Dialectical Behavior Therapy Adherence Ratings for Dr. Alan Fruzzetti

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The role-play was done with a ‘patient’ who was a 32 year-old single Caucasian female. She came to session following the fight with her boyfriend, reporting self-harm behaviors and expressing suicidal ideation including a specific plan that she was reluctant to share with her therapist. The ‘patient’ was played by a Yale graduate student.

Adherence and competence profile from DBT perspective

The ratings for this study were made using the DBT adherence rating scale (Linehan & Korslund, 2003), which is regarded as the gold standard of DBT treatment integrity coding (Lynch, Trost, Salsma, & Linehan, 2007). The scale is used to code individual and group skills training sessions. This scale consists of 66 items reflecting 12 major DBT strategies domains. Each item on the scale is operationalized in the accompanying DBT adherence strategy manual. The manual provides behaviorally defined anchor points to guide coders in demining whether (a) a certain strategy is present; (b) if not present, whether this strategy was required given the context; and (c) whether the strategy was done sufficiently, including frequency, duration and execution. The first two objectives aim to evaluate the degree to which therapist utilized prescribed procedures and avoided prohibited tasks and, thus, assess therapist adherence. Although it is not iterated in the manual, the third aim actually evaluates therapist competence, as it assesses the level of skill and judgment shown by a therapist in delivering a treatment strategy. Thus, this measure assesses adherence and competence of treatment delivery and derived scores represent a combined adherence and competence level.

Scores range from 0 to 5 and represent “averages” for strategies across an entire session. If a strategy is not used and is not required, the item is scored as “0.” If a strategy is required but not used, the item is scored as ≤ 3, and the degree of downgrade depends on how
essential this strategy was given the context. The score is computed by summing all non-zero items. A score of 4.0 indicates adherent and competent delivery, with higher scores representing better performance. The inter-rater reliability of mean scores for items range from 0.78 to 0.83 (Lynch et al., 2007).

The present rater (FP) has been trained by Kathryn Korslund at the University of Washington as DBT adherence rater and was established as calibrated to Dr. Linehan’s research team. This rater adapted the DBT adherence manual and rating scale to the downward extension of DBT to pediatric population and is currently the lead coder on two randomized trials on DBT for children.

**DBT adherence and competence profile of Alan Fruzzetti**

The duration of the clinical vignette featuring Alan Fruzzetti was 28 min., which is approximately half of the usual session. However, the role-play was structured as a demonstration of the entire DCB session from the arrival of the patient to the session completion, and, thus, was rated as a typical session. It has to be noted, though, that time limitation could have influenced the number of utilized strategies. Overall score: 4.59 (high adherence and competence demonstrated).

1. **Structural strategies.** Patient entered the session being obviously emotionally deregulated and therapist appropriately checked on her initial mood as it could have interfered with therapy. Therapist assessed the problem, generated and implemented solutions that resulted in reduction in emotional arousal. Therapist helped patient to slow down, step back and attend to the thoughts processes associated with patient’s emotional reactions, challenged them and helped patient change the dysfunctional cognitions. He also helped patient expose herself to the emotional experiencing. During the diary card review, therapist scanner the diary card and started to review it with patient by highlighting out-loud the high intensity urges. However, therapist had to continue to attend to patient’s deteriorating emotional state, which clearly interfered with his ability to be review the diary card
thoroughly, set a session agenda and discuss progress. Therapist organized session according to the DBT primary targets, focusing on treating parasuicidal behaviors and suicidality, in session therapy-interfering behaviors, and skill use (e.g., helped patient increase mindfulness of self-judgment). Further, therapist weaved in the work on one secondary target - emotional vulnerability verses self-invalidation (e.g., highlighted extreme emotional reactions and attempted to elicit self-validation). Therapist checked on other modes of DBT therapy (i.e., inquired into patient's participation in skills group in the way that conveyed importance of this modality, discussed which skills patient learned during the last group and asked for an example of a learned skill used during the past week). Therapist formulated problems in terms of emotions, including intensity of emotional reactions that interfere with ability to adaptively cope with problematic situation, as well as inhibited emotional experiencing. Therapist used several session ending strategies. He reviewed agreed upon tasks for homework, gave a notice that session is about to end, helped patient rate current urges and feelings, and gave patient a sense of continued presence (“If you get stuck with any of this, call me, send me an email, and I will remind you”). Therapist implemented all required strategies for this domain. Rating: 4.67

2. Problem assessment strategies. Therapist consistently evaluated the essence of the presented problems and helped patient formulate problems in terms of behaviors to decrease (e.g., self-judgments). Therapist modeled and elicited from patient specific and accurate descriptions of emotions, thoughts and behaviors. Therapists appropriately selected self-harm behavior (i.e., cutting) to target for assessment via a chain analysis, as in DBT suicidal and parasuicidal behaviors as considered primary targets. During the chain analysis, therapist helped patient specify vulnerability factors (e.g., hunger due to the restriction of food intake, lack of sleep), identify prompting event, and consequences of maladaptive behavior. He attended to small units or links of the chain (i.e., thoughts, feelings and behaviors), and help patient describe events specifically, including figuring out the exact time the event occurred,
describing contextual factors, giving severity ratings to emotional reactions, and specifying
the sequence of events. However, therapist did not assess what got in the way of doing an
effective behavior in the situation. Throughout session therapist asked relevant questions,
continued to assess risk for suicide and parasuicide, willingness and commitment to decrease
dysfunctional behaviors. Therapist implemented all required strategies in this domain. Rating:
4.60.

3. **Problem solving.** Therapist actively helped generated sound and acceptable solutions
to problems in session and outside of session (e.g., self-validation, monitoring and
challenging judgmental thoughts, exposure to emotional experiencing). Although, for the
most part, therapist was offering solutions to patient, he also pushed patient to generate
solutions on her own. Therapist also oriented patient to the use of audio recording in order to
provide her with another opportunity to listen to the session when she is in a more neutral
state. Therapist generalized new learning by assigning the generated solutions to be used
outside of the session (i.e., noticing her judgmental thoughts) and giving the patient the audio
recording of the session. Therapist elicited commitment to no-suicide and to completion of
behavioral rehearsal assignment between sessions. However, therapist did not troubleshoot
difficulties, which is required after the commitments is elicited. Therapist activated new
behaviors from patient during session, including maintaining eye contact when feeling
ashamed instead of withdrawing, pushing patient to generate solutions, throwing a ball in
patient’s course and waiting for a response, and eliciting self-statements. Rating: 4.00.

4. **Contingency management.** Therapist reinforced patient’s adaptive behaviors
throughout session via verbal statements of approval, increased warmth, and indication of
support and interest. He provided reinforcements were specific (“e.g., this is great, it shows
that you really got the skill”), immediate and enthusiastic in the tone of voice. Other
strategies within this domain, such as ignoring or aversive consequences were not utilized.
Therapist implemented all required strategies for this domain. Rating: 5.00
5. *Exposure-based procedures.* Therapist blocked action tendencies associated with emotional experiences, such as directly instructing the patient to look at him when patient felt ashamed. Rating: 4.00

6. *Cognitive strategies.* Therapist helps patient clarify contingencies in terms of the effects her behavior has on her current relationship with therapist and current outcomes for her daily life. Further, therapist helped patient catch, challenge and change maladaptive cognitions (e.g., this therapist is going to fire me just like all my previous therapists), impositions on reality (e.g., “shoulds”) and judgments. Therapist implemented all required strategies for this domain. Rating: 4.67.

7. *Validation strategies.* Therapist provided multiple levels of validation. Therapist appeared interested in client’s agenda and gave this patient time to express herself. He accurately paraphrased, summarized and reflected the essence of what patient’s verbal and nonverbal behaviors. Therapist ‘mindread’ unstated emotions (e.g., when you are looking at me you are feeling really ashamed right now”). On multiple occasions, therapist communicated the “kernel of truth” in what patient was feeling, thinking and doing, and normalized patient’s responses. For example, “Do I blame you for having this horrible set of experiences that made you worried like this? No! It completely makes sense to me why you would be so scared of this.” Therapist was spontaneous, natural and genuine and interacted with patient in an ordinary manner. Therapist implemented all required strategies for this domain. Rating: 4.60

8. *Reciprocal communication strategies.* Therapist was responsive to patient, was open to her perspective, appeared vulnerable to her influence and took her agenda seriously. He also remembered important information (e.g., prior discussions they had on her relationships with other therapists). He attended to and commented on small changes of patients behavior. Therapist expressed warmth toward the patient through the caring tone of voice, appropriate eye contact, statements that he likes the patient, using ‘‘we” statements, and offering help and
contact via email if patient needs assistance with her behavioral rehearsal assignment. Therapist use non-judgmental attitude towards the client and counteracted patient’s judgmental expressions. Therapist used self-involving self-disclosures, by sharing his reactions to patient’s behavior (e.g., Is there any chance that at level 6 urges you are going to bolt out of the session and go kill yourself? Because if this is the situation, then I will really get very anxious and will go sit in front of the door”) and personal self-disclosures (e.g., “This is what I say to my wife, she does not take it the same way”). Therapist maintained reasonable and appropriate power equilibrium by staying within his role as an individual therapist. Therapist implemented all required strategies for this domain. Rating: 4.67.

9. Irreverent strategies. Therapist used matter-of-fact, straightforward and direct manner in discussing patient’s dysfunctional behaviors. Therapist weaves a web of logic, directly confronted maladaptive behaviors and communicated “bullshit” to dysfunctional in-session responses. For example, therapist stopped short patient’s emotional outpour and had her observe a replay of the exchange that just occurred between therapist and patient and was misperceived by patient as therapist wanting to quit therapy with her. Therapist used humor, facial expressions, and dramatic pauses to help push patient off balance, so re-balancing could occur. For example, when patient continued to look away despite the direct instruction from the therapist to look at him during the emotional exposure, therapist humorously commented “What, am I growing tumors here, what’s the story?” after which patient smiled and established eye contact. Therapist also used dramatic moves. For example, during the intense emotional display by patient, therapist got up and removed his jacket, saying “I got to say, this is hard, you’re making me hot,” which interrupted the emotional outburst and helped patient move on. Rating: 5.00

10. Dialectical strategies. Therapist balanced acceptance and change strategies (i.e., being accepting and irreverent; nurturing patient and demanding change), alternated between strategies, assumed positions wholeheartedly and maintained a rapid speed and flow that
helped keep patient slightly off balance throughout the entire session. Therapist used metaphors and similes during session (e.g., compared patient’s extreme emotional reaction as a “black hole,” compared practicing skills during neutral mood to practicing bicycle riding first on flat ground; indicated that her idea of ‘protecting’ herself via these means is like driving on the wrong side of the street)). Therapist modeled dialectical thinking by constantly searching for what was left out of the picture patient was describing. Further, he acknowledging both sides of an issue (e.g., “So on one hand you want to sink into this luxurious lap of closeness <in boyfriend’s arms> and you have cold black hole to sink in instead, this is a pretty big contrast”) and helped patient come up with a synthesis of the opposing poles (e.g., “the rocket ship out of the black hole” might have been the use of self-validation). Therapist implemented all required strategies for this domain. Rating: 5.00.

11. Case management strategies. No procedures in this domain were used. Rating: 0

12. Protocols. Therapist employed suicidal/parasuicidal behavior protocol and therapy interfering behavior protocol. Further, therapist utilized phone call protocol (e.g., indicated accepting contact between sessions via phone call or email). Rating: 4.33.

Summary of DBT adherence and competence profiles of Dr Fruzetti

Dr. Fruzetti demonstrated DBT adherence and competence at significantly above the minimum level for nine out of eleven utilized categories (Mrating = 4.73). The two categories with ratings just at adherence and competence level (=4.0) were problem solving and exposure-based procedures. In the problem solving domain, the score was downgraded due to the absence of one required strategy (troubleshooting). In the exposure domain, utilized strategies were just sufficient to indicate adherence level. Although therapist repeated the exposure frequently, he focused primarily on blocking the escape action tendency associated with a painful emotion, but did not check on whether the emotional response decreased nor helped enhance patient’s sense of control (e.g., by collaborating on designing and implementing exposure procedures).
During the clinical vignette, Dr. Fruzzetti implemented 42 out of 66 strategies (63.6%) and missed one required strategy. Dialectically, of note was his interaction style, with this DBT therapist exhibiting more dramatic moves, exaggerated pauses, rapid switches between strategies, fast speed and flow, use of humor, and direct confrontations. He also showed good attention to reported suicidality and self-harm behaviors. This DBT therapist organized the session according to the target hierarchy, where suicidality and self-harm are seen as the highest priority to address during session.

References