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Mechanisms of change in group therapy for treatment-seeking university students

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ABSTRACT

The present study examined mechanisms of change in dialectical behavior therapy (DBT) skills group and positive psychotherapy (PPT) group intervention, two treatments that have previously been shown to be effective at reducing symptoms of BPD and depression over a 12-week treatment protocol within the context of a college counseling center (Uliaszek et al., 2016). The present study is secondary data analysis of that trial. We hypothesized that change in dysfunctional coping skills use would be a specific mechanism for DBT, while change in functional coping skills use and therapeutic alliance would be mechanisms of change for both treatments. Fifty-four participants completed self-report and interview-based assessments at pretreatment, weeks 3, 6, 9, and posttreatment. Path models examined the predictive power of the mechanisms in predicting outcome; the moderating effect of group membership was also explored. Dysfunctional coping skills use across the course of treatment was a significant mechanism of change for BPD and depression for the DBT group, but not the PPT group. Conversely, therapeutic alliance was a significant mechanism of change for the PPT group, but not the DBT group. Findings highlight the importance of each mechanism during mid-to late-treatment specifically.

Dialectical behavior therapy (DBT) is an empirically-supported treatment for suicide, non-suicidal self-injury, and symptoms of borderline personality disorder (BPD; e.g., Koons et al., 2001; Linehan et al., 2006). Derived from cognitive-behavioral therapy, it includes a dialectical philosophy, radical behaviorism, and mindfulness (Linehan, 1993). While this literature continues to grow exponentially with adapted versions of DBT targeting specific ages (e.g., Miller, Rathus, & Linehan, 2006), psychiatric populations (e.g., Harned, Korslund, & Linehan, 2014; Lynch, Morse, Mendelson, & Robins, 2003), and settings (e.g., Pistorello, Fruzzetti, MacLane, Gallop, & Iverson, 2012), there is a paucity of evidence regarding mechanisms underlying the treatment.

The present study involves secondary data analysis from a randomized control trial (Uliaszek, Rashid, Williams, & Gulamani, 2016) that demonstrated that both DBT and a comparison group treatment (positive psychotherapy group treatment; PPT) resulted in large effect size changes in self-report and diagnostic-interview assessed BPD and depressive symptoms. However, it is unclear whether the mechanism of change differed across treatments. Elucidating treatment mechanism is important because it provides 1) information for improving treatment efficacy, 2) insight into necessary and sufficient conditions for change within a set of symptoms, and 3) proof of theory for a specific intervention.

1. Mechanisms of change in psychotherapeutic outcomes

Mechanisms of change are the processes through which change occurs. The study of mechanisms in psychotherapy aids in optimizing treatments by allowing for increased focus on the areas known to contribute most to the change process. This is also particularly relevant to dissemination of evidence-based treatments into real-world settings where complex treatments such as DBT may need to be adapted. Kazdin (2007) explains that in order to translate research into practice one must know, “what is needed to make treatment work, what are the optimal conditions, and what components must not be diluted to achieve change” (p. 4). Mechanisms of change also allow for better understanding of the factors that are most associated with change in a particular clinical population.

A recent review of mechanisms in evidence-based treatments for BPD located 12 papers related to DBT and two related to CBT (Rudge, Feigenbaum, & Fonagy, 2017). These authors found three broad themes of mechanisms of change in the DBT literature: 1) emotion regulation and self-control, 2) skills use, and 3) therapeutic alliance and

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investment in treatment. These mechanisms are not altogether surprising, given their association with Linehan's (1993) treatment model and conceptualization of BPD as a disorder of pervasive dysregulation. Alliance and investment in treatment as mechanisms is consistent with common challenges in treating individuals with BPD, given that treatment dropout rates have been reported as high as 52% (Priebe et al., 2012).

A component analysis of DBT for women with BPD provides further support for skills use as a mechanism. This study compared DBT skills training with crisis management, DBT individual therapy with a non-skills based activities group (to control for treatment dose), and standard DBT treatment (includes individual therapy, group skills training, telephone coaching, and therapist consultation meeting). Linehan et al. (2015) found that while all treatment conditions produced significant improvement in suicidality, self-harm, and use of crisis services, those including skills training resulted in significantly greater improvement in frequency of self-harming behavior and depression. Interestingly, they found that improvements were comparable between the skills training group and the standard DBT treatment package, indicating that skills training is a potent component of the treatment.

2. DBT skills group

Emotion regulation/self-control and skills use have both been cited as mechanisms in BPD treatment outcome and are primary components to the DBT skills group module of DBT. As mentioned above, there is mounting evidence that DBT skills group is a necessary and sufficient component to treatment outcome in DBT. Several studies have examined DBT skills group as a stand-alone treatment targeting symptom reduction for a range of disorders (Valentine, Bankoff, Poulin, Reidler, & Pantalone, 2015). A review of this literature indicates that DBT skills group alone is efficacious at reducing symptoms of depression and anxiety. Several additional studies have examined DBT skills group as an add-on to various individual treatments with positive results (e.g., Fleming, McMahon, Moran, Peterson, & Dreessen, 2015; Klein, Skinner, & Hawley, 2013; Uliaszek et al., 2016). It is important to note that the populations assessed include substantial variation, including BPD (Barnicot, Gonzalez, McCabe, & Priebe, 2016), eating disorders (Klein et al., 2013), and depression (Webb, Beard, Kertz, Hsu, & Björgvinsson, 2016) in both adults and adolescents. Thus understanding the specific mechanisms associated with DBT skills group may be particularly relevant for the future dissemination of this treatment.

The specific skills that are taught in DBT skills group are typically grouped according to module – distress tolerance, emotion regulation, interpersonal effectiveness, and mindfulness. Altogether, DBT skills group instructs participants in dozens of skills, while at the same time encouraging the cessation and replacement of dysfunctional coping skills. These two sets of behaviors – functional coping skills and dysfunctional coping skills-are often measured in DBT studies with the DBT Ways of Coping Checklist (WOCCL; Neacsiu, Rizvi, Vitaliano, Lynch, & Linehan, 2010). In this regard, functional coping skills represent those skills taught in DBT skills group, as well as other evidence-based group therapies. These skills, as assessed by the WOCCL, are characterized by adaptive ways to deal with problems or difficult emotions emphasizing both cognitive and behavioral tools. Skills include focusing on positive aspects of a situation, seeking social support, acting assertively, self-soothing, and active problem-solving. The dysfunctional coping skills instead refer to ways a person may address a perceived problematic situation, person, or emotion that can actually worsen problems over time. This includes blaming, avoidance, criticism, and self-medicating. While these behaviors are often seen in those with BPD, they are not specific to a BPD diagnosis and are considered transdiagnostic dysfunctional coping skills.

3. Current study

The present study examines potential mechanisms of action in a randomized control trial comparing DBT skills group to a PPT group intervention for treatment-seeking university students. PPT is a strengths-based treatment approach, where, instead of targeting symptoms explicitly, strengths-based skills are used to encounter symptomology. Previously published results have demonstrated that both interventions resulted in significant reductions in BPD and depressive symptomatology (for details, see Uliaszek et al., 2016). The current study examines change in both functional and dysfunctional coping skills use (reflective of DBT skills), as well as therapeutic alliance, as mechanisms of action in BPD and depressive outcome. Because of the unique study design, we are able to examine the effects of the potential mechanism across the beginning, middle, and end of the treatment protocol.

The hypotheses are as follows:

1. Increases in functional coping skills use throughout treatment will predict a reduction in BPD and depression symptoms for both groups, as the primary goal of both modalities is to improve skills and strengths among participants.
2. A reduction in dysfunctional coping skills use early in treatment will predict a reduction in BPD symptoms, specifically for the DBT group. This is specific to the DBT group because the PPT group does not explicitly target dysfunctional coping skills use.
3. Improved therapeutic alliance will be a mechanism for improved outcome throughout treatment for both groups.

4. Method

A detailed description of the method of this study can be found in Uliaszek et al. (2016).

4.1. Participants

Participants were 54 treatment-seeking university students at a mid-sized university in a large metropolitan area. Participants represented a range of symptoms of psychopathology deemed relevant for group therapy targeting "severe emotion dysregulation." Exclusion criteria included severe cognitive disturbance or psychotic disorder. Table 1 displays the demographic characteristics of the sample. The groups did not differ on any demographic or diagnostic variables at baseline.

4.2. Procedures

Identification numbers were assigned to all eligible participants; these numbers were randomly selected and separated into two groups (A and B). Groups A and B were then randomly assigned to be either DBT or PPT. Both groups ran at the same time and day on campus to avoid day or time effects. This also eliminated the option of participants self-selecting into a particular group based on scheduling. The group schedule was 12 weeks, 2 h per week. The DBT group included skills from all four of the standard skills training modules (Linehan, 2015), but was modified for a 12-week curriculum. This included three weeks each of distress tolerance, interpersonal effectiveness, and emotion regulation skills with a single mindfulness-focused group preceding each new module. The PPT group included weekly handouts, activities, and homework assignments focusing on increasing pleasure, engagement, and meaning-making in life (Seligman, Rashid, & Parks, 2006).

The pretreatment assessment included informed consent procedure, two self-report questionnaires, and a full diagnostic interview. Participants completed an additional battery of questionnaires through an online survey system. Mid-treatment assessments were completed in the final 15 min of group sessions on weeks three, six, and nine. Participants absent from group did not complete these measures.

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