DBT in Schools

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- Dr. Chugani has received funding from the Citrone 33 Foundation, University of Pittsburgh CTSI, and Hillman Foundation for her work related to DBT in Schools
- Dr. Chugani receives consulting fees from the Citrone 33 Foundation and also offers private consulting services related to DBT in Schools
- Dr. Chugani will be joining Mantra Health as Vice President of Clinical Content and Affairs, beginning in June 2022

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Who Am I?

Quick Refresher: What is DBT?

- Evidence-based treatment for BPD, chronic suicidality, and self-injurious behavior
- Four primary components
- Specialized, time-intensive treatment – most appropriate when less intensive treatments are not appropriate or have already failed

Why Offer DBT in Schools?

- Suicide is the second leading cause of death for youth aged 10-24
- Pediatric specialists and/or evidence-based treatments may not be available in the local area
- COVID-19 has made things worse
  - Depression (25%) and anxiety (20%)
  - Increased pediatric ED visits for mental health

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Who do you want to treat?

ALWAYS ASK THIS QUESTION FIRST!

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DBT STEPS-A

- Universal socio-emotional skills training developed for middle and high schools
- Manualized and developed to be taught by general education teachers (e.g., in health class)
- Developers also offer training in DBT-Informed school counseling strategies
- Elementary school book is coming soon!

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DBT STEPS-A Outcomes

- Only uncontrolled studies thus far
- A study in Ireland found preliminary effectiveness for emotional symptoms and internalizing problems[1]
- Another study found improvements in social resilience and emotion regulation in racially diverse, rural 9th grade students[2]
- Implementation research shows that the program can be difficult to implement in low-resource schools[3]

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Comprehensive DBT (C-DBT)

- All four modes of DBT are offered
- Reserved for suicidal/complex students
- Common adaptations
- Other considerations

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C-DBT: Other Considerations

- Should parents be involved?
- Grades as a treatment target
- Length of skills training groups
- Benefit of shorter-term DBT for the individual

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C-DBT: Outcomes

- Pistorello et. al, 2012: RCT vs. optimized TAU in students with suicidality, 3+ BPD traits, and hx of NSSI and/or suicide attempt.
- DBT therapists were doctoral psychology interns who received 30 hours of DBT training and weekly supervision by experts
- Significantly reduced depression, number of self-injury event, suicidality, and BPD traits

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DBT Lite

- Adapted programs with a bigger focus on fitting the center scope of services or serving a specific population
- Meet some but not all the functions of standard DBT
- Can treat suicidal/complex students, but may serve broader populations whose needs are aligned with what the DBT program can offer

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DBT Lite: Example 1

- Target Population: Students with BPD or BPD traits, suicidality, and/or NSSI
- DBT Modes Offered: 12-week skills training groups, DBT or DBT informed individual therapy, weekly team consultation, and phone coaching during business hours of the center
- Reference: Chugani (2017)

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DBT Lite: Example 2

- Target Population: Students who needed coping skills (behavioral skills deficits)
- DBT Modes Offered: Bi-weekly DBT or DBT-informed individual therapy, 6-13 week skills training groups, biweekly team consultation, and telephone coaching
- Reference: Panepinto, Uschold, Olandese & Linn (2015)

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DBT Lite: Outcomes

- Panepinto and colleagues published a study (n=64)
- Significant reductions in confusion about self, impulsivity, emotion dysregulation, interpersonal chaos, depression, anxiety, and overall distress
- Limitation – No control group, variability in dose

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Adjunctive DBT Skills Groups

- DBT skills training is the primary component of DBT offered
- Students may have individual therapists, psychiatrists, case management, etc.
- Suicide risk is not managed by the DBT team
- Probably the most common approach in university counseling centers currently

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Adjunctive Group: Example 1

- Target Population: Students diagnosed with BPD
- DBT Modes Offered: 8-weeks of DBT skills training group
- Other Elements: Participants required to have weekly counseling and to collaboratively develop a list of after-hours contacts
- Reference: Meaney-Taveres & Hasking (2013)

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Example 1 Outcomes

- n=17 (no control group)
- Significant reductions in depression symptoms and BPD features. Significant increases in coping skills.
- Limitations: No control group, hard to attribute results only to DBT because all participants also had weekly individual counseling

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Adjunctive Group: Example 2

- Target Population: Students identified as having severe psychopathology who could benefit from a group targeting emotion dysregulation
- DBT Modes Offered: 12-weeks of skills training
- Other Elements: Students allow to receive concurrent individual therapy, but not required
- Reference: Uliaszek, Rashid, Williams, & Gulamani (2016)

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Example 2 Outcomes

- Pilot randomized controlled trial (n=54)
- Students randomized to receive either DBT or positive psychology group for 1 term
- Both groups significantly improved on symptoms of depression, anxiety, BPD, and adaptive coping skills - but DBT had bigger effect sizes
- DBT participants had significantly better life satisfaction and therapeutic alliance, DBT group had significantly better attendance and less drop out
- Limitations: Study is underpowered, hard to control for effect of other treatments students received

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DBT Skills Only

- Stand-alone DBT skills training
- Can only include students who are clinically stable and do not require individual care
- Variety of skills modules vs. single module
- Psychoeducation vs. treatment

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Other Models to Note

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Student Specific Programs in Community

- University – Hospital partnerships to develop programs just for college students (Co-STAR)
- Benefit of providing a special service for students while staying within limits of what the University can provide
- Telehealth may extend the availability of these programs to students in more rural areas

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DBT Skills as Prevention

- Why wait for emotional distress to teach healthy coping and and self-regulation skills to young people?

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What questions do you have about the models we discussed?

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Program Development and Implementation

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Developing Your Program

- Focus on target population
- Focus on scope of services and available resources (be realistic!)
- Consider training first
- Consider the benefits of including trainees

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Adapting DBT for Schools

- Dialectic: Fidelity vs. Flexibility
- Key Points:
  - Be strategic!
  - Be specific!
    - Develop a protocol or program manual

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Implementation Considerations

- Observing Limits
- Feasibility and Sustainability
- Consider starting small and growing over time
- Dialectic: Observing Limits vs. Pushing Limits

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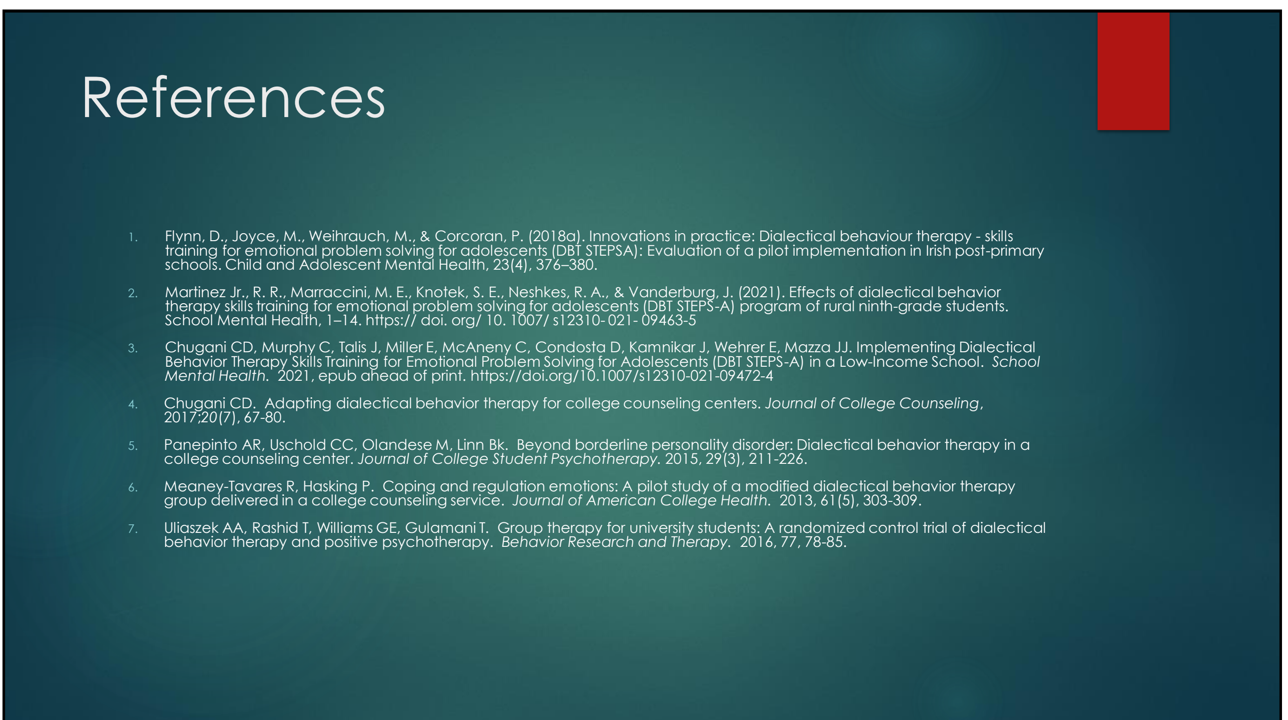

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