

Loma Linda University

TheScholarsRepository@LLU: Digital Archive of Research, Scholarship & Creative Works

Loma Linda University Electronic Theses, Dissertations & Projects

9-2021

Stage Two Outpatient Adolescent Recovery Program

Kaylin Miller

Follow this and additional works at: <https://scholarsrepository.llu.edu/etd>

Recommended Citation

Miller, Kaylin, "Stage Two Outpatient Adolescent Recovery Program" (2021). *Loma Linda University Electronic Theses, Dissertations & Projects*. 1174.
<https://scholarsrepository.llu.edu/etd/1174>

This Doctoral Project is brought to you for free and open access by TheScholarsRepository@LLU: Digital Archive of Research, Scholarship & Creative Works. It has been accepted for inclusion in Loma Linda University Electronic Theses, Dissertations & Projects by an authorized administrator of TheScholarsRepository@LLU: Digital Archive of Research, Scholarship & Creative Works. For more information, please contact scholarsrepository@llu.edu.

LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with the
Department of Psychology

Stage Two Outpatient Adolescent Recovery Program

by

Kaylin Miller

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

September 2021

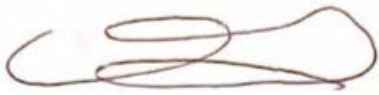
© 2021

Kaylin Miller
All Rights Reserved

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



_____, Chairperson
Bryan Cafferky, Assistant Professor of Counseling and Family Sciences



Cameron Neece, Professor of Psychology

ACKNOWLEDGEMENTS

I would like to express my deepest gratitude to G-d, who created the world perfectly in His image and has guided me through each moment of my life. Without G-d's love, this project and my future work as a Clinical Psychologist would not be possible.

I would also like to thank Dr. Bryan Cafferky and Dr. Cameron Neece for their guidance and unwavering support throughout the research and writing process of my doctoral project. Dr. Cafferky and Dr. Neece provided their expertise and wisdom in creating this trauma-informed manual, and I am forever grateful to their dedication and willingness to give of their time to make this project possible.

To my father and loving sister, your love and support throughout my doctoral degree gave me strength to pursue my dream of becoming a Clinical Psychologist. Dad, thank you for believing in me. Kendra, thank you is not enough to express my gratitude for you. You showed me what true, unconditional love is. You are my hero and my love for you is endless. I cherish you as my sister, best friend, soul mate and inspiration for living a life that is happy, joyous, and free.

CONTENT

Approval Page.....	iii
Acknowledgements.....	iv
List of Tables	vii
List of Abbreviations	viii
Abstract.....	ix
Chapter	
1. Theory and Literature Review	1
Trauma	7
Theoretical Models of Self-Harm Behaviors	12
Biosocial Theory of Personality.....	13
Emotional Vulnerability and Invalidation	14
Development of Maladaptive Coping Skills.....	16
Dialectical Behavioral Therapy for Adolescents	17
Walking the Middle Path	19
Group Therapy for Trauma Treatment	19
Trauma-Focused Cognitive Behavioral Therapy	22
The Trauma Resiliency Model.....	25
2. Assessment of Progress During Treatment.....	29
Child and Adolescent Trauma Screen (CATS) Youth Report and Caregiver Report.....	29
CATS PTSD Symptom Progress Monitoring Report	32
Youth Outcome Questionnaire	32
Diary Cards	33
3. Aims.....	34
Method	34
Target Professionals.....	34

Target Techniques.....	35
Criteria for Included Material and Techniques.....	36
Intervention.....	37
Potential Risks and Considerations.....	39
4. Conclusion	43
References.....	45
Appendix	
A. Treatment Manual.....	50

TABLES

Tables	Page
1. Assessment Measures	31
2. Treatment Modalities	40

ABBREVIATIONS

DBT	Dialectical Behavioral Therapy
DBT-A	Dialectical Behavioral Therapy- Adolescent
SOAR	Stage Two Outpatient Adolescent Recovery Program
YOQ	Youth Outcome Questionnaire
TF-CBT	Trauma Focused Cognitive Behavioral Therapy
PTSD	Posttraumatic Stress Disorder
TRM	Trauma Resiliency Model
CRM	Community Resiliency Model
CATS	Child and Adolescent Trauma Screen
DSM-V	Diagnostic and Statistical Manual- 5 th Edition
PHQ-9	Patient Health Questionnaire
APA	American Psychological Association

ABSTRACT OF THE DOCTORAL PROJECT

Stage Two Adolescent Recovery Program

by

Kaylin Miller

Doctor of Psychology, Graduate Program in Psychology
Loma Linda University, September 2021
Dr. Bryan Cafferky, Chairperson

Non-suicidal self-harm is a broad term used to describe the intentional injury to oneself. Dialectical Behavior Therapy (DBT) is an evidence-based treatment, originally developed for adults with Borderline Personality Disorder, that has been adapted for use with adolescents to treat self-harm and suicidal ideation (DBT-A). Stage one of DBT, which focuses on teaching skills to replace self-harm behaviors and reduce suicidal ideation, has been researched extensively. However, there is limited research on stage two of DBT, which focuses on treating the underlying psychological causes that lead to self-harm. Loma Linda University's Behavioral Medicine Center offers intensive outpatient DBT stage one treatment for adolescents. Stage Two Outpatient Recovery Program (SOAR) was developed at Loma Linda University's Behavioral Health Institute to provide additional support and stage two treatment for adolescents who completed the stage one program. However, based on scores from the Youth Outcome Questionnaire (YOQ) collected each week during SOAR, it appeared that participants' symptoms were not improving. A qualitative study at Loma Linda University was conducted to examine the opinions and feedback from 28 participants (10 adolescents, 18 parents) from the previous SOAR program. The qualitative study used grounding-theory techniques to code and analyze the information gathered through phone interviews with the participants. The

themes that were discovered through this analysis informed the content and structure of the current treatment manual. This manual is critical for recovery of adolescent self-harm, with a focus on treating the underlying trauma symptoms that influence the onset and maintenance of self-harm behaviors.

CHAPTER ONE

THEORY AND LITERATURE REVIEW

Non-suicidal self-injury may be defined as the intentional injury to oneself with no intent to die (Stewart et al., 2016). Though self-harm may co-occur with suicidal ideation, attempts, or completion, this literature review will focus solely on adolescent non-suicidal self-injurious behaviors. Most of the information known about non-suicidal self-harm is derived from encounters with individuals from inpatient or out-patient psychiatric care, or other institutionalized settings (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007). Anonymous self-report surveys indicate the following six non-mutually exclusive behaviors as the most common types of self-harm: cutting-type behaviors, hitting or biting the self, abusing pills, eating disordered behavior, reckless behavior, and bone-breaking/falling/jumping (Laye-Gindhu & Schonert-Reichl, 2005). Self-harm behaviors are often identified as a trait of Borderline Personality Disorder (Koerner, 2012) however, the Diagnostic and Statistical Manual of Mental Disorders-V criteria states that Borderline Personality Disorder cannot be formally diagnosed before the age of 18-years-old. Though a cluster of symptoms consistent with Borderline Personality Disorder may be present for an adolescent, a formal diagnosis is withheld until adulthood if criteria is still met (American Psychiatric Association, 2013). Given that these traits appear to be pervasive and not limited to a particular developmental stage or mental disorder, a thorough investigation into demographic information, comorbidity with mental illness, and risk factors that coincide with self-harm is recommended to inform research, prevention, and intervention (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006).

Although the demographics presented here are not exhaustive, previous and current research indicates that self-injury is a serious problem among adolescents throughout the world. According to the World Health Organization, suicide and accidental death from self-harm were the third cause of death among adolescents, ages 10 to 19-years-old, resulting in 67,000 mortalities out of 1.2 million adolescent deaths worldwide in 2015. The rate of death by self-harm is more prevalent for adolescent females than males; self-injury is the third cause of death for females and the fifth cause of death for males, ages 10 to 19-years-old. In Europe and South-East Asia, self-harm fluctuates between the leading or second cause of death across all adolescents (World Health Organization, 2017). Estimates of prevalence rates of self-harm behavior among adolescents range from 6.9% (Hawton, Rodham, Evans, & Weatherall, 2002), to 15% (Laye-Gindhu, Schonert-Reichl, 2005), or 16% (Brown, Williams, & Collins, 2007). One international meta-analysis examined fifty-two studies between 2005 and 2011 in order to ascertain prevalence rates of self-harm among adolescents, and found that 18% of adolescents (ages 13 to 19) engaged in deliberate self-harm at least once (Muehlenkamp, Clae, Havertape, & Plener, 2012).

The age of onset for self-harm behavior is not fixed, however, previous research indicates that the onset of self-harm behavior and the pubertal phase often coincide (Hawton, Saunders, and O'Connor, 2012). Community, longitudinal studies suggest an onset of anywhere from 14-years-old (Moran et al., 2012) to 15 or 16-years-old (O'Connor, Rasmussen, Miles, & Hawton, 2009). One longitudinal survey of 568 adolescents in British Columbia identified the mean age of onset of self-harm behavior as 15.2-years-old (Nixon, Cloutier, & Jansson, 2008). Some reports indicate that self-harm

may begin as early as 8 years old, however limited information is available about characteristics and long-term outcomes for those that engage in self-harm under 15 years old (Hawton & Harris, 2007). Given the conflicting information presented throughout the literature, it is possible that self-harm may begin during the elementary school years, or sometime between 14 to 16-years-old, though a person may engage in self-harm at any age.

Gender is another demographic that must be explored to better inform prevention and intervention. Previous research indicates that adolescent females are up to three times more likely than adolescent males to engage in self-harm. One study (Barrocas, Hankin, Young, & Abela, 2012) sampled 665 children ages 7 to 16-years-old and found that 9% of female participants and 6.7% of male participants reported to engage in some form of non-suicidal self-harm in their lifetime. Within the sample of participants that reported self-harm behaviors, 55% identified as female (Barrocas, Hankin, Young, & Abela, 2012). In terms of older adolescents, within a sample of 390 high school students ages 14 to 18-years-old, results indicated that 15.9% of participants engaged in self-harm, with 69.7% of self-injurers identifying as female (Muehlenkamp & Gutierrez, 2004). After the age of 13, girls are twice as likely as boys to develop depression and other psychological disorders, which may help to explain the difference in prevalence rates between boys and girls (Barrocas, Hankin, Young, & Abela, 2012). For females, the most common motivating factor to self-harm may be internal (i.e., self-hatred), whereas for males, self-harm may be used as a “test of will” or strength (Laye-Gindhu & Schonert-Reichl, 2004). Similarly, Rodham, Hawton, and Evans (2004) also found that 52% of female self-cutters used self-harm as punishment or to relieve a negative state of mind, compared to 25% of

their male peers.

Although it is important to understand self-harm for all adolescents, regardless of gender identity, it is noteworthy to mention that gender-nonconforming youth have a particularly greater risk for suicidal ideation and self-harm in comparison to their binary peers. In one study of 9,369 adolescents, it was found that gender-nonconforming youth have a 1.6 to 3.9 times greater risk for developing PTSD than heterosexual youth (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). Additionally, the primary investigator conducted literature searches across Google Scholar and PSYCHInfo, searching for articles specific to male, adolescent self-harm in comparison to articles about female adolescent self-harm. On both databases, “female adolescent self-harm” generates nearly three times as many articles as searching for “male adolescent self-harm.” For example, on Google Scholar, across 21 articles, 2 focused specially on male adolescent self-harm, whereas 6 articles focused specifically on female self-harm. Although there is a gap in available research on male adolescent self-harm, the current manual will be accessible to all adolescents, regardless of gender identity.

There is no single factor or predictor to distinguish an individual who may engage in self-harm from an individual who does not engage in self-harm. Instead, a number of factors likely contribute to the onset and maintenance of the behavior. In a sample of 220 students, ages 15 to 16-years-old, who self-reported to engage in cutting behaviors indicated the following reasons as motivation to self-harm: to get relief from a terrible state of mind (73%), punish myself (45%), die (40%), show how desperate I was feeling (37%), find out if someone really loved me (27%), attention (21%), frighten someone (18%), and to get back at someone (12%) (Rodham, Hawton, & Evans, 2004).

Depression, hopelessness, anger, poor problem-solving skills, impulsiveness, and low self-efficacy have been identified as some of the psychological factors that predispose individuals to engage in self-harm (Hawton, Kingsbury, Steinhardt, James, & Fagg 1999).

Similarly, another study (Skegg, 2005) found that leading up to self-harm, individuals reported negative feelings, most commonly anger, depression, loneliness, and frustration. These aversive feelings were reduced during the act of self-harm, however guilt, shame, and disgust increased after the act of self-harm. More than 90% of individuals who present for self-harm at a hospital meet criteria for depression, substance abuse, or anxiety disorders (Skegg, 2005). Other research suggests that anxiety and tension maintain deliberate self-harm behaviors more than depression or hopelessness. Individuals report to feel a build-up of tension and anxiety, and the need to release the tension drives and maintains the self-harm behavior, more so than feelings of depression (Klonsky, Oltmanns, & Turkheimer, 2003). Research is mixed in terms of whether depressive symptoms (i.e., hopelessness) or anxiety (i.e., tension, pressure build-up) drives the act of self-harm. Perhaps one feeling is not more powerful than another; it is possible that depression, hopelessness and anger contribute to feelings of anxiety and tension, and the act of self-harm is used to alleviate the anxiety, anger, and sadness.

In terms of social risk factors, low socioeconomic status, maladaptive family systems, and adverse childhood environmental experiences may contribute to the onset and maintenance of self-harm behaviors (Skegg, 2005). Negative family environment during childhood, such as witnessing marital discord or divorce may also contribute to adolescent self-harm (Skegg, 2005). Other factors such as sexual orientation,

homelessness, and physical illness have also been implicated as social risk factors for self-harm behaviors but additional research is needed in this area (Skegg, 2005). Though psychological and environmental factors are important to consider, trauma has been noted as one of the most prominent factors among those that self-harm.

Previous research indicates that childhood trauma is a significant correlate with self-harm behavior. One meta-analysis was performed across 22 studies to examine the relationship between self-harm and childhood trauma. Congruent with previous research, a significant relationship between self-harm and childhood trauma, specifically sexual abuse, was found (Lang & Sharma-Patel, 2011). Similarly, Zoroglu, et. al (2003) examined the prevalence rate of abuse, neglect, and self-harm behaviors among 862 high school students; 21% of the students self-reported to engage in at least one form of self-harm, across their lifetime. The results indicated that 34.3% of adolescents experienced at least one type of trauma (physical, emotional, sexual, neglect), and that there was a significant relationship between neglect (16.5%) and self-harm, and sexual abuse (10.7%) and self-harm. Additionally, there was a significant relationship between the number of types of trauma and self-harm; 72.7% of those that experienced four types of trauma engaged in self-harm, 65.7% of those that experienced three types of trauma engaged in self-harm, 41.5% of those that experienced two types of trauma engaged in self-harm, and 24.5% of those that experienced one type of trauma engaged in self-harm. Based on previous literature, and congruent with psychological models of self-harm behavior, trauma is a significant factor to consider when looking at adequate treatment for self-harm behavior.

Trauma

Trauma may be defined as an individual's perception of an event as threatening to oneself or others (Miller-Karas, 2015). A key consideration in discussing trauma is to understand that traumatic events are perceived by survivors not by observers. Definitions of trauma serve as a guideline but should not be used to determine the validity of an individual's experience. Traumatic events include one-time incidents such as natural disasters, surgery, death, violence (i.e., a shooting, terrorist attack), or may be chronic, as in circumstances of ongoing poverty, domestic violence, abuse, or neglect. The event commonly involves abuse of power, entrapment, confusion, and feelings of loss, fear, and helplessness. Survivors may feel cognitively, emotionally, and physically overwhelmed (Giller, 1999).

Research suggests that by the age of four-years-old, 26% of children will witness or experience a traumatic event (National Center for Mental Health Promotion and Youth Violence Prevention, 2012). By the age of 18-years-old, 34% of adolescents will experience at least one of the following: neglect or emotional, physical, or sexual abuse (Zoroglu et. al, 2003). During childhood, children may be powerless over the adults that are tasked with protecting and caring for them. Children may experience trauma at school, in the home, in the community, via the Internet, by adults, peers, siblings, systems, etc. Though traumatic events differ in the nature of the event, research lends a clear picture of how these events impact individuals at a biological and psychological level, and how these effects play a role in the development of psychopathology.

During the 1930's, Walter Cannon completed a series of studies that examined the human body's response to stress. The term, "fight or flight" was coined by Cannon and

became the default explanation of the physiological response to stress. The theory postulates that the central nervous system is triggered by a threatening interaction with the environment, and stimulates the release of hormones that prepare an individual to either fight against the threatening stimuli, or flee. Advances in modern science have confirmed and extrapolated on Cannon's theory; between the 1970's and early 2000's, more than 2,000 articles about the interaction between the mind and the body were published in scientific journals, and research into this interaction continues to evolve (Jacobs, 2004). When a stressful stimulus (i.e., a traumatic event) is intercepted by the amygdala, a signal is sent to the hypothalamus to trigger the pituitary gland to release adrenocorticotrophic hormone. An increase in the production of cortisol is released to initiate physiological responses, such as dilating the pupils, suppressing the appetite, and bolstering the lungs to prepare for "flight" (Jacobs, 2004). Another advantage of cortisol secretion during arousal is that high levels of cortisol may result in enhanced memory abilities (Buchanan & Lovallo, 2001). While cortisol is effective at the time of the event, too much cortisol may actually have a negative impact on an individual if it is released regularly.

Cannon argued for two possible responses to stressful events, fight or flight, while another researcher, Pierre Janet presented the "freeze and dissociate continuum" as another possible response to stress (Perry, 2003). Typically, when a child faces distress or threat, the child cries out to the caregiver. However, this is not always effective; the caregiver may also be in danger, may be the abuser, may be absent, or may not respond to the child's needs appropriately. The child may attempt to "fight or flee," but if the child is unable, the child may "freeze" due to increasing anxiety and decreasing cognitive

abilities (Perry, Pollard, Blaickey, Baker, & Vigilante, 1995). This avoidant psychological process allows the child to withdraw from the outside world and focus inward; the child may feel numb and detached, become compliant, faint, or enter a “mini-psychoses” in what is known as dissociation or de-realization (Perry, 2003). Research suggests that catecholamines may influence the state of dissociation at the neuronal level (Perry, Pollard, Blaickey, Baker, & Vigilante, 1995). The state of dissociation may benefit the child during the stressful event, however this coping mechanism may become maladaptive after the threat of the event has passed.

After the threat of a traumatic event ends, the parasympathetic nervous system releases different hormones that allow the individual to return to normal functioning. During this time, the heart rate returns to normal levels and cortisol levels should decrease. However, the psychological effects of the event may continue to torment the survivor long after the traumatic event has passed. Pierre Janet suggested that traumatic events are encoded in our minds as “traumatic” as a result of the intense emotional responses interfering with the integration of our memories of the event (Van der Kolk, 1994). At the same time, per the discussion of cortisol in the previous section, our ability to remember these events may be enhanced. The combination of these two factors leads to what Bessel van der Kolk refers to as “defensive reaction,” or a reflexive response to threats after the traumatic event has occurred (Van der Kolk, 1994).

Similar to Pavlov’s theory of conditioning, the theory of defensive reaction postulates that after a traumatic event, previously innocuous stimuli may be perceived as threatening, which may lead to the same feelings of fear, panic, and terror as the individual experienced during the previous traumatic event (Van der Kolk, 1994). For

children living in environments that are constantly chaotic, as in cases of chronic abuse or neglect, the child is focused on survival and adapting to the environment. Development of the appropriate cognitive, emotional, or social abilities is stunted (Hart, Gunner & Cicchetti, 1996). As a result, a child may feel but not be able to verbally express rage, fear, or shame. Behavioral indications of trauma include delays or regression in speech, enuresis, tantrums, and global delays at various milestones. In later childhood, adolescence, or adulthood, individuals may experience hypervigilance, panic, and dread of an unexpected flashback of the event(s) (Van der Kolk, 2005).

Pierre Janet postulated that memories of intensely arousing experiences are still encoded during dissociation as well. Moreover, these memories may return to consciousness through feeling states, somatic sensations, visual images, or behavioral reenactments (Van der Kolk, Brown, & Van der Hart, 1989). Behaviorally, a child may act “stunned,” and withdraw from previously enjoyed activities or interactions with other children and adults. Children may feel a loss of trust in the community or social agencies set out to protect them (i.e., police officers), or blame themselves and experience guilt (Perry, 2003). Regardless of how the child reacted to the traumatic event, psychological effects are evident after the event has ended.

As mentioned previously, the limbic system is the first to respond to threatening stimuli. Information is quickly interpreted and sent to other parts of the brain to determine a response.

In terms of the lasting neurobiological effects of traumatic experiences, the concept of a positive feedback loop is especially important (Van der Kolk, 1995). During the traumatic event, the hippocampus records the memory of the event in spatial and

temporal dimensions. After the event, when an individual has a new experience, the new information is compared to previously stored information in the hippocampus to determine if and how the new information is associated with old information, and if that experience was positive or negative. However, the amygdala may interfere with proper hippocampal consolidation of the memory, when flooded with intense, emotional information; proper storage and categorization of stressful events may be disrupted (Van der Kolk, 1995). According to the theory of a positive feedback loop, this flawed consolidation triggers a physiological and emotional response to innocuous, new information, placing a survivor back in a terrorized state, even when no “real” threat exists. Consistent reactivation of these connections has negative implications in the development of psychopathology. As a certain pattern of neural activation occurs more frequently, the strength of the connections increases, creating a “template” for new input to be processed (Perry, Pollard, Blaikley, Baker, & Vigilante, 1995). In other words, the more a memory is recalled and processed, the stronger and more salient the pathway becomes, and the stronger the patterns of reactions and behaviors become as well.

Although this theory of “use-dependent internalization” is typically cited in examples of learning theory, it is relevant to the discussion of trauma in terms of sensitized neural responses (Perry, Pollard, Blaikley, Baker, & Vigilante, 1995). Overtime, the sensitization of the pattern of activation renders a more sensitive system, where the positive feedback loop is constantly retriggered. Increased sensitization leads to lack of, or disruptions to, neurotransmitters and hormones, which overtime may influence the function of specific structures in the brain (Perry, Pollard, Blaikley, Baker, & Vigilante, 1995). This process is further explained by the concept of plasticity, where

the brain produces more neurotransmitters or neurohormones that are often used, and curtails supplies of those that are not often used. In the developing brain of a child, these connections become “trait-like,” and play a role in the development of psychopathology.

Although the brain structure may be altered due to traumatic experiences, it is also important to note that psychologically, a person who has experienced trauma may be more likely to perceive events as traumatic. As Van der Kolk hypothesized, we interpret new information based on past information (1995). Therefore, when someone has experienced a traumatic event, when new information is processed that resembles a previous threat, it may be perceived as “traumatic” at a lower threshold than individuals who have not experienced the traumatic event (Van der Kolk, 1995). Just as the limbic system may be “triggered” by new stimuli at a lower threshold after a traumatic event, so too can our memories of past events influence the likelihood of perceiving a new event as traumatic in nature. As mentioned previously, those who experience multiple forms of trauma are more likely to engage in self-harm, so this information is important note in assessing for traumatic events; we must keep in mind that trauma is a perceptual experience of the individual and should not be judged as either traumatic or not by an outsider observer.

Theoretical Models of Self-Harm Behaviors

Favazza (1989) completed a literature review to examine the motivating factors for adolescents to engage in self-harm. Eight theoretical models were used to explain the function and maintenance of self-harm behaviors. The first four models (behavioral, systemic, avoidance of suicide, and sexual) highlight environmental or systemic factors

which maintain and reinforce self-harm behaviors, whereas the second four models (expression of affect, control of affect, ending depersonalization, and creating boundaries) focus on affect and sense of self (Suyemoto & Macdonald, 1995). During the current literature view, Favazza's theoretical models of deliberate self-harm behavior were cited by many, but empirical evidence to support these theories was not found. Within the psychological community, Marsha Linehan's Biosocial Theory of Personality is currently accepted as a theoretical model that encompasses the biological and social factors that contribute to maladaptive personality traits.

Biosocial Theory of Personality

The leading researcher on treatment for traits of Borderline Personality Disorder is Marsha Linehan. Much of her work has been extensively researched and informed the field for effective treatment of self-harm, suicidality, and other behavioral symptoms of Borderline Personality Disorder. The core problem for individuals with Borderline Personality Disorder traits (i.e., self-harm) is emotional dysregulation. Emotion dysregulation is defined as the inability, despite one's best efforts, to change or regulate emotional cues, experiences, actions, verbal responses, and/or nonverbal expressions under normative conditions (Koerner, 2012). Further, the inability to regulate emotions occurs across emotions, problems, and situations. Linehan (1993) argued that three biologically based characteristics contribute to emotion dysregulation: high sensitivity, high reactivity, and long-lasting arousal (slow return to baseline). People prone to emotion dysregulation react more immediately at a lower threshold, experience and express emotion intensely, and experience long-lasting arousal. The biological

vulnerability may be compounded by interactions between the emotionally vulnerable person and a social environment that is pervasively invalidating. Long-term invalidation by caregivers may lead to a pattern of avoidance of expressing emotion, or emotional blunting, masking or distorting to protect the individual from experiencing emotions that have been habitually invalidated.

Those prone to emotion dysregulation likely experience more invalidation and come to alternate between strategies that either overregulate or under regulate emotion. Behavioral patterns are dialectically conceptualized as: 1) emotional vulnerability versus invalidation, 2) active passivity versus the apparently competent person, and 3) unrelenting crisis versus inhibited grieving. These disruptive patterns can lead to maladaptive behaviors, such as self-harm, and may be used as an attempt to regulate emotions or as a consequence of failed emotion regulation (Linehan, 1993). Interestingly, the biosocial theory may describe the origins of Borderline Personality Disorder, specifically the role of childhood sexual abuse; it is possible that parental invalidation surrounding sexual abuse experiences may influence the development of the disorder (Wanger & Linehan, 1997). Treatment techniques, like Dialectical Behavior Therapy, utilize behavioral theories of change to replace maladaptive behaviors with more adaptive responses (Koerner, 2012).

Emotional Vulnerability and Invalidation

The key components to the biosocial model are vulnerability (biological) and invalidation (social). The model looks at biological and environmental factors that lead to emotion dysregulation; once an individual becomes dysregulated, they are at risk of

engaging in self-harm behaviors when better coping strategies are unknown or not utilized. For individuals who engage in self-harm, it is difficult to regulate emotional responses. Any kind of stimuli, even low-level stimuli may trigger a disproportionate response. For example, an individual may become enraged by a friend running 20 minutes late to a planned visit. Linehan explains that vulnerability is likely physiological, characterized by unregulated and intense affective responses, and has both etiological and functional relevance to emotion dysregulation. Individuals may cope with intense feelings by avoiding or blocking emotional stimuli, or by intensely overreacting (Koerner, 2012). Self-harm behaviors serve as coping mechanisms when the individual perceives emotional stimuli as overwhelming or painful. When this theory was developed, research suggested that the low threshold of activation within these individuals may be associated with abnormal limbic structures (Linehan, 1993). Current research continues to support this theory, particularly that volume loss in the frontolimbic region of the brain, have been assessed in female patients with a Borderline personality diagnosis (Tebartz van Elst, et. al, 2003). As brain imaging and work with genes becomes more advanced, it is possible that the biological component of this theory will be better understood in the future.

Linehan (1993) described invalidation as the tendency for some parents to deprive their children of understanding and acceptance of their affective responses. In other words, parents may diminish the emotional experiences of a child by either expressing disapproval for such feelings, or by minimizing the child's experience. These parents may be more likely to place higher importance on achievement or appearing happy and problem-free. This teaches children that negative feelings are not important, not valid,

and should not be expressed. The environment teaches the child to stifle emotions and avoid unpleasant feelings altogether. The child creates their own coping strategies, and is less likely to seek comfort from the parent, due to consistent invalidation of feelings (Koerner, 2012). An invalidating environment alone may create unstable emotion regulation, but likely will not warrant a pervasively maladaptive behavioral pattern as seen in Borderline Personality Disorder. However, when a person has both biological vulnerability and a history of an invalidating environment, the slightest emotional stimuli may trigger dysregulation, and return to a stable state may be difficult for the individual. Maladaptive coping strategies (i.e., self-harm) may help the individual return to a stable state, but eventually prove to delay, not treat, the underlying dysregulation (Koerner, 2012). Moreover, the individual may use self-harm behaviors to punish the self for negative feelings that were previously invalidated or criticized by primary caregivers (Koerner, 2012). Treatment for emotion dysregulation involves teaching skills like mindfulness, recognizing emotions, and distraction techniques, like increasing positive activities or attempting to think about something else.

Development of Maladaptive Coping Skills

Psychopathology results from a combination of all the aforementioned processes. Intense emotional experiences, invalidating environments, traumatic experiences, and consistent biological feedback all play a role in the development of psychopathology and maladaptive coping skills. Defensive reaction (psychological) and use-dependent internalization (physiological) work together in the positive feedback loop (psychological and physiological) to create specific patterns of thoughts, emotions, behaviors, and

reactions induced and maintained by physiological responses; some of these patterns may be considered “psychopathology” (Saltzman, Steinberg, Layne, Aisenberg, and Pynoos, 2002). Psychopathology develops through the mind-body interaction. For infants and young children specifically, Perry et. al described the reactionary process of trauma influencing the development of psychopathology as a “simple and unavoidable result of sequential neurodevelopment” (1995). The mind is attempting to adapt to its circumstances, however this may ultimately lead to abnormal development. Not all children who experience trauma will go on to develop psychopathology, however the scope of this paper is a broad generalization of how psychopathology may develop, though individual differences always provide mitigating factors. It is logical to extrapolate on this research to say that those who exhibit psychopathology may use maladaptive coping strategies (i.e., self-harm) to cope with overwhelming emotions, dysregulation, and reliving the experiences of traumatic events.

Dialectical Behavior Therapy for Adolescents

Dialectical Behavior Therapy (DBT) is an evidence-based treatment, originally developed for adults with Borderline Personality Disorder, that has been adapted for use with adolescents to treat self-harm and suicidal ideation (DBT-A). Stage one of DBT, which focuses on teaching skills to replace self-harm behaviors and reduce suicidal ideation, has been researched extensively. Stage one of DBT has four domains to replace life-threatening behaviors and teach coping strategies: mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance (McKay, Wood, and Brantley, 2007). Within each domain, different skills are taught in individual and group therapy

sessions. Mindfulness skills include: self-soothing techniques that use the senses and creation of a relaxation plan to focus on the present and minimize thoughts about the past or future. Interpersonal effectiveness skills include: mindful attention to others (i.e., asking, “How are you?” instead of guessing what another person is feeling), and knowing what you want, asking for what you want, negotiating conflicting wants, getting information, saying no, and acting according to your values in appropriate ways. Emotion regulation skills include: recognizing and labeling emotions. Distress tolerance skills include: radical acceptance, distracting yourself, and self-soothing (McKay, Wood, and Brantley, 2007). DBT-A has shown to decrease suicide ideation and self-harm behaviors in adolescents. Multiple studies have supported the efficacy of this treatment, and it is considered one of the only empirically validated treatment models for adolescent self-harm (Courtney & Flament, 2015; Fleischhaker et. al., 2011; Goldstein et. al., 2015). There is limited research on stage two of DBT, which focuses on treating the underlying psychological causes that lead to self-harm (Lynch, 2007). Stage two DBT should consist of an evidence-based trauma treatment, as Marsha Linehan did not develop a specific stage two DBT protocol. As such, this manual will use elements of stage one DBT, elements of Trauma Focused Cognitive Behavioral Therapy (TF-CBT), and elements of the Trauma Resiliency Model. The SOAR treatment will consist of meeting one time per week as a group for two hours, using the manual attached in Appendix A. Additionally, individuals in the SOAR program must attend weekly individual treatment one time per week. Parents will also attend a weekly support and education group.

Walking the Middle Path

A unique module in the adolescent adaptation of DBT is the module, “Walking the Middle Path.” In this module, the family and adolescent focus on dialectics, or the ability to see opposing viewpoints at once. The two skills discussed in Walking the Middle path are change and acceptance. Change is achieved by discovering the adolescents’ triggers (events prior to engaging in self-harm) and working with the family to create strategies that reduce the likelihood of the trigger taking place. Additionally, parents are taught positive and negative reinforcement and other behavioral strategies to help shape the adolescents’ behavior to be more adaptive. The other advantage of this module is that by seeing multiple perspectives, instead of in extreme or “black and white” ways, communication can improve between parents and their adolescents. Given that invalidation may be present in the home environment, this skill is especially useful as many adolescents still live at home with their families, so changing parent invalidation is critical. Adolescents and their parents are taught that if change is not possible, radical acceptance of the person/situation that will not change is the best alternative (Rathus, Campbell, Miller, & Smith, 2015).

Group Therapy for Trauma Treatment

Jacob Levy Moreno (1946) has been noted as the, “Father of Group Psychotherapy.” Moreno argued that to understand group psychotherapy dynamics, one must understand sociometry, the study of human relations. He proposed the idea that the group served as an “audience” for individual’s “psychodrama” (Moreno, 1946). In other words, the processes which took place between individuals within the group during

therapy influenced change within the individual members. Similarly, Irvin Yalom, in his book, *The Theory and Practice of Group Psychotherapy*, wrote that, “For many patients, then, working out problems with therapists and other members is also working through unfinished business from long ago,” (pg. 15). Moreover, Yalom argues that group therapy serves as a tool to learn and experience interpersonal relationships and explore corrective emotional experiences (pg. 17). The group is also seen as a “social microcosm” (pg. 17).

In his book, *The Theory and Practice of Group Psychotherapy*, Irvin Yalom postulates the following factors that make group therapy effective: universality, altruism, instillation of hope, imparting information, developing social skills, interpersonal learning, cohesion, catharsis, existential factors, imitative behavior, and the corrective emotional recapitulation of the primary family group. According to one meta-analysis that examined 111 studies on group therapy, post-treatment scores indicated some form of improvement, suggesting that group therapy is an effective form of treatment (Burlingame, Fuhriman, & Mosier, 2003). The authors found that client variables such as, diagnosis, chronicity, inpatient or outpatient status, gender, age, etc., provided an explanation of how much individuals improved. For example, those diagnosed with eating disorders or depression seemed to improve the most throughout group therapy treatment. The only groups that did not show improvement were those who sought treatment in the outpatient setting for substance abuse, thought disorders, and criminal behavior, however a discussion of these findings is out of the scope of this paper (Burlingame, Fuhriman, & Mosier, 2003). This information suggests that for most individuals, group psychotherapy can improve a variety of symptoms; individual differences may be accounted for by the diagnosis and setting of treatment.

Research into the use of group therapy as a treatment for trauma typically involves adults diagnosed with Posttraumatic Stress Disorder. Although the adolescents that may benefit from the current treatment program are not required to be diagnosed with PTSD, this empirical evidence serves as a theoretical basis for the use of group therapy in the SOAR program. One meta-analysis that examined 16 studies (1686 participants) compared group therapy treatment outcomes to wait-list conditions, as well as “active treatment” (individual therapy) conditions (Sloan, Feinstein, Gallagher, Beck, & Keane, 2013).. The results showed that compared to a wait-list condition, group therapy improved symptoms of PTSD, however there were no significant findings to suggest that group therapy was a better treatment option than individual therapy (Sloan, Feinstein, Gallagher, Beck, & Keane, 2013). These findings suggest that group therapy will improve PTSD symptoms, but more research is needed to conclusively understand its effects.

Another study examined the effects of group therapy treatment for adolescents that had survived wartime in Bosnia. The treatment utilized a group psychotherapy manual for “war-traumatized adolescents” in a school-based program (Layne et. al, 2001). The manual focused on five factors: traumatic experiences, trauma and loss reminders, postwar adversities, bereavement and the interplay of trauma and grief, and developmental impact. Students with a mean age of 16.8-years-old attended the program throughout the academic school year. Meetings were between 80 and 100 minutes long, and took place weekly or bi-weekly at the discretion of the supervisors.

Pre-treatment measures for PTSD, depression, and grief were gathered in the fall and post-treatment measures were collected at the end of the academic year. The results

showed a reduction in posttraumatic stress, depression, and grief symptoms. Further, the authors found that an increase in psychosocial adaptation as distress symptoms decreased (Layne et. al, 2001). Although the current program is not specifically for survivors of war, these findings provide promising support for the use of a manualized trauma treatment in the group therapy setting.

Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a manualized trauma treatment for children and adolescents. Since it was developed 25 years ago, 14 randomized controlled trials have been conducted to assess the efficacy of TF-CBT compared to other available treatments. Results indicate that TF-CBT has improved trauma responses and symptoms. The treatment is available for traumatic symptoms, but has shown to effectively treat cognitive and behavioral problems, and address caregiver concerns as well. The treatment model is based in 8 to 25 sessions that utilize techniques like creating a trauma narrative, exposure, mindfulness, deep breathing, etc., as well as teaching parents to use effective skills to support their child in their interactions (Trauma-Focused Cognitive Behavioral Therapy, 2018).

TF-CBT has eight modules for the therapist to complete with a child or adolescent during individual treatment. The first module, psychoeducation, involves specific information about the traumatic event that the child or adolescent has experienced, tailored to fit the age and developmental level of the child. Psychoeducation also includes “risk reduction,” which helps the child develop a safety plan and strategies to avoid further incidents. The next module, stress management, teaches the child relaxation

techniques (controlled breathing, progressive muscle relaxation, thought stopping) to address distressing thoughts and emotions. The affect expression module teaches patients to identify feelings, rate intensity of feelings, and express emotions appropriately; this module also includes teaching parents to model labeling and reinforce the child's attempts at labeling emotions. The cognitive coping module outlines the thoughts, feelings, and behavior (known as the cognitive triangle) that patients may experience, and teaches patients to identify and label the triangle and create more "helpful thoughts." Creation of the trauma narrative is another step of TF-CBT, where the patient generates a narrative (in the form of a story, book, song, etc.) and describes their perceptions of the traumatic event; additional steps in this module include exploring the thoughts and feelings surrounding the traumatic event. During a later module, the narrative may be shared with the parent (Trauma-Focused Cognitive Behavioral Therapy, 2018).

After the initial reading and exploration of the trauma narrative, the cognitive processing module allows the patient to explore the thoughts and "inaccurate cognitions" related to the traumatic event through discussion of thoughts or role playing exercises. As mentioned previously, parents are an integral part of TF-CBT. In the behavior management module, parents are taught parent training skills, like positive praise, intentionally ignoring of undesirable behavior, and reinforcement strategies to increase desired behavior while decreasing undesirable behaviors. The final stage of TF-CBT is for the child to share the trauma narrative with the parent; the narrative should only be shared once both the child and the parent have the tools to manage the emotions and thoughts that are brought up by discussing the event. The parent should be a supportive figure in the room, where praise is offered to the child for sharing the narrative, and the

parent is prepared to utilize stress management skills with the child (Trauma-Focused Cognitive Behavioral Therapy, 2018). The current researchers argue that using the relaxation elements of this treatment in a trauma-focused group therapy setting is a logical use of this technique. Further, this program may provide new empirical evidence for support of TF-CBT in the group therapy setting. In the SOAR program, TF-CBT will mostly be utilized during individual sessions in the form of the trauma narrative. In the group setting, therapists will utilize questions from TF-CBT to direct conversation during group (see Appendix A).

Empirical support for TF-CBT in the group setting, to specifically treat adolescents recovering from self-harm is not currently available. However, two studies have looked at the administration of group CBT to children who have experienced sexual abuse. The first study followed children between the age of two and six years as they completed group cognitive behavioral therapy. The goal of the treatment was to decrease feelings of “stigmatization and isolation to improve the overall sense of well-being” of the child. During the 9-week sessions of child groups, children were able to explicitly share about the traumatic experience; group activities included playing, coloring, and reading stories, as well as teaching communication and coping skills to cope with the child’s feelings.

Children were also taught about appropriate touching and body safety. Mothers also attended a parent group, where the goal was to reduce distress related to the child’s abuse; mothers were taught coping skills and techniques to manage difficult behaviors (i.e., tantrums). The results indicated that symptoms for both the child and mother improved and were sustained at 3 months, post-treatment. Additionally, mothers reported

to be satisfied with the results, and felt parenting skills were improved throughout treatment (Stauffer & Deblinger, 1996). The second study examined the same treatment program (mothers and their sexually abused children) in comparison to a “supportive therapy” group treatment. Results indicated that those who underwent cognitive behavioral group treatment had a decrease in symptoms (intrusive thoughts, negative parental reactions to the trauma), suggesting that the cognitive behavioral component of the treatment was more effective than support only (Deblinger, Stauffer, & Steer, 2001). The current treatment manual may be used to further research into this treatment modality for children and adolescent survivors of traumatic experiences. TF-CBT is used in the current manual to inform therapists to ask certain questions about emotions, thoughts, and behaviors in the group setting (see Appendix A).

The Trauma Resiliency Model

The Trauma Resiliency Model (TRM) is used to treat the physical and psychological sensations associated with a traumatic experience. The model focuses on teaching skills that reduce symptoms by calming the central nervous system and reprocessing the traumatic experience. This is referred to as bringing the client back to the resilient zone; it is theorized that when a traumatic experience takes place, we are “pumped out” of the resilient zone- in other words, our nervous system takes over- in order to survive the ordeal. However, it is difficult to function outside the resilient zone. TRM’s main focus is to bring the individual back to the resilient zone, by calming the nervous system through various skills and techniques. The first six skills are called the Community Resiliency Model (CRM). The goal is for the client monitor and identify

sensations as good, bad, or neutral throughout the body, with the intention of acknowledging the bad sensations, while focusing attention on the good or neutral. The first and foundational skill of TRM is called *tracking*; tracking refers to noticing different sensations (good, bad, or neutral) throughout the body. This fundamental skill introduces the patient to becoming aware of bodily sensations. The second skill is *resourcing and resource intensification*; individuals are asked to identify an external resource (a person, place, or thing), an internal resource (bodily strength,) or an imagined resource (i.e., a fictional superhero, dream vacation, etc.). Resource intensification refers to enhancing the strength of the resource by associating more senses with the resource (i.e., describing its color, taste, touch, sounds).

Once the resource is identified, the client is asked to call on the resource while tracking in order to increase positive or neutral sensations. The third skill is *grounding*; similar to tracking, grounding asks the individual to identify positive or neutral sensations within the body, by scanning the body and attending to the pleasant or neutral places. The fourth skill is *gesturing*; the clinician identifies a self-soothing gesture that the client uses while speaking. The clinician draws the individual's attention to the gesture, and guides the client to repeat the gesture to stabilize the nervous system. The fifth skill is *Help Now!* which is similar to DBT tactics to self-soothe by engaging in activities, like drinking water, naming colors, or pushing hands against the wall and feeling the muscles at work. The sixth skill is *shift and stay*; this skill plays on the five previous skills. The goal is shift focus to one of the previous skills to bring attention away from the distressing stimuli.

The seventh skill is *titration*; the clinician guides the client to acknowledge small

sensations and manage the sensation without asking details about the sensation. The eighth skill is *pendulation*; this skill is led by the clinician, and the client is asked to alternate between paying attention to negative and positive or neutral sensations until the negative sensations is nearly nonexistent and the positive or neutral sensation dominates. The ninth skill is *completion of survival responses*; the clinician works with the client to reprocess traumatic events (Miller-Karas, 2015). Some of these skills will be taught in the SOAR program (see Appendix A) in order to reprocess traumatic events without explicitly sharing details of the traumatic event with the group. TRM/CRM has been adapted to work in group settings as well (Miller-Karas, 2015), so the group model will be utilized during the SOAR treatment group (see Appendix A). The current treatment manual will teach the skill, Resourcing, as a distraction technique for distress tolerance. Mindfulness and meditation is an integral part of the SOAR program, and the Trauma Resiliency Model provides a different type of skill that may be useful to participants. Participants of the SOAR program are introduced to TRM skills during individual therapy sessions.

In summary, each framework provides a specific skill for the program (see Table 2), but all of the modalities work together to create a cohesive treatment manual. Unlike Stage One of DBT, Stage Two sets out to heal the underlying trauma that may have contributed to the onset of self-harm behaviors and suicidal ideation. In the SOAR program, individual processing of traumatic experiences occurs during individual treatment sessions, while the group sessions focus on reinforcement of DBT skills. According to the feedback provided by the pilot SOAR study, parents and adolescents appreciated the continued practice of DBT skills. Therefore, DBT is included here only to

reinforce skills in the group settings. TF-CBT and the Trauma Resiliency Model will be used in individual sessions for explicit processing of trauma (see Appendix A). TRM skills are discussed in the group setting only as reinforcement of what is learned in individual sessions. This is included in the group session given the feedback that rehearsal of skills is seen as beneficial to this population.

CHAPTER TWO

ASSESSMENT OF PROGRESS DURING TREATMENT

In order to determine the efficacy of the SOAR treatment program, a number of measures are given to participants at the beginning of treatment, during treatment, and prior to graduation. As mentioned previously, a qualitative study was conducted via phone interviews with previous SOAR participants and their parents, and results indicated that participants' symptoms were not improving. As such, the revisions to the SOAR program include changes to assessment tools, as well as the frequency of assessment throughout the program. The first assessment, Child and Adolescent Trauma Screen (CATS) Youth Report, is given at the beginning on treatment during intake into the program. Second, the CATS PTSD Symptom Progress Monitoring youth self-report is given weekly to participants during group treatment meetings. Lastly, the Youth Outcome Questionnaire is administered during individual therapy sessions that occur weekly while the participant is enrolled in the SOAR program.

Child and Adolescent Trauma Screen (CATS) Youth Report and Caregiver Report

The Child and Adolescent Trauma Screen (CATS) Youth Report and Caregiver Report are available in three different languages. The CATS assessment is based on the Diagnostic and Statistical Manual of Mental Disorders-V (DSM-V) symptoms of Posttraumatic Stress Disorder. The first part of the measure is 15 questions that are answered as "yes" or "no" to indicate what type of traumatic event(s) the child or adolescent has experienced. For example, one of the questions is, "Slapped, punched, or beat up by someone not in the family," and the individual selects yes or no to indicate if

that experience has happened or not, at some point across the lifetime. The next part of the measure consists of 20 items that describe symptoms from four clusters: re-experiencing, avoidance, negative alterations in mood and cognition, and hyperarousal. Children and adolescents fill out the child report, while caregivers fill out the caregiver report about the child or adolescent. Reports are age specific with one report for children ages three to six years old, and children ages seven to 17 years old (Sachser et. al, 2017) (see Table 1).

Each item is answered on a scale where 0 indicates never, 1 indicates once in a while, 2 indicates half the time, and 3 indicates almost always, and the child, adolescent, or caregiver is asked to report on the experience of symptoms within the last two weeks. Some questions asked on the assessment are, “Bad dreams related to a stressful event,” and “Being overly alert or on guard.” 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) (see Table 1).

An international study that examined child, adolescent, and caregiver reports was conducted to assess the internal consistency and construct validity of the Child and Adolescents Trauma Screen. A total of 1,089 children, adolescents, and caregivers participated in this study, with 706 from the U.S., 212 from Germany, and 171 from Norway. In each country, there were slightly more female, adolescent participants than

males, children, and their caregivers. Internal consistency for the 20-item child/adolescent self-report and the caregiver report produces a Cronbach's alpha between 0.88 and 0.94 across all countries involved in the study. For the United States specifically, 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 Patient Health Questionnaire (PHQ-9), a highly regarded assessment for depression, lends a Cronbach's alpha of 0.9 (Sachser et. al, 2017) (Table 1).

Table 1. Assessment Measures.

Measure	Norm Group	Correlation coefficient	Reliability (r)
Youth Outcome Questionnaire (YOQ)	206 outpatient, adolescents (mean age 15 years old)	$\alpha = 0.94$	$r = 0.81$
Child and Adolescent Trauma Screening Youth Report (CATS-screener)	439 trauma-exposed children M=15.3(1.5)	$\alpha = 0.92$ for the child (ages 3 to 6) self-report $\alpha = 0.92$ for the child/adolescent (ages 7 to 17) self-report	$r = 0.88-0.94$
Child and Adolescent Trauma Screening PTSD Symptom Progress Monitoring Youth Self-Report (CATS Progress Checklist)	439 trauma-exposed children M=15.3(1.5)	$\alpha = 0.92$ for the child (ages 3 to 6) self-report $\alpha = 0.92$ for the child/adolescent (ages 7 to 17) self-report	$r = 0.88-0.94$

CATS PTSD Symptom Progress Monitoring Report

The Child and Adolescent Trauma Screening Symptom Progress Monitoring is a 6-item scale that is used to assess symptoms each week during SOAR group treatment

sessions. The scale is for children ages seven to 18 years old. Some sample items include, “Feeling as if what happened is happening all over again,” or “Trying not to think about what happened, or to not have feelings.” The child or adolescent reports symptoms “since [their] last appointment,” which during SOAR treatment will be once per week. The choices to endorse are 0 for never, 1 for once in a while, 2 for half the time, and 3 for almost always. The total of all responses is added together and the score is considered “clinical” if the score totals more than 4. When the participant receives a score of less than four for four consecutive weeks, the 20-item Child and Adolescent Trauma Screen (CATS) Youth Report is administered again. If the participant scores within the “non-clinical” threshold, the participant is discharged from the SOAR group therapy component. Aftercare consists of family therapy sessions, however that is out of the scope of the current manual and will be addressed in another manual (see Table 1).

Youth Outcome Questionnaire

The Youth Outcome Questionnaire (YOQ) is used to track progress during individual treatment sessions throughout the SOAR program. The YOQ is a self-report measure for children and adolescents ages 4 to 17-years-old, which assesses the child’s distress across personal and interpersonal domains. The YOQ uses a Likert-scale, where the individual rates how much a specific item is causing distress (i.e., Never, Always, Some of the Time, Most of the Time). The measure has six subscales that examine interpersonal distress and relationships, somatic symptoms, behavioral dysfunction, social problems, and critical items, which look at more serious symptoms, such as suicidal ideation. A higher overall YOQ score indicates higher levels of distress; a score

of less than 47 indicates “average” functionality (Burlingame et. al, 2001) (see Table 1).

The psychometric properties of the YOQ indicate a reliable and stable measure. The YOQ is composed of six domains: intrapersonal distress, somatic symptoms, interpersonal relations, critical items, social problems, and behavioral dysfunction. The internal consistency for an outpatient, adolescent population for the overall YOQ is a Cronbach’s alpha of 0.94. The internal consistency is high for each domain; intrapersonal distress ($\alpha= 0.88$), somatic ($\alpha= 0.70$), interpersonal relations ($\alpha= 0.81$), social problems ($\alpha= 0.76$), behavioral dysfunction ($\alpha= 0.85$), and critical items ($\alpha= 0.70$). The intercorrelations between YOQ subscales indicate a significant relationship ($p < 0.01$). At a four-week follow-up, internal consistency of the total OQ is 0.81, meaning that this measure is fairly stable over time (Burlingame et. al, 2001) (see Table 1).

Diary Cards

Diary cards are used during individual treatment to assess the triggers an adolescent has encountered throughout the week, and how the adolescent has dealt with such triggers. The adolescent fills in the card each day, listing the skills used and the rate of distress experienced each day. During individual treatment sessions, the therapist and the client use the diary card to measure progress of skill use in between sessions.

CHAPTER THREE

AIMS

The overall goal of this manual is to reduce the number of traumatic symptoms (i.e., feelings of guilt, ruminating thoughts) experienced by adolescent participants of the SOAR treatment program. The Child and Adolescent Trauma Screen (CATS) Youth Report is given at the start of treatment (time one) and at the end of treatment (time two). The dependent variable is the participants' score on the CATS assessment. Our overarching hypothesis is that completion of the SOAR treatment program can reduce the experience of traumatic and distressing symptoms in adolescents who previously engaged in self-harm behaviors.

Method

Target Professionals

The purpose of this manual is to provide a step-by-step guide for therapists that facilitate the Stage Two Outpatient Adolescent Program at Loma Linda University's Behavioral Medicine Center. Licensed psychologists, marriage and family therapists or interns, social workers, and other licensed mental health professionals may use this manual. Target professionals also include student therapists that have been sanctioned by an accredited institution to participate in the practicum experience(s) at Loma Linda University's Behavioral Medicine Center or at Loma Linda's Behavioral Health Institute. All therapists attend a two-week training prior to facilitating group therapy. In the first week, therapists will learn Dialectical Behavior Therapy skills and receive basic

CRM/TRM skill training. During the second week, therapists become familiar with the manual through role play exercises, as well as learn the protocols for different scenarios (i.e., emergencies, explicit discussion of trauma) that may occur during treatment (see Appendix A). Throughout training, therapists shadow the current SOAR therapists, if applicable.

Target Techniques

The techniques presented in this manual were gathered from the following treatments: Dialectical Behavior Therapy (stage one) (Linehan, 1987), DBT Skills Manual for Adolescents (Rathus, Miller, & Linehan, 2015), the Trauma Resiliency Model (Miller-Karas, 2015), and Trauma-Focused Cognitive Behavioral Therapy (Trauma-Focused Cognitive Behavioral Therapy, 2018). The adolescents that participate in this program must have previous experience with Dialectical Behavior Therapy treatment. Therefore, the use of DBT is a review of skills to ensure the adolescent maintains effective coping strategies while processing the traumatic experiences that may influence self-harm behaviors. The use of the Trauma Resiliency Model is to teach two skills: resourcing and grounding. The adolescents are taught how to use resourcing and grounding as coping strategies to use as traumatic experiences are revisited throughout treatment. The use of Trauma-Focused Cognitive Behavioral Therapy is in the form of the module, cognitive coping, where the therapists challenge adolescents to conceptualize or think about their trauma and experiences in a different light.

Criteria for Included Material and Techniques

Stage one of Dialectical Behavior Therapy has been extensively researched for treatment of adolescent self-harm. Specifically, stage one of DBT has been used to teach adolescents who struggle with emotion regulation new skills to cope, in order to replace self-harm behaviors. However, stage two of DBT does not provide therapists with a manual or guide to treat the underlying psychological causes of such behavior. The creators of the current manual, therefore, conducted a search of empirically valid treatment for trauma and self-harm behaviors.

A search of the American Psychological Association's approved treatments for trauma provides the following treatments: Cognitive Processing Therapy for Post-Traumatic Stress Disorder, Eye Movement Desensitization and Reprocessing for Post-Traumatic Stress Disorder, Present-Centered Therapy for Post-Traumatic Stress Disorder, and Psychological Debriefing for Post-Traumatic Stress Disorder. The APA, Division 12, offers information about the best-practice, evidence-based treatments for a variety of disorders (Psychological Treatments, 2016). However, these treatments have been tested and validated for adult populations. For children and adolescents who experience trauma, Trauma-Focused Cognitive Behavioral Therapy is indicated as an evidence-based practice for child and adolescent trauma treatment (Trauma-Focused Cognitive Behavioral Therapy, 2018). Dialectical Behavior Therapy-Adolescent (DBT-A) is also a line of treatment for adolescent self-harm that has been validated through numerous research studies. As such, the current manual will employ techniques from TF-CBT and DBT-A as these have been tested on adolescent populations. Because TRM is not an empirically based treatment and instead considered a biologically based skill set, the use

of TRM in this manual is to engage the adolescents in additional coping and calming strategies.

Intervention

Treatment takes place at Loma Linda University's Behavioral Health Institute. Group therapy meets one time per week for two hours. Adolescents must have previous experience with DBT treatment. Adolescents must attend concurrent individual therapy one time per week. The parents of the adolescents are required to attend a weekly parent group, where DBT and trauma-focused skills are taught and reviewed each week.

PURPOSE

The purpose of the SOAR program is to address the underlying psychological processes that contributed to the onset of self-harm behaviors amongst adolescents that have completed a Stage One DBT program. The overall treatment goal is to reduce symptoms of distress related to previous trauma and provide psychoeducation about emotions and coping strategies. Weekly individual and group treatment, as well as a parent support and educational group are the components of this Stage Two DBT program.

SUMMARY

The program consists of once weekly group sessions with adolescents ages 12-17- years old that are well versed in Stage One DBT skills, and are ready to process previous trauma or underlying psychological issues that contributed to the onset and maintenance of self-harm behaviors. Adolescents attend weekly individual therapy for 60 minutes in addition to the 2-hour group session one time per week. The treatment manual consists of skills and therapeutic techniques from Dialectical Behavior Therapy (Stage One), Trauma-Focused Cognitive Behavioral Therapy, and the Community Resiliency Model.

FORMAT AND SCHEDULE OF SESSION

Orientation/Introductions	5 minutes
Mindfulness Practice	5 minutes
CRM/TRM Skill Discussion	10 minutes
Emotion of the week/Open Space	1 hour
Break	5 minutes
DBT Skill Discussion	30 minutes
Closing	5 minutes

GROUP PARTICIPANTS

Participants of the SOAR program must have prior experience with Dialectical Behavior Therapy. Eligible participants include those that graduated from Loma Linda University’s Stage One DBT program, or an equivalent program at another facility. Additionally, SOAR groups are separated by age; one group is established for 12-14 years-old, and another group is for adolescents 15-17 years-old. If a participant transitions from 14 to 15 years old during the course of treatment, it is up to the discretion of the individual therapist and the group leaders to move the individual to the “older” group, or remain with the 12-14 year old group.

ELIGIBILITY CRITERIA

1. 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
2. SI/HI Risk: Low to moderate risk
3. DBT Skills Use and Knowledge: Score of >1.00 in DBT-WCCL DSS subscale and familiarity of DBT Stage 1 modules and skills during intake interview (knowledge of 1-2 main skills for each DBT-A module and example of how/when to use the skill)

GOALS FOR TREATMENT

The goal of SOAR’s group therapy component is to decrease symptoms of post-traumatic stress to subclinical levels by the completion of the 10-week program. The CATS Symptom Progress Monitoring Report, a 6-item trauma screening symptom report, is used to track progress of symptoms throughout the SOAR program. Scores below 4 on the CATS report indicate non-clinical levels of post-traumatic stress. Therefore, it is the goal of this program to reduce adolescents’ scores on the CATS Symptom Monitoring Report to less than 4 by the end of treatment.

GRADUATION CRITERIA	Four consecutive weeks of scores of less than four on the CATS Symptom Monitoring Report.
TIMELINE	10 weeks- each module is visited twice.
SKILLS	DBT Stage One skills, Resourcing and Grounding from the Community Resiliency Model
CO- COMPONENTS	Individual therapy one time per week, 60 minutes. Parent education/support group one time per week, 2 hours.
ROLES AND RESPONSIBILITIES OF CLINICIANS	Licensed psychologists, marriage and family therapists or interns, social workers, and other licensed mental health professionals may lead the group. Student therapists may also lead the group, if sanctioned by an accredited institution to participate in the practicum experience(s) at Loma Linda University's Behavioral Medicine Center or at Loma Linda's Behavioral Health Institute. Student therapists are supervised by a licensed psychologist at either location.
MEASURES	<ol style="list-style-type: none"> 1. Child and Adolescent Trauma Screen (CATS) Youth Report (during intake) 2. CATS PTSD Symptom Progress Monitoring Youth Self-Report (weekly) 3. Youth Outcome Questionnaire (weekly)

Potential Risks and Considerations

The SOAR program uniquely combines three treatment modalities: Dialectical Behavior Therapy, Trauma-Focused Cognitive Behavioral Therapy, and the Trauma Resiliency Model (see Table 2). Although each modality brings unique skills to this program, there is a potential for overlap between the mindfulness skills in each modality. Additionally, given that the participants in this program have completed a Stage One DBT program, rehearsal of DBT skills in this program may seem redundant. However, as

noted in Table 2, each modality brings a special component to either the group or individual setting. Though overlap may be observed across the modalities in terms of mindfulness skills, the skills pulled from each modality are unique in their own right, and each skill serves a different purpose in the program.

Table 2. Treatment Modalities.

MODALITY	DBT	TF-CBT	TRM
SKILL(S)	Cheerleading statements; DEARMAN; STOP; ACCEPTS	Deep breathing; Progressive Muscle Relaxation; Trauma Narrative	Resourcing
JUSTIFICATION	Reinforcement of Interpersonal Effectiveness skills in the group setting	Use of relaxation skills to cope with trauma during group process	Unique skill taught in SOAR to improve processing of traumatic experiences
PURPOSE	Regulate interpersonal conflict	Regulate Emotions	Improve regulation of ANS
EXPOSURE	<u>Individual Session:</u> Rehearsal of skills, diary cards, behavior chains, etc. <u>Group session:</u> Rehearsal of skills	<u>Individual Session:</u> Trauma narrative <u>Group session:</u> Therapists use questions derived from TF-CBT to direct conversation	<u>Individual Session:</u> Learn resourcing and the TRM <u>Group session:</u> Rehearsal of resourcing skill

In the group setting, the therapist should rely on DBT to rehearse previously learned skills and reinforce the modules of DBT Stage One. TRM skill rehearsal is also a component of the group session, to reinforce what is learned in individual sessions. In contrast, during individual sessions, TF-CBT will be used to discuss explicit trauma that

will not be discussed during group sessions. Given that discussion of these topics may be triggering or difficult to process, individual therapists should also rely on Resourcing, pulled from TRM, in order to help the participant remain in their “resilient zone.”

Therefore, therapists must be trained to use DBT and TRM in the group setting only, and TF-CBT and TRM in the individual sessions only.

As these modalities overlap and offer unique qualities at the same time, special consideration for each modality is critical. Therapists must be aware of which modality to use during each session. It is possible that the overlap between modalities may cause confounding factors in the treatment outcome, given that many modalities are being used at once. However, the current researcher believes that the three modalities work together to each bring a unique component to the program that could not be achieved if only one modality were used in the SOAR program.

The greatest challenge within this program is carefully balancing each component at the right time (i.e., in group versus individual settings). However, this is also a strength of the program- the use of multiple evidence-based practices may enhance the efficacy of the program. Therapists are specifically trained to use specific skills during group and individual sessions. Should a question arise as to which skill should be used at which time will depend on the setting; group sessions should focus on DBT and TRM skills while individual sessions focus *processing trauma* using TF-CBT and TRM skills. The feedback received from the pilot SOAR program explicitly stated that reinforcement of DBT skills was necessary for the participants. Therefore, DBT skills will continue to be used in the group setting. However, in the previous SOAR program, individual sessions were not offered. The current researcher believes that offering individual sessions will

allow for explicit discussion of traumatic experiences, as well as unique education in TRM skills that will allow the participants to utilize new calming strategies that were not taught during DBT Stage One programs.

This is what uniquely sets the SOAR program apart from DBT Stage One programs, and is the justification behind calling the program a Stage Two Recovery Program. In DBT Stage One, participants were discouraged from discussing traumatic experiences. Therefore, the difference between Stage One DBT programs and the SOAR program lies in the explicit discussion of traumatic experiences in individual sessions, as well as the use of new, TRM skills to allow the participant to process the trauma without becoming overwhelmed in session. The justification of this program was discussed earlier, however it is important to reiterate here that the main purpose of this program is to explicitly discuss and process traumatic experiences that may influence self-harm behaviors in the individual sessions. The group component offers additional rehearsal of DBT skills, and therefore is considered only a component of the SOAR program as a whole.

CHAPTER FOUR

CONCLUSION

In conclusion, a stage two treatment manual is vital for the recovery of adolescents who previously engaged in self-harm behaviors. Stage one DBT for adolescents offers a manualized treatment plan and has been further developed to give clinicians access to workbooks and worksheets to expand on the stage one skills. Stage two DBT does not currently offer the same quality of treatment for adolescents. The current manual is an initial attempt to create a manualized, stage two DBT treatment plan. Given the lack of research on adolescent stage two DBT treatment, this manual also serves as a stepping stone to bridge the gap in research between stage one and stage two treatment.

Although the treatment manual is intended to reach all adolescents that have engaged in self-harm, it may be challenging to provide generalizability outside of Loma Linda, CA. Additionally, the program requires consistent attends, meaning participants are asked to make a significant time commitment to the program, which may result in high rates of drop-out. However, assessment of the adolescents each week ensures that treatment is effective. Additional fidelity of the therapists takes place one time per month to ensure quality of care and that each therapist is up to date on any relevant research pertaining to adolescent self-harm.

As noted at the onset of this manual, adolescent self-harm is a serious problem around the world. The purpose of this manual is to provide a thorough treatment plan for reduction of distress symptoms associated with experience of trauma or other adverse events. The goal of the program is to treat the underlying psychological symptoms that

led to the onset and maintenance of adolescent self-harm behaviors. As distressing symptoms decrease, and coping skills increase, adolescents are able to graduate the program and maintain recovery with the help of their support systems.

REFERENCES

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Barrocas, A. L., Hankin, B. L., Young, J. F., and Abela, J. R. (2012). Rates of Nonsuicidal Self-Injury in Youth: Age, Sex, and Behavioral Methods in a Community Sample. *Pediatrics*, *130*(1), 39-45.
- Brown, S., Williams, K., and Collins, A. (2007). Past and recent deliberate self-harm: Emotion and coping strategy differences. *Journal of Clinical Psychology*, *63*(9), 791-803.
- Buchanan, T.W. and Lovallo, W.R. (2004). Enhanced memory of emotional material following stress-level cortisol treatment in humans. *Psychoneuroendocrinology*, *26*(3), 307-317.
- Burlingame, G. M., Fuhriman, A., and Mosier, J. (2003). The differential effectiveness of group psychotherapy: a meta-analytic perspective. *Group Dynamics: Theory, Research, and Practice*, *7*(1), 3-12.
- Burlingame, G. M., Mosier, J. L., Wells, M. G., Atkin, Q. G., Lambert, M. J., Whoolery, M., and Latkowski, M. (2001). Tracking the influence of mental health treatment: the development of the youth outcome questionnaire. *Clinical Psychology and Psychotherapy*, *8*(5), 361-379.
- Courtney, D. B., and Flament, M. F. (2015). Adapted Dialectical Behavior Therapy for Adolescents with Self-injurious Thoughts and Behaviors. *The Journal of Nervous and Mental Disease*, *203*(7), 537-544.
- Deblinger, E., Stauffer, L. B., and Steer, R. A. (2001). Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their nonoffending mothers. *Child Maltreatment*, *6*, 332-343. Eth, S. (2001). PTSD in Children and Adolescents. Washington, DC: American Psychiatric Publishing, Inc.
- Favazza, A. R. (1989). Why patients mutilate themselves. *Hospital and Community Psychiatry*, *40*(2), 137-245.
- Fleischhaker, C., Bohme, R., Sixt, B., Bruck, C., Schneider, C., and Schulz, E. (2011). Dialectical Behavioral Therapy for adolescents (DBT-A): a clinical trial for patients with suicidal and self-injurious behavior and borderline symptoms with a one-year follow-up. *Child and Adolescent Psychiatry and Mental Health*, *5*(3), 1-10.
- Goldstein, T. R., Fersch-Podrat, R., Rivera, M., Axelson, D. A., Merranko, J., Haifeng,

- Y., Brent, D., and Birmaher, B. (2015). Dialectical Behavior Therapy for Adolescents with Bipolar Disorder: Results from a Pilot Randomized Trial. *Journal of Child and Adolescent Psychopharmacology*, 25(2), 140-149.
- Giller, E. (May 1999). What is Psychological Trauma. Retrieved from: <https://www.sidran.org/resources/for-survivors-and-loved-ones/what-is-psychological-trauma/>.
- Hart, J., Gunnar, M., and Cicchetti, D. (1996). Altered neuroendocrine activity in maltreated children related to symptoms of depression. *Development and Psychopathology*, 8(1), 201-214.
- Hawton, K. and Harriss, L. (2007). Deliberate self-harm by under 15-year-olds: characteristics, trends and outcome. *The Journal of Child Psychology and Psychiatry*, 49(4), 441-448.
- Hawton, K., Rodham, K., Evans, E., and Weatherall, R. (2002). Deliberate self-harm in adolescents: self-report survey in schools in England. *British Medical Journal*, 325(7374), 1207- 1211.
- Hawton, K., Kingsbury, S., Steinhardt, K., James, A., and Fagg, J. (1999). Repetition of deliberate self-harm by adolescents: the role of psychological factors. *Journal of Adolescence*, 22(3), 369-378.
- Hawton, K., Saunders, K. E. A., and O'Connor, R. C. (2012). Self-harm and suicide in adolescents. *The Lancet*, 379(9834), 2373-2382.
- Hensley, P. (2006). Treatment of bereavement-related depression and traumatic grief. *Journal of Affective Disorders*, 92(1), 117-124.
- Jacobs, G.D. (2004). The Physiology of Mind-Body Interactions: The Stress Response and the Relaxation Response. *The Journal of Alternative and Complementary Medicine*, 7(1), 83-92.
- Koerner, K. (2012). *Doing Dialectical Behavior Therapy: A Practical Guide*. New York, NY: Guilford. ISBN-13: 978-1462502325.
- Klonsky, E. D., Oltmanns, T. F., and Turkheimer, E. (2003). Deliberate self-harm in a nonclinical population: prevalence and psychological correlated. *The American Journal of Psychiatry*, 160(8), 1501-1508.
- Lang, C. M., and Sharma-Patel, K. (2011). The Relation Between Childhood Maltreatment and Self-Injury: A Review of the Literature on Conceptualization and Intervention. *Trauma, Violence & Abuse*, 12(1), 23-37.
- Laye-Gindhu, A. and Schonert-Reichl, K. A. (2005). Nonsuicidal self-harm among

community adolescents: understanding the “whats” and “whys” of self-harm. *Journal of Youth and Adolescence*, 34(5), 447-457.

Layne, C. M., Pynoos, R. S., Saltzman, W. R., Arslanagic, B., Black, M., Savjak, N., Popovic, T., Durakovic, E., Music, M., Campara, N., Nermin, D., and Houston, R. (2001). Trauma/grief-focused group psychotherapy: school-based postwar intervention with traumatized Bosnian adolescents. *Group Dynamics: Theory, Research, and Practice*, 5(4), 277-290.

Linehan, M. M. (1987). Dialectical Behavior Therapy for Borderline Personality Disorder Theory and Method. *Bulletin of the Menninger Clinic*, 51(3), 261-276.

Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York, NY: Guilford Press.

Lloyd-Richardson, E. E., Perrine, N., Dieker, L., and Kelley, M. L. (2007). Characteristics and functions of non-suicidal self-injury in a community sample of adolescents. *Psychological Medicine*, 37(8), 1183-1192.

Miller-Karas, E. (2015). *Building Resilience to Trauma*. New York, NY: Routledge.

McKay, M., Wood, J. C., and Brantley, J. (2007) *The Dialectical Behavior Therapy Skills Workbook*. Oakland, CA: New Harbinger Publications, Inc.

Moran, P., Coffey, C., Romaniuk, H., Olsson, C., Borschmann, R., Carlin, J. B., and Patton, G. C. (2012). The natural history of self-harm from adolescence to young adulthood: a population-based cohort study. *The Lancet*, 39(9812), 236-243.

Moreno, J. L. (1946). Psychodrama and Group Psychotherapy. *Sociometry*, 9(2,3), 249-253.

Muehlenkamp, J. J., Claes, L., Havertape, L., and Plener, P. L. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health*, (6)10, 1-9.

Muehlenkamp, J. J. and Gutierrez, P. M. (2004). An investigation of differences between self-injurious behavior and suicide attempts in a sample of Adolescents. *Suicide and Life-Threatening Behavior*, 34(1), 12-23.

National Center for Mental Health Promotion and Youth Violence Prevention. (July 2012). Childhood Trauma and Its Effect on Healthy Development. Retrieved from: <http://www.recognizetrauma.org/statistics.php>.

Nixon, M. K., Cloutier, P., and Jansson, S. M. (2008). Nonsuicidal self-harm in youth: a population-based survey. *Canadian Medical Association Journal*, 178(3), 306-312.

- Nocker, M. N., Joiner, T. E. Jr., Gordon, K. H., Lloyd-Richardson E., and Prinstien, M. J. (2006). Non-suicidal self-injury among adolescents: diagnostic correlates and relation to suicide attempts. *Psychiatry Research*, 144(1), 65-72.
- O'Connor, R., Rasmussen, S., Miles, J., and Hawton, K. (2009). Self-harm in adolescents: self-report survey in schools in Scotland. *British Journal of Psychiatry*, 194(1), 68-72.
- Perry, B.D. (2003). Effects of Traumatic Events on Children. Retrieved from: <http://www.fa-sett.no/filer/perry-handout-effects-of-trauma.pdf>
- Perry, B.D., Pollard, R.A., Blaicley, T.L., Baker, W.L., and Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation and “use-dependent” development of the brain: how “states” becomes “traits.” *Infant Mental Health Journal*, 16(4), 271-291.
- Psychological Treatments. (2016). Society of Clinical Psychology. Retrieved from: <https://www.div12.org/treatments/>
- Rathus, J., Campbell, B., Miller, A., and Smith, H. (2015). Treatment acceptability study of walking the middle path, a new DBT skills module for adolescents and their families. *American Journal of Psychotherapy*, 69(2), 163-178.
- Rodham, K., Hawton, K., and Evans, E. B. (2004). Reasons for Deliberate Self-Harm: comparison of self-poisoners and self-cutters in a community sample of adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(1), 80-87.
- Roberts, A. L., Rosario, M., Corliss, H. L., Koenen, K. C., and Austin, S. B. (2012). Elevated risk of posttraumatic stress in sexual minority youths: mediation by childhood abuse and gender nonconformity. *American Journal of Public Health*, 102(8), 1587-1593.
- Romans, S. E., Martin, J. L., Anderson, J. C., Herbison, G. P., and Mullen, P. E. (1995). Sexual abuse in childhood and deliberate self-harm. *The American Journal of Psychiatry*, 152(9), 1336-1342.
- Rathus, J. H., Miller, A. L. and Linehan, L. (2015). *DBT Skills Manual for Adolescents*. New York, New York: The Guilford Press.
- Sachser, C., Berliner, L., Holt, T., Jensen, T. K., Jungbluth, N., Risch, E., Rosner, R., and Goldbeck, L. (2017). International development and psychometric properties of the Child and Adolescent Trauma Screen (CATS). *Journal of Affective Disorders*, 210, 189-195.
- Saltzman, W. R., Steinberg, A. M., Layne, C. M., Aisenberg, E., and Pynoos, R. S.

- (2002). A developmental approach to school-based adolescents exposed to trauma and traumatic loss. *Journal of Child and Adolescent Group Therapy*, 11(2), 43-56.
- Shearin, E. N. and Linehan, M. M. (1994). Dialectical behavior therapy for borderline personality disorder: theoretical and empirical foundations. *Acta Psychiatrica Scandinavica*, 89(379), 61-68.
- Skegg, K. (2005). Self-harm. *The Lancet*, 336(9495), 1471-1483.
- Sloan, D. M., Feinstein, B. A., Gallagher, M. W., Beck, J. G., and Keane, T. M. (2013). Efficacy of group treatment for posttraumatic stress disorder symptoms: a meta-analysis. *Psychological Trauma: Theory, Research, Practice and Policy*, 5(2), 176-183.
- Stauffer, L. B., and Deblinger, E. (1996). Cognitive behavioral groups for nonoffending mothers and their young sexually abused children: a preliminary treatment outcome study. *Child Maltreatment*, 1, 65-76.
- Steinberg, A. M., Brymer, M. J., Decker, K. B., and Pynoos, R. S. (2004). The University of California at Los Angeles Post-traumatic Stress Disorder Reaction Index. *Current Psychiatry Reports*, 6(2), 96-100.
- Stewart, J. G., Esposito, E. C., Glenn, C. R., Gilman, S. E., Pridgen, B., Gold, J., and Auerbach, R. (2016). Adolescent self-injurers: Comparing non-ideators, suicide ideators, and suicide attempts. *Journal of Psychiatric Research*, 84(2017), 105-112.
- Suyemoto, K. L., and Macdonald, M. L. (1995). Self-cutting in female adolescents. *Psychotherapy*, 32(1), 162-171.
- Tebartz van Elst, L., Hesslinger, B., Thiel, T., Emanuel, G., Haegele, K., Lemieux, L., Lieb, K., Henning, J., and Ebert, D. (2003). Frontolimbic brain abnormalities in patients with borderline personality disorder: a volumetric magnetic resonance imaging study. *Biological Psychiatry*, 54(2), 163-171.
- Trauma-Focused Cognitive Behavioral Therapy. (2018). *About Trauma-Focused Cognitive Behavior Therapy (TF-CBT)*. Retrieved from: <https://tfcbt.org/about-tfcbt>.
- U.S. Department of Veterans Affairs (November 17, 2017). Clinician's Guide to Medication for PTSD. Retrieved from: <https://www.ptsd.va.gov/professional/treatment/overview/clinicians-guide-to-medications-for-ptsd.asp>.
- Van der Kolk, B. (1994). The body keeps the score: memory and the evolving

- psychobiology of posttraumatic stress. *Harvard Review Psychiatry*, 253-265.
- Van der Kolk, B. (2005). Developmental trauma disorder. *Psychiatric Annals*, 35(5), 401-408.
- Van der Kolk, B., Brown, P., and Van der Hart, O. (1989). Pierre Janet on post-traumatic stress. *Journal of Traumatic Stress*, 2(4), 365-378.
- Wanger, A. W., and Linehan, M. M. (1997). Biosocial perspective on the relationship of childhood sexual abuse, suicidal behavior, and borderline personality disorder. In M. C. Zanarini (Ed.), *Progress in psychiatry, No. 49. Role of sexual abuse in the etiology of borderline personality disorder* (203-223). Arlington, VA: American Psychiatric Association.
- World Health Organization. (2017, May 16). *More than 1.2 million adolescents die every year, nearly all preventable* [Press Release]. Retrieved from <http://www.who.int/mediacentre/news/releases/2017/yearly-adolescent-deaths/en/>.
- Yalom, I. D. and Molyn, L. (2005). *The Theory and Practice of Group Psychotherapy*. New York: Basic Books.
- Zoroglu, S. S., Tuzun, U, Sar, V., Tutkun, H., Savacs, H. A., Ozturk, M., Alyanak, B., and Kora, M. E. (2003). Suicide attempt and self-mutilation among Turkish high school students in relation with abuse, neglect and dissociation. *Psychiatry and Clinical Neurosciences*, 57(1), 119-126.

APPENDIX A
TREATMENT MANUAL

Stage Two Outpatient Adolescent Recovery Program: A Trauma-Focused Intervention
for Adolescent Self-Harm Recovery

Loma Linda University

Kaylin Miller

TABLE OF CONTENTS

1. Justification of Program
 - a. Participants
 - b. Group Expectations
 - c. Group Dynamics
 - d. Diary Cards
 - e. Individual Therapy
2. Intake and Admissions
3. Weekly Format
 - a. Orientation/Introduction
 - b. Mindfulness Practice
 - c. CRM/TRM Skill Discussion
 - d. Open Space
 - e. Break
 - f. DBT Skill Discussion
 - g. Closing
4. Group Leader Protocol
5. Assessment of Progress
 - a. CATS
 - b. CATS Progress
 - c. YOQ
6. Graduation and Beyond

Justification of Program

Non-suicidal self-harm is a broad term used to describe intentional injury to oneself. Dialectical Behavior Therapy (DBT) is an evidence-based treatment, originally developed for adults with Borderline Personality Disorder, that has been adapted for use with adolescents to treat self-harm and suicidal ideation (DBT-A). Stage One of DBT, which focuses on teaching skills to replace self-harm behaviors and reduce suicidal ideation, has been researched extensively. However, there is limited research on Stage Two of DBT, which focuses on treating the underlying psychological causes that lead to self-harm. Loma Linda University's Behavioral Medicine Center offers intensive outpatient DBT Stage One treatment for adolescents. Stage Two Outpatient Recovery Program (SOAR) was developed at Loma Linda University's Behavioral Health Institute to provide additional support and Stage Two treatment for adolescents who completed the Stage One program. However, based on scores from the Youth Outcome Questionnaire (YOQ) collected each week during SOAR, it appeared that participants' symptoms were not improving. A qualitative study that examined the opinions and feedback from 28 participants (10 adolescents, 18 parents) from the previous SOAR program informed the current project. The current treatment manual is critical for recovery of adolescent self-harm, with a focus on treating the underlying trauma symptoms that influence the onset and maintenance of self-harm behaviors.

Purpose

The purpose of the SOAR program is to address the underlying psychological processes that contributed to the onset of self-harm behaviors amongst adolescents that have completed a Stage One DBT program. The overall treatment goal is to reduce

symptoms of distress related to previous trauma and provide psychoeducation about emotions and coping strategies. Weekly individual and group treatment, as well as a parent support and educational group are the components of this Stage Two DBT program.

Treatment Goal

The goal of SOAR's group therapy component is to decrease symptoms of post-traumatic stress to subclinical levels by the completion of the 10-week program. The CATS Symptom Progress Monitoring Report, a 6-item trauma screening symptom report, is used to track progress of symptoms throughout the SOAR program. Scores below 4 on the CATS report indicate non-clinical levels of post-traumatic stress. Therefore, it is the goal of this program to reduce adolescents' scores on the CATS Symptom Monitoring Report to less than 4 by the end of treatment.

Participants

Participants of the SOAR program must have prior experience with Dialectical Behavior Therapy. Eligible participants include those that graduated from Loma Linda University's Stage One DBT program, or an equivalent program at another facility. Additionally, SOAR groups are separated by age; one group is established for 12-14 years-old, and another group is for adolescents 15-17 years-old. If a participant transitions from 14 to 15 years old during the course of treatment, it is up to the discretion of the individual therapist and the group leaders to move the individual to the "older" group, or remain with the 12-14 year old group. Parents of the adolescents must agree to attend a weekly parent group while participating in the SOAR program.

Group Expectations

Discussion of explicit descriptions or specificity of traumatic events is not allowed during group treatment. According to feedback from the pilot SOAR study, parents and adolescents felt that explicit discussion of traumatic experiences and self-harm during group sessions was not helpful. For example, some found these discussions to be triggering and difficult to process during the group. For this reason, explicit discussion of self-harm and traumatic experiences is prohibited during group and should be redirected immediately by the therapist, who should encourage the participant to share about such experiences in individual sessions only. For instructions on how to approach this situation, should explicit information be shared during group, **please see Section 5, Protocols for Group Leaders on page 12 of this manual.**

Additionally, descriptions and specific details of self-harm behaviors is also discouraged during SOAR group meetings. For instructions on how to approach this situation, should explicit details of self-harm behaviors occur during group, **please see Section 5, Protocols for Group Leaders on page 12 of this manual.** During group treatment, processing and personal disclosure is optional, however, participation in activities and group discussion is mandatory. For instructions on how to approach resistance to group participation, **please see Section 5, Protocols for Group Leaders on page 12 of this manual.** The members of each SOAR group create the rules/boundaries for the group (i.e., no cursing, no socializing outside of group) and review the rules briefly before the start of each group session. All cellphones and electronics will be collected by Behavioral Health Institute staff prior to the start of group.

Group Guidelines

1. All information shared in group (including group member names) is confidential.

2. It is prohibited for adolescents or parents to come to group session under the influence of drugs or alcohol.
3. Contact with group members outside of group is prohibited and will result in immediate discharge from the program.
4. Group members are prohibited from contacting each other outside of group during a crisis
5. Group members may not form relationships (i.e., friendships, dating) with other group members while in the program.

Group Dynamics

The SOAR group is led by two group leaders. Licensed psychologists, marriage and family therapists or interns, social workers, and other licensed mental health professionals may lead the group. Student therapists may also lead the group, if sanctioned by an accredited institution to participate in the practicum experience(s) at Loma Linda University's Behavioral Medicine Center or at Loma Linda's Behavioral Health Institute. Student therapists are supervised by a licensed psychologist at either location. All therapists must attend a two-week training prior to facilitating group therapy. In the first week, therapists will learn Dialectical Behavior Therapy skills and receive basic CRM/TRM skill training. During the second week, therapists will become familiar with this manual through role play exercises, as well as learn the protocols for different scenarios (i.e., emergencies, explicit discussion of trauma) that may occur during treatment. Throughout training, therapists may shadow the current SOAR therapists, if applicable.

Group sessions are closed. No parents, siblings, caretakers, etc., may observe group therapy. SOAR meets one day per week, for two hours, over a span of ten weeks.

If an individual does not meet criteria for graduation by the end of ten weeks, the individual will be advised to participate in the program until criteria is met. All participants must attend weekly, individual therapy sessions concurrent with the SOAR group program. Participants will be asked to make a commitment to the SOAR program, by agreeing to attend weekly individual and group therapy, and adhere to an attendance of policy of no more than two missed sessions across group or individual treatment.

Diary Cards

Diary Cards are utilized during individual treatment. Please see the “Diary Cards” section of the RISE program manual for further detail. All participants of SOAR will use this Diary Card weekly and bring it to individual sessions each week.

Individual Therapy

Individual therapy is required for all adolescents to attend concurrent to SOAR group sessions. Individual sessions will be used to process explicit information about traumatic experiences, self-harm behaviors, relapse, etc. Trauma narratives (as used in TF-CBT) will be used to expose participants to trauma and process using the TF-CBT model. Resourcing (as used in TRM) will be implemented in individual sessions to reprocess trauma responses and neutralize the Automatic Nervous System (see Table 2) when processing trauma in individual therapy. Please see the “SOAR Individual Sessions” manual for further detail. Individual therapists must meet weekly with the group therapists. Failure to do so may result in removal of the therapist from the program.

Table 2. Treatment Modalities.

<i>MODALITY</i>	<i>DBT</i>	<i>TF-CBT</i>	<i>TRM</i>
-----------------	------------	---------------	------------

SKILL(S)	Cheerleading statements; DEARMAN; STOP; ACCEPTS	Deep breathing; Progressive Muscle Relaxation; Trauma Narrative	Resourcing
JUSTIFICATION	Reinforcement of Interpersonal Effectiveness skills in the group setting	Use of relaxation skills to cope with trauma during group process	Unique skill taught in SOAR to improve processing of traumatic experiences
PURPOSE	Regulate interpersonal conflict	Regulate Emotions	Improve regulation of ANS
EXPOSURE	<u>Individual Session:</u> Rehearsal of skills, diary cards, behavior chains, etc. <u>Group session:</u> Rehearsal of skills	<u>Individual Session:</u> Trauma narrative <u>Group session:</u> Therapists use questions derived from TF-CBT to direct conversation	<u>Individual Session:</u> Learn resourcing and the TRM <u>Group session:</u> Rehearsal of resourcing skill

Intake and Orientation to SOAR

Intake

Intake to SOAR may occur after an individual has met sufficient admission criteria as outlined below. If an individual has graduated from an intensive outpatient program at Loma Linda University’s Behavioral Medicine Center, the individual will be given a “welcome packet” to the Stage Two Outpatient Adolescent Recovery Program at graduation. The welcome packet is a packet of assessments for the child and parent to fill out and give to the therapist conducting the clinical interview for admission. If an individual has graduated from an intensive Stage One program outside of the Loma Linda University system, then the welcome packet can be obtained at the Behavioral Health Institute at the time of the intake interview. The intake interview is a semi-structured 60-minute interview (see Intake Manual) that assesses if the adolescent possesses adequate DBT skill knowledge to join the process-oriented Stage Two group.

The welcome packet includes following five measures:

1. The DBT Ways of Coping Checklist (DBT and Dysfunctional Coping subscales)
2. Behavioral Assessment System for Children III (BASC-3)
3. Child and Adolescent Trauma Screen (CATS) Youth Report
4. Child and Adolescent Trauma Screen (CATS) Parent Report
5. CATS PTSD Symptom Progress Monitoring Youth Self-Report

The following specific criteria must be met prior to intake into SOAR:

1. 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
2. SI/HI Risk Low to moderate risk
3. DBT Skills Use and Knowledge Score of >1.00 in DBT-WCCL DSS subscale and familiarity of DBT Stage 1 modules and skills during intake interview (knowledge of 1-2 main skills for each DBT-A module and example of how/when to use the skill)

Admissions

Admission to the SOAR group is rolling. Adolescents may join either group at any point during a ten-week period.

Orientation

Orientation takes place on the Friday prior to the week that the adolescent begins SOAR. During orientation, the adolescent and parent sign informed consent for treatment, schedule the first session with an individual therapist, and the orienting therapist reviews the group guidelines and attendance policy with the adolescent and parent(s).

Weekly Format

Each session follows the format listed below. Please see individual sections of the format for further detail in the following sections. All skills that are reviewed throughout treatment are derived from the following sources: Dialectical Behavior Therapy (stage one) (Linehan, 1987), DBT Skills Manual for Adolescents (Rathus, Miller, & Linehan, 2015), the Trauma Resiliency Model (Miller-Karas, 2015), and Trauma-Focused Cognitive Behavioral Therapy (Trauma-Focused Cognitive Behavioral Therapy, 2018).

Orientation/Introductions	5 minutes
Mindfulness Practice	5 minutes
CRM/TRM Skill Discussion	10 minutes
Emotion of the week/Open Space	1 hour
Break	5 minutes
DBT Skill Discussion	30 minutes
Closing	5 minutes

Orientation and Introductions (5 minutes)

Each group session begins with the introduction of group members. Group members should take turns stating their preferred name and pronouns, and how long they have been in the SOAR program. If no new members are present, introduction time is used as a “check-in,” where each member makes a brief statement about their mood/feelings for the day (i.e., “I am here today, but feeling like I don’t want to be here,” or “I am anxious today,” etc.). After introductions or “check-ins” are completed, a review of group rules is delivered by a volunteer. Once rules are reviewed, group session may begin.

Group Rules

For an inaugural group, rules/norms are established during the first week of sessions. Group leaders may give feedback or suggestions for group rules/boundaries. Relationships and contacting group members outside of group is prohibited. Group leaders must inform the members of the limits to confidentiality prior to each group: 1) if

an individual in SOAR discloses suicidal means/plans/etc., 2) if an individual in SOAR discloses abuse of a child or elderly or dependent adult, and 3) if an individual in SOAR discloses plans to harm someone else. Additionally, group leaders should set the rule that all information shared during SOAR treatment group is confidential and should stay within the group only.

Mindfulness Practice (5 minutes)

The mindfulness practice is led by a participant volunteer. If a volunteer cannot access a practice from memory, the following exercises are available for use:

Sound Ball: The participants in the group will work together for this mindfulness exercise. One participant will begin by making a sound, which they will then “throw” across the room towards another participant. The participant who receives the throw will then imitate the exact sound they heard the first participant make. They will then make a sound of their own and throw it to someone else in the group. The goal is to tap into observing others and participating with them mindfully (Rathus, Miller, & Linehan, 2015).

What’s Different About Me: two group members will pair up with one another and mindfully observe the other. After a some time, they each turn around, giving their backs to one another, and change three aspects of themselves (eg., glasses, hairstyle, watch). The two partners then turn around to face each other and try to point out the differences in their partner. The goal of this exercise is to be able to observe one-mindfully (Rathus, Miller, & Linehan, 2015).

Grounding: is the practice of centering your physical body in the present moment. Grounding makes use of any kind of surface (i.e. a chair, a table, the ground while walking), and allows the individual using the skill to tailor it to their needs and the

limitations of the physical space around them. Making physical contact with a surface allows the individual to bring their awareness to the sensations experienced between their body and the surface, like the pressure of placing a hand on a table or the support of a chair on your back. Focusing on these sensations as you scan down your body, paying particular attention to those places that feel positive or neutral, brings our awareness back to the here and now and away from stress related to past or future experiences (Miller-Karas, 2015).

CRM/TRM Skill Discussion (10 minutes)

During skill discussion, volunteers are encouraged to share an experience from the week, when they were able to either successfully or unsuccessfully use a CRM/TRM skill. SOAR participants learn the skills, **Resourcing**, during individual therapy sessions. In an inaugural group, with no veteran members, group leaders may explain the skill discussion to participants and offer an example, such as: “At school on Tuesday, my teacher called on me to answer a question that I didn’t know the answer to. I had to admit in front of the class that I didn’t do my homework. I felt embarrassed and I was angry at the teacher for calling on me. As I sat in my chair, I decided to use my grounding skill, and by the end of class, I felt less angry and bothered by my teacher.”

- After an experience is shared, group leaders ask the volunteer if they are open to feedback.
- Upon consent, group leaders ask other participants to comment/offer support to the volunteer using constructive and positive feedback.

Emotion of the Week & Open Space (1 hour)

Open space is a time for the group to focus on emotion and dialectics- the highs and lows of different experiences throughout the week. Each week, an emotion will be

presented by the group leaders using a psychoeducational approach. Please see below for the weekly schedule of emotions.

Emotion

Group leaders provide the **name of the emotion**, and participants are asked to give a brief example of how this emotion may be triggered and sensed within the body.

A group leader says, “How can we describe (the emotion)? What do we sense in our bodies as we think about being (the emotion)?”

Survive

The group leaders will facilitate a discussion with the participants by asking volunteers to discuss how emotions have been useful or hurtful to them in the past.

A group leader says, “How has (the emotion) helped us in the past? How has it been useful? How has (the emotion) worked against our goals?”

Thrive

The group leaders will facilitate a discussion with the participants by asking volunteers to discuss how we can transform seemingly negative emotions into something positive.

A group leader says, “How can we transform (the emotion) into something positive?”

<u>Emotion of the Week</u>	
1	Overwhelmed
2	Self-Sabotaging
3	Avoidance
4	Fear
5	Denial
6	Sadness
7	Hopelessness
8	Grief
9	Chaotic
10	Shame

After the psychoeducation piece of Emotion of the Week, an open discussion takes place. Group members share a high and a low for the week, describing experiences with the “emotion of the week” and how they coped with said emotion. If the emotion did not come up during a given week, recall a time that it did. Group leaders interact using the following questions as needed: “What were the thoughts you were having?” “How

were your thoughts connected to your feelings and behaviors?” “Could you take the same situation and adjust your thinking to respond in a different way?” (Trauma-Focused Cognitive Behavioral Therapy, 2018).

****Please see Section 5, Protocols for Group Leaders of this manual to redirect individuals who share explicit information about trauma or self-harm behaviors.****

Break

A 5-minute break is given after the Open Space discussion.

DBT Skill Discussion (30 minutes)

During skill discussion, volunteers are encouraged to share an experience from the week, when they were able to either successfully or unsuccessfully use a DBT skill. The DBT modules will rotate each week (see schedule below). The group leaders will initiate the discussion by introducing the module for the week. In an inaugural group, with no veteran members, group leaders may explain the skill discussion to participants and offer an example, such as: “I texted my friend earlier this week and they still haven’t gotten back to me. I started to feel anxious, like my friend doesn’t like me anymore. I got overwhelmed and texted them 3 other times to see if they’d respond.” In this example, no skill was used, so the group may offer support or group leaders may elicit information as to why no skill was used.

- After an experience is shared, group leaders ask the volunteer if they are open to feedback.
- Upon consent, group leaders ask other participants to comment/offer support to the volunteer using constructive and positive feedback.

<u>Week</u>	<u>Module</u>
1	Mindfulness

2	Interpersonal Effectiveness
3	Distress Tolerance
4	Emotion Regulation
5	Walking the Middle Path
6	Mindfulness
7	Interpersonal Effectiveness
8	Distress Tolerance
9	Emotion Regulation
10	Walking the Middle Path

Closing

Group sessions end with a **cheerleading statement** from each member.

Cheerleading statements are statements we make to ourselves to give us permission to ask for what we need.

In an inaugural group, with no veteran members, group leaders model a cheerleading statement. Each member makes a statement about a need they want met throughout the next week.

Group Leader Protocols

Group leaders takes turns to introduce and lead each of the activities during sessions. Additionally, group leaders consult with each adolescent’s individual therapist to inquire about the SOAR member’s history, background, trauma history, etc. Ongoing consultation should take place throughout treatment by meeting with individual therapists at least one time per month per adolescent.

Protocols to follow when a participant shares explicit details of trauma or self-harm:

What do I do if a member shares explicit information about a traumatic experience?

Redirect. Group leaders can say one of the following:

“We understand that at times you may feel compelled to tell your story, however we want to encourage you to share those stories in individual sessions. Instead, here you can focus on how you feel now thinking about or when it happened. Talk about the experience rather than details of the event explicitly.”

OR

“Sometimes, certain details can be triggering to the other individuals in the group so we want to be sensitive and considerate to everyone’s different levels of trauma and where they are at in their process.”

OR

“What does it mean to you that that happened to you? What feelings did you have as that came up? Did you notice any physical sensations when that came up and what are your feelings now?”

What do I do if a member shares about self-harm behaviors?

Redirect. Group leaders can say one of the following:

“We understand that at times you may feel compelled to tell your story, however we want to encourage you to share those stories in individual sessions. Instead, here you can focus on how you feel now.”

OR

“What emotions are you feeling as you discuss those behaviors?”

How do I address a participant that is resistant to treatment?

Either have a conversation before or after group, or address it with their individual therapist.

Emergency Protocols:

Group member discloses suicidal ideation:

1. Alert the supervisor on duty ASAP
2. During break or at the end of session, conduct a suicide assessment
3. Follow instructions of supervisor on duty
4. Document in Progress Note

Group member discloses abuse:

1. Alert the supervisor on duty ASAP
2. Inform the adolescent you have a duty to break confidentiality
3. If supervisor advises, file a formal Child Protective Services Report or Adult Protective Services Report
4. Alert the adolescent's parent of the disclosure

Group member becomes dysregulated during group:

1. Alert the supervisor on duty ASAP
2. Remove the adolescent from the group temporarily
3. Engage the adolescent to use coping skills
4. Rejoin the group as soon as possible to avoid disruption

Assessment of Progress

In order to determine the efficacy of the SOAR treatment program, a number of measures will be given to participants at the beginning of treatment, during treatment, and prior to graduation. The first assessment, Child and Adolescent Trauma Screen (CATS) Youth Report, will be given at the beginning of treatment during intake into the program. Second, the CATS PTSD Symptom Progress Monitoring youth self-report will be given weekly to participants during group treatment meetings. Lastly, the Youth Outcome Questionnaire will be given will be administered during individual therapy sessions that occur weekly while the participant is enrolled in the SOAR program.

Participants are required to arrive 5-10 minutes prior to the start of group to fill-out the CATS PTSD Symptom Progress Monitoring form.

Graduation and Beyond

When a participant receives a score of less than four for four consecutive weeks, the 20-item Child and Adolescent Trauma Screen (CATS) Youth Report will be administered again. If the participant scores within the “non-clinical” threshold, the participant will be discharged from the SOAR group therapy component. Aftercare consists of family therapy sessions, however that is out of the scope of the current manual and will be addressed in another manual.