**Competence Rating Scale for DBT-PTSD (Release Version)**

**(CRS-DBT-PTSD-R)\***

Rater: \_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Code: \_\_\_\_\_\_\_\_\_\_\_ Session No.: \_\_\_\_\_\_\_\_\_\_\_

Below is a detailed description of the scale used to assess the different aspects of therapeutic competence. Enter ratings for each dimension on a separate rating sheet on a scale from 0-6. Use the following scale:

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| --- | --- | --- | --- | --- | --- | --- |
| 0......... |  .........1.......... | ..........2......... | ..........3......... | ..........4......... | …......5......... | …......6 |
| Poor |  | Moderate |  |  Good |  | Very Good |

To avoid distortion, the rater should sense his/her own opinion about the therapist being evaluated and prevent them from influencing the subsequent evaluation. For this purpose, please indicate how likeable you find the therapist after 2 minutes have passed, in the middle of the session and at the end of the session:

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| Beginning of the session (after 2 min.): |
| 0.........  |  .........1.......... | ..........2......... | ..........3......... | ..........4......... | …......5......... | …......6 |
| Middle of the session (please set an alarm):  |
| 0......... | .........1.......... | ..........2......... | ..........3......... | ..........4......... | …......5......... | …......6 |
| Very dislikable | Dislikable | Rather dislikable | Indifferent | Rather likable | Likeable | Very Likable |

**DBT-PTSD-specific competences**

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| 1. **1. Adequate development of skills with respect to the regulation of distress and emotions**

**Key feature:** Whenever possible and necessary, the therapist teaches the patient how to use new skills to regulate distress and emotions and in a phased and patient-oriented manner. Besides teaching skills and discussing the application in everyday life, the therapist labels corresponding skills in the session, or the therapist points out skills that the patient had used but not recognized as such. **The focus should always be on tolerating emotions and not on avoiding emotions.**  |
| 0 | The therapist does not initiate/accompany/train/repeat the development of skills. |
| 1 | between 0 and 2 |
| 2 | The therapist explains/initiates/trains or repeats skills and their implementation, but does so in a theoretical way and fails to create any reference to the patient’s everyday life, e.g. the therapist overlooks skills that the patient used, or fails to name them, or the therapist explains skills when there is an adequate opportunity, but fails to make sure that the patient has understood the skills.  |
| 3 | between 2 and 4 |
| 4 | The therapist explains/initiates/accompanies/ trains or repeats skills and their implementation. However, he or she fails to take into consideration the patient´s knowledge and responsiveness, e.g. he or she explains skills on a theoretical level and does not make the patient practice them on a behavioral level.  |
| 5 | between 4 and 6 |
| 6 | The therapist explains/initiates/trains or repeats skills and their implementation in an optimal way which considers the respective treatment phase and the patient’s current symptomatology. He takes into account the patient’s knowledge, already existing skills, and the patient´s motivation. Depending on the patient´s current level of distress, the therapist asks the patient to use or practice adequate skills during the treatment session and discusses their use in the patient´s everyday life. Skills that are used by the patient or explained in session are immediately and decidedly labeled.  |

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| * **2. Promotion of a mindful and benevolently supportive attitude of the patient towards himself; Promotion of a meta-cognitive level during treatment**
* **Key feature:** The therapist promotes a mindful and compassionate attitude of the patient towards himself or herself with the help of The specific exercises that can either be explicit (e.g. talking about mindfulness, giving examples) or implicit (e.g. the therapist serves as a model, instructs mindfulness exercises).

Concerning maladaptive cognitions and convictions of the patient, the therapist encourages a meta-cognitive awareness of the patient by labeling and relativizing their appearance (e.g. “Ah, there is the monster again…”, “Here at this point you are blaming yourself again…” “I am not fear, I am only feeling like it). This means that the therapist tries to alter the patient´s secondary appraisal of her dysfunctional cognitions to encourage the patient to distance himself or herself from the present experience, and to classify certain experiences as part of his or her symptomatology.  |
| 0 | The therapist does not employ any strategies to promote mindfulness, a benevolent support and meta-cognitive awareness (i.e. mindfulness exercises). Neither does the therapist explain the concepts using examples, nor does the therapist label relevant positive or negative behaviors of the patient.  |
| 1 | between 0 and 2 |
| 2 | The therapist implements strategies to promote mindfulness, a benevolent support, and meta-cognitive awareness; he or she encourages the patient to practice mindfulness exercises regularly but shows difficulties and uncertainties in conveying them. The therapist does not address difficulties, does not ask for feedback from the patient and does not make sufficient use of the relevant concept when opportunities arise.  |
| 3 | between 2 and 4 |
| 4 | The therapist implements strategies to promote mindfulness, a benevolent support, and meta-cognitive strategies. He or she shows minor difficulties in the selection and implementation of the exercises or does not make optimal to address the topics (e.g. not enough mindfulness exercises in the session). The therapist encourages the application of these strategies in the patient´s everyday life. |
| 5 | between 4 and 6 |
| 6 | The therapist applies strategies that are optimally adapted to the patient and the situation to promote mindfulness benevolent support or meta-cognitive awareness. He or she regularly obtains feedback from the patient and addresses difficulties. He or she uses many opportunities to name and explain the concepts, also outside of specific exercises. The therapist encourages the application of the strategies within the sessions (e.g. a mindfulness exercise at the beginning and end of the session) as well as outside the sessions. |

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| **3. Appropriate promotion of corrective emotional experiences in relation to the trauma and its consequences****Key features:** The therapist uses interventions adapted to the respective patient and the treatment phase which enable the patient to have **corrective emotional experiences**. The patient should be able to take away from each session a new and corrective experience in relation to the typical consequences of the trauma. Such experiences can be “I could allow the memory to linger for a short moment”; "The therapist does not devalue me when he finds out what happened to me."; "I was able to tolerate the terrible feelings."; “I may not be the only one to blame.”; "Back then I was completely helpless and at the perpetrator´s mercy, but today I am not anymore ...".Appropriate interventions can be: role play, self-monitoring, behavioral experiments, imaginary interventions, cognitive interventions, exposure, creating a life-line, …  |
| 0 | The therapist does not induce new corrective emotional experiences.  |
| 1 | between 0 and 2 |
| 2 | The therapist's approach offers few opportunities to induce new emotional experiences. |
| 3 | between 2 and 4 |
| 4 | By and large, the therapist employs appropriate strategies to induce corrective emotional experiences. Minor difficulties are visible, e.g. the therapist could have used more time for debriefing or could have chosen more appropriate interventions which appear more promising for the progress of therapy.  |
| 5 | between 4 and 6 |
| 6 | With the help of an appropriate intervention, the therapist induces new corrective emotional experiences in the patient in an optimal manner. These new experiences are also formulated by the therapeutic team at the end of the session. |

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| **4. Optimal activation of the trauma network****Key features:** The therapist regulates the activation of the patient's trauma network in an adequate manner. He or she tries to achieve an optimal balance between avoidance and overactivation of the trauma network. Depending on the therapy phase and the therapy content, and taking into account the treatment hierarchy, a stronger activation (e.g. imaginal re-experiencing in the exposure phase) or a less strong activation (e.g. occurrence of problem behavior, interventions from the last treatment phase) can be useful. |
| 0 | Trauma-related topics are avoided, or the therapist does not recognize an excessive emotional activation of the patient in relation to the trauma (e.g. flashbacks), does not use counter-regulatory strategies. |
| 1 | between 0 and 2 |
| 2 | To a lesser extent, the therapist uses strategies to optimally activate the trauma network but shows difficulties in their implementation. For example, the therapist shows only a very hesitant application of counter-regulatory strategies, or does not implement them clearly enough, e.g. he does not speak louder during strong emotional activation of the patient. |
| 3 | between 2 and 4 |
| 4 | The therapist ensures appropriate activation of the trauma memory so that new learning experiences are possible for the patient. Minor difficulties are visible, e.g. he allows the patient to answer on a general, superficial level during a discrimination exercise (“Today I am an adult…”) and does not ask for details (“How do you determine that you are an adult today?”). |
| 5 | between 4 and 6 |
| 6 | If the patient is highly emotionally activated, the therapist uses counter-regulatory strategies e.g. he emphasizes that this is an old feeling, he answers on a meta level (e.g. "Is that typical for you, this reaction ... does it also happen at home?"). If the activation is very low, the therapist tries to activate the patient's trauma network more strongly by e.g. asking more targeted and courageous questions or using imagination. In the exposure phase in particular, the therapist pays attention to an adequate balance between activating the trauma-associated primary emotions and activating the patient's reference to the present. |

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| **5. Focus on validation strategies****Key features:** Validation strategies are used which are appropriate for the patient and the therapy phase. The dosage and use of the techniques are appropriate.The therapist uses the 6 levels of validation:Level 1 validation: Paying attention (e.g. attentive listening), Level 2 validation: accurate reflection (e.g.  paraphrasing), Level 3 validation: Accurately reading and addressing the unsaid (naming emotions if the patient reports cognitions), Level 4 validation: Validation with respect to previous life experiences or biological aspects (e.g. indicates that the patient's experience and behavior make sense from his subjective perspective against the background of his or her life story (learned basic assumptions etc.)), Level 5 validation: Validation in relation to specific dysfunctional behavior patterns (e.g. “as long as you assume that ...”), Level 6 validation: Radical authenticity and validation in relation to normative behavior (e.g. normalizing normal behavior)The therapist validates desired behavior, but not undesired behavior. |
| 0 | The therapist does not use validation strategies or uses them in an inappropriate way. |
| 1 | between 0 and 2 |
| 2 | The therapist partly uses validation strategies which are appropriate for the treatment phase. He or she validates in a routine manner without adapting sufficiently to the patient, or the therapist could have used significantly more opportunities for validation. |
| 3 | between 2 and 4 |
| 4 | The therapist mainly uses validation strategies that are appropriate for the treatment phase but shows a rather limited repertoire of validation strategies. |
| 5 | between 4 and 6 |
| 6 | The therapist uses validation strategies which are optimally suited to the treatment phase. In doing so, he or she shows a balanced ratio of different validation strategies adapted to the respective patient and the content of the session. |

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| **6. Adequate motivation of the patient****Key features:** The therapist promotes the patient’s motivation for change. In doing so, he or she uses techniques adapted to the patient and the treatment phase, both explicitly and implicitly.Explicit techniques: e.g. values ​and goal analysis, ​working on advantages and disadvantages of (problematic) behavior, discussing the consequences of behavior and alternative behavior, also in the context of behavioral analysis.Implicit techniques: e.g. use of the therapeutic relationship for contingency management (reinforcement of desired patient behavior: e.g. turning more to the patient, arranging an extra phone call, etc.); extinction of dysfunctional behavior: e.g. moving slightly away from the patient, leaving the room, etc.)If no motivational strategies appear to be necessary in this session and none are recognizable, please code N/A (not applicable). |
| N/A | Not applicable |
| 0 | The therapist does not use phase-appropriate strategies to motivate the patient. Or he or she does not use any opportunities to use them. |
| 1 | between 0 and 2 |
| 2 | Partly the therapist uses appropriate strategies for motivating the patient. However, he or she shows difficulties in implementing the strategies, e.g. gets into discussions with the patient, does not draw any conclusions in the end etc. |
| 3 | between 2 and 4 |
| 4 | The therapist mainly uses strategies that are appropriate for the treatment phase in order to continuously motivate the patient. There are minor uncertainties, or the therapist could have chosen interventions that seem more promising for therapy progress.  |
| 5 | between 4 and 6 |
| 6 | The therapist optimally uses strategies appropriate for the treatment phase to motivate the patient. He or she always succeeds in activating a motivation for change in the patient. In doing so, he or she shows a high degree of flexibility and creativity in the selection and application of strategies. |

**Likeability of the therapist**

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| End of the session: |
| 0......... |  .........1.......... | ..........2......... | ..........3......... | ..........4......... | …......5......... | …......6 |
| Very dislikable | Dislikable | Rather dislikable | Indifferent | Rather likable | Likable | Very likable |

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| **What is your overall impression of the therapist’s competence in this session?** **Key features:** The evaluation of this item addresses the question of how competently the therapist used the manual and adapted it to the following:* this specific patient (disorder, personality, intelligence),
* this phase of therapy (degree of difficulty of interventions, directivity), and
* this session (current problem, goals).

Was the therapist able to adapt his/her behavior to the specific difficulties of the traumatized patient, e.g. emotional instability? The statement about the therapist’s competence is related to the current session, the patient in question and the present manual. This does not constitute a “competence-judgment” in a global sense. |

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| --- | --- | --- | --- | --- | --- | --- |
| 0......... |  .........1.......... | ..........2......... | ..........3......... | ..........4......... | …......5......... | …......6 |
| Poor |  | Average |  | Good |  | Very good |

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| **How committed did the patient appear to you?** **Key features:** Patient commitment during therapy and while completing homework assignments is a key feature of the therapy’s success. It should be assessed independently of the assessment of the patient’s characteristics. This item assesses how much effort the patient makes in the session to ensure his or her understanding, how thoroughly he/she completed his/her homework assignments, how interested and involved he/she appeared and whether there is sufficient motivation for change. |

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| --- | --- | --- | --- | --- | --- | --- |
| 0......... |  .........1.......... | ..........2......... | ..........3......... | ..........4......... | …......5......... | …......6 |
| Very bad |  | Rather bad |  | Good |  | Very good |

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| **How difficult was the therapeutic work with this patient?****Key features**: The difficulty of working with a patient does not necessarily result from the severity of the disorder; instead, it also includes his/her interpersonal style, understanding, and openness towards psychological aspects etc.This item assesses the extent to which the patient’s characteristics have made therapeutic work more difficult. Aggravating characteristics on the patient side can include: taciturnity, hostility, cognitive restrictions, pronounced avoidance as well as a high proportion of borderline-personality traits, multiple trauma-clusters and other factors that can make therapy exceptionally difficult. Starting point for the evaluation should be 0. Depending on the peculiarity, the judgment is shifted towards 6.  |

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| 0......... |  .........1.......... | ..........2......... | ..........3......... | ..........4......... | …......5......... | …......6 |
| Easy |  | Rather easy |  | Rather difficult |  | Extremely difficult |