>
</tr>
</tbody>
</table>
Skills Training Curricula

- Schedule 1: Linehan Standard Adult DBT Skills Training Schedule
  - 24 weeks
  - Research studies 2006 and after

- Schedule 2: Linehan Standard Adult DBT Skills Training Schedule
  - 24 weeks
  - Research studies prior to 2006

- Schedule 6: Adolescent Multifamily DBT Skills Training
  - 25 weeks

- Schedule 7: Inpatient DBT Skills Training (Intermediate Unit and Acute Unit)

Schedules outlined on pp. 110-122 (Linehan, 2015)

Which Skills Training Curriculum Should I Use?

- Use research-based schedules when possible at a pace that matches clients’ level of understanding
  - Decide how many total weeks your skills training program will last, and how long each group will be
  - Decide which skills you definitely want to teach, and which will be optional
  - Decide which handouts & worksheets you want to use
Questions

Thank you for attending!
www.behavioraltech.org