9-2020

SOAR (Stage 2 Outpatient Adolescent Recovery) Clinical Interview Manual

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in conjunction with the
Department of Psychology

SOAR (Stage 2 Outpatient Adolescent Recovery) Clinical Interview Manual

by

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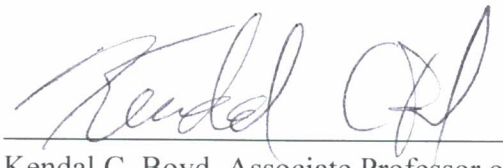
A Project submitted in partial satisfaction of
the requirements for the degree
Doctor of Psychology in Clinical Psychology

September 2020

Each person whose signature appears below certifies that this project in his/her opinion is adequate, in scope and quality, as a project for the degree Doctor of Psychology.



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ACKNOWLEDGEMENTS

I would like to acknowledge and thank Dr. Bryan Cafferky and Dr. Kendal Boyd for their help in completing and editing this project. I would also like to thank other members of SOAR Research Laboratory who provided feedback, support, and discussions of the literature reviewed for the completion of this project. Finally, I would not be able to complete this work without support from my family members, friends, professors, and colleagues.

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ABBREVIATIONS

SOAR	Stage 2 Outpatient Adolescent Recovery
RISE	Refine and Improve Skills and Emotions
DBT	Dialectical Behavior Therapy
DBT-A	Dialectical Behavior Therapy for Adolescents
RISE&SOAR	Clinical research group and laboratory
BPD	Borderline Personality Disorder

ABSTRACT OF THE DOCTORAL PROJECT

SOAR (Stage 2 Outpatient Adolescent Recovery) Clinical Interview Manual

by

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Doctor of Psychology, Graduate Program in Psychology
Loma Linda University, September 2020
Dr. Bryan Cafferky, Chairperson

The SOAR (Stage 2 Outpatient Adolescent Recovery) initial interview treatment manual was developed at Loma Linda Behavioral Health Institute (BHI) to assess adolescent participants enrolled in a Dialectical Behavioral Therapy for Adolescents (DBT-A) Program and appropriately place them in a treatment group that would meet their mental health needs effectively. The interview manual was developed to address concerns regarding readiness of individuals enrolled in a Stage 1 DBT-A program in progressing into Stage 2 of treatment. In this interview manual, a clinical intake interview and four assessment measures are used to inform group placement in either the Refine and Improve Skills and Emotions (RISE) group or the Stage 2 Outpatient Adolescent Recovery (SOAR) group, inform clinicians regarding participant treatment needs, and measure changes in emotional functioning

CHAPTER ONE

PURPOSE OF STUDY

One of the applications of Dialectical Behavior Therapy (DBT) Stage 2 is to treat problems related to prolonged and severe trauma (Eist, 2015). Upon review of related literature, there are no well evaluated criteria for Stage 2 DBT treatment. More specifically, there is little research on examining the readiness of participants, specifically adolescent participants, in progressing from Stage 1 to Stage 2 of treatment. There is also limited information that outlines a Stage 2 treatment manual, especially one that assesses emotional functioning before, during, and after Stage 2 treatment.

The purpose of this project is to outline an interview manual that will assess participants' preparedness for Stage 2 DBT and assess mastery of their Stage 1 DBT skills. The SOAR interview manual is designed to help clinicians determine if the participant will successfully engage in Stage 2 DBT treatment or if they need additional skills development to minimize life-interfering behaviors or improve coping skills to life-stressors before starting Stage 2 DBT. The interview manual is also designed to provide a baseline for future research to determine if the measures and variables that are used in the RISE&SOAR clinic are correlated with better treatment outcomes (e.g., reduced recidivism rates). This interview manual will include a combination of assessment measures and an intake interview to provide RISE&SOAR clinicians with the information necessary in placing participants in either group that will be most beneficial to them: RISE (Refine and Improve Skills and Emotions - a group that focuses on relearning and reintegration of Stage 1 DBT skills) or SOAR (Stage 2 Outpatient Adolescent Recovery - a group that focuses on Stage 2 trauma processing).

CHAPTER TWO

BACKGROUND AND SIGNIFICANCE

Dialectical Behavioral Therapy for Adolescents (DBT-A)

Dialectical Behavioral Therapy for adolescents and young adults is a clinical treatment program for high risk adolescents (Miller, Rathus, & Linehan, 2017). This program specializes in identifying and treating depression and risky behavior in adolescents, including self-injury, suicidal ideation, suicide attempts, substance abuse, bingeing and purging, risky sexual behavior, physical fighting, and other forms of risk-taking (Miller, & Smith, 2015). DBT-A has been adapted by Alec Miller and Jill Rathus from Marsha Linehan's initial conceptualization of DBT, which was developed for adults diagnosed with borderline personality disorder (Eist, 2015) . The RISE&SOAR clinic uses and follows DBT-A guidelines as outlined by Rathus and Miller.

DBT-A has been shown to be effective in treating self-harming adolescents who demonstrate traits of depression and borderline personality disorder that is atypical of adolescent development (Miller et al., 2017). Depression in adolescents is characterized by depressed or irritable mood, changes in appetite and sleep, withdrawal from and loss of interest in usual activities and friends, feelings of hopelessness and worthlessness, agitation, fatigue, difficulty concentrating, difficulty making decisions, and suicidal ideation (Essau & Chang, 2009). Some traits of borderline personality disorder that may be of concern to teens and parents include: unstable sense of self, unstable interpersonal relationships, inappropriate or uncontrollable anger or other emotions, mood swings, recurrent self-harm, and impulsivity that puts the adolescent at risk (Linehan, 1993). The

main goal of DBT-A is to “build a life worth living” (Miller et al., 2017). This means having things that are meaningful and important to an individual in his/her life. DBT-A is not a suicide prevention program or a way to stop people from engaging in behaviors that bother others (Courtney & Flament, 2015). DBT-A presents one way to overcome these feelings of suicidality.

To understand what DBT-A is, it is important to break down what each letter in the acronym means. The ‘D’ stands for dialectical, which means two things that can seem like opposites but can in fact both be true at the same time. In DBT, we often think of dialectics as a great big scale, tilting back and forth, where participants believe that everyone is doing the best they can, and they must try harder. The main dialectic in DBT is that we are always trying to balance acceptance (i.e., doing the best we can, how life is currently) with change (i.e., trying different things, being motivated and working harder) (Courtney & Flament, 2015; Mehlum et al., 2014). A DBT therapist is constantly trying to make sure they understand and accept where the participant is coming from while also pushing them to change when they can.

The ‘B’ in DBT stands for behavior. A behavior is anything that can reinforced or rewarded, and a reinforcer is anything that increases the likelihood that a behavior will occur again (Levis, 2017). DBT recognizes this and tries to harness the power of behavior change to move participants closer to their goals (i.e., a life worth living). In DBT-A, therapists work with participants to establish target behaviors and things they are working to increase, or often in the beginning decrease, to make their lives better (Webb, 2016). Common initial targets in DBT-A include: thinking of suicide or self-injury, restricting meals, using drugs or alcohol, engaging in risky sexual behavior, reckless driving,

physical aggression, and shoplifting (Fleischhaker et al., 2011).

The ‘T’ in DBT stands for therapy. DBT is different from other therapies in that DBT therapists have specialized training in DBT and follow many assumptions and guidelines in their work that differ from other therapy modalities (Miller et al., 2017). Therapists’ first goal in DBT-A is to make sure participants stay alive, which ties directly into the second goal, which is making sure participants stay in therapy until they can meet their goal of building a life worth living (Rathus & Miller, 2014). Sometimes these goals may seem unattainable, and it is the therapist’s job to understand how hard it is to change and to simultaneously push participants to keep moving forward. DBT-A therapists also believe that therapy with a participant is a real relationship between equals (Mehlum et al., 2014). That means that if a participant asks a therapist a question about their lives, they are likely to answer honestly instead of asking why they are interested. It also means that the work in therapy is carried out between both therapist and participant, where they are working together toward the participant’s goals.

Most DBT-A participants have difficulties in emotion regulation (Courtney & Flament, 2015). DBT-A might work best for adolescents who get more disappointed than most when things don’t go their way, cry at movies or commercials a lot, or for adolescents who sometimes they feel being born in the wrong family. A goal of DBT-A is to keep participants functioning normally in their lives (Fleischhaker et al., 2011). This means going to school, work, seeing their friends, so it does not take up most of their time like some other intensive treatment options might.

DBT-A has four modes of treatment (Courtney & Flament, 2015; Maffezzoni & Steinhausen, 2016). The first is structured individual therapy, where there is a focus on

behavior and dialectics; the balance of acceptance and change. Participants are also asked to track their emotions and behaviors in between sessions. For adolescents, family therapy is also included as part of the DBT-A program (Maffezzoni & Steinhausen, 2016). The second mode is the skills group; this is a weekly meeting usually about two hours long where participants learn a different behavioral skill each week to help manage emotions, tolerate distress, and have effective interpersonal relationships. This saves time in individual therapy to discuss things that are most central to the participant. For teens and young adults, family members usually attend a separate group to learn the skills as well (Maffezzoni & Steinhausen, 2016) . The third mode of treatment is skills coaching, where participants can discuss with their therapists how to get help using their coping skills and to avoid engaging in target behaviors (Courtney & Flament, 2015; Maffezzoni & Steinhausen, 2016). The therapist acts as a personal coach to help change how participants react to things during times when it is hardest to do so. The fourth mode is the consultation team. DBT-A therapists work on a team, where they support each other and give the best treatment possible. This is essential because changing behaviors that have been going on for a long time can be really stressful for both therapists and participants (Courtney & Flament, 2015; Maffezzoni & Steinhausen, 2016). These four modes of treatment usually take about 3 to 4 hours per week.

DBT vs DBT-A

While DBT-A utilizes most concepts from original DBT, DBT-A has fundamental differences in its approach to treatment. DBT-A usually has shorter intervention periods, ranging from 12-16 weeks compared to DBT, which typically lasts

up to one year (Hersen & Thomas, 2007). The shorter time period is more appropriate for adolescents' schedules, which allows for greater engagement and completion of therapy.

In DBT-A family members of participants are usually included during weekly skills training group sessions. They may either participate in a separate group session or join their children during their group sessions. This serves to educate family members who can then serve as coaches and to improve the dysfunctional home environment of the adolescent participant. Similarly, family members may also be included during individual sessions when discussing familial issues. This helps the participant improve familiar relationships.

DBT and DBT-A usually utilize handouts that show a wide range of skills taught during therapy. DBT-A, however, uses a reduced range of skills taught and a simplified language used in these handouts to maximize the skills they learn and maintain them during a shortened intervention period (Lavender et al. 2017).

Finally, DBT-A introduces the "Walking the Middle Path" skills module. This module is aimed at adolescents and their families, with emphasis on the problematic and stressful relationship between the adolescent and their family. The "Walking the Middle Path" skills module is further discussed below.

Stages 1 and 2 of DBT-A

There are four main stages to DBT-A (Lungu & Linehan, 2017). The first stage of treatment focuses on getting behavioral control, the second stage focuses on emotional experiencing, the third stage is for solving problems of everyday living, and the fourth stage focuses on achieving transcendence and a capacity for joy. Table 1 provides an

overview of these stages as well as tasks and modes of treatment used at each stage.

Table 1. DBT Stages, Tasks, and Modes of Treatment

Stage and aims	Tasks	Mode of Treatment
Stage 1: Achieve stable behavior	Reduce immediate risk of life-threatening behaviors	Skills group
	Reduce therapy interfering behaviors	Individual therapy
	Reduce behaviors that interfere with quality of life	Skills coaching
	Increase interpersonal skills	Consultation team
Stage 2: Emotional processing of trauma	Reduce PTSD-like symptoms	Group therapy
	Employ skills learned in Stage 1	Individual therapy
Stage 3: Maintain regular levels of emotion and teach problem solving	Increase self-respect and self-validation	Individual therapy
	Continue working towards a life worth living	Employment services
Stage 4: Enhance capacity for joy	Resolve existential issues of life	Individual therapy
		Voluntary organization therapy

For the purposes of this project, Stage 3 and 4 will not be discussed because these stages involve a higher level of skills that most adolescent participants do not attain in a

clinical setting (Day, 2004). Stage 1 and Stage 2 of treatment will be discussed further as it is the main research interest in the RISE&SOAR clinic.

Stage 1 DBT-A

Stage 1 DBT-A primarily targets learning skills to manage intense emotions and the maladaptive behaviors that manage those emotions (Linehan, 1991). Participants who enter Stage 1 treatment are struggling with life interfering behaviors, such as non-suicidal self-injurious behaviors, and excessive drug use, and treatment interfering behaviors, such as being expelled from school, and physical aggression towards others. (Fleischhaker et al., 2011). Stage 1 DBT-A often focuses on gaining control of these behaviors because progress to the next stages cannot be made until the participant has the skills to manage behaviors and emotions without engaging in dangerous behaviors. There are five modules that are taught, which are split into two separate sides: change and acceptance (Fleischhaker et al., 2011; Miller et al., 2017). On the change side, there are two modules: emotion regulation and interpersonal effectiveness. On the acceptance side are three modules: mindfulness, distress tolerance, and walking the middle path.

Mindfulness

Mindfulness teaches participants to pay attention to the present moment, without any judgment so they can see reality as it is and respond in a more effective way. Mindfulness teaches participants how to regulate their emotions. It is used to learn how to take control of thoughts and feelings, which can guide participants where they want these feelings to go (Rathus & Miller, 2014). The goal of mindfulness is to calm the mind and

regulate full body responses, such as heart rate, sweating, and shaking, that might be associated with intense emotions. DBT uses three states of mind: the reasonable mind, the wise mind, and emotional mind (Miller et al., 2017) . Reasonable mind is rational, task focused, attends only to the facts, and ignores any emotion. It is associated with our ability to follow instructions and solve logical problems. The emotional mind is mood dependent and emotion focused. It does not allow us to see things clearly because our feelings overrule everything else. Emotional mind can be exaggerated by a lack of sleep, drugs, alcohol, hunger, bloating, stress, threats from environmental. Wise mind is the mix of the reasonable mind and the emotional mind. It is the balancing of the feelings and the facts where we can make wise choices. It is the wisdom within each person, seeing the value of both emotion and reason.

DBT encourages participants to use the wise mind in dealing with distressing situations (Rathus & Miller, 2014). DBT teaches the “What” skills of mindfulness: these are “what” participants do when practicing mindfulness, which are observe, describe, and participate. “Observe” is when we notice or attend to a sensory experience inside ourselves (feelings, urges) and outside ourselves (sights, temperature, smells, sounds). It is noticing these experiences without describing them. The “describe” skill is when we put into words what we observe. When a thought or feeling arises, it is when we acknowledge it (e.g., “I can’t do this”, “I feel sad”). The final “What” skill is “Participate”; this is where the participant engages completely into the activity of the current moment and becomes one with whatever they are doing. “Participating” means being present and alive in all aspects of an activity.

DBT also includes the “How” skills of mindfulness; meaning “how” we observe,

describe, and participate in our surroundings. The first “How” skill is acting non-judgmentally; letting go of the good and the bad and viewing and describing reality for what it is. It simply means trying to describe the facts. The second “How” skill is one mindfully; it teaches participants on how to be present in a moment, doing one thing at a time, and focusing full awareness and attention upon it that can lead to completing tasks more efficiently. It means being able to appreciate the present, relationships, so they are less likely to be wrapped up in negative thoughts about the past and negative thinking about the future. The third “How” skill is acting effectively; being effective means an individual doing what works for them to achieve their goals.

DBT-A asks participants to conceptualize goals by using the SMART (specific, measurable, attainable, realistic, timely) technique to work effectively on them (Miller et al., 2017). This helps in having their emotions not get in the way of completing goals. Participants are encouraged to focus on their most important goal at a time.

Interpersonal Effectiveness

This DBT-A module is about learning how to improve communication in the participant’s relationships, how to be assertive, and how to deal with conflict situations so they are able to get what they need and say no to people in a way that maintains their self-respect and other people's’ respect for them (Lenz et al., 2016). Simply, this module teaches basic social skills so that interactions with others are less problematic. Participants getting DBT-A treatment usually have reduced interpersonal effectiveness because they lack the skills, have negative ruminations, display exaggerated emotions, and indecisive. The goal for this module is to make participants effectively attend to their

relationships (and not the problem), balance their priorities, and have self-respect (maintaining firm and healthy boundaries). The skills taught during this module include: DEARMAN (describe, express, assert, reinforce, stay mindful, appear confident, negotiate) which provide guidelines for getting what a participant wants from a relationship, GIVE (be Gentle, act Interested, Validate, Easy Manner) which provide guidelines for keeping relationships with others, and FAST (be Fair, no Apologies, Stick to values, be Truthful), which provide guidelines for keeping self-respect.

Emotional Regulation

Emotional regulation teaches participants to gain better control of their emotions. These skills help participants when an emotional crisis is apparent and teaches them how to manage their emotions before they gets worse (Miller et al., 2017; Rathus & Miller, 2014). Participants are taught the functions of emotions and the consequences of different emotions in communicating and influencing others. Emotion regulation teaches three main skills: ABC (accumulate positive experience, build mastery, cope ahead of time), PLEASE (physical, illness, eat balanced meals, avoid mood altering drugs, sleep balance, exercise), and VITALS (validate self, imagine, take small steps, applaud yourself, lighten your load, sweeten the pot). The goals of these three skills are to help the participant understand their emotional experiences (e.g., understanding and labeling emotions), reduce their emotional vulnerability (e.g., checking facts, reduce sensitivity through opposite action, changing situations that cause painful emotions) and decrease their emotional suffering (e.g., learning about biological factors of emotions, awareness of mood reactivity).

Distress Tolerance

Distress tolerance teaches participants how to cope with distress and crises that cause overwhelming emotions without making them worse. They are also known as crisis survival skills (Linehan, 1993). These skills are used to help participants tolerate short-term or long-term pain and help them build emotional resilience so that participants can cope with normality. Simply, the aim is to learn to tolerate pain and suffering by accepting the reality of a situation as it is, rather than how they want it to be.

Distress tolerance makes use of four main distraction techniques, which are aimed at diverting attention away from distressing thoughts when a problem cannot be solved or when distress is inevitable. Using the IMPROVE (imagery, meaning, meditation, relaxation, one thing at a time, vacation, encouragement) technique, participants are taught to bring their attention back to the present moment if their mind resorts back to negative self-evaluations. The Wise Mind ACCEPTS (activities, contributing to others, comparisons, emotions, pushing away, thoughts, sensations) technique helps participants deal with situational distress. Self-soothing is a strategy that uses our five senses to help with thought distractions and builds upon a participant's mindfulness skills. Finally, Pros and Cons skill encourages participants to weigh the options and consequences of potential behaviors to tolerate with distress.

Walking the Middle Path

The Walking the Middle Path module was added specifically for DBT-A for families and teens. It focuses on learning that there is more than one way to see a situation or solve a problem by balancing acceptance and change (Fleischhaker, Sixt, &

Schulz, 2010). Participants are taught to recognize these problems and their goal is to work on changing painful or difficult thoughts, feelings, or circumstances, while also accepting themselves, others, and the situations they are currently in. The main skill taught in this module is verbal and nonverbal validation, which include active listening, being mindful, observing, reflecting, showing tolerance, and responding appropriately. They are taught to communicate to another person, mainly family members, that their feelings, thoughts, and actions make sense and are acceptable in a situation. It is emphasized that validation does not mean agreeing or liking what the other person is saying/feeling; rather it means that they understand the other person's perspective. The Walking the Middle Path module instills open-mindedness and facilitates fairness and respect between participants and their interpersonal relationships. The five modules of DBT-A are summarized in Table 2 below.

Table 2. DBT-A Modules, Aims, and Core Skills

DBT-A Skill	Definition	Aims	Core Skills
Mindfulness	Living with awareness in the present moment	Increase control of mind	States of mind: wise mind, reasonable mind, emotion mind
		Experience reality as it is	"what" and "how" skills
Interpersonal Effectiveness	Thinking and acting dialectically	Build skills in getting what you need from others	Objectives effectiveness (DEARMAN)
		Build positive relationships	Relationship effectiveness (GIVE)
			Self-respect effectiveness (FAST)
Emotion Regulation	Managing negative and overwhelming emotions	Recognize primary and secondary emotions	Checking facts, using opposite action (VITALS)
		Decrease unwanted emotions	Reducing vulnerability to emotion short and long-term (ABC, PLEASE)
		Reduce emotional vulnerability	
Distress Tolerance	Tolerate crises without engaging in problem behaviors	Survive crises	Tolerating painful events and urges (IMPROVE)
		Avoid acting on unhealthy desires and urges during intense emotional moments	Pros and cons
			Distraction (wise mind ACCEPTS)
Walking the Middle Path	Balancing acceptance and change	Build respect between participant and their relationships	Verbal/nonverbal validation; Active listening and reflecting

Stage 2 DBT-A

Once a participant has control over self-harm behaviors, he/she can decide to enter Stage 2 DBT. The main target of Stage 2 DBT is to increase the capacity for nontraumatic emotional experiencing, and to address the ways in which post-traumatic symptoms are interfering with quality of life goals such as social and vocational functioning (Brodsky & Stanley, 2013; Fleischhaker et al., 2010). For Stage 2 DBT, participants focus on their emotional experiences. This is the stage where past trauma is explored, and maladaptive thoughts, beliefs, and behaviors are identified. The primary goal of Stage 2 DBT is to reduce traumatic stress through exposure and emotional processing (Brodsky & Stanley, 2013; Fleischhaker et al., 2010). This is achieved by remembering and accepting facts of earlier traumatic events, reducing stigmatization and self-blame, reducing intrusive responses and resolving dialectical tensions regarding who to blame for the trauma.

Stage 2 DBT-A targets are explored only when a participant's self-harm behaviors are under control. This is because the participant should not be forced to process past trauma until they have knowledge of adaptive coping strategies, which they learn in Stage 1. Ideally, participants in Stage 2 must have the knowledge to manage to their self-harm behaviors, even if their emotional health remains challenging (Linehan, 1993). The treatment goals are to replace symptoms with non-traumatic emotional experiencing. This is achieved through eliminating distortions that are related to a participant's trauma, such as self-blaming and denying facts. The participant's tendency toward self-invalidation and self-stigmatization is also challenged by their therapist.

Ultimately, the therapist's goal is to make the participant experience emotions

appropriate, in a way that will not trigger any trauma (Rathus & Miller, 2014) . In addition to trauma, Stage 2 DBT-A is used to treat any residual mental disorders with moderate severities that were not treated in Stage 1 (e.g., anxiety, eating, and mood disorders). During Stage 2, participants process emotions with dysfunctional intensity associated with shame, guilt, sensitivity to criticism, anger, envy, jealousy, grieving, excessive sadness, and fear (Swenson, 2016).

Considerations for Stage 2 DBT-A

Despite the criteria outlined to progress from Stage 1 to Stage 2 treatment of DBT, there is a lack of research and literature that examine Stage 2 DBT treatment and outcomes. Most of the literature currently available focuses on Stage 1 and acquisition of DBT skills and the treatment outcomes from Stage 1. In addition, there is no manualized Stage 2 DBT treatment, meaning there are no standardized methods in place to assess Stage 2 readiness, progress, or completion. Currently, the work done by Melanie Harned, who developed a manualized prolonged exposure (PE) DBT intervention, is what most clinicians use when incorporating DBT stage 2 treatment in their programs (Harned, 2013).

DBT PE intervention is based on prolonged exposure therapy and was adapted to fit the needs of participants undergoing DBT treatment (Harned et al. 2016). The DBT PE protocol was designed to help participants recover from trauma and build a life worth living. Because PTSD symptoms and the inability to experience emotion can be an obstacle to reducing self-harm behaviors, the PE intervention was introduced not as part of Stage 2, but as an adjunct to Stage 1, where life-threatening behaviors are still the

primary target. Preliminary results indicate that even participants who are still in Stage 1 DBT can tolerate emotional exposure to PTSD if they have acquired emotional regulation skills (Harned et al., 2016).

CHAPTER THREE

METHODS

Introduction

The SOAR Clinical Interview Manual was developed in response to the results of a pilot study and follow up qualitative study that were conducted by the RISE&SOAR clinic in 2015. Findings from the pilot study suggested a need for improving program development to address the high rates of recidivism from the Stage 2 DBT-A program. Results of the follow up qualitative interviews from adolescent participants and their parents also indicated a need for restructuring the intervention. The RISE&SOAR research team utilized information from both studies for program development and it was determined that a semi-structured clinical interview would be essential to improving the effectiveness of the intervention.

The original goal of the clinic's pilot study was to measure treatment outcomes based on a group intervention focused on providing Stage 2 DBT-A trauma processing to maintain the effects of Stage 1 DBT-A interventions. The participants in the pilot study were enrolled in a 16-20 week DBT-A Stage 2 program that was directed at maintaining skills use and application. Participants were administered questionnaires, including the BASC-2, DSHI, and the Functional Assessment of Self-Mutilation (FASM) at pre-treatment and post-treatment. Throughout treatment, participants were also filled out weekly diary cards to track skills use and progress. Results of the pilot study indicated a high rate of recidivism of self-harming behaviors and emotional dysregulation during participation in RISE&SOAR's Stage 2 program, such that reductions in these behaviors

were not maintained even though participants had previously completed a Stage 1 DBT-A program (Herman, 2015).

A follow up qualitative study to further investigate the results of the pilot study, which interviewed participants and their parents, indicated that part of the negative outcomes was due to lack of assessment that measured participants' readiness for Stage 2 DBT-A treatment (Alido, 2016). The qualitative study also indicated that the participants did not have a good grasp of Stage 1 DBT-A skills, which they should have learned in their previous programs. Many of the participants felt they did not have the right skills to help them process trauma, which Stage 2 DBT-A focuses on (Alido, 2016).

The clinic sought to address these shortcomings from the pilot study by restructuring the format of the intervention. First, the clinic determined that a skills group that re-teaches Stage 1 DBT-A skills, or RISE (Refine and Improve Skill Effectiveness), was needed to ensure mastery before advancing to Stage 2. The goal of the RISE group is to provide Stage 1 treatment for participants who exhibit self-harming behaviors within the past month in addition to endorsing clinically elevated levels of emotional dysregulation, impulsivity, or low interpersonal skills. RISE focuses on mastery of the five main DBT-A Stage 1 skills and providing individual therapy for these participants as additional support. RISE also gives parents of our participants a chance to form supervised therapy support groups.

Second, the clinic determined that a Stage 2 DBT-A group, or SOAR (Stage 2 Outpatient Adolescent Recovery), should remain the focus of the clinic. The goal of SOAR is to provide a manualized treatment to improve quality and treatment outcomes for Stage 2 DBT-A and to focus treatment on emotional exposure and experiencing,

provided that participants indicated their readiness for Stage 2 treatment. The re-designed SOAR group is a wrap-around program with group therapy as the main intervention for participants who have learned Stage 1 skills and are ready to process their trauma, according to the qualifications that were described previously (see Stage 2 DBT section). The clinician's guide will further explain how these criteria will be assessed by the therapists in SOAR. In general, these participants exhibit some (but not clinically elevated levels) emotional dysregulation, but do not endorse non-suicidal self-harming ideation or incidents. In addition, SOAR also provides individual therapy and family support groups, as well as post-treatment family sessions to participants that serve as follow-up and progress check-ins.

After determining the best way to meet the needs of the participants and maintain treatment effects, the challenge for the clinic then became a matter of how to assess participant readiness for a Stage 2 DBT-A program and distinguish between those who needed further supportive Stage 1 DBT-A treatment. After reviewing the literature for Stage 2 DBT-A and reviewing the results of our pilot study and follow-up qualitative study, we determined that using more robust measures that help determine readiness and fit of participants for the appropriate stage of DBT (Stage 1 or Stage 2) would be a good start. This means that we had to incorporate measures that directly assess the unique problems of adolescents presenting with BPD symptoms in a DBT program, including evaluating adolescents' capacity of control over engaging in self-harming behaviors and quality of life interfering behaviors.

This was how the idea of an interview manual was conceived; by incorporating a clinical interview, self-report measures, and a DBT-A skills review, we hope to assess

participants' treatment needs based on a set of criteria to evaluate whether it would be more beneficial for them to continue receiving Stage 1 DBT-A or receive Stage 2 DBT-A. The clinical interview is important in obtaining historical information and qualitative information about participant readiness for Stage 2. The self-report measures help to confirm and provide information about self-harming that might not be endorsed in the interview as well as some more robust measures of emotional dysregulation. Finally, a DBT-A skills review is needed because it addresses our concern regarding skill proficiency; this was an important reason why we think the pilot study was not effective. Using these three components in an interview manual, the clinic hopes to appropriately place participants in one of two treatment groups, RISE (Stage 1 DBT-A) or SOAR (Stage 2 DBT-A), which will target different treatment needs.

Essentially, the goal of the SOAR interview manual is to protect and prepare adolescents who are not ready to process trauma, and to make sure that adolescents who are ready to process their trauma are able to do so in a supported environment tailored to meet that need. Thus, a robust assessment of a participant's readiness is necessary for the success of both RISE and SOAR.

Participants

Participants subject to the SOAR clinical interview will be recruited from other DBT-based programs such as the SHIELD program at the Behavioral Medicine Center in Redlands, CA. Participants and their families from the community who have experience in DBT will have an open invitation to participate in the clinic. All graduates of SHIELD are invited and encouraged to interview for RISE&SOAR and will be approached by

RISE&SOAR facilitators before the graduation date from SHIELD. They will be given an intake questionnaire and assessment measures to complete and bring to the first intake session. Family members are also contacted by RISE&SOAR facilitators and encouraged to meet staff and learn about the program. All interested individuals and families will be invited to participate in the two-session interview process to determine eligibility to participate in either RISE or SOAR.

Adolescents referred to the RISE&SOAR program typically have many traits that are associated with depression and borderline personality disorder. This includes a pattern of instability in mood, impulse control and interpersonal relationships, which can lead to difficulties in fulfilling their obligations in school and at home. Repetitive non-suicidal self-harming and suicidal behaviors are common in our participants, which is why a robust assessment of readiness is pivotal for treatment success. Addressing and processing trauma with this population before mastery of effective skills is achieved can lead to increased symptoms of emotional dysregulation as well as increased suicidal ideation, self-harming behaviors, and suicide attempts (Fleischhaker et al., 2010). It is essential to the effectiveness of this intervention as well as the successful recovery of the participants that readiness for processing of trauma be accurately assessed and group membership properly assigned through the SOAR Clinical Interview Manual.

Measures

Assessment materials for the SOAR clinical interview were chosen based on measures that directly target the unique problems presented by adolescents in a DBT program. In theory, these adolescents typically present with acute symptoms of

borderline personality disorder, such as recurrent self-harm, impulsive behaviors, and inappropriate anger. The use of well-established measures with good reliability and validity that are widely used in clinical and research settings is important for outcomes research. Self-report measures, which have been widely used in population-based studies of BPD and as screening measures in clinical settings, are the best tools in evaluating social emotional functioning and symptomatology (Lenz et al., 2016). The clinic determined that the Deliberate Self-Harm Inventory (DSHI), Behavior Assessment System for Children - 3rd Edition (BASC-3; Parent Rating Form and Self-Report Form), Childhood and Adolescent Trauma Screen (CATS), and the DBT Ways of Coping Checklist (DBT-WCCL) were the best and most appropriate instruments to investigate these traits and include in the SOAR interview manual because they show measurable results that allow us to define clear rules for group placement and track treatment outcomes.

Deliberate Self-Harm Inventory (DSHI)

The DSHI is a behaviorally based, 17-item, self-report questionnaire based on the conceptual definition of deliberate self-harm as the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent, but resulting in injury severe enough for tissue damage to occur (Gratz, 2001).

The DSHI assesses various aspects of deliberate self-harm, including frequency, severity, duration, and type of self-harming behavior. The specific acts of deliberate self-harm listed in the questionnaire were based on clinical observation, individual testimonies of individuals who engage in self-harming behaviors that are commonly

reported in literature, such as cutting, burning with cigarette, burning with lighter/match, carving words into skin, carving pictures into skin, severe scratching, biting, rubbing sandpaper on skin, dripping acid on skin, using bleach or oven cleaner to scrub skin, rubbing glass into skin, breaking bones, banging head, punching self, and interference with wound healing (Gratz 2001).

The DSHI has a high internal consistency (α = .82) and high test-retest reliability (r = .92, p < .001), which means that the number of self-harming behaviors endorsed by participants on the first and second administration were highly correlated. The DSHI also has high correlations with other measures that examine BPD symptoms, such as the Borderline Personality Organization Scale. Therefore, individuals who score highly on this questionnaire have symptoms consistent with self-harming in BPD participants.

The DSHI enables RISE&SOAR clinicians to measure behaviors and ensure that participants report behaviors related to self-harming that are commonly reported by BPD participants. In addition, it provides an assessment of the frequency of self-harming behavior, as opposed to the presence or absence of behavior, making these behaviors easier to monitor and track over time. Inclusion of this measure was vital to the SOAR Clinical Interview Manual because it provides one of the most important benchmarks for evaluating adolescent readiness for the Stage 2 DBT-A group. Recent self-harming behavior is an indicator of poor skill use and application as well as a lack of readiness to process trauma. Participants who indicate multiple and frequent self-harming behaviors on the DSHI would not be eligible for SOAR but would meet criteria for RISE where they could refine their use of DBT skills.

Behavioral Assessment System for Children - Third Edition (BASC-3)

The BASC-3 is a comprehensive set of rating scales and forms that is designed to determine the behavioral and emotional strengths and weaknesses in children and adolescents between ages 2-21. It uses a multidimensional approach for conducting assessment, so clinicians can better understand a child's emotions and behavior from a variety of perspectives (Matazow & Kamphaus, 2001). Items on the BASC-3 are rated on a 1-point Likert scale (1=never, 2=sometimes, 3=often, 4=almost always). Responses are then summed within each scale to yield total scores. The BASC-3 is scored using T-scores and percentiles. A T-score indicates the distance of a raw score from the norm-group mean and a percentile indicates the percentage of the norm sample scoring below a given raw score. On the BASC-3, a T-score of 60-70 on a clinical and content scale is indicative of at-risk concerns while a T-score of 70 and above is indicative of possible clinical concerns.

The BASC-3 includes the Teacher Rating Scales (TRS), Parent Rating Scales (PRS), Self-Report of Personality (SRP) and was designed for use in school and clinical settings. Used individually, the components give a view of behavior in a specific context/setting. Used together, they provide a comprehensive view of a participant's behavioral and emotional functioning that helps inform clinical diagnosis. The RISE&SOAR clinic will be using the PRS and SRP adolescent (12 through 21) forms. These components will be administered using a paper form, which will be scored using corresponding hand-scoring worksheets and the BASC-3 manual. The hand-scoring worksheets include a graph that is used to plot scale T-scores.

The BASC-3 is a reliable measure; it has $\alpha = .85$ for the SRP-adolescent clinical

& adaptive scales and α = .83 for the content scales. It has α = .89 for the PRS-adolescent clinical & adaptive scales and α = .90 for the content scales. The PRS-adolescent has a test-retest reliability of α = .88 for both clinical/adaptive and content scales and the SRP-adolescent has test-retest reliability of α = .83 for clinical/adaptive scale and α = .76 for content scales.

It is important to remember, however, that the BASC is not a diagnostic tool; it is only meant to highlight and assess a participant's behavioral/emotional functioning and inform the clinicians of clinical areas that are concerning (Zhou, Reynolds, Zhu, Kamphaus, & Zhang, 2017). The BASC-3 is beneficial for use in the RISE&SOAR clinic because it uses a multidimensional and multi-method approach for conducting a comprehensive assessment, which examine different components of a participant's functioning coming from a self-perspective (Self-Report Form) or a parent perspective (Parent Rating Scales), Across these components, of particular interest to the RISE&SOAR clinicians are the clinical/adaptive scales and content scales.

Among the clinical scales, the clinicians will examine a participant's self-report scores on hyperactivity and somatization scales and the parent's scores on anxiety and depression scales as these scales are related to identifying trajectories of borderline personality disorder features in adolescents (Haltigan & Vaillancourt, 2016). More specifically, the Anxiety scale looks at a participant's tendency to be nervous, fearful, or worried. The Depression scale examines feelings of unhappiness that may result in inability to carry out everyday activities. The Hyperactivity scale examines a participant's tendency to overly active, rush through work or activities and act without thinking. The Somatization scale examines a participant's tendency to be overly sensitive to and

complain about relatively minor physical problems.

Among the content scales, the RISE&SOAR clinicians will examine a participant's scores on the anger control scale (tendency to become irritated and angry quickly and regulate affect) and negative emotionality scale (tendency to react in an overly negative way to any changes in everyday routines. These specific clinical and content scales are related to borderline personality features in early adolescence and inform therapists on the potential prodromal course of later BPD (Haltigan & Vaillancourt, 2016).

The information provided by these subscales, both through parent and adolescent report, is another essential component of the SOAR Clinical Interview Manual for determining participant readiness for the Stage 2 DBT-A program. BASC-3 profiles based on these subscales will be used to distinguish whether participants are eligible for RISE or SOAR. The participant's profile will also be clinically useful to aid in the design of treatment plans, monitor progress, and highlight emotional and behavioral strengths as well as problem behaviors.

Dialectical Behavioral Therapy Ways of Coping Checklist (DBT-WCCL)

The DBT-WCCL is a self-report measure consisting of 59 items that investigate the frequency of skills used to manage difficult situations over the past month. It measures how participants cope by using skills learned in DBT while also showing whether participants continue to use ineffective methods of managing emotions in stressful situations (Wilks et al. 2016).

The measure is divided into the DBT Skills Subscale (DSS) and Dysfunctional

Coping Subscale (DCS) (Neacsiu et al., 2010). Examples of DSS items included focusing on the good aspects of life rather than focusing attention on negative thoughts or feelings, responding in a way that still resulted in respecting oneself afterward, accepting those things that are next-best to one's original desires, and accepting strong feelings but not allowing them to interfere. Examples of DCS items includes improving feelings by eating, drinking, smoking, or talking, refusing to believe the event happened, avoiding the problem, avoided people, figuring out who to blame, and keeping feelings to oneself. Responses on the DBT-WCCL are rated on a 4-point Likert scale, from 0 (never used) to 3 (regularly used). The measure has shown good reliability (DSS $\alpha = 0.93$ and DCS $\alpha = 0.87$) and validity, in addition to being able to discriminate between treatment programs that provide DBT skills versus those who do not (Neacsiu, Rizvi, & Linehan, 2010). The DBT-WCCL is scored by averaging across all items in the scale. In addition, this measure has been shown to be an effective measure of DBT skills for DBT participants, showing an increase in scores for participants in the DBT program and maintaining these scores during follow up treatment (Stein et al., 2016). The mean score for suicidal BPD participants who have been enrolled in a DBT program was 1.33 (SD = .46) for the DSS and 2.07 (SD = 0.34) for the DCS.

The DBT-WCCL is included in the SOAR Clinical Interview Manual to establish whether participants meet the eligibility criteria of mastery of DBT skills. DBT skills help individuals regulate their emotions and behaviors, which is essential for processing trauma. Participants who demonstrate mastery of DBT skills as indicated by the DBT-WCCL will be eligible for SOAR.

Child and Adolescent Trauma Screen (CATS)

The Child and Adolescent Trauma Screen (CATS) is a questionnaire based on the DSM-5 criteria for PTSD that assesses for trauma specific symptoms that may or may not be reported during intake. It has two components that are relevant to our target sample: self-report (7-17 years old), caregiver report (7-17 years old). The CATS uses a checklist of 15 potentially traumatic events. Participants are asked on the first part of the questionnaire whether they have experienced at least one potential traumatic event. Participants who endorse at least one potential traumatic event will then rate the stress symptoms associated with that event on a 4-point Likert-type system that indicates frequency and severity of each traumatic symptom/event.

Scores are calculated by adding the total number of items together. For children ages three to six years old, scores that are less than 11 indicate no clinical elevation, scores between 12 to 15 indicate moderate trauma-related distress, and scores greater than 15 indicate probable PTSD. For children ages seven to 17-years-old, scores that are less than 15 indicate no clinical elevation, scores between 15 to 20 indicate moderate trauma-related distress, and scores greater than 21 indicate probable PTSD (Sachser et. al, 2017).

The CATS shows good psychometric properties and has proven good to excellent internal consistency of the symptom scales with α ranging between 0.88 – 0.94 for the different language versions (Sachser et. Al, 2017). For the United States version, the Cronbach alpha coefficient is 0.92 for the child (ages 3 to 6) self-report, a 0.92 for the child/adolescent (ages 7 to seventeen) self-report, and 0.94 for the caregiver reports. Convergent validity between Child and Adolescent Trauma Screening and the Participant

Health Questionnaire (PHQ-9), a highly regarded assessment for depression, lends a Cronbach's alpha of 0.9 (Sacher et. Al, 2017).

The SOAR lab will not be using CATS as a diagnostic tool for trauma nor for distinguishing readiness for Stage 2, but rather to provide information on each participant's trauma profile, inform future clinical treatment, and evaluate effectiveness of the SOAR group in terms of reducing trauma symptomatology.

Table 3 summarizes the four self-report measures included in the SOAR clinical interview manual, including description, reliability values, and reason for inclusion in the SOAR interview manual.

Table 3. Rationale for Measure Inclusion in the SOAR Clinical Interview Manual

Measure	Description	Reliability	Rationale
DSHI (self-report)	Assesses self-harming behaviors	Internal consistency (α = .82) and test-retest reliability (r = .92, $p < .001$)	Criterion for determining group placement based on self-harming behaviors
BASC-3 (self-report and parent report	Assesses behavioral/emotional functioning	Self-report: α = .85 for clinical & adaptive scales and α = .83 for the content scales. Test-retest reliability of α = .83 for clinical/adaptive scale and α = .76 for content scales. Parent report: α = .89 for clinical & adaptive scales and α = .90 for the content scales. Test-retest reliability of α = .88	Criterion for determining group placement based on impulsivity, emotional reactivity, and risky behaviors.
DBT-WCCL (self-report)	Investigate frequency of skills used to manage difficult situations	DBT Skills Subscale (DSS) α = 0.93 Dysfunctional Coping Subscale (DCS) α = 0.87	Criterion for determining group placement based on DBT skill mastery
CATS (self-report and parent report)	Assesses trauma-specific symptoms	α = 0.92 for self-report α = 0.94 for parent report	Provide information on participants' trauma profile only. Not used as a criterion for group placement

SOAR DBT-A skills review

While the questionnaires of the SOAR interview manual provide a good assessment of a participant's social emotional functioning, symptoms, and DBT skills use, it does not truly give the clinic information on a participant's specific knowledge of Stage 1 DBT skills that he/she should have learned in their previous DBT program. DBT programs teach concrete and specific skills that they encourage their participants to practice in everyday life. The goal is for these skills to become a part of a participant's natural repertoire once learned and practiced regularly.

Proficiency of these skills is important to the RISE&SOAR clinic because a participant is not recommended to progress to Stage 2 DBT treatment if they do not have the appropriate coping strategies to help them overcome self-harming behaviors (Read, 2015). In addition, each DBT module builds upon the other, so it is important for participants to be able to name explicitly the modules and the skills within each module (Levis, 2017). While the DBT-WCCL evaluates DBT skills use, the test-items are situation specific, meaning the questionnaire does not require the participant to explicitly name any DBT skills.

In order to evaluate proficiency with DBT-A skills, the intake clinician will ask a series of short review questions which assess a participant's ability to explicitly name the DBT-A modules (distress tolerance, interpersonal effectiveness, emotion regulation, mindfulness, and walking the middle path) and skills within each module. The questions are specific, requiring both yes/no answers and elaborative answers from the participant for each skill module they should have learned in their Stage 1 DBT treatment. The clinician will ask follow-up questions which assess familiarity, understanding, and

usefulness of the skill to that participant. The clinician will note the participant's identification and proficiency of skills within each DBT-A module. Table 4 shows the DBT-A skills commonly associated with each module as well as the general interview questions that the clinician can ask the participant. The DBT-A Skills Review Form that will be used by the clinician, which includes the complete checklist of core skills from each module, can be found in Appendix C.

Table 4. SOAR DBT-A Skills Review Summary

DBT-A Module	DBT-A skills list	Interview Question Examples
Mindfulness	Observe, Describe, and Participate ("What skills")	"Are you familiar with the mindfulness module of DBT?" (assess familiarity)
	Non-judgmentally, one-mindfully, and effectively ("How skills")	"Tell me a mindfulness skill and when you would use it" (assess understanding)
		"When was the last time you used that skill? Was it useful?" (assess usefulness)
Distress Tolerance	Temperature, Intense Exercise, Paced Breathing, Paired Muscle Relaxation (TIPP)	"Are you familiar with the distress tolerance module of DBT?"
	Activities, Contributing, Comparisons, Emotions, Push Away, Thoughts, and Sensation (ACCEPTS)	"Tell me a distress tolerance skill and when you would use it"
		"When was the last time you used that skill? Was it useful?"
	Imagery, Meaning, Prayer, Relaxation, One Thing in the Moment, Vacation, and Encouragement (IMPROVE)	

Table 4. (continued).

	Pros and Cons List	
	Self-Soothe	
	Radical Acceptance	
Emotional Regulation	ABC PLEASE	"Are you familiar with the emotion regulation module of DBT?"
	Opposite Action	"Tell me an emotion regulation skill and when you would use it"
		"When was the last time you used that skill? Was it useful?"
Interpersonal Effectiveness	Think, Have Empathy, Interpretations, Notice, Kindness (THINK)	"Are you familiar with the interpersonal effectiveness module of DBT?"
	Fair, Apologies, Stick to your Values, Truthful (FAST)	"Tell me an interpersonal effectiveness skill and when you would use it"
	Gentle, Interested, Validate, Easy Manner (GIVE)	"When was the last time you used that skill? Was it useful?"
	Describe, Express, Assert, Reinforce, Mindful, Appear Confident, Negotiate (DEARMAN)	
Walking the Middle Path	Self-Validation	"Are you familiar with the walking the middle path module of DBT?"
	Increasing Positive Behaviors	"Tell me a walking the middle path skill and when you would use it"

Table 4. (continued)

		"When was the last time you used that skill? Was it useful?"
	Opposite Action	"Tell me an emotion regulation skill and when you would use it"
		"When was the last time you used that skill? Was it useful?"
Interpersonal Effectiveness	Think, Have Empathy, Interpretations, Notice, Kindness (THINK)	"Are you familiar with the interpersonal effectiveness module of DBT?"
	Fair, Apologies, Stick to your Values, Truthful (FAST)	"Tell me an interpersonal effectiveness skill and when you would use it"
	Gentle, Interested, Validate, Easy Manner (GIVE)	"When was the last time you used that skill? Was it useful?"
	Describe, Express, Assert, Reinforce, Mindful, Appear Confident, Negotiate (DEARMAN)	
Walking the Middle Path	Self-Validation	"Are you familiar with the walking the middle path module of DBT?"
	Increasing Positive Behaviors	"Tell me a walking the middle path skill and when you would use it"
		"When was the last time you used that skill? Was it useful?"

CHAPTER 4

SOAR CLINICAL INTERVIEW MANUAL

Introduction

The RISE&SOAR program is adapted from years of clinical practice and research by Marsha Linehan's Dialectical Behavioral Therapy and Rathus and Miller DBT for Adolescents. Our program is divided into two groups: the RISE (Refine and Improve Skills and Emotions) group which provides Stage 1 DBT treatment to adolescents and young adults and the SOAR (Stage 2 Outpatient Adolescent Recovery) group which provides Stage 2 DBT treatment to adolescents and young adults.

The SOAR interview process serves as a tool to determine each participant's placement in either RISE or SOAR using four self-report questionnaires, a clinical intake interview, and a DBT skills review. The clinic will be evaluating certain aspects of your functioning in order of what is most important for treatment success in our program. These criteria also help us formulate appropriate goals for group therapy and your individual therapy sessions.

The interview process, which is divided into two parts, lasts approximately 1-2 hours. The first part of the session will include an intake interview. The second part of the session will include determination of group membership and orientation to the RISE&SOAR program if accepted. In addition to the interview we will provide a formal assessment process using four questionnaires. These questionnaires will be filled out by you and your parent/caregiver. An overview of the intake interview process is presented in Table 5 below.

Table 5. Overview of SOAR Intake Process

Pre-interview: The Welcome Packet	First Part of Intake	Second Part of Intake
Intake Form and Policies Forms	Intake Interview	Group Placement
Deliberate Self-Harm Inventory	Risk Assessment	Orientation
Behavior Assessment System for Children	Skills Review	DBT Contract
DBT-Ways of Coping Checklist		
Children and Adolescent Trauma Screen		

Pre-Interview

There are several things you can do to prepare before your first session. First it is important that you and your parent/caregiver complete the forms in our Welcome Packet; this is the packet that you received from one our therapists during your final session at SHIELD or during our open enrollment. The welcome packet includes four questionnaires: DSHI, BASC, DBT-WCCL, and CATS. It generally takes one to two hours to complete them. These questionnaires will inquire about symptoms, behavior patterns, and associated difficulties in your personal and social life. The welcome packet also includes an intake questionnaire that you complete with your information as well as a clinic policies form, privacy form, and informed consent form that you and your parent must sign. Please bring a completed welcome packet with you to the first session. It is recommended that you and your family arrive 15-30 minutes before session so we can discuss any questions or concerns you have regarding the welcome packet.

Before your first session, we want you to take note of the symptoms you have

been experiencing, including examples of how your symptoms interfere with day to day life. If you have been prescribed medication of take any recreational drugs, it is helpful to tell us which substances you are taking and how it was affected the way in which you experience your symptoms. Tell us what you found helpful or unhelpful from your previous therapy program so we can tailor our approach to best meet your needs. Also, it is a great idea to come to the evaluation with a sense of the goals that you hope to achieve during your time with us.

First Part of Intake Session

The first part of the intake process is the first step in the treatment process that will help our team understand the nature and severity of your symptoms so we can make informed recommendations about your treatment options. Before we begin, we want to emphasize that your mental health information is confidential. However, therapists are mandated reporters which mean that in certain circumstances, we are required by law to release information without your consent. For example, if you make a specific threat to harm yourself or someone else and the risk of danger is imminent, I must take the appropriate steps to protect you or warn the appropriate individuals. If I suspect that you have physically or sexually abused or neglected a child or vulnerable adult, I must make a report to the proper authorities. Finally, I can release information without your consent if there is court order to release your records to the legal authorities.

During this time, I will start with a clinical interview which will take approximately 30 to 50 minutes, where I will ask about challenges or symptoms that you have been experiencing. I want to get a sense of how well you are functioning in different

areas of your life, including at home, work, school, and in your personal relationships. You will also be asked questions about the type of stressors you might be experiencing and any personality traits or behaviors or emotional problems that might be contributing to your current difficulties. I will also ask you to complete a DBT skills review, which will take approximately 10 minutes, where I will ask you questions regarding the skills you have learned in your previous DBT program. Once the intake interview is completed, we will take a 5-minute break while I consult with the RISE&SOAR team to determine the status of your placement into the program.

Second Part of Intake Session

The second half of the intake session includes an orientation in the RISE&SOAR program, where we will provide you and your family a description and overview of the two therapy groups: RISE (Stage 1 DBT-A) and SOAR (Stage 2 DBT-A). This part will take about 30-50 minutes. The goal for this allotted session time is to give you information about your group placement and answer any questions or address any reservations you may have about our clinic. I will also discuss the requirement of individual sessions. If there is not enough time during our intake session to provide you all this information, I will provide it to you through the phone after our session. I may also provide you the information regarding your therapy group placement through the phone later if the RISE&SOAR team has not yet agreed on the status your placement by the second part of the intake session.

If a participant is placed in the RISE group: You will be part of our RISE group, which stands for Refine and Improve Skills Effectiveness. It is a DBT Stage 1 group

where the main goal is to master coping skills necessary to get your self-harming behaviors under control. In this group, you will receive weekly group therapy and individual therapy. These sessions are usually structured; there will be weekly homework in group therapy, such as diary cards, that you must complete. In individual therapy you will be addressing your therapy goals with the help of your therapist. Group skills training is a two-hour psychoeducation group, usually with three to ten individuals in your group. You will be learning the five modules of DBT-A that may or may not be already familiar to you: mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness, and walking the middle path. Within the DBT perspective, the treatment of a participant requires a team, which includes your individual therapist, the group leader, co-leader, and the supervisor. Their job is to make sure your treatment needs are met and to support you in this process. Generally, the structure of DBT includes an agreement to stay in therapy and not engaging in self-harm or suicide attempts (Silverman, 2014). This is an agreement that you will review and sign with your individual therapist. It is important that your team emphasizes the treatment goal for all our participants is to "graduate" or meet criteria for admission to SOAR.

If participant is placed in the SOAR group: You will be part of our SOAR group, which stands for Stage 2 Outpatient Adolescent Recovery. It is a stage 2 DBT group where the main goal is to reduce any trauma related symptoms that may or may not fit the criteria for PTSD. You are placed in the SOAR group because you have your life-interfering and therapy-interfering behaviors under control. The treatment team also thought that you have a good grasp of the DBT skills that were taught in your previous DBT program. In this group, you will receive weekly group therapy and individual

therapy. Since your therapists are going to be processing traumatic events with you, it is important that you continue using the skills you have learned. Within the DBT perspective, the treatment of a participant in DBT requires a team, which includes your individual therapist, the group leader, co-leader, and the supervisor. Their job is to make sure your treatment needs are met and to support you in this process. Generally, the structure of DBT includes an agreement to stay in therapy and continue to abstain from engaging in self-harm or suicide attempts. This is an agreement that you will review and sign with your individual therapist.

CHAPTER FIVE

CLINICIAN'S GUIDE TO THE SOAR CLINICAL INTERVIEW MANUAL

Introduction

The RISE&SOAR Clinical Interview Manual is a newly developed manual grounded in theory and practices of Dialectical Behavioral Therapy for Adolescents (DBT-A). This manual is intended to serve as a guideline for DBT-A clinics seeking to utilize the principles and techniques of the RISE&SOAR clinic, such as evaluating participant readiness to transition from Stage 1 to Stage 2 DBT-A. This interview manual should be used in conjunction with training provided by a licensed clinician experienced in running and supervising DBT-A therapy groups and individual therapy sessions. Clinicians who will lead the treatment groups should have adequate training and experience in leading DBT-A groups; they should have a solid grasp of DBT-A skills and full understanding on how to teach them. In addition, they need to know basic behavior therapy techniques and various DBT treatment strategies.

The purpose of the SOAR Clinical Interview Manual is to evaluate a specific set of skills and behaviors in order to inform clinical decisions regarding the most appropriate level of treatment for that participant (either Stage 1 or Stage 2 DBT-A). By maintaining focus on evaluating DBT skills use, self-harming behaviors, and therapy-interfering behaviors during the interview process, participants are set up for future success in the program because group assignment error due to lack of readiness is minimized. Use of this manual should result in detection of those adolescents who demonstrate a reduction of symptoms (impulsivity, emotional dysregulation, suicidality)

and mastery of skills that indicate readiness to process trauma.

The interview manual is an approach that employs assessment of participant functioning that will be used to enhance participant outcomes, provide continuity of care, provide checks throughout the treatment process, and create detailed participant profiles, analyze patterns of change, and allows for program evaluation and outcome assessment. This interview manual is the first step in formalizing the RISE&SOAR treatment approach so that it may be utilized at other clinics.

Preparing for the Intake Session

Participants and their parents who are referred to the RISE&SOAR clinic are given a "welcome packet" containing measures, consent forms, and an intake questionnaire immediately after the last session from their previous DBT program. Typically, participants will have one week between their last session and the intake session with the RISE&SOAR clinic. Participants are encouraged to complete the measures included in the welcome packet between that time, which they will submit to the clinician at the beginning of the clinical interview session. The measures in the welcome packet include: The Deliberate Self-Harm Inventory (DSHI), Behavior Assessment System for Children - 3rd Edition (BASC-3; Parent Rating Form and Self-Report Form), Childhood and Adolescent Trauma Screen (CATS), and the DBT Ways of Coping Checklist (DBT-WCCL). Copies of these assessment measures can be found in Appendix B. The RISE&SOAR clinic forms in the welcome packet include: a clinic policies handout (explaining billing and fees, no shows, and contact information), a privacy policy/HIPAA document (details confidentiality and privacy concerns, as well

rights regarding the participant's records) and an Informed Consent/Disclosure form for the RISE&SOAR research group. Participants are also asked to fill out a detailed history form that includes educational, medical, and social history before the start of first session. Copies of these forms are available in Appendix A.

It is important that the clinician prepare before the initial clinical interview. Before the first call, the clinician reviews the participant's medical notes and treatment history to get a brief background of the participant. During the first call, the clinician should try to get general information regarding the participant's current stressors and presenting problems that may barriers to setting up the appointment. It is also important to let the participant's parents know that the RISE&SOAR clinic does not bill insurance, so they will have to pay at time of service. Once the appointment for the initial session is set up, the family is asked is to arrive about 15-30 minutes early, so they can complete any paperwork or self-report measures that they did not complete from the welcome packet given the week prior.

Intake Session – First Part

Once the participant has arrived with their family, the clinician will greet and introduce themselves at the time of the participant's appointment. The clinician will then gather the completed welcome packet that was given to the participant's family the week prior to their appointment. If the family has any questions regarding any of the items in the measures, the clinician will answer any questions and/or guide the participant to complete any missing items. Once the welcome packet is completed and collected, the clinician will hand the packet to another RISE&SOAR treatment team member, where

the measures will be scored and interpreted.

The family will then be invited into the therapy room. The clinician will give the family a road map of what the session will look like: review consent and confidentiality, gather information, and conduct a skills review. From there, the clinician will review the informed consent and privacy policies. The clinician will verbally go through disclosure and privacy policies with them. It is critical that the participant understands his/her rights. The clinician will start by telling the participant information regarding keeping confidentiality and the conditions where a clinician can break confidentiality (e.g., suspected abuse of a child, elderly, or a dependent adult, if a participant is determined to be a danger to himself/herself or others).

Next, the clinician will review clinic policies with the family and participant, including what happens if the participant misses a therapy session without calling, how much notice is needed before cancelling session, and how to contact the clinic's supervisor. Since RISE&SOAR is also a research clinic, the clinician will also go over consent regarding being able to anonymously use the participant's intake and assessment data for research. Once all this information has been reviewed, the participant and the family will be given the chance to ask questions regarding the policies and consent. Once they have had the chance to ask questions, the therapist will proceed to gather the participant's information.

It is important for clinicians to focus on gathering information regarding the participant's presenting problem, family history, treatment history, and past hospitalizations. The clinician may begin by asking about the participant's story; which is, in their own words, what happened and why they are seeking help. This allows the

clinician a basis for figuring out what's going on from a psychological perspective. The clinician will then ask questions about family, significant others, friends, education, and other information depending on what the presenting problems are. It is important for the clinician to spend as much time as possible talking to the participant about their situation. Another goal is to gather more details that the self-report measures are limited in obtaining. For example, a therapist can use critical items in the BASC-3 to further gather details regarding how, why, when, or what happened regarding the endorsement of a symptom.

Once information regarding any relevant history is gathered, the participant's parents will be asked to wait in the waiting room, so the clinician can discuss more sensitive topics with the participant. During this time, it is critical that the clinician gathers information about alcohol and illicit substance use, prescription medications, physical abuse, sexual abuse, and emotional abuse. The clinician is careful to explain that if the participant is using these substances, the clinician will not break privacy to report this. The clinician explains that they are not asking these questions to embarrass or judge, but because they help the clinician understand what happened and how it is currently affecting the participant.

If necessary, the therapist will do a suicide risk assessment with the participant. The therapist will follow the suicide risk assessment form obtained during the intake preparation. During the risk assessment, the therapist will assess suicidal ideation and evaluate passive or active intent. The therapist will also determine if the participant has access to means to carry out any suicidal ideation. The therapist will also determine with the participant any risk and protective factors. Finally, the participant will be making a

suicide prevention action plan with the therapist. The participant will be asked to list at least three people the participant can call if feeling suicidal and list three positive affirmations (i.e., reasons to live) on the action plan. The next section is to make a plan to remove lethal means. It is a plan to remove whatever objects a participant may use to attempt suicide such as locking up guns and knives, emptying poisonous bottled chemicals, or having a trusted family member dispense prescription drugs. Any risk level that is above mild risk must involve a supervisor consult before the participant leaves. Moderate risk may or may not be manageable without hospitalization, but extreme risk will likely require hospitalization.

SOAR DBT-A Skills Review

Once the clinician completes the information-gathering from the participant and his/her family, the clinician will complete the DBT-A skills review with the participant only. The DBT-A skills review is a brief form that is used by the clinician to evaluate a participant's knowledge of the five DBT-A Stage 1 modules: distress tolerance, interpersonal effectiveness, emotion regulation, mindfulness, and walking the middle path.

The SOAR DBT-A skills review is meant to assess proficiency in DBT-A by having participants name the modules and skills involved in DBT-A. It is a simple review that allows RISE&SOAR to investigate how much experience a participant has had in a DBT program. The skills review is meant to complement the DBT-WCCL, in that it allows clinicians to assess participants' knowledge, understanding, and usefulness of their DBT skills in addition to proper use.

Before beginning the skills review, the clinician must have the checklist of the modules and the skills associated with each module (see Appendix C). The clinician will then begin by asking the participant, “Are you familiar with (insert DBT-A module) module of DBT?” If the participant does not respond, the clinician may follow up with the question “Did you learn (insert DBT-A module) from your previous DBT program?” If the participant answers “yes”, the clinician will follow up with “Great! Do you remember any (insert DBT-A module) skills that you learned from your previous program?” If the participant names a skill that is on the skills review checklist form, the clinician will then ask, “When would you use this skill?” and/or “When was the last time you used this skill?” This last question will be repeated for each skill that the participant describes. The clinician will repeat these questions for each DBT-A module as described in the skills review checklist. If the participant answers “No” or “I don’t remember” to the first question, the clinician will record that answer and proceed to ask questions for the other modules.

The skills review is semi-structured, but it is not scored; the clinician, however, is expected to make note of the participant’s answers in their checklist for review after the first session. The skills review is meant to elicit a natural conversation between clinician and participant on their previous experience with a DBT program. The clinician can modify the questions asked, as long as the questions still give the clinician a clear idea of a participant’s familiarity, understanding, and usage of each module and skill. Of note, the participant is not expected to know exact terminology of the DBT-A skills (e.g., know what the DEARMAN acronym stands for), but they are required to explicitly name the module or skill.

Intake Session – Second Part

Once the clinician gives the welcome packet to another RISE&SOAR treatment team member, the treatment team will score and interpret the welcome packet measures in the RISE&SOAR lab while the clinician conducts the first part of the intake session. During the 5-minute break between the first and second part of the intake session, the clinician will meet with the rest of the treatment team to discuss the participant's placement in either the RISE or SOAR group. Decisions regarding group placement in either RISE or SOAR is formed based on the results of the screening assessment measures, DBT-A skills review, as well as reports from participants, parents, and observations by the therapist during the initial intake session. The flowchart in Figure 1 below will be used to make these clinical decisions regarding participant placement.

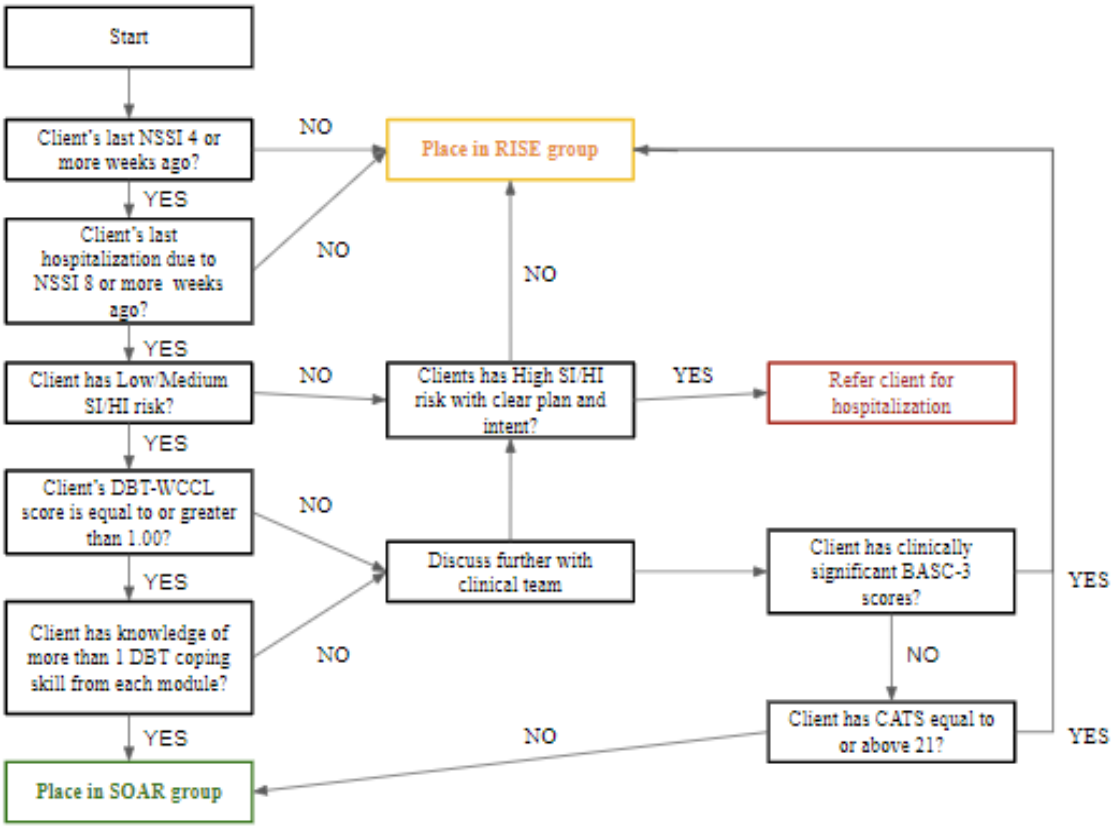

Figure 1. Flowchart for Determining Participant Group Placement

The RISE&SOAR treatment team will be using a multi-criteria decision-making process where each criterion is weighted (e.g., provides the relative importance of the criteria). The ranking method weight was determined by the clinical team, and it involves ranking the criteria according to the literature, which states the necessary qualifications for DBT treatment stage progression from Stage 1 to Stage 2.

The most important criteria, and thus weighted heaviest, for determining group placement is the incidence of self-harming behaviors within the last month and a hospitalization due to self-harming behavior within the past two months. Since SOAR focuses on addressing trauma issues and emotional experiences through exposure, the participant must have control over their self-harming behaviors in case they are activated

during group therapy. A participant who reports self-harming behaviors within the past month on the DSHI measure is not ready for the SOAR group and will be placed in the RISE group because he/she may need additional support (e.g., learning coping skills). This is because the participant should not be forced to process past trauma until they have knowledge of adaptive coping strategies, which are skills that participants learn in the RISE group. If the participant did not engage in self-harming behaviors in the past month or was not hospitalized within two months, it is still important to consider the participant's history of self-harm and motivation when self-harming to make a more solid conceptualization of the participant.

The second most important criteria to consider in group placement is level of suicidality risk. The reasoning for choosing the weight of this criterion is like that of the self-harming criteria in that a participant who is showing high risk of suicidal ideation is not ready for treatment that involves emotional processing of trauma and may require immediate hospitalization. Low to medium risk participants may also not be ready for SOAR because these participants need additional support to obtain control over their thoughts and behaviors. Suicidal ideation will be assessed during the clinical intake interview. If suicide intent/plan is determined the clinician will make an action plan with the participant as necessary.

The third criterion to consider in group placement is level of mastery of DBT Stage 1 skills. This is assessed through the DBT-WCCL and skills review. DBT-WCCL is scored by averaging across all items in the scale. Literature shows that the mean score for suicidal BPD participants who have been enrolled and completed a DBT program was 1.33 (SD = .46) for the DBT Skills Subscale (DSS), meaning this score indicates good

utilization of DBT skills in most situations. RISE&SOAR's criterion will be more lenient; a score between 1.00 to 1.33 in the DSS will warrant consideration for placement to the SOAR group. This leniency is due to two reasons: 1) not all participants' diagnoses meet criteria for BPD, which is what the DSS score of 1.33 is normed on, and 2) not all RISE&SOAR participants' have successfully completed a DBT program. Criterion consideration regarding the DBT skills review during intake will depend on clinical judgment; while the skills review is not scored, familiarity, understanding, and perceived usefulness of 1-2 main skills for each DBT-A module should warrant consideration for placement in the SOAR group. It is important to note, however, that since mastery of DBT Stage 1 skills is third on the criteria list, failure to meet cutoffs for the DBT-WCCL and skills review does not entirely rule out a participant's placement in the SOAR group. Presence of self-harming behaviors and suicidality risk still take precedence as criteria for determining SOAR vs RISE placement.

Finally, RISE&SOAR clinicians will consider scores from the assessment measures included in the welcome packet. The clinic team evaluates specific scores for the CATS and BASC-3 measures: For the BASC-3, certain clinical and content scales will be examined by RISE&SOAR clinicians due to their relation to borderline personality features in early adolescence and the potential prodromal course of later BPD (Haltigan &Vaillancourt, 2016). Among the clinical scales, the clinicians will examine a participant's self-report scores on hyperactivity (tendency to be overly active) and somatization scales (tendency to be overly sensitive and complain about relatively minor physical problems) and the parent rating scores on anxiety (tendency to be nervous, fearful or worried) and depression (feelings of unhappiness) scales. Among the content

scales, the RISE&SOAR clinicians will examine a participant's scores on the anger control scale (tendency to become irritated and angry quickly and regulate affect) and negative emotionality scale (tendency to react in an overly negative way to any changes in everyday routine. A T-score of 60-70 on a clinical and content scale is indicative of at-risk concerns while a T-score of 70 and above is indicative of possible clinical concerns. The CATS can be scored by summing up the raw scores of the items. A raw score of 15 to 20 indicate moderate trauma-related distress while a score of >21 is recommended as an indication of clinically relevant levels of PTSD (Sachser et. Al, 2017).

Scores from the BASC-3 and CATS will not be used as a discount criterion for placement into the SOAR group. However, they are important in providing clinicians critical information regarding participants' diagnostic profiles and trauma experiences to inform treatment planning during group and individual sessions.

A summary of the criteria that will justify strong consideration for placement to the SOAR group by the treatment team is found in Table 6 below.

Table 6. Rank of Criteria Considered for Placement in SOAR Group

Rank	Criteria
1st: Self-harm	Measured through DSHI and intake interview; last NSSI incident must be 4 weeks or longer and hospitalization due to NSSI must be 8 weeks or longer
2nd: SI/HI Risk	Low to moderate risk
3rd: DBT Skills Use and Knowledge	Score of >1.00 in DBT-WCCL DSS subscale and familiarity of DBT Stage 1 modules and skills during skills review (knowledge of 1-2 main skills for each DBT-A module and example of how/when to use the skill)
4th: Other Psychological measures	BASC-3: scores used for data collection, participant information, and treatment planning; T-scores of 60-70 on clinical and content scales will be noted by the clinical team
	CATS: scores used for data collection, participant information, and treatment planning. A raw score 15 to >21 will be noted by the clinical team

Orientation

Once the clinical team determines a participant's group placement, the clinician will inform the participant and their family of the RISE&SOAR therapy groups. The RISE&SOAR clinic considers the orientation as one of the most critical stages of the interview process, because this is when the idea of DBT-A under the RISE&SOAR clinic will be first introduced. Participants' initial introduction to the idea of DBT-A stage 1 or stage 2 therapy can determine their attitude towards group therapy and whether they follow through with the treatment (Boss et al. 2016). Therefore, it is important for the RISE&SOAR clinician to ensure that the participant can consistently make the time and location of the group they are assigned to and address any possible resistance to treatment.

Creating a welcoming culture within the RISE&SOAR clinic is a key element in this process. This requires full support from the parents and all members of the clinical team. The RISE&SOAR clinical team must make the group program a priority to find the most success. During orientation, the clinician educates the participant on what the group sessions will look like, the type of participants that will be participating in groups, and the benefits of attending group therapy. The clinician will go through the guidelines for the RISE&SOAR group, including treating each other with respect, keeping strict confidentiality of information shared within the groups, and rules for being dropped out of treatment (missing 5 sessions in total or 3 sessions in a row during the program).

The clinician will then review the RISE&SOAR contract to be signed by the participant, which states agreement and adherence to clinic rules, attendance policy, and full participation in the program. The clinician will go through a brief overview of the program the participant is placed in, including stages of each treatment and target goals for each treatment module. Once the initial recommendation to RISE or SOAR is made, it is recommended that the clinician ask the participant what their initial reaction is to the group assignment. If positive, the clinician provides the basic information of the group to the participant and ensure that logistically they can attend a group. If the reaction is negative or neutral, the clinician may need to address the participant's resistance before making a group referral.

There are many reasons why participants can be resistant to the idea of joining group therapy or individual therapy. It is important to assess the sources of resistance to facilitate a successful transition. Frequently, the source of the resistance may be the very reason that group would be the most beneficial treatment modality. It is important to

remember the fundamental skills of a clinician when addressing resistance. Warmth and empathy are critical for a participant to feel heard, understood, and validated. This allows them to feel safe within the therapeutic relationship to be pushed and challenged to take the risk of joining a group.

Finally, the clinician will discuss the requirement of attending individual sessions, which is a part of both RISE and SOAR, and provide details about goal setting and goal achievement. Goal setting will be discussed during individual sessions and is beyond the scope of this manual.

CHAPTER SIX

DISCUSSION

The SOAR clinical interview manual aims to formalize an evidence-based and effective interview protocol for determining readiness for Stage 2 DBT-A treatment. It also aims to contribute to a much-needed Stage 2 DBT research; more specifically to the limited research on examining the readiness of adolescent participants in progressing from Stage 1 to Stage 2 DBT. This interview manual could serve as an integral component of every DBT-A program because it is designed to help clinicians determine if the participant will successfully engage in Stage 2 DBT trauma processing or if they need additional skills development in Stage 1 DBT. It also hopes to provide a baseline for future research to determine if the measures and variables that are used in the manual are correlated with better treatment outcomes.

Since the SOAR interview manual is a new component of the RISE&SOAR clinic, it comes with many challenges and limitations that will need to be addressed in future iterations of the manual. For example, this manual, in its current form, requires training and instruction by a clinician experienced in running and supervising DBT-A clinicians and participants. It also assumes the users of the manual have had an academic course in DBT and have general experience in conducting clinical interviews, scoring assessments, and running psychotherapy groups. This may present a challenge for university training clinics and clinics that do not have the resources to train their clinicians in DBT-A.

Other treatment manuals may challenge the utility of this interview manual. For example, the DBT PE treatment manual, which uses exposure therapy, proposes that

trauma processing can be done concurrently with Stage 1 DBT. The SOAR clinical interview manual is grounded on the DBT principle that a patient is not recommended to engage in Stage 2 trauma processing until quality-of-life interfering behaviors are under control and coping skills are learned from Stage 1 (Fleischhaker et al., 2011). However, it can be argued that DBT PE still adheres to this principle; DBT PE treatment cannot be implemented until client has at least learned emotion regulation skills (Harned, 2013). In addition, DBT PE treats trauma through in vivo exposure, and not through therapy group processing seen in DBT-A Stage 2. Nevertheless, it is crucial for the clinic to refer to DBT PE literature and adapt some of the manual's practices to our clinic to continually improve the RISE&SOAR program.

Self-report measures, which are included in this manual, generally have limitations and can be improved. These questionnaires usually rely on honesty of participants. It would be unwise to assume that participants will always be truthful in their reports, especially at a level in which the participants will want to manage how they appear to others (e.g., disclosing self-harming behaviors, drug use). Even if the participants are completely honest, their lack of introspective ability (e.g., the ability to view themselves as others see them) and varying interpretation of questions, may affect the accuracy of responses. In addition, response bias when completing rating scales can also be challenging; some participants may present as liberal or conservative in their responding patterns, especially if they want to influence treatment considerations. Self-report measures rely on normative data. Some measures included in the manual are based on small samples or have limited validity or reliability data. Finally, progress is being made in the availability of these measures in multiple languages, but the restricted range

of languages and cultural influences also demands consideration.

Components of the SOAR interview manual also contain limitations that require further research. The DBT skills review is semi-structured questionnaire that was formulated for the purposes of this manual. Similarly, the weighted, multi-criteria decision-making process for determining group placement of participants is not based on prior studies and data. The criteria are simply based on the requirements outlined in DBT manuals for progressing to Stage 2 of treatment. Both components, while they will not be used as research instruments for the clinic, will eventually require reliability and validity testing especially if the SOAR interview manual will be adapted by other clinics.

Conclusions and Future Direction

The next step in formalizing this treatment approach will be the creation of a manualized treatment for the RISE&SOAR program. The complete treatment manual should include a full theoretical overview, case examples, and process for supervising clinicians running the groups. Ideally, a RISE&SOAR complete treatment manual allows clinicians to use it in their own practice without any additional training.

The SOAR interview manual will continue to evolve and become more refined over time. Future versions of the interview manual must reflect treatment outcomes. For example, criteria for group placement may need adjustment to account for participants' response to treatment, such as perceived readiness to start processing trauma in Stage 2 DBT-A. In addition, if participants' show a high rate of recidivism to self-harming behaviors while in the SOAR group, we may need to adjust the details and weight of each criteria for group placement. For instance, if lack of skill proficiency is the biggest factor

that contributes to negative outcomes rather than self-harming, we may re-consider that hierarchy of eligibility criteria for the SOAR group (see table 6). Similarly, we might discover that we should add an additional criterion (e.g., perceived quality of interpersonal relationships). In addition to providing information on group placement, treatment outcomes should serve as an indicator of the interview manual's ability to properly place in the correct DBT treatment group. There must be a reciprocal relationship between the intake process and the treatment outcomes to help us hone the SOAR interview manual.

The SOAR DBT-A skills review section of the interview manual will also warrant future revision. Proving skills proficiency through verbal means may not be enough; participants may need to show proficiency through more comprehensive ways, such as demonstrating/teaching the clinician a skill from each module.

RISE&SOAR program is currently working with participants who do not use their insurance to pay for sessions; however, as we continue to grow our program and start accepting insured participants, our session model may undergo a few changes to accommodate this issue. Further research on the effectiveness of RISE&SOAR is necessary to validate the treatment. It is likely that as a formalized approach is used across multiple sites, data collection and analysis will continue. This will be a critical element to support the treatment for a wider distribution and use.

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APPENDIX A

INTAKE FORM, INFORMED CONSENT, POLICIES

ADOLESCENT INTAKE QUESTIONNAIRE
** THIS FORM TO BE FILLED BY ADOLESCENT**

This form will assist your therapist in knowing about you and will be kept confidential. Please complete all pages. **Print clearly.**

PARTICIPANT DEMOGRAPHICS

Participant Name: _____ Date:_____
Email: _____
Telephone number: _____

Birth date: _____/_____/_____ Age: _____ Gender: Female Male

PRESENTING PROBLEM

Describe the problems you are having and when they began:

_____

_____

What has contributed to this difficulty?

_____

_____

MEDICAL HISTORY

List allergies, serious illnesses, surgeries, injuries, hospitalizations:

_____

List both prescription and over-the-counter medications presently used for physical conditions:

_____

_____

My overall general health is: ___Excellent ___Fair ___Poor

What physical illnesses run in your family?

_____

What is the name of your Doctor/Pediatrician?

_____

EDUCATIONAL HISTORY

What is the highest grade you have completed? _____
Do you have any problems in school? YES NO

If yes, please explain:

_____

Have you ever repeated or skipped a grade? YES NO Which one?
Have you ever dropped out, been expelled, or been suspended?
What happened?

_____

How has your attendance been? ___Excellent ____Fair ___Poor
Do you have learning difficulties or attend special classes? YES NO
Have you ever had psychological testing? YES NO
What are your extra-curricular activities?

LEGAL HISTORY (child or any family member)

Have you ever been involved with the legal system? YES NO
If so, in what way?

_____

_____

Are you currently involved with the legal system? YES NO If so, in what way?

_____

_____

Do you have any criminal or civil cases pending? YES NO
Do you currently have a probation/parole officer? YES NO
If so, who? _____
Do you anticipate any involvement with the legal system in the future? YES NO

TREATMENT HISTORY

Have you been in counseling before? YES NO
If so, with whom? _____
What was the primary issue
When? _____ For how long?_____
What was the outcome?

_____

What medications have you taken in the past for emotional or mental problems?

_____

What medications are you currently taking for emotional or mental problems?

_____

Is there a history of mental illness in your family? If so, please explain:

_____

SOCIAL HISTORY

What are your strengths?

_____

What are your major weaknesses?

_____

From whom do you get emotional support?

_____

Do you have friends? YES NO

How do you get along with those friends?

_____

Has there been a change in your circle of friends lately? YES NO

Do your friends tend to get into trouble? YES NO

Do you belong to a gang? YES NO

Do any of your friends belong to a gang? YES NO

What have been the losses, changes, crises, and transitions in your life?

_____

_____

Do you have a belief system (cultural, moral, spiritual, religious, etc.) which influences your life? Please explain:

_____

_____

Is there anything about your lifestyle (or the family's) that would be helpful for us to know?

_____

_____

Name	Age	Relationship to You
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

Immediate family/relatives/significant others

Name	Age	Relationship to You
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

Do you live with your parents? YES NO
Have you ever lived away from your parents? YES NO
Under what circumstances?

_____

Your experiences while growing up can affect your life. What experiences and events (discipline, favoritism, trauma, affection, lack of attention, etc.) have been important in your life?

_____

_____

PHYSICAL DEVELOPMENT

Please complete/check the following:

_____Height _____Underarm hair
_____Weight _____Menstruation (fem)
_____Build (light, average, heavy) _____Voice change (male)
_____Breast development (female) _____Beard (male)
_____Genital hair _____Acne

SEXUAL HISTORY

Are you currently sexually active? YES NO
Do you use Condoms? YES NO
Do you use Birth Control? YES NO
Have you ever had a STD (Sexually Transmitted Disease)? YES NO
If so what?

_____

Have you ever been sexually abused? YES NO
If yes, by whom and for what length of time?

_____

CONCERNS

For you or any of the above relationships (household, brothers/sisters, partners), have you or any of those persons ever experienced any of the following problems:

Concern	Person(s) Who Experienced This
Mental Illness	_____
Depression	_____
Neglect	_____
Sexual Dysfunction	_____
Financial Difficulty	_____
Emotional Abuse	_____

Physical Abuse _____
Sexual Abuse _____
Alcohol Abuse _____
Drug Abuse _____
Other: _____

SUBSTANCE ABUSE

Do you use drugs? Regularly? Occasionally?
How does your usage affect your life?

_____

_____

What drugs have you taken:

_____Depressants: Alcohol, Tranquilizers, Sleeping Pills,
_____Stimulants: Cocaine, Crack, Crank, Speed, Diet Pills
_____Stimulants: Caffeine, Nicotine
_____Narcotics: Heroin, Codeine, Morphine
_____Hallucinogens: LSD/Acid, PCP, Peyote, Shrooms
_____Cannabis: Marijuana
_____Other

When did you first use? _____
When did you last use? _____

SUICIDE/HOMICIDE

Have you ever had or do you have? Check all that apply.	Past	Now
Thoughts of hurting yourself?	_____	_____
Thoughts of committing suicide?	_____	_____
Plans to commit suicide?	_____	_____
Attempts to commit suicide?	_____	_____
Threats to commit suicide?	_____	_____
Thoughts of harming someone?	_____	_____
Plans to harm someone?	_____	_____
Attempts to harm someone?	_____	_____
Threats to harm someone?	_____	_____

DEPRESSION

Have you ever or do you now have? Check all that apply.	Past	Now
Inability to sleep or sleeping longer?	_____	_____
Increased or decreased appetite?	_____	_____
Tearfulness or feelings of despair?	_____	_____

Lack of energy or feelings of fatigue?	_____	_____
Preoccupation with life events?	_____	_____
Decreased contact with others?	_____	_____
Feelings of depression?	_____	_____
Decreased interest in pleasurable activities	_____	_____

Is there anything else that may be helpful for your counselor to know that we have not asked?

Informed Consent for E-mail/Electronic Communication

Notice to Participants: Use of e-mail/electronic communications between participants and their therapists has risks regarding protection of your private health care information. Some examples include:

- E-mails/electronic communication can be intercepted by someone who is not the intended recipient.
- Intercepted e-mails/electronic communication can be stored and printed by the unauthorized recipient.
- Your identity can be determined from knowing your e-mails/electronic communication address.
- E-mails/electronic communication are easily, and sometimes, accidentally, forwarded to unintended recipients
- E-mails/electronic communication can transport computer viruses and other malicious software.
- Receipt of e-mails/electronic communication sometimes are not noticed, not responded to, in a timely manner.
- Detailed identifying information, diagnoses and treatment information about you should not be put in the subject line or body of an e-mails/electronic communication, nor be transmitted as an attachment to an e-mail
- E-mails/electronic communication should **never** be used to communicate emergency, urgent or other time-sensitive information.

If you choose to use e-mails/electronic communication communicate with your therapist, please read and sign below.

- I have read and understand the information provided /electronic communication. I have had my questions regarding this answered to my satisfaction.
- I understand that Loma Linda University is required by Federal and State Law to try to protect my private health care information, which is the reason I am being informed of the risks involved with e-mails/electronic communication.
- I understand that I am not required to participate in e-mail and electronic communication, but if I do consent, I may withdraw this consent at any time by notifying my therapist.

I give my informed consent to participate in e-mail and electronic communication with Loma Linda SOAR clinic.

_____ _____

Signature Date

_____ _____

Witness Date

HIPPA Notice of Privacy Practice

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from the Loma Linda SOAR clinic. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change.

I acknowledge receipt of the Notice of Privacy Practices.

Signature: _____ Date: _____
(Parent/Guardian)

Signature: _____ Date: _____
(Participant Name)

CONFIDENTIALITY

Your mental health information is confidential; however, therapists are mandated reporters which mean that in certain circumstances, I am required by law to release information without your consent. These situations are described below. Please read these situations and feel free to ask any questions about them.

- If you make a specific threat to harm yourself or someone else (and the risk of danger is deemed imminent), I must take appropriate steps to protect you or warn the appropriate parties.
- If I suspect you have physically or sexually abused or neglected a child or vulnerable adult, I must make a report to the proper authorities. This includes some cases of domestic abuse when a child is exposed to weaponry or is physically threatened and/or used as a weapon.
- If you are pregnant and using a controlled substance, such as heroin, cocaine, phencyclidine, methamphetamine, or their derivatives.
- When there is a court order to release your records to the legal authorities.

By writing and signing my name below, I am indicating that the above information is accurate and that I understand and accept the above billing and cancellation policy.

_____	_____	_____
Printed Name	Date	Signature

AUTHORIZATION /CONSENT FOR RELEASE OF MEDICAL INFORMATION

Participant Name: _____ Date of Birth: _____
Email: _____
Phone: _____
Address: _____
City/State/Zip: _____

Above listed participant authorizes the following healthcare provider to make record disclosure:
Provider Name: _____ Phone: _____
Provider Email: _____
Provider Address: _____Fax: _____
City, State, Zip: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.
This information may be disclosed and used by the following individual or organization:
Release To:_____
Address_____
City, State, Zip: _____
Fax: _____ Phone: _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____

Signature of Participant / Parent / Guardian or Authorized Representative Date

_____

Printed name of Authorized Representative Relationship/Capacity to participant

_____

Address and telephone number of authorized

_____

Date of Signature

Emergency Contact Information Form

This information will be extremely important in the event of an accident or medical emergency.

Name:_____

Phone Cell: _____ Date of Birth: _____

Home Address: _____

Street City State Zip Code: _____

Email: _____

Primary Emergency Contact Name:

Name: _____

Relationship:_____

Phone: Home: _____ Cell: _____

Email: _____

Secondary Emergency Contact Name:

Name: _____

Relationship: :_____

Phone Home: _____ Cell: _____

Email: _____

Comments (include any special medical or personal information you would want an emergency care provider to know – or special contact information:

_____

_____

Signature: _____ Date: _____

APPENDIX B

ASSESSMENT MEASURES

DBT-Ways of Coping Checklist

CITATION: Dialectical Behavior Therapy Ways of Coping Checklist (DBT-WCCL): Development and Psychometric Properties. Neacsiu, A.D., Rizvi, S.L., Vitaliano, P.P., Lynch, T.R., & Linehan, M.M.

Data Entry Initials: _____ Participant ID #: _____
Date: _____ Date: _____
Second Entry: _____ Assessment: _____ Session: _____
Date: _____

The items below represent ways that you may have coped with stressful events in your life. We are interested in the degree to which you have used each of the following thoughts or behavior to deal with problems and stresses.
Think back on the LAST ONE MONTH in your life. Then check the appropriate number if the thought/behavior is never used, rarely used, sometimes used, or regularly used (i.e., at least 4 to 5 times per week). answer whether it seems to work to reduce stress or solve problems—just whether or not you use the coping behavior. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

0 Never Used **1 Rarely Used** **2 Sometimes Used** **3 Regularly Used**

I have:

1. Bargained or compromised to get something positive from the situation	0 1 2 3
2. Counted my blessing	0 1 2 3
3. Blamed myself	0 1 2 3
4. Concentrated on something good that could come out of the whole thing	0 1 2 3
5. Kept feelings to myself	0 1 2 3
6. Made sure I am responding in a way that does not alienate others	0 1 2 3
7. Figured out who to blame	0 1 2 3
8. Hoped a miracle would happen	0 1 2 3
9. Tried to get centered before taking any action	0 1 2 3
10. Talked to someone about how I have been feeling	0 1 2 3
11. Stood my ground and fought for what I wanted	0 1 2 3
12. Refused to believe that it had happened.	0 1 2 3
13. Treated myself to something really tasty	0 1 2 3
14. Criticized or lectured myself	0 1 2 3

15. Took it out on others	0	1	2	3
16. Came up with a couple of different solutions to my problem	0	1	2	3
17. Wished I was a stronger person – more optimistic and forceful	0	1	2	3
18. Accepted my strong feelings, but not let them interfere with other things too much.	0	1	2	3
19. Focused on the good things in my life	0	1	2	3
20. Wished that I could change the way that I felt	0	1	2	3
21. Found something beautiful to look at to make me feel better	0	1	2	3
22. Changed something about myself so that I could deal with the situation better.	0	1	2	3
23. Focused on the good aspects of my life and gave less attention to negative thoughts or feelings.	0	1	2	3
24. Got mad at the people or things that caused the problem	0	1	2	3
25. Felt bad that I could not avoid the problem	0	1	2	3
26. Tried to distract myself by getting active	0	1	2	3
27. Been aware of what must be done, so I have been doubling my efforts and trying harder to make things work	0	1	2	3
28. Thought that others were unfair to me	0	1	2	3
29. Soothed myself by surrounding myself with a nice fragrance of some kind	0	1	2	3
30. Blamed others	0	1	2	3
31. Listened to or played music that I found relaxing	0	1	2	3
32. Gone on as if nothing had happened	0	1	2	3
33. Accepted the next best thing to what I wanted.	0	1	2	3
34. Told myself things could be worse	0	1	2	3
35. Occupied my mind with something else.	0	1	2	3
36. Talked to someone who could do something concrete about the problem.	0	1	2	3
37. Tried to make myself feel better by eating, drinking, smoking, taking medications, etc.	0	1	2	3
38. Tried not to act too hastily or follow my own hunch	0	1	2	3
39. Changed something so things would turn out right.	0	1	2	3
40. Pampered myself with something that felt good to the touch (e.g., bubble bath or a hug)	0	1	2	3
41. Avoided people	0	1	2	3
42. Thought how much better off I was than others.	0	1	2	3
43. Just took things one step at a time.	0	1	2	3
44. Did something to feel a totally different emotion (like gone to a funny movie)	0	1	2	3
45. Wished the situation would go away or somehow be finished.	0	1	2	3
46. Kept others from knowing how bad things were	0	1	2	3
47. Focused my energy on helping others.	0	1	2	3
48. Found out that another person was responsible.	0	1	2	3
49. Made sure to take care of my body sand stay healthy so that I was less emotionally sensitive.	0	1	2	3

50. Told myself how much I had already accomplished	0	1	2	3
51. Made sure I respond in a way so that I could still respect myself afterwards	0	1	2	3
52. Wished that I could change what had happened	0	1	2	3
53. Made a plan-of-action and followed it.	0	1	2	3
54. Talked to someone to find out about the situation	0	1	2	3
55. Avoided my problem	0	1	2	3
56. Stepped back and tried to se things as they really are.	0	1	2	3
57. Compared myself to others who are less fortunate.	0	1	2	3
58. Increased the number of pleasant things in my life so that I had a more positive outlook	0	1	2	3
59. Tried not to burn my bridges behind me, but leave things open somewhat.	0	1	2	3

Scoring description for the DBT-Ways of Coping Checklist (DBT-WCCL):
The scoring is the average of relevant items for each subscale.
The score for the skills use scale is the average of these items: 1, 2, 4, 6, 9, 10, 11, 13, 16, 18, 19, 21, 22, 23, 26, 27, 29, 31, 33, 34, 35,36, 38, 39, 40, 42, 43, 44, 47,49, 50, 51, 53, 54, 56, 57, 58,59

The dysfunctional coping scale 1 (general dysfunctional coping factor) has these items (and you compute an average score for them): 3,5, 8, 12, 14,17, 20, 25, 32, 37, 41, 45, 46,52, 55

And the dysfunctional coping scale 2 (blaming others factor) has these items: 7,15, 24, 28, 30,48

Behavior Assessment System for Children, Third Edition (BASC-3)
Self-Report - Adolescent

Child Information	**Test Information**
ID:	Test Date:
Name:	Rater Name:
Gender:	Rater Gender:
Birth Date:	Relationship:
Age:	Language
Grade:	
School:	

Mark: T – True F – False

1. I like who I am.	T	F
2. I hate taking tests.	T	F
3. Nothing goes my way.	T	F
4. My muscles get sore a lot.	T	F
5. People tell me I should pay more attention.	T	F
6. Things go wrong for me, even when I try hard.	T	F
7. I get mad at my parents sometimes.	T	F
8. I used to be happier	T	F
9. I often have headaches.	T	F
10. I don't care about school.	T	F
11. I can never seem to relax	T	F
12. I always go to bed on time.	T	F
13. My classmates don't like me.	T	F
14. I worry about tests more than my classmates do	T	F
15. My parents are always right.	T	F
16. If I have a problem, I can usually work it out.	T	F
17. I never break the rules.	T	F
18. I have not seen a car in at least 6 months.	T	F
19. What I want never seems to matter.	T	F
20. I worry about little things.	T	F
21. Nothing is fun anymore.	T	F
22. I never get into trouble.	T	F
23. I tell the truth every single time.	T	F
24. I never seem to get anything right.	T	F
25. I have never been mean to anyone	T	F
26. My friends have more fun than I do	T	F

27. I like loud music.	T	F
28. I always do what my parents tell me.	T	F
29. No matter how much I study for a test, I'm afraid I will fail.	T	F
30. I cover up my work when the teacher walks by	T	F
31. I wish I were different.	T	F
32. I have just returned from a 9-month trip to an ocean liner.	T	F
33. Nobody ever listens to me	T	F
34. Often, I feel sick in my stomach	T	F
35. I think that I have a short attention span.	T	F
36. My parents have too much control over my life.	T	F
37. My teacher understands me.	T	F
38. I just don't care anymore.	T	F
39. Sometimes my ears hurt for no reason.	T	F
40. I don't like thinking about school.	T	F
41. I worry a lot of the time.	T	F
42. I get along well with my parents.	T	F
43. Other children don't like to be with me.	T	F
44. I wish I were someone else.	T	F
45. I tell my parents everything.	T	F
46. I can handle most things on my own.	T	F
47. I like to take chances.	T	F
48. I am sometimes jealous.	T	F
49. My parents are always telling me what to do.	T	F
50. I often worry about something bad happening to me.	T	F
51. I don't seem to do anything right	T	F
52. I like everyone I meet.	T	F
53. I have attention problems.	T	F
54. Most things are harder for me than for others.	T	F
55. I have some bad habits.	T	F
56. Other children are happier than I am.	T	F
57. I would rather be a police officer than a teacher.	T	F
58. I always do homework on time.	T	F
59. I take a plane trip to Chicago at least twice a week.	T	F
60. I never quite reach my goal.	T	F
61. I feel good about myself.	T	F
62. Sometimes, when alone, I hear my name.	T	F
63. Nothing ever goes right for me.	T	F
64. I get sick more than others.	T	F
65. I give up easily.	T	F
66. My parents blame too many of their problems on me.	T	F
67. My teacher cares about me.	T	F
68. Nothing about me is right.	T	F
69. My stomach gets upset more than most people's	T	F

Remember: N – Never S – Sometimes O – Often A – Almost Always

70. My school feels good to me	N	S	O	A
71. I get nervous I can't breathe	N	S	O	A
72. I am proud of my parents.	N	S	O	A
73. Other kids hate to be with me.	N	S	O	A
74. I like the way I look	N	S	O	A
75. People say bad things to me.	N	S	O	A
76. I am dependable.	N	S	O	A
77. I like it when my friends dare me to do something.	N	S	O	A
78. When I get angry, I can't think about anything else.	N	S	O	A
79. I get blamed for things I can't help.	N	S	O	A
80. I worry when I go to bed at night.	N	S	O	A
81. I feel like my life is getting worse and worse.	N	S	O	A
82. School is boring.	N	S	O	A
83. I forget things.	N	S	O	A
84. Even when I try hard, I fail.	N	S	O	A
85. My teacher trusts me.	N	S	O	A
86. People act as if they don't hear me.	N	S	O	A
87. I like to play rough sports.	N	S	O	A
88. I have trouble standing still in lines.	N	S	O	A
89. I can't seem to turn off my mind.	N	S	O	A
90. I am disappointed with my grades.	N	S	O	A
91. I get upset about my looks.	N	S	O	A
92. I feel like people are out to get me.	N	S	O	A
93. I feel depressed.	N	S	O	A
94. I sleep with my schoolbooks.	N	S	O	A
95. I listen when people are talking to me.	N	S	O	A
96. I stay awake for 24 hours without getting tired.	N	S	O	A
97. Teachers make me feel stupid.	N	S	O	A
98. No one understands me.	N	S	O	A
99. I feel dizzy.	N	S	O	A
100. Someone wants to hurt me.	N	S	O	A
101. I feel guilty about things.	N	S	O	A
102. I like going places with my parents.	N	S	O	A
103. I feel that nobody likes me.	N	S	O	A
104. I am good at things.	N	S	O	A
105. I am lonely.	N	S	O	A
106. I can solve difficult problems by myself.	N	S	O	A
107. I like to experiment with new things.	N	S	O	A
108. I get nervous.	N	S	O	A
109. My parents expect too much from me.	N	S	O	A
110. I worry but I don't know why.	N	S	O	A
111. I feel sad.	N	S	O	A
112. I get bored in school.	N	S	O	A
113. I have trouble paying attention to the teacher.	N	S	O	A

114.	When I take tests, I can't think.	N	S	O	A
115.	Teachers look for the bad things that you do.	N	S	O	A
116.	I am left out of things.	N	S	O	A
117.	I like to ride in a car that is going fast.	N	S	O	A
118.	I talk while other people are talking.	N	S	O	A
119.	Even when alone, I feel like someone is watching me.	N	S	O	A
120.	I want to do better, but I can't.	N	S	O	A
121.	My looks bother me.	N	S	O	A
122.	I hear voices in my head that no one else can hear.	N	S	O	A
123.	I am good at making decisions.	N	S	O	A
124.	I have trouble sitting still.	N	S	O	A
125.	I pay attention when someone is telling me to do something.	N	S	O	A
126.	My parents are easy to talk to.	N	S	O	A
127.	Teachers are unfair.	N	S	O	A
128.	I have a hard time slowing down.	N	S	O	A
129.	I like going to bed at night.	N	S	O	A
130.	I see weird things.	N	S	O	A
131.	I get nervous when things do not go the right way for me.	N	S	O	A
132.	My mother and father like my friends.	N	S	O	A
133.	People think I am fun to be with.	N	S	O	A
134.	I feel like I have to get up and move around.	N	S	O	A
135.	Other people find things wrong with me.	N	S	O	A
136.	I like to make decisions on my own.	N	S	O	A
137.	I like to be the first one to try new things.	N	S	O	A

Child and Adolescent Trauma Screen (CATS) – Youth Report

Name: Date:

*Stressful or scary events happen to many people. Below is a list of stressful and scary events that sometimes happen. Mark **YES** if it happened to you. Mark **NO** if it didn't happen to you.*

1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire	□ Yes	□ No
2. Serious accident or injury like a care/bike crash, dog bite, sports injury.	□ Yes	□ No
3. Robbed by threat, force, or weapon.	□ Yes	□ No
4. Slapped, punched, or beat up in your family.	□ Yes	□ No
5. Slapped, punched, or beat up by someone not in your family.	□ Yes	□ No
6. Seeing someone in your family get slapped, punched, or beat up.	□ Yes	□ No
7. Seeing someone in the community get slapped, punched, or beat up.	□ Yes	□ No
8. Someone older touching your private parts when they shouldn't.	□ Yes	□ No
9. Someone forcing or pressuring sex, or when you couldn't say no.	□ Yes	□ No
10. Someone close to you dying suddenly or violently.	□ Yes	□ No
11. Attacked, stabbed, shot at, or hurt badly.	□ Yes	□ No
12. Seeing someone attacked, stabbed, shot at, hurt badly, or killed.	□ Yes	□ No
13. Stressful or scary medical procedure.	□ Yes	□ No
14. Being around war.	□ Yes	□ No
15. Other stressful or scary event? Describe:	□ Yes	□ No

Which one is bothering you the most now? _____

If you marked YES to any stressful or scary events, then turn the page and answer the next questions.

Mark 0, 1, 2, or 3 for how often the following things have bothered you in the last two weeks.

0 - Never 1 - Once in a while 2 - Half the time 3 - Almost Always

1. Upsetting thoughts or pictures about what happened that pop into your head.	0 1 2 3
2. Bad dreams reminding you of what happened.	0 1 2 3
3. Feeling as if what happened is happening all over again.	0 1 2 3
4. Feeling very upset when you are reminded of what happened.	0 1 2 3
5. Strong feelings in your body when you are reminded of what happened (sweating, heart beating fast, upset stomach)	0 1 2 3
6. Trying not to think about or talk about what happened or to not have feelings about it.	0 1 2 3
7. Staying away from people, places, things, or situations that remind you of what happened.	0 1 2 3
8. Not being able to remember part of what happened.	0 1 2 3
9. Negative thoughts about yourself or others. Thoughts like I wont have a good life, no one else can trusted, the whole world is unsafe.	0 1 2 3
10. Blaming yourself for what happened or blaming someone else when it isn't their fault.	0 1 2 3
11. Bad feelings (afraid, hungry, guilty, ashamed) a lot of the time.	0 1 2 3
12. Not wanting to do things you used to do.	0 1 2 3
13. Not feeling close to people.	0 1 2 3
14. Not being able to have good or happy feelings.	0 1 2 3
15. Feeling mad. Having fits of anger and taking it out on others.	0 1 2 3
16. Doing unsafe things.	0 1 2 3
17. Being overly careful or on guard (checking to see who is around you)	0 1 2 3
18. Being jumpy.	0 1 2 3
19. Problems paying attention.	0 1 2 3
20. Trouble falling or staying asleep.	0 1 2 3

Please mark YES or NO if the problems you marked interfered with:

1. Getting along with others	□ Yes	□ No
2. Hobbies/Fun	□ Yes	□ No
3. School or work	□ Yes	□ No
4. Family relationships	□ Yes	□ No
5. General happiness	□ Yes	□ No

Child and Adolescent Trauma Screen (CATS) – Caregiver Report

Child's Name:

Caregiver's Name:

Date:

*Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Mark **YES** if it happened to the child to the best of your knowledge. Mark **NO** if it didn't happen to the child.*

1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire	□ Yes	□ No
2. Serious accident or injury like a care/bike crash, dog bite, sports injury.	□ Yes	□ No
3. Threatened, hit, or hurt badly within the family.	□ Yes	□ No
4. Threated, hit, or hurt badly in school or the community.	□ Yes	□ No
5. Attacked, stabbed, shot at, or robbed by threat	□ Yes	□ No
6. Seeing someone in the family threatened, hit, or hurt badly	□ Yes	□ No
7. Seeing someone in school or the community threatened, hit, or hurt badly	□ Yes	□ No
8. Someone doing sexual things to the child or making the child do sexual things to them when he/she could not say no. Or when the child was forced or pressured.	□ Yes	□ No
9. Online or social media, someone asking of pressuring the child to do something sexual, like take or send pictures	□ Yes	□ No
10. Someone bullying the child in person. Saying very mean things that scare him/her	□ Yes	□ No
11. Someone bullying the child online. Saying very mean things that scare him/her	□ Yes	□ No
12. Someone close to the child dying suddenly or violently	□ Yes	□ No
13. Stressful or scary medical procedure.	□ Yes	□ No
14. Being around war.	□ Yes	□ No
15. Other stressful or scary event? Describe:	□ Yes	□ No

Turn the page and answer the next questions about all the scary and stressful events that happened to the child.

Mark 0, 1, 2, or 3 for how often the following things have bothered the child in the last two weeks. **0 - Never 1 - Once in a while 2 - Half the time 3 - Almost Always**

1. Upsetting thoughts or pictures about a stressful event. Or re-enacting a stressful event in a play	0 1 2 3
2. Bad dreams related to a stressful event.	0 1 2 3
3. Acting, playing, or feeling as if a stressful event is happening right now.	0 1 2 3
4. Feeling very emotionally upset when reminded of a stressful event.	0 1 2 3
5. Strong physical reactions when reminded of a stressful event (sweating, heart beating fast)	0 1 2 3
6. Trying not to remember, talk about, or have feelings about a stressful event.	0 1 2 3
7. Avoiding activities, people, places, or things that are reminders of a stressful event.	0 1 2 3
8. Not being able to remember an important part of a stressful event.	0 1 2 3
9. Negative changes in how he/she thinks about self, others, or the world after a stressful event.	0 1 2 3
10. Thinking a stressful event happened because he/she or someone else did something wrong of did not do enough to stop it.	0 1 2 3
11. Having very negative emotional states (afraid, angry, guilty, ashamed)	0 1 2 3
12. Losing interest in activities he/she enjoyed before a stressful event, including not playing as much.	0 1 2 3
13. Feeling distant or cut off from people around him/her	0 1 2 3
14. Not showing or reduced positive feelings (being happy, having loving feelings)	0 1 2 3
15. Being irritable. Or having angry outbursts without a good reason and taking it.	0 1 2 3
16. Risky behavior of behavior that could be harmful.	0 1 2 3
17. Being overly alert or on guard	0 1 2 3
18. Being jumpy or easily startled.	0 1 2 3
19. Problems with concentration	0 1 2 3
20. Trouble falling or staying asleep.	0 1 2 3

Please mark YES or NO if the problems you marked interfered with:

1. Getting along with others	□ Yes □ No
2. Hobbies/Fun	□ Yes □ No
3. School or work	□ Yes □ No
4. Family relationships	□ Yes □ No
5. General happiness	□ Yes □ No

Deliberate Self-Harm Inventory

This questionnaire asks about several different things that people sometimes do to hurt themselves. Please be sure to read each question carefully and respond honestly. Often, people who do these kinds of things to themselves keep it a secret, for a variety of reasons. However, honest responses to these questions will provide us with greater understanding and knowledge about these behaviors and the best way to help people. Please answer yes to a question only if you did the behavior intentionally, or on purpose, to hurt yourself. Do not respond yes if you did something accidentally (e.g., you tripped and banged your head on accident). Also, only answer yes to a question if you did not intend to kill yourself. Do not respond yes if you engaged in a behavior with the intention of ending your life.

1. **In the past 1 month (since __ / __ / __)**, have you intentionally (i.e., on purpose) cut your wrist, arms, or other area(s) of your body (without intending to kill yourself)? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few).** _____

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

2. **In the past 1 month (since __ / __ / __)**, have you intentionally (i.e., on purpose) burned yourself with a cigarette? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few).** _____

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

3. **In the past 1 month (since __ / __ /__)**, have you intentionally (i.e., on purpose) burned yourself with a lighter or a match? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few). _____**

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

4. **In the past 1 month (since __ / __ / __)**, have you intentionally (i.e., on purpose) carved words into your skin? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few). _____**

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

5. **In the past 1 month (since __ / __ / __)**, have you intentionally (i.e., on purpose) carved pictures, designs, or other marks into your skin? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few). _____**

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

6. **In the past 1 month (since __ / __ / __)**, have you intentionally (i.e., on purpose) severely scratched yourself, to the extent that scarring or bleeding occurred? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few). _____**

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

7. **In the past 1 month (since __ / __ / __)**, have you intentionally (i.e., on purpose) bit yourself, to the extent that you broke the skin? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few). _____**

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

8. **In the past 1 month (since __ / __ / __)**, have you intentionally (i.e., on purpose) rubbed sandpaper on your body? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few). _____**

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

9. **In the past 1 month (since __ / __ / __)**, have you intentionally (i.e., on purpose) dripped acid onto your skin? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few). _____**

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

10. **In the past 1 month (since __ / __ / __)**, have you intentionally (i.e., on purpose) used bleach, comet, or oven cleaner to scrub your skin? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few). _____**

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

11. **In the past 1 month (since __ / __ / __)**, have you intentionally (i.e., on purpose) stuck sharp objects such as needles, pins, staples, etc. into your skin, **not including** tattoos, ear piercing, needles used for drug use, or body piercing? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few). _____**

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

12. **In the past 1 month (since __ / __ / __)**, have you intentionally (i.e., on purpose) rubbed glass into your skin? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few).** _____

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

13. **In the past 1 month (since __ / __ / __)**, have you intentionally (i.e., on purpose) broken your own bones? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few).** _____

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

14. **In the past 1 month (since __ / __ / __)**, have you intentionally (i.e., on purpose) banged your head against something, to the extent that you caused a bruise to appear? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few).** _____

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

15. **In the past 1 month (since __ / __ / __)**, have you intentionally (i.e., on purpose) punched yourself, to the extent that you caused a bruise to appear? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few).** _____

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

16. **In the past 1 month (since __ / __ / __)**, have you intentionally (i.e., on purpose) prevented wounds from healing? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few).** _____

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

17. **In the past 1 month (since __ / __ / __)**, have you intentionally (i.e., on purpose) done anything else to hurt yourself that was not asked about in this questionnaire? (circle one):

1. Yes 2. No

If yes,

a. When did you first do this (**in the past 1 month**)? **Please write the date.**

_____

b. How many times have you done this **in the past 1 month**? **Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few).** _____

c. When was the last time you did this? **Please write the date.**

_____

d. **In the past 1 month**, did this behavior result in hospitalization or injury severe enough to require medical treatment? (circle one):

1. Yes 2. No

If yes, please write the number of times each level of medical treatment was required:

Doctor/nurse visit _____ Emergency room visit _____

Medical Floor _____ ICU _____

APPENDIX C

SOAR DBT-A SKILLS REVIEW FORM

DBT-A Module	DBT-A skills checklist	Notes
Mindfulness	☐ Observe (“What skills”) ☐ Describe (“What skills”) ☐ Participate (“What skills”) ☐ Non-judgmentally (“How skills”) ☐ One-mindfully (“How skills”) ☐ Effectively (“How skills”)	
Distress Tolerance	☐ Temperature, Intense Exercise, Paced Breathing, Paired Muscle Relaxation (TIPP) ☐ Activities, Contributing, Comparisons, Emotions, Push Away, Thoughts, and Sensation (ACCEPTS) ☐ Imagery, Meaning, Prayer, Relaxation, One Thing in the Moment, Vacation, and Encouragement (IMPROVE) ☐ Pros and Cons List ☐ Self-Soothe ☐ Radical Acceptance	
Emotional Regulation	☐ Accumulate, Build, Cope (ABC) ☐ Physical, Illness, Eat balanced meals, Avoid mood-altering drugs, Sleep, Exercise (PLEASE)	

	☐ Validate self, Imagine, Take small steps, Applaud yourself, Lighten your load, Sweeten the pot (VITALS) ☐ Accept/Change; Opposite Action	
Interpersonal Effectiveness	☐ Think, Have Empathy, Interpretations, Notice, Kindness (THINK) ☐ Fair, Apologies, Stick to your Values, Truthful (FAST) ☐ Gentle, Interested, Validate, Easy Manner (GIVE) ☐ Describe, Express, Assert, Reinforce, Mindful, Appear Confident, Negotiate (DEARMAN)	
Walking the Middle Path	☐ Self-Validation ☐ Increasing Positive Behaviors ☐ Open Mind Thinking ☐ Problem Solving vs. Problem Acceptance (or other “dialectical versus”)	