IMPLEMENTING DIALECTICAL BEHAVIOUR THERAPY INTO CHILD AND ADOLESCENT MENTAL HEALTH SERVICES: A PILOT STUDY OF IMPLEMENTATION STRATEGIES AND INITIAL CLINICAL OUTCOMES

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A thesis submitted for the degree of Doctor of Psychology (Clinical) of the Australian National University
I hereby certify that the work embodied in this thesis is the result of original research and contains acknowledgement of all non-original work.

[Signature]
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ABSTRACT

Adolescent clients presenting to child and adolescent mental health services (CAMHS) with suicidal behaviour, depression and Borderline Personality Disorder (BPD) represent a highly complex and compromised group of consumers. Their risk for ongoing suicidal behaviour and mental illness requires timely access to effective treatment programs. Such programs are best founded on good mental health policy, established clinical guidelines and research derived from routine clinical settings. The current study outlines the design, implementation and evaluation of a Dialectical Behaviour Therapy (DBT) program for suicidal adolescents in a CAMHS context. Results from the current study are used to promote the ongoing use of DBT within CAMHS. Recommendations are made to bolster and further develop the CAMHS DBT program.

Youth suicide is a significant public health concern requiring an effective response from child and adolescent mental health services. Suicide is a leading cause of mortality for young Australians and those at risk for suicide have multiple social and emotional difficulties. Such risk factors include previous suicide attempts, non-suicidal self-injurious behaviour, mental illness and personality disorder. Often occurring together, depression and borderline personality disorder are predictive of high service utilization, poor prognosis and ongoing distress and dysfunction. At the time of the current study, treatment for such clients characteristically involved an eclectic mix of various therapeutic approaches. In order to effectively respond to this high risk group of adolescents it was recommended that a comprehensive systematic treatment program be developed within Child and Adolescent Mental Health Services.

Dialectical Behaviour Therapy for suicidal adolescent clients was identified as a comprehensive treatment most capable of providing for the needs of adolescent clients and
their families presenting to ACT CAMHS. DBT is an established outpatient treatment for adult clients presenting with suicidal behaviour and multiple social and emotional difficulties. The CAMHS DBT program was based on standardised DBT with additional adaptations developed for adolescent populations and their parents. The intent was to make the treatment as adherent as possible to the standardised model in order to maximise the potential for the program to assist clients and families to change. The 20 week program consisted of weekly individual therapy, skills group, team consultation group, as needed phone coaching and family therapy sessions. Some amendments were required due to the service characteristics of CAMHS. For example, a strategy was developed to provide effective after hours phone coaching using the existing after hours crisis assessment and treatment team. Client and clinician materials were developed over the course of the pilot program including a clinician’s toolkit and client workbook.

The current study describes the design, development and implementation of a comprehensive DBT program with a focus on evaluating initial clinical outcomes. The development of the program included identifying and problem solving a number of barriers to implementation. Barriers to successful implementation of DBT included lack of access to skills based training for clinicians and limited clinical supervision, limited leadership and lack of treatment fidelity. After identifying these barriers and their potential to impact deleteriously on implementation, an implementation strategy was designed including a numbers of phases and concurrent practices. The implementation strategy included exploring and then adopting a treatment design, workforce development, pilot implementation and evaluation. Concurrently throughout the development and implementation of the program DBT principles and strategies were used to problem solve barriers to the success of the implementation. Critically, it was planned that the DBT pilot program would be best
advocated and empowered if it remained under the stewardship of an existing team leader within the service who participated as DBT clinician and clinical leader.

A program evaluation was undertaken to measure the initial clinical effectiveness of the program. The primary outcome for the current study was to reduce suicidal and non-suicidal self-injurious behaviour. Secondary outcomes consisted of reducing symptoms of depression, core clinical features of Borderline Personality Disorder and increasing factors protective against suicide such as concerns about suicidal behaviour and future hopefulness. At follow-up, CAMHS clients who completed the program reported both clinical and statistically significant reductions in suicidal behaviour, depression and core clinical features of Borderline Personality Disorder such as: interpersonal chaos, impulsivity, emotion dysregulation and confusion about self. Apart from concerns about suicidal behaviour there was no other statistically significant increases in protective factors were found. Limitations of the current study are described. Overall, the clinical results of the current study provide encouraging initial evidence for the ongoing use, program development and evaluation of DBT within CAMHS.

Based on the evaluation of the current study, recommendations were developed with the purpose of maximising the potential for the DBT program to survive and flourish as well as boosting its effectiveness in producing positive client outcomes. In terms of the program surviving and flourishing, the following recommendations were made: 1) ensure the leader of the CAMHS DBT program has equal operational status and authority as other team leaders within the service, 2) build on the promising results of the current study by developing research infrastructure and supporting a randomised control trial of the CAMHS DBT program and 3) undertake a needs analysis and feasibility study for the development of a service wide DBT centre to provide assessment and treatment across the developmental lifespan.
In terms of boosting the effectiveness of the program in producing positive client outcomes, the following recommendations were made: 4) continue using a comprehensive DBT program within CAMHS for the treatment of suicidal behaviour, BPD and other treatment resistant conditions such as depression, 5) clients presenting with high levels of suicidal behaviour should be referred to the DBT program for assessment, recommendations and potential treatment, 6) behaviour activation protocol should be integrated into the to enhance the effects of DBT on reducing depression, 7) implement an introductory group session to enhance orientation, motivation and commitment to the program, 8) prioritising the integration of additional family therapy sessions, 9) further developing the CAMHS workforce by sending the CAMHS DBT team to the DBT intensive training and 10) implement an ongoing group for DBT graduates to reduce relapse and support ongoing skill development.
# TABLE OF CONTENTS

Acknowledgments

Abstract

**CHAPTER 1: The Need for a CAMHS DBT Program**

1.1 Introduction 1

1.2 Definitions 2

1.3 Youth suicide 2

1.4 Non suicidal self-injurious behaviour 3

1.5 Human, social and economic cost 3

1.6 Clinical severity, co morbidity and risk factors for suicidal behaviour 5

1.6.1 Suicidal behaviour 6

1.6.2 Depression 7

1.6.3 Borderline personality disorder 7

1.6.4 NSSIB and emotion regulation difficulties 12

1.6.5 The relationship between BPD and other conditions 13

1.7 Treatment 14

1.7.1 Suicidal behaviour and BPD 14

1.7.2 Working with families 16

1.7.3 Depression 17

1.7.4 Emotion regulation 18

1.7.5 Summary 20

1.8 Applied research 20

1.8.1 The current study 22

1.8.2 General aims 22
1.8.3 Specific aims and hypothesis

1.9 Project design

CHAPTER 2: Program Development and Program Design

2.1 Program development

2.1.1 Applying DBT to CAMHS

2.2 Program design

2.3 Stage one: Assessment, orientation and commitment

2.3.1 Assessment and feasibility

2.3.2 Orientation and commitment

2.3.3 Establishing a therapeutic alliance

2.3.4 Orienting the adolescent and family

2.3.5 Defining primary target behaviours

2.3.6 Long term goals

2.3.7 Biosocial theory

2.3.8 Treatment format and characteristics

2.3.9 Diary card

2.3.10 Therapy agreements

2.3.11 Commitment Strategies

2.4 Stage two: 20 week program

2.4.1 Program structure

2.4.2 Individual therapy

2.4.3 DBT multifamily skills group

2.4.4 Phone coaching

2.4.5 Family therapy

2.4.6 DBT team consultation group
2.5 Treatment strategies

2.5.1 Validation strategies

2.5.2 Problem solving strategies

2.5.3 Dialectical Strategies

2.5.4 Stylistic strategies

2.5.5 Case management strategies

2.6 Stage three: Graduation

2.7 Summary

CHAPTER 3: Implementation Barriers

3.1 Implementation

3.1.1 Implementation as usual

3.1.2 Implementation for impact and performance

3.2 Barriers to successful implementation

3.2.1 High fidelity DBT

3.2.2 Ethical issues

3.2.3 Administrative barriers to high fidelity DBT

3.2.4 Paradigm shift

3.3 Leadership

3.3.1 DBT Leader

3.3.2 Mental health service directors

3.3.3 Clinicians

3.4 Summary

CHAPTER 4: Implementation Strategy and Outcomes

4.1 Implementation phases
4.2 Phase 1: exploration and adoption 66
  4.2.1 Building support 67
  4.2.2 Resolving barriers 70

4.3 Phase 2: workforce development 72
  4.3.1 Initial status of CAMHS workforce 72
  4.3.2 Workforce development strategy 73
  4.3.3 Training outcomes 74

4.4 Phase 3: implementation 75
  4.4.1 Implementation drivers 76

4.5 Phase 4: evaluation 77

4.6 DBT principles and strategies 78

4.7 Summary 79

CHAPTER 5: Clinical Evaluation Design 80

5.1 Overview 80

5.2 Procedure 80

5.3 Participants 81

5.4 Outcome measures 82
  5.4.1 Suicidal behaviour 82
  5.4.2 Protective factors 84
  5.4.3 Borderline personality disorder behaviours 86
  5.4.4 Depression 87

5.5 Summary 87

CHAPTER 6: Clinical Outcomes 89

6.1 Group and individual outcomes 89

6.2 Group primary outcomes 89
6.2.1 Statistically significant reductions in suicidal ideation and behaviour 89
6.2.2 Clinically significant reductions in suicidal ideation and behaviour 90

6.3 Secondary outcomes 94
6.3.1 Statistically significant reductions in depression 94
6.3.2 Clinically significant reductions in depression 94
6.3.3 Statistically significant reductions in borderline personality disorder 95
6.3.4 Clinically significant reductions in borderline personality disorder 95
6.3.5 Statistically significant increases in protective factors 95
6.3.6 Clinically significant changes in protective factors 96
6.3.7 Summary of secondary outcomes 96

6.4 Individual outcomes 96
6.4.1 Suicidal ideation 97
6.4.2 Depression 99
6.4.3 Borderline personality disordered behaviours 99
6.4.4 Protective factors 106

6.5 Non response to treatment 108

6.6 Summary 111

CHAPTER 7: Discussion 112

7.1 Support for the ongoing implementation of the CAMHS DBT program 112
    7.1.1 Establishing behavioural control 112
    7.1.2 Reductions in core aspects of BPD 113
    7.1.3 Reduced depression 114
    7.1.4 Protective factors 115

7.2 Ongoing program development 116
    7.2.1 Mid-program improvement implications 116

xiii
7.2.2 Graduation to follow-up implications 118

7.3 Implementation outcome implications 119

7.3.1 Leadership 120

7.3.2 Sustainability 121

7.3.3 Workforce development 122

7.4 The use of DBT in other areas of mental health services 123

7.5 Limitations 124

7.6 Summary and recommendations 126

Reference list 128

Appendices 157
LIST OF TABLES AND FIGURES

Tables

Table 1. Borderline Personality Disorder – features and diagnostic criteria 8
Table 2. National Institute of Clinical Excellence BPD guidelines 26
Table 3. DBT program inclusion and exclusion criteria 31
Table 4. Feasibility criteria 32
Table 5. Orientation and commitment strategies 33
Table 6. CAMHS DBT program functions and corresponding treatment modes 38
Table 7. Individual therapy structure 41
Table 8. CAMHS DBT program and skills training format 42
Table 9. DBT consult agreements 46
Table 10. Suicidal Ideation Questionnaire Content Descriptions 85
Table 11. Summary of primary and secondary outcomes and associated outcome measures 88
Table 12. Primary and secondary continuous measure outcomes 92
Table 13. Primary and secondary binary measure outcomes 93
Table 14. Recommendations 127

Figures

Figure 1. The developmental stages of CAMHS DBT program 29
Figure 2. CAMHS 20 week DBT program 39
Figure 3. DBT individual therapy treatment hierarchy 40
Figure 4. Skills group hierarchy of target behaviours 43
Figure 5. DBT team consult group 47
Figure 30. Non responders on LPI Impulsivity

Figure 31. Non responders on LPI Confusion about Self

Figure 32. Non responders on LPI Interpersonal Chaos

Figure 33. RFL Family Alliance subscale

Figure 34. RFL Peer Acceptance and Support subscale

Figure 35. RFL Self Acceptance subscale

Figure 36. RFL Future Optimism subscale
CHAPTER ONE

The need for a CAMHS DBT program

1.1 Introduction

Within the Australian Public Mental Health System the States and Territories are responsible for delivery of public mental health services (Smyth, 2011). Within the Australian Capital Territory, public mental health services provide speciality treatment and support to people experiencing moderate to severe mental illness. Mental health services are divided into inpatient and community streams, within which are specialised teams providing care across the age span; child and adolescent mental health (CAMHS), adult mental health and older person mental health (http://health.act.gov.au/health-services/mental-health-act/mental-health-services).

The Australian Capital Territory, Child and Adolescent Mental Health Services (CAMHS) provide assessment and treatment for clients presenting with suicidal behaviour and moderate to severe mental illness. Based on their risk status and level of mental illness, CAMHS provides ongoing risk management and treatment through clinical management. Clinical management is delivered by a number of varying professions within CAMHS including psychologists, social workers, occupational therapists and nurses. The treatment delivered through clinical management is generic and usually based on a mixture of approaches and techniques. The approach and techniques used depends on the professional and personal beliefs of the clinician as well as service protocols.

There is no current specific treatment protocol in CAMHS for working with suicidal and non-suicidal self-injuring adolescent clients presenting with multiple difficulties including Borderline Personality Disorder (BPD) and depression. Treatment is usually composed of a
range of strategies including supportive counselling, Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT), Interpersonal Psychotherapy (IPT) and psychodynamic approaches. Clients presenting with suicidal behaviour and co-morbid conditions such as BPD and depression represent a specific and high risk group of clients requiring specialist intervention. Understanding the specific needs of adolescents presenting with suicidal behaviour, depression and BPD is critical to CAMHS delivering effective interventions.

1.2 Definitions

Suicidal behaviour is a broad term encapsulating a spectrum of behaviours including completed suicide, suicide attempts (suicidal behaviour with the intention of taking of one’s own life), suicidal ideation (serious thoughts about taking one’s life) and non-suicidal self-injurious behaviour (NSSIB) (Miller, Rathus, & Linehan, 2007). NSSIB is defined as self-injuring behaviour, causing tissue damage, without intent to die. NSSIB is included as an important aspect of suicidal behaviour due to its relationship with fatality (Miller et al., 2007). For example, NSSIB remains a clear risk factor for completed suicide (Hawton et al., 2012).

1.3 Youth Suicide

Suicide is a major global public health concern. Of the 2.6 million deaths that occurred worldwide in people aged 10-24 years in 2004, 156 000 (6%) were attributed to suicide (Patton et al., 2009). According to a seminal Australian report into suicide and suicide prevention, analysis of 2008 Australian Bureau of Statistics (ABS) data indicates that suicide is the leading cause of death for woman aged 15-34 and men 15-44 and that eighty Australians a day are admitted to hospital for self-harming behaviour (as cited in Mendoza & Rosenberg, 2010).
1.4 Non-suicidal self-injurious behaviour

Although NSSIB is not classified as a mental illness, it is a common adolescent presentation to mental health services and a clinically significant marker for high levels of psychopathology and suicide risk (Cloutier, Martin, Kennedy, Nixon, & Muehlenkamp 2010; Hankin & Abela 2011; Tang et al., 2011; Wilkinson, Kelvin, Roberts, Dubicka, & Goodyer, 2011). Studies indicate clients hospitalised for NSSIB have both Axis 1 and Axis 2 diagnosis (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006) and NSSIB is common among youth with depression and Borderline Personality Disorder (Asarnow et al., 2011; Muehlenkamp, Ertelt, Miller, & Claes, 2011; Nitkowski & Petermann 2011). NSSIB first emerges and then peaks in adolescents with females peaking at 15-19 years and males 10-14 years (Martin, Swannel, Hazell, Harrison, & Taylor, 2010; Klonsky 2011). In Australia, the four week prevalence of NSSIB was found to be 1.1% with a lifetime prevalence of 8.1% (Taylor et al., 2011).

1.5 Human, social and economic cost

Suicidal behaviour has enormous human, social and economic costs. The internal struggle, anguish and suffering experienced by people displaying suicidal and NSSIB is immense. Suicidal individuals experience intense overwhelming emotional distress (Miller et al., 2007; Zayas, Gulbas, Fedoravicius, & Cabassa, 2010) not only suffering through the suicidal crisis but also experiencing subsequent distressing emotions about failing the attempt and hurting friends and family (Vatne & Naden 2012; Zayas et al., 2010). Additionally, vulnerability can be further compounded by negative health care experiences resulting from feeling invalidated, stigmatised and not receiving clear follow-up information (Cerel, Currier, & Conwell, 2006; Taylor, Hawton, Fortune, & Kapur, 2009). Some studies have indicated that negative health care experiences are related to increased risk and future suicidal behaviour (Samuelsson, Wiklander, Asberg, & Saveman, 2000; Strike, Rhodes, Bergmans, Links,
Research has shown that risk for suicide peaks immediately after discharge from psychiatric contact, especially for adolescents with depression and personality disorders (Christiansen & Larsen, 2012). Positive contact with mental health services is a critical issue as engaging suicidal youth in treatment can be highly challenging and many do not complete treatment (Burns, Cortell, & Wagner, 2008; Miller, Smith, Klein, & German, 2010). As a corollary, providing clients with timely and engaging treatment is critical to improving their path towards better mental health.

Additionally, people bereaved by suicide are at risk of developing a number of adverse physical and mental health reactions including intense shame, the exacerbation of a priori health difficulties, stigma, social isolation, financial difficulties and increased risk for suicide (Cvinar, 2005; Krysinska, 2003; Szanto, Prigerson, Houck, Ehrenpreis, & Reynolds, 1997). Those bereaved by suicide experience a more complicated pattern of grief characterised by heightened feelings of rejection and responsibility (Bailley, Kral, & Dunham, 1999). In the case of youth suicide, parents, friends, teachers, and professionals are all affected. Parents report having limited access to support to process the suicide, feel stigmatised, experience self blame and shame which can lead to vulnerability to developing depression (Lindqvist, Johansson, & Karlsson, 2008; Maple, Edwards, Plummer, & Minichiello, 2010). Moreover, mothers with chronically suicidal adolescents report feeling like a failure as a parent, rejected, alone, helplessness, powerlessness and needing to keep an emotional distance (Daly, 2005).

Children and adolescents who lose a sibling to suicide can experience serious posttraumatic and grief reactions, depression and anxiety (Dyregrov & Dyregrov, 2005). Additionally, research suggests that bereaved youth are at elevated risk for depression, anxiety, post traumatic stress disorder, impaired social adjustment and alcohol and substance abuse (Brent, Melhem, Donohoe, & Walker, 2009; Dyregrov & Dyregrov, 2005; Sethi &
Bhargava, 2003). For clinicians, exposure to client suicide can lead to relationship difficulties, feelings of being responsible, incompetent and burnout (Gaffney et al., 2009; Tillman, 2006).

The economic cost of suicide on the Australian community, based on suicides, suicide attempts, prevalence rates, number of days out of role, lost average weekly earnings, hospital admission and cost data, has been conservatively estimated to be 17.5 billion dollars every year (Mendoza & Rosenberg, 2009). Although a minority of young people who self-harm seek treatment (De Leo & Heller, 2004), it is clear the economic cost of suicidal behaviour on hospitals is significant (Bethell & Rhodes, 2008; Rogers, Pease, & Ricketts, 2009; Sinclair, Gray, Rivero-Arias, Saunders, & Hawton, 2011).

1.6 Clinical severity, co-morbidity and risk factors for suicidal behaviour

Specialised mental health services such as CAMHS have an important role to play in the prevention of suicide by providing early detection and treatment for depression and co-morbid conditions such as BPD (Moran et al., 2011). Typically, clients presenting to CAMHS with suicidal behaviour display distress and dysfunction across an array of individual, family and social domains (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Beautrais 2000; Mitrou et al., 2010; Vander Stoep et al., 2011). Moreover, adolescent clients who have made repeated suicide attempts have severe clinical profiles (Laget et al., 2006) including compromised affect regulation capacities (Esposito, Spirito, Boergers, & Donaldson, 2003). Psychiatric illness is a strong predictor of suicide attempts in young people and those with co-morbid diagnoses are at increased risk of repeated suicide attempts (Jakobsen, Christiansen, Larsen, & Waaktaar, 2011). Additionally, studies of people displaying suicidal behaviour have shown that more than 90% have at least one mental disorder (Skegg, 2005).
Depression and BPD, conditions often seen by mental health services, are both strong predictors of suicide and ongoing suicidal behaviour (Beautrais 2000; Rey & Dudley 2005). Both depression and severity of depression at first suicide attempt is heavily implicated in ongoing suicidal behaviour in adolescents (Beghi & Rosenbaum 2010; Sheikholeslami, Kani, & Ghafelebashai, 2009; Spirito, Valeri, Boergers, & Donaldson, et al. 2003). Personality Disorders and difficulties regulating problematic affect is associated with repeated suicide attempts (Fritsch, Donaldson, Spirito, & Plummer, 2000; Groholt & Ekeberg, 2009; Osvath, Kelemen, Erdos, Voros, & Fekete, 2003). For example, BPD is predictive of suicide attempts and NSSIB in adolescents (Muehlenkamp, Ertelt, Miller, & Claes, 2011).

1.6.1 Suicidal behaviour

Previous suicidal behaviour (Ruengorn et al., 2012; Sani et al., 2011) and severity of suicidal ideation (Ben-Zeev, Young & Depp, 2012) are strong predictors of ongoing suicidal behaviour. Moreover, people who engage in suicidal behaviour are more likely to attempt and complete suicide than people who don’t self-harm (Bebbington et al., 2010; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). Additionally, between 31% and 50% of adolescent suicide attempters reattempt suicide, with 21% of females and 27% of males reattempting within 3 months of their first attempt (cited in Miller et al., 2007).

Young age of onset of suicidal behaviour has been found to be predictive of further suicide attempts (Borges et al., 2007; Johnsson-Fridell, Ojehagen, & Traskman-Bendz, 1996). Moreover, repeated suicide attempts during adolescence appear to be one of the major risk factors in attempting suicide again within 10 years, confirming the importance of preventive measures after a first suicide attempt (Gehin, Kabuth, Pichene, & Vidaihet, 2009). Additionally, suicidal ideation (seriously thinking about suicide) has been shown to be predictive of suicidal behaviour in adolescents (Buchman, Blomeyer, & Laucht, 2012; Wang,
Lai, Hsu, & Hsu, 2011) and is associated with high severity of depression, functional impairment and co morbidity (McCarty et al., 2011).

1.6.2 Depression

Research has found depression to be the most prevalent diagnosis given to clients presenting to CAMHS (Wiggins, Oakley Browne et al. 2010). Adolescent depression is a highly distressing and dysfunctional condition characterised by irritable low mood, social withdrawal, loneliness, poor concentration and indecisiveness (Crowe, Ward, Dunnachie, & Roberts, 2006). Adolescent depression is associated with having other psychiatric disorders including anxiety disorders, bipolar disorder and personality disorders in adulthood (Carballo et al., 2011). The first onset of major depressive disorder often occurs in mid to late adolescence with most new cases developing between the ages of 15 and 18 years (Hankin et al., 1998). By the end of adolescence, the 1 year prevalence rate for depression exceeds 4% (Thapar, Collishaw, Pine, & Thapar, 2012).

Major depressive disorder is an established risk factor for suicidal behaviour (Riedel et al., 2012; Ruengorn et al., 2012; Wedig et al., 2012). Moreover, adolescent depression is suggestive of elevated suicide risk (Riedel et al., 2012; Swahn et al., 2012; Thapar et al., 2012) and treatment resistant depression in adolescents has been found to be a risk factor for ongoing suicidal behaviour (Asarnow et al., 2011; Jonsson et al., 2011). Furthermore, when depression co occurs with attempted suicide the trajectory of depression in adolescents is characterized by more severe psychopathology, poorer prognosis, and future suicidal behaviour (Kim et al., 2011).

1.6.3 Borderline personality disorder

According to the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV), a diagnosis of BPD requires a “pervasive pattern of instability of interpersonal relationships, affects and self-image as well as marked impulsivity as indicated by five (or
more)” of nine diagnostic criteria as outlined in Table 1 below (American Psychiatric Association, 2000). In positing the underlying cause of BPD being an inability to regulate problematic emotions Linehan (1993) reorganised the nine BPD DSM-IV diagnostic criteria into five areas of dysregulation (see Table 1 below). These areas and associated symptoms are believed to be either the direct result of experiencing problematic emotions or maladaptive efforts to regulate them (Linehan, 1993). Adolescent BPD populations often display a number of these symptoms including impulsive behaviours, marked interpersonal difficulties and family discord, suicidal threats, gestures and behaviour, NSSIB and emotional instability (Miller, Rathus, & Linehan, 2007).

Table 1: Borderline Personality Disorder- Features and diagnostic criteria

<table>
<thead>
<tr>
<th>Area of Dysregulation</th>
<th>DSM-IV Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Inappropriate, intense anger or lack of control of anger</td>
</tr>
<tr>
<td>2. Interpersonal dysregulation</td>
<td>3. A pattern of unstable and intense relationships</td>
</tr>
<tr>
<td></td>
<td>4. Frantic efforts to avoid real or imagined abandonment</td>
</tr>
<tr>
<td>3. Behavioral dysregulation</td>
<td>5. Recurrent suicidal threats, gestures, or behaviour or self-mutilating behaviour</td>
</tr>
<tr>
<td></td>
<td>6. Impulsivity in at least 2 areas that potentially self-damaging</td>
</tr>
<tr>
<td>4. Cognitive dysregulation</td>
<td>7. Transient, stress-related severe dissociative symptoms or paranoid ideation</td>
</tr>
<tr>
<td>5. Self dysregulation</td>
<td>8. Identity disturbance: persistent and markedly disturbed, distorted or unstable self image or sense of self</td>
</tr>
<tr>
<td></td>
<td>9. Chronic feelings of emptiness</td>
</tr>
</tbody>
</table>
BPD causes severe psychosocial impairment and is associated with high suicide risk, greater usage of mental health resources and high mortality (Leichsenring, Leibing, Kruse, New, & Leweke, 2011; Lenzenweger, Lane, Loranger, & Kessler, 2007; Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). In a large national epidemiologic survey on alcohol and related conditions in the USA, the prevalence of BPD in the general population was found to be much greater than previously recognized, with a lifetime prevalence of 5.9% (Grant et al., 2008). Locally, at the time of this study, a survey of the various Mental Health ACT community teams indicated that there were 90 adult and 30 CAMHS clients with a diagnosis of Borderline Personality Disorder (Personal Communication with Principle Psychologist, April 13, 2010). Within CAMHS this figure is likely to be underestimated significantly due to the reluctance to diagnose BPD in adolescents.

Personality disorders have been found to be recognisable in adolescents and diagnosable from age 14 to 18 (Westen, Shedler, Durrett, Glass, & Martens, 2003) and predictive of long term negative prognosis (Cohen, Crawford, Johnson, & Kasen, 2005). Moreover, researchers have identified that BPD emerges in adolescence (Paris 2003; Cohen et al., 2005; Chanen, McCutcheon, Jovev, Jackson, 2007; Chanen & Kaess 2012), the prevalence of BPD in adolescents is comparable to adult samples (Miller, Muehlenkamp, & Jacobson, 2008), the symptoms and experiences are comparable to those of adults (Bradley, Zittel-Conklin, & Western, 2005) and BPD remains stable during adolescence (Chanen, Jackson, McGorry, Allot, Clarkson, & Yuen, 2004). Furthermore, adolescent personality disorder such as BPD, is associated with negative long term outcomes over and above adolescent Axis I diagnosis (Chanen et al., 2007; Cohen, 2008). For example, severity of BPD symptoms in adolescents is associated with increased NSSIB and suicide attempts (Muehlenkamp et al., 2011).

Additionally, adolescents do not need to meet the full criteria for a diagnosis of BPD to experience severe distressing symptoms and dysfunction (Miller et al., 2007). Specific BPD
traits such as affective instability, confusion about self, unstable interpersonal relationships and impulsivity predict ongoing suicidal behaviours (Crowne et al., 2012; Miller et al., 2008; Muehlenkamp et al., 2011). Impulsivity, a key diagnostic criterion for BPD, has been found to be associated with high levels of negative affect and a precipitant to NSSIB (Armey, Crowther, & Miller, 2011) and highly impulsive adolescents with low distress tolerance are more likely to engage in NSSIB (You, Leung, FU, & Lai, 2011). Some studies have identified specific impulsivity traits including negative urgency, lack of premeditation and lack of perseverance as predictive of NSSIB (Lynam, Miller, Miller, Bornovalova, & Lejuez, 2011). Moreover, impulsivity has been found to be a more significant predictor of suicidal behaviour over and above depression (Javdani, Sadeh, & Verona, 2011).

BPD is considered the most serious and most common personality disorder seen presenting to mental health services (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004) and is regularly seen by clinicians working in mental health settings with adolescents (Zanarini, Frankenburg, Khera, & Bleichmar, 2001; Chanen, Jovev, & Jackson, 2007). Although associated with high levels of service utilization (Bender et al., 2001; Skodol et al., 2005; Bender et al., 2006) BPD is not usually formally diagnosed in CAMHS. Lack of diagnosis of BPD in adolescents is likely due to a number of factors including the stigma associated with having a diagnosis of BPD, the perception that personality is unstable in adolescents, and the notion that adolescent BPD symptoms are better accounted for by Axis I diagnosis (Aviram, Brodsky, & Stanley, 2006; Chanen et al., 2007; Lequesne & Hersh, 2004; Nehls, 1998; Stepp, 2012). Additionally, negative attitudes towards BPD among clinicians, health care administrators, and policy-makers can perpetuate marginalization of BPD within systems of mental health care (Kealy & Ogrodniczuk, 2010). For example, believing that BPD is not a legitimate disorder and not providing people with this diagnosis with adequate treatment options.
People meeting the diagnostic criteria for BPD are often described as difficult to treat (Zanarini et al., 2001; Frankenburg & Zanarini, 2004; Bland & Rossen, 2005). Clinicians often look to avoid working with BPD (Black et al., 2011) and describe working with BPD as harder than other disorders presenting to mental health services (Cleary, Siegfried, & Walter, 2002; O'Brien & Flote, 1997). Clinicians often display negative attitudes towards clients presenting with BPD including attributing pejorative characteristics to them (Bodner, Cohen-Fridel, & Iancu, 2011; Deans & Meocevic, 2006; Markham & Trower, 2003). Negative attitudes towards clients with BPD undermine the quality of interaction between clinician and client and the capacity to build effective working relationships (Deans & Meocevic, 2006). Marginalisation and negative attitudes can lead to highly unsatisfactory experiences for clients including a lack of access to specialised psychological treatment and reliance on medication (Rogers & Acton, 2012).

Research suggests that clinicians working with BPD believe the care clients receive is less than adequate and more specialised services are required (James & Cowman, 2007) and clinicians working with BPD are motivated to learn more about the disorder and develop skills to be more effective (Bodner et al., 2011). Training has been found to replace pessimistic outlooks with optimistic views and more effective ways of relating (Hazelton, Rossiter, & Milner, 2006; Krawitz, 2004). Additionally, the modifiability of attitudes towards people with BPD through education workshops can result in greater empathy and more willingness to work with BPD and feelings of increased competence (Shanks, Pfohl, Blum, & Black, 2011). In terms of training content, adopting a specific treatment to learn and apply systematically has been found to reduce clinician stress when working with BPD (Perseius, Kaver, Ekdahl, Asberg, & Samuelsson, 2007). This training may relate to the need by clinicians for a coherent framework which will provide confidence in understanding BPD as well as effectively guiding treatment.
The growth in understanding and treatment of BPD has blossomed over the past 30 years. Theories of BPD, therapeutic modalities and treatment guidelines are now well established and should impel legitimacy of the diagnosis and hope for recovery (Linehan, 1993). Leadership across various levels of mental health systems of care is needed to permeate and influence attitudes, drive appropriate service delivery, and reduce marginalization. For example, pioneers in the understanding and treatment of BPD highlight the treatability of the disorder including the cost effectiveness of targeted treatments (Linehan, Heard, & Armstrong, 1993; Pasieczny & Connor, 2011). Additionally, adolescents presenting with BPD symptoms to CAMHS are in an early malleable stage of the disorder making this a critical period for early intervention (Miller et al., 2007).

1.6.4 NSSIB and emotion regulation difficulties

Intense emotional experiences with limited access to emotion regulation coping strategies is associated with NSSIB (Turner, Chapman, & Layden, 2012). NSSIB can serve various functions including alleviating problematic emotions, eliciting care and as a form of punishment (Armey & Crowther, 2008; Jacobson & Gould, 2007; Klonsky & Muehlenkamp, 2007; Martin, Swannell, Hazell, Harrison, & Taylor, 2010; Wilkinson & Goodyer, 2011; Zlotnick, Donaldson, Spirito, & Pearlstein, 1997). NSSIB is associated with comparatively elevated physiological arousal, poor ability to tolerate distress and deficits in social problem solving skills (Nock & Mendes, 2008). Moreover, for adolescents who self injure emotional regulation difficulties mediate the link between interpersonal stress and NSSIB (Adrian, Zeman, Erdley, Lisa, & Sim, 2011).

Emotion regulation represents a risk factor for future various psychological disorders and problems in adolescents (McLaughlin, Hatzenbuehler, Mennin, & Nolen-Hoeksema, 2011). Maladaptive emotion regulation strategies are associated with suicidal behaviour, suicidal ideation, depression, alcohol and drug use and anxiety in adolescents (Keenan, Hipwell,
Hinze, & Babinski, 2009; Joormann & Gotlib, 2010; Weinberg & Klonsky, 2009). Moreover, social stressors are more likely to lead to suicidal behaviour in adolescents when the adolescent has poor emotion regulation skills (Garisch & Wilson, 2010). Research has shown that emotion regulation abilities can be enhanced through behavioural interventions (Svaldi, Griepenstroh, Tuschen-Caffier, & Ehring, 2012).

1.6.5 The relationship between BPD and other conditions

BPD is predictive of co morbidity and for the poor prognosis of co morbid mental health conditions. In particular, as well as being a highly distressing and dysfunctional condition, borderline personality disorder is a predictor of major depressive disorder (Morgenstern, Langenbuecher, Labouvie, & Miller, 1997; Skodol et al., 2011). Those with co morbid depression and BPD have a younger age of onset of depression, more depressive episodes and a higher prevalence of comorbid anxiety disorders, substance use disorders, and number of previous suicide attempts (Galione & Zimmerman, 2010). Additionally, studies have shown the combination of depression and BPD in adolescents is associated with long term interpersonal problems and potential for ongoing suicidal behaviour (Marton et al., 1989).

BPD is associated with a number of negative outcomes including poor social role functioning (Bagge et al., 2004), drug and alcohol disorders (Links, Heslegrave, Milon, Van Reekum, & Patrick, 1995; Watzke, Schmidt, Zimmermann, & Preuss, 2008), long term social, interpersonal and intimate partner difficulties (Daley, Burge, & Mammen, 2000; Gunderson et al., 2011; Selby, Braithwaite, Joiner, & Fincham, 2008) and anorexia nervosa (Gaudio & Di Ciommo, 2011). Moreover, BPD is predictive of greater severity of anorexia nervosa and when BPD is combined with Binge eating disorder it is predictive of a greater number of other non-eating disordered psychopathology (Chen, Brown, Harned, & Linehan, 2009; Gaudio & Di Ciommo, 2011). BPD is related to greater Obsessive Compulsive Disorder (OCD) symptoms and OCD relapse (Ansell et al., 2011) and people with BPD and
co morbid schizophrenia experience less psychiatric improvement (Bahorik & Eack, 2010). PTSD and BPD have a high degree of lifetime co-occurrence which is associated with poorer functioning compared to either diagnosis alone (Pagura et al., 2010).

Although BPD has seriously detrimental prognostic effects on psychosocial functioning and other co morbid conditions, at the time of the present study, no targeted treatment program existed with ACT mental health services for this client group. Given the likelihood that BPD emerges in adolescence, identifying the occurrence of BPD in a CAMHS setting could result in a better trajectory for adolescent clients including reducing BPD criterion behaviours and their effects on co morbid disorders (Zimmerman, Rothschild, & Chelminski, 2005). As a corollary, out of this understanding emanates the need to identify appropriate treatment options for CAMHS for clients presenting with suicidal behaviour, NSSIB, BPD and depression.

1.7 Treatment

Co morbid BPD, depression and suicidal behaviour create a complex client profile and challenge the effectiveness of approaches built to treat one discrete presenting problem at a time (Miller et al, 2007). Given the ongoing likelihood of high risk co morbid presentations to CAMHS, a framework capable of treating suicidal clients with multiple difficulties will be required. In conjunction with evidence-based treatment guidelines, programs are best developed in accordance with relevant national and state policy frameworks ensuring high standards of public health care.

1.7.1 Suicidal behaviour and BPD

Adolescents experiencing suicidal ideation and displaying suicidal behaviour have coping skill deficits and experience difficulty regulating problematic emotions and interpersonal problems (Wang et al., 2011). Cognitive behavioural treatments used to target suicidal behaviour directly can be effective in reducing suicidal behaviour (Miller & Glinski, 2000;
Slee, Spinhoven, Garnefski, & Arensman, 2008). Research suggests that interventions should build alternative coping, communication and stress management skills (Lloyd-Richardson, Perrine, Dierker, & Kelly, 2007). As a corollary, taking a targeted early intervention coping skills based approach would be beneficial in the treatment of at risk youth (Lloyd-Richardson et al., 2007; O'Connor, Rasmussen, Miles, & Hawton, 2009; Wang et al., 2011).

The Council of Australian Governments (COAG) developed a policy response to suicide outlined in the document, “Living is for everyone: A Policy Framework for Prevention of Suicide in Australia” (Commonwealth of Australia, 2008). This policy highlights the importance of early intervention with identified at risk groups with a focus on providing specialist care to reduce suicide attempts. The policy recommends increasing individual protective factors through treatments that build personal competence in social and emotional coping skills. Additionally, “The National Standards for Mental Health Services” (Commonwealth of Australia, 2010) was developed to guide practice and quality improvement in the mental health sector. Of relevance to this study, standard 10 indicates that treatment should be consistent with current evidence based guidelines and provide clinicians with access to continuing professional development.

Dialectical Behaviour Therapy (DBT), a form of Cognitive Behavioural Therapy originally developed for the treatment of suicidal clients, provides a comprehensive framework for directly targeting life threatening behaviour and associated emotional and social skill deficits (Linehan, 1993). DBT represents both a best practice option for early intervention as well as a mechanism for ongoing work force development. DBT has a credible base of evidence for its effectiveness with replicated efficacy for reducing suicidal behaviour with chronically suicidal adult clients with BPD and co morbid disorders (Backer, Miller, & van den Bosch, 2009). DBT has nine published randomized controlled trials that support the effectiveness of treating a number of behavioural problems including suicide.
attempts, NSSIB and BPD criterion behaviours in adults (Linehan et al., 2006; van den Bosch, Koeter, Stijnen, Verheul, & van den Brink, 2005; Verheul et al., 2003).

Although at the time of this study no randomized controlled trials had been published using DBT with adolescents, DBT is likely to be just as effective with adolescents as it is with adults (Backer et al., 2009; Miller, Rathus & Linehan, 2007). Quasi-experimental and pre-post treatment design studies have shown promising results including reductions in: suicide attempts, NSSIB, suicidal ideation, depression, borderline personality disorder, the need for hospital admissions and behavioural incidents while an inpatient (Backer et al., 2009; Fleischhaker et al., 2011; Katz, Cox, Gunasekara, & Miller, 2004; Rathus & Miller, 2002). Further evidence of the utility of DBT with younger age groups can be seen in its effectiveness with preadolescent children, where it has been shown to increase adaptive coping and decrease depressive symptoms and suicidal ideation (Perepletchikova et al., 2011).

Additionally, clinicians find participating in DBT programs protective against the difficulties associated with working with BPD by having access to ongoing professional development, peer support and supervision (Perseius, Kaver, Ekdahls, Asberg, & Samuelsson, 2007). Other studies have shown that training in DBT can result in less pessimistic and more hopeful relating to clients presenting with BPD (Hazelton, Rossiter, & Milner, 2006). Moreover, clients believe DBT can be life saving and value the mutual respect collaboration, understanding and capacity building aspects of DBT (Perseius et al., 2003).

1.7.2 Working with families

The NICE guidelines (2009) emphasis on embedding treatment programs for BPD within CAMHS highlights the importance of providing a systemic approach to working with adolescent clients and their families. Research suggests that family interventions are important when working with youth with depression and BPD (Tuisku et al., 2009). In terms
of the emotion regulation difficulties seen in suicidal youth, studies indicate parenting can moderate the effects of emotion regulation difficulties on the development of depressive symptoms (Feng et al., 2009). DBT adaptations for adolescents emphasize the importance of parental involvement in treatment including skills group attendance by both parent and adolescent (Miller et al., 2007).

Additionally, parents require timely support, information and knowledge including reassurance that appropriate care and treatment is being provided (Byrne et al., 2008). DBT provides a comprehensive framework, direction for recovery and an easily understood treatment rationale (Miller et al., 2007). DBT clearly outlines the role, goals and targets of therapy and actively engages clients and parents to participate in the treatment framework (Miller et al., 2007). For example, suicidal behaviour is considered the highest priority treatment target in DBT and is explicitly treated by the individual therapist and functionally analysed in relation to its antecedents including family discord. Moreover, the explicit and direct conversations about suicidal behaviour and collaborative underpinnings of DBT may provide parents with reassurance hope and support.

1.7.3 Depression

Although Cognitive Behavioural Therapy (CBT) has been found to be effective in treating adolescent depression (Abeles et al., 2009; Crail-Melendez, Herrera-Melo, Martinez-Juarez, & Ramirez-Bermudez, 2012; Hides et al., 2011; Jimenez Chafey, Bernal, & Rossello, 2009; Klein, Jacobs, Reinecke, 2007) its impact may be limited with highly complex clients presenting with co morbid BPD and suicidal behaviour (Miller et al., 2007). Difficulties emerge, for example, when suicidal and life threatening behaviour are not treated directly or when therapy interfering behaviour associated with BPD are not included in the treatment model and compromise the effectiveness of treatment (Miller et al., 2007).
Dialectical Behaviour Therapy (DBT) is designed to treat suicidal clients with multiple comorbid conditions (Miller et al., 2007). This occurs through a comprehensive multi modal behavioural approach including weekly individual therapy, skills group, telephone consultation to aid skills generalisation, family therapy (as required) and peer supervision (for clinicians). DBT aims to motivate clients to change, enhance client psychological coping capabilities, ensure skills are generalised to client’s environment and structure the environment so that it supports the clients’ recovery (Linehan, 1993; Miller et al., 2007).

Additionally, quasi experimental designs have shown DBT brings significant reductions in depression (McQuillan et al., 2005). In a promising study with treatment resistant adult clients for whom medication had not produced change, participation in a DBT skills group showed significant reductions in depressive symptoms at follow-up (Harley, Sprich, Safren, Jacobo, & Fava, 2008). Additionally, DBT has been found to enable effective emotion processing in youth with treatment resistant depression and helped reduce depressive symptoms (Harley et al., 2008; Feldman, Harley, Kerrigan, Jacobo, & Fava, 2009).

1.7.4 Emotion regulation

Researchers suggest targeting emotion regulation difficulties and associated psychiatric distress is a clinically meaningful construct that should be targeted in clinical settings (Bradley et al., 2011). As mentioned above emotion regulation difficulty has been implicated in suicidal behaviour, BPD and depression. DBT represents a treatment specifically designed to treat emotion regulation difficulties and maladaptive behaviours functionally related to regulating problematic emotions (Linehan, 1993) and research has demonstrated improved emotion regulation accounts for increased behavioural control in BPD patients (Axelrod, Perepletchikova, Holtzman, & Sinha, 2011).

The underlying theory and approach of DBT provides clinicians with a framework for understanding clients presenting with emotion regulation difficulties and associated
dysfunctional behaviour. DBT lays out a developmental biosocial theory of emotion regulation difficulties (Linehan, 1993). The core tenet of the bio social theory is the primacy of a pervasively disordered emotion regulation system (Miller et al., 2007). Difficulties arise when an emotionally vulnerable person with difficulties modulating emotions experiences a pervasively invalidating environment. Emotional vulnerability refers to having high sensitivity to emotional stimuli, intense emotional responses and slow return to emotional baseline (Linehan, 1993). Deficits in emotion modulation include problems maintaining goal oriented behaviour while experiencing strong emotions, inability to increase or decrease physiological arousal, difficulty inhibiting mood dependent dysfunctional behaviour, inability to distract from emotionally evocative material and exposure to emotional experiences without reactive avoiding or producing an extreme secondary emotional response (Linehan, 1993).

Invalidation refers to a tendency to respond erratically and inappropriately to private experiences (Linehan, 1993). This includes dismissing, trivialising, punishing and disregarding emotional experiences or attributing them to socially unacceptable characteristics such as over reactivity, inability to see things realistically, lack of motivation and being manipulative (Miller et al., 2007). In this situation the environment does not teach the emotionally vulnerable person to label private experiences, effectively regulate emotions and trust their experiences as valid responses to events. Instead they learn to actively search the environment for cues on how to respond and oscillate between extreme emotional inhibition and emotional displays (Linehan, 1993; Miller et al., 2007). Additionally, the environment does not teach the person how to tolerate distress, solve difficult problems in living and use shaping and other behavioural strategies to effectively self regulate. Instead, the person learns to respond with high negative arousal to failure, form unrealistic goals and expectations and hold perfectionist standards (Linehan, 1993; Miller et al., 2007).
DBT espouses a concurrent acceptance and change methodology to treatment with an emphasis on validating the client’s experience while at the same time pushing for more adaptive responses. With evidence indicating emotion regulation difficulties play a role in suicidal behaviour, BPD and depression in adolescents, DBT may provide a trans diagnostic approach to clients presenting to CAMHS.

1.7.5 Summary

Specialised mental health services such as CAMHS have an important role to play in the prevention of suicide by providing early detection and treatment. At the time of the present study, no specific CAMHS treatment protocol existed for working with suicidal and non-suicidal self-injuring clients presenting with BPD and depression. Acknowledging the serious impact suicidal behaviour, BPD and depression has on the trajectory of young people and understanding the specific needs of adolescent clients presenting with these difficulties is critical for CAMHS to implement effective treatment programs. Clients presenting with suicidal behaviour, BPD and depression typically have coping skill deficits in a number of psychosocial domains. For example, dysregulated anger, impulsivity and unstable relationships. These difficulties can be conceptualised as emotion regulation deficits including maladaptive behaviours designed to regulate problematic emotions. In the current study, DBT was identified as a credible treatment option because it aims to target the reduction of suicidal behaviour directly as well as emotion regulation difficulties associated with BPD and depression.

1.8 Applied research

Research conducted in routine clinical settings can provide valuable information for services wanting to implement best practice interventions. In a Swedish outpatient study with BPD adolescents and youth, DBT was implemented successfully, with decreases in client NSSIB and measures of distress (Hjalmarssson, e., Kaver, A., Perseius, K., Cederberg, &
Ghaderi, 2008). Additionally, using an adapted version of DBT for adolescents (Miller et al., 2007), a German pilot study achieved positive results including reductions in suicidal behaviour and suicide attempts (Fleischhaker, Munz, Bohme, & Schulz, 2006). These and other preliminary results provide initial evidence for the usefulness DBT in applied settings. Locally, preliminary research has shown that DBT has clinical utility and can be successfully implemented within existing Australian public mental health services (Brassington & Krawitz, 2006). In a separate applied Australian study with adults meeting the diagnostic criteria for BPD, DBT was found to be cost effective and produced reductions in depression, suicidal behaviour, emergency department visits and psychiatric admissions (Pasieczny & Connor, 2011). Additionally, DBT has resulted in improved disability and quality of life in an Australian public mental health service setting (Carter, Wilcox, Lewin, Conrad & Bendit, 2010).

Although DBT is regarded as a best practice intervention for suicidal youth, clients often do not get access to established best practice interventions in routine clinical mental health care (Shafran et al., 2009). If it is assumed that people accessing public mental health services should be able to access best practice therapeutic interventions, local pilot programs need to be implemented to develop best practice interventions in these settings. This evidence could provide mental health administrators with the incentive to provide ongoing resources to implementing DBT. Moreover, as outlined in “The National plan for Suicide Prevention” (Department of Health and Ageing, 2007), it is important to determine what types of treatments are needed for specific groups as well as researching outcomes to determine treatment effectiveness.
1.8.1 The current study

As discussed above, the literature indicates that suicidal behaviour, borderline personality disorder and depression are highly prevalent and complex conditions in adolescent populations presenting to CAMHS. Moreover, emotion regulation difficulties are characteristic of these problems and amenable to skills based interventions such as DBT. DBT has been shown to be effective in reducing suicidal behaviour, BPD and depression. Additionally, DBT appears to be well received by clinicians who develop greater knowledge and skills as a consequence of participation in DBT training and programs. Nevertheless, there are not yet many studies that give an indication as to the effectiveness and feasibility of DBT within a routine Australian CAMHS setting.

1.8.2 General aims

At the time of this study, there had been no systematic comprehensive DBT program within Mental Health Services in the Australian Capital Territory. The initial aim of the present study was to design, implement and evaluate a pilot CAMHS DBT program for suicidal adolescents presenting with BPD and depression.

1.8.3 Specific aims and hypothesis

The first aim of the current study was to design and implement a comprehensive CAMHS DBT program. This required a significant period of service development including: program design, identifying barriers to implementing the program effectively and developing an implementation strategy.

In terms of clinical aims, the goal of the first stage of DBT is the establishment of behavioural control (Linehan, 1993). To establish behavioural control DBT prioritises behaviours to be changed according to a treatment hierarchy. At the top of the hierarchy is reducing suicidal behaviour followed by reducing therapy interfering behaviour and quality of life interfering behaviour. As a corollary, the primary clinical target of the CAMHS pilot
DBT program was to reduce suicidal ideation and suicidal behaviour. Reducing suicide risk and crisis behaviour enables clients to benefit more fully from ongoing therapy. Further down the DBT treatment hierarchy is the reduction of quality of life interfering behaviour. Although secondary to the priority of reducing suicidal behaviour and ideation, quality of life interfering behaviour, such as depression and BPD criterion behaviours including impulsivity, interpersonal chaos, confusion about self and emotion dysregulation, was also addressed in the CAMHS pilot DBT program. Reducing quality of life interfering behaviour such as core BPD behaviours and depression were addressed by the program as secondary targets. Additionally, as social and emotional difficulties are reduced protective factors against suicide should emerge.

The primary clinical aim of the present study was to determine the effectiveness of the CAMHS pilot DBT program in reducing suicidal behaviour and ideation. It was hypothesised that at follow-up, clients graduating from the CAMHS DBT program would have significantly reduced suicidal behaviour and suicidal ideation.

The secondary aim of the CAMHS DBT program was the reduction of core BPD behaviour and depression. It was hypothesised that at follow-up, clients graduating from the CAMHS DBT program would have significantly reduced core symptoms of depression and BPD including impulsivity, emotion dysregulation, interpersonal chaos and confusion about self.

An additional secondary aim of the CAMHS DBT program was the development of protective factors against suicide. It was hypothesised that at follow-up clients graduating from the CAMHS DBT program would have significantly increased protective factors against suicide such as future optimism, peer acceptance and support and suicide related concerns.
1.9 Project design

The current study aimed to design, implement and evaluate DBT into CAMHS as a fully integrated coordinated approach for the treatment of suicidal, NSSIB, BPD and co morbid conditions such as depression. The design of the current study consisted of three interrelating aspects including a) program development and program design, b) implementation barriers, implementation design and outcomes, and c) evaluation design and outcomes. Initially, a period of program development was undertaken in collaboration with relevant stakeholders using core treatment guidelines and protocols. A program design was then established ready for implementation. An implementation design was then developed including strategies to manage foreseeable barriers to implementation. The treatment was then implemented using a 4 phase strategy from January 2010 to December 2010. An evaluation designed was then used to measure the clinical effectiveness of the program.
CHAPTER TWO

Program Development and Design

2.1 Program development

After identifying the need for a systematic approach to working with suicidal behaviour and BPD, ACT Mental Health Services set up a DBT working group to promote both the National Institute of Clinical Excellence (NICE) clinical treatment guidelines for BPD (The National Collaborating Centre for Mental Health, 2009) and the implementation of DBT within the various directorates of mental health services. The working group used the NICE guidelines and mental health policy frameworks to support the promotion of developing DBT programs across the different directorates of the service. The working group consisted of the principle psychologist of Mental Health ACT, 1 adult team leader (psychologist), 1 CAMHS team leader (the author – psychologist) and 1 senior clinician (psychologist). Table 2 identifies points from the NICE guidelines most relevant to young people and the current study.

The DBT working group aimed to align with “The Council of Australian Governments” (COAG) National Action Plan for Mental Health (2006). The Plan aimed to; increase the proportion of people with an emerging or established mental illness who are able to access the right health care, invest in health services for young people with a focus on early intervention and develop more specialist mental health services. In terms of early intervention, studies have shown significant reductions in all BPD criterion behaviours when using DBT with adult and adolescent clients (Rathus & Miller, 2002; Stepp, Epler, Jahng, &
Trull, 2008). Developing a specialist CAMHS DBT program would provide clients with access to a best practice, early intervention and skills based program designed to reduce suicidal behaviour and increase behavioural skills.

Table 2. National Institute of Clinical Excellence

<table>
<thead>
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<th>BPD Guidelines</th>
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<tr>
<td>• Young people with a diagnosis of Borderline Personality Disorder or symptoms and behaviour that suggest it should have access to the full range of treatments and services recommended in the guidelines, but within CAMHS.</td>
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<tr>
<td>• Public mental health services should develop multidisciplinary specialist teams and/or services for people with personality disorders.</td>
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<tr>
<td>• Dialectical Behaviour Therapy (DBT) is effective in reducing suicidal behaviour.</td>
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<tr>
<td>• Therapy programs should be embedded by the theoretical underpinnings of the chosen treatment.</td>
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In order to develop DBT as a comprehensive treatment program within CAMHS, a period of marked service development and integration was required. Importantly, clinical guidelines such as the NICE recommendations and service development plans and priorities provide an opportunity for implementing new treatment practices. The ACT “Mental Health Services Plan” (2009) identifies a life stage model for reconfiguring mental health services. This involves reconfiguring services built around developmental and life milestones for children and youth including moving from 0-18 to 2 new services, child (0-11) and Youth (12-25). In terms of the 12 to 25 year old youth service, the plan outlines the importance of focussing on early onset mood and BPD with an emphasis on early identification, pre crisis intervention and family carer involvement. In the context of the move to a youth model, pilot programs aimed at reducing suicidal behaviour, BPD and depressive symptoms are of critical importance in building readiness for a move to a 12 to 25 model. DBT may provide a
comprehensive framework for use with a number of suicidal co morbid presentations where emotion regulation is implicated in these conditions. Moreover, DBT specifically aims to reduce suicidal and crisis generating behaviours and actively engages families in treatment.

DBT dovetails with the “National plan for Suicide Prevention” (Department of Health and Ageing, 2007), “The National Standards for Mental Health Services” (Commonwealth of Australia, 2010), “The National Action Plan for Mental Health” (COAG, 2006) and “The ACT Mental Health Services Plan” (2009). Additionally, DBT has a promising base of evidence supporting its use with adolescents and is an endorsed treatment by a panel of experts responsible for the development of The National Institute of Health and Clinical Excellence for working with BPD (NICE, 2009). Furthermore, DBT provides an understandable and supportive framework for parents and builds capacity into services by empowering clinicians and teams.

As a corollary, after scoping relevant clinical guidelines and policy frameworks, the DBT working group recommended proceeding with piloting a DBT program within CAMHS. Additionally, this recommendation was endorsed by the CAMHS executive and the Chief Executive Officer of mental health ACT. The author was nominated to lead the project.

2.1.1 Applying DBT to CAMHS

The design of the CAMHS DBT program drew from a number of core sources. These sources included: Linehan’s (1993) Cognitive Behavioural Treatment for Borderline Personality Disorder, Miller et al. (2007) adaptation of Dialectical Therapy for Suicidal Adolescents (DBT-A), DBT intensive training attended by the author (Comtois & McCann, 2007) and previous experience participating in DBT programs. Linehan (1993) and Miller et al. (2007) outline core elements of DBT including a developmental framework of integrated treatment stages, a prioritised hierarchy of treatment targets within each stage, a
comprehensive set of functions and modes, biosocial theory of emotional difficulties, selected strategies to accomplish behavioural targets and a dialectical approach to treatment.

The developmental framework of DBT outlines stages of client recovery including orientation and commitment to therapy, establishing behavioural control, decreasing post traumatic distress, increasing self-respect and achieving individual goals (Linehan, 1993; Miller et al., 2007). Using this developmental framework was considered a priority in designing the CAMHS DBT program.

2.2 Program design

The CAMHS DBT program represents a direct attempt to adapt and implement many of the recommendations and protocols outlined in “Dialectical Behavior Therapy with Suicidal Adolescents” (Miller et al., 2007). After liaising with Dr Miller (personal communication, January 2010), a 20 week version of DBT-A was designed to integrate the first two developmental stages of DBT including: orientation, commitment and establishing behavioural control. As seen below in figure 1, the program was divided into 3 stages. Stage 1 included assessment, orientation and commitment. Stage 2 included participation in the twenty week multimodal program. Stage 3 involved graduation, ongoing treatment and discharge, depending on the client’s needs.
Stage 1
Approximately 8 sessions
Assessment
- Inclusion criteria
- Feasibility
Pre-treatment
- Orientation
- Commitment

Stage 2
20 week Multi Modal DBT Program
- Establishing behavioural control
- Reduce suicidal behaviour
- Reduce emotional instability and suffering

Stage 3
Graduation
- Skill consolidation
- Ongoing therapy
- Discharge

Figure 1. The developmental stages of CAMHS DBT program
2.3 Stage one: Assessment, orientation and commitment

Stage 1 of the treatment design involved conducting a clinical interview with the client and family, determining the feasibility of treatment for the client, building a productive relationship with the client, orienting the client to the treatment goals and tasks and establishing sufficient commitment to treatment. This phase was allocated approximately 8 sessions.

2.3.1 Assessment and feasibility

The first stage of the CAMHS DBT program included assessment of inclusion criteria, assessment of treatment feasibility and completion of the pre-treatment tasks. Initially a comprehensive assessment was conducted to determine if the adolescent met the inclusion criteria for the program (inclusion and exclusion criteria for the program are listed below in table 3). In line with Miller et al. (2007) a comprehensive DBT program assessment battery was developed to evaluate suicide risk, NSSIB, mental disorders and feasibility for inclusion in the DBT program. The assessment protocol integrated the Structured Clinical Interview for DSM-IV Personality Disorders (First, Gibbon, Spitzer, Williams, & Benjamin, 1997), and the Suicide Attempt Self Injury Interview (Linehan, Comtois, Brown, Heard, & Wagner, 2006) to provide additional structure to the existing CAMHS assessment module. Additionally, the assessment battery investigates specific outcomes targeted by DBT including suicidal and non-suicidal self-injurious behaviour, protective factors against suicide, core aspects of BPD and depression.
### Table 3. DBT program inclusion and exclusion criteria

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<tr>
<th>Inclusion Criteria</th>
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<tr>
<td>Ages 15 - 18</td>
<td>Psychosis</td>
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<tr>
<td>Suicide attempt in the past 20 weeks</td>
<td>Cognitive impairment</td>
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<tr>
<td>Suicidal ideation</td>
<td>Primary conduct disorder</td>
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<tr>
<td>Exhibiting at least 3 Borderline Personality features</td>
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<td>Depression</td>
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<td>Using unsustainable behaviours to regulate emotion</td>
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</tbody>
</table>

Treatment feasibility is a critical issue for clients with self-management deficits, whom experience regular crisis, and are reliant on parents and others for transport (Miller et al., 2007). Feasibility factors investigated by the assessing clinician included: does the client want to attend and are they willing to work on treatment targets, do the parents endorse the treatment program and can at least one parent attend the duration of the program with the adolescent. Clinicians were asked to view feasibility issues non-judgementally and to focus on validating the family’s feasibility issues as well as taking a problem-solving approach to resolving them. It was hoped that time spent problem solving feasibility issues in stage 1 would provide the adolescent and parents with a successful early experience in treatment. The core principle at this step of the assessment process was ensuring client and parent had sufficient commitment to potentially benefit from the program. Anything short of this would mean the client would remain in pre-treatment up until the time when they and the parent were able to make a behavioural commitment that would make benefitting from the program possible.

Contingent on meeting the inclusion criteria and establishing the feasibility of treatment, clients were then moved into pre-treatment. Clients not meeting the criteria for the program
or for whom treatment was highly unlikely to be successful due to feasibility issues are referred back to community teams for treatment as usual. Table 4 below lists the feasibility component of the DBT assessment adapted from Miller et al. (2007).

Table 4. Feasibility criteria

<table>
<thead>
<tr>
<th>Feasibility Issue</th>
<th>Feasibility Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is DBT the appropriate treatment?</td>
<td>Are other less comprehensive interventions likely to be effective?</td>
</tr>
<tr>
<td></td>
<td>Does the client meet the inclusion criteria?</td>
</tr>
<tr>
<td>Does the client want to attend?</td>
<td>Is the client able to make a behavioural commitment to attend individual and group sessions for the 20 weeks?</td>
</tr>
<tr>
<td>Is the client willing to prioritise treatment targets?</td>
<td>Is the client willing to prioritise reducing life threatening behaviour, therapy interfering behaviour, quality of life interfering Behaviour?</td>
</tr>
<tr>
<td></td>
<td>Is the client willing to learn and apply skilful behaviours?</td>
</tr>
<tr>
<td>Do the parents endorse the program?</td>
<td>Do the parents understand the different aspects of the program and their associated goals?</td>
</tr>
<tr>
<td></td>
<td>Have the parents made a commitment to twice-weekly attendance?</td>
</tr>
<tr>
<td></td>
<td>Has at least one parent made a commitment to attend group?</td>
</tr>
</tbody>
</table>

2.3.2 Orientation and commitment

An orientation and commitment checklist was adapted from Miller et al. (2007) to provide a readily accessible in-session guide to working through pre-treatment tasks (See Appendix A, Clinicians Toolkit). Pre-treatment aims to facilitate improved understanding for the client of their difficulties, to gain an appreciation of the goals and tasks of the DBT program, to
underline the emphasis on learning new behaviours and the importance of making a
behavioural commitment to the program (Linehan, 1993; Miller et al., 2007). Using the
checklist provided both new and more experienced clinicians with a framework to discuss
progress through pre-treatment and problem solve pre-treatment difficulties. Table 5 below,
lists tasks designed to move the client through pre treatment adapted from Miller et al (2007).

**Table 5. Orientation and commitment strategies**

<table>
<thead>
<tr>
<th>Orientation and Commitment Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Begin to establish a therapeutic alliance</td>
</tr>
<tr>
<td>2. Fold adolescent's specific problems into areas of regulation difficulties and explain corresponding skills to develop to address each problem area</td>
</tr>
<tr>
<td>3. Define adolescent's specific problems as primary target behaviours</td>
</tr>
<tr>
<td>4. Elicit Clients long-term goals, and link these to work on stage 1 target behaviours</td>
</tr>
<tr>
<td>5. Introduce the biosocial theory</td>
</tr>
<tr>
<td>6. Introduce the treatment's format and characteristics</td>
</tr>
<tr>
<td>7. Introduce DBT diary cards</td>
</tr>
<tr>
<td>8. Review treatment agreements</td>
</tr>
<tr>
<td>9. Use commitment strategies with adolescent to obtain and strengthen commitment</td>
</tr>
<tr>
<td>10. Use commitment strategies with adolescent and family members to obtain and bolster commitment</td>
</tr>
</tbody>
</table>

2.3.3 Establishing a therapeutic alliance

Fostering a productive therapeutic alliance with adolescent clients is important to the overall success of treatment. Some studies have indicated that negative health care experiences are related to increased risk and future suicidal behaviour (Samuelsson et al., 2000; Strike, Rhodes, Bergmans, Links, 2006). This is a critical issue as engaging suicidal youth in treatment can be highly challenging and many do not complete treatment (Burns, Cortell, & Wagner, 2008; Miller, Smith, Klein, & German, 2010). In line with recommendations made by Linehan (1993) and Miller et al. (2007), the first stage of the
CAMHS DBT program was designed to maximise the potential for engaging the client in treatment by laying the foundations of a successful therapeutic alliance. A successful therapeutic alliance with adolescent clients has been found to predict treatment satisfaction, retention and outcomes (Friedberg & Brelsford, 2011; Hawke, Hennen, Gallione, 2005; Hintikka, Laukkanen, Marttunen, & Lehtonen, 2006; Karver, Handelsman, Fields, & Bickman, 2006; Thompson, Bender, Lantry, & Flynn, 2007). The therapeutic alliance has been found to be critical in helping adolescent clients experiencing a number of psychological difficulties including reducing cannabis use (Diamond et al., 2006), suicidal behaviour and alcohol use (Esposito-Smythers, Spirito, & LaChance, 2006), depression (Shirk, Gudmundsen, Kaplinski, & McMakin, 2008), obsessive compulsive disorder (Keeley, Geffken, Ricketts, McNamara, & Storch, 2011) and BPD (Bennett, Parry, & Ryle, 2006). Additionally, a strong alliance between therapist and parent has been found to predict positive outcomes for adolescents in family based interventions (Isserlin & Couturier, 2012). Moreover, researchers have identified the importance of building a supportive alliance of stakeholders to provide a social structure that supports the growth and development of the adolescent (Feinstein, Fielding, Udvari-Solner, & Joshi, 2009; Thompson et al., 2007).

Conversely, ruptures in the therapeutic alliance and therapy incompletion are very common with patients who have a diagnosis of borderline personality disorder (Bennett et al., 2006) and clients with interpersonal and emotion regulation difficulties potentially challenge the development of a successful therapeutic alliance (Saunders, 2001). As a corollary, factors conducive to the development of a successful therapeutic alliance were prioritised in the early pre-treatment stages of the program. For example, therapists actively used adolescent friendly communication and engagement strategies to secure a bond with their client and parents were engaged as valued participants in the program with an important contribution to make.
Attending to the parent’s fears and concerns in relation to their child was prioritised during this stage.

**2.3.4 Orienting the adolescent and family**

Orienting the adolescent and family to DBT ensures the adolescent and parents have a firm grasp of the program and the associated expectations and agreements (Miller et al., 2007). Initially, orienting clients to DBT involved reconceptualising their problems into the five problem areas of dysregulation: confusion about self, interpersonal chaos, emotional instability, impulsivity and adolescent-family dilemmas (Linehan, 1993; Miller et al., 2007). The clinician then outlined specific skills for each problem area as outlined in the Clinician Toolkit (appendix A). This process explicitly connects the adolescent’s difficulties into a coherent framework of understanding and recovery (Linehan, 1993).

**2.3.5 Defining primary target behaviours**

DBT is predominantly a behavioural treatment with an emphasis placed on clearly defined behaviours to increase and decrease (Linehan, 1993; Miller et al., 2007). Defining adolescent behaviours to increase and decrease within the DBT treatment hierarchy provides additional clarity and focus for treatment in terms of how the content of future sessions will be derived. Life threatening, therapy interfering and quality of life interfering behaviours were identified for each client with an emphasis on explaining how each group of behaviours is prioritised. For example, suicidal behaviour is prioritised over therapy interfering behaviour and quality of life interfering behaviour.

**2.3.6 Long term goals**

A fundamental tenet of DBT is decreasing and increasing certain behaviours for the purpose of building life worth living (Linehan, 1993, Miller et al., 2007). Goal setting was designed to personalise the treatment program and provide context for change. Numerous questions, adapted from Linehan (1993) and Miller et al. (2007), were used at this stage of
the treatment design to elicit goals from client (see Clinicians Toolkit, Appendix A). Clinicians were encouraged to take what they could when clients had difficulty setting concrete goals.

2.3.7 Biosocial theory

The bio-social theory of emotion regulation is critical to helping clients and parents understand their difficulties and provide a clear rational on how emotion regulation difficulties emerge and are maintained (Linehan, 1993: Miller et al., 2007). Introducing the biosocial theory at this stage of the program was designed to promote shared understanding and hope for the adolescent and parent. Moreover, it was hoped that orienting families to the biosocial theory would enable parents to experience increased comprehension and understanding of the adolescent’s behaviours without feeling attacked or blamed. The Clinicians Toolkit in Appendix A, outlines the components of the biosocial theory used in pre-treatment adapted from Linehan (1993) and Miller et al., (2007).

2.3.8 Treatment format and characteristics

Reviewing the treatment format with the client and family member is designed to promote clear understanding and expectations of the comprehensive nature of the program (Linehan, 1993; Miller et al., 2007). Times, dates and the importance of attendance were explicitly outlined as was the importance of actively participating in all aspects of the program.

2.3.9 Diary card

Following a structured approach to treatment has been shown to improve the therapeutic alliance with adolescent clients (Langer, McLeod, & Weisz, 2011) and emphasising the structure of the DBT program was a key pre-treatment design feature. DBT uses a diary card to record the intensity of emotions, behavioural urges, and the frequency of target behaviours occurring between individual therapy sessions (Linehan, 1993; Miller et al., 2007). The diary card was used to identify the agenda for each individual therapy session, enhance client
mindfulness, promote accurate recall of feelings and treatment targets and monitor commitment and motivation (Linehan, 1993; Miller, et al., 2007). Introducing the diary card during pre-treatment allowed the therapist to identify and troubleshoot any difficulties or misunderstanding about the use of the diary card early in the program (Miller et al., 2007).

2.3.10 Therapy agreements

Client, therapist, and family agreements were discussed towards the culmination of the orientation stage of treatment as per the treatment protocol (Linehan, 1993; Miller et al., 2007). They set out the responsibilities and goals for therapist, adolescent and parents. Therapists ask for a verbal agreement from clients to complete the 20 week program and to work on reducing life threatening, therapy-interfering and quality of life interfering behaviours and increase skilful behaviour. Therapists agree to make every effort to be effective, to work in an ethical and professional manner, to be available for phone coaching, to act respectfully to the client, to adhere to confidentiality requirements and participate in supervision (Miller et al., 2007).

2.3.11 Commitment Strategies

Commitment strategies are weaved throughout DBT and are critical to galvanising an initial behavioural commitment to participating in the program (Linehan, 1993; Miller et al., 2007). DBT uses specific techniques to elicit and reinforce client commitment including the following techniques: foot in the door, door in the face, pros and cons, freedom to choose and absence of alternatives and reconnecting to previously made commitments (Linehan, 1993). It was anticipated that adolescents presenting to the program would likely have some difficulties with commitment and the strategy of shaping commitment was emphasized. This practice was designed to validate commitment difficulties while concurrently eliciting and reinforcing incremental commitment from clients.
2.4 Stage two: 20 week program

After completing pre-treatment the client was then moved into stage 2 of the CAMHS DBT program. Stage 2 consists of adolescent and parent attending the 20 week comprehensive multi modal intervention based on the primary functions of DBT (Linehan, 1993; Miller et al., 2007). The overall goal of stage 2 was establishing behavioural control by targeting the reduction of suicidal and life threatening behaviour, therapy interfering behaviour, quality of life interfering behaviour and increasing adaptive skillful behaviour (Linehan, 1993). Miller et al., (2007) adapted standardised DBT to adolescent populations by introducing developmentally tailored approaches and integrating families into the treatment. DBT for suicidal adolescents (DBT-A) identifies 5 functions that the program as a whole must fulfil in order for these targets to be met (Miller et al., 2007). Table 6 below lists the 5 functions and their corresponding modes of delivery.

Table 6. CAMHS DBT program functions and corresponding treatment modes

<table>
<thead>
<tr>
<th>Function</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improving motivation</td>
<td>Weekly individual therapy</td>
</tr>
<tr>
<td>2. Enhancing capabilities</td>
<td>Weekly skills training with adolescents and parents</td>
</tr>
<tr>
<td>3. Skill generalisation</td>
<td>Telephone consultation, individual therapy, family therapy</td>
</tr>
<tr>
<td>4. Structuring the environment</td>
<td>Interventions with family members and other providers</td>
</tr>
<tr>
<td>5. Enhancing capabilities and</td>
<td>Weekly consultation team</td>
</tr>
<tr>
<td>motivation of therapists</td>
<td></td>
</tr>
</tbody>
</table>

2.4.1 Program structure

The 20 week CAMHS DBT program consisted of weekly individual therapy of 1 hour, weekly skills group of 2 hours, as needed phone coaching, as needed family therapy and weekly clinician consultation group. Figure 2 below outlines treatment modalities provided to adolescents and their parents during the 20 week program.
2.4.2 Individual therapy

In line with the standard treatment model, the individual therapist in the CAMHS DBT program was the primary clinician responsible for the client (Linehan, 1993; Miller et al., 2007). Individual therapists are responsible for building and enhancing client motivation and capabilities, identifying behaviours to increase and decrease, setting and monitoring goals with the client, helping the client develop insight into their patterns of behaviour and helping them find and commit to more skilful solutions.

**Figure 2. CAMHS 20 week DBT program**

DBT individual therapy has a firm hierarchy informing the content and agenda for each session as well as a clearly laid out structure designed to shape more functional behaviour (Linehan, 1993; Miller et al., 2007). The hierarchy identifies targets in order of treatment priority: decreasing suicidal and life threatening behaviour, decreasing therapy interfering behaviour, decreasing quality of life interfering behaviour and increasing more skilful
behaviour. Using the hierarchy to prioritise the session agenda enables the therapist to collaboratively assess and problem-solve suicidal behaviour before moving onto to other target behaviours further down the hierarchy. Figure 3 below outlines DBT hierarchy for the CAMHS DBT program individual therapy sessions.

Figure 3. DBT individual therapy treatment hierarchy

As outlined in Miller et al. (2007), individual therapy sessions have a beginning, middle and ending sequence. After identifying the occurrence of any target behaviours in the previous week, a functional analysis was conducted to better understand and generate insight into dysfunctional behaviour. Strategies were then employed to develop skilful solutions to future similar situations. Orienting the client to the importance of implementing the identified skill and gaining a commitment to perform such behaviour was then targeted. Barriers to implementation were then identified and problem-solved and homework set for the coming week. Table 7 below outlines the individual therapy session structure.

2.4.3 DBT multifamily skills group

The CAMHS DBT skills group followed a didactic behavioural format as outlined in Lineman’s (1993) “Skills Training Manual for Treating Borderline Personality Disorder”
combined with some adolescent specific adaptations (Callahan, 2008; Christensen, Riddoch, & Huber, 2009; Miller et al., 2007). The resources listed above were used and adapted in the design of the “CAMHS DBT Program Work Book” (Appendix B). The purpose of developing the workbook was to provide the adolescent and the parent with a readily accessible amalgam of the skills taught in group.

DBT skills group blends a classroom and therapy group environment with an emphasis on the acquisition and generalisation of behavioural skills (Linehan, 1993). The original DBT skills group for adults is a year-long program and unlikely to be feasible with adolescents due to the length of commitment required (Miller et al., 2007). As a corollary, the CAMHS program was designed to run for 20 weeks. Although, at the time of this study, DBT for suicidal adolescents was 16 week protocol (Miller et al., 2007), consultation with Dr Miller lead to expanding the CAMHS program to 20 weeks to ensure enough time was given to learning the skills (personnel communication, February, 2011).

Table 7. Individual therapy structure

<table>
<thead>
<tr>
<th>Session Sequence</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning session</td>
<td>1. Mindfulness exercise</td>
</tr>
<tr>
<td></td>
<td>2. Review diary card</td>
</tr>
<tr>
<td></td>
<td>3. Set session agenda</td>
</tr>
<tr>
<td></td>
<td>4. Review homework</td>
</tr>
<tr>
<td>Mid-session</td>
<td>5. Chain analysis</td>
</tr>
<tr>
<td></td>
<td>6. Solution Analysis</td>
</tr>
<tr>
<td>Session-ending</td>
<td>7. Set and agree on homework</td>
</tr>
<tr>
<td></td>
<td>8. Summarize session</td>
</tr>
</tbody>
</table>

The CAMHS DBT skills group contained modules from Lineman’s original skills training manual (1993) including mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance. Additionally, the CAMHS program included developmental adaptations.
including a module designed for adolescent and parent difficulties (Miller et al., 2007). Each module was designed to teach replacement behaviours for previously ineffective responses. Table 8 below lists the 20 week skills group schedule, modules and module function.

The CAMHS DBT skills group format involved meeting for 2 hours weekly for the 20 week program. The first 45 minutes was designed to review skill practice and to foster learning and the generalisation of skills. After a break of 15 minutes the group would reconvene and new skills were taught. To keep the group engaged a number of strategies were used including different teaching modalities, irreverent communication, humour, quick quizzing and adolescent friendly worksheets. Different teaching modalities included using “YouTube” video, movie and television clips to illustrate different skills and stimulate discussion. Interactive activities including role play was used to enhance learning. In order to generate more participation, group facilitators were encouraged to continually trace client difficulties back to learning and applying skills. Additionally, given the shorter time frame of group, clinicians continually emphasised the urgency of learning and applying the skills.

Table 8. CAMHS DBT program and skills training format

<table>
<thead>
<tr>
<th>Week</th>
<th>Module</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>Orientation, goals, group rules</td>
</tr>
<tr>
<td>2</td>
<td>Mindfulness</td>
<td>Strategies to direct and maintain the minds attention</td>
</tr>
<tr>
<td>4</td>
<td>Distress tolerance</td>
<td>Strategies to survive painful emotions or situations without making them worse.</td>
</tr>
<tr>
<td>9</td>
<td>Interpersonal effectiveness</td>
<td>Strategies to achieve goals, keep current relationships and maintain self respect.</td>
</tr>
<tr>
<td>13</td>
<td>Emotion regulation</td>
<td>Strategies to regulate painful affective states.</td>
</tr>
<tr>
<td>17</td>
<td>Walking the middle path</td>
<td>Strategies to help parent and child get unstuck</td>
</tr>
<tr>
<td>20</td>
<td>Review &amp; graduation</td>
<td>Review entire course and graduation ceremony.</td>
</tr>
</tbody>
</table>
All clinicians participating in the CAMHS DBT program participated in the skills group teaching roster. This was an explicit strategy designed to build additional learning about the skills and solidify the notion that DBT represents a community of clinicians treating a community of clients (Linehan, 1993). Usually, 2 clinicians were rostered to either take the homework review (first hour) or teach skills (second hour). A third or fourth clinician would also attend as an observer. After the completion of group, facilitators and observers would then feedback what they thought were effective and less effective behaviours by clinicians. Observations of client responses, participation and progress were then discussed and significant contributions or group interfering behaviour fed back to individual therapists.

The hierarchy of target behaviours for skills group are set out below in figure 4 (Linehan, 1993: Miller et al., 2007). The targets are designed to increase the probability of clients learning and applying skilful behaviour. Unlike the hierarchy in individual therapy, therapy interfering behaviour is put further down the hierarchy so as not to become overly preoccupied by moderately disruptive behaviour but rather aiming to reinforce effective participation in group and the use of DBT skills.

![Skills group hierarchy of target behaviours](image)

**Figure 4. Skills group hierarchy of target behaviours**

DBT-A utilises parents as key agents of change by including them in skills group (Miller et al., 2007). The CAMHS DBT Program was designed for the adolescent and at least one
parent to attend. Miller et al. (2007) suggests that utilising parents as agents of change can be critical to the success of treatment for adolescents. Parents can be a valuable model for their adolescent by displaying commitment to learn and apply skills. Moreover, parents can reinforce more skilful behaviour and help with identifying skills for particular situations.

Additionally, skills training provides another way of targeting the adolescent’s invalidating environment (Miller et al. 2007). Both adolescent and parent learn skills to communicate and manage conflict more effectively, to manage their feelings when interpersonal needs aren’t met and to work collaboratively to solve problems. As a corollary, an important strategy in setting up the program was ensuring both adolescent and parent felt welcome and had their learning needs identified and validated.

In order to strike a balance between providing enough spaces in group to meet demand and the unlikelihood of clients benefitting from a too large group, the CAMHS DBT program settled for 6 clients and 6 parents for each of the first two programs. It was viewed that more than a total of 12 participants would limit the effectiveness of group. For example, by limiting the capacity of facilitators to effectively review homework and spend enough time problem solving difficulties performing skills.

2.4.4 Phone coaching

The CAMHS DBT program was designed to provide phone coaching to clients and parents on an as needed basis. Phone coaching is designed to provide clients with the opportunity to access support and to facilitate the generalisation of skills to situations where more skilful responses are required (Linehan, 1993). At the time of this study, the program was unable to provide after hours phone coaching due to operational limitations. In order to bolster this part of the program, the author met with the local after-hours crisis and assessment team (CATT) Team Leader to orient them to the DBT program, the importance of
reinforcing and shaping skilful behaviour and the use of DBT oriented crisis plans and phone coaching.

2.4.5 Family therapy

The biosocial model clarifies the central role of the social and family environment in the development, maintenance and relapse associated with severe emotion regulation difficulties (Linehan, 1993; Miller et al., 2007). As a corollary, the CAMHS DBT program aimed to change dysfunctional aspects of family environs impacting significantly on life threatening behaviour, therapy interfering behaviour, quality of life interfering behaviour and the use of more effective functional behaviour. The CAMHS DBT program family sessions were conducted by individual therapists and designed to be scheduled on an as needed basis. The program used the guidelines set out by Miller et al. (2007) to guide clinicians to determine the need for scheduling a family session as well as the structure and goals for sessions (Appendix A, Clinicians Toolkit).

2.4.6 DBT team consultation group

Consultation group is an integral component of DBT which acknowledges that effective treatment of BPD must pay as much attention to therapist experiences and behaviour as it does to clients (Linehan, 1993). DBT consult group is designed to provide regular opportunities to discuss inevitable difficulties arising in therapy. Consult group emphasises applying DBT agreements, principles and strategies to create opportunities for improving clinician capabilities and the chances of successful therapy for clients (Linehan, 1993). The CAMHS DBT program consultation group was designed to provide ongoing support and problem solving opportunities to clinicians. The DBT consult agreements listed below in table 9, common to all adherent DBT programs, are designed to keep the therapist working within the principles and assumptions of DBT. This can be critical when clinicians become frustrated with clients and or feel hopeless about the therapy progressing (Linehan, 1993).
Table 9. DBT consult agreements

<table>
<thead>
<tr>
<th>Agreement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialectical</td>
<td>Consult members agree to accept a dialectical philosophy. There is no absolute truth so the goal is to look for the synthesis between opposites.</td>
</tr>
<tr>
<td>Consistency</td>
<td>Failures to carry out the treatment plans are indicative of living in the real world and provide opportunities for clients to respond effectively to real world situation.</td>
</tr>
<tr>
<td>Consultation-to-the-client</td>
<td>Consult with clients on how to interact with other treatment providers not on their behalf.</td>
</tr>
<tr>
<td>Observing Limits</td>
<td>All therapists should observe their own personal and professional limits.</td>
</tr>
<tr>
<td>Phenomenological Empathic</td>
<td>Search for the non pejorative and empathic interpretations of patients’ behaviour. Clients are trying their best and want to improve.</td>
</tr>
<tr>
<td>Fallibility</td>
<td>All therapists are fallible.</td>
</tr>
</tbody>
</table>

The CAMHS DBT program consisted of weekly consult meetings for 1.5 hours. At the start of consult different roles were assigned including chair, scribe, mindfulness and agreement observer. A mindfulness exercise would be followed by selecting an agreement to focus on which would be tracked by the observer. The agenda was developed according to the DBT hierarchy including issues relating to life threatening behaviour, therapy interfering behaviour, quality of life interfering behaviour, skills, burnout, good news stories, skills group and administration. In terms of clinician self-care, clinicians were asked to rank their level of motivation and burnout, and were supported by consult to problem solve challenges.

Additionally, consult provided clinicians with regular professional development opportunities. For example, new learning and training was taught to other consult members and new clinicians were asked to deliver mindfulness exercises or teach a skill to consult as
practice for teaching at skills group. Figure 5 below outlines the importance of consult group in relation to clinician motivation and capabilities.

**Figure 5. DBT team consult group**
2.5 Treatment strategies

DBT blends both acceptance and change based technologies in the service of helping clients achieve their goals (Linehan, 1993; Miller et al., 2007) DBT employs five sets of coordinated treatment strategies across all treatment modes including validation strategies, problem solving strategies, dialectical strategies, stylistic strategies and case management strategies (Linehan, 1993).

2.5.1 Validation strategies

Validation is the main acceptance strategy in DBT and “communicates to the person that their behaviour makes sense and is understandable in the current context” (Linehan, 1993, p. 221). When participating in predominantly change oriented therapeutic interactions, clients presenting with emotion regulation difficulties and BPD can be highly sensitive to invalidation. Feelings of intense fear, anger and shame can be elicited and perpetuate negative experiences and self-constructs (Linehan, 1993). As a corollary, validation is weaved into all interactions with clients.

Linehan (1993) describes six levels of validation. Levels 1 through 4 represent empathic interpretations common to most clinicians working in CAMHS. Level 5 and 6 are definitional of DBT and heavily emphasised in the design of the DBT program. In level 5 validation, the therapist communicates to the client that their experience makes sense and is understandable in terms of their current situation. Level 6 involves relating to the adolescent as being capable of learning new skills in the service of reaching their goals.

2.5.2 Problem solving strategies

Problem solving is the core change strategy employed by DBT and is designed to foster an active problem solving orientation (Linehan, 1993). Problem solving strategies involve using...
a two stage process to solve client difficulties (Linehan, 1993; Miller et al., 2007). Firstly, individual therapists conduct a functional analysis of behaviour, in DBT called a chain analysis, to build a clear understanding for client and therapist of the antecedents, consequences and function of problematic behaviours. This step provides a platform for non judgmental understanding of the client’s behaviour and aims to build insight into what is eliciting and maintaining maladaptive patterns of behaviour. Step 2 involves orienting clients to solutions likely to bring about desired change and galvanising a commitment to implement solutions. Solutions may involve skill development, non reinforced exposure and cognitive modification (Miller et al., 2007).

2.5.3 Dialectical Strategies

Dialectical philosophy in DBT relates to the notion that opposites can both be true and synthesising polarities can lead to a new understanding and growth (Linehan, 1993). Linehan (1993) identified a number of dialectical dilemmas for clients with severe emotion regulation difficulties. For example, polarised states of active passivity and apparent competence result in clients approaching difficulties with passivity, helplessness and eliciting others to solve problems versus the opposite approach where clients are viewed or view themselves as skilful without recognising mood states where they don’t have the capacities to regulate difficult emotions. DBT aims to help clients resolve the tension between the two states by attending to the truth in both positions. In the case of active passivity versus apparent competence the goal is to help the client to increase accurate communication of emotions and competence, request help skilfully and increase active problem solving (Miller et al., 2007).

Miller et al. (2007) identified a number of specific dialectical dilemmas associated with suicidal adolescents and their parents. For example, fostering dependence versus forcing autonomy is a dialectical tension often seen when working with adolescents and parents in a CAMHS setting. Fostering dependence refers to ways parents can suppress adolescent’s
natural movement towards autonomy. Forcing autonomy refers to parents pushing the adolescent towards independence without titration according to the adolescent’s capabilities. The failure to resolve the tension between fostering dependence versus forcing autonomy can result in excessive dependence on parents or thrusting the adolescent into a situation in which they do not have the capacities to cope (Miller et al., 2007). DBT aims to resolve this tension by helping parent’s balance teaching skills and doing things for the adolescent as well as reinforcing effective self reliance by the adolescent. The synthesis of opposites is described as walking the middle path and represents the key orientation in working with suicidal adolescents and their parents (Miller et al., 2007).

2.5.4 Stylistic strategies

DBT stylistic strategies are used to guide the clinician to mindfully choose communication approaches likely to move their client towards their goals (Linehan, 1993; Miller et al., 2007). Stylistic strategies include reciprocal and irreverent communication. Reciprocal communication involves being responsive to the client and taking their needs seriously, using self disclosure and being genuine. Irreverent communication refers to, for example, using an offbeat unexpected form of communication to help the client get unstuck. Competency in both reciprocal and irreverent communication strategies was developed through training and consult group professional development sessions.

2.5.5 Case management strategies

The CAMHS DBT program was designed to embrace the consultation to the patient strategy (Linehan, 1993). Unlike ‘treatment as usual’ this involves consulting with and coaching the client rather than acting on the client’s behalf. Principally the idea is to allow clients to build mastery in managing their life effectively with other professionals, family and friends. In situations where the client’s environment would not, after repeated use of skills, reinforce skilful behaviour or punish the use of skills, family sessions were called or the
individual therapist would liaise with other service providers. This was critical when ongoing invalidation of incrementally effective behaviour led to life threatening and therapy interfering behaviour.

2.6 Stage three: Graduation

After completing the CAMHS DBT program and achieving behavioural control, clients were provided with a number of ongoing options depending on their needs. Options included ongoing short term counselling with their current individual therapist, referral to other services internal and external to CAMHS and discharge.

2.7 Summary

The CAMHS DBT program consisted of a three stage treatment process involving assessment, pre-treatment, standardised 20 week treatment protocol for suicidal adolescents and ongoing treatment options post graduation. The twenty week CAMHS DBT protocol consisted of weekly individual therapy, skills group, clinician consultation group, as needed phone coaching and family therapy. The group consisted of teaching 5 skills modules including mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness and walking the middle path. The program predominantly based on standardised DBT (Linehan, 1993: Miller et al., 2007), made developmental adjustments to the skills group including using more adolescent friendly materials and teaching modalities. The program emphasised a structured treatment format using a hierarchy of treatment targets to inform the agenda for individual therapy. A number of strategies were used throughout the program including validation, problem solving, stylistic, dialectical and case management strategies.
CHAPTER THREE

Implementation Barriers

3.1 Implementation

Implementation has been referred to as “a specified set of activities designed to put into practice an activity or program of known dimensions” (Fixsen, Naoom, Blase, Friedman & Wallace, 2005). Implementing DBT into a large organization like a mental health service represented a significant challenge. Understanding contextual barriers such as resourcing issues, opinions about DBT and staff turnover are critical to the successful implementation of DBT in a community mental health setting (Herschell, Kogan, Celedonia, Gavin, & Stein, 2009). In planning the implementation of the DBT program, a number of implementation methods were identified as unlikely to lead to effective DBT practices. Less effective implementation methods include paper implementation and process implementation, and for the purpose of this study are described as implementation as usual (IAU) (Fixsen et al., 2005). Implementation methods that focus on making an impact through demonstrable changes in practice are critical for implementing new interventions such as DBT-A (Fixsen et al., 2005). These practices are driven by the performance of new practices, with the intention of producing client and system change, and were the strategies most likely to result in the successful implementation of the CAMHS DBT program. Performance based strategies include focusing on changes to practice, maintaining treatment fidelity, the need for a paradigm shift, leadership, structural changes to accommodate DBT and workforce development.
3.1.1 Implementation as usual

Evidence based programs (EBPs) such as DBT often do not proceed to successful implementation (Fixsen, Blase, & Van Dyke, 2011; Tansella & Thornicroft, 2009) and public mental health services face great challenges in successfully implementing EBPs (Fixsen et al., 2005). In the same way treatment as usual (TAU) can produce less than optimal clinical results, IAU can deliver less than optimal evidence based implementation practices. Impotent IAU practices have been categorised as paper implementation and process implementation (Fixsen et al., 2005). Paper implementation involves putting into place policies and procedures designed to reflect evidence based practice with a corresponding lack of change at a practice level. In the context of implementing the CAMHS DBT program, paper implementation would equate to expecting the development of documented DBT policies and procedures alone to impact changes in practice.

Process implementation involves putting in place operational structures that inadvertently don’t support the implementation of the new EBP (Fixsen et al., 2005). In process implementation, fragmentation occurs when implementation strategies don’t directly relate or lead to changes in practice. This may include providing training that doesn’t increase clinician capacities or supervision that doesn’t focus on linking training to the implementation of specific DBT practices. Process implementation represented a significant barrier to the successful implementation of DBT within CAMHS. An example of process implementation would be failing to provide clinical staff with skills based training and supervision specific to the practice of DBT. Additionally, in process implementation, evaluation is not meaningfully related to specific treatment targets of the EBP. For example, using generic MHS outcome measures instead of measures designed to pick up change specifically targeted by DBT. Fragmentation occurs in process implementation when specific
training, supervision and outcome measures are not aligned with specific targets of delivering and measuring DBT outcomes.

3.1.2 Implementation for impact and performance

Implementation for impact and performance refers to implementing new procedures and operating structures in a way that directly supports the adoption of DBT practices (Fixsen et al., 2005). Impact comes from focusing on aspects of practice that directly affect desired client outcomes. It involves developing clinician competencies and providing support at administrative and system levels (Fixsen, Scott, Blase, Naoom, & Wagar, 2011). Moreover, implementation for impact and performance relies on knowing exactly what components of practice have to be in place to achieve desired results for clients and stakeholders (Arthur & Blitz, 2000). In terms of the CAMHS pilot DBT program, impact came from strong focussed leadership determined to ensure the workforce is developed and DBT treatment modalities are implemented effectively. As a corollary, successful implementation of DBT practices within CAMHS required an implementation alliance of directors, team leaders, discipline principles and clinicians to lead the successful implementation of DBT within CAMHS.

3.2 Barriers to successful implementation

As well as IAU, a number of barriers and challenges existed to the successful implementation of the CAMHS DBT program. Barriers included treatment fidelity, administration challenges, paradigm shifting and leadership. Such barriers are characteristic of challenges faced when aiming to introduce changes to practice and administration.

3.2.1 High fidelity DBT

Maintaining treatment fidelity is an important factor in the successful implementation of EBP (Isett et al., 2008). At the time of this study, it was not known precisely what specific DBT components are responsible for producing change (Comtois et al., 2007) impelling the need to deliver standardised DBT with minimal modifications (Drake et al., 2001). As a
corollary, removing key functions and modes from the CAMHS DBT program risked attenuating its effectiveness and experts encourage implementing DBT with high fidelity (Comtois et al., 2007; Koerner et al., 2007). It was therefore important to safeguard against drift away from the treatment model thereby increasing the chances of achieving successful client outcomes (Swenson, Torrey, & Koerner, 2002). This represented a significant challenge as some administrators and clinicians within CAMHS identify DBT predominantly as a group intervention without understanding the necessity for other treatment modes, such as individual therapy.

3.2.2 Ethical issues

Promoting DBT as an EBP without safeguarding fidelity creates ethical dilemmas such as encouraging clients and parents to participate in a program described as being EBP without ensuring it contains adequate fidelity (Koener et al., 2007). Lack of fidelity may result in less than optimal treatment outcomes. Clients and parents would then be vulnerable to believing that change is not possible rather than reflecting the limitations of the program.

3.2.3 Administrative barriers to high fidelity DBT

Administrative barriers must be addressed if DBT can comprehensively be implemented into CAMHS (Herschell et al., 2009). Mental health service (MHS) executive administrators influence the implementation of best practice interventions by setting priorities and organizing operational aspects of MHS (Torrey et al., 2001). DBT is regarded as an intensive outpatient intervention and the comprehensive multimodal components of DBT, together with the need for workforce development, requires a concerted re-allocation of recourses by mental health administrators. This elicits inevitable concerns for administrators including: the capacity of the service to support comprehensive DBT, how to monitor the effective implementation of the program, staff turnover and being unable to support new operational procedures and roles important to the implementation and sustainability of DBT (Burroughs
& Somerville, 2012; Herschell et al., 2009). Other studies have identified that treatment fidelity and successful implementation can suffer when expectations about the fidelity of treatment have not been made clear prior to implementation (Swenson et al., 2002).

3.2.4 Paradigm shift

Perhaps the most central barrier to the comprehensive implementation of DBT is the challenge of shifting from TAU to a paradigm of EBP for suicidal adolescents presenting with suicidal behaviour, BPD and depression. Comtois et al., (2007) suggests three aspects of DBT are likely to diverge significantly from TAU. Firstly, MHSs operate through a disease model paradigm where clients get increasing levels of access to care based on higher levels of dysfunction. At variance with this paradigm, increased contact in DBT is contingent on functional behaviour (Linehan, 1993). For example, continued participation in DBT is determined by increased functionality and crisis contacts are contingent on skilful client behaviour in managing difficult situations including accessing phone coaching. This approach represents a significant paradigm shift to EBP and relies on having a clear understanding of the behavioural tenets of DBT and the rationale for such an approach.

Secondly, DBT aims not to view clients as being overly fragile and expects that with effective participation in the program they can learn new behaviours to create a more satisfying and fulfilling life (Linehan, 1993). This approach is different to the palliative oriented TAU approach seen in MHSs where clients can be viewed as needing mental health services on a chronic basis. As a corollary, directors, team leaders and clinicians can become accustomed to seeing a lack of progress reinforcing a prevailing paradigm of palliative care. DBT assumes clients will at some point no longer require MHS as they become more functional and that BPD is treatable and not a life sentence (Comtois et al., 2007). Moreover, research suggests that DBT can lead to functional change indicative of a higher quality of life.
such as meaningful employment, participation in education and discharge from MHSs (Comtois, Kerbrat, Atkins, Harned, & Elwood, 2010).

Finally, DBT views hospitalisation as a powerful reinforcer of suicidal behaviour (Linehan, 1993). DBT views a suicidal crisis as an opportunity to use skills and build more functional responses to managing difficult situations (Linehan, 1993; Miller et al., 2007). Practicing crisis survival skills is important in building more functional behavioural responses from suicidal clients (Linehan, 1993; Miller, 2007). Moreover, researchers have identified situations where taking short term risk for long term gain enhances client recovery (Krawitz et al., 2004). Although clear guidelines exist within MHSs to manage suicidal behaviour, they do not align with any coherent treatment theory, format or treatment strategies. Shifting to a DBT approach to managing suicidal behaviour involved the need to integrate assessment and treatment strategies across MHS including emergency admissions and outpatient treatment. This would represented a significant paradigm shift as TAU involves multiple different contact points for clients with various treatment and assessment approaches.

3.3 Leadership

Researchers believe successful implementation occurs simultaneously at multiple levels including practitioners, managers and administrators (Fixsen et al., 2011). Leadership across these levels was critical to the effective implementation of the DBT program and required breaking with the past, operating outside of existing paradigms and challenging prevailing values and norms (Fixsen et al., 2005). Leadership was required to overcome a number of barriers including: ensuring the program has sufficient administrative support, ensuring the program has adequate fidelity, ensuring that sufficient training and supervision opportunities are made available, ensuring operational aspects of TAU are changed or adjusted.
In terms of MHSs, changes needed to occur at both clinical and administrative levels and at various points of the MHS hierarchy. Figure 6 below outlines the hierarchy embedded into CAMHS. The Chief Executive Officer (CEO) of Mental Health is the highest ranking officer in mental health services. The CAMHS Director is the highest ranking officer responsible for setting strategic direction and managing budgeted outcomes for CAMHS. CAMHS Team Leaders primarily perform an administrative role and are responsible for ensuring team members are practicing within clinical and administrative guidelines of the service. Team leaders report directly to the CAMHS Director and meet regularly with the CAMHS director, other MHS directors and participate on committees. CAMHS clinicians are primarily responsible for the delivery of clinical services to clients presenting to CAMHS and have limited involvement in setting the strategic direction for the service.

Figure 6. Mental Health Service hierarchy
Fixsen and Blase (2011) suggest that successful implementation involves a team with sufficient power to impact client and system outcomes. In strategising the implementation of the CAMHS DBT program, directors, team leaders and clinicians were conceived on a matrix to determine their potential to impact implementation at both clinical and systemic levels. This matrix provided a useful mechanism to identify stakeholders critical to the success of the implementation as well as clarifying potential barriers and strengths of that role to progress the implementation effectively.

3.3.1 DBT Leader

Research suggests that for EBP to flourish, a committed, focussed and stable leader throughout the period of implementation is needed (Isett et al., 2008). Moreover, flourishing DBT programs have a strong team leader and active administrative support (Comtois et al., 2007). The leader needs to be in a hierarchically influential position, actively participating in the clinical delivery of DBT, providing clinical leadership and ensuring the operational requirements of the program are met (Comtois, 2007; Fixsen et al., 2005). Koerner et al. (2007) identified a number of critical functions for DBT program leaders including: building team competencies, maintaining adherence to treatment protocols, enhancing motivation and commitment to delivering effective DBT and problem solving barriers effecting the successful implementation of the program.

As can be seen by figure 7 below, team leaders within mental health services, had sufficient influence to directly affect both client outcomes and implementation at a strategic service level. At a clinical level, with the addition of participating in clinical work, the leader of the DBT program impacted implementation by working directly with clients and developing clinician competencies through supervision, modelling DBT treatment strategies and coaching.
Figure 7. Dialectical Behaviour Therapy program leader matrix

Additionally, MHS team leaders have regular interactions with other team leaders and directors providing ongoing opportunities to impact implementation at a larger organizational level. This occurred through various team leader practices including: developing quality initiatives, participating in committees that potentially affect clinical practices, meeting regularly with the director and other mental health executives and participating in MHS planning days. This level of access to key decision makers provides opportunities to influence the design of the DBT program and associated changes to CAMHS. As dissemination of DBT is channelled through these access points, DBT could become a normalised component of MHSs in the same way other specialised programs have done in the past (such as the eating disorders program).

At the time of this study, no such team leader role had been created for the DBT program and no funding was available to create such a role. This represented a significant barrier to effectively implementing DBT. Strategically, team leadership status provided the program with leadership embedded into the existing structures of MHS. Without the DBT program
leader having team leader status, the program could be easily diluted, dismantled or negatively impacted by sources not fully aware of DBT principles, the importance of treatment fidelity and the fundamental benefits of DBT to clients, parents, clinicians and the service.

Additionally, research into the implementation of DBT has identified a number of barriers to successful implementation experienced by team leaders (Swensonn et al., 2002). These include the ongoing burden of recruitment and training, lack of understanding of the importance of treatment fidelity and the need for summative outcomes to justify the program. Additionally, acceptance and promotion of the program could be impeded if other team leaders within the service believe clients presenting with BPD traits and NSSIB are not deserving of EBP (Swenson et al., 2002). Moreover, given the re-allocation of resources needed to set up the program, team leaders may resist and prefer a more diluted version of DBT. As a corollary, providing similar status to the DBT leader as that of other leaders within CAMHS was critical in advocating for the program.

3.3.2 Mental health service directors

Implementing high fidelity EBP required effective leadership to promote a paradigm shift at both practice and systems levels (Torrey, Bond, McHugo, & Swain, 2012). As can be seen by figure 8 below, MHS directors had a major impact on implementation at a strategic systemic level within CAMHS. Directors are responsible for setting the strategic direction of MHSs and set the tone for the use of DBT as an EBP. Research suggests MHS executive administrators directly affect the success of EBP implementation through the level of support and credibility they attach to such practices (Isett et al., 2008). Successful implementation of evidence based practice requires MHS executive administrators to take a proactive approach by providing formal policies, strategic efforts, leadership and power to those implementing new practices (Isett et al., 2007). Moreover, experts suggest implementation should take 2-5
years and occur in stages including exploration, initial implementation and full implementation (Fixsen et al., 2005). As a corollary, director level administrators need to be sufficiently supportive of and committed to implementing DBT to ensure it embeds into the service effectively. The impact of leadership at this level was critical to the success of the program.

<table>
<thead>
<tr>
<th>Impact on implementation at systemic level</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHS Director</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Figure 8. Mental health service director matrix**

A number of director level factors were anticipated as having potentially critical impact on the DBT program implementation and without attending to these factors, it was believed that comprehensive implementation of the program could be compromised. Implementing DBT effectively required a paradigm shift from TAU to EBP (Comtois et al., 2007). Moving to a DBT framework represented a significant change requiring commitment and a sustained and concerted effort. Additionally, successful implementation of DBT required changing from a technically eclectic TAU approach to a commitment to working within the parameters and guidelines of DBT. At the time of this study, TAU for suicidal adolescent clients presenting with NSSIB, BPD traits, depression and other co morbid difficulties, consisted of an array of treatment techniques derived from a number of different theories of psychopathology and change. Implementing DBT effectively required a paradigm shift to working within one
treatment framework including: the biosocial theory, a philosophically dialectical approach to clients and treatment, behavioural principles of change, the integration of acceptance and change technologies and a developmental model of client recovery (Miller et al., 2007). Director support was critical to shifting to a DBT framework and actively endorsing commitment to the new model.

Without director level endorsement and allocation of programmatic resources the implementation of DBT was not viable. The DBT program required clinical staff, space, time and money to accomplish the goals of the program. Moreover, the introduction of the program will required operational changes to the service which need to be endorsed and supported by the CAMHS director if they are to be ratified by the CEO of MHSs. Such changes included, reviewing and changing caseloads for clinicians participating in the program, providing work force development opportunities and allocating material resources.

Additionally, developing new position descriptions and job functions required the endorsement and active support of the Director. For example, the strategic impact of ensuring the DBT program has an officially endorsed team leader was extremely important to implementing DBT effectively and should not be underestimated. It would provide the leader with sufficient power to advocate on behalf of the program and participate in disseminating DBT other areas of the service. Strategically, developing this role within the service and allowing the DBT team leader to promote, design, and evaluate the program would implicitly provide status and authority to the program.

3.3.3 Clinicians

Clinicians are the most important players in directly impacting client outcomes using DBT. As seen below in figure 9, clinicians had limited power to directly impact system change and the strategic direction and priorities for CAMHS. Their influence over system change comes indirectly through the potential impact they can have on positive outcomes for
clients participating in the DBT program. Positive outcomes for clients and families can reinforce the validity of the program as a useful way of working with the client population.

**Figure 9. Clinician matrix**

The main impact on implementation from clinicians was on using DBT directly to affect changes for clients and families. The major barrier on this impact was on becoming an effective DBT practitioner (Swenson et al., 2002). Factors likely to interfere with becoming an effective DBT practitioner included the unmet need for role redefinition and lack of professional development opportunities. Role redefinition is critical to allowing DBT practitioners to implement DBT clinical roles effectively. At the time of this study, CAMHS teams operated a generic clinical case manager approach to working with clients. Conversely, DBT practitioners are required to undertake specific DBT roles such as individual therapist and skills group facilitator. These roles can be highly demanding when clinicians are first starting out with DBT, and require significant time to prepare. As a corollary, without role redefinition and associated changes in other operational demands placed on DBT practitioners, they may become vulnerable to role ambiguity and associated stress.
Clinicians wanting to participate in the DBT program included psychologists, social workers and occupational therapists and came to the DBT program with a variety of training and experience in using DBT. For example, at the time of this study, the majority of CAMHS clinicians had not completed any advanced or intensive training in DBT nor had worked in a DBT program. This is a critical factor that could have potential negative effects on treatment fidelity and potential client outcomes. Providing skills based training in building competency in practicing DBT was critical to the effective implementation of the DBT program.

3.4 Summary

In summary, implementation as usual practices such as paper and process implementation were identified as significant methodologies unlikely to progress the implementation of high fidelity DBT in an effective way. An implementation framework designed to directly impact client and service outcomes was adopted. Due to the need for a paradigm shift to DBT from TAU, leadership across multiple levels of the service was seen as critical to implementation of the CAMHS DBT program. Specifically, leadership from directors, team leaders and clinicians was seen as having a potentially penetrating affect on high fidelity implementation of DBT-A. Leadership was required to ensure the DBT program is implemented with high treatment fidelity and targeted workforce development opportunities are provided.
CHAPTER FOUR

Implementation Strategy and Outcomes

4.1 Implementation phases

After having identified a number of factors critical to successfully implementing the CAMHS DBT program, an implementation strategy was developed. This strategy involved 4 phases including: exploration and adoption, work force development, implementation and evaluation. Initially, in phase 1, after exploring the need for a credible intervention to work with suicidal adolescents displaying BPD traits and depression, a comprehensive DBT program was adapted for CAMHS. A concurrent phase of orientation and commitment was entered into as a primer for changing to the new treatment and the required paradigm shift. Phase 2, workforce development, consisted of evaluating training needs for the program, partnership building with other services and building clinician capabilities through training and supervision. Phase 3, program implementation, involved establishing program structures and guidelines as well and piloting the CAMHS DBT program. Phase 4, evaluation, included evaluating the initial clinical effectiveness of the CAMHS pilot DBT program. Additionally, as outlined in the previous chapter, simultaneous leadership across the 4 implementation phases was seen as critical to the ongoing success of the program. These 4 interlinked implementation phases with concurrent leadership and DBT strategies can be seen in figure 10 below.

4.2 Phase 1: exploration and adoption

The exploration and adoption phase started by scoping the need for a treatment program for adolescent clients displaying suicidal behaviour, BPD traits and treatment resistant depression.
4.2.1 Building support

Initial discussions about the development of a CAMHS DBT program occurred with the CAMHS Director and the DBT project leader. The then Director endorsed the development of a comprehensive DBT program including developing goals for the program, flow into and out of the program, protocols and materials for the program, workforce development, building partnerships with other service providers and evaluating the program. The Director acknowledged the groundswell of interest in DBT and the need to work more effectively with clients presenting with suicidal behaviour and BPD. Additionally, with the move to a 12-25 year old youth model, it was expected that the service would be required to provide effective treatment for increased numbers of people displaying suicidal behaviour, BPD traits and
other co-morbid conditions. Strategically, it was decided to pilot the program with the view of providing initial evidence of the feasibility of implementing DBT into CAMHS. It was agreed that outcome measures designed specifically to measure change for clients presenting with suicidal behaviour, BPD traits and depression should be used to measure the clinical effectiveness of the program. The Director suggested the author take carriage of the development of the program.

During case discussions, intake meetings and supervision, clinical staff within CAMHS described difficulties working effectively with suicidal clients presenting with BPD traits and depression. They indicated that standard approaches to these difficulties were not effective, clients with these difficulties were difficult to engage and some clinicians were reporting burnout. CAMHS clinicians endorsed developing a CAMHS DBT program with the view of providing a more comprehensive approach to treatment.

Initially, there were several meetings with the Principle Psychologist of MHSs and the author discussing the need for a systematic best practice approach to working with BPD, suicidal behaviour and co-morbidity. After collecting local team data and consulting relevant clinical guidelines (see chapter 1) the Principle Psychologist and the author met with the Chief Executive Officer (CEO) of MHSs to discuss the systematic implementation of DBT across the service. The CEO endorsed initiating the pilot program within CAMHS and setting up a DBT working group to progress the development and use of DBT within MHSs. The working group consisted of the principal psychologist, two team leaders, including the author, who had completed intensive training in DBT. The working group identified CAMHS as being at a more advanced stage of development and that a comprehensive program was feasible.
Initial discussions with CAMHS team leaders yielded support for the development of a CAMHS DBT program. Team leaders spoke of the high volume of clients displaying suicidal behaviour with co-morbid problems and identified the need for a comprehensive program to provide treatment structure for clients and clinicians. Team leaders indicated that having a treatment for suicidal behaviour, BPD traits and unremitting depression would provide access to needed specialised services not previously available for clients and parents. Moreover, team leaders believed the intensive and time limited focus of DBT to establish stability was relevant to the clients presenting to the service. The finite nature of the DBT program was favoured over TAU where clients would cycle in and out of treatment with limited therapeutic engagement and treatment gains. Additionally, team leaders worried about clinician burnout due to high levels of service utilization and crisis presentations by clients with BPD and unremitting depression. Having a properly structured program would hopefully provide a consistent approach from which clinicians would feel more empowered to work effectively with suicidal clients displaying BPD traits and co-morbidity. Notwithstanding the support offered by team leaders, there was an understandable caveat that given the chronic shortage of clinicians that the DBT program should minimise creating staffing difficulties in other areas of the service.

All Psychiatrists within CAMHS endorsed the development of the DBT program through input and feedback given to the DBT project leader. The view was that it was in the best interest of the service to develop and provide a skill based intervention that would build capacities in clients, parents and CAMHS. The clinical director of CAMHS and the head psychiatrist for the service invited the author to present on the development of the CAMHS program to a forum of MHS psychiatrists where the program was met with endorsement and encouragement. Significantly, there was a consensus of opinion that the emergence of BPD
was visible in clients presenting to CAMHS and specific specialised treatments needed to be made available.

4.2.2 Resolving barriers

Koerner et al. (2007) identify distinctive features of DBT that can be considered unchangeable and changeable when designing a DBT program. Changeable components include those that could be designed differently from the standardised model depending on the service characteristics of the applied setting. This approach allows for different translations of the treatment while concurrently remaining true to the core principles and strategies of DBT. Moreover, Koerner et al. (2007) suggest that when local service characteristics impede full implementation of standardised DBT treatment modes, adjusting the mode of delivery requires creative solutions.

Characteristically, after-hours phone coaching in community mental health outpatient settings represents a barrier to the successful implementation of standardised DBT (Comtois et al., 2007). CAMHS administrators were unable to provide funding or flexible working hours to accommodate after hours phone coaching. This related to clinician job classification, budget constraints and the historical separation of crisis work undertaken by the service. For example, after hour’s crisis responses are budgeted to be conducted by the crisis assessment and treatment team (CATT) and historically, specialist teams have not carried out phone consultation after business hours. The unavailability of individual therapists for after hours phone coaching represented a significant barrier to the successful implementation of high fidelity DBT. The function of phone coaching (ensuring skill generalisation) is critical to clients successfully graduating from the program with a robust array of DBT skills for managing their difficulties and creating a life worth living (Linehan, 1993). The powerfully influencing relationship of the individual therapist is critical to phone coaching and individual therapists develop an intimate understanding of the client’s suicidal behaviour patterns, skill
capacity and are able to use their influence to pull for more effective behaviour from clients (Linehan, 1993; Miller et al., 2007). Additionally, clinicians not trained in phone coaching can inadvertently elicit and reinforce less effective behaviour. For example, clinicians unwilling to use validation strategies during phone coaching may reduce client motivation and capacity to participate in identifying and applying skills.

In resolving this design dilemma the author followed principles outlined by Koerner et al. (2007) which suggested applying dialectical thinking to resolve local implementation difficulties. This involved finding a balance between accepting the constraints of the service while at the same time acknowledging the need for clients to access effective after-hours phone coaching. Comtois et al. (2007) identifies a number of strategies that can be used to satisfy the function of phone coaching for programs struggling with completely adherent implementation. These suggestions were incorporated into the design of the DBT program and included: teaching distress tolerance skills early in the program, collaboratively setting up explicit crisis management plans with client, therapist and CATT, setting up contingency management that reinforces adherence to crisis management plans, and scheduling weekly coaching calls with clients to trouble shoot difficulties that may arise during the week. Additionally, plans were put in place to set up a strategic partnership with CATT including providing workshops in DBT. The goal was to ensure that both client and crisis worker were clear about the importance of sticking with the crisis plan, that both parties were familiar with the plan, and that any changes of the plan would be made by the individual therapist in collaboration with the client. It was hoped that these design solutions would provide access to effective phone coaching as well as providing an opportunity for DBT principles and practices to permeate another area of the service likely to come in contact with DBT program clients.
4.3 Phase 2: workforce development

As identified in the previous chapter, successful implementation of DBT requires clinicians to have sufficient knowledge and skills in DBT. After designing the CAMHS pilot DBT program, a period of workforce development began. This involved identifying barriers and strengths of the CAMHS workforce before designing a program of training.

4.3.1 Initial status of CAMHS workforce

Overall, CAMHS is a service with a culture of providing early intervention and therapy. Characteristically, CAMHS clinicians have solid experience in working with clients displaying suicidal behaviour, BPD traits and other co morbid conditions and are regularly exposed to the difficult clinical dilemmas associated with working with this client population. Although clinicians enjoy the autonomy from TAU, an appreciation emerged for a comprehensive framework, structure and strategies to guide treatment. Clinicians described feeling somewhat out of their depth with BPD, and in line with research, indicated a preference for the DBT approach and further training opportunities in DBT (Ogrodniczuk, Kealy, & Howell-Jones, 2009). Additionally, a number of clinicians expressed feelings of dissatisfaction with the current service approach to working with suicidal clients displaying BPD traits and other co morbid conditions. Clinicians felt DBT provided a useful structure and an opportunity to develop specialised skills in working with this heavily compromised client population.

At the time of the study, CAMHS had a number of clinicians wanting to participate in the pilot program with varying degrees of training and experience in DBT. Clinicians had usually completed at least some training in CBT with the minority completing at least 2 days of introductory workshops in DBT. Most clinicians had attempted to use DBT skills and some strategies eclectically with their clients. For example, using distress tolerance skills to help clients build crisis survival plans, while not necessarily focussing on other aspects of DBT
individual therapy. Additionally, concerns were raised by some clinicians whom believed that the service would not be able to allocate sufficient resources to the program and that DBT would not be sustainable for CAMHS. These and other views were somewhat similar to those in research on using CBT with schizophrenia such as severe workloads, time pressure, the need for specialist staff and pessimistic views of recovery (Prytys, Garety, Jolley, Onwumere, & Craig, 2011).

4.3.2 Workforce development strategy

Training in DBT has been found to shift therapeutic pessimism towards BPD to better understanding of the disorder and a more optimistic outlook (Hazelton et al., 2006). Although not all CAMHS clinicians possessed ideal levels of training and experience in DBT, research indicates that effective training can provide reasonable mastery of DBT (Hawkins & Sinha, 1998). Moreover, clinicians hoping to participate in the pilot program were characteristically motivated to learn and apply DBT as well providing a more comprehensive intervention for their clients.

Critical to the effectiveness of the DBT program is the capacity of clinicians to apply DBT effectively. As a corollary, skills based training opportunities and supervision was of paramount importance to the effective implementation of DBT. Research has shown that various training methods including instructor lead workshops have been found to increase clinician capabilities in applying DBT to situations likely to be found in clinical practice (Dimeff et al., 2009). In line with Comtois et al. (2007), the training program for the initial pilot program was designed to increase knowledge of DBT and the development of specific DBT clinical skills likely to maximise the impact on client outcomes. This strategy involved rolling out skills based training workshops in the use of DBT with adolescents and their families, using weekly consult group to increase clinician capacities, developing individual therapy session adherence summaries and setting readings.
4.3.3 Training outcomes

A partnership was developed with an adjacent state health service after similar training needs in DBT for suicidal adolescents were identified for both services. A four day workshop was developed and both services sent clinicians interested in applying DBT to the training. The training occurred 2 months prior to the implementation of the initial program to give clinicians enough time to practice DBT and reflect on their commitment to participating in the DBT pilot program. The training consisted of prioritising those aspects of practice believed to have the biggest impact on program implementation and treatment fidelity. For example, individual therapy structure, using diary cards and conducting chain analysis. Clinicians were also encouraged to attend the adult oriented DBT workshops provided to MHS staff to further enhance their learning and development.

A weekly DBT consultation group was established some three months prior to the commencement of the pilot program. The consult group consisted of clinicians committed to learning and implementing adherent DBT and participating in the study. The focus of consult during this period was to deliver additional training in line with recommendations made by Comtois et al., (2007). For example, to gain practice in teaching skills, clinicians were put on a consult teaching roster where they prepared, taught skills and set homework for consult.

Additionally, each week a DBT skill, the “DBT skill of the week,” was emailed to all clinicians within CAMHS to cue interest and learning and readings were set and learning’s reported back to consult with an emphasis on consult members learning from each other. In-service training was provided by the DBT project leader to the consult group after surveying for aspects of DBT considered most difficult by new clinicians to DBT.

“Packaged” evidenced based programs with known parameters such as DBT provide a framework for practitioners to practice the new intervention effectively (Fixsen et al., 2005). Packaging the key aspects of the treatment into practice guidelines thought to maximise
impact on the success of implementation were created. Using Miller et al. (2007) a DBT Toolkit was developed to provide clinicians with easy access to a resource for practicing DBT (Appendix A). For example, pre-treatment checklist, family therapy session format and individual therapy sessions using the “Weekly Therapist Summary,” were adapted into the toolkit to provide clinicians with easy access to these protocols during therapy sessions.

4.4 Phase 3: implementation

The implementation phase of the pilot project involved delivering a comprehensive DBT program to clients and their parents as per the treatment design outlined in chapter 2. All modalities of the treatment were delivered during the implementation phase including skills group, individual therapy, consultation group, as needed family interventions and adapted phone coaching. Two 20 weeks programs were completed over the course of 2010. The first program commenced in February 2010 and finished in June 2010. The second program commenced in July 2010 and finished in December 2010. The group component of the program was implemented at the CAMHS south side community team clinic.

Clinicians participating in the program were those assessed through an interview by the project leader as being committed to delivering adherent DBT for the 12 month pilot program. Clinicians who had displayed a liking for working with suicidal behaviour, BPD and depression and who had a history of attending training in DBT were given preference over others. Having a non judgemental attitude towards the client population as well as a willingness to follow DBT principles, assumptions and guidelines was favoured. The pilot program consisted of 6 psychologists, from both CAMHS north and south side community teams, whom either conducted individual therapy or participated in facilitating skills group. All clinicians participated in consultation group that alternated between both team venues. Individual and family therapy sessions were held at the individual therapists CAMHS community team site.
4.4.1 Implementation drivers

In order to keep momentum moving forward during the implementation phase, a number of concurrent implementation drivers were identified. Factors considered important drivers of implementation, include ongoing skills based learning opportunities and administrative support (Fixsen et al., 2005).

Leadership remained an important driver during the implementation phase in order to ensure that the functions of DBT were maintained, training continued and adequate support was afforded to the program. Additionally, leadership was critical to maintain positive relationships with other stakeholders and to create good will for the program.

Without sufficient opportunities to orient administrators to the importance of treatment fidelity and the associated benefits of DBT, the incentive can be to dilute DBT and inadvertently potentially limit its effectiveness. To ensure the program had ongoing administrative support, the author maintained the role of team leader and coordinated the program through this position. This strategic decision was made to increase the chances that the program would have knowledgeable and assertive advocacy to acquire needed resources and support. In conjunction with training opportunities, efforts were made to structure the environment to support effective implementation of DBT in as many ways as possible. This included adjusted case loads, practice preferences, flexible working conditions and the timely acquisition of resources including a room for skills group, non standard outcome measures, teaching materials and technologies. Additionally, as a team leader the author was able to market on behalf of the program to other team leaders, directors and external agencies through involvement in committees, regular executive meetings with team leaders and directors and regular meetings with the CAMHS director.

In terms of maximising the impact from directors within MHSs, it was important to build strong relationships in order to generate good will for the program. Good will was generated
in a number of ways including providing clinical consultation to other teams and clinicians, providing training for other teams, presenting the program at a mental health conference, reinforcing the service’s willingness to be the first to implement a comprehensive DBT program and completing paper work.

Implementation of DBT is a complex process that occurs across different levels of the service involving different perspective and points of view. Successful implementation involves working collaboratively with stakeholders to provide opportunities to discuss and resolve divergent points of view and continue to disseminate accurate information about DBT (Aaron’s, Wells, Zaagursky, Fettes, & Palinkas, 2009). A key component of the implementation strategy was the development of an implementation team operating at both clinical and administrative levels of the service (Fixsen & Blase, 2011). The team represented a coalition of advocates for the use of DBT within MHSs and consisted of CAMHS clinicians, CAMHS team leaders, the CAMHS director, the CEO of MHSs and the principal psychologist whom was additionally responsible for the implementation of psychological therapies for the service. Research suggest the strength and persuasiveness of the coalition is more important than the available scientific evidence when implementing new practices (Rosenheck, 2001). Having both senior clinical staff and mental health executives advocating for the program provided significant strength and persuasiveness. For example, at clinical meetings both team leaders and clinicians would advocate for the specific needs of clients presenting with suicidal behaviour and the importance of having a specialised DBT program available as a referral option.

4.5 Phase 4: evaluation

Researchers suggest that evaluating results is an important part of the implementation process as it establishes an accountability loop where outcomes can be held up against high clinical standards (Rosenheck, 2001). In large community organisations like MHSs outcome
data can be critical to elicit further support and funding (Comtois et al., 2007). Given that DBT has been shown to be both clinically and cost effective in other community mental health settings, in the current study it was seen as a worthwhile pursuit to further establish the credentials of using DBT in CAMHS (Pasieczny & Connor, 2011). Furthermore, research in applied settings is critical to determine the effectiveness of interventions designed to treat seriously distressing and debilitating conditions such as BPD and unremitting depression. As a corollary, the implementation strategy integrated an evaluation component throughout the treatment program.

4.6 DBT principles and strategies

DBT principles and strategies were used concurrently throughout the development and implementation of the DBT program. Comtois et al., (2007) encourage program developers to use DBT strategies to overcome inevitable barriers that occur in large systems like MHSs. Orientation and commitment strategies featured heavily in the implementation strategy for the DBT program. Given the need for high levels of treatment fidelity, the reallocation of resources and likely need for system change, implementation barriers were expected. As a corollary, many opportunities were taken to practice DBT orientation and commitment strategies. For example, when discussing the project initially with the CEO of MHSs, the foot in the door technique was used to garner initial support followed by a request for additional time to develop the program. This was granted by both the CEO and the then director of CAMHS, to develop program protocols and guidelines.

Additionally, interpersonal effectiveness skills were used in conjunction with acceptance based strategies to request additional resources. For example, when designing the program, the project leader requested a number of planning days away from normal team leader duties which were granted. During the implementation phase of the program, clinicians were
encouraged to use DBT skills to manage their limits and difficulties managing work demands.

4.7 Summary

The CAMHS DBT program used a 4 phase strategy to successfully promote, implement and evaluate the program. Phase 1 consisted of scoping out the need and support for a DBT program, resolving treatment fidelity tensions and adapting a program design to fit with CAMHS. Phase 2 consisted of evaluating the workforce needs of CAMHS in order to develop a DBT workforce development plan. After implementing a training plan, phase 3 involved implementing the program driven by an implementation team of clinicians, team leaders and administrators. The implementation team represented a coalition of advocates determined to see that the implementation of the CAMHS DBT program impacted on improving client outcomes and system change. Phase four consisted of an evaluation to determine the initial effectiveness of the pilot program. DBT principles and strategies were used throughout the four phases of the implementation plan.
CHAPTER FIVE

Clinical Evaluation Design

5.1 Overview

The present study aims to implement and evaluate the effectiveness of a pilot Dialectical Behaviour Therapy Program for adolescents in a routine Australian CAMHS clinical setting. In terms of the clinical evaluation, the overall goal is to establish initial evidence of the efficacy of DBT for suicidal clients displaying BPD traits and experiencing depression. Initially, evaluating the clinical effectiveness of the program should determine the potential ongoing usefulness of the program and feasibility of implementing DBT within CAMHS. Should the outcomes from the initial pilot program produce identifiable changes for clients, further commitment to using DBT within CAMHS would be warranted.

5.2 Procedure

The program evaluation utilized both an uncontrolled pre-post treatment design as well as single case multiple baseline design. The evaluation consisted of 6 measurement phases including baseline (phase 1), pre treatment (phase 2), program participation (phase 3 and 4), graduation (phase 5), and follow-up (phase 6). For the pre-post test design, measures were obtained during baseline (phase one) and for purpose of measuring the robustness of potential treatment gains, measures were taken at phase 6 (at least 3 months after graduation from the program). For the single case design, participants completed measures at multiple phases during the program. Measures were administered by individual therapists, marked by movement into the next phase of treatment. These included, assessment (phase 1), orientation and commitment (phase 2), active participation in group (phase 3 and 4), graduation (phase 5)
and follow-up (phase 6). Figure 11 below lays out the 6 collection points for outcome measures used in the single case design.

![Figure 11. Outcome measure collection points]

**5.3 Participants**

Clients referred to the program were either existing or newly registered CAMHS clients. Clients and parents were assessed and given information about the current study before making a decision regarding their consent to participate in the program evaluation. Consent for participation in the pilot program was provided by 15 participants (given by the adolescent (or a consenting parent for clients under 16)). Participants ranged in age from 13 to 19 (mean = 16.27, $SD = 1.10$, mode = 17) and came from a variety of socio economic backgrounds. Of the original 15 clients commencing the program 12 completed the program. All clients met the inclusion criteria for the program including depression, at least 3 BPD criterion behaviours, long standing difficulties regulating problematic emotions including suicidal and non-suicidal self-injurious behaviour. Additionally, other social and emotional difficulties characteristic of those commencing the program included family discord, anxiety disorders, academic difficulties and cannabis use. The 3 non completers did not differ markedly from the 12 completers. Both completers and non-completers all had histories of suicidal and non-suicidal self-injurious behaviour and depression. Additionally, both completers and non-completers were all female and came from a similar mix of socio
economic backgrounds. All 15 clients commencing the DBT program were typical of the client type described as being challenging to treat by CAMHS, presenting with suicidal and non-suicidal self-injurious behaviour, and multiple social and emotional difficulties. Given similarities between completers and non-completers this study will focus on those that completed the program.

5.4 Outcome measures

Primary outcomes for the program include the reduction of suicidal behaviour and suicidal ideation. Secondary outcomes include reducing BPD behaviours, depression and increasing protective factors against suicide. Outcome measures were selected based on previous use in similar studies and sensitivity to measuring outcomes specifically targeted by DBT (Miller, 2007).

5.4.1 Suicidal behaviour

The Suicidal Ideation Questionnaire (senior high school version) is a 30 item self-report questionnaire designed to measure thoughts about suicide in adolescents (Reynolds, 1987). The Suicidal Ideation Questionnaire (SIQ) was developed to provide a reliable and valid estimate of the seriousness of adolescent suicidal ideation. The majority of participants for this study were either in late high school or college so the SIQ high school version was administered. The adolescent rates the 30 SIQ items on a 7-point scale which assesses the frequency with which the cognition occurs. Items are scored from 0 to 6 scale in a pathology direction including; 6 = “Almost every day,” 5 = “Couple of times a week,” 4 = “About once a week,” 3 = “Couple of times a month,” 2 = “I had this though before but not in the past month,” and 0 = “I never had this thought.” The maximum possible score on the SIQ is 180 which suggest that the adolescent endorsed suicidal cognition at least every day. The lowest possible score of zero would indicate that the adolescent endorsed never having the thoughts as indicated by the 30 items. The content of the SIQ was designed to include items indicative
of mild to severe suicidal ideation. Table 10 below, displays the abbreviated content descriptions for the SIQ. Item content ranges from the most severe, serious and specific thoughts of suicide indicating heightened risk (e.g., 2, 3, 4, 7, 9) to general more passive thoughts of death (e.g., 1, 6, 12). Items were developed based on clinical interviews with adolescents and young adults with moderate to severe depression and for whom a significant portion had significant suicide attempts or admitted to suicidal intent.

Psychometric studies support the reliability, validity, and clinical utility of the SIQ as a measure of suicidal ideation in adolescents (Reynolds, 1987). Of significance to clinicians working with suicidal adolescent clients and researches targeting reducing the risk of suicide, the SIQ has good clinical validity (Reynolds, 1987).

Total SIQ scores, critical item total scores, and the percentage of clients scoring above clinically significant suicidal ideation are the primary outcome derived for the SIQ. SIQ total scores were calculated by summing all 30 SIQ items with higher scores indicating a greater number and frequency of suicidal thoughts. The Suicidal Ideation Questionnaire identifies eight critical items specified for their potency for more serious self destructive behaviour. When three or more critical items are endorsed at a frequency of every day (score of 6) or a couple of times a week (score of 5) the risk for suicide is considered heightened irrespective of SIQ total score. The maximum participants could score on these eight critical items is 48 while not endorsing any critical items would result in a score of 0. The number of endorsed critical items provides a measure of clinical severity. Although not a diagnostic or predictive measure, the SIQ identifies a raw cut-off score of or above 41 as an indicator of severe suicidal ideation and potentially significant psychopathology and suicide risk. The percentage of scores above the cut-off will be used as a primary outcome measure for this study.
5.4.2 Protective factors

Protective factors against suicide are targeted directly by DBT and were measured using the Reasons for Living Inventory Adolescent version (Osman et al., 1998). The Reasons for Living Inventory Adolescent version (RFL-A) is a 32 item self-report questionnaire designed to measure adolescent expectations for living versus suicide and assesses the importance the adolescent places on reasons for living. Adolescents rate how important each statement is for them for not committing suicide on a 6 point scale (1= "Not at all important," 2= "Quite unimportant," 3= "Somewhat unimportant," 4= "Somewhat important," 5= "Quite important," 6= "Extremely important"). The RFL-A has six subscales including family alliance, suicide-related concerns, self-acceptance, peer-acceptance and support, and future optimism which are negatively related to suicidal behaviour. The RFL-A has been found to have satisfactory reliability and validity (Osman et al., 1998). Total RFL-A total and subscale scores will be used to measure protective factors against suicide.
### Table 10. Suicidal Ideation Questionnaire content descriptions

<table>
<thead>
<tr>
<th>Item</th>
<th>Content Description</th>
<th>Item</th>
<th>Content Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Better if not alive</td>
<td>16</td>
<td>Wished had nerve</td>
</tr>
<tr>
<td>2</td>
<td>Thoughts of killing self</td>
<td>17</td>
<td>Wished never been born</td>
</tr>
<tr>
<td>3</td>
<td>Thoughts of Method</td>
<td>18</td>
<td>Would if had chance</td>
</tr>
<tr>
<td>4</td>
<td>Thought of time</td>
<td>19</td>
<td>Ways people kill themselves</td>
</tr>
<tr>
<td>5</td>
<td>Thought of people dying</td>
<td>20</td>
<td>Thought, but would not</td>
</tr>
<tr>
<td>6</td>
<td>Thought of death</td>
<td>21</td>
<td>Having a bad accident</td>
</tr>
<tr>
<td>7</td>
<td>Writing suicide note</td>
<td>22</td>
<td>Life not worth living</td>
</tr>
<tr>
<td>8</td>
<td>Writing will</td>
<td>23</td>
<td>Life too rotten</td>
</tr>
<tr>
<td>9</td>
<td>Telling others</td>
<td>24</td>
<td>Only way to be noticed</td>
</tr>
<tr>
<td>10</td>
<td>Others happier if gone</td>
<td>25</td>
<td>Others realize worth</td>
</tr>
<tr>
<td>11</td>
<td>How others would feel</td>
<td>26</td>
<td>No one cared if alive</td>
</tr>
<tr>
<td>12</td>
<td>Wished were dead</td>
<td>27</td>
<td>Thought of hurting self</td>
</tr>
<tr>
<td>13</td>
<td>How easy it would be</td>
<td>28</td>
<td>If could kill self</td>
</tr>
<tr>
<td>14</td>
<td>Would solve problems</td>
<td>29</td>
<td>If things didn’t improve</td>
</tr>
<tr>
<td>15</td>
<td>Others better off</td>
<td>30</td>
<td>Right to kill self</td>
</tr>
</tbody>
</table>
5.4.3 Borderline personality disorder behaviours

The Life Problems Inventory (LPI) is a 60 item self report questionnaire designed for adolescents as a baseline assessment and treatment outcome measure (Rathus, & Miller, 1995, as cited in Miller et al., 2007). The LPI contains four 15-item subscales including; impulsivity, confusion about self, emotions dysregulation and interpersonal chaos. These factors represent core aspects of BPD directly targeted by DBT. Adolescents rate how each statement describes the way they are most of the time on a 5 point scale (1= “Not at all like me,” 2= “A little bit like me,” 3= “Somewhat like me,” 4= “Quite a bit like me,” 5= “Extremely like me”). The LPI has good psychometric properties including internal consistency, convergent and criterion validity (Rathus, Wagner, & Miller, 2005, as cited in Miller et al., 2007). Life Problem Inventory factors are directly targeted through corresponding skills taught in the DBT skills group. Mindfulness is taught to reduce confusion about self, emotion regulation skills are taught to reduce emotion dysregulation, distress tolerance skills are taught to reduce impulsivity, and interpersonal effectiveness skills are taught to reduce interpersonal chaos. Total LPI scores will be used to evaluate global changes in core aspects of BPD. The emotion dysregulation subscale will be used to determine changes in client capacity to regulate problematic emotions.

Additionally, in terms of suicidal behaviour, item 26 on the LPI, “I have made at least one suicide attempt” will be used to measure changes in suicidal behaviour. Higher scores on this item indicate endorsement of at least one suicide attempt in the past month. Scores on item 22, “I have deliberately hurt myself without meaning to kill myself” will be used to provide outcomes for non suicidal self injurious behaviour. Higher scores on this item indicate endorsement of at least one episode of deliberate non suicidal self injurious behaviour in the past month. A risk reduction percentage for items 26 and 22 will be used to calculate the level of reduction in suicidal behaviour from baseline to follow-up.
5.4.4 Depression

DBT targets emotion regulation difficulties including chronic low mood associated with depression. The Beck Depression Inventory-II (Groth-Marnat, 2003) is a 21-item self report inventory developed to measure the presence and severity of depressive symptoms. The Beck Depression Inventory-II (BDI) questionnaire is presented in multi choice format with each item scored from 0 to 3 in terms of intensity with total scores ranging from 0 to 63. Higher scores correspond with increasing levels of clinical severity. The BDI has established psychometric properties with adolescents (Beck, Steer, & Ranieri, 1998, as cited in Miller et al., 2007). BDI total scores will be used to examine the effect of the DBT program on reducing depression. Cut-off for clinical severity will be used to calculate a percentage proportion of reduction in symptom severity. Scores on item nine, regarding suicidal thoughts and wishes, will be used to provide another index of suicidal ideation. High scores on this item would be indicative of elevated suicidal ideation (0 = “I don’t have any thoughts of killing myself” and 2 = “I would kill myself if I had the chance”). A risk reduction percentage for item nine will be used to calculate the level of reduction in suicidal thoughts and wishes from baseline to follow-up.

5.5 Summary

The goal of the evaluation was to determine the initial clinical effectiveness of using DBT with the target population. Outcomes targeted by the program include the reduction of suicidal behaviour, core aspects of BPD targeted by DBT and symptoms of depression. Protective factors against suicide were also investigated. Table 11 below outlines primary, secondary outcomes and clinician outcomes for the program.
<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Measures</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Outcomes</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Suicidal Ideation                           | Suicidal Ideation Questionnaire | *Total score:* Higher SIQ scores indicating a greater number and frequency of suicidal thoughts. \  
|                                              |                                 | *Total critical Item Score:* Higher critical item total scores indicative of more serious suicidal ideation. \  
|                                              |                                 | *Cut-off %:* Percentage of scores above the clinically significant cut-off score. \  
|                                              |                                 | *Suicidal Thoughts or Wishes:* BDI item 9 with higher scores indicating elevated suicidal ideation. \  
| Suicidal Behaviour                          | Beck Depression Inventory       | *Suicide Attempt score:* High endorsement of item 26 associated with suicide attempts.                                                     |
| Non Suicidal Self Injurious Behaviour        | Life Problems Inventory         | *NSSIB total:* High endorsement of item 22 indicative of elevated non-suicidal self-injurious behaviour.                                  |
| **Secondary Outcomes**                      |                                 |                                                                                                                                         |
| Protective Factors                          | Reasons for Living Inventory    | *Total Score:* Higher scores indicative of more reasons for living.                                                                      |
| Depression                                   | Beck Depression Inventory-II     | *Total BDI:* High BDI scores indicative of elevated depression. \  
|                                              |                                 | *% moderate to severely depressed:* Percentage of clients moderately to severely depressed.                                                   |
| BPD Symptoms                                 | Life Problems Inventory         | *Total score:* Higher scores indicative of higher frequency of behaviours associated with BPD. \  
|                                              |                                 | *Confusion about Self total:* Higher scores indicative of confusion about self \  
|                                              |                                 | *Impulsivity total:* Higher scores indicative of impulsive behaviour. \  
|                                              |                                 | *Interpersonal difficulties total:* Higher scores indicative of interpersonal chaos. \  
|                                              |                                 | *Emotion Dysregulation:* Higher scores indicative of emotion dysregulation.                                                             |
CHAPTER SIX

Clinical Outcomes

6.1 Group and individual outcomes

Group and individual results were used to determine the clinical effectiveness of the CAMHS DBT program on primary and secondary outcomes. The primary outcome for the DBT program was to reduce suicidal thinking and behaviour. Secondary outcomes included reducing depression, core aspects of BPD and increasing protective factors. Statistically and clinically significant changes on primary and secondary outcomes will be presented using continuous and binary outcomes. Individual level outcomes will then be presented to further determine the clinical effectiveness of the program on primary and secondary outcomes across the 6 outcome phases of the study.

6.2 Group primary outcomes

DBT aims to establish behavioural control by prioritising the reduction of suicidal thinking, suicide attempts and NSSIB. As a corollary the primary outcome of the CAMHS DBT program was the reduction in suicidal ideation and behaviour. It was predicted that at follow up, graduates from the DBT program would have significantly reduced suicidal behaviour and suicidal ideation.

6.2.1 Statistically significant reductions in suicidal ideation and behaviour

Table 12 presents mean and standard deviation pre and post scores on the Suicidal Ideation Questionnaire (SIQ). Significant reductions in average SIQ total scores were found for clients completing the program from baseline to follow-up. These reductions were larger than what you would expect by chance and indicative of reduced seriousness of self-destructive suicidal
thinking and behaviour. No statistically significant reductions were found from baseline to follow-up on total critical item scores.

6.2.2 Clinically significant reductions in suicidal ideation and behaviour

Of clinical significance, as seen in Table 12, the mean reduction in critical item scores from baseline to follow-up is suggestive of an overall amelioration from a more severe level of suicidal thinking and intent to a level of ideation characterised by morbid ideas and general wishes. Although not statistically significant, this is an important clinical outcome as it suggests that on average clients showed a trajectory towards reduced frequency and intensity of items indicative of clinically significant suicidal ideation and severe psychopathology. Table 13 presents binary outcomes outlining the reduction in risk associated clinically significant suicidal ideation and suicidal behaviour from baseline to follow-up. Although not a diagnostic or predictive measure, the SIQ identifies a raw cut-off score of or above 41 as an indicator of severe suicidal ideation and potentially significant psychopathology and suicide risk. This cut-off was used to determine clinically significant suicidal ideation. Of clinical significance, 11 out of 12 (91%) participants reported severe suicidal ideation and suicide risk at baseline reducing to 4 (33%) at follow-up. This represents a 58% reduction in risk of participants reporting clinically significant suicidal ideation at follow-up.

Item 9 on the BDI measures suicidal thoughts or wishes and was used to ascertain reductions in suicidal ideation and suicidal intent. Scoring above 1 on this item is indicative of elevated suicidal ideation and suicidal intent. As seen in Table 13, of clinical significance, 7 out of 12 (58%) participants reported elevated suicidal ideation and intent at baseline reducing to 0 (0%) participants at follow-up. This represents a 58% risk reduction in the proportion of participants reporting clinically significant suicidal ideation at follow-up.

Additionally, as seen in Table 13, LPI items 22 and 26 measuring NSSIB and suicide attempts respectively were also included as primary outcomes for the program evaluation. Item 26 on the LPI was used to measure changes in suicidal behaviour. Participants endorsing making a suicide attempt at a level of “quite a bit like me” and above were identified as being
at elevated risk and displaying acute suicidal ideation. Of clinical significance, eight out of 12 (66%) participants reported the LPI item of making at least one suicide attempt, as being “quite at bit like me” and above at baseline, reducing to 2 (16%) participants at follow-up. This represents a 50% risk reduction in the proportion of participants endorsing suicide attempts as being “quite a bit like me” at follow-up.
### Table 12. Primary and secondary continuous measure outcomes

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th></th>
<th>Follow-up</th>
<th></th>
<th>Paired Sample t-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
<td>t</td>
</tr>
<tr>
<td>Primary Outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal Ideation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIQ Total</td>
<td>82.6</td>
<td>43</td>
<td>40.8</td>
<td>12.6</td>
<td>3.30</td>
</tr>
<tr>
<td>SIQ critical item totals</td>
<td>14.8</td>
<td>12.1</td>
<td>8.6</td>
<td>2.7</td>
<td>1.75</td>
</tr>
<tr>
<td>Secondary outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDI Total</td>
<td>34.10</td>
<td>9.76</td>
<td>20.25</td>
<td>9.52</td>
<td>6.43</td>
</tr>
<tr>
<td>BPD Behaviours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LPI Total</td>
<td>180.50</td>
<td>25.10</td>
<td>134.25</td>
<td>31.80</td>
<td>4.00</td>
</tr>
<tr>
<td>Confusion about Self</td>
<td>51.20</td>
<td>9.34</td>
<td>36.80</td>
<td>10.28</td>
<td>3.70</td>
</tr>
<tr>
<td>Impulsivity</td>
<td>37.92</td>
<td>8.50</td>
<td>29.92</td>
<td>11.00</td>
<td>3.12</td>
</tr>
<tr>
<td>Emotion Dysregulation</td>
<td>49.92</td>
<td>12.24</td>
<td>34.33</td>
<td>10.40</td>
<td>3.51</td>
</tr>
<tr>
<td>Interpersonal Chaos</td>
<td>44.75</td>
<td>9.20</td>
<td>34.70</td>
<td>9.60</td>
<td>3.40</td>
</tr>
<tr>
<td>Protective Factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RFL-A Total</td>
<td>3.48</td>
<td>1.00</td>
<td>4.00</td>
<td>.55</td>
<td>-1.60</td>
</tr>
<tr>
<td>RFL-A Family Alliance</td>
<td>3.83</td>
<td>1.24</td>
<td>4.31</td>
<td>1.29</td>
<td>-1.52</td>
</tr>
<tr>
<td>RFL-A Suicide Concerns</td>
<td>2.02</td>
<td>.70</td>
<td>3.11</td>
<td>1.40</td>
<td>-2.80</td>
</tr>
<tr>
<td>RFLA-Self Acceptance</td>
<td>2.92</td>
<td>1.35</td>
<td>3.36</td>
<td>1.05</td>
<td>-1.08</td>
</tr>
<tr>
<td>RFL-A Peer Acceptance</td>
<td>4.35</td>
<td>1.10</td>
<td>4.74</td>
<td>.50</td>
<td>-1.23</td>
</tr>
<tr>
<td>RFL-A Future Optimism</td>
<td>3.68</td>
<td>1.36</td>
<td>4.23</td>
<td>.81</td>
<td>-1.32</td>
</tr>
</tbody>
</table>

92
Table 13. Primary and secondary binary measure outcomes

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Follow-up</th>
<th>Risk Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal Ideation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIQ &gt; Cut-off</td>
<td>11/12 (91%)</td>
<td>4/12 (33%)</td>
<td>58%</td>
</tr>
<tr>
<td>BDI Item 9</td>
<td>7/12 (58%)</td>
<td>0/12 (0%)</td>
<td>58%</td>
</tr>
<tr>
<td>LPI Item 26 attempt</td>
<td>8/12 (66%)</td>
<td>2/12 (16%)</td>
<td>50%</td>
</tr>
<tr>
<td>LPI item 22 NSSIB</td>
<td>5/12 (41%)</td>
<td>2/12 (16%)</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Secondary Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDI Severe</td>
<td>8/12 (66%)</td>
<td>1/12 (8%)</td>
<td>58%</td>
</tr>
<tr>
<td>Moderate to severe</td>
<td>12/12 (100%)</td>
<td>5/12 (41%)</td>
<td>59%</td>
</tr>
</tbody>
</table>
Item 22 on the LPI was used to measure changes in NSSIB. Of clinical significance, five out of 12 (41%) participants reported NSSIB as being “quite at bit like me” and above at baseline reducing to 2 (16%) participants at follow-up. This represents a 25% risk reduction in the proportion of participants endorsing NSSIB at follow-up.

In terms of hypothesis one, the results of the current study are promising showing both statistical and clinically significant reductions in suicidal behaviour and ideation. At follow-up clients were less suicidal and using less NSSIB, suggestive of clinically significant improvement in behavioural control and stability.

6.3 Secondary outcomes

The DBT treatment hierarchy targets life threatening behaviour as well as quality of life interfering behaviour such as depression and BPD. Outcomes secondary to the reduction of suicidal ideation and behaviour included reducing depression and core aspects of BPD. Additionally, it was predicted that protective factors would increase for graduating participants at follow-up.

6.3.1 Statistically significant reductions in depression

As can be seen in Table 12, results indicate that graduates of the DBT program had statistically significant reductions in depressive symptoms at follow-up. The reduction in total mean depression scores from baseline to follow-up was larger than what you would expect by chance and indicative of reduced severity of depression and improved functioning. This promising result suggests that the program was able to significantly reduce the average severity rate of depression, a quality of life interfering behaviour targeted by the program and a known risk factor for suicidal behaviour.

6.3.2 Clinically significant reductions in depression

As outlined in Table 13, of the eight participants who met the criteria for severe depression at baseline, one participant remained severely depressed at follow-up. This represents a 58% reduction in the proportion of clients with severe depression at follow-up. Looked at another
way, grouping both moderate and severely depressed participants together, 12 (100%) participants presented with moderate to severe depression at baseline compared with five (41%) at follow-up. As can be seen in Table 13, the reduction of the proportion of participants meeting the criteria for moderate to severe depression was 59%.

6.3.3 Statistically significant reductions in borderline personality disorder

The LPI was used to mark changes in core aspects of BPD directly targeted by DBT. As can be seen in Table 12, there were statistically significant reductions in overall BPD behaviours as well as for all factor scores including confusion about self, impulsivity, emotion dysregulation and interpersonal chaos. The reduction in mean total and subscale LPI scores from baseline to follow-up was larger than what you would expect by chance and indicative of reduced BPD behaviours. Additionally, the maintenance of these skills at follow-up suggests a robust degree of stabilised improvement and capacities in mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance.

6.3.4 Clinically significant reductions in borderline personality disorder

Although the LPI is not a diagnostic tool, the average reduction in emotion dysregulation from baseline to follow-up has important clinically implications. Regulating problematic emotions, the core underlying factor associated with BPD, was on average, reduced for graduating clients at follow-up. This result provides preliminary evidence, showing that the program has to the potential to reduce the impact of emotion dysregulation and its relationship with other psychological difficulties and ongoing psychosocial development.

6.3.5 Statistically significant increases in protective factors

Protective factors against suicide such as family, concerns about suicide, self-acceptance, peer acceptance and optimism were measured using the RFL-A. As illustrated in Table 12, no statistically significant differences were found on RFL-A total scores from baseline to follow-up. In terms of the RFL-A subscales, a large and statistically significant increase was found on mean suicide-related concerns scores from baseline to follow-up. This increase was larger than what you would expect by chance and indicative of increased protectiveness against
suicide. Items on this subscale include “It would be painful and frightening to take my own life,” “I am afraid to die, so I would not kill myself,” “The thought of killing myself scares me,” “I am afraid of using any method to kill myself,” “I am afraid of killing myself” and “I would be frightened or afraid to make plans for killing myself.” No statistically significant increases in protective factors were found on the remaining factors including Family Alliance, Self Acceptance, Peer Acceptance and Support and future optimism.

6.3.6 Clinically significant changes in protective factors

Although RFL-A total and most subscale scores were not statistically significant, an overall trend towards psychological protection against suicide was observed. The incremental improvement on total and subscale protective factor scores represents a clinically significant outcome suggesting a gradual increase in clients endorsing specific reasons for not committing suicide. Any movement and momentum generated in the direction of increased protection against suicidal ideation and behaviour represents an important outcome clients participating in for the program.

6.3.7 Summary of secondary outcomes

The secondary aim of the CAMHS DBT program was to reduce depression, BPD behaviour and increase protective factors against suicide. Both statistical and clinically significant changes were found in all secondary outcomes providing initial evidence for the effectiveness of the CAMHS DBT program in reducing life threatening and quality of life interfering behaviour.

6.4 Individual outcomes

In addition to group outcomes, individual changes were studied using repeated measures over the 6 phases of the study including: baseline (phase 1), pre treatment (phase 2), program participation (phase 3 and 4), graduation (phase 5), and follow-up (phase 6). Figures 12 to 24 depict the phase outcome for each participant for the primary and secondary outcomes.
6.4.1 Suicidal ideation

As can be seen in Figure 12, a declining trajectory of suicidal ideation was observed for most participants who completed the program. Within this downward slope clients appeared to experience characteristic fluctuations in suicidal ideation over the six phases of the study. Additionally, participants showed pronounced reductions in suicidal ideation after moving into a period of full participation in the program (phase 3). Figure 13, shows the trajectory of participants who responded to the program with the most pronounced reductions in suicidal ideation (the majority of participants). A characteristic pattern of elevating and declining suicidal ideation can be seen within a declining suicidal ideation trajectory. Overall, initial spikes, including an increase in suicidal ideation during phase two and three, were followed by a trend of pronounced reduction in suicidal ideation from phase three and four. Two patterns can be seen from graduation (phase 5) to follow-up (phase 6). These include an ongoing tailing down towards reductions in suicidal ideation and for the minority of clients, no change or a slight increase in suicidal ideation.

Overall, the majority of individual suicidal ideation outcomes show characteristic variability in the rate of decline over the course of the program to clinically significant reduction at follow-up. Usually after phase 3, reductions in suicidal ideation were observed and ongoing reductions, maintenance and slight increases in suicidal ideation occurred between graduation and follow-up.
Figure 12. Suicidal Ideation Questionnaire for all participants

Figure 13. Suicidal Ideation Questionnaire for the majority of participants
6.4.2 Depression

As can be seen in Figure 14, a slope trending downwards to mild and moderate symptoms of depression is evident in the later phases of the study. Most clients showed marked declining depressive symptom severity from phase four of the study with some showing improvement from phase three. A characteristic pattern of fluctuating depressive symptom severity was observed, as can be expected from clients with emotion regulation difficulties. Figure 15, shows the trajectory of participants who responded to the program with the most pronounced reductions in depression (the majority of participants). A characteristic increasing reduction in depressive symptoms can be seen for participants at varying phases in the study. These sharp improvements may have corresponded with the timing of the acquisition of new and effective behavioural skills and their affects on improving mood. The trajectory of ameliorating depression seen in the current study is also characterised by further reductions in depressive symptoms from graduation to follow-up. Figure 16, illustrates the ongoing reduction in depressive symptoms from graduation to follow-up for the majority of participants (9 out of 12) completing the study.

Overall, the majority of clients showed an improved trajectory finishing with less depression than at the start of the program. Within this improved trajectory of declining depressive symptom severity, a pattern of both fluctuating depressed mood and exponential declines in depression were observed. Maintenance and ongoing reductions in depressive symptoms can be seen from graduation to follow-up.

6.4.3 Borderline personality disordered behaviours

As can be seen in Figure 17, a characteristic downward trajectory in BPD behaviours can be seen for most participants across the six phases of the study as measured by the LPI. Within this downward slope, and as can be expected from this client population, fluctuating core BPD behaviours were observed. Consistent with patterns seen on the SIQ and BDI, marked reductions in core BPD behaviours were observed towards the second half of the program.
Figure 14. Beck Depression Inventory for all participants

Figure 15. Beck Depression Inventory for the majority of participants
Figure 16. Improved treatment gains from graduation to follow-up on BDI

Figure 17. Total Life Problem Inventory scores for all participants
from phase 3. Figure 18, shows the trajectory of participants who responded to the program with the most pronounced reductions in core BPD behaviours (the majority of participants). The marked steep downward slope seen from phase 3 may reflect the time needed for the treatment to start having an effect on increasing the capacity of participants to more effectively regulate.

Improved individual outcomes were also seen on LPI subscales. As illustrated in Figure 19, participant responses on the LPI emotion dysregulation subscale show a slope trending towards reduced emotion regulation difficulties over the six phases of the study. While fluctuations continued to occur for some clients throughout the course of the program, most clients show a discernible movement towards improved capacity in regulating difficult emotions. As seen with suicidal ideation, an exponential decline in emotion regulation difficulties appears to have occurred from phase three of the study. Additionally, divergent trajectories from graduation to follow-up suggest that this period may be clinically significant in terms of producing marked improvement or relapse.

Similar patterns of declining core BPD behaviours were seen on the remaining LPI subscales. Figure 20, shows an overall pattern of reducing impulsivity from Baseline to follow-up with characteristic fluctuations throughout. The clear spike in impulsivity from graduation to follow-up by one participant in figure 20, represented a trend reversal for that client, and appeared to reflect the lack of opportunity to consolidate and further develop her skills in the context of ongoing family discord. Figure 21, shows the declining trajectory of participants on the LPI subscale of confusion about self. Most clients showed sharp declining identity disturbance over the course of the study with characteristic fluctuations within this trajectory. Figure 22, shows an overall pattern of reducing interpersonal chaos with characteristic fluctuations throughout.

Overall, most participants showed a trajectory of reducing core BPD behaviours over the course of the study. LPI total and subscale trajectories suggest participants were able to learn
Figure 18. Life Problems Inventory for the majority of participants

Figure 19. LPI Emotion Dysregulation subscale
Figure 21. LPI Impulsivity subscale

Figure 20. LPI Impulsivity subscale
Figure 22. LPI Interpersonal Chaos subscale
skills to help them reduce impulsivity, interpersonal chaos, identity disturbance and emotion regulation difficulties.

**6.4.4 Protective factors**

Although statistical significance was not found for changes in total protective factor scores for the group outcomes, a slightly inclining slope of increasing protective factors with concurrent fluctuations can be seen across the six phases of the study (Figure 23). Sharp declining and inclining scores were seen over the 6 phases of the program for many participants. The only statistically significant protective factor was for suicide related concerns (Figure 24). The majority of participants showed a pattern of oscillating concerns about suicide within an overall trajectory of improvement from baseline to follow-up. As can be seen in Figure 24, a number of clients displayed a sharp increase in suicide related concerns early in the program from phase 2 (pre-treatment). This may have reflected the emphasis clinicians placed on treating suicidal behaviour directly and the concurrent hope for change that early participation in the program may bring. Because no significant reductions in protective factors were seen on the remainder of the RFL subscales, they have been put in Appendix D for the reader.
6.5 Non response to treatment

Although most participants showed a clear trajectory of reduced clinical severity not all displayed sharp declines in suicidal ideation, depression and BPD. Identifying factors associated with non responding clients is important for the ongoing development of the program. This may allow clinicians to identify and respond effectively to clients who may be at risk of not fully benefitting.

In terms of suicidal ideation, Figure 25 displays the trajectory of two clients distinctive by their lack of reduced suicidal ideation at follow-up. As can be seen by the trajectory of the participant in the lower line, no change in suicidal ideation from baseline (phase 1) to follow-up (phase 6) with a spike in suicidal ideation in the middle phase of the study (phase 3) was observed. This client started and completed the program with below clinically significant suicidal ideation. As can be seen by the trajectory of the client in the upper line of Figure 25, a flat line of clinically significant suicidal ideation was observed from Baseline (phase 1) to graduation (phase 5) followed by a tailing upward from graduation to follow-up (phase 6).

In terms of depression, Figure 26 identifies participants showing a somewhat flat trajectory with minimal improvement from baseline to follow-up. Participants represented by the lower 2 lines in Figure 26 showed a somewhat flat trajectory and no improvement from baseline to follow-up. The participant represented by the upper line in Figure 26, could be described as having one of the severest clinical profiles of all participants in the study, with the highest BDI and the second highest SIQ score. Although her depression remained somewhat stable at a severe level across the course of the program she graduated with clinically significant less suicidal ideation. Her strong initial reluctance to participate shifted mid way through the program to a point where she became a leader within the group. Her trajectory altered to increasing stability with the willingness to participate in ongoing therapy.

In terms of core BPD behaviours, Figure 27 shows participants displaying a flatter trajectory with limited reductions in core BPD behaviours across the six phases of the study.
The gradual sloping downwards suggests that these participants did not acquire the capacities to replace core BPD behaviours at the same rate or sharpness as their peers. Additionally, a number of individuals did not have the same steep reductions in LPI subscale scores as illustrated by figures 29 (emotion dysregulation), 30 (impulsivity), 31 (confusion about self) and 32 (interpersonal chaos). These participants displayed a flatter trajectory and in some cases others showed characteristic oscillating core BPD behaviours.

In extrapolating potential factors specific to non responding clients, 2 participants were identified as consistent non responders, thus having the potential to provide valuable information to improve the capacity of the program to identify and respond effectively to future non responding participants. Both clients showed minimal improvement on suicidal ideation, depression, core BPD behaviours and protective factors. Their clinical profile remained somewhat constant across the 6 phases of the study and they appear on all non responding figures on page 112. Rather than severity explaining their lack of progress (other participants with equally severe profiles were able to improve), observations from skills group facilitators suggested that passive parental participation may have negatively impacted progress. Although collecting data on parental participation was not within the scope of the current study, observations made by clinicians identified passive parental participation as characterised by low endorsement of the usefulness of participating in the tasks of skills group such as learning and trying new skills and low expectations for change.
6.6 Summary

Overall, individual outcomes suggest that while there was heterogeneity, most participants showed improved clinical trajectories including reduced suicidal ideation, depression and core BPD behaviours. Within this improved trajectory most clients displayed fluctuations in suicidal ideation, depression and core BPD behaviours, somewhat characteristic of a client population identified and having difficulties with emotion regulation. The middle of the 20 week program (Phase 3 and 4) was identified as a sharp turning point for many participants suggesting the importance of keeping clients in the program so they can potentially benefit after reaching the mid way point. Additionally, divergent trajectories from graduation to follow-up suggest that this period may be clinically significant in terms of producing marked improvement or relapse. Two clients were identified as characteristically not responding to treatment across all outcome measures. Differences in parental participation and expectations were identified as potential factors impacting their lack of progress.
7.1 Support for the ongoing implementation of the CAMHS DBT Program

The overall goal of the current study was to design, implement and evaluate the effectiveness of a pilot Dialectical Behaviour Therapy (DBT) program. The major focus of the evaluation was to determine the feasibility of implementing DBT within Child and Adolescent Mental Health Services (CAMHS) by evaluating initial clinical outcomes. The aim of the current study was to reduce suicidal behaviour, core aspects of Borderline Personality Disorder (BPD) and depression using DBT. Additionally, in the context of plans to move from a child and adolescent (0-18) to a child and youth (0-25) model of service, the project aimed to build capacity and prepare for a likely increase in presentations of suicidal behaviour, BPD and depression. It was hypothesised that as a result of graduating from the CAMHS DBT program clients would report significantly reduced suicide ideation and behaviour, core aspects of BPD and reduced symptoms of depression. These reductions would represent amelioration from severe psychopathology and elevated suicide risk to a phase of behavioural stabilization and control. In this non controlled study of client outcomes a number of promising preliminary findings were observed. Statistical and clinically significant reductions were found in suicidal ideation, suicidal behaviour, depression and core aspects of DBT. These promising client outcomes support the ongoing implementation and development of the CAMHS DBT program.

7.1.1 Establishing behavioural control

The first phase of DBT involves establishing stability and behavioural control through helping clients attain basic capacities (Linehan, 1993). Behavioural control and stability is
achieved by decreasing suicidal behaviour, therapy-interfering behaviour, quality-of-life-interfering behaviour and increasing more adaptive skilful behaviour (Linehan, 1993). The reductions in suicidal behaviour, depression and core aspects of BPD, such as impulsivity, found in the current study, indicate that graduating clients were at significantly reduced risk for suicide at follow-up. Moreover, these results suggest clients had attained clinically significant behavioural control and stability. This result is in line with other studies where DBT has been shown to help individuals gain strategies that promote and establish behavioural control (Davenport, Bore & Campbell, 2010; Fleischhaker et al., 2011). Attaining behavioural control is a significant marker of progress in DBT and represents clinically significant outcome for clients participating in the current study. This encouraging result suggests that clients presenting with high levels of suicidal behaviour can be treated effectively in a community mental health setting, using a relatively short-term intervention.

7.1.2 Reductions in core aspects of BPD

In the current study, reductions were found in all core aspects of BPD including: confusion about self, impulsivity, emotion regulation and interpersonal chaos. This result is consistent with research showing reductions in BPD criterion behaviours using DBT (Fleischhaker et al., 2011) underlying the importance of providing targeted evidence based treatment of BPD in an early intervention CAMHS context (National Collaborating Centre for Mental Health, 2009). Moreover, the preliminary results from the current study provide promising indications that clinicians and administrators can be more hopeful of improved clinical outcomes for clients presenting with BPD participating in the DBT program. Given the deleterious effects of BPD, this represents a promising result encouraging the ongoing use of DBT with this challenging client population.
7.1.3 Reduced depression

Graduates of the CAMHS pilot DBT program had significant reductions in depressive symptoms at follow-up. Together with reductions in suicidal behaviour and core aspects of BPD, clinically significant reductions in depressive symptoms combine to represent a markedly reduced risk profile for graduating participants of the current study. This promising result is in line with research showing significantly reduced depression and anxiety at follow-up using DBT (Pasieczny & Connor, 2011), where the mediating properties of DBT skills (Neacsiu, Rizvi & Linehan, 2010) and their capacity to help clients process negative emotional experiences (Feldman, Harley, Kerrigan, Jacobo, & Fava, 2009) have been hypothesized to reduce depressive symptoms. Additionally, research has shown that increased hope is predictive of reduced depressive symptoms at the completion of an adolescent DBT program (Ritschel, Cheavens & Nelson, 2012). Furthermore, although not within the scope of this study, reductions in suicidal behaviour, depression and core aspects of BPD may reflect the underlying emotion regulation difficulties associated with these conditions and position DBT as a trans-diagnostic treatment for mental health services.

Additionally, it was hypothesized by the DBT team that the reductions in depression found in the current study may also be associated with changes occurring in the adolescent’s environment. Targeting change in the adolescent’s environment was considered a priority due to the powerful crisis eliciting effects of family discord seen with many clients participating in the current program. For example, family discord was targeted through parental participation in skills group and family sessions to actively promote validation, support and improved communication between parent and adolescent. Moreover, parents were coached to actively look for more effective behaviour from their adolescent and provide immediate reinforcement of approximations of desired behaviours. The CAMHS DBT program would
likely benefit from future research into the potential effects of improved family functioning on changes in adolescent mood.

Additionally, given the high rates of depression found in the current study, and the likely ongoing co-morbid presentation of depression with suicidal behaviour and BPD, bolstering the program’s capacity to provide effective treatment for depression will be critical to its ongoing success. Behavioural activation therapy has been recommended as an adjunctive approach with DBT to more directly target depression (Hopko, Sanchez, Hopko, Dvir, & Lejuez, 2003). Behavioural activation therapy for depression stipulates the importance of ensuring the availability of reinforcement in the client’s environment and building skills where skill deficits exist (Kanter et al., 2010). The consistencies between behavioural activation and DBT such as, identifying client goals, linking skills to goals and setting weekly behavioural homework to elicit environmental reinforcement, provide a solid basis from which to integrate a behavioural activation protocol for depression into the DBT program (Hopko et al., 2003; Kanter et al., 2010). Moreover, the development of an adjunctive behavioural activation protocol and associated training would likely further enhance the potential for the CAMHS DBT program to reduce depression. This could provide additional utility for the program to provide much needed services to clients presenting primarily with depression and suicide risk.

7.1.4 Protective factors

It was hypothesised that as clients became less suicidal, depressed and displayed more functional emotion regulation behaviour, they would identify more reasons for living (Miller et al., 2007). Although protective factors against suicide remained mostly constant and stable throughout the current study, no substantial increases were found across family, self, peer and optimism domains of protectiveness. The lack of concurrent increases in endorsed protective factors against suicidal behaviour in these domains was an unexpected outcome of the current
study. This may reflect the lack of explicit targeting of family and friends as protective against suicide by individual therapists. Although individual therapists prioritised the reduction of suicidal behaviour as a primary target of the program, emphasis was not explicitly placed on connecting the reduction of suicidal behaviour with other protective factors such as family and peers. In the current study, the major emphasis was placed on reducing suicidal behaviour and the negative associations of using suicidal behaviour such as a solution to manage distress; aversive emergency department experiences, feelings of shame and guilt, given that these factors predict further suicidal behaviour. This emphasis may have contributed to reinforcing concerns about suicidal behaviour which was the only significant domain that increased as protective against suicide during the course of the current study. Future programs should aim to develop strategies to maximise protection against suicide using family, peer, self acceptance and future optimism domains.

7.2 Ongoing program development

The ongoing development of the CAMHS DBT program should aim to maximise learning gained from the current pilot implementation. A number of patterns were observed across the six phases of the current study including significant clinical improvement occurring from the middle phase of the program and divergent trajectories between graduation and follow-up. These patterns provide valuable information for the ongoing development and refinement of the program.

7.2.1 Mid-program improvement implications

A pattern of improvement from midway through the program was observed for a number of participants in the current study. This may relate to the time taken to establish a therapeutic alliance, the ongoing use of commitment strategies and social desirability factors. Characteristically, a number of clients participating in the early stages of the program displayed a reluctance to commit to reducing suicidal behaviour to using more effective
interpersonal, distress tolerance and emotion regulation strategies. To improve commitment to reducing suicidal behaviour, DBT commitment strategies were used within a developing therapeutic relationship, to influence clients to disengage in suicidal behaviour. During the initial phases of the program a concentrated effort was placed on influencing clients to replace suicidal behaviour with the skills taught in the program. This was a consistent and relentless approach undertaken across the program by individual therapists and skills group facilitators, requiring maximum effort from clients, as it meant giving up behaviour that had become entrenched and resistant to change. The effects of this focus and the use of the therapeutic relationship and commitment strategies, may have taken hold by the middle phases of the study. From phase three onwards, a pattern emerged where clients had invested more into taking suicide away as an option and were more committed to learning and applying skills.

Additionally, it was observed that after a number of clients expressed the importance of committing to the program during group, a number of other clients became more committed and willing to participate more effectively in learning and applying the skills. Clients who changed to more explicit committed behaviour and participation appeared to influence other group members creating a new norm of participation for the remainder of the program. From approximately phase three of the program, active participation developed and an exponential investment into learning and applying skills appeared to become socially desirable within the group. This effect is in line with social psychological research that shows people will conform on the subjective validity of social norms rather than power structures (Festinger, 1950, cited in Whitley, 2002). This suggests that group participation could be influenced heavily by peers and provides an opportunity to design the program using social desirability to promote commitment and enhance earlier take-up of learning and applying skills. For example, enhancing commonalities and influence by using DBT program graduates to
promote the benefits of the program to new participants (Miller et al., 2007). Graduating adolescents and parents could attend orientation night or an early group session to discuss their difficulties and what they were able to achieve as a result of participation in the program.

### 7.2.2 Graduation to follow-up implications

Characteristic patterns from graduation to follow-up included a mixture of maintenance of treatment gains, continued improvement and reduced treatment gains. These patterns emphasise the importance of maintaining an environment supporting ongoing learning, practice and consolidation after graduation from the program. For example, adolescents with supportive parents provide valuable cheerleading, modelling and reinforcement and may have helped reinforce skilful behaviour post graduation from the program (Miller, 2007). Conversely, adolescents graduating from the program with limited opportunities for ongoing support, modelling and reinforcement may have experienced a reversal of treatment gains.

Throughout the program it was noteworthy that some clients had less optimal opportunities for reinforcement, modelling and support for practicing the skills. Assuming this pattern continued after graduation it is likely that without reinforcement from individual therapists, skills group facilitators and other group participants, some clients may have drifted away from practicing the skills and consolidating their learning. As a corollary, opportunities for ongoing support, modelling and reinforcement of the skills may not have been adequate to maintain and promote further treatment gains such as those seen with other clients. The observed divergent post graduation trajectories indicate the need for a post graduation adjunctive treatment modality designed to provide opportunities for support, ongoing skill use and consolidation.

Miller et al. (2007) suggests using a graduation group to limit the chances of relapse and to consolidate treatment gains. The aim of the graduation group is to provide an opportunity
for goal setting, ongoing skill development and consolidation. Although a graduation group was identified in the initial development phase of the current program, it was unable to be implemented due to operational constraints such as limited clinical resources and hours of operation restrictions. Follow-up results from the current study impress the need for a graduate group to ensure all clients have access to ongoing opportunities to set goals and practice skills. Moreover, the graduate group would provide the structure and environment necessary to help clients continue to prioritise the use of skills and limit the chances of relapsing to formerly dysfunctional patterns of behaviour.

Additionally, given that it is recommended that adult DBT client participants complete skills training and individual therapy over a period of 12 months (Linehan, 1993), consideration could be given to extending the length of the CAMHS DBT program or encouraging participants to complete two cycles of the program. Having access to longer treatment could benefit ongoing skill consolidation and development as well as provide support to those clients who have yet to fully benefit from 1 cycle of the program as seen in the current study.

7.3 Implementation outcome implications

A four phase implementation strategy was developed to embed DBT-A as a high fidelity specialised treatment program into CAMHS. In reviewing the effectiveness of the implementation strategy a number of factors stand out. Firstly, effective leadership across all levels of the service did provide sufficient momentum and support for the DBT program to be implemented at a somewhat effective range of fidelity. Secondly, the ongoing development and sustainability of the DBT program will likely benefit from ongoing learning derived from implementing the program and disseminating positive client, family and clinician outcomes. Finally, regular targeted supervision, training and support appeared to be critical to the
effectiveness of the program by increasing the capacity and motivation of DBT team members to implement DBT with sufficient treatment fidelity.

### 7.3.1 Leadership

Securing a commitment for the development and implementation of the CAMHS DBT program was a critical outcome achieved through the implementation strategy. Mental health executives provide leadership through their overt endorsement and support for new clinical practices (Fixsen et al., 2005) such as supporting the intention that DBT should be implemented with high treatment fidelity. Moreover, due to the need for a paradigm shift to DBT from TAU, leadership across multiple levels of the service was seen as critical to implementation of the CAMHS DBT program. Specifically, leadership from psychiatrists, directors, team leaders and clinicians was seen as having a potentially penetrating affect on delivering high fidelity implementation of DBT-A.

In line with recommendations made by Comtois et al. (2007) it was critical for the implementation of the current pilot program, that the author assume the additional responsibility of leading the DBT program while in the existing role as a team leader. This was a strategic decision designed to ensure the program had effective leadership and administrative support within the current leadership structures of MHSs (Comtois et al., 2007). Team leadership provided the platform from which to advocate for the needs of clients with BPD, the needs of the program to fulfil the requisite functions and modes of an effective DBT program and the needs of clinicians to deliver therapeutic experiences for clients. Furthermore, team leadership provided some influence over organizational barriers such as uncertain leadership and bureaucratic constraints that have been implicated as barriers to implementing evidence based practice (Corrigan, McCracken, & Blaser, 2003).

Additionally, maintaining authoritative leadership within current MHS leadership structures will likely be advantageous to the ongoing development and effectiveness of the
DBT program. This could operate in a similar way to other specialist programs operating within MHSs such as the eating disorders program. Without this level of embedded authority, the DBT leadership role would be somewhat blunted in its capacity to advocate for the ongoing development of the CAMHS DBT program, the needs of clients presenting with suicidal behaviour and BPD and the needs of clinicians working with this challenging client population. Furthermore, leadership of the DBT program requires a driven leader who has the authority to address operational challenges to ensure the needs of the program are being met (Comtois et al., 2007). For example, clinical leadership through modelling effective skills group facilitation and administrative leadership through timely and targeted recruitment of clinicians to the team. More critically, providing the leader of the CAMHS DBT program with enough time and flexibility to manage both clinical and administrative duties will require organizational change. As a corollary, changing and developing new organisational roles to adapt to the needs of new innovative clinical practices, is seen as critical to the success of implementing new evidence based practices and will likely be critical to the ongoing effectiveness of the DBT program (Fixsen et al., 2005).

7.3.2 Sustainability

The DBT program will likely face ongoing challenges to implementation such as administration, staffing and funding priorities (Comtois et al., 2007; Koerner et al., 2007). Administrators had understandable concerns relating to the large commitment required to implement the various DBT treatment modalities and the associated training and supervision costs. The comprehensive implementation of DBT involved redistributing existing resources at the potential cost of other areas of the service. Understandably, administrators require evidence indicating that allocated resources are producing positive outcomes for clients and capacity building for the service. To maintain commitment to the program, Koerner et al. (2007) suggest providing certainty to administrators by highlighting the benefits of the new
program. For example, summarising and presenting the results of the current study to the strategic executive committee of mental health services and having executives attend orientation and commitment sessions (see recommendations below) to witness graduates discussing the benefits of the program. Additionally, investigating the effectiveness of the DBT program using a larger study such as a randomised control trial (RCT) could highlight the benefits of the DBT program for suicidal youth. Outcomes from the RCT would likely have significance in furthering the science around the implementation and effectiveness of DBT with adolescents and their parents. Locally, outcomes could justify the ongoing allocation of resources into the program. Furthermore, investigating other outcomes such as drug and alcohol use and anxiety could provide additional evidence implicating DBT as an effective behavioural intervention for a number of mental health conditions. Ongoing leadership would be required to ensure the research project received sufficient support and resources and results were used to inform funding decisions relating to program sustainability.

In the current study, promising preliminary evidence showed that clients graduating from the program had significant reductions in suicidal ideation, symptoms of depression and BPD traits at follow-up. These preliminary findings provide mental health administrators with the opportunity to justify further investment into the use of DBT within CAMHS. Moreover, the relatively short term aspect of DBT provides mental health executives with a potentially viable cost effective treatment for suicidal clients presenting with chronic depression and BPD.

7.3.3 Workforce development

The promising initial results of the current study suggest that investment into the ongoing development of the CAMHS DBT team would be warranted. In the current study, a workforce development program was initiated to provide clinicians with sufficient training,
ongoing supervision and practice guidelines to provide initial competence in the delivery of DBT. Although this may have proven adequate for the current pilot program, the ongoing need to build mastery in DBT and understanding the complex needs of the target population require ongoing training in DBT. To ensure clinicians have opportunities to advance their competencies, ongoing training should aim to consolidate, challenge and continue to build mastery in applying DBT to the target population. As a corollary, the CAMHS DBT team would likely benefit from attending the DBT intensive training, considered to be the gold standard in training for DBT teams (Comtois et al., 2007). The adjunctive use of internet based training would also be useful as it has been found to be an effective training and supervision modality (Worrall & Fruzzetti, 2009).

The significant investment of time, effort and money required by attending the DBT intensive training and internet based training modules, would be potentially offset by the potential ongoing cost effectiveness of DBT, as seen in its application to other routine Australian public mental health services (Pasieczny & Connor, 2011). Moreover, the DBT intensive training could provide greater service wide capacity to provide treatment, consultation and leadership in relation to complex high risk complex presentations.

7.4 The use of DBT in other areas of mental health services

The amelioration of suicidal behaviour, depression and behaviours consistent with BPD provide encouraging preliminary evidence supporting the ongoing use of DBT within CAMHS. These findings converge with other studies indicating that DBT is an effective and implementable treatment within public mental health services (Burroughs & Somerville, 2012; Carter, Willcox, Lewin, Conrad, & Bendit, 2010; Ritschel et al, 2012) and more specifically, with adolescents (Fleischhaker et al., 2011: Katz, Cox, Gunasekara, & Miller, 2004; Klein & Miller, 2011). With empowered and effective leadership DBT can be
effectively implemented within CAMHS producing positive outcomes for high risk clients in an outpatient setting.

The encouraging initial evidence from the current study suggests that DBT could have greater utility across the service. For example, DBT has been found to be useful with depression in older adults (Lynch, Morese, Mendelson, & Robins, 2003) and binge eating and bulimia (Safer, Telch, & Chen, 2009). Effective leadership will enable the learning, knowledge and experience derived from the implementation of the CAMHS DBT program, to inform other areas of the service hoping to implement DBT. For example, in conjunction with the principle psychologist and the DBT working group, a DBT program for the adult service was promoted using the CAMHS implementation to inform the adult service model.

Additionally, given the potential utility of DBT to be used as a trans diagnostic treatment framework for emotion dysregulation difficulties seen in a number of diagnosis, a needs analysis and feasibility study for the development of a service wide DBT centre to provide assessment and treatment across the developmental life span is warranted. The centre could provide treatment for adolescent, youth and adult clients presenting with suicidal behaviour, Borderline Personality Disorder and other complex co morbid difficulties.

7.5 Limitations

Although results from the current pilot study are encouraging, limitations need to be considered. The primary limitation of the current study was the lack of a control group and randomization. Without using a randomised control trial, we are unable to rule out the possibility that the changes found in the current study are due to other extraneous factors such as: maturation, statistical regression and demand characteristics (Whitley, 2002). Consequently, the results of the current study do not allow for definitive statements as to the effectiveness of DBT over TAU. Notwithstanding the promising pattern of improvement found the current study, maturation may have occurred where improvements were
attributable to the effects of various adolescent experiences external to the direct impact of the DBT program. Additionally, statistical regression may have played a confounding role in the current study where the initial extreme scores are likely to be less extreme on post test measures.

In terms of demand characteristics, all clients participating in the current study were aware the program was being evaluated. This may have lead to demand characteristics potentially leading participants to respond in a socially favourable way rather than reflecting their true responses on outcome measures (Whitley, 2001). Additionally, the reliance on adolescent self-report measures in the current study and the lack of other behavioural observations such as from parent reports and diary cards, limited the capacity of the current study to control for demand characteristics. Future research into the effectiveness of the CAMHS DBT program may benefit from interviewing participants from the current study to ascertain their perspective on potential demand characteristics.

Additionally, the current study used a small convenient sample of participants. As a corollary, the results of the current study may not generalise to other similar settings or populations and may reflect a trade-off inherent in conducting research in an applied setting such as CAMHS (Whitley, 2001).

Notwithstanding these caveats, the results of the current study are encouraging and suggest that DBT can be applied in an Australian CAMHS setting. Moreover, Hayes et al. (1999) suggests the aim of feasibility studies, such as the current study, is to examine the capacity to apply treatments in routine clinical contexts rather than rigorous scientific control. As a corollary, the results of the current study are promising and suggest that DBT can be effectively applied within CAMHS.
7.6 Summary and recommendations

The promising results of the current study suggest that complex presentations such as clients displaying suicidal behaviour, BPD and unremitting depression, can be treated effectively with an evidence based framework implemented within a public mental health service. It is foreseeable that with ongoing program and work-force development that the CAMHS DBT program could evolve and maximises its capacity to deliver positive outcomes for the target population. Listed below in table 12 are 9 recommendations based on the current study. These recommendations were developed with the purpose of maximising the potential for the DBT program to survive and flourish as well as boosting its effectiveness in producing positive client outcomes.
Table 14. Recommendations

Recommendations from the current study

*Recommendations for the program to survive and flourish*

1. Ensure the leader of the CAMHS DBT program has equal operational status and authority as other team leaders within the service.

2. Build on the promising results of the current study by developing research infrastructure and supporting a randomised control trial of the CAMHS DBT program.

3. Undertake a needs analysis and feasibility study for the development of a service wide DBT centre to provide assessment and treatment across the developmental lifespan.

*Recommendations for boosting the clinical effectiveness of the program*

4. Continue using a comprehensive DBT program within CAMHS for the treatment of suicidal behaviour, BPD, and other treatment resistant conditions such as depression.

5. Clients presenting with high levels of suicidal behaviour should be referred to the DBT program for assessment, recommendations and potential treatment.

6. Behavioural activation protocol should be integrated into the program to enhance the effects of DBT on reducing depression. Training in behavioural activation should be undertaken by DBT team members.

7. Develop and implement an introductory group session to enhance orientation, motivation and commitment to the program. Have graduates present the benefits of the program to new participants. Invite local sporting identities and or artists to describe their stories of recovery, goal setting and practice.

8. The integration of additional family sessions should be prioritised for future programs.

9. Further develop the CAMHS workforce by sending the CAMHS DBT team to the DBT insensitive training.

10. Implement a DBT graduate group to reduce relapse and support ongoing recovery.
REFERENCE LIST


128


Commonwealth of Australia (2010). *National Standards for Mental Health Services 2010*. Barton, ACT.


137


smyth.ppt++&hl=en&gl=au&pid=bl&srcid=ADGEESi9XEj5X1ugbco5hRuPHswLHoWXAYRBzfBee1Tq_JIHU5hIU-ZzWcJkwGnxgeDdcn3_OHL1EyAmYrF_T-ZHDqjkwF9Yn4HTo96q-Vs0dBuLrlfHU_K11sSo7M_rFy68a9Yqj3cF&sig=AHIEtbQeQ7aozr4Ah68mVMqxGUf7TuNOWQ


APPENDICES

Contents

Appendix A. Clinicians Toolkit 158
Appendix B. CAMHS DBT Program Workbook 229
Appendix C. Letters of ethics approval 338
Appendix D. Reasons For Living Subscales 339
Appendix A

Clinicians Toolkit
CAMHS DBT Program

Clinician Toolkit

1. Assessment and Allocation Protocol
2. Client and Parent Information Sheet
3. Clinician Information Sheet
4. Adolescent Consent Form
5. Parent Consent Form
6. Clinician Consent Form
7. Case Formulation Format
10. Pre-Treatment Checklist
11. Weekly Individual Therapist Summary
12. Consult Group Template
13. DBT Informed Family Therapy

Adapted from:
### DBT Program - Assessment and Allocation Protocol

**Client Details**

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
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<table>
<thead>
<tr>
<th>Contact numbers (h)</th>
<th>(m)</th>
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**Parent/ Legal guardian Details**

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<th>(m)</th>
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<td>y / n</td>
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**Referral Details**

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<thead>
<tr>
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<th>Profession</th>
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<tr>
<th>Organization</th>
<th>Phone number</th>
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**Reason for Referral**

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Assessment Protocol

The assessment procedure for the CAMHS DBT program involves 2 steps:

**Step 1: DBT assessment**

Step 1 of the assessment process is achieved by conducting a DBT Full Assessment with the client and or family. The purpose of the DBT Program Full Assessment is to determine if the client meets the inclusion criteria for the CAMHS DBT program (see below). The clinician completes a full assessment as well as administering the DBT assessment Battery. The assessment battery investigates suicidal and non suicidal self injurious behaviour, protective factors, major problem areas associated with BPD diagnostic criteria, mental disorders, family functioning, and mental Drug and Alcohol problems. The assessment battery consists of:

- CAMHS DBT integrated Full assessment protocol
- Structured Clinical Interview for DSM-IV AXIS II Personality Disorders
- Suicide Attempt-Self-Injury Interview (SASSII) Standard (short) version
- Suicidal Ideation Questionnaire.
- Reasons for Living Inventory – Adolescent Version.
- Life Problems Inventory.
- BDI - II.
- Feasibility assessment
- Present and discuss DBT Information sheet and start consent process
After completing the above assessment battery, the clinician should then present the DBT program information sheet to clients who meet the criteria and for whom treatment is feasible.

**Step 2: Present to consult group**

- Present assessment to consult group
- Clarifying the feasibility of DBT for the client
- Complete consent process
- Clarifying stage 1 treatment targets;
- Develop an initial treatment plan.
- Pre treatment Targets.

After compiling a formulation and presenting the client to consultation group, a determination is made as to the client meeting the inclusion criteria for the program and the feasibility of participating in treatment. The allocated clinician will then complete the consent process for the program evaluation, proceed with pre-treatment, clarify stage 1 treatment targets and develop an initial treatment plan.

When the clinician is unsure if the client meets the inclusion criteria or about the feasibility of the client participating in the DBT program, the client should first be presented at consult group before starting the information sheet/consent process. When clients are assessed as not meeting the inclusion criteria or for whom treatment is not feasible, other appropriate treatment recommendations will be identified, discussed, and follow-up arrangements made.
# DBT Program Inclusion Criteria

## Exclusion criteria (Please circle)

- Psychotic disorder including actively manic or psychotic clients.  
  - y / n  maybe
- Severe cognitive impairment (IQ lower than 70).  
  - y / n  maybe
- Severe receptive or expressive language problems.  
  - y / n  maybe
- Primary conduct disorder.  
  - y / n  maybe

## Inclusion Criteria (Please circle)

- Female only for first group  
  - y / n
- Ages 15 - 20  
  - y / n
- Suicide attempt in the past 20 weeks or current suicidal ideation.  
  - y / n
- **Exhibit Borderline Personality Features (at least 3 diagnostic criteria).**
  - Frantic efforts to avoid real or imagined abandonment.  
    - y / n
  - Pattern of unstable and intense interpersonal relationships  
    - y / n
  - Identity disturbance: markedly and persistently unstable self-image or sense of self.  
    - y / n
  - Impulsivity in at least 2 domains that is potentially self-damaging.  
    - y / n
  - Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.  
    - y / n
  - Affective instability due to a marked reactivity of mood.  
    - y / n
  - Chronic feelings of emptiness  
    - y / n
  - Inappropriate, intense anger or difficulty controlling anger (and or other emotions).  
    - y / n
  - Transient, stress-related ideation or severe dissociative symptoms.  
    - y / n

## Total

- Symptoms of depression (including long standing symptoms).  
  - y / n  maybe
- Using suicide, self-harming, and/or other unsustainable behaviours to regulate emotion.  
  (e.g. drug and alcohol use)  
  - y / n  maybe
Assessment and Allocation Overview

Referral - documented history, signs, and symptoms consistent with meeting DBT program inclusion criteria.

DBT Assessment

Meets DBT Program
- Meets inclusion criteria
- Treatment feasible
- Start consent process

Doesn’t meet DBT Program
- Inclusion criteria/treatment not feasible

Offer appropriate intervention including CAMHS or other service providers

Presented to DBT Consult Group
- Allocated DBT Clinician
- Clarify stage 1 treatment targets
- Develop an initial treatment plan
- Complete consent process

Full DBT Program
- Individual Therapy
- Skills Group
- Family Therapy
- Phone Coaching
Full Assessment

Assessment Process Details: (Record details of participants if module completed over several sessions).

<table>
<thead>
<tr>
<th>Date</th>
<th>Clinicians Present</th>
<th>Others present</th>
<th>Location</th>
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Client and Referral Details:

Client D.O.B
Age m / f
Home Phone Mobile Numbers (client, parent, primary care giver)

Referred by
Phone
Assessing DBT Stage 1 Targets Behaviors

In the process of conducting the comprehensive assessment the assessing clinician should be focusing the assessment on DBT Stage 1 treatment targets. The emphasis on stage 1 target behaviour details will have a significant impact on strengthening the client’s commitment and informing treatment planning.

Life Threatening Behaviours

List all self-harming behaviours including those with and without suicidal intent. Attention should be placed on assessing the function of life threatening behaviours using Life Time Parasuicidal Count (LPC). The LPC will allow you to identify antecedents and consequences that may help explain the function of these behaviours and provide valuable information that can sign post warning signs for the client. This information can be used immediately in treatment.

Therapy interfering behaviours

Given the high rates of treatment non compliance and drop out among suicidal multi problem adolescents it is important to elicit what lead to these previous therapeutic terminations. This information can potentially help in keeping the client better engaged in the current treatment by anticipating and addressing the same pitfalls.

Quality of life interfering behaviours

In order to navigate the often confounding array of problems faced by the assessing clinician, and to manage time effectively, it is important to focus this part of the assessment on behaviours that are either functionally related to either life threatening or therapy interfering behaviour. If the behaviours are not linked to higher priority targets, base the sub hierarchy on the clients own prioritization of what
important to him or her, while assessing the functional impairment caused by each of
the behaviours.

**Increase behavioural skills**

The assessing clinician should look for opportunities to evaluate their clients’ skills
repertoires and the context in which they can and cannot employ specific skills.
**Reason for Referral:** (Include expectations of referrer/family/client, and reported attitudes of family and child to referral. Consider cultural views of attending service).

**Presenting Problem:** (If conducting a family interview, each person to identify what the problem is, how they would know the problem was resolved, times the problem is worst/best, how they would like CAMHS to assist. Note the frequency, intensity and duration and impact on the client in terms of distress and dysfunction).
Confusion about self? (Not knowing what you feel or why you get upset; dissociation).

Impulsivity? (Acting without thinking it all through).

Emotional Instability? (Fast, intense mood changes with little control; or steady negative emotional state).

Interpersonal Problems? (Pattern of difficulty keeping relationships steady, getting what you want, or keeping your self respect; frantic efforts to avoid abandonment).

Teenager-Family Dilemmas (Polarized thinking, feeling, and acting e.g., all-or-nothing thinking).
Previous Treatment and Therapy Experiences: Include previous diagnosis, previous treatment the client/family has undertaken, length of previous interventions, previous admissions, what were the outcomes?

History of the presenting problem: (Include perspectives of all parties, parents, child, others. Consider premorbid functioning).

Psychiatric History: (Self, Family Hx Mental Illness, Psychological Tests).
Medical History: (Please include any significant discrete and chronic medical conditions including broken bones, head trauma, diabetes, chronic pain, and previous medications etc)

Development History: (Please details under the following headings).

Pregnancy:

Birth: (premature, full term, overdue, natural birth, induced, caesarean, forceps, O2 Required, duration etc):

0-24 Months:

Sleeping

Eating

Crying

Activity levels

Temperament

Milestones: (specific age).

Sitting    Crawling    Walking    First words    Talking sentences
Toilet training: (Day) (Night)

Further development history:

2 – 5

5 – 12

12 +

Educational / Vocational:

Current school and year:

Name of Teacher, school counsellor etc:

Previous schools:

Academic Performance:

Behaviour:

Social interaction:

Attendance:

Current Concerns (Client, Parent/s, School):

Interventions (previous, current) regarding school based problems:
Social Situation: (Include peer relationships, excessive use of electronic media (games), number and perceived quality of relationships, sexual orientation).

Family History: (Include marital, parental, and sibling relationships with identified client eg the presence or absence of sibling conflicts, jealousy, abuse and also affection and other positive interactions, parenting skill issues, significant events/trauma, relocation, cultural views as to role and position in the family, domestic violence, occupational and financial factors etc).

Genogram:
Assessment of strengths: (Include factors that may contribute to resilience/recovery such as creativity, intelligence, special talents, hobbies, interests, skills, religious and spiritual beliefs/supports, community group membership, sport, social roles, and secure relationships).

Current and Previous Medication:

Prescribed:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Indication</th>
<th>Side Effects etc</th>
<th>Doctor</th>
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Non-Prescribed:
Mental State Examination:

Appearance and Behaviour (Including physical features, dress, grooming; reaction to interview eg hostile, friendly, withdrawn, guarded; awareness, attention; motor activity eg retardation, restless).

Speech (including rate, volumes, tone, and any unusual characteristics such as poverty/pressure of speech).

Mood & Affect (Mood: depressed, euphoric, childish, labile, suspicious, fearful; affect is the external emotional response eg normal, restricted, blunted, flat).

Thought Form: (amount of thought eg poverty of ideas, flight of ideas, slow, vague: loosening of associations, distractible, perseveration, echolalia, thought blocking, illogical thinking).
Thought content: (include preoccupations, ideas of hopelessness/guilt, phobias, obsessions, compulsions, delusions, suicidal thought).

Perceptual disturbances (hallucinations, depersonalisation – self as different, derealisation – environment as unreal).

Sensoriam and Cognition (Level of consciousness, attention, memory, orientation to time/place/person, concentration, abstract thinking).

Judgement and Insight (psychosis – insight into whether client is ill or not; neurosis – understanding of underlying emotional causes; personality disorder – acknowledgement of person’s contribution to relationship difficulties)

Examiners Response to Interview (credibility, consistency, comprehensiveness, emotional reaction to client).
Drug and Alcohol Assessment:

Over the past month how often have you used the following substances?

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>never</th>
<th>Once or Twice</th>
<th>weekly</th>
<th>Almost daily</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Products</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(cigarettes, cigars, etc)</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Alcoholic beverages</td>
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<td></td>
</tr>
<tr>
<td>(beer, wine, spirits, etc.)</td>
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<tr>
<td>Cannabis</td>
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<tr>
<td>(marijuana, pot, grass, hash, etc.)</td>
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<tr>
<td>Cocaine</td>
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<tr>
<td>(coke, crack, etc.)</td>
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<tr>
<td>Amphetamine type stimulants</td>
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<td></td>
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<tr>
<td>(speed, diet pills, acstacy, ice, etc.)</td>
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<tr>
<td>Inhalants</td>
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<tr>
<td>(glue, petrol, paint thinner)</td>
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<tr>
<td>Sedatives or sleeping pills</td>
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<tr>
<td>(Valium, Serepax, Rohypnomol etc.)</td>
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<td>Halluinogens</td>
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<td>(LSD, ACID, Mushrooms, PCP, Special K, etc.)</td>
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<td>Opiods</td>
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<td>(Heroin, morphine, methadone, codeine, etc.)</td>
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<tr>
<td>Other</td>
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## Outcome Measures

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<thead>
<tr>
<th>Outcome Measure</th>
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<tr>
<td>Suicidal Ideation Questionnaire</td>
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<tr>
<td>Reasons for Living Inventory</td>
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<tr>
<td>Life Problems Inventory</td>
<td></td>
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<tr>
<td>Beck Depression Inventory</td>
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<tr>
<td>SASSI</td>
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<tr>
<td>SCID IV</td>
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Assessing Feasibility

1. Is DBT the appropriate treatment? Does the adolescent meet inclusion criteria for the DBT program?

2. Does the client want to attend, and if so, can she or he get to our clinic for individual therapy and group?

3. Is the client willing to commit to making an attempt at working on treatment targets, especially decreasing life-threatening behaviours?

4. Do the parents endorse the DBT treatment program, explicitly acknowledging that the outpatient treatment is twice-weekly?

5. Is at least one parent or another family member willing to participate actively?
6. Can the adolescent and family commit to the duration of treatment?

7. How feasible do you think attending weekly individual therapy and skills group is for the client and family at the moment?

8. In terms of treatment feasibility what do you see as barriers and strengths for the young person and their family to actively participate in the DBT program?

**Initial Impression/Formulation** (Suicidal Behaviour, Inclusion criteria, Feasibility, Outcome measures, Recommendations):
1. Does the client meet the criteria for the DBT program?

2. Outcome Measures (Please complete DBT Outcome Measures Form):

3. DSM-IV TR Multi axial Diagnosis

   Axis I:

   Axis II: (or what BPD criteria).

   Axis III:

   Axis IV:

   Axis V:
   Problems with primary support group
   Problems related to the social environment
   Education problems
   Occupational problems
   Housing problems
   Economic problem
   Problems related to interaction with the legal system/crime

   AXIS V:
   Global Assessment of Functioning Score.

   Time frame
4. Is the treatment currently feasible for client and 1 parent?

5. If the treatment is not currently feasible what would need to change for treatment to proceed?

6. If the client does not meet the inclusion criteria and or treatment isn’t feasible, what treatment can the young person and family access at this stage?

- Treatment as usual (CAMHS Case Management).
- Other CAMHS intervention.
- DBT wait list/Pre-treatment.
- Private practitioner.
- Community organization/NGO.
- Other
- Presentation summary including formulation and recommendations

Stage 1 Target Behaviours

What are the clients Stage 1 Target behaviours?

Reducing life-threatening behaviours?

Reducing therapy-interfering behaviours?

Reducing quality-of-life interfering behaviours?

What skills does the client have and what are their skills deficits?

Client Goals

Commitment

What kind of a commitment is the client willing to give at this stage?
Information Sheet

Child and Adolescent Mental Health Services (CAMHS) has developed a Dialectical Behaviour Therapy (DBT) program for young people aged 15-18 years experiencing serious emotional difficulties and who display suicidal and or self-harming behaviour.

What is Dialectical Behaviour Therapy?

Dialectical Behaviour Therapy is a powerful form of psychotherapy that asks you to identify areas of conflict and resolve them differently than you may have in the past. DBT helps you work with your emotions, your thoughts, and your behaviour. It requires that you allow yourself to feel your experiences rather than run away from your feelings. DBT can thus at times be painful, because you allow yourself to experience feelings that you may have avoided in the past. However, the benefits of doing so are that you are able to accomplish your objectives better, see your situation more clearly, and develop plans more effectively.

DBT has 4 major treatment components. The first is weekly individual therapy where you meet with your DBT therapist and explore your individual feelings, situations, and goals. The second is weekly parent and adolescent psycho education skills group, which is the teaching of more effective psychological coping skills. Thirdly, phone coaching involves being able to have phone contact with your therapist between appointments for support in using your skills. Finally, Family therapy occurs on an as needed basis with the aim of resolving conflict by using coping skills.

These are the 5 major components of the psycho education skills group sessions:

- **Mindfulness skills**: Learning to be in the moment rather than always in your thoughts.
- **Emotion regulation skills**: Learning how to change emotions so that emotions that hurt you linger less and emotions that you like linger more.
- **Distress tolerance skills**: Learning how to put up with emotions that hurt but can’t be changed.
- **Interpersonal effectiveness skills**: Learning how to get what you want from your relationships while maintaining your self-respect and potentially improving the relationship.
- **Walking the middle path skills**: Learning how to make balanced decisions in your life.
In both individual therapy sessions and skills group, both parent and adolescent will be asked to complete homework assignments between sessions. The purpose of homework assignments is to better understand concepts, apply them to your life, and promote faster emotional behavioural changes than would be the case if you only paid attention to your sessions and had no between-session homework.

DBT is not a “new fad” treatment and has over a decade of research supporting its effectiveness in helping people make important changes in their lives. DBT appears to be effective for both youth and adults struggling with self-harm, suicide, suicidal thinking, depression, anxiety, anger, and a number of other conditions.

**CAMHS DBT Program Evaluation**

The DBT program is a service quality improvement initiative designed to provide a comprehensive intervention for young people experiencing serious emotional difficulties and displaying suicidal and or self-harming behaviour. For the purpose of measuring the impact of the program and making the program better, an evaluation of the DBT program will be occurring through ACT Health and the Australian National University Clinical Doctorate in Psychology Program. The evaluation will be conducted by the DBT Program Team Leader Dean Buckmaster and be supervised by Dr Richard O’Kearney. The evaluation aims to measure the following outcomes:

- Targeted outcomes for young people include reduced suicidal and self-harming behaviour, reduced depression, and improved ability to manage distress, relationships, and emotions.
- Targeted outcomes for parents include improved family functioning and satisfaction with the service provided by CAMHS.
- Targeted outcomes for clinical staff include improved skills, knowledge, and attitudes.
- Targeted outcomes for the service include reduced hospital and other crisis presentations, reduced suicidal and self-harming behaviours, high levels of client and family satisfaction with CAMHS, and a high degree of treatment compliance by the DBT team.

For the purpose of measuring the above outcomes you will be required to complete various questionnaires at different stages throughout your participation in the program. It is hoped that this information will be instrumental in improving the program for future clients and families.

**Consent**

Please note that participation in the program involves consenting to the use of your information to evaluate the program.

It is important that you read through the following points below before you consent to the program:

1. Approval has been given by the ACT Department of Health Ethics Committee.
2. Involvement in the DBT Program is entirely voluntary and you can withdraw at any time without this affecting your clinical care with CAMHS.
3. The research will be monitored by Dean Buckmaster who is team leading and evaluating the program and Dr Richard O’Kearney who is the principal investigator and research supervisor (see below for contact details). Should you have any problems or queries about the way in which the study was
conducted, and do not feel comfortable contacting Dean Buckmaster or the research supervisor Richard O’Kearney, please contact the ACT Health Human Research Ethics Committee Secretariat, ACT Health Research Office, Building 10, Level 6, Canberra Hospital Yamba Drive

Garran, 2605 PO BOX 11, Woden 2606. Telephone (02) 6205 0846 Fax (02) 62443092. email acthealth-hrec@act.gov.au

4. Identities of all participants in this research project will be protected. Only members of the treating team will have access to clinical file information.

5. The aim of this project is to evaluate the DBT program as a service quality improvement initiative. This will include evaluating outcomes for clients, parents, clinical staff and the service in order to identify the strengths and weaknesses of the program for the purpose of making the program more effective.

6. The results of the study will be used directly to enhance the provision of services to clients of ACT Child and Adolescent Mental Health Services.

7. Identities of all participants in this research project will be protected.

8. The results of the research will be made accessible and your involvement and identity will not be revealed. A copy of this evaluation will be kept at both Child and Adolescent Mental Health Services Belconnen and Woden clinics.

Principal Investigator and Research Supervisor: Dr Richard O’Kearney

Contact details: Department of Psychology (Building 39)

The Australian National University

Canberra ACT 0200

Australia

Phone: 02 61258158 Fax: 02 61250499

CAMHS DBT Program Team Leader: Dean Buckmaster

Contact details: Building A Level 2, Callam Office, Easty Street

WODEN ACT 2606

GPO Box 158 Canberra ACT 2601

Phone: 02 6205 1469 Fax 02 6205 2627
Clinician Information Sheet

Child and Adolescent Mental Health Services (CAMHS) has developed a Dialectical Behaviour Therapy (DBT) program for young people aged 15-18 years experiencing serious emotional difficulties and who display suicidal and or self-harming behaviour.

What is Dialectical Behaviour Therapy?

Dialectical Behaviour Therapy is a powerful form of psychotherapy that asks clients to identify areas of conflict and resolve them differently than they may have in the past. DBT helps clients work with their emotions, thoughts, and behaviour. DBT requires that clients allow themselves to feel their experiences rather than running away from their feelings. DBT can thus at times be painful, because clients are required to experience feelings that they may have avoided in the past. However, the benefits of doing so are that they are able to accomplish their objectives better, see their situation more clearly, and develop plans more effectively.

DBT is not a “new fad” treatment and has over a decade of research supporting its effectiveness in helping people make important changes in their lives. DBT appears to be effective for both youth and adults struggling with self-harm, suicide, suicidal thinking, depression, anxiety, anger, and a number of other conditions.

The DBT Program has 4 components.

- **Weekly individual therapy for 1 hour.** This aspect of the program aims to increase client motivation and improve capabilities to make desired behavioural changes.
- **Weekly DBT skills group for 2 hours.** DBT Skills group is a psycho educational group format that teaches clients skills and aims to help clients and families generalize these skills to their lived environments.
- **As needed phone coaching and family therapy.** Phone coaching involves the client calling the therapist between sessions when in need of coaching to use skills (10 to 20 minutes). Family therapy occurs when the young person and parent need to undertake behavioural analysis of targeted behaviour (30 to 45 minutes).
- **Consultation group 1.5 hours weekly.** This aspect of the program aims to support clinical staff and help them stay in the DBT model.

Treatment fidelity is extremely important in DBT and as a clinician participating in the DBT program it is expected that every effort will be made to adhere to the treatment model. This includes attending weekly consult group, completing outcome measures, structuring sessions appropriately, and attending DBT education sessions and supervision.
DBT Program Evaluation

The DBT program is a service quality improvement initiative designed to provide a comprehensive intervention for young people experiencing serious emotional difficulties and displaying suicidal and or self-harming behaviour. For the purpose of measuring the impact of the program and making the program better, an evaluation of the DBT program will be occurring through ACT Health and the Australian National University Clinical Doctorate in Psychology Program. The evaluation will be conducted by the DBT Program Team Leader Dean Buckmaster and be supervised by Dr Richard O’Kearney. The evaluation aims to measure the following outcomes:

- Targeted outcomes for young people include reduced suicidal and self-harming behaviour, reduced depression, and improved ability to manage distress, relationships, and emotions.
- Targeted outcomes for parents include improved family functioning and satisfaction with the service provided by CAMHS.
- Targeted outcomes for clinical staff include improved skills, knowledge, and attitudes.
- Targeted outcomes for the service include reduced hospital and other crisis presentations, reduced suicidal and self-harming behaviours, high levels of client and family satisfaction with CAMHS, and a high degree of treatment compliance by the DBT team.

For the purpose of measuring the above outcomes you will be required to complete various questionnaires at different stages throughout your participation in the program. It is hoped that this information will be instrumental in improving the program for future clients and families.

Consent

Please note that participation in the program involves consenting to the use of your information to evaluate the program.

It is important that you read through the following points below before you consent to the program:

1. Approval has been given by the ACT Department of Health Ethics Committee.
2. Involvement in the DBT Program is entirely voluntary and you can withdraw at any time without this affecting your employment with CAMHS.
3. The research will be monitored by Dean Buckmaster who is team leading and evaluating the program and Dr Richard O’Kearney who is the principal investigator and research supervisor (see below for contact details). Should you have any problems or queries about the way in which the study was conducted, and do not feel comfortable contacting Dean Buckmaster or the research supervisor Richard O’Kearney, please contact the ACT Health Human Research Ethics Committee Secretariat, ACT Health Research Office Building 10, Level 6, Canberra Hospital Yamba Drive Garran, 2605 PO BOX 11, Woden 2606. Telephone (02) 6205 0846 Fax (02) 62443092.
4. Identities of all participants in this research project will be protected. Only members of the treating team will have access to clinical file information.
5. The aim of this project is to evaluate the DBT program as a service quality improvement initiative. This will include evaluating outcomes for clients, parents, and clinical staff, CAMHS, and to evaluate the strengths and weaknesses of the program in order to make the program more effective.
6. The results of the study will be used directly to enhance the provision of services to clients of ACT Child and Adolescent Mental Health Services.
7. Identities of all participants in this research project will be protected.
8. The results of the research will be made accessible and your involvement and identity will not be revealed. A copy of this evaluation will be kept at both Child and Adolescent Mental Health Services Belconnen and Woden clinic.
Principal Investigator and Research Supervisor: Dr Richard O’Kearney

Contact details:
Department of Psychology (Building 39)
The Australian National University
Canberra ACT 0200
Australia
Phone: 02 61258158 Fax: 02 61250499

CAMHS DBT Program Team Leader: Dean Buckmaster

Contact details:
Building A Level 2, Callam Office, Easty Street
WODEN ACT 2606
GPO Box 158 Canberra ACT 2601
Phone: 02 6205 1469 Fax 02 6205 2627
Adolescent Consent Form

The DBT program is a service quality improvement initiative designed to provide a comprehensive intervention for people experiencing serious emotional difficulties and displaying suicidal and or self-harming behaviour. The program will use acceptance and change strategies and teach skills to help you regulate powerful emotions, manage relationships, tolerate distress, and develop a grounded sense of self. This will be achieved through, weekly individual therapy (1 hour), weekly skills group (2 hours), as needed phone coaching (10-20 minutes), and as needed family therapy (30 minutes).

An evaluation of the DBT program will be occurring through ACT Health and the Australian National University Clinical Doctorate in Psychology Program. The purpose of evaluating the program is to determine its impact on helping clients and parents achieve their goals, to empower clinicians to work effectively with clients and parents, and to improve the provision of services offered by CAMHS. The evaluation will be conducted by the DBT Program Team Leader Dean Buckmaster and be supervised by Dr Richard O’Kearney.

Chief Investigator: Dean Buckmaster
Contact details: Building A Level 2, Callam Office, Easty Street
WODEN ACT 2606 GPO Box 158 Canberra ACT 2601
Phone: 02 6205 1469 Fax 02 6205 2627

Research Supervisor: Dr Richard O’Kearney
Contact details: Department of Psychology (Building 39)
The Australian National University
Canberra ACT 0200
Australia
Phone: 02 61258158 Fax: 02 61250499

I, ____________________________________________
(name of participant)
of ____________________________________________
(Street) (Suburb/Town) (State & Postcode)
have been asked to consent to my participation in a research project entitled:

**Child and Adolescent Dialectical Behaviour Therapy Program Evaluation**

In relation to this project I have read the patient information sheet and have been informed of the following points:

1. Approval has been given by the ACT Department of Health Ethics Committee.

2. Involvement in the DBT Program and the evaluation of the program is entirely voluntary and I can withdraw at any time without my withdrawal affecting my clinical care with CAMHS.

3. I am aware that Dean Buckmaster is team leading and evaluating the program and Dr Richard O’Kearney is the principal investigator and research supervisor. Should I have any problems or queries about the way in which the study is being conducted, and do not feel comfortable contacting Dean Buckmaster or the research supervisor Richard O’Kearney, I am aware that I may contact the ACT Health Human Research Ethics Committee Secretariat, ACT Health Research Office, Building 10, Level 6, Canberra Hospital Yamba Drive Garran, 2605 PO BOX 11, Woden 2606. Telephone (02) 6205 0846 Fax (02) 62443092. email acthealth-hrec@act.gov.au

4. Identities of all participants in this research project will be protected.

5. The aim of this project is to evaluate the DBT program as a service quality improvement initiative. I am aware that the study will evaluate outcomes for me, my parents, the therapists involved in the program, and the service.

6. The results of the evaluation will be used to directly enhance and improve the DBT program.

7. I understand that the results of the research will be made accessible and that my involvement and my identity will not be revealed. A copy of this evaluation will be kept at both Child and Adolescent Mental Health Services Belconnen and Woden clinic.

After considering all these points, I accept the invitation to participate in this program and program evaluation.

<table>
<thead>
<tr>
<th>Date</th>
<th>Witness</th>
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<tbody>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Signature</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>(of participant)</td>
<td>(of witness)</td>
</tr>
</tbody>
</table>

(please print name) (please print name)

Investigators signature
Parent Consent Form

The DBT program is a service quality improvement initiative designed to provide a comprehensive intervention for people experiencing serious emotional difficulties and displaying suicidal and or self-harming behaviour. The program will use acceptance and change strategies and teach skills to help your daughter regulate powerful emotions, manage relationships, tolerate distress, and develop a grounded sense of self. This will be achieved through, weekly individual therapy (1 hour), weekly skills group (2 hours), as needed phone coaching (10-20 minutes), and as needed family therapy (30 minutes). Your participation in the program with your daughter will be crucial in helping her make important changes in her life. This will require you actively supporting your daughter’s participation in the program and attending weekly skills group and as needed family therapy sessions.

An evaluation of the DBT program will be occurring through ACT Health and the Australian National University Clinical Doctorate in Psychology Program. The purpose of evaluating the program is to determine its impact on helping clients and parents achieve their goals, to empower clinicians to work effectively with clients and parents, and to improve the provision of services offered by CAMHS. The evaluation will be conducted by the DBT Program Team Leader Dean Buckmaster and be supervised by Dr Richard O’Kearney.

Chief Investigator: Dean Buckmaster

Contact details: Building A Level 2, Callam Office, Easty Street
WODEN ACT 2606 GPO Box 158 Canberra ACT 2601
Phone: 02 6205 1469 Fax 02 6205 2627

Research Supervisor: Dr Richard O’Kearney

Contact details: Department of Psychology (Building 39)
The Australian National University
Canberra ACT 0200
Australia

Phone: 02 61258158 Fax: 02 61250499

I, ________________________________

(name of parent)
Being the _______ of _______
(State relationship eg., parent) (Name of client)

of _______
(Street) (Suburb/Town) (State & Postcode)

have been asked to consent to my daughter and my participation in a research project entitled:
Child and Adolescent Dialectical Behaviour Therapy Program Evaluation.

In relation to this project I have read the patient information sheet and have been informed of the following points:

1. Approval has been given by the ACT Department of Health Ethics Committee.
2. Involvement in the DBT Program and the evaluation of the program is entirely voluntary and I can withdraw at any time without withdrawal affecting your daughter's clinical care with CAMHS.
3. I understand that consent will explicitly be sought from my daughter in order to facilitate greater ownership of her role in therapy.
4. I am aware that Dean Buckmaster is team leading and evaluating the program and Dr Richard O'Kearney is the principal investigator and research supervisor. Should I have any problems or queries about the way in which the study is being conducted, and do not feel comfortable contacting Dean Buckmaster or the research supervisor Richard O'Kearney, I am aware that I may contact the ACT Health Human Research Ethics Committee Secretariat, ACT Health Research Office Building 10, Level 6, Canberra Hospital Yamba Drive Garran, 2605 PO BOX 11, Woden 2606. Telephone (02) 6205 0846 Fax (02) 62443092. email: acthealth-hrec@act.gov.au
5. Identities of all participants in this research project will be protected.
6. The aim of this project is to evaluate the DBT program as a service quality improvement initiative. This will include evaluating outcomes for clients, parents, clinical staff, and to evaluate the strengths and weakness of the program in order to make the program more effective.
7. The results of the study will be used to directly enhance the DBT program.
8. I understand that the results of the research will be made accessible and that my involvement and my identity will not be revealed. A copy of this evaluation will be kept at both Child and Adolescent Mental Health Services Belconnen and Woden clinic.

After considering all these points, I accept the invitation to participate in this program and program evaluation.

Date ____________________   Witness __________________________

Signature ___________________________   (of participant) 

Signature ___________________________   (of witness) 

Investigators signature ___________________________

193
Clinician Consent Form

The DBT program is a service quality improvement initiative designed to provide a comprehensive intervention for people experiencing serious emotional difficulties and displaying suicidal and or self-harming behaviour. The program will use acceptance and change strategies and teach skills to help clients regulate powerful emotions, manage relationships, tolerate distress, and develop a grounded sense of self. This will be achieved through, weekly individual therapy (1 hour), weekly skills group (2 hours), as needed phone coaching (10-20 minutes), and as needed family therapy (30 minutes). It is hoped your participation in the program as a practicing DBT clinician will be crucial in helping clients and parents make important life changes. Your effective participation in the program will require you to aim to be as effective as possible in adhering to the DBT treatment protocols including appropriately structuring therapy sessions, completing weekly therapist summaries, completing DBT assessment batteries, and attending DBT consult group and other training opportunities.

An evaluation of the DBT program will be occurring through ACT Health and the Australian National University Clinical Doctorate in Psychology Program. The purpose of evaluating the program is to determine its impact on helping clients and parents achieve their goals, to empower clinicians to work effectively with clients and parents, and to improve the provision of services offered by CAMHS. The evaluation will be conducted by the DBT Program Team Leader Dean Buckmaster and be supervised by Dr Richard O’Kearney.

Chief Investigator: Dean Buckmaster

Contact details: Building A Level 2, Callam Office, Easty Street
               WODEN ACT 2606  GPO Box 158 Canberra ACT 2601
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Research Supervisor: Dr Richard O’Kearney

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                 Australia

                 Phone: 02 61258158    Fax: 02 61250499
have been asked to consent to my participation in a research project entitled:

**Child and Adolescent Dialectical Behaviour Therapy Program Evaluation**

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5. The results of the study will be used directly to enhance outcomes for clients, parents, and clinical staff of Child and Adolescent Mental Health Services.
6. I understand that the results of the research will be made accessible and that my involvement and my identity will not be revealed. A copy of this evaluation will be kept at both Child and Adolescent Mental Health Services Belconnen and Woden clinic.
7. I am aware that my participation in the DBT program will involve my best efforts to remain adherent to the DBT model.

After considering all these points, I accept the invitation to participate in this program.

Date ________________________ Witness ________________________

Signature ________________________ "(please print name)

Signature ________________________ "(please print name)

(of participant) (of witness)
Case Formulation Format

Date: 

Client:

Therapist:

Client’s Goals: *(what is the client's passion, what does the client most wanted for the future):*

Primary Targets

1. Life Threatening Behaviour

   Suicidal attempts

   NSSIB

   Suicidal ideation and communications

   Suicide related expectancies and beliefs

   Suicide related affect
2. Therapy interfering behaviours

Of the client (e.g., non-attendance, noncompliant, non-collaborative, disrespectful)

Of the therapist (e.g., lack of balance, disrespectful)

3. Quality of life interfering behaviours

List all that are significantly affecting current quality of life. Order should reflect treating most disruptive first

Secondary Targets

List examples of secondary target behaviours or general patterns

<table>
<thead>
<tr>
<th>Emotion dysregulation</th>
<th>Vs</th>
<th>Self invalidation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active passivity</td>
<td>Apparent competence</td>
<td></td>
</tr>
<tr>
<td>Crisis generating behaviour</td>
<td>Inhibited grieving</td>
<td></td>
</tr>
<tr>
<td>Making light of problem behaviours</td>
<td>Making too much of typical adolescent behaviour</td>
<td></td>
</tr>
<tr>
<td>Being too lose</td>
<td>Being too strict</td>
<td></td>
</tr>
<tr>
<td>Forcing independence too soon</td>
<td>Holding on too tight</td>
<td></td>
</tr>
</tbody>
</table>
**Task analysis**

Based on chain analyses, note critical weak links which lead to target behaviours and types of skills client is already doing effectively. Consider: urges, physical sensations, emotions, cognitions, and actions as well as events in the client's environment.

<table>
<thead>
<tr>
<th>Critical weak links</th>
<th>Strong skills</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Task analysis:** what steps need to be taken in treatment to fix weak links and further strengthen use of skills? Essentially, create a to-do list for yourself. Consider: areas for further assessment, the DBT skills to increase, avoidance versus exposure behaviours, cognitive modification areas, reinforcing contingencies, validation needed, dialectical synthesis, psychology of normal behaviour, and your own personal experience in handling these problems. Consider your own behaviours to target as well — both in and out of the session.
Pre Treatment Checklist

Pre treatment is an important stage of DBT including specific behavioural targets. The pre treatment stage of orientation and commitment to DBT begins once suicide risk and diagnostic assessments are complete and the adolescent has been found to meet the inclusion criteria for the DBT program and the treatment has initially been assessed as being feasible. The key goals of this stage are for the client and therapist to arrive at a mutually informed decision to work together and to make explicit their agreed-on expectations about work. The process involves the primary therapist’s helping the adolescent identify his or her long term goals, orienting her to treatment, and obtaining the teen’s commitment to treatment. For some client’s pre treatment will likely take more than one session and for others a lot longer.

This stage of treatment involves the following targets:

Targets

- Informing the adolescent about and orienting adolescent to DBT
- Informing adolescent’s family about and orienting family to DBT
- Securing adolescent’s commitment to treatment
- Securing therapist’s commitment to treatment
Orientation and Commitment Strategies

1. Begin to establish a therapeutic alliance:
   a. Use friendly, egalitarian, down-to-earth, and open demeanour
   b. Simultaneously earning respect and gaining credibility
   c. Convey realistic degree of confidence in oneself as a therapist, the client, and the treatment
   d. Establish active stance while collaboratively setting the agenda

2. Fold adolescent’s specific problems into areas of dysregulation and explain corresponding skills developed to address each problem area:
   a. Confusion about self.
   b. Impulsivity.
   c. Emotional instability.
   d. Interpersonal problems.
   e. Adolescent-family dilemmas.

3. Define adolescent’s specific problems as primary target behaviours:
   a. Life-threatening behaviours.
   b. Treatment interfering behaviours (based on prior treatment history).
   c. Quality-of-life interfering behaviours.
   d. Skills capacities and deficits.

4. Elicit Clients long-term goals, and link these to work on stage 1 target behaviours

5. Introduce the biosocial theory

6. Introduce the treatment’s format and characteristics

7. Introduce DBT diary cards

8. Review treatment agreements:
   a. Client agreements.
   b. Therapist agreements.
   c. Client-therapist relationship agreement.
   d. Family agreements
9. Use commitment strategies with adolescent to obtain and strengthen commitment

10. Use commitment strategies with family members to obtain and strengthen commitment

11. How certain do you believe the client understands the structure of treatment and associated commitments (e.g., weekly individual therapy for 1hr and skills group for 2 hrs)?

Not at all clear     Mostly not clear     Somewhat clear     mostly clear     Excellent understanding

1   2   3   4   5

12. Has the client given some behavioural, doing, action oriented commitment (e.g., “I will make it my highest priority to attend therapy and group sessions.”)?

No commitment     Minimal commitment     Some commitment     High levels of commitment     Ideal commitment

1   2   3   4   5

13. How committed are you to working with this client for the duration of the program?

No commitment     Minimal commitment     Some commitment     High levels of commitment     Ideal commitment

1   2   3   4   5

14. How committed do you believe parents are in supporting the adolescent participate in the treatment.

No commitment     Minimal commitment     Some commitment     High levels of commitment     Ideal commitment

1   2   3   4   5

15. How committed is the parent/carer to attending skills group and as needed family therapy?

No commitment     Minimal commitment     Some commitment     High levels of commitment     Ideal commitment

1   2   3   4   5

16. What are the client’s long-term goals?

17. Do you have any comments relating to the orientation and commitment of the client and or family member to the DBT program?
<table>
<thead>
<tr>
<th>PROBLEMS</th>
<th>SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(What to Decrease)</td>
<td>(What to increase)</td>
</tr>
<tr>
<td>I. Confusion about yourself</td>
<td>I. Mindfulness</td>
</tr>
<tr>
<td>(Not always knowing what you feel or why you get upset: dissociation).</td>
<td></td>
</tr>
<tr>
<td>II. Impulsivity</td>
<td>II. Distress Tolerance</td>
</tr>
<tr>
<td>(Acting without thinking it all through).</td>
<td></td>
</tr>
<tr>
<td>III. Emotional instability</td>
<td>III. Emotion Regulation</td>
</tr>
<tr>
<td>(Fast, intense mood changes with Little control; or, steady negative emotional state).</td>
<td></td>
</tr>
<tr>
<td>IV. Interpersonal problems</td>
<td>IV. Interpersonal Effectiveness.</td>
</tr>
<tr>
<td>(Pattern of difficulty keeping relationships Steady, getting what you want, or keeping your self-respect; frantic efforts to avoid abandonment).</td>
<td></td>
</tr>
<tr>
<td>V. Teenager-family dilemmas</td>
<td>V. Walking the Middle Path.</td>
</tr>
<tr>
<td>(Polarized thinking, feeling, and acting- e.g., all-or-nothing thinking)</td>
<td></td>
</tr>
</tbody>
</table>
DBT Treatment Hierarchy

The individual therapist (who may or may not be the same clinician as the diagnostic interviewer) is responsible for eliciting the information relevant to the DBT Stage 1 targets. Much of this information may have already been gathered during the diagnostic evaluation. The therapist connects the client's specific problems with DBT's primary target behaviours. The therapist might say, "So those overdoses are considered life-threatening behaviours, and your depression, your cannabis use, your school problems, and your intense conflicts with your parents are what we call life threatening problems." Reframing these problems in DBT language enables the therapist to explain how DBT will be able to target these problems, while also beginning (unobtrusively) to teach the client this language.

Once the DBT treatment targets are identified, the DBT therapist is then able to review the stage 1 treatment target hierarchy and informs the client that individual sessions will be organized accordingly from that day forward. Drawing the below pyramid is a good way of illustrating this for the adolescent.
1. Decrease: Life-threatening

2. Decrease: Therapy-interfering behaviors, including coming late to sessions, missing sessions, and dropping out of therapy.

3. Decrease: Quality-of-life interfering behaviours, including depression, anxiety, D&A use, school truancy, relationship problems etc.

4. Increase Behavioural Skills, including mindfulness, distress tolerance, interpersonal effectiveness, emotion regulation, and walking the middle path.
Eliciting Long-Term Goals

It is critical to link stage 1 target behaviours to the clients overall long-term goals. This can often be a difficult task. Sometimes it isn’t useful initially putting to much pressure on the client to explicitly spread out their life goals. They may have very good reason for not feeling hopeful and may not be very connected to the idea of having goals. In such cases it can be useful for the therapist focusing on trying to give the adolescent some hope and then seeing what comes out. Often the client might elude to finishing college, going to uni, becoming a chef, getting a boyfriend, becoming a chef. In such cases it is important to start where there client is currently at and further scaffold these goals over time.

Be mindful that DBT is about building life worth living so for some clients living in dire chronically invalidating circumstances, using such strategies as the miracle question can be a useful place to start.

e.g., “If you didn’t have these problems what would you be doing?”

Asking the client the following questions might also be useful.

- My life worth living might look like?
- Things in my life that get in the way of building a life worth living are?
- Things in my life that support a life worth living are?
- Ways I can do more things that build a life worth living are?
Bio Social Theory

The Biosocial theory review, like other aspect of orientation to treatment, typically occurs first with the adolescent alone and then is reported with the entire family. Stylistically it is important to talk about the bio-social theory in a curious, collaborative, and non judgemental way with both clients and family members.

First review and define the two components of the theory: “Bio” and “social.”

**BIO**

Bio is derived from the word biology and involves the biochemistry of one’s brain. This component of the theory involves 3 specific components.

1. **High sensitivity**
   - Immediate reactions
   - Low threshold for emotional reaction
   - “Do things get under your skill easily,” “Sometime does it feel like you don’t have any emotional skin to protect you?”

2. **High reactivity**
   - Extreme reactions.
   - High arousal dysregulates cognitive processing.
   - There emotional reactions seem more intense and reactive (e.g., not just a little sad, but feeling very depressed; not mildly anxious but having panic attacks; not merely irritated, but experiencing angry outbursts).

3. **Slow return to Baseline**
   - Long-lasting reactions.
   - Contributes to high sensitivity to next emotional stimulus.
   - This can be explained by drawing on a white board or piece of paper, with a line half way up the bell curve to indicate the adolescents moderate to high level of
emotional arousal. Instead of returning back to 0, the line remains elevated at this level for an extended period (sometimes hours or even days). “Do you find really hard to chill out when your emotions get charged.”

SOCIAL

The social part of the theory is described as the invalidating environment.

Invalidating environment

Pervasively negates or dismisses behaviour independent of the actual validity of the behaviour.

Characteristics of an Invalidating Environment

- Indiscriminately rejects communication of private experiences and self-initiated behaviours.
- Intermittently reinforces escalation of emotional responses and display.
- Over-simplifies ease of problem solving and meeting goals.

Validation

- Validation communicates to another person that her or his feelings, thoughts, and actions make sense and are understandable to you in a particular situation.
- Self-validation involves perceiving your own feelings, thoughts, and actions as accurate and acceptable in
- Validation does not necessarily mean you agree with what the other person is doing, saying, or feeling. It means you understand where the other person is coming from.

After defining validation and invalidation and then give an example.

e.g., “...Jenny you mentioned that whenever you feel depressed and lonely your Father tells you to snap out of it. You also mentioned that when you don’t clean up after yourself, your Father yells at you, you become scared and fearful and start crying, and that he then tells you to stop crying, yells at you
more, and tells you ‘to stop trying to get out of cleaning up your mess.’ These experiences are examples of invalidation—in other words, communications indicating that your thoughts, feelings, or actions are wrong, inappropriate, and invalid. Who’s to say how you should feel and act and what you should think? It’s like telling you that your not feeling the rain falling on your skin.”

- The Therapists can suggest that parents who invalidate often learned this as children from their parents and don’t know any other way to communicate more effectively.

- Regardless of intent, the therapist targets the invalidation experienced by the family, in order for the adolescent to feel better understood by the family and for the family members to feel better understood by the adolescent.

*It is important to finish this component of orientation by informing the adolescent and young person that they can learn to validate each other and that validation often leads to improved relationships. Additionally;*

- Validation shows that we are listening, we understand, we are nonjudgemental, we care about the relationship., and conflict is possible with decreased intensity.

- Validation can result in a communication partner who is less angry, more calm, and more receptive to what we have to say.
Introducing the Treatment Format

Review the treatment format by outlining the following structure and components of treatment. Make sure to check in regularly with the client to ensure they understand what is being said.

Structure

- Individual therapy for 1 hour weekly.
- Weekly 2 hour client/family member skills group.
- Family therapy as required (Conducted by Individual therapist).
- The client is expected to call for phone coaching between sessions for phone coaching.

Describe the 7 characteristics of DBT to the adolescent in the first or second individual session

1. *DBT IS NOT* a suicide prevention program, *but rather a life enhancement program.*
2. *DBT is supportive of clients’ attempts to improve the quality of their lives.*
3. *DBT is behavioural.*
4. *DBT teaches skills.*
5. *DBT is collaborative.*
7. *DBT is a team treatment.*
Introducing Diary Cards

Introduction of the diary card typically occurs at the end of the first or second session. The client is told that the diary card is a crucial component of the treatment, and that she or he is expected to complete it and return it to the therapist each week. Clients should rate their urges and emotions on a 0-5 scale and the figure entered into the diary card should represent the most intense urge or emotion they felt.

It is important to orient the client to the important functions of the diary card:

1. Self monitoring target behaviours and, skills, and emotions can have the effect of reducing symptoms and provide the opportunity for a consistent and ongoing mindfulness practice.
2. The card functions as an overview of the client’s week enabling both therapist and client a clear view of difficult days for the client over the past week.
3. The card helps keep an accurate daily record of urges, targets, skills, emotions that would be difficult for the client to recall accurately in session.
4. The diary card allows both client and therapist to discern with some skill links occurring between emotions and maladaptive as well as adaptive behaviours.
5. The diary card is the primary tool used at the start of every session to help focus the content of the session.

Tips

- Start by only requesting the client fill out a portion of the card. This can build mastery for the client and guard against them feeling overwhelmed.
- Make a point of explaining the difference between urges and actions and have these listed on the diary card.
• For some clients, choose only a few target behaviours initially (e.g., suicide attempts, cutting, cannabis use with a list of emotions and actions). Having a diary card with too many targets can be overwhelming for clients and therapists.

• If the client isn’t willing to fill in the card use *Foot in the Door* and then give them a bargain by accepting a less than complete card.

• It’s OK to be creative with the cards. Some clients like making their own cards, decorating them etc.

• Make sure you trouble shoot the client completing the diary card for the coming week. E.g., “What might interfere with you completing the card and bringing it back next week? What could be some potential barriers? Where could you put it to help you remember to fill it out?”

• Remember to use shaping, for some clients getting them to bring in a portion of the diary card is a good start.
Review Treatment Agreements

Client, therapist, and family agreements are discussed towards the culmination of the orientation phase. They set out the responsibilities and goals for all parties involved.

Client Agreements

1. To enter into and stay in therapy for a specified length of time (e.g., 20 week program).
2. To attend both weekly individual therapy and skills group.
3. To work on reducing specific life-threatening, therapy-interfering, and quality of life interfering behaviours that have been identified during the full assessment and orientation phase and to increase using behavioural skills.
4. To use phone coaching when deemed effective to do so.

Therapist Agreements

1. To make every reasonable effort to be effective.
2. To act ethically.
3. To be available to the client where availability doesn’t exceed the therapists explicitly outlined limits.
4. To show respect for the client.
5. To maintain confidentiality in line with service protocol.
6. To obtain consultation as needed from supervisors and colleagues attending the therapist consultation team meetings.

Family Agreements

1. To attend and actively participate in multi family skills training group or family skills training.
2. To participate in family therapy sessions in an as needed basis.
3. To facilitate transportation for the adolescent by providing transportation or money for same.

4. To observe rules of confidentiality by not asking the primary therapist to provide specific information covered in individual sessions.
Strategies for Obtaining Commitment

Inadequate commitment by the client, therapist, or both leads to many therapy failure and early terminations. The client may make an insufficient or superficial commitment in the initial stages of the change process—or, more likely, events both within and outside of therapy may conspire to reduce strong commitments previously made. This last point particularly relates to working with adolescents, since they are usually residing in their invalidating environments and often feel hopeless about any improvement in their situations. Client commitment in DBT serves as both an important prerequisite for effective therapy and a goal of therapy. Thus a therapist does not assume a client's commitment. DBT views commitment as a behavior itself, which can be elicited, learned, and reinforced. The therapist's task thus includes figuring out ways to help this process along.

Selling Commitment: Evaluating Pros and Cons

In evaluating Pros and Cons of proceeding with treatment, the therapist wants:

1. To review the advantages of the decision to proceed.
2. Develop counter arguments based on reservations that are likely to arise later, when the client is alone and has no help in diffusing doubts.
3. Highlight the short and long term nature of each pro and con.

Playing Devil's Advocate

The therapist poses arguments against making a commitment to treatment, with the intent that the client will make his or her argument for participating in treatment.

- “Wouldn’t you rather be in a treatment that wasn’t so demanding?”
- Trying to make clients make a strong case for themselves.
• “Why would you do that?...remember how you felt 10 minutes before you cut etc...you still will have the pain?” – You need the client to give the reason; you need committed behaviour coming out of their mouth.

• Anchor them to the commitment.

Foot in the Door Technique

Making a request that seems easy, followed by a more difficult request.

• “OK, I understand that you don’t think cannabis is a problem for you. Im not sure either yet. So let’s not have you try to reduce it. How about if you merely track your use on the diary card like you do for your alcohol use, which we agree you are trying to reduce. Ok?”

• “Can we at least agree that you wont drop out of therapy.”

Door in the Face Technique

The therapist makes a harder request initially and then solicits a more easily performed behaviour. This strategy proves helpful in obtaining early commitment to treatment and to reducing suicidal behaviour and self harming.

• “Allan would you please join the group, pull your hood off your face, and lead us in a mindfulness exercise?” Allan, “I’m not doing all that!” “How about if you just come to the table and lower your hood, then?”

• “You wont leave this earth by your own hand! What I want to hear now is that you wont do this…”

Connecting Present Commitments to Prior Commitments

When the therapist has a sense that the commitment is fading, or when the clients behaviour in incongruent with previous commitments, the therapist can remind the client of commitments made previously.
• “Remember you made that commitment you made when we agreed to work together...remember you said you would try your hardest not to cut before using skills?”

**Highlighting Freedom to Choose and Absence of Alternatives**

Good strategy for adolescents who are not particularly interested in treatment at this point. The idea behind this strategy is that commitment and compliance are enhanced when people, especially adolescents, believe that they have chosen freely and when they believe there are no other alternatives to reach their goal. Enhance the feeling of choice, while at the same time stressing the lack of effective alternatives.

• ‘You have the freedom to choose what you want in your life...but your choices aren’t that good...not gonna help you finish school, keep your boyfriend, get on with you Mum...”

**Cheerleading**

The purpose of cheerleading is to generate hope. Major problem confronting suicidal adolescents with BPD or BPD traits is their lack of hope that they can effect change in their lives.

• Reinforce even minimal progress.

• Consistently point out that the client has the qualities needed to handle his or her problems.
Weekly Therapist Summary

(Please complete after each weekly individual therapy session)

What are the client’s goals?

What are the target behaviours?

Behaviours to increase? Behaviours to decrease?

1. Did your client have a hospital admission in the past week for suicidal or self-harming behaviour? y / n

2. Did your client make a suicide attempt in the past week? y / n

3. Did your client engage in any self-harming behaviour without suicidal intent in the past week? y / n

4. Did your client attend any ED departments in the past week? y / n

5. Did your client call CATT in the past week? y / n

6. Did your client;
   a. Attend Individual therapy? y / n
b. Attend Skills Group? y / n
c. Parents attend skills group? y / n
d. Use phone coaching? y / n
e. Have a family therapy session? y / n

7. Over the past week how effective has the client been at (Please circle);

a. Managing Relationships?

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b. Regulating Problematic Emotions?

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c. Managing urges to suicide?

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d. Managing urges to self-harm (without intent to die)?

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e. Tolerating distress?

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f. Validating Self?

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g. Moving towards their goals?

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8. In your therapy session how effective were you at;

a. Structuring the session according to the DBT treatment hierarchy?

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b. Using the diary card to influence the session agenda?

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c. Conducting a mindfulness exercise?

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d. Conducting a chain analysis on target behaviours?

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e. Conducting a solution analysis with an emphasis on using skills from the DBT treatment manual?

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f. Reviewing and setting homework?

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g. Balancing validation and problem solving strategies?

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h. How effective were you at using DBT stylistic strategies?

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9. Overall how effective do you believe you are working with your client?

Not at all effective  Mostly not effective  Somewhat effective  Mostly effective  Highly effective
1  2  3  4  5

10. How effective do you believe you are at working within the DBT model?

Not at all effective  Mostly not effective  Somewhat effective  increasing signs of effectiveness  Consistently effective
1  2  3  4  5

11. How effective do you feel in your capacity to work with suicidal, self-harming, multi-problem clients, as a result of participating in the DBT program?

Not at all effective  Mostly not effective  Somewhat effective  increasing signs of effectiveness  Consistently effective
1  2  3  4  5

12. Is there anything you need from this week’s consult group?

12. What did you learn about working as a DBT therapist, group facilitator, and or phone coach this week?
Consult Group

Date Time:

Attendees:

DNA:

Apologies:

Chair:

Minutes:

Previous minutes:

1. Mindfulness

Clinician

Exercise

Specific mindfulness skills

2. Consult agreement

Clinician

Agreement

3. Clinician ratings

Motivation (1-10; 10 = best motivation).

Burnout (1-5; 5 = leaving the program today).

4. Review last week’s notes/commitments

5. Anyone out of compliance with assessments/paper work etc?

Clinician

Plan

221
6. Training and development

**Reading/key learning**

**Training/Key learning**

**Skills group training/key learning**

7. *Is anyone treating a potential 4 misses person? Any clinicians at risk of meeting 4 consecutive consults?*

**Client/Clinician Plan**

8. *Is anyone treating someone at high risk for imminent suicide?*

**Client Plan**

9. **Client Updates** (using the DBT hierarchy as a guide - Life threatening Behaviour, Therapy interfering Behaviour, Quality of life interfering Behaviour, and Increased use of Behavioural Skills).

10. **Skills Group updates.**

11. **Good news stories (e.g., effective therapist or client behaviours).**

**Client & Clinician**

12. *Any out of town dates need to be considered?*

13. **Clinician Commitments**

14. **Wait list/Pre-treatment Follow-up/New presentations**

**Next consult:**

**Where & time:**

**Chair:**

**Minutes:**

**Mindfulness:**
DBT Informed Family Therapy

Key Functions

The key function of DBT informed Family Therapy is to identify and strengthen relationship-enhancing behaviours such as:

- Active Listening;
- Validation;
- Boundaries and limit setting;
- Minimising reinforcement of self-harm;
- Dialectical problem-solving skills.

Additional functions include;

- Generalisation of skills to the environment – setting homework tasks, review of homework, review skill use;
- Improving motivation;
- Enhancing capabilities – supporting the family to provide a more validating and responsive environment.

Indications for Scheduling a Family Session as Part of Individual Therapy with an Adolescent

1. A family member is providing a central source of conflict; the adolescent needs intensive coaching or support in attempting to resolve this conflict.

2. A crisis erupts within the family
3. The case would be enhanced by orienting one or more family members to or educating them about a set of skills, treatment targets, or other aspects of treatment.

4. The contingencies at home continue to reinforce dysfunctional behaviour or punish adaptive behaviour.

**Targets of Intervention for Family Sessions in Crisis Situations**

*Prepare the adolescent for family interactions:*

- Identify goals of the family meeting;
- Consider possible familial sources of the adolescent’s emotion dysregulation;
- Rehearse effective skill use, including ways to handle the adolescent’s emotion dysregulation in the family session;
- Anticipate difficulties and trouble shoot.

*Increase parental understanding of the adolescent’s emotional vulnerability:*

- Provide psycho education regarding emotion dysregulation;
- Help parents to increase their empathy for the adolescent’s pain while decreasing judgmental reactions;

*Address the parent’s emotional dysregulation:*

- Anticipate despair, anxiety, and other strong emotional reactions from parents
- Validate parent’s distress and concerns.
- Cheer lead parent’s ability to get through the crisis.

*Improve communication between the adolescent and family members:*

- Increase validating and decrease invalidating communication.
- Decrease negativity in family interactions.
- Increase use of behavioural skills.

*Modify contingencies in the familial environment:*

- Increase parental responsiveness during noncrisis periods.
- Increase reinforcement of adaptive and decrease reinforcement of maladaptive behaviours

*Take steps to keep the adolescent safe:*

- Provide psycho education to parents regarding risk assessment.
- Increase parental monitoring of the adolescent.
- Devise a detailed plan to keep the adolescent safe.
- Anticipate crisis reoccurrence and stay in touch.

**Strategies for Handling Mismatches in Perceptions of Crises**

*When parents’ and adolescent’s perceptions of a crisis do not match:*

- Increase empathy and perspective taking.
  
  Aim: To achieve dialectical synthesis.

- Enhance accurate communication; employ behavioural rehearsal.
  
  Aim: To help adolescent increase accurate communication of distress.
  
  Aim: To help parents increase accurate communication of concern.

*When parents’ and therapists perceptions of a crisis do not match:*

- Assess further; consider input from parents seriously; empathize with their viewpoint.

- Consider parents to be additional experts on their children
  
  Aim: to achieve dialectical synthesis.

- Explain therapist perspective; provide rationale; employ psycho education (e.g. regarding disorder, treatment, learning theory); employ commitment strategies.
  
  Aim To gain commitment to crisis plan.

*When synthesis cannot be achieved and therapist still differs from parents:*

- Provide a range of options when possible (i.e., alternative strategies or treatments)

- Consult team when possible.
  
  Aim: To maintain alliance while still providing optimal care.
If pursuing other options is not possible or there is still no agreement:

- Refer parents and teen to another provider.

  Aim: To provide parents with a satisfactory option while therapist maintains values or works within areas of competence.

- Report for medical neglect.(a)

  Aim: to ensure adequate treatment for adolescent.

(a) This option should be considered only after other options have been exhausted and a second opinion has been sought, typically from the team.

Guidelines for Breaking Confidentiality

From treatment outset

- Explain limits of confidentiality

- Discuss how therapist will handle confidentiality regarding sensitive

Under these conditions, therapist does not need to break confidentiality:

- Legal standards for breaking confidentially are not met (therapist must know ACT laws).

- Therapist believes that disclosure would be likely to result in exacerbation of the crisis or place adolescent in danger.

Under these conditions, therapists might choose to break confidentiality:

- Even when no clear-cut case for breaking confidentiality exists (i.e., no imminent danger to self or to others) therapist may elect to encourage disclosure of crisis state to a parent or other family member if:

- Such a disclosure would be likely to do more good than harm.

- Therapist believes that the parent’s knowledge of situation would result in support for the adolescent.
• Therapist believes that lack of disclosure would significantly interfere with client’s ability to get through the crisis.

• Therapist believes that lack of disclosure is seriously undermining family work or is somehow maintaining crisis situation

• Therapist believes that holding a particular secret regarding the adolescents’ welfare is too great a violation of family trust.

• Therapist sees parent as critical in monitoring and aiding the adolescent through crisis, even if therapist coaching is needed to assist the parent in being helpful

• Therapist may initiate contact with family members directly if he or she determines that short-term gain in reporting crisis is worth potential cost of adolescent’s (1) trust (2) learning to communicate difficulties and seek help appropriately.

Under these conditions therapist does need to break confidentiality:

• Behaviour reaches threshold of legal mandate (i.e., suspicion) to report abuse or neglect.

• Behaviours escalate significantly.

• Behaviours are maintained at significant level of risk, so that:
  • Minor client is in danger.
  • Treatment does not appear to be helping.
  • Minor client is threatening to harm a particular person.

How to handle breaking confidentiality when adolescent agrees:

• Engage adolescent actively in process.

• Inform adolescent about therapist’s plans.

• Allow adolescent to voice concerns.

• Plan with adolescent how, when, and to whom the disclosure will take place.

• Use behavioural rehearsal to plan disclosure.
How to handle breaking confidentiality when adolescent does not agree:

- Engage adolescent actively in process.
- Inform adolescent about therapist’s plans.
- Explain rational; communicate directly about intentions.
- Allow adolescent to voice concerns.
- Be sure to understand the adolescent’s perspective (can conduct behavioural analysis of unwillingness to disclose if becomes therapy-interfering behaviour).
- Discuss pros and cons of disclosing.
- Discuss potential consequences of not disclosing.
- Plan with adolescent how, when, and to whom the disclosure will take place.
- Use behavioural rehearsal to plan disclosure.
- Stress intention to work to ensure that family interaction around crisis remains adaptive.
- Consider alternative (e.g., temporarily delaying disclosure to parents; disclosing to a selected and trusted family member).
- Employ commitment strategies (e.g., devil’s advocate, shaping).
- Convey support and respect for adolescent’s position.
Appendix B

CAMHS DBT Program Workbook
Distress Tolerance  
Skills to survive and not make things worse  
* ACCEPTS  
* SELF SOOTHE  
* IMPROVE  
* PROS & CONS  
* ACCEPTANCE  
* HALF SMILE  
* WILLINGNESS

Interpersonal Effectiveness  
Skills to get what you need while keeping relationships and your self respect  
* DEAR MAN  
* GIVE  
* FAST  
* TIMING INTERPERSONAL ACTION  
* RECOGNISING FACTORS THAT REDUCE EFFECTIVENESS  
* CHEERLEADING STATEMENTS

Mindfulness

Emotion Regulation  
Skills to build a life worth living  
* UNDERSTAND THE EMOTIONS YOU EXPERIENCE  
* REDUCE YOUR VULNERABILITY TO EMOTIONS  
* DECREASE EMOTIONAL SUFFERING

Middle Path  
Skills to get unstuck  
* BEING MINDFUL OF BEING STUCK  
* VALIDATION  
* BEING WILLING TO WALK THE MIDDLE PATH  
* REWARDING YOURSELF AND OTHERS TO CREATE CHANGE

Compiled by Dean Buckmaster, Emily McIntyre and Fiona Perrett
Mindfulness Week 1 Mindfulness orientation, States of mind, What skills

1. Orientation to DBT
2. Orientation to skills group
3. Orientation to mindfulness
4. STOPP skills
5. States of mind: taking hold of your mind
6. What skills: three steps to wise mind
7. What skills: practice
8. Practice to try before session 2
Dialectical Behaviour Therapy
Multi-Family Skills Training Group

What is Dialectical Behaviour Therapy?

- DBT is an treatment for people who have difficulty controlling their emotions and behaviours
  - DBT aims to reduce problem behaviour and increase skilful behaviour.
- DBT helps people learn how to better understand and value themselves and others.
  - DBT helps people create a life worth living.

What does "Dialectical" Mean?

Dialectical = 2 opposing ideas can be true at the same time.

- There is always more than one way to see a situation, and more than one opinion, idea or dream.
  - All people have something unique and different to offer.
- A life worth living is rich with events and emotions – some painful and some joyful, some boring and some exciting
Week 1: Orientation to skills group

1. Ice Breaking Mindfulness Activity
2. Getting to know each other Activity
Week 1: Orientation to mindfulness

What Skills:
- Observe
- Describe
- Participate

How Skills:
- One mindfully
- Nonjudgmentally
- Effectively
Week 1: orientation to mindfulness

What we want you to learn from the Mindfulness Module:

1. Core mindfulness skills are the foundation to learning DBT.

2. To be effective in implementing all DBT skills you need to be able to choose where you focus your attention in order to work out what is most effective.

3. Mindfulness is used to balance emotion mind and reasonable mind in order to access WISE mind.

4. These skills allow us to experience with awareness what is happening in the moment, rather than leaving a situation or trying to stop an emotion.

5. Allows us to STOP and describe what we are thinking and feeling in a given moment so that we can make choices about how to proceed mindfully and effectively, rather than being controlled by them.

6. To help you balance the different states of mind, the "what" and "how" skills were invented.

7. The "what" skills facilitate the ability to effectively observe, describe, observe, and participate fully in your experience?

8. The "how" skills create the ability and awareness to be non-judgemental, stay focused in the moment, and do what works for the situation.
Mindfulness Handout One
Taking Hold of Your Mind

States of Mind

**Emotional Thoughts**
Based on and driven by our opinions and personal interpretation of events. What went through my mind? What disturbed me? What is it that is making me feel this way? What am I reacting to? What’s the worst thing about that, or the worst thing that could happen? What do I want to do or to happen? What am I feeling?

**Rational Thoughts**
Based on factual evidence. What would be more reasonable? What am I thinking I should do? What advice would I give to a friend, or what would a caring friend say to me? Is this really as important as it seems? What evidence is there about what I think is likely to happen? I’ve felt this way before and I’ve got through it.

**Wise Mind**
STOP! Take a breath. What does Wise Mind make of this? What’s the bigger picture? What will the consequences of my reaction be? (short and long term) What can I change about this situation? If I can’t change the situation, what is within my control? What skill can I use for this situation? What’s going to be the best response to this situation – best for me, for others, for the situation. What will be most helpful and effective, all things considered?
MINDFULNESS
3 STEPS TO ACHIEVE WISE MIND
WHAT SKILLS
HANDOUT 2

OBSERVE
• Just notice the experience.
• Watch your thoughts and feelings come and go like clouds in the sky.
• Do not push away your thoughts and feelings; just let them happen.

DESCRIBE
• Put words on the experience.
• For example: “I feel sad right now,” or “My stomach muscles are tightening.”

Call a thought just a thought, a feeling just a feeling. Don’t get caught in content

PARTICIPÂTE
• Become one with your experience.
• Fully experience your feelings without being self-conscious.

MINDFULNESS PRACTICE EXERCISE 2

GETTING INTO WISE MIND:
Please check off (1) "what" skill that you will practice during the week.

WHAT SKILLS
_____ OBSERVE
_____ DESCRIBE
_____ PARTICIPATE

Briefly describe your experience using this skill during the week (include when and where you used it):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Briefly describe whether or not using the skill affected your thoughts, feelings or behaviors:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Week 1 Practice

1. Wise Mind Work Sheet
2. Getting Into Wise Mind Work Sheet

What barriers might get in the way of you doing the practice?

What can I do to solve these barriers?
Mindfulness Week 2 Mindfulness, How skills, STOPP

1. Practice review

2. How skills: three steps to wise mind

3. How skills practice worksheet

4. STOPP skill

5. STOPP skill practice worksheet

6. Practice to try before session 3
MINDFULNESS
3 STEPS TO ACHIEVE WISE MIND
HOW SKILLS
HANDOUT 3

NON-JUDGMENTALLY
- Don’t evaluate. Just the facts.
- Accept the moment.
- Just acknowledge the emotion.

ONE-MINDFULLY
- Do one thing at a time.
- Let go of distractions.
- Think of one thing at a time.

EFFECTIVELY
- Focus on what works.
- Play by the rules. “Don’t cut off your nose to spite your face.”
- Keep your eye on what you want in the long run.
- Let go of vengeance and useless anger that hurts you and doesn’t work.

MINDFULNESS PRACTICE EXERCISE 3

GETTING INTO WISE MIND:
Please check off (1) “how” skill that you will practice during the week.

HOW SKILLS
_____ NONJUDGMENTAL (DON’T JUDGE)
_____ ONE-MINDFUL (STAY FOCUSED)
_____ BE EFFECTIVE (DO WHAT WORKS)

Briefly describe your experiences using this skill during the week (include when and where you used it):

________________________________________________________

________________________________________________________

________________________________________________________

Briefly describe whether or not using the skill affected your thoughts, feelings or behaviors:

________________________________________________________

________________________________________________________

________________________________________________________

STOPP Skill

STOPP

Stop
Don’t act immediately. Wait.

Take a Breath
Slowly breathe in and out a couple of times.

Observe
What am I thinking about?
What am I focusing on?
What am I reacting to?
What am I feeling in my body?

Pull Back
Zoom out!
See the bigger picture.
Is this fact or opinion?
Is there another way of looking at this?
What would someone else say about it?
How does this affect others?
What advice would I give a friend in this situation?
How important is this situation right now?

Practise what works
Consider the consequences.
What’s the BEST thing to do?
Do what will help most!

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www.getselfhelp.co.uk/stopp.htm
Week 2 Practice

1. How Skills – Getting Into Wise Mind Worksheet
2. STOPP Worksheet

What barriers might get in the way of you doing the practice?

What can I do to solve these barriers?
Distress Tolerance
Skills to survive and not make things worse

* ACCEPTS
* SELF SOOTHE
* IMPROVE
* PROS & CONS
* ACCEPTANCE
* HALF SMILE
* WILLINGNESS
Week 3 of 20: Contents

Distress Tolerance Week 1

1. Practice review

2. Overview of distress tolerance module

3. Distress tolerance: what we want you to learn

4. Why bother coping with urges and feelings?

5. Crisis survival plan

6. Survival pack

7. Overview of crisis survival skills

8. Distract with ACCEPTS

9. Wise mind ACCEPTS practice sheet

10. Metaphors for surviving a crisis

11. Practice to try before session 4
**Distress Tolerance**

- Learning to tolerate distress is about surviving a crisis without making it worse.
- It is not about changing or regulating emotion (we look at this in another module).
- It is not about problem solving.
- We need to use our mindfulness skills to be aware of needing to use distress tolerance skills.

**Leaning the skill of distress tolerance is useful when:**

- Distress is intense but it is an inappropriate time to work it out-school, work, skills training
- Problem can't be solved right now.
- Problem can be solved but you don't have the skills
- Problem can be solved, you have the skills but can't use them (overwhelmed, tired)

**Clues to when you may need distress tolerance**

Notice situations where you are tempted by or are trying to escape a situation or feelings e.g. quit important things, drink, sex, drugs, tantrum, avoid people, suicide, self harm.

**Your goal is to survive; therefore these skills work if you survive and get through the moment without making it worse, not whether the problem is solved or you feel better.**
Distress Tolerance Week 1: Why bother to tolerate distress?

Distress Tolerance

Coping with urges and feelings:

Why bother doing this?

Coping with pain is important for three reasons:

1) Pain is a part of life and can’t always be avoided.

2) If you can’t deal with your pain, you may act impulsively or withdraw and isolate.

3) When you do these things, you may end up not getting your needs met or achieving your goals.

Distress Tolerance

MY CRISIS SURVIVAL PLAN

My goals:

❖ To tolerate my pain / emotional distress until I can make things better
❖ To not make things worse

<table>
<thead>
<tr>
<th>Distress</th>
<th>Common Triggers/Signs</th>
<th>Skills I can use</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distress</td>
<td>Common Triggers/Signs</td>
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<td>34-66</td>
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<td>Distress</td>
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</tr>
<tr>
<td>67 – 99</td>
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</tr>
</tbody>
</table>
My Survival Pack

Things I can put in my pack to help me to use skills
DISTRESS TOLERANCE

CRISIS SURVIVAL STRATEGIES

SKILLS FOR COPING WITH PAINFUL EVENTS AND EMOTIONS WHEN YOU CAN’T MAKE THINGS BETTER RIGHT AWAY.

DISTRACT

SELF-SOOOTHE

IMPROVE THE MOMENT

PROS AND CONS

**Distress Tolerance**

**Distract with Accepts**

**Wise Mind Accepts**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Call or visit a friend, go to a movie, play sport, video games, writes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributing</td>
<td>Give something to someone; do something nice for someone</td>
</tr>
<tr>
<td>Comparisons</td>
<td>Compare yourself to others less fortunate or compare yourself to a time when you had worse distress and can notice it is not always like this.</td>
</tr>
<tr>
<td>Emotions</td>
<td>Do something that creates different emotions, listen to music, read comics, watch a funny tv show.</td>
</tr>
<tr>
<td>Pushing Away</td>
<td>Push the painful situation out of your minds temporarily; build an imaginary wall between you and the situation.</td>
</tr>
<tr>
<td>Thoughts</td>
<td>Read; do word puzzles, count something, notice the colours in something like a painting or poster.</td>
</tr>
<tr>
<td>Sensations</td>
<td>Cool or warm shower/bath, eat something hot (chilli, mint).</td>
</tr>
</tbody>
</table>

**Remember Distraction is useful as a:**

- short term skill,
- to be used when the problem can not be solved,
- if it can be solved need to work on problem,

**If Distraction becomes avoidance:**

- it no longer helps you move forward towards your goals,
- it instead ends up restricting opportunities for new ideas .

---


Distress Tolerance

Crisis Survival Skills

Please tick 2 Wise Mind Accepts skills you practiced during the last two weeks when you felt upset:

___ Activities Call or visit a friend, go to a movie, play sport, video games, write

___ Contributing Give something to someone; do something nice for someone

___ Comparisons Compare yourself to others less fortunate or compare yourself to a time when you had worse distress and can notice it is not always like this.

___ Emotions Do something that creates different emotions, listen to music, read comics, watch a funny tv show.

___ Pushing Away Push the painful situation out of your minds temporarily; build an imaginary wall between you and the situation.

___ Thoughts Read; do word puzzles, count something, notice the colours in something like a painting or poster.

___ Sensations Cool or warm shower/bath, eat something hot (chilli, mint).

Briefly describe the stressful situation you were in when you chose to practice your skill:

________________________________________________________________________

________________________________________________________________________


Did using this skill help you to cope with uncomfortable urges and feelings?  
YES/NO

If YES please describe how it helped:

If NO what got in the way and what could you do differently next time?

If you did not practice this skill what got in the way?

Captain Surviving Sinking Boat

- Not necessarily the time to work out what happened
- Need to survive and float
- Hard to work it out when you are fearful of drowning
- Working it out can be done later
Practice for Distress Tolerance Session 1

1. ACCEPTS Worksheet - Choose at least 5 of these to add to your crisis survival plan

2. Start your survival pack

3. What Mindfulness How and What skill will I practice and when?
   What Skill......................
   How Skill......................

What barriers might get in the way of you doing the practice?

What can I do to solve these barriers?
Week 4 of 20: contents

distress tolerance week 2

1. Practice review

2. Self soothe

3. Self soothe practice sheet

4. Improve the moment

5. Improve the moment practice sheet

6. Pros and cons

7. Pros and cons practice sheet

8. Practice to try before session 5
Distress Tolerance

Self Soothe

Vision
Watch a sunset; look at a picture or poster that you like; make one space in a room look pretty/appealing; look at nature around you; paint your nails; look at a beautiful picture; watch a scenic movie or show.

Hearing
Listen to soothing music; sing or hum your favorite song; pay attention to sounds of nature (birds, rain); seek out human voices (radio, recorded messages).

Smell
Put on your favorite lotion/perfume/aftershave or try them on in the store; light a scented candle; use aromatherapy; bake; smell flowers; breathe in smells of nature.

Taste
Have a good meal; have a favorite soothing drink such as hot chocolate or herbal tea; have your favorite flavour of ice-cream; really taste the food you eat; eat one thing mindfully.

Touch
Pat your dog or cat; have a massage; soak your feet; take a soothing bath; brush your hair for a long time; hug someone; notice touch that is soothing, put clean sheets on the bed; wrap yourself in a doona or blanket; wear something that feels good to touch; try on something in a shop; use heat packs on stomach/back and cold pack on forehead.

To get the best use out of this skill you need to practice it when things are not okay and you need to comfort yourself in times of distress. Remember it is a short-term crisis survival skill and only addresses short-term problems.
Crisis Survival Skills

Please tick 2 Self Soothe skills to practice during the week when you feel upset:

Self soothe with the 5 senses:

___ Vision
___ Hearing
___ Smell
___ Taste
___ Touch

Briefly describe the stressful situation you were in when you chose to practice your skill:

__________________________________________________________________________

__________________________________________________________________________

Did using this skill help you to cope with uncomfortable urges and feelings?

YES/NO

__________________________________________________________________________

__________________________________________________________________________

If YES please describe how it helped:

__________________________________________________________________________

__________________________________________________________________________

If NO what got in the way and what could you do differently next time?

__________________________________________________________________________

__________________________________________________________________________

If you did not practice this skill what got in the way?

__________________________________________________________________________
Imagery: Imagine very relaxing scenes. Imagine a secret room within yourself, seeing how it is decorated. Go into the room whenever you feel threatened. Close the door on anything that can hurt you. Imagine everything going well. Imagine coping well. Make up a fantasy world that is calming and beautiful and let your mind go with it. Imagine hurtful emotions draining out of you like water out of a pipe. This fantasy or image should be created when you are not in a crisis, so it is ready for you to use in a crisis situation.

Meaning: Find or create some purpose, meaning, or value in the pain. Remember, listen to, or read about spiritual values. Focus on whatever positive aspects of a painful situation you can find. Repeat them over and over in your mind. Make lemonade out of lemons.

Prayer: Open your heart to a supreme being, greater wisdom, God, your own wise mind. Ask for strength to bear the pain in this moment. Turn things over to God or a higher being.

Relaxation: Try muscle relaxing by tensing and relaxing each large muscle group, starting with your hands and arms, going to the top of your head, and then working down. Listen to a relaxation tape, exercise hard, take a hot bath, drink hot milk, massage your neck and scalp, your calves and feet. Get in a tub filled with very cold or hot water. Breathe deeply, half smile, change facial expression.

One thing in the moment: Focus your entire attention on just what you are doing right now. Keep yourself in the very moment you are in; put your mind in the present. Focus your entire attention on physical sensations that accompany non-mental tasks (eg. walking, washing, doing dishes, cleaning, fixing). Be aware of how your body moves during each task. Use the awareness exercises from Radical Acceptance for this purpose.

Vacation: Give yourself a brief vacation. Get in bed and pull the covers up over your head for 20 minutes. Rent a motel room at the beach or in the mountains for a day or two; drop your towels on the floor after you use them. Ask a friend to bring you coffee in bed or make you dinner (offer to reciprocate). Get a trashy magazine or newspaper; get in bed with chocolates and read. There are two important rules for vacations: 1) Don't take vacations that can harm you. 2) Don't make vacations too long – to avoid making the problem worse.

Encouragement: Cheerlead yourself. Repeat over and over: "I can stand it", "It won't last forever", "I will make it out of this", "I'm doing the best I can do". There are two important rules for Encouragement: 1) Say it like you mean it. 2) Only say things that are factual.

Crisis Survival Skills

Please tick 3 IMPROVE skills you practiced during the week when you felt distressed.

___ Imagery  
___ Meaning  
___ Prayer  
___ Relaxation  
___ One thing in the moment  
___ Vacation  
___ Encouragement  

Briefly describe the difficult situation you were in when you chose to practice your skill.

______________________________________________________________________________________

Did using this skill help you to cope with uncomfortable urges and feelings?

Yes/No

If Yes please describe how it helped:

______________________________________________________________________________________

If No, please describe what got in the way of it helping, what could you do differently next time:

______________________________________________________________________________________

If you did not practice this skill what got in the way:

______________________________________________________________________________________

Adapted from Linehan, M. (1993).
DISTRESS TOLERANCE
CRISIS SURVIVAL SKILLS – Thinking of PROS and CONS

Urge or Impulse: ________________________________

<table>
<thead>
<tr>
<th>Resisting Impulse</th>
<th>Acting on Impulse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROS</strong></td>
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<td></td>
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<tr>
<td><strong>CONS</strong></td>
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</tbody>
</table>

*Remember to consider SHORT-TERM and LONG-TERM pros and cons. When in Emotion Mind, focus on the Pros of Resisting the Impulse and the Cons of Acting on the Impulse.

DISTRESS TOLERANCE PRACTICE
CRISIS SURVIVAL SKILLS

Practice using Pros & Cons this week, when you have an urge or an impulse.

Urge or Impulse: ____________________________________________

<table>
<thead>
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<th>Resisting Impulse</th>
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<tbody>
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*Remember to consider SHORT-TERM and LONG-TERM pros and cons. When in Emotion Mind, focus on the Pros of Resisting the Impulse and the Cons of Acting on the Impulse.

Distress Tolerance session 2 practice

1. Mindfulness
   WHAT:
   HOW:

2. SELF SOOTH worksheet

4. IMPROVE Worksheet

5. Choose at least 5 of each of these to add to your crisis survival plan

6. Complete Pros and Cons Worksheet

What barriers might get in the way of you doing the practice?

What can I do to solve these barriers?
Week 5 of 20: contents

Distress tolerance week 3

1. Practice review
2. Radical acceptance
3. Turning the mind
4. Willingness and willfulness
5. Metaphors
6. Practice to try before session 6
DISTRESS TOLERANCE HANDOUT

Basic Principles of Accepting Reality

RADICAL ACCEPTANCE

- Freedom from suffering requires ACCEPTANCE from deep within of what is. Let yourself go completely with what is. Let go of fighting reality.
- ACCEPTANCE is the only way out of hell.
- Pain creates suffering only when you refuse to ACCEPT the pain.
- Deciding to tolerate the moment is ACCEPTANCE.
- ACCEPTANCE is acknowledging what is.
- To ACCEPT something is not the same as judging it good.

TURNING THE MIND

- Acceptance of reality as it is requires an act of CHOICE. It is like coming to a fork in the road. You have to turn your mind towards the acceptance road and away from the "rejecting reality" road.
- You have to make an inner COMMITMENT to accept.
  The COMMITMENT to accept does not itself equal acceptance. It just turns you toward the path. But it is the first step.
  You have to turn your mind and commit to acceptance OVER AND OVER AND OVER again. Sometimes, you have to make the commitment many times in the space of a few minutes.

WILLINGNESS

Cultivate a WILLING response to each situation.

- Willingness is DOING JUST WHAT IS NEEDED in each situation, in an unpretentious way. It is focusing on effectiveness.
- Willingness is listening very carefully to your WISE MIND, acting from your inner self.
- Willingness is ALLOWING into awareness your connection to the universe—to the earth, to the floor you are standing on, to the chair you are sitting on, to the person you are talking to.

(over) WILLFULNESS

Replace WILLFULNESS with WILLINGNESS.

- Willfulness is SITTING ON YOUR HANDS when action is needed, refusing to make changes that are needed.
- Willfulness is GIVING UP.
- Willfulness is the OPPOSITE OF "DOING WHAT WORKS," being effective.
- Willfulness is trying to FIX every situation.
- Willfulness is REFUSING TO TOLERATE the moment.

Metaphors for Acceptance

Ship

Ladder out of Hell

Playing the hand of cards you've been dealt

Cricket ball machine
Basic Principles for Accepting Reality

- Radical Acceptance
- Turning the Mind
- Willingness
- Willfulness
Write down a situation that you would like to change but can't right now.

________________________________________________________

________________________________________________________

What will you have to accept about the situation that will help you tolerate it?

________________________________________________________

________________________________________________________

What are you afraid will happen if you accept the situation?

________________________________________________________

________________________________________________________

What is the outcome of being willful and not accepting the situation?

________________________________________________________

________________________________________________________

What skills can you use to accept and tolerate the situation?

________________________________________________________

________________________________________________________

What would it look like if you used Willingness to accept this situation?

________________________________________________________

________________________________________________________

What would I gain if I made a commitment and chose to accept the situation? (When acceptance is the WISE thing to do)
Practice for Distress Tolerance Week 3

1. Mindfulness
   WHAT:
   HOW:

2. Radical Acceptance Worksheet

3. Add any new skills to your crisis survival plan

What barriers might get in the way of you doing the practice?

What can I do to solve these barriers?
Week 6 of 20: contents

distress tolerance week 4

1. Practice review

2. Guidelines for accepting reality

3. Observing breath

4. Half smile

5. Awareness exercises

6. Practice to try before session 7
DISTRESS TOLERANCE HANDOUT

Guidelines for Accepting Reality:
Awareness Exercises

1. AWARENESS OF THE POSITIONS OF THE BODY
   This can be practiced in any time and place. Begin to focus your attention on your
   breath. Breathe quietly and more deeply than usual. Be mindful of the position of your
   body, whether you are walking, standing, lying, or sitting down. Know where you
   walk, stand, lie, or sit. Be aware of the purpose of your position. For example, you
   might be conscious that you are standing on a green hillside in order to refresh your­
   self, to practice breathing, or just to stand. If there is no purpose, be aware that there
   is no purpose.

2. AWARENESS OF CONNECTION TO THE UNIVERSE
   This can be practiced any time, any place. Focus your attention on where your body
   touches an object (floor or ground, air molecules, a chair or arm rest, your bed sheets
   and covers, your clothes, etc.). Try to see all the ways you are connected to and ac­
   cepted by that object. Consider the function of that object with relation to you. That
   is, consider what the object does for you. Consider its kindness in doing that. Ex­
   perience the sensation of touching the object and focus your entire attention on that
   kindness until a sense of being connected or loved or cared for arises in your heart.

   Examples: Focus your attention on your feet touching the ground. Consider the
   kindness of the ground holding you up, providing a path for you to get to other
   things, not letting you fall away from everything else. Focus your attention on your
   body touching the chair you sit in. Consider how the chair accepts you totally, holds
   you up, supports your back, keeps you from falling down on the floor. Focus your at­
   tention on the sheets and covers on your bed. Consider the touch of the sheets and
   covers holding you, surrounding and keeping you warm and comfortable. Consider the
   walls in the room. They keep out the wind and the cold and the rain. Think of how
   the walls are connected to you via the floor and the air in the room. Experience your
   connection to the walls that provide you with a secure place to do things. Go hug a
   tree. Think of how you and the tree are connected. Life is in you and in the tree and
   both of you are warmed by the sun, held by the air and supported by the earth. Try
   and experience the tree loving you by providing something to lean on, or by shading
   you.

3. AWARENESS WHILE MAKING TEA OR COFFEE
   Prepare a pot of tea or coffee to serve a guest or to drink by yourself. Do each move­
   ment slowly, in awareness. Do not let one detail of your movements go by without be­
   ing aware of it. Know that your hand lifts the pot by its handle. Know that you are
   pouring the fragrant, warm tea or coffee into the cup. Follow each step in awareness.
   Breathe gently and more deeply than usual. Take hold of your breath if your mind
   strays.

4. **AWARENESS WHILE WASHING THE DISHES**

Wash the dishes consciously, as though each bowl is an object of contemplation. Consider each bowl as sacred. Follow your breath to prevent your mind from straying. Do not try to hurry to get the job over with. Consider washing the dishes the most important thing in life.

5. **AWARENESS WHILE HAND-WASHING CLOTHES**

Do not wash too many clothes at one time. Select only three or four articles of clothing. Find the most comfortable position to sit or stand so as to prevent a backache. Scrub the clothes consciously. Fold your attention on every movement of your hands and arms. Pay attention to the soap and water. When you have finished scrubbing and rinsing, your mind and body will feel as clean and fresh as your clothes. Remember to maintain a half-smile and take hold of your breath whenever your mind wanders.

6. **AWARENESS WHILE CLEANING HOUSE**

Divide your work into stages: straightening things and putting away books, scrubbing the toilet, scrubbing the bathroom, sweeping the floors, and dusting. Allow a good length of time for each task. Move slowly, three times more slowly than usual. Focus your attention fully on each task. For example, while placing a book on the shelf, look at the book, be aware of what book it is, know that you are in the process of placing it on the shelf, and know that you intend to put it in that specific place. Know that your hand reaches for the book, and picks it up. Avoid any abrupt or harsh movement. Maintain awareness of the breath, especially when your thoughts wander.

7. **AWARENESS WHILE TAKING A SLOW-MOTION BATH**

Allow yourself 30 to 45 minutes to take a bath. Don't hurry for even a second. From the moment you prepare the bath water to the moment you put on clean clothes, let every motion be light and slow. Be attentive of every movement. Place your attention to every part of your body, without discrimination or fear. Be aware of each stream of water on your body. By the time you've finished, your mind will feel as peaceful and light as your body. Follow your breath. Think of yourself as being in a clean and fragrant lotus pond in the summer.

8. **PRACTICING AWARENESS WITH MEDITATION**

Sit comfortably on the floor with your back straight, on the floor or in a chair with both feet touching the floor. Close your eyes all the way, or open them slightly and gaze at something near. With each breath, say to yourself, quietly and gently, the word "One." As you inhale, say the word "One." As you exhale, say the word "One," calmly and slowly. Try to collect your whole mind and put it into this one word. When your mind strays, return gently to saying "One." *If you start wanting to move, try not to move. Just gently observe wanting to move. Continue practicing a little past wanting to stop. Just gently observe wanting to stop.*

*Note.* Exercises 1 and 3–8 are adapted from *The Miracle of Mindfulness: A Manual on Meditation* (pp. 84–87) by Thich Nhat Hanh, 1976, Boston: Beacon Press. Copyright 1976 by Thich Nhat Hanh. Adapted by permission.

Guidelines for Accepting Reality: Half-Smiling Exercises

HALF-SMILE
Accept reality with your body. Relax (by letting go or by just tensing and then letting go) your face, neck, and shoulder muscles and half-smile with your lips. A tense smile is a grin (and might tell the brain you are hiding or masking). A half-smile is slightly up-turned lips with a relaxed face. Try to adopt a serene facial expression. Remember, your body communicates to your mind.

1. HALF-SMILE WHEN YOU FIRST AWAKE IN THE MORNING
Hang a branch, any other sign, or even the word “smile” on the ceiling or wall so that you see it right away when you open your eyes. This sign will serve as your reminder. Use these seconds before you get out of bed to take hold of your breath. Inhale and exhale three breaths gently while maintaining a half-smile. Follow your breaths.

2. HALF-SMILE DURING YOUR FREE MOMENTS
Anywhere you find yourself sitting or standing, half-smile. Look at a child, a leaf, a painting on a wall, or anything that is relatively still, and smile. Inhale and exhale quietly three times.

3. HALF-SMILE WHILE LISTENING TO MUSIC
Listen to a piece of music for 2 or 3 minutes. Pay attention to the words, music, rhythm, and sentiments of the music you are listening to (not your daydreams of other times). Half-smile while watching your inhalations and exhalations.

4. HALF-SMILE WHEN IRRITATED
When you realize “I’m irritated,” half-smile at once. Inhale and exhale quietly, maintaining a half-smile for three breaths.

5. HALF-SMILE IN A LYING-DOWN POSITION
Lie on your back on a flat surface without the support of mattress or pillow. Keep your two arms loosely by your sides and keep your two legs slightly apart, stretched out before you. Maintain a half-smile. Breathe in and out gently, keeping your attention focused on your breath. Let go of every muscle in your body. Relax each muscle as though it were sinking down through the floor, or as though it were as soft and yielding as a piece of silk hanging in the breeze to dry. Let go entirely, keeping your attention only on your breath and half-smile. Think of yourself as a cat, completely relaxed before a warm fire, whose muscles yield without resistance to anyone’s touch. Continue for 15 breaths.

6. HALF-SMILE IN A SITTING POSITION

Sit on the floor with your back straight, or on a chair with your two feet touching the floor. Half-smile. Inhale and exhale while maintaining the half-smile. Let go.

7. HALF-SMILE WHILE CONTEMPLATING THE PERSON YOU HATE OR DESPISE THE MOST

Sit quietly. Breathe and smile a half-smile. Imagine the image of the person who has caused you the most suffering. Regard the features you hate or despise the most or find the most repulsive. Try to examine what makes this person happy and what causes suffering in his or her daily life. Imagine the person's perceptions; try to see what patterns of thought and reason this person follows. Examine what motivates this person's hopes and actions. Finally, consider the person's consciousness. See whether the person's views and insights are open and free or not, and whether or not the person has been influenced by any prejudices, narrow-mindedness, hatred, or anger. See whether or not the person is master of himself or herself. Continue until you feel compassion rise in your heart like a well filling with fresh water, and your anger and resentment disappear. Practice this exercise many times on the same person.

Notes/Other times to half-smile: ___________________________________________

Note. Adapted from The Miracle of Mindfulness: A Manual on Meditation (pp. 77–81, 93) by Thich Nhat Hanh, 1976, Boston: Beacon Press. Copyright 1976 by Thich Nhat Hanh. Adapted by permission.

GUIDELINES FOR ACCEPTING REALITY:
OBSERVING-YOUR-BREATH EXERCISES

1. DEEP BREATHING

Lie on your back. Breathe evenly and gently, focusing your attention on the movement of your stomach. As you begin to breathe in, allow your stomach to rise in order to bring air into the lower half of your lungs. As the upper halves of your lungs begin to fill with air, your chest begins to rise and your stomach begins to lower. Don't tire yourself. Continue for 10 breaths. The exhalation will be longer that the inhalation.

2. MEASURING YOUR BREATH BY YOUR FOOTSTEPS

Walk slowly in a yard, along a sidewalk, or on a path. Breathe normally. Determine the length of your breath, the exhalation and the inhalation, by the number of your footsteps. Continue for a few minutes. Begin to lengthen your exhalation by one step. Do not force a longer inhalation. Let it be natural. Watch your inhalation carefully to see whether there is a desire to lengthen it. Continue for 10 breaths.

Now lengthen the exhalation by one more footstep. Watch to see whether the inhalation also lengthens by one step or not. Only lengthen the inhalation when you feel that it will give delight. After 20 breaths, return your breath to normal. About 5 minutes later, you can begin the practice of lengthened breaths again. When you feel the least bit tired, return to normal. After several sessions of the practice of lengthened breath, your exhalation and inhalation will grow equal in length. Do not practice long, equal breaths for more than 10 to 20 breaths before returning to normal.

3. COUNTING YOUR BREATH

Sit cross-legged on the floor (sit in the half or full lotus position if you know how); or sit in a chair with your feet on the floor; or kneel; or lie flat on the floor; or take a walk. As you inhale, be aware that "I am inhaling, 1." When you exhale, be aware that "I am exhalinig, 1." Remember to breathe from the stomach. When beginning the second inhalation, be aware that "I am inhaling, 2." And slowly exhaling, be aware that "I am exhalinig, 2." Continue on up through 10. After you have reached 10, return to 1. Whenever you lose count, return to 1.

(cont.)
4. FOLLOWING YOUR BREATH WHILE LISTENING TO MUSIC

Listen to a piece of music. Breathe long, light, and even breaths. Follow your breath; be master of it while remaining aware of the movement and sentiments of the music. Do not get lost in the music, but continue to be master of your breath and yourself.

5. FOLLOWING YOUR BREATH WHILE CARRYING ON A CONVERSATION

Breathe long, light, and even breaths. Follow your breath while listening to a friend's words and to your own replies. Continue as with the music.

6. FOLLOWING THE BREATH

Sit cross-legged on the floor (sit in the half or full lotus position if you know how); or sit in a chair with your feet on the floor; or kneel; or lie flat on the floor; or take a walk. Begin to inhale gently and normally (from the stomach), aware that "I am inhaling normally." Exhale in awareness, "I am exhaling normally." Continue for three breaths. On the fourth breath, extend the inhalation, aware that "I am breathing in a long inhalation." Exhale in awareness, "I am breathing out a long exhalation." Continue for three breaths.

Now follow your breath carefully, aware of every movement of your stomach and lungs. Follow the entrance and exit of air. Be aware that "I am inhaling and following the inhalation from its beginning to its end. I am exhaling and following the exhalation from its beginning to its end."

Continue for 20 breaths. Return to normal. After 5 minutes, repeat the exercise.

Maintain a half-smile while breathing. Once you have mastered this exercise, move on to the next.

7. BREATHING TO QUIET THE MIND AND BODY

Sit cross-legged on the floor (sit in half or full lotus position if you know how); or sit in a chair with your feet on the floor; or kneel; or lie flat on the floor. Half-smile. Follow your breath. When your mind and body are quiet, continue to inhale and exhale very lightly; be aware that "I am breathing in and making the breath and body light and peaceful. I am exhaling and making the breath and body light and peaceful." Continue for three breaths, giving rise to the thought, "I am breathing in while my body and mind are at peace. I am breathing out while my body and mind are at peace."

Maintain this thought in awareness from 5 to 30 minutes, according to your ability and to the time available to you. The beginning and end of the practice should be relaxed and gentle. When you want to stop, gently massage the muscles in your legs before returning to a normal sitting position. Wait a moment before standing up.

**Note.** Adapted from *The Miracle of Mindfulness: A Manual of Meditation* (pp. 81-84) by Thich Nhat Hanh, 1976, Boston: Beacon Press. Copyright 1987 by Mobi Ho. Adapted by permission.

Guidelines for Accepting Reality Homework Sheet

Observing Breath

What exercise did I practice?

What are some barriers to my ongoing practice?

How will I solve those barriers?

Half-Smile

What exercise did I practice?

What are some barriers to my ongoing practice?

How will I solve those barriers?
Guidelines for Accepting Reality Homework Sheet continued

**Awareness Exercise**

What exercise did I practice?

What are some barriers to my ongoing practice?

How will I solve those barriers?
Module Review

What have you learned from the Distress Tolerance Module

1. What are your strengths in this area?

2. What areas need development?

3. Review of Crisis Survival Plan
1. Mindfulness
   WHAT:
   HOW:

2. Guidelines for Accepting Reality Worksheet

3. Add any new skills to your crisis survival plan

4. Review the distress tolerance module with the worksheet

What barriers might get in the way of you doing the practice?

What can I do to solve these barriers?
Interpersonal Effectiveness
Skills to get what you need while keeping relationships and your self respect

* DEAR MAN
* GIVE
* FAST
* TIMING INTERPERSONAL ACTION
* RECOGNISING FACTORS THAT REDUCE EFFECTIVENESS
* CHEERLEADING STATEMENTS
Week 7 of 20: Contents

Interpersonal Effectiveness Week 1

1. Practice review

2. Overview

3. Situations for Interpersonal Effectiveness

4. Goals / Levels for Interpersonal Effectiveness

5. Overview of DEAR MAN GIVE FAST

6. Practice to try before session 8
Week 7 Interpersonal effectiveness week 1 overview of module

Situations for Interpersonal Effectiveness

Attending to Relationships
- Don’t let hurts and problems build up.
- Use relationship skills to head off problems.
- End hopeless relationships.
- Resolve conflicts before they get overwhelming.

Balancing Priorities vs. Demands
- If overwhelmed, reduce or put off low-priority demands.
- Ask others for help; say no when necessary.
- If not enough to do, try to create some structure and responsibilities; Offer to do other things.

Balancing the Wants-to-Shoulds
- Look at what you do because you enjoy doing it and “want” to do it; and how much you do because you “should” do it. Try to keep the number of each in balance, even if you have to:
  - Get your opinions taken seriously
  - Get others to do things
  - Say no to unwanted requests

Building Mastery and Self-Respect
- Interact in a way that makes you feel competent and effective, not helpless and overly dependent.
• Stand up for yourself, your beliefs and opinions; follow your own wise mind.
INTERPERSONAL EFFECTIVENESS HANDOUT

Goals of Interpersonal Effectiveness

OBJECTIVES EFFECTIVENESS:
Getting Your Objectives or Goals in a Situation
- Obtaining your legitimate rights
- Getting another to do something
- Refusing an unwanted or unreasonable request
- Resolving an interpersonal conflict
- Getting your opinion or point of view taken seriously

QUESTIONS
1. What specific results or changes do I want from this interaction?
2. What do I have to do to get the results? What will work?

RELATIONSHIP EFFECTIVENESS:
Getting or Keeping a Good Relationship
- Acting in such a way that the other person keeps liking and respecting you
- Balancing immediate goals with the good of the long-term relationship

QUESTIONS
1. How do I want the other person to feel about me after the interaction is over?
2. What do I have to do to get (or keep) this relationship?

SELF-RESPECT EFFECTIVENESS:
Keeping or Improving Self-Respect and Liking for Yourself
- Respecting your own values and beliefs; acting in a way that makes you feel moral
- Acting in a way that makes you feel capable and effective

QUESTIONS
1. How do I want to feel about myself after the interaction is over?
2. What do I have to do to feel that way about myself? What will work?

## Interpersonal Effectiveness

<table>
<thead>
<tr>
<th>Levels</th>
<th>Objective</th>
<th>Relationship</th>
<th>Self Respect</th>
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<tbody>
<tr>
<td>D</td>
<td>Describe</td>
<td>Gentle</td>
<td>F (be) Fair</td>
</tr>
<tr>
<td>E</td>
<td>Express feelings</td>
<td>Interested</td>
<td>A (no) Apologies</td>
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<tr>
<td>A</td>
<td>Assert wishes</td>
<td>Validate</td>
<td>S Stick to Values</td>
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<td>R</td>
<td>Reinforce</td>
<td>Easy Manner</td>
<td>T Truthful</td>
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<tr>
<td>M</td>
<td>(be) Mindful</td>
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<tr>
<td>A</td>
<td>Appear Confident</td>
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<tr>
<td>N</td>
<td>Negotiate</td>
<td></td>
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</tbody>
</table>
Goals for Interpersonal Effectiveness Homework Sheet 1

Prompting Event
Who did what to whom? What led up to what? What is it about this situation that is a problem for me? DESCRIBE Non Judgementally:

What are my goals/levels?

Objective = /10
What specific results do I want? What changes do I want the person to make?

Relationship = /10
How do I want the other person to feel about me after the interaction?

Self Respect = /10
How do I want to feel about myself after the interaction?

What are my priorities?

Objectives?
Relationship?
Self Respect?

What are the conflicts in my priorities that may make it hard to be effective in this situation?
Practice for interpersonal effectiveness week 1

1. Mindfulness

WHAT:

HOW:

2. Homework Sheet 1: Goals for Interpersonal Effectiveness

What barriers might get in the way of you doing the practice?

What can I do to solve these barriers?
Week 8 of 20: Contents

Interpersonal effectiveness week 2

1. Practice review

2. Linking skills to goals and levels

3. DEAR MAN

4. GIVE

5. Role play DEAR MAN with/without GIVE

6. Repairs

7. Practice to try before session 9
INTERPERSONAL EFFECTIVENESS HANDOUT

Guidelines for Objectives Effectiveness: Getting What You Want

A way to remember these skills is to remember the term "DEAR MAN."

DESCRIBE
EXPRESS
ASSERT
REINFORCE
(stay) MINDFUL
APPEAR CONFIDENT
NEGOTIATE

Describe
Describe the current SITUATION (if necessary).
Tell the person exactly what you are reacting to. Stick to the facts.

Express
Express your FEELINGS and OPINIONS about the situation.
Assume that your feelings and opinions are not self-evident. Give a brief rationale. Use phrases such as "I want," "I don't want," instead of "I need," "You should," or "I can't."

Assert
Assert yourself by ASKING for what you want or SAYING NO clearly.
Assume that others will not figure it out or do what you want unless you ask. Assume that others cannot read your mind. Don't expect others to know how hard it is for you to ask directly for what you want.

Reinforce
Reinforce or reward the person ahead of time by explaining CONSEQUENCES.
Tell the person the positive effects of getting what you want or need. Tell him or her (if necessary) the negative effects of your not getting it. Help the person feel good ahead of time for doing or accepting what you want. Reward him or her afterwards.

(cont.)

Week 8 Interpersonal effectiveness week 2 DearMan continued
INTERPERSONAL EFFECTIVENESS HANDOUT  (cont.)

(stay) Mindful

Keep your focus ON YOUR OBJECTIVES.
Maintain your position. Don’t be distracted.

“Broken record”

Keep asking, saying no, or expressing your opinion over and over.

Ignore

If another person attacks, threatens, or tries to change the subject, ignore the threats, comments, or attempts to divert you. Don’t respond to attacks. Ignore distractions. Just keep making your point.

Appear confident

Appear EFFECTIVE and competent.
Use a confident voice tone and physical manner; make good eye contact. No stammering, whispering, staring at the floor, retreating, saying "I'm not sure," etc.

Negotiate

Be willing to GIVE TO GET. Offer and ask for alternative solutions to the problem. Reduce your request. Maintain no, but offer to do something else or to solve the problem another way. Focus on what will work.

Turn the tables

Turn the problem over to the other person. Ask for alternative solutions: “What do you think we should do?” “I'm not able to say yes, and you seem to really want me to. What can we do here?” “How can we solve this problem?”

Other ideas:

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Week 8 Interpersonal effectiveness week 2 give
INTERPERSONAL EFFECTIVENESS HANDOUT

Guidelines for Relationship Effectiveness:
Keeping the Relationship

A way to remember these skills is to remember the word "GIVE" (DEAR MAN, GIVE):

[(be) GENTLE]
[(act) INTERESTED]
[VALIDATE]
[(use an) EASY MANNER]

(be) Gentle

Be COURTEOUS and temperate in your approach.

No attacks

No verbal or physical attacks. No hitting, clenching fists. Express anger directly.

No threats

No "manipulative" statements, no hidden threats. No "I'll kill myself if you. . . ." Tolerate a no to requests. Stay in the discussion even if it gets painful. Exit gracefully.

No judging

No moralizing. No "if you were a good person, you would. . . ." No "You should. . . ." "You shouldn't. . . ."

(act) Interested

LISTEN and be interested in the other person.

Listen to the other person's point of view, opinion, reasons for saying no, or reasons for making a request of you. Don't interrupt, talk over, etc. Be sensitive to the person's desire to have the discussion at a later time. Be patient.

Validate

Validate or ACKNOWLEDGE the other person's feelings, wants, difficulties, and opinions about the situation. Be nonjudgmental out loud: "I can understand how you feel, but . . . ."; "I realize this is hard for you, but . . . ."; "I see that you are busy, and . . . ."

(use an) Easy manner

Use a little humor. SMILE. Ease the person along. Be light-hearted. Wheedle. Use a "soft sell" over a "hard sell." Be political.

Other ideas:

Interpersonal Effectiveness Skills

Repairs

Ways that apologizing is hard from me:


Strategies that I can use to improve my ability to apologize:


Ways that it is difficult for me to accept apologies from others:


Strategies that I can use to improve my ability to accept apologies:


Ways that it is hard for me to let go:


Strategies that I can use to improve my ability to let go:


D.B.T. in Life™
Situation:
You are feeling really upset after a fight with a friend. You have tried to use some skills at home but are still struggling with your feelings. You feel that you would like support from someone in your family.

What are my goals/levels?

Objective = /10

What results do I want? What changes do I want the person to make?

Relationship = /10

How do I want the other person to feel about me after the interaction?

Self Respect = /10

How do I want to feel about myself after the interaction?

What skills will I use?
- DEAR MAN
- GIVE

What words will I use? What body language do I need to think about?

What did I say?
Interpersonal Effectiveness practice Sheet 2 continued

**Prompting Event**

Who did what to whom? What led up to what? DESCRIBE NON-Judgementally:

...

**What are my goals/levels?**

**Objective = /10**

What results do I want? What changes do I want the person to make?

**Relationship = /10**

How do I want the other person to feel about me after the interaction?

**Self Respect = /10**

How do I want to feel about myself after the interaction?
Week 8 Interpersonal effectiveness week 2 practice sheet 2 continued

What skills will I use?

DEAR MAN

_ Described situation
_ Expressed feelings / opinions
_ Asserted
_ Reinforced

Mindful
Broken Record
Ignored attacks
Appeared confident?
Negotiated

GIVE

_ Gentle
_ no threats
_ no attacks
_ no judgements

_ Interested
_ Validated
_ Easy Manner

What words will I use? What body language do I need to think about?

What would I change / improve for next time?
Practice for interpersonal effectiveness week 2

1. Mindfulness

WHAT:

HOW:

2. Homework Sheet 2: Interpersonal Effectiveness

3. Repairs Homework Sheet

What barriers might get in the way of you doing the practice?

What can I do to solve these barriers?
Week 9 of 20: Contents

Interpersonal Effectiveness Week 3

1. Practice review

2. FAST

3. Timing Interpersonal Action

4. Practice to try before session 10
Guidelines for Self-Respect Effectiveness:
Keeping Your Respect for Yourself

A way to remember these skills is to remember the word "FAST" (DEAR MAN, GIVE FAST).

(be) **FAIR**
(no) **APOLOGIES**
(stick to values)
(be) **TRUTHFUL**

**Fair**
Be fair to YOURSELF and to the OTHER person.

**Apologies**
No OVERLY apologetic behavior. No apologizing for being alive, for making a request at all. No apologies for having an opinion, for disagreeing.

**Stick to values**
Stick to YOUR OWN values.

Don’t sell out your values or integrity for reasons that aren’t very important. Be clear on what you believe is the moral or valued way of thinking and acting, and “stick” to your guns.

**Truthful**
DON’T LIE, ACT HELPLESS when you are not, or EXAGGERATE. Don’t make up excuses.

Other ideas:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Week 9 Interpersonal effectiveness week 3 practice sheet

Interpersonal Effectiveness

Practice Sheet

Situation:
Your best friend has just started going with a new boyfriend. You are happy for her as he is a nice guy. However over the past few weeks your friend has started to cancel planned catch ups with you and doesn’t answer her phone much either. You really miss her and feel sad, lonely and rejected by her behaviour.

What are my goals/levels?

Objective = /10
What results do I want? What changes do I want the person to make?

Relationship = /10
How do I want the other person to feel about me after the interaction?

Self Respect = /10
How do I want to feel about myself after the interaction?

What skills will I use?

- DEAR MAN
- GIVE
- FAST

What words will I use? What body language do I need to think about?
Being interpersonally effective requires thinking through whether it is appropriate to ask for something or to say no to a request. The TIMING interpersonal ACTION skill involves being mindful of the following important factors:

**Timing**

- When would be a good time? Is the other person in the mood for listening and paying attention? When would be a good time?

**Investigate the facts**

- Know all the facts? Do the facts support your position? Do the facts support the other person's position?

**Manage the timing**

- Suggest a time to discuss? Ask the person for a time that would work for them.

**Invest in planning and practice**

- Prepare and practice for the interaction using your Dear Man Give Fast skills?

**No acting helpless**

- Every journey begins with the first step. Build mastery. A little can go a long way.
- Reinforce yourself

**Give and take**
• Are you and the person in a reciprocal relationship of give and take? Have you done things for this person? Have you used give with this person regularly?

---

**INTERPERSONAL**

**A**ppropriate

• Is it appropriate to the relationship? Is it understandable that the person may not give you everything you want? Do they have the right to say know or request something of you?

**C**apability

• Does the person have what you want? Can they give what you want? Make sure you are mindful of short term and long term goals?

**T**ime out

• Sometimes creating some time out space can allow you to regroup and access wise mind

• Don’t avoid

**I**magine yourself performing the behaviour effectively

• See yourself being effective and managing all kind of responses

**O**utline what you want to happen

• Create some space to activate your wise mind goals for the situation

**N**egotiate

• Time, place, outcome. Be prepared and know what you will negotiate on.
Week 9 Interpersonal effectiveness week 3 timing practice sheet
Interpersonal Effectiveness
Practice Sheet 4

Prompting Event
Who did what to whom? What led up to what? DESCRIBE:

What are my goals/levels?
Objective = /10
What results do I want? What changes do I want the person to make?

Relationship = /10
How do I want the other person to feel about me after the interaction?

Self Respect = /10
How do I want to feel about myself after the interaction?

What skills will I use?

DEAR MAN
_ Describe situation
_ Express feelings / opinions
_ Assert

_ Mindful
_ Broken Record
_ Ignore attacks
_ Reinforce

_ Appear confident?

_ Negotiate
Week 9 Interpersonal effectiveness week 3 timing practice sheet continued

GIVE

_ Gentle  _ Interested
_ no threats  _ Validated
_ no attacks  _ Easy Manner
_ no judgements

FAST

_ Fair  _ Stick to values
_ (no) Apologies  _ Truthful

What words will I use? What body language do I need to think about?

Which TIMING Interpersonal ACTION factors did you need to consider? List these and why they are relevant to the situation.
What would I change / improve for next time?
Practice for Interpersonal Effectiveness Week 3

1. Mindfulness

WHAT:

HOW:

2. Homework Sheet 4: Interpersonal Effectiveness

What barriers might get in the way of you doing the practice?

What can I do to solve these barriers?
Week 10 of 20 Contents

Week 4 Interpersonal Effectiveness

1. Practice review

2. Factors Reducing Interpersonal Effectiveness

3. Myths about Interpersonal Effectiveness

4. Cheerleading Statements

5. Interpersonal Navigator

6. Practice sheet: how to cope with worry thoughts

7. Practice sheet: cheerleading statements

8. Practice to try before session 11
Week 10 Interpersonal effectiveness week 4 factors reducing interpersonal effectiveness
Factors Reducing Interpersonal Effectiveness

<table>
<thead>
<tr>
<th>LACK OF SKILL</th>
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<tbody>
<tr>
<td>You actually DON'T KNOW what to say or how to act. You don't know how you should behave to achieve your objectives. You don't know what will work.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WORRY THOUGHTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worry thoughts get in the way of your ability to act effectively. You have the ability, but your worry thoughts interfere with doing or saying what you want.</td>
</tr>
</tbody>
</table>
| • WORRIES ABOUT BAD CONSEQUENCES.  
  "They won't like me," "She will think I am stupid." |
| • WORRIES ABOUT WHETHER YOU DESERVE TO GET WHAT YOU WANT.  
  "I am such a bad person I don't deserve this." |
| • WORRIES ABOUT NOT BEING EFFECTIVE AND CALLING YOURSELF NAMES.  
  "I won't do it right," "I'll probably fall apart," "I'm so stupid." |

<table>
<thead>
<tr>
<th>EMOTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your emotions (ANGER, FRUSTRATION, FEAR, GUILT) get in the way of your ability to act effectively. You have the ability, but your emotions make you unable to do or say what you want. Emotions, instead of skill, control what you say and do.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INDECISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>You CAN'T DECIDE what to do or what you really want. You have the ability, but your indecision gets in the way of doing or saying what you want. You are ambivalent about your priorities. You can't figure out how to balance:</td>
</tr>
<tr>
<td>• Asking for too much versus not asking for anything.</td>
</tr>
<tr>
<td>• Saying no to everything versus giving in to everything.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ENVIRONMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristics of the environment make it impossible for even a very skilled person to be effective. SKILLFUL BEHAVIOR DOESN'T WORK.</td>
</tr>
<tr>
<td>• Other people are too powerful.</td>
</tr>
<tr>
<td>• Other people will be threatened or have some other reason for not liking you if you get what you want.</td>
</tr>
<tr>
<td>• Other people won't give you what you need or let you say no without punishing you unless you sacrifice your self-respect, at least a little.</td>
</tr>
</tbody>
</table>

Week 10 Interpersonal effectiveness week 4 myths about interpersonal effectiveness

Myths about Interpersonal Effectiveness

1. I can't stand it if someone gets upset with me.
   CHALLENGE: ____________________________________________________________

2. If they say no, it will kill me.
   CHALLENGE: ____________________________________________________________

3. I don’t deserve to get what I want or need.
   CHALLENGE: ____________________________________________________________

4. If I make a request, this will show that I am a very weak person.
   CHALLENGE: ____________________________________________________________

5. I must be really inadequate if I can't fix this myself.
   CHALLENGE: ____________________________________________________________

6. I have to know whether a person is going to say yes before I make a request.
   CHALLENGE: ____________________________________________________________

7. Making requests is a really pushy (bad, self-centered, selfish, un-Christian) thing to do.
   CHALLENGE: ____________________________________________________________

8. It doesn’t make any difference; I don’t care really.
   CHALLENGE: ____________________________________________________________

9. Obviously, the problem is just in my head. If I would just think differently I wouldn't have to
   bother everybody else.
   CHALLENGE: ____________________________________________________________

10. This is a catastrophe (is really bad, is terrible, is driving me crazy, will destroy me, is a disaster).
    CHALLENGE: ____________________________________________________________

11. Saying no to a request is always a selfish thing to do.
    CHALLENGE: ____________________________________________________________

12. I should be willing to sacrifice my own needs for others.
    CHALLENGE: ____________________________________________________________

13. ____________________________________________________________
    CHALLENGE: ____________________________________________________________

14. ____________________________________________________________
    CHALLENGE: ____________________________________________________________

Week 10 Interpersonal effectiveness week 4 cheerleading statements

Cheerleading Statements for Interpersonal Effectiveness

1. It is OK to want or need something from someone else.
2. I have a choice to ask someone for what I want or need.
3. I can stand it if I don’t get what I want or need.
4. The fact that someone says no to my request doesn’t mean I should not have asked in the first place.
5. If I didn’t get my objectives, that doesn’t mean I didn’t go about it in a skillful way.
6. Standing up for myself over "small" things can be just as important as "big" things are to others.
7. I can insist on my rights and still be a good person.
8. I sometimes have a right to assert myself, even though I may inconvenience others.
9. The fact that other people might not be assertive doesn’t mean that I shouldn’t be.
10. I can understand and validate another person, and still ask for what I want.
11. There is no law that says other people’s opinions are more valid than mine.
12. I may want to please people I care about, but I don’t have to please them all the time.
13. Giving, giving, giving is not the be-all of life. I am an important person in this world, too.
14. If I refuse to do a favor for people, that doesn’t mean I don’t like them. They will probably understand that, too.
15. I am under no obligation to say yes to people simply because they ask a favor of me.
16. The fact that I say no to someone does not make me a selfish person.
17. If I say no to people and they get angry, that does not mean that I should have said yes.
18. I can still feel good about myself, even though someone else is annoyed with me.

OTHERS: ____________________________________________

____________________________________________________

The Interpersonal Effectiveness Navigator  Take the journey

What has happened, what do I really want, and what do I do?

1. What Happened?

2. What are my goals and levels

Objective What results do I want? What changes do I want the person to make?

Relationship How do I want the other person to feel about me after the interaction?

Level 0 ______________ 10

3. What Factors could reduce my effectiveness?

Thoughts

Environment

Emotions

Indecision

Lack of

Skill

What Interpersonal Myths am I buying into?

4. Cheerleading statements? Say to yourself what you would say to someone in your situation that you love!

Level 0 ______________ 10

5. Timing Interpersonal Action

What factors do you need to be mindful of?

6. Taking effective action

What skills am I going to use?

What am I going to say? How am I going to say it? Be mindful of your DEER MAN GIVE FAST LEVELS

How will I notice and reinforce my growing mastery?

What is my plan for tolerating my distress should I not entirely get what I want?

Take a bowl!
INTERPERSONAL EFFECTIVENESS PRACTICE EXERCISE 2
How to Cope with Worry Thoughts

Positive statements we can say to ourselves to help us cope with worry thoughts.

Briefly describe the situation where you chose to practice the Cheerleading skills:

____________________________________________________________________________________

Which Cheerleading statement did you try (from Handout 3)?

____________________________________________________________________________________

What was the outcome of the situation?

____________________________________________________________________________________

Did using the sheet: Help you better keep your self-respect? Circle: YES/NO.
If YES, describe how it helped:__________________________________________________________

If NO, describe why you think it did not help:______________________________________________

Adapted from Marsha Linehan’s Skills Training Manual for Treating Borderline Personality Disorder. Guilford Press. 1993
Week 10 Interpersonal effectiveness week 4 practice cheerleading

Cheerleading Statement Practice Sheet

Sometimes our worry thoughts can get in the way of being interpersonally effective. We can challenge these worry thoughts, even though it may feel awkward to do so.

Write a cheerleading statement to challenge the following worry thoughts:

1. Why bother asking, it won't make a difference anyway.
   CHALLENGE:
   
2. If I ask for something, she'll think I'm stupid.
   CHALLENGE:
   
3. I'm such a bad person. I don't deserve this.
   CHALLENGE:
   
4. If I say no, they'll never talk to me again.
   CHALLENGE:
Practice for Interpersonal Effectiveness Week 4

1. Mindfulness

   WHAT:

   HOW:

2. Interpersonal Effectiveness Practice Exercise 2 – How to Cope with Worry Thoughts

3. Cheerleading Statement Practice Sheet

4. Interpersonal Navigator

What barriers might get in the way of you doing the practice?

What can I do to solve these barriers?
Appendix C

Letter of ethics approval
Dear Mr Dean Buckmaster,

Protocol: 2009/298
Dialectical Behavior Therapy Program Evaluation

I am pleased to advise you that your Human Ethics protocol received approval by the Deputy Chair of the HREC on 14 April 2010.

For your information:

1. Under the NHMRC/AVCC National Statement on Ethical Conduct in Human Research we are required to follow up research that we have approved. Once a year (or sooner for short projects) we shall request a brief report on any ethical issues which may have arisen during your research or whether it proceeded according to the plan outlined in the above protocol.

2. Please notify the committee of any changes to your protocol in the course of your research, and when you complete or cease working on the project.

3. Please notify the Committee immediately if any unforeseen events occur that might affect continued ethical acceptability of the research work.

4. The validity of the current approval is five years' maximum from the date shown approved. For longer projects you are required to seek renewed approval from the Committee.

All the best with your research,

Kim

Ms Kim Tiffen
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F: +61 2 6125 4807
Kim.Tiffen@anu.edu.au or human.ethics.officer@anu.edu.au

CRISCOS Provider Code: 00120C
Appendix D

Reasons for Living subscales