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Understanding dialectical behavior therapy through the voice of adolescent clients in a community mental health center

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UNDERSTANDING DIALECTICAL BEHAVIOR THERAPY THROUGH THE VOICE OF ADOLESCENT CLIENTS IN A COMMUNITY MENTAL HEALTH CENTER

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ABSTRACT

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Dialectical behavior therapy (DBT) has recently been shown to be an effective therapy for treating adolescents with suicidal and self-harming behaviors. Despite the growing interest of DBT, there is a lack of research on the subjective experiences of DBT from the perspectives of adolescent clients. Therefore, the purpose of this qualitative study was to explore how adolescents experienced DBT in a community mental health setting. Using constructivist, case study methodology, semi-structured interviews were conducted with nine adolescent participants. Findings emerged from the shared experiences of the participants including themes related to treatment modality, use of skills, and the impact of DBT on their lives. Participants reported beneficial results such as decreased suicidality and self-harming behaviors, improved ability to tolerate distress, increased mindfulness and emotion regulation, and healthier relationships with others. Negative experiences included difficulty understanding DBT terminology, too broad of an age range in group therapy, and inconsistent family involvement. Clinical implications and future research directions for the use of DBT with adolescents were discussed.

Keywords*:* adolescent, dialectical behavior therapy, community mental health, self-harming behaviors, suicidality

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INTRODUCTION

Some Call

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As it runs across my skin
Leaving me to ponder
And decide how deep I cut in
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Makes me feel at ease
I no longer feel like a coward
Fucking up on everything with every breath I breathe
But some days I want to stop
Feeling like everything's wrong
Trying to let go of the blade
Sometimes I can but not for long
It’s like I'm addicted to the pain
The feeling taking refuge in my veins
Leaving me feeling confused and alone
Wiping at the streaked tears that seem to be stained
Burned into my skin forever
Becoming a part that I cannot escape
Sometimes I just want to hurt all over
To scream at the top of my lungs until they break

I want to escape from my sadness
It's taking over me
Why can't I just rest
Why won't it let me be
I just want to be free. (Johnson, 2007)

Recently, there has been an increase in the number of adolescents seeking psychological treatment for recurrent suicidal ideation, suicide attempts, and self-harming behaviors (Choate, 2012). In the United States, suicide is the third leading cause of death among persons aged 15-24 years (Centers for Disease Control and Prevention, 2011). In a 2011 nationally-representative sample of youth in grades 9-12, it was found that regarding the 12 months preceding the survey, 15.8% of students reported they had seriously considered attempting suicide; 12.8% of students reported they made a plan about how they would attempt suicide; 7.8% of students reported they had attempted suicide one or more times; and 2.4% of students reported they had made a suicide attempt that resulted in an injury, poisoning, or an overdose that required medical attention (Centers for Disease Control and Prevention, 2011).

The most common forms of self-injury include cutting, burning, branding, piercing, and self-hitting (Aguirre, 2007; Grunbaum et al., 2004). While self-injurious behavior differs from suicidal behavior with regard to intent to die, there are dangerous effects from self-injury (Choate, 2012): infections and medical risks, permanent scarring, and the risk of unintentional death (Aguirre, 2007). Research shows that without treatment, adolescents will likely continue to engage in self-injurious behaviors into adulthood (Wagner & Linehan, 2006).

Self-injurious behaviors and suicide attempts are the most common symptoms among adolescents diagnosed with borderline personality disorder (BPD) or with BPD

features (Robins & Chapman, 2004). Along with these potentially life-threatening behaviors, other features consistent with the diagnosis of BPD were often present in adolescents receiving intensive outpatient services (American Psychological Association [APA], 2002; Woodberry & Popenoe, 2008). These features included self-harming behaviors, suicidal ideation and attempts, trouble regulating emotions, poor interpersonal skills, and difficulty tolerating stress (Becker, Grilo, Edell, & McGlashan, 2002; Gould, Greenberg, Velting, & Shaffer, 2003).

While a diagnosis of BPD is not typically given to adolescents because they are still developing and maturing, a diagnosis is possible; early symptoms and features of BPD often emerge during adolescence (APA, 2002; Santisteban, Muir, Mena, & Mitrani, 2003). Adolescents are increasingly seeking treatment for self-injurious behaviors, suicidality, and features of BPD (Choate, 2012). Although hospitalization is the most common form of treatment for this population, more of these behaviors are being seen in community mental health settings (Theisen, 2007). However, the use of empirically-supported, effective treatment for suicidal adolescents in this setting has only been recently investigated (Choate, 2012).

Statement of the Problem

Adolescents presenting with self-harming behaviors and suicidality can be a challenge for therapists in community mental health settings because of the complexity of symptoms, likelihood of hospitalization, and the lack of empirically-supported treatment interventions available (Groves, Backer, van den Bosch, & Miller, 2012; Koons et al., 2001). Additionally, suicide attempts, suicide ideations, and self-harming behaviors place enormous demands on clinical services and health care costs involving

hospitalization as well as increase the risk of associated medical problems while predicting serious negative psychosocial outcomes for adolescents (Stanley, Gameroff, Michalsen, & Mann, 2001). There is an economic impact of suicide attempts and self-harming behavior on the healthcare system. The most recent data from 2013 found that non-fatal injuries due to self-harm cost an estimated two billion dollars for medical care and another 4.3 billion was spent for indirect costs such as lost wages (Centers for Disease Control and Prevention, 2013).

The treatment approach with the most empirical support for treating suicidal and self-harming adolescents is dialectical behavior therapy (DBT), which was developed by Marsha Linehan for working with adults diagnosed with borderline personality disorder and then adapted for use with adolescents (Linehan, 1993a; Miller, Rathus, & Linehan, 2007). The effectiveness of DBT has been demonstrated with multiple psychological disorders and across a variety of settings (Lynch & Cozza, 2009; Lynch, Trost, Salzman, & Linehan, 2007; Miller et al., 2007; Robins & Chapman, 2004).

In 2007, Miller et al. created a standardized manual, *The Adolescent Adaption of Dialectical Behavior Therapy*, as a modified treatment for suicidal and self-harming adolescents. Using this manual, several studies have found DBT to be a promising treatment for adolescents with a variety of disorders and problems including oppositional defiant disorder, bipolar disorder, substance abuse, family conflict, and juvenile delinquency (Katz, Gunasekara, & Miller, 2002; Miller et al., 2007; Robins & Chapman, 2004; Trupin, Stuart, Beach, & Boesky, 2002). Additionally, several treatment settings have been studied including inpatient settings, hospitals, outpatient settings, residential treatment centers, and juvenile correctional facilities (Katz, Gunasekara, Cox, & Miller,

2000; Koons et al., 2001; Robins & Chapman, 2004; Trupin et al., 2002; Woodberry & Popenoe, 2008).

While these studies are promising, a lack of research remains that investigates DBT from the subjective experience of adolescents (Katz, Cox, Gunasekara, & Miller, 2004). There is a need to understand *how* DBT might be effective in treating adolescents (Quinn & Shera, 2009; Woodberry & Popenoe, 2008). To date, there has been one qualitative study about how adults perceive DBT and none from the perception of adolescent clients (Cunningham, Wolbert, & Lillie, 2004). This case study sought to contribute to the research by understanding *how* adolescents experience DBT. Findings uncovered from this study might benefit adolescent mental health treatment providers and researchers by exploring a deeper understanding of how DBT works with adolescents in an outpatient setting. Therefore, this qualitative case study explored how adolescents experienced a DBT program in a community mental health setting.

Purpose of the Study

The purpose of this qualitative study was to understand, through a constructivist lens, the experience of adolescents ages 13 to 17 who have completed an Adolescent Dialectical Behavior Therapy Program in a community mental health setting. Findings from quantitative research studies found that DBT might be an effective treatment for adolescents with suicidal and self-injurious behaviors. The focus of these studies was on measuring clients' symptoms through objective assessments and not on the subjective experiences of the clients (Cunningham et al., 2004). Exploratory studies of adolescents' subjective experiences of DBT might contribute to a greater understanding of treatment for suicidal and self-harming adolescents. Additionally, a sparse amount of research has

been conducted in the area of DBT with adolescents in outpatient community mental health settings.

Qualitative research was best fitted for this type of investigation because the methodology allowed for meanings, views, and contexts to emerge directly from the clients (Coleman, Cox, & Roker, 2008). Qualitative research supports the development of rich, detailed insights of the meanings, perceptions, and beliefs pertaining to adolescents who have completed a DBT program. Further, there is growing support for the inclusion of adolescents in qualitative research to honor their voice and gain access to their thoughts and perceptions rather than rely on proxy information gathered from an adult's responses to questions on the adolescent's behalf (Creswell, 2007).

Through the use of phenomenological case study methodology, the goal was to provide a rich narrative of the meaning and experiences of DBT from the perspective of adolescents who recently completed a DBT program at a community mental health center. By providing adolescents the opportunity to voice their own perceptions of their experiences with DBT and by posing questions that probe specifically into the components of DBT, inductive and interpretive analyses would reveal a more complete understanding of how adolescents experienced DBT (Merriam, 1998).

Significance of the Study

To date, research on DBT with adolescents has not allowed readers to hear directly from participants in matters concerning their mental health and wellbeing. The qualitative methodology used in this study provided adolescents the chance to voice how their lives had been affected by DBT. Thick, rich description (Creswell, 2007) used to portray the data allowed for a more in-depth understanding of clients' experiences. This

study is significant in that the participants had an opportunity to directly inform the treatment of other adolescents through their shared experiences. The unique insights and meanings gained from the current study will benefit mental health professionals using DBT with adolescents, psychological agencies that have or are starting a DBT program, and provide feedback specific to community mental health settings. Along with clinical benefits, the findings of this study might contribute to much-needed research on suicide prevention, an understanding of borderline personality disorder in adolescents, a decrease in self-harming behaviors, and provide possible new directions for further research.

Guiding Questions

The following research questions guided this study.

Q1 How do adolescents experience DBT in a community mental health center?

Q2 How have the lives of adolescents been impacted by completing a DBT program?

Q3 How are the skills learned in DBT being used by adolescents after treatment?

Rationale

Dialectical behavior therapy was developed by Marsha Linehan (1993a) to treat suicidal adults with borderline personality disorder. Historically, clients with borderline personality disorder and suicidality have been a challenging population to treat due to the pervasive nature of personality disorders, the high risk for self-harm, and the high rate of treatment noncompliance (Koerner, Dimeff, & Swenson, 2007). Furthermore, treatment for BPD is costly to treat due to the frequency of inpatient stays, emergency room visits, hospitalizations, and long-term psychotherapy treatment (Katz et al., 2004). Linehan

(1993a) created dialectical behavior therapy (DBT) to address treatment challenges associated with clients with BPD and complex mental health problems.

Dialectical behavior therapy has been demonstrated to be an effective treatment approach for adults with BPD (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). In a randomized clinical trial, DBT was compared with treatment-as-usual (TAU) and was shown to be more effective in reducing the number of days patients spent in psychiatric hospitals, suicide attempts, parasuicidal behaviors, anger, and depressive symptoms (Linehan et al., 1991). Furthermore, DBT was more effective at increasing treatment compliance and positive social adjustment (Linehan et al., 1991). These results have since been replicated in numerous studies and DBT has been demonstrated to be a well-established, empirically-supported treatment for persons with BPD or BPD features (Koons et al., 2001; Linehan et al., 1991; Robins & Chapman, 2004). Since Linehan's (1993a) original study, DBT research has primarily focused on adults, especially women with BPD. New studies have emerged that explore adults and DBT in the areas of geriatric psychology, forensic settings, substance dependence, veterans, and eating disorders (Woodberry & Popenoe, 2008).

Only recently have the effects of DBT with suicidal and parasuicidal adolescents been explored. An early study applied DBT to adolescents exhibiting BPD traits (Rathus & Miller, 2002) and was groundbreaking since it targeted, rather than excluded, participants with high Axis I and Axis II comorbidity and suicidality. Traditionally, adolescent studies looking at Axis I disorders did not include suicidal participants or participants with Axis II features (Linehan, Heard, & Armstrong, 1993). Parents of the adolescents were also included in the DBT skills group to maintain the progress and

enhance skill practice generalizability to the home, which was a new variation from Linehan's DBT (1993a) work with adults. Results of this study showed that DBT decreased psychiatric hospitalizations for adolescents and increased treatment compliance (Rathus & Miller, 2002). However, there were no significant differences in the number of suicide attempts made during treatment. Dialectical behavior therapy was shown to be a promising treatment option for adolescents with BPD characteristics (Rathus & Miller, 2002).

Following this study, many other researchers began to adapt traditional DBT for treatment of adolescents. Some major adaptations included the inclusion of parents in skills group, family therapy, a change in therapeutic language, and alternate age-appropriate handouts. A module, Walking the Middle Path, was designed specifically for families (Miller et al., 2007; Rathus & Miller, 2002). A review of 12 studies on DBT with adolescents found the use of adolescent adaptations of DBT might lead to better outcomes than TAU in reducing parasuicidal behaviors, depressive symptoms, days in psychiatric hospitalization, and conflict in families (Dimeff & Koerner, 2007). These studies were conducted in outpatient, residential, forensic, and inpatient settings with adolescents and their families (Dimereff & Koerner, 2007).

Dialectical behavior therapy is conducive for understanding suicidal adolescents in many ways. First, suicidal adolescents have a high rate of noncompliance in therapy (Trautman, Stewart, & Morshima, 1993). Dialectical behavior therapy directly targets noncompliance and has shown to be effective at keeping adolescents engaged in therapy. Also, therapy with suicidal clients can be very stressful for therapists (Katz et al., 2004). When a therapist works with a suicidal adolescent client, he/she might experience a sense

of fear or confusion about where to start treatment as there are often many serious problems competing for attention simultaneously (Katz et al., 2004). Dialectical behavior therapy addresses this problem by offering a structure to the treatment and guiding the focus of treatment to the most urgent problem based on a hierarchy of treatment targets. Not only does DBT provide a structured treatment approach for high-risk suicidal youth, it was specifically developed to target high-risk behaviors. Finally, the four areas of dysfunction addressed in DBT (emotional instability, interpersonal problems, confusion about oneself, and impulsivity) also correspond with some of the developmental tasks of adolescence (Rathus & Miller, 2002), making DBT an age appropriate treatment for adolescents. One of the adaptations made to DBT for adolescents was creating specific treatment targets to address developmental struggles for adolescents and their families (Stanley et al., 2001).

Evidence has shown that group therapy settings provide a relatively safe environment for adolescents to learn how to be in a social group with others, which is an essential skill in society (Linehan, 1993b). Furthermore, group programs for youth provide an opportunity for teenagers to work on issues of adolescence with other teenagers--their primary social learning group (Chang, 2002). Dialectical behavior therapy makes the most of this peer social learning by incorporating weekly skills groups into the model. This ensures that adolescents have regular opportunities to practice their new skills with peers in a structured setting with therapeutic support available if needed (Miller et al., 2007).

Dialectical behavior therapy is congruent with the psychological treatment of adolescents because it actively includes family therapy as an integral part of the model.

The dialectical approach encourages therapists to see individuals within their context (Woodberry, Miller, Glinski, Indik & Mitchell, 2002). Thus, adolescents are conceptualized within the context of their family and community (Katz et al., 2004). Part of understanding emotional dysregulation in adolescents is looking at the interaction between their biological predisposition and their social environment (Rathus & Miller, 2002). Adolescents are often still living with their families, which means their home life is a major component of their social environment. If changes need to be made to the environment, then family therapy is an appropriate approach.

Finally, the family therapy component in DBT also addresses the developmental tasks of separation and individuation adolescents and families go through (Woodberry et al., 2002). Three new dialectical dilemmas were created and added to the model specifically to address dysfunctional patterns in families (Rathus & Miller, 2002). Along with family therapy sessions two to three times a month, DBT offers additional support through parent/caretaker groups and telephone coaching as needed.

Conclusion

Dialectical behavior therapy is a well-established, empirically-supported treatment for adults diagnosed with BPD. Current research shows DBT to be a promising treatment for adolescents with parasuicidal and suicidal behaviors. Many aspects of DBT support work with adolescents such as inclusion of families in treatment, the structured nature of therapy, support provided for the therapists, targeting of treatment noncompliance, and alignment of skills with developmental tasks. While several preliminary studies showed possible effectiveness of DBT with adolescents, much still needs to be explored in terms of how adolescents are impacted by their experience in

DBT (Katz et al., 2004). Findings uncovered from this study might benefit adolescent mental health treatment providers and researchers by exploring a deeper understanding of how adolescents experience DBT in an outpatient setting.

Delimitations

This study was geographically restricted to northern Colorado. This ensured an accessible location to both the researcher and participants. The community mental health center where the participants completed the DBT program primarily serves clients from low socioeconomic households and from diverse multicultural backgrounds. Participants were between the ages of 13 and 17 and clients of the community mental health center.

Definitions

To clarify certain psychological, clinical, theoretical, and other relevant terms used throughout this study, a list of definitions is provided below.

Adolescence. The stage of human development where individuals are transitioning between childhood and adulthood (Steinberg, 2005). Adolescence typically begins at the onset of puberty and lasts until the early 20s, although this time frame varies for different individuals and among cultures (Brent, Baugher, Bridge, Chen, & Chiappetta, 1999). Participants in this study were adolescents ages 13-17.

Borderline personality disorder (BPD). A personality disorder marked by a pervasive pattern of instability in interpersonal relationships, self-image, emotions, and pronounced impulsivity beginning in early adulthood and present in a variety of contexts. To be diagnosed with BPD, an individual must meet five or more of the diagnostic criteria in the DSM-IV-TR (APA, 2000).

Community mental health center. For this study, the name of the center where the participants completed their DBT program remained anonymous to protect the identity of the participants. The community mental health center is in the Rocky Mountain region and provides services to children, adolescents, and families for a variety of outpatient mental health services mostly funded by Medicaid.

Dialectical Behavior Therapy (DBT). A comprehensive, cognitive, behavioral-based therapy used most commonly in the treatment of borderline personality disorder; it has recently been studied in a variety of other populations including adolescents (Miller et al., 2007). Dialectical behavior therapy combines cognitive behavioral interventions and strategies with Eastern mindfulness practices that embrace the idea of dialects (Linehan, 1993a).

Dialects. Two seemingly opposing forces along the same continuum where both hold truths (Linehan, 1993a). Dialectical thinking encourages the integration of opposites to find a middle ground (Katz et al., 2004).

Dysregulation. A term used in DBT to refer to a state of instability and lack of control (Linehan, 1993a). This term refers to a state of lack of order or control, e.g., a person's emotions being dysregulated (or out of control) or a dysregulated relationship (significant, constant instability; Rathus & Miller, 2002).

Parasuicidal behavior. The act of intentionally injuring oneself in a manner that results in damage to the body without any conscious suicidal intent (Linehan et al., 1991). Linehan (1993a) used this term to combine self-injurious behaviors and suicide attempts into the same category--the commonality being the lack of suicide intent.

Self-injurious behaviors. Behaviors where an individual purposefully causes injury to their body without intent to die (Lewinsohn, Rohde, & Seeley, 1996). Self-injurious behaviors include cutting, piercing, burning, and scratching of the skin (Miller et al., 2007). While these behaviors are not intended to be lethal if the injury is severe, they can become a non-intentional suicidal act (Miller et al., 2007).

Suicidal ideation. Thoughts or wishes of killing oneself, of dying, or of being killed (Lewinsohn et al., 1996). Ideation is the strongest predictor of suicide attempts. As suicidal ideation becomes more frequent and intense, the risk of completing suicide increases (Choate, 2012).

Suicide. The completed act of intentional self-inflicted injury with the intent of death (Grunbaum et al., 2002).

Suicide attempts. Self-injurious behaviors in which the individual is ambivalent about dying or has an intent to die (Lewinsohn et al., 1996).

Treatment as usual (TAU). A condition where the group of participants does not receive the treatment being investigated but instead receives TAU-- services normally offered. A TAU group serves as a comparison or control group to the treatment group being studied (Quinn & Shera, 2009).

Overview of Remaining Chapters

This chapter provided a general description of the study including research questions, rationale, purpose, significance, and limitations. Chapter II reviews current literature, theories, and empirical studies related to adolescents, borderline personality disorder, and DBT. Case study methodology and a constructivist theoretical framework are described in Chapter III along with data collection methods and procedures. Chapter

IV presents the findings from each individual's experience of DBT and Chapter V presents themes from the participants' shared experiences. Chapter VI provides a discussion of the research findings, limitations, implications, and directions for future research.

CHAPTER II

LITERATURE REVIEW

This chapter reviews literature related to the physical, neurological, social, cognitive, and emotional transitions of adolescent development. A discussion of borderline personality disorder (BPD) and how it applies to an adolescent population is also included. The theoretical and treatment components of dialectical behavior therapy (DBT) are addressed as they pertain to BPD in adults and then as they have been adapted specifically for use with adolescents. Finally, a summary of the outcome research regarding the effectiveness of DBT with various disorders, populations, and settings is presented.

Adolescent Development

The second decade of life is now known to be as essential to a child's development as the first decade (Steinberg, 2005). Adolescence has been defined as the period between puberty and adulthood (Brent et al., 1999). When children grow into adolescents, they are faced with a new set of challenges such as more demanding school work, developing social skills, meeting peer expectations, struggling with growing independence, and often making very important decisions that will affect the rest of their lives (Furby & Beyth-Marom, 1992). Adolescents have some impairment in their decision-making process and impulse control related to their cognitive development (Grant & Dawson, 1997). Examples of impairment include the high number of teen

drinking and driving accidents, teenage pregnancy, drug and alcohol use, and lack of impulse control (Grant & Dawson, 1997; McGue, Iacono, Legrand, Malone, & Elkins, 2001). Not all adolescents make poor decisions but among those who do, engaging in one risky behavior increases the probability of engaging in others (Dryfoos, 1991). Given that adolescence is a risk period for the initiation of maladaptive behaviors, it is important to help adolescents learn skills to make better decisions and learn from their mistakes.

Adolescence is characterized by "more biological, psychological, and social role changes than other life stages except infancy" (Holmbeck & Updegrove, 1995, p. 16). To understand any psychological problems in adolescence, it is important to have an understanding of normal human development (Steinberg, 2005). The tasks of adolescent development are influenced by the physical, neurological, social, cognitive, and emotional transitions happening at this stage (Brent et al., 1999). Each of these transitions is described below.

Physical Transitions

Physical changes in adolescence center mostly around puberty (Steinberg, 2005). During puberty, an adolescent experiences brain and hormonal changes, physical growth, and changes in reproductive maturation (Brent et al., 1999). The development of secondary sex characteristics is an important physical change during this time because these changes indicate the body is ready to reproduce (Steinberg, 2005). For female adolescents, the onset of menstruation signifies reproductive maturation and is accompanied by many physical, behavioral, and emotional changes (Brent et al., 1999). Hormonal changes also have an effect on adolescent behavior, physical development, and

self-image (Compas, Conner-Smith, Saltzman, Thomsen, & Wadsworth, 2001). Recent research has focused on how the relationship between hormonal and physical changes might affect mood, behavior, sexuality, and social adjustment (Compas et al., 2001). Adjusting to the rapid physical and sexual changes associated with puberty can be a challenge; not successfully adapting to these changes can have a profound impact on an adolescent's emotional health and wellbeing (Steinberg, 2005).

Neurological Transitions

Given that adolescence is a risk period for the initiation of maladaptive behaviors, it is important to understand the connection between the development of the adolescent brain and the development of cognitive functioning. The first decade of life was originally thought to be the most important years for brain development (Blakemore, 2012). Studies of children's brains revealed major changes around the first three years of life (Kuhn, 2006). Therefore, until recently, the majority of neuropsychological research had been done on young children (Blakemore, 2012). Research on the teenage brain is limited because it was thought the brain had already completed most of its development by adolescence (Blakemore, 2012).

In the past decade, technological advances in neurology, such as MRI, have allowed a shift toward researching adolescent brains (Kuhn, 2006). Although the brain reaches its full structural size around 5 to 10 years of age, research now indicates the brain continues to develop during adolescence and into early adulthood (Casey, Giedd, & Thomas, 2000; Giedd et al., 1999). Giedd et al. (1999) used MRI studies to show the brain goes through major changes during the second decade of life that are distinct from the developmental phase of childhood.

Research has shown that the area of the brain thought to be responsible for cognitive processes such as decision-making, planning, and impulse control is the prefrontal cortex (Bechara & Damasio, 1997; Bechara, Damasio, Damasio, & Anderson, 1994; Overman et al., 2004). Segalowitz and Davies (2004) examined the development and maturation of the frontal lobes in children and found the prefrontal cortex was still developing into late adolescence. Furthermore, Giedd et al. (1999) found the prefrontal cortex does not reach full adult functioning levels until the early 20s. This line of research demonstrated that an adolescent's prefrontal cortex is still developing even though other areas of the brain have already reached maturation. As the prefrontal cortex is an area of the brain that is crucial for important cognitive processes such decision-making, impulse control, and predicting consequences of behavior, it then leads that adolescents might have cognitive impairment in these areas. These cognitive deficits might have a profound impact on high-risk behaviors in which some adolescents engage (Blakemore, 2012).

Social Transitions

During adolescence, an individual is transitioning into society as a young adult. This transition has historically maintained a reputation as being one of the most challenging and developmental stages in life. Adolescents take on social responsibilities ranging from driving a car, beginning to date, voting, holding a job, having the ability to purchase cigarettes and lottery tickets, and are legally allowed to marry. These markers of responsibility contribute to adolescents' redefined status in society. During this time, adolescents are recognizing their capabilities and are offered choices previously not available to them. Adolescents are also highly impacted by social influences such as

social media and pressured to conform to gender-role stereotypes or to rebel against them. Along with these pressures, adolescents are faced with changing expectations at school and from family members (Steinberg, 2005). There is a shift from spending time with family to spending time with friends during adolescence (Steinberg, 2005). Adolescents are more likely to focus on being accepted by their peers and forming romantic relationships than their families (Hankin & Abramson, 2001).

The feedback adolescents receive from their environment about their physical characteristics can have an effect on social development (Compas et al., 2001). Social influences such as the media, current celebrities, and trends in fashion cause adolescents to shift a large amount of their focus to body image and physical appearance (Compas et al., 2001). Adolescents are still learning to adapt to their new bodies after going through physical changes; this can be difficult when their bodies are not meeting social norms or portrayals of an "ideal body" (Kuhn, 2006). As a result of these social pressures, individuals are at a higher risk for developing poor body image during adolescence than any other period in their life (Rosenblum & Lewis, 1999).

The development of self-esteem, or a strong sense of self, helps equip adolescents with coping mechanisms needed to deal with stress, anxiety, and social criticism. Adolescents with high self-esteem are fundamentally satisfied with themselves as people. On the other hand, poor self-esteem is known to be an important predictor of negative body image, eating disorders, and substance abuse (Yager & O'Dea, 2010). Self-esteem typically differs between genders--girls tend to have lower self-esteem than boys during this age of development (Clay, Dittmar, & Vignoles, 2005). In Western societies, girls' self-esteem declines substantially during the middle adolescent years with the decline

peaking at the age of 16. In contrast, boys' self-esteem is much more stable, showing only a slight decline from the ages of 14 to 16 (Clay et al., 2005). Researchers believe positive self-esteem development during adolescence diminishes the impact of social factors that contribute to self-injurious behaviors, eating disorders, and substance abuse (Clay et al., 2005; Yager & O'Dea, 2010).

Cognitive Transitions

The cognitive capacities of adolescents are also changing as they begin to think in more sophisticated ways. Cognitive changes include the ability to synthesize complex material and an increase in abstract reasoning (Brent et al., 1999). Adolescents' thinking moves from concrete, in-the-moment, focused thinking to hypothetical and future oriented (Steinberg, 2005). With this transition, adolescents begin to understand deductive reasoning and associate possible consequences with their actions (Steinberg, 2005).

According to Piaget (cited in Steinberg, 2005), most children advance to the formal operations stage by the age of 12. During this stage, a child's thinking becomes more logical and his/her view of the world is more advanced. At the formal operations stage, adolescents are capable of understanding the logic of arguments and developing their own beliefs and values (Steinberg, 2005). Although adolescents have acquired more advanced cognitive skills, they lack experience in using them. Therefore, they might experience frustration and disappointment when there is conflict between their values and what they experience in the world. This is especially true when adolescents experience a traumatic event that contradicts their beliefs and sense of security, which can lead to the development of psychological problems (McGue et al., 2001).

As adolescents increase their cognitive skills, they also become better at overall communication and at formulating opinions about relevant social issues. Their ability to express their own viewpoint as well as their ability to understand the perspective of others increases as well (Steinberg, 2005). Changes in abstract reasoning also contribute to adolescents' development of a sense of morality and an understanding of social conventions (Brent et al., 1999).

Emotional and Psychological Transitions

One of the primary tasks of adolescence is individuation and separation (Erickson, 1968). During this time, adolescents begin to separate from their parents or caretakers and start forming their own identities (Kuhn, 2006). In this developmental stage, adolescents are more influenced by their peers than their parents and are starting to develop an identity based on how it is similar and dissimilar from the values of their parents (McGue et al., 2001).

According to Erickson's (cited in Steinberg, 2005) psychosocial theory of development, children must resolve developmental conflicts in various stages to establish an achieved identity. If an adolescent has not mastered conflicts of previous developmental stages, there will be barriers to successful identity development. Aspects of adolescents' identity development include forming beliefs about sex roles, future vocations, love, marriage, parenthood, religion, and figuring out their role in society (Steinberg, 2005).

Challenges associated with the development of identity can be the cause of anxiety and confusion when entering into adulthood. Heightened awareness of the social importance of appearance and stigmas that arise from being different begin to emerge

quite early for the adolescent (Graber & Sontag, 2006). When adolescents begin to define their identity in terms of who they want to become, they must, at times, go against the values of their family and turn to their peers for guidance; this is a dilemma that might intensify identity confusion (Feist & Feist, 2009. According to Erickson (1968), adolescence is one of the most crucial developmental stages because it is when the crisis of identity confusion reaches its all-time high. This is seen as a time of identity climax because adolescents strive to find out who they are, who they are not, and how this fits into how they understand the world around them. An identity crisis emerges in response to the psychosocial conflicts of one's perceived identity in contrast to one's own identity confusion. Erickson did not see this crisis as a negative phase but as a turning point that could result in an increase in ego strength if resolved in a positive manner (Feist & Feist, 2009). It is necessary for adolescents to experience some type of doubt or confusion so they might develop a stable sense of self (Erickson, 1968).

Adolescence seems to be a time not only of transition but also of psychological challenges. Difficulty adapting to the physical, cognitive, and psychological developmental tasks of adolescence can place some individuals at a greater risk for mental illness (Brent et al., 1999). Research showed an increase in depression and anxiety symptoms during adolescence (Chang, 2002). These symptoms could be traced to both hormonal as well as social factors (Dahl & Hariri, 2005). Adolescence is a time that often results in intense feelings of self-consciousness, self-concern, and preoccupation with one's appearance (Dahl & Hariri, 2005). Adolescents' symptoms of depression and anxiety are most often related to conflicts with parental and peer group relationships and self-image (Dahl & Hariri, 2005).

Psychological and emotional difficulties noted during the adolescent period include confusion about values, beliefs and identity, difficulty tolerating distressing situations, problems managing their emotions, and increased conflict in interpersonal relationships. According to Linehan (1993a), adolescents who experience a high level of difficulty managing their emotions combined with an invalidating environment might be especially at risk for developing characteristics of borderline personality disorder (BPD; Miller et al., 2007).

Borderline Personality Disorder

This section describes the diagnostic criteria of BPD, historical and current theories of the etiology of BPD, and an emphasis on Linehan's (1993a) biosocial theory. Then the controversial debate on diagnosing BPD in adolescents is discussed including arguments for and against diagnosing adolescents with a personality disorder. Finally, empirical support for the early diagnosis and treatment of BPD in adolescents is presented.

Diagnostic Criteria of Borderline Personality Disorder

According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; APA, 2000), the essential features of BPD are "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts" (p. 706). To be diagnosed with BPD, an individual must meet five or more of the following criteria (APA, 2000):

1. Frantic efforts to avoid real or imagined abandonment
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self

4. Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation or severe dissociative symptoms. (p. 710)

The DSM-IV-TR (APA, 2000) estimates the prevalence of BPD to be about 2% of the general population with approximately 10% of clients in outpatient mental health clinics and approximately 20% as psychiatric inpatients. The effects of BPD on a person are most impairing during the young adult years when the risk of suicide is the greatest (APA, 2000). Although the tendency toward intense emotions, impulsivity, and chaotic relationships can be a lifelong struggle for people with BPD, research indicated greater stability in these areas during later adult years (APA, 2000). Some of the common background factors in individuals with BPD are physical and sexual abuse, neglect, hostile conflict, and early parental loss or separation (APA, 2000).

Historical Theories of Borderline Personality Disorder Etiology

The term *borderline* was first used by Adolf Stern in 1938 to describe a group of patients who did not fit into the available categories of mental illness: neurotic or psychotic (Linehan, 1993a). Since that time, a number of theories have been used by professionals to understand individuals who present with unpredictable moods, strained relationships, and self-harming behaviors (Koerner & Linehan, 2000). Most of the theories used to explain BPD have been psychodynamic in nature, e.g., object relations theory and ego psychology. Psychoanalytic theory used the term *borderline* to refer to

those patients who were noncompliant with classical analysis and did not meet criteria for other disorders. Original descriptive characteristics of a person diagnosed with BPD were clients' symptoms were more pronounced than were neurotic clients and they were especially resistant to psychoanalytic therapy (Millon, 1992). Some of the original traits are still relevant to the diagnosis criteria in today's DSM-IV-TR: inferiority, hypersensitivity, negative therapeutic reactions, and projection (Steinberg, 2005). Other theorists thought the development of BPD was due to early needs in childhood going unmet and a child's failure to successfully individuate and separate from his or her mother (Millon, 1992).

Object relations theory (ORT) has influenced more recent hypotheses of BPD. Kernberg (cited in Steinberg, 2005) labeled the disorder borderline personality organization (BPO) and described a cluster of symptoms around serious difficulties in the intrapsychic structure: unstable, intense relationships marked by extremes of idealizing and demonizing the other person; impulsivity; identity disturbance; and self-destructive acts. He stated that BPO might be caused by affectively charged, interpersonal experiences that accumulated through childhood and became internalized over time. According to ORT, a person develops a splitting defense mechanism to protect themselves from the pain of internalized experiences (Steinberg, 2005). The split might be seen as a defense mechanism against the "bad" parts of self and the "bad" object representations such as aggressive impulses, fears, and self-hatred so the "good" parts of self and the "good" object representations are safeguarded (Clarkin, Levy, Lenzenweger, & Kernberg, 2007). An example of splitting is when a person vacillates back and forth between seeking an intense, clinging relationship with poor boundaries (the good object)

and intense rage and heightened emotions when others fail to meet the need for perfect unity (an attempt to destroy the bad object; Steinberg, 2005). A person's experience of self, others, and the environment in general is all seen through a distorted lens when diagnosed with BPO. A treatment was specifically designed for persons with BPO called transference-focused psychotherapy (Foelsch & Kernberg, 1998). This therapy focuses on integrating the splits between the self and an object representation and addresses the person's distorted perceptions. By integrating the split off parts of self and object representations, the borderline characteristics lessen and the person might develop a unified sense of self, increased emotional flexibility, and improved relationships with self and others (Clarkin et al., 2007).

Biosocial Theory of Borderline Personality Disorder

The biosocial theory is a more recent theory of the etiology of BPD developed by Linehan (1993a). Linehan (1993a) stated that BPD is a pervasive inability to regulate emotions and control behaviors linked to negative feelings. The biosocial theory describes how this emotional dysregulation develops out of the interaction between two factors: a biological disposition to difficulties regulating emotions and childhood experiences of being raised in an invalidating environment. Linehan describes the development of BPD:

> Borderline personality disorder is primarily a dysfunction of the emotional regulation system; it results from biological irregularities combined with certain environments, as well as from their interactions and transaction over time. The characteristics associated with BPD are sequelae of, and thus secondary to, this fundamental emotional dysregulation. Moreover, these same patterns cause further deregulation. Invalidating environments during childhood contribute to the development of emotional dysregulation; they also fail to teach the child how to label and regulate arousal, how to tolerate emotional distress, and when to trust her own emotional responses as reflections of valid interpretations of events. (p. 42)

Some individuals are born with a biological vulnerability to being especially sensitive to emotional stimuli (Linehan, 1993a). This emotional vulnerability can lead to overreacting to emotions as well as having a harder time returning to a baseline level of affect after becoming emotionally over-aroused. The biological *hardwiring* of the brain can create more extreme emotional responses and more frequent, longer lasting, aversive states of emotion (Blakemore, 2012).

The second component of the biosocial theory is an invalidating environment, which has been described by Linehan (1993a) as the caretakers of a child not being attuned to the inner life or needs of the child. Either they do not respond appropriately to the child's needs or they overreact with extreme negative consequences. A child growing up in this environment perceives the world as pervasively blaming, rejecting, and socially "toxic." This creates incongruence between the child's inner experience and his/her experiences of the outside world, which then leads to behaviors associated with BPD (Linehan, 1993a).

This combination of biologically-based, intense sensitivity, and reactivity to emotions with the inability to regulate emotions arising from one's environment due to a history of an invalidating environment results in self-destructive behaviors (Linehan, 1993a). These behaviors are learned coping strategies for intense, negative, and painful emotions. Some environmental stressors that place a heavy load on an already extra sensitive system include a toxic prenatal environment, exposure to domestic violence, intense conflict between family members, extreme differences in temperament between child and caregiver, emotional losses and/or bereavement, trauma, physical abuse, sexual abuse, and neglect (Miller et al., 2007).

Frequently, invalidating environments teach children an excessive need to control their emotions, especially negative ones, because these emotions were attributed to negative traits of the child (Linehan, 1993a). This might be learned from punishment, abuse, or prohibiting the child from making certain demands to get needs met from the caretaker. As a result of excessive control over emotional expression, the child does not learn how to modulate his/her emotions and without modulation, extreme emotional states result (Linehan, 1993a). Children are unable to self-validate their emotions; thus, they are constantly looking for cues in the environment about how they should feel or behave. Without the connection between emotion expression and prosocial behavior, a biologically vulnerable child might develop maladaptive coping strategies that result in features of BPD such as self-harming behavior, suicidal thoughts, impulsivity, emptiness, fear of abandonment, unstable sense of self, and dysfunctional relationships (Rathus & Miller, 2002).

A common theme among psychodynamic, object relations, self-psychology, and biosocial theories of BPD is that etiology (or origin of a disorder) might be related to psychological factors from childhood. Furthermore, as BPD begins to form in childhood, symptoms might appear early and be detected during adolescence (Steinberg, 2005). Despite this idea from BPD theorists, many clinicians are hesitant to give a diagnosis of BPD to adolescents (Paris, 2005).

Borderline Personality Disorder in Adolescents

Although personality disorders are more often diagnosed in adults, research suggests that BPD might begin in adolescence (Ludolph et al., 1990; Pinto, Whisman, & McCoy, 1997) and should, therefore, be diagnosed and treated during adolescence (Links

& Heslegrave, 2000). There is a debate over whether individuals under the age of 18 should be given diagnoses of personality disorders (Santisteban et al., 2003). The DSM-IV-TR (APA, 2000) encourages clinicians to be cautious of diagnosing adolescents with personality disorders but does allow for it so long as the maladaptive personality traits are pervasive, persistent, not associated with a development stage or Axis I disorder, and present for at least one year.

Treatment for adolescents diagnosed with BPD at an early age is currently being implemented at the Adolescent Dialectical Behavior Therapy Center at McLean Hospital in Massachusetts (Aguirre, 2007). Research conducted at this hospital found that adolescents diagnosed with BPD presented with chaotic relationships, were confused about their identity and values, engaged in self-harm, were overly impulsive, felt empty, possessed irrational beliefs, and experienced frequent dissociation (Aguirre, 2007). Clinicians at the McLean Hospital reported these symptoms shared a great deal of overlap with the adult presentation of BPD and warranted a diagnosis and treatment of BPD in adolescents (Aguirre, 2007).

Aguirre's (2007) research also addressed the high amount of comorbidity between BPD and other childhood disorders and the importance of differential diagnosis (or diagnosing the client with the most accurate disorder). According to Aguirre, the main differences were in the degree of self-destructive behavior, the degree of self-loathing, and the unremitting thoughts of suicide. Research at McLean Hospital found that adolescents who met the DSM-IV-TR (APA, 2000) criteria for BPD were most often admitted for services due to their suicidal ideations and parasuicidal behaviors (Aguirre, 2007). These self-injurious behaviors helped differentially diagnose BPD as they are

very rare in oppositional defiant disorder or conduct disorder but might be seen in clinical depression and are highly occurring in BPD (Koerner & Linehan, 2000). Impulsive behaviors in individuals with BPD can often look like impulsivity in attention deficit hyperactivity disorder (Rathus & Miller, 2002). Furthermore, aggressive behavior is not a common presenting symptom in adolescents with BPD but when they are aggressive, they feel remorseful after the event (Koerner & Linehan, 2000). In contrast, adolescents with conduct disorders exhibit a high level of aggression and a notable lack of remorse following aggressive behavior toward others (APA, 2000).

Awareness of these differences in common child and adolescent disorders might assist clinicians in correctly diagnosing BPD. In addition to understanding the differences in symptoms, researchers at McLean Hospital are investigating other means of early identification of BPD. Future areas of research include studying the prevalence of BPD in families through genetic testing using advanced imaging technology to identity brain differences and developing a standardized interview that would help clinicians distinguish BPD from normal adolescent behavior (Aguirre, 2007).

Linehan et al. (1999) stated that symptoms of BPD are recognizable in adolescents but clinicians are often misinformed about the diagnosis, thinking it is only an adult disorder. Linehan et al. advocated for the education of clinicians on this important topic and emphasized the importance of treating BPD early. Adolescents often still live in their original invalidating environment; thus, the effects of this invalidation are ongoing (Koerner & Linehan, 2000). The transaction between a biological vulnerability and an invalidating environment can leave adolescents with problems in emotional dysregulation--the central problem for clients with BPD (Linehan, 1993a).

From the biosocial theory (to be described in detail in a following section), disordered behavior is conceptualized as a result of emotional dysregulation, an attempt to modulate emotion, or both. These attempts are often in the form of parasuicidal behaviors, which are defined as "any acute, intentional self-injurious behavior resulting in physical harm with or without the intent to die" (Katz et al., 2004, p. 276). Parasuicidal behaviors are one of the primary symptoms of BPD. Studies showed that early interventions with adolescents were associated with fewer severe symptoms of BPD and better treatment outcomes (Linehan, 1993a).

Empirical Support for Diagnosing Borderline Personality Disorder in Adolescents

Although the diagnosis of BPD in adolescents is a controversial topic, research has demonstrated empirical support for the validity of diagnosing adolescents with BPD. For example, Durrett and Westen (2005) identified that personality pathology is not limited to adulthood: "To the extent that the DSM-IV-TR provides criteria useful for assessing adults, these criteria yield diagnoses with similar operating characteristics in adolescents" (p. 457). Other researchers supported the belief that many symptoms in adolescents are similar to those seen in adults with personality disorders (Paris, 2005). As a main aspect of personality disorders is their chronic nature, it is understandable that many clinicians prefer to wait until early adulthood to diagnose BPD, especially given the transitional nature of adolescence. Despite this, Paris (2005) noted, "There is no reason why the same pathology should be called one thing before a defined age and another afterword" (p. 237). Adolescence should be regarded as a high-risk period for the onset of BPD. Numerous adolescents meet the diagnostic criteria for BPD but are not being

treated due to clinicians' perspectives that personality disorders should not be diagnosed in adolescence (Paris, 2005).

Longitudinal studies have shown that the presentation of personality disorder symptoms displayed in adolescence is a potential correlate of serious pathology in adulthood (Durrett & Westen, 2005). The most important predictors of the continuation of personality disorder symptoms from adolescence into adulthood are severity of symptoms and age of onset with a greater severity and younger age of onset predicting a greater continuation of symptoms (Paris, 2005). Onset of BPD is typically in adolescence, specifically around puberty (Steinberg, 2005). When compared to adults, the psychosocial risk factors of BPD are the same for adolescents (Steinberg, 2005). According to Durrett and Westen (2005), adolescents (ages 12-17) met the criteria for personality disorders at the same rate as young adults (18-37) using a structured interview. These findings suggested there does not seem to be a specific age criteria for BPD, which is consistent with the DSM-IV-TR (APA, 2000).

Adolescents with a diagnosis of BPD can be distinguished from adolescents with other disorders. Adolescents with BPD are more likely to have diagnoses of posttraumatic stress disorder, mood disorders, and substance abuse disorders than adolescents without BPD (Paris, 2005). A study by Pinto et al. (1997) compared depressed adolescents with a BPD diagnosis to depressed adolescents without a BPD diagnosis; they found both groups exhibited significant levels of anxiety, anger, and hopelessness as well as an external locus of control and poor self-concepts. Adolescents with BPD displayed a greater level of symptomology in these areas as well as a significant difference in self-concept (Pinto et al., 1997). Adolescents with BPD reported

significantly poorer self-concept especially on measures of popularity, physical appearance, and happiness. These results suggested that self-concept was one area that distinguished depressed adolescents with BPD from depressed adolescents without BPD (Pinto et al., 1997).

Studies supported the diagnosis of BPD in adolescents among hospitalized inpatient adolescents and outpatient female adolescents (Goldston et al., 1999; Katz et al., 2002). These studies found that female adolescent inpatients who met the criteria for BPD shared much in common with developmental factors associated with BPD in adults such as difficult childhoods, chronic family disruption, maternal neglect and rejection, and histories of physical and sexual abuse. Garnet, Levy, Mattanah, Edell, and McGlashen (1994) found great variability of symptoms among inpatient adolescents who met the diagnostic criteria for BPD. In the follow-up portion of their study, they found that two years after inpatient treatment, some symptoms remained stable (feelings of emptiness, inappropriate anger, affective instability, identity confusion, and suicidal behaviors) whereas others were less stable (intense relationships and impulsiveness; Garnet et al., 1994). These studies suggested that BPD in adolescents might share some symptom similarities with BPD in adults but the duration of symptoms might vary (Garnet et al., 1994).

Becker et al. (2002) compared hospitalized adolescents and adults with BPD and found some meaningful differences in diagnostic efficacy. Diagnostic efficacy was defined as "the extent to which diagnostic criteria (or symptoms) are able to discriminate individuals with a given disorder from those without that disorder" (Becker et al., 2002, p. 243). Results indicated that adolescents who met one diagnostic criterion for BPD

were more likely to meet the full criteria for diagnosis than adults with one BPD symptom. Another difference was in what symptoms predicted the diagnosis. In adults, the highest overall predictive symptom was impulsiveness and in adolescents, it was affective instability (Becker et al., 2002). These results aligned with Linehan's (1993a) research--adolescents with BPD demonstrated difficulty in regulating emotions (affective instability), which often manifested in symptoms of parasuicidal behaviors.

The BPD symptoms of affective instability, uncontrolled anger, impulsivity, and identity disturbance are common in adolescents (Katz et al., 2004). However, one must question how these symptoms differentiate from the "normal" adolescent behaviors related to the developmental transitions of adolescence. Paris (2005) addressed this question by stating, "No one denies that moodiness and some degree of impulsive behavior are common in this age group. But most adolescents are not seriously troubled or rebellious" (p. 240). This suggested that clinicians should look at the severity of the adolescent's behavior and the impact those behaviors have on his or her functioning when differentiating non-pathological behaviors from behaviors indicative of an appropriate BPD diagnosis (Paris, 2005).

Growing clinical and research interest currently surrounds the role of brain development in individuals exhibiting difficulty in controlling their emotions and behaviors (Blakemore, 2012). As discussed in a previous section, adolescence is a period of significant neurological development, particularly with regard to behavior changes, social development, and risk-taking. This is also a developmental period in which psychiatric symptoms emerge (Blakemore, 2012). With the advancement of brain imaging technology, several studies implicated altered brain maturation in a variety of

clinical disorders (Blakemore, 2012; Kaufman & Charney, 2003). One study focused on neurodevelopment in adolescent girls and BPD characteristics through P300 event-related electroencephalographic potential (Houston, Bauer, & Hesselbrock, 2004). The results were that adolescents exhibiting BPD characteristic had altered brain maturation detected at an early age (Houston et al., 2004). The authors of this study suggested that measures of brain maturation during adolescents in clinical populations might improve clinicians' ability to diagnose BPD features and comorbid disorders in adolescents and through early treatment prevent the development of BPD in adulthood (Houston et al., 2004).

There are numerous treatment options for adolescents diagnosed with BPD including individual psychotherapy, cognitive-behavior therapy, substance abuse treatment, inpatient hospitalization, and psychopharmacology (Swenson, Torrey, & Koerner, 2002). Borderline personality disorder has been shown to be a challenging disorder to treat due to the chronic nature of the disorder and the many overlapping symptoms with other disorders (Paris, 2005). Research findings suggested that clinicians should consider the diagnosis of BPD when clients present with the trademark features of affective instability, chronic suicidality, self-harming behaviors, chaotic relationships, and impulsivity (Paris, 2005). When treating clients with BPD, psychologists should be guided by empirical literature as part of best practices (APA, 2002). The best evidence-based outcomes for clients with BPD are from dialectical behavior therapy (Robins & Chapman, 2004).

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) is based on dialectics--the continual synthesis of seemingly opposing forces. The most fundamental dialectic of DBT is the "necessity

of accepting patients just as they are within a context of trying to teach them to change" (Linehan, 1993a, p. 19). This theory was founded on Linehan's (1993a) biosocial theory, which posited that emotional dysregulation in persons with BPD resulted from the interaction between the biology of an individual and the social environment (Katz et al., 2002). This section describes the theoretical and treatment components of DBT including the origin of DBT, the stage model of treatment, dialectic dilemmas, skills modules, theoretical assumptions, treatment strategies, and characteristics of a DBT therapist.

Origin of Dialectical Behavior Therapy

Dialectical behavior therapy is an evidence-based psychotherapy originally developed by Marsha Linehan (1993a, 1993b) for adults diagnosed with borderline personality disorder. Linehan (1993a) created DBT in response to her failed attempts at treating suicidal clients with standard cognitive-behavioral therapy. She reported that suicidal clients felt too much emphasis was being put on changing their behaviors, which felt invalidating to them, and thus were not motivated to change. Linehan (1993a) also noticed that therapists were often unwittingly providing positive reinforcement to BPD symptoms such as backing away from encouraging client change when the client became angry or withdrew. Alternatively, the therapist might allow the client to shift away from painful topics because the client became more warm and positive toward the therapist when avoiding these topics. Linehan (1993a) addressed these treatment-interfering behaviors by providing a structured treatment that balanced encouraging change and facilitating change with clients.

Brief Overview

Dialectical behavior therapy combines interventions and strategies from cognitive behavioral therapy (CBT) with mindfulness practices and dialectics (the synthesis of opposites) from Eastern traditions (Linehan, 1993a). Dialectical behavior therapy is employed in four stages, each with corresponding behavioral targets of treatment. Five basic functions of treatment are implemented through several modalities: individual therapy for the client, group therapy for the client, family therapy for the client, phone consultations, and consult group for the treatment team (Koerner & Linehan, 2000). Five major areas of dysfunction are identified and remedied through the teaching of four skills modules. Additionally, behavioral patterns of BPD clients are addressed through the use of three dialectics. Each of these areas is expanded upon in the following sections.

Stages of Treatment

Dialectical behavior therapy utilizes a stage model consisting of a pretreatment stage and four treatment stages. Within each stage are associated behavioral targets. All clients start in the pretreatment stage wherein the therapist orients the client to DBT, the client and therapist agree on treatment goals, and they mutually agree to being committed to treatment by signing agreement contracts (Miller et al., 2007).

Stage I is designed for the most severe and complex presenting problems. Stage I focuses on client stability, safety, and establishing a connection to the therapist (Linehan, 1993a). A main goal of Stage I for the client is “moving from being out of control of one’s behavior to being in control” (Miller et al., 2007, p. 14). Four targets are associated with this major first stage:

- Target 1: Reduce and then eliminate life-threatening behaviors (e.g., suicide attempts, parasuicidal behavior).
- Target 2: Reduce and then eliminate therapy-interfering behaviors (e.g., sporadic attendance, not completing Diary Cards, using substances)
- Target 3: Reduce behaviors that lower the quality of life (e.g., depression, phobias, eating disorders, non-attendance at school or work, lack of friends)
- Target 4: Learn new skills (Mindfulness, Distress Tolerance, Emotion Regulation, Interpersonal Effectiveness; Miller et al., 2007).

Stage I is typically the longest and most challenging stage of treatment. The primary purpose of Stage I is to enable the client to have enough control over his/her behavior to move on to the second stage of treatment. Stage I of treatment takes approximately one year for the client to reach stabilization (Linehan, 1993a).

Stage II of treatment involves working toward a decrease in posttraumatic stress disorder (PTSD) symptoms (Linehan, 1993a). A goal for clients in this stage is "moving from being emotionally shut down to experiencing emotions fully" (Miller et al., 2007, p. 14). Literature has reported a significant overlap in symptoms between PTSD and BPD (Zlotnick, Franklin, & Zimmerman, 2002). The rate of comorbidity is approximately 56% between BPD and PTSD (Swartz, Blazer, George, & Winfield, 1990; Zanarini et al., 1998). Targets of this stage include reducing self-blame, acceptance and verbalization of the trauma, acknowledging how the trauma was invalidating, breaking through denial, working with intrusive symptoms such as flashbacks, and finding acceptance with the abuse. The therapist teaches the client to experience all of his or her emotions without shutting down and letting the emotions take over (Linehan, 1993a). Clients in this second

stage have been prepared for this work by going through Stage I treatment and, therefore, have the skills, behavioral control, and emotional regulation to address their PTSD.

Stage III focuses on improving the client's quality of life. Targets of this stage are increasing self-esteem, finding a "life worth living," and setting future goals. Clients focus on "building an ordinary life and solving ordinary life problems" (Miller et al., 2007, p. 15). In this stage, clients often work on ordinary problems such as job dissatisfaction and conflict in relationships (Linehan, 1993a). Clients might choose to work with a different therapist, take a break from therapy and work on the goals alone, or try a different mode of therapy in this stage. The emphasis of Stage III is for clients to generalize the skills they have learned to real-life situations and decrease dependence on the therapist (Katz et al., 2000).

Stage IV is the final stage of DBT in which clients are in a healthy place from which to examine existential problems in their life (Linehan, 1993a). Universal existential questions might be around spirituality, finding meaning in life, feelings of emptiness, career choices, and feelings about death (Katz et al., 2000). Although this stage of research has not been researched, Linehan (1993a) felt it was important to include because she found her clients continued to seek meaning in their lives through spiritual paths after completing therapy.

Although these stages of treatment and targets are presented in order of importance, they are all interconnected. Miller et al. (2007) provided an example of how this worked. If a person kills herself, she will not get the help she needs to change the quality of her life. Therefore, DBT focuses on life threatening behavior first. However, if the client stays alive but neither comes to therapy nor does the things required in

therapy, she will not get the help needed to solve non-life threatening problems like depression or substance abuse. For that reason, treatment interfering behaviors are the second priority in Stage I. But coming to treatment is in itself not enough for change. A client stays alive and comes to therapy to solve the other problems making her miserable. To truly have a life worth living, the client must learn new skills, learn to experience emotions, and accomplish ordinary life goals. Therapy is not finished until all of this is accomplished.

Major Functions of Dialectical Behavior Therapy

The five major functions of DBT are

1. to motivate clients by reducing emotions, beliefs and reinforces conducive to dysfunctional behavior,
2. to increase client's capabilities and skills,
3. to ensure client's new behaviors generalize to the natural environment,
4. to structure the environment to support both the therapist and the client, and
5. to improve therapist' motivation and capability for conducting effective therapy with treatment-resistant clients (Miller et al., 2007).

These functions are implemented through the use of different treatment modalities described next.

Treatment Modalities

A full DBT model includes four different modes of treatment: individual, skills group, telephone coaching, and team consultation group (Linehan, 1993a). It is not the mode of therapy that is crucial but how well the mode addresses a particular treatment function of DBT (described in the previous section). Having different modes of therapy

is a way to organize the functions in DBT. The following treatment descriptions are based on Linehan's (1993b) DBT treatment manual.

Individual therapy. Individual therapy for clients occurs once a week (or biweekly during times of crisis) for an hour and focuses on Stage I behaviors and the corresponding four treatment targets. The therapist begins each session by reviewing the client's diary card for that week. The diary card is a technique to track frequency of target behaviors and intensity of emotions and to monitor the client's use of skills from week to week. The cards provide ways to track the client's use of substances, suicidal ideations, parasuicidal behaviors, and other therapeutic issues. The therapist uses the diary card to identify target behaviors the client engaged in that week. This then informs the therapist which targets behaviors should be addressed first.

Dialectical behavior therapists are trained to structure sessions in terms of target hierarchy (i.e., Stage I behaviors take precedence over Stage II behaviors). The therapist orders the target behaviors by importance and then addresses the targets sequentially. The first order target behaviors are addressed first, e.g., parasuicidal behaviors. Second order behaviors are addressed next such as the client being late for group or the therapist focusing excessively on change without balancing validation. The third order targets include behaviors that interfere with the client's quality of life such as impulsive spending or unemployment. The last order targets are skills learned from group (mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness). The skills are taught in groups but should be reinforced in individual therapy and practiced in real-life crisis situations.

During individual therapy, the therapist facilitates a chain analysis of events that led to the problematic target behavior. Other traditional cognitive behavior therapy approaches are also used such as addressing cognitive distortions, skill deficits, and vulnerability factors. Strategies of validation are also employed such as problem-solving. The sessions should be a balance between change and acceptance.

Skills training group. Acquiring skills in individual therapy can be difficult because of the need for crisis intervention and response to Stage I behaviors (Linehan, 1993b). Therefore, a separate component of treatment is needed to directly target the function of enhancing capabilities and skills (Miller et al., 2007). The skills training group allows the clients to learn skills within a calm, structured, validating environment (Linehan, 1993b). Skills groups are organized based on the four skills modules of DBT (mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness), which are described in a separate section.

Unlike individual therapy, where the agenda is determined primarily by the adolescent's current problematic behavior, group agendas are set by the skill to be taught that week. Groups are held weekly for two hours with a short break in the middle and are structured the same way every week (Linehan, 1993b). Group begins with a mindfulness exercise, check-in of homework assigned during the previous group, and brief review of the current skill module being learned. After a break, the leaders present the didactic portion of the group in which they teach skills related to the current module and then end the group with wind-down exercises. These can include deep breathing, listening to music, meditation, or visualization (Linehan, 1993b).

Ideally, two leaders should facilitate the skills training group. Each leader has a prescribed role for the group sessions but they work together as a team (Miller et al., 2007). The major role is with the leader responsible for reviewing homework, teaching the didactic material, assigning homework, and leading group exercises (Linehan, 1993b). The role of the other leader is to encourage participants, cheerlead, and share his or her examples of how skills have been useful in their lives. Cheerleading is described as validating the client's ability to use skills (Katz et al., 2004).

An important characteristic of skills training group is that it is psychoeducational in nature and not process oriented (Koerner & Linehan, 2000). With any serious therapy, interfering behaviors or Stage I behaviors occur during group; one of the co-leaders will take the participant outside of the group room to triage any emergency situations. If there is no imminent harm, the client is encouraged to bring up the concerning behaviors in his/her next individual therapy session or to use the telephone coaching services.

Telephone consultation. The phone consultation is an integral part of the comprehensive DBT model, especially in outpatient settings (Katz et al., 2000). The client is allowed contact with the therapist in order to provide emergency crisis interventions, encourage skill generalization to real-life situations, and assist clients in developing more adaptive help-seeking behavior (Linehan, 1993b).

Strict guidelines are involved in phone consultation. For example, clients are required to contact their therapist during a crisis *before* engaging in harmful behavior. If the client has already self-harmed, he or she might not contact the therapist for 24 hours but must seek help elsewhere (i.e., family members, emergency services; Katz et al., 2000). Additionally, the therapist does not conduct therapy over the phone but acts as a

skills coach (Linehan, 1993a). With the exception of life-threatening behaviors, the therapist should treat all phone consults the same way as much as possible. The therapist coaches the client in using appropriate skills to avoid dysfunctional behavior and to tolerate distress until the client's next therapy appointment (Linehan, 1993a). Behavioral techniques are used to reward positive behavior and avoid reinforcement of negative, parasuicidal behavior (Koerner & Linehan, 2000).

Phone consults can also be used for reporting "good news" so the suicidal behaviors and crisis situations do not become linked to the therapist's attention (Miller et al., 2007). The therapist can insist that a client who calls in crisis also call during times of success. This validates the client's need for more time with the therapist but decreases the reinforcing power of parasuicidal behavior (Linehan, 1993a).

Consultation team. Treating acute and intensive populations is enormously stressful and keeping to the integrity of the DBT model can be difficult at times (Miller et al., 2007). Dialectical behavior therapy assumes that effective treatment of clients requires as much attention to the therapist's behavior as the client's (Rathus & Miller, 2002). An integral part of therapy is DBT therapists are required to be in a DBT consultation team made up of professionals using the DBT model (Linehan, 1993b). These consultation meetings last between one to two hours every week and are different than staff meetings or administrative meetings.

The first goal of the consult group is to provide each member time to present and receive feedback on a client(s). This allows the therapist time to discuss difficulties he/she has providing treatment in a nonjudgmental and supportive environment, which also improves their motivation and capabilities (Miller et al., 2007). In turn, the

consultation group helps the therapist adhere to the DBT model and provides support and cheerleading to each other to help avoid burnout and maintain a nonjudgmental attitude toward clients (Linehan, 1993a). In some ways, the consult group is "therapy for the therapists" in that members are expected to learn and practice the DBT skills throughout the process of the team meeting (Koerner & Linehan, 2000).

Areas of Dysregulation

A person with BPD has dysregulation in five areas (Linehan, 1993a). The central area is emotional dysregulation. Anger, lack of emotional control, vacillating feelings, and feelings of helplessness in emotional dysregulation contribute to the four other areas of dysfunction: interpersonal dysregulation, self-dysregulation, cognitive dysregulation, and behavioral dysregulation. Interpersonal dysregulation is where the individual struggles with fears of abandonment and chaotic relationships. Instability in emotions and relationships might lead to self-dysregulation and confusion about one's identity, value and/or feelings, as well as a chronic sense of emptiness. Cognitive dysregulation is rigid thinking, irrational beliefs, paranoid ideation, and dissociation. Finally, as a consequence of emotional dysregulation or in an attempt to regulate emotions, a person might act impulsively, which often comes in the form of parasuicidal behaviors (Koerner & Linehan, 2000).

Dialectical Behavior Therapy Skills Modules

Four DBT skills modules have been developed to directly address these five areas of dysregulation (Koerner & Linehan, 2000). The purpose of the skills is to reduce the frequency, duration, and intensity of the dysfunctional behaviors of clients and to provide a means to create a meaningful, worthwhile life (Miller et al., 2007). The skills modules

are taught in the group therapy format and are also reinforced in individual therapy (Linehan, 1993a). For adults, Linehan (1993a) recommends participating in two to three rounds of the full cycle of modules so clients can deeply absorb the material and generalize the learned skills to their lives. Thus, clients remain in skills training groups for about one year--usually the first year of DBT treatment (Linehan, 1993a). The modules are mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness. Mindfulness is considered a core foundation for all of the skills and overlaps with the other modules (Rathus & Miller, 2002). All of the modules address dysregulation in clients. The first two modules are related to validation and acceptance and the last two modules are related to motivation and change (Miller et al., 2007).

Mindfulness. This core skills module addresses dysregulation in clients (Linehan, 1993a). Linehan (1993a) describes mindfulness as awareness without judgment. Mindfulness skills are psychological and behavioral versions of mediation practices found in Eastern spiritual philosophies (Linehan, 1993a). Practicing mindfulness helps clients stay present in the moment instead of focusing on painful experiences from the past or frightening possibilities of the future (Miller et al., 2007). Mindfulness practice also gives clients tools to overcome habitual negative judgments about themselves, others, and their life situations. Zen meditations are incorporated to help clients increase their awareness and acceptance of reality (Linehan, 1993a). Mindfulness skills include participating actively in your life, taking a non-judgmental stance, increasing awareness of self and the environment, focusing on one thing at a time, and being effective.

Distress tolerance. This skill module addresses behavioral and cognitive dysregulation (Koerner & Linehan, 2000). Distress tolerance skills focus on survival strategies to help clients cope with crises in their lives. Group members learn to develop resiliency for painful emotions and events as well as develop new skills to cope with the crisis. These skills include distraction techniques, self-soothing, using imagery, finding meaning in the crisis, and creating lists of the pros and cons of tolerating the distress (Linehan, 1993a). Group members are also taught to accept what they cannot change in a non-judgmental manner. Acceptance does not equal agreement with what has happened to them in their lives in the past or currently, only that a stance of non-acceptance is contributing to their pain. The skills of radical acceptance, turning the mind, and willingness help with distress tolerance (Miller et al., 2007).

Emotional regulation. This module addresses emotional dysregulation by giving the client a non-judgmental place to experience and then decrease emotional distress (Linehan, 1993a). Emotional regulation skills teach clients how to identify emotions, understand the purpose of emotions, and control their emotions. The goal is to decrease emotional vulnerability and suffering and increase the ability to identify and experience emotions without becoming overwhelmed by their intensity, which can lead to impulsive or self-harming behavior. Group members learn to notice early physical signs associated with emotions such as clenching of the jaw when becoming angry. Skills for this module include strengthening ability to have positive experiences; being mindful of both positive and negative emotions; observing, describing, and accepting the emotions; and understanding that emotions are temporary (Koerner & Linehan, 2000).

In the emotional regulation module, clients are taught the three states of mind: reasonable, emotional, and wise (Miller et al., 2007). Reasonable Mind is a rational, logical approach to a problem; a person thinking from this state of mind focuses on facts and ignores intuitions or emotions. When clients are stuck in Reasonable Mind, they often avoid recognizing and experiencing their feelings, which results in a need to purge their emotions later, often through self-harming behaviors (Linehan, 1993a). The Emotional Mind is described as the state in which a person approaches all problems in an emotional manner at the expense of reason and logic. Clients with BPD often find themselves making choices based purely in Emotional Mind. People can become overwhelmed in Emotional Mind and feel that their emotions are in charge of them instead of being in charge of their emotions. The Wise Mind is the overlap between the two other states of mind where a balanced perspective is achieved. By integrating Emotional Mind and Reasonable Mind, clients balance their feelings and logic so they are not pulled to either extreme. Clients are encouraged to make Wise Mind decisions; a common phrase in skills groups is "What would your Wise Mind tell you to do?" (Miller et al., 2007, p. 46).

Interpersonal effectiveness. This module addresses interpersonal dysregulation through skills that help clients express their needs more effectively, stand up for their values and beliefs, set personal limits, and negotiate solutions to their problems (Koerner & Linehan, 2000). Interpersonal effectiveness skills teach individuals to act assertively to get their needs met, improve their relationships through validating others, and to maintain self-respect (Miller et al., 2007). Group members are taught the importance of

attending to relationships, balancing priorities with demands, balancing "wants" with "shoulds," and building mastery in their lives.

Behavioral Patterns and Dialectical Dilemmas

In addition to treating Stage I primary targets (decreasing life threatening behaviors), DBT also addresses secondary behavioral patterns. Linehan (1993a) organized frequently occurring behavioral patterns of clients with BPD into dialectical dilemmas. The concept of a dialectical dilemma involves several assumptions about the nature of reality: (a) everything is connected to everything else, (b) change is constant and inevitable, and (c) opposite views can be integrated to form a closer approximation to the truth, which is always evolving (Linehan, 1993a). A dialectical dilemma can be described as opposing polarities along a common dimension (Miller et al., 2007). Dialectical behavior therapy seeks to teach clients how to come closer to the truth by integrating these opposites into a coherent synthesis in order to have a more balanced perspective on life. Dialectics speak to an individual's unique world views and each person's own truth; there is no absolute truth according to DBT (Linehan, 1993a).

Three main dialectical dilemmas are associated with BPD: emotional vulnerability vs. self-invalidation, active passivity vs. apparent competence, and unrelenting crisis vs. inhibited grieving (Linehan, 1993a). Individuals with BPD experience discomfort at either extreme points of these dialectical dimensions and frequently vacillate back and forth between these polarities, creating a great deal of discomfort and disruption in their lives. A main problem for individuals with BPD is their inability to move to a balanced position in the dilemma and find synthesis between the opposing sides (Linehan, 1993a). In DBT, the goal of working within these dilemmas

is to achieve a synthesis between the opposing polarities inherent in each of these dialectics so clients can live a more manageable life (Katz et al., 2004). Practicing dialectical thinking helps individuals move away from "black and white" thinking, or "all good or all bad" perspectives, and move instead toward "both- and" thinking, remembering that the truth is somewhere in the "grey" (Miller et al., 2007). Linehan's (1993a) three dialectical dilemmas are described below.

Emotional vulnerability versus self-invalidation. Emotional vulnerability refers to the intense emotional suffering experienced by clients when they are emotionally dysregulated (Katz et al., 2004). Self-invalidation occurs when the client decides his or her behavior is invalid and, as a result, blocks an emotional experience (Koerner & Linehan, 2000). The goals of working within this dialectical dilemma are to increase the client's emotional modulation, decrease his/her emotional reactivity, and increase his/her self-validation and decrease his/her self-invalidation.

Active passivity versus apparent competence. Active passivity is a client's tendency to respond to all problems passively and feel helpless in solving them in an effort to elicit help from others (Katz et al., 2004). Apparent competence refers to when clients behave in ways that make others overestimate their capabilities, usually in an attempt to avoid emotional vulnerability. Treatment targets in this dilemma are to decrease feelings of helplessness and to recognize and reinforce areas of actual competence (Koerner & Linehan, 2000).

Unrelenting crisis versus inhibited grieving. Unrelenting crisis is when the client experiences pain and reacts by engaging in impulsive behavior to avoid the pain, thus creating a new crisis (Katz et al., 2004). This creates a self-perpetuating pattern in

which the client both creates and is controlled by constant crises (Koerner & Linehan, 2000). Some clients, especially adolescents, are continually placed in unrelenting crisis situations due to external factors such as family of origin, poverty, lack of social support, etc. (Miller et al., 2007). Inhibited grieving refers to when clients automatically engage in behaviors to avoid experiencing painful emotions. These behaviors are often self-harming, such as cutting or promiscuity, and can result in new, painful experiences. Treatment goals include stopping the cyclical nature of these dialectics and improving the client's ability to tolerate distressing emotions. Skills within this dialectic dilemma focus on decreasing crisis-generating behaviors and increasing emotional awareness (Katz et al., 2004).

Assumptions of Dialectical Behavior Therapy

There are eight main assumptions in which therapists and clients work from within the DBT model (Katz et al., 2004). These assumptions are acknowledged during the client's initial introduction to DBT as well as emphasized in individual and group therapies. The purposes of the assumptions are to assist clients and therapists in working from a nonjudgmental frame of mind and to balance acceptance versus change (Linehan, 1993a).

1. The first assumption is *clients are doing the best they can.* This assumption acknowledges that these clients are working very hard but ineffectually toward change. A person who has repeated experiences of failure to change the way they think, behave, cope, feel, or relate to others has often received the advice "if you just tried harder" or "if you wanted to change you could" (p. 16). Dialectical behavior therapy takes an opposite stance to that

message and holds the position that the client is trying his/her very best even if it is not working.

2. The second assumption is *clients want to improve.* Therapists need to assume clients want to change and then look for what factors are interfering with their motivation to improve. Often fear, shame, skills deficits, faulty beliefs, and reinforcing behaviors can block a client's motivation to improve.

3. Third, *clients need to do better, try harder, and be more motivated to change.* This assumption seems to contradict the first two assumptions—that clients are trying their hardest and do want to change. However, doing their best and wanting to change do not alone guarantee those efforts and motivation will work for clients. If what the clients were already doing was working, then they would not be experiencing the amount of problems they were. The purpose of therapy is to examine things that interfere with efforts and motivation to improve and then apply problem solving strategies to increase the client's skillful efforts and direct motivation. All three of the first assumptions can be true and work together.

4. The fourth assumption is *clients may not have caused all of their problems but they have to solve them anyway*. This is a core belief in DBT--the client must change his/her behaviors and his/her environment in order to change. Moving beyond a place of blame or victimhood can be difficult for some clients. Dialectical behavior therapy emphasizes the regaining of power and accountability in solving problems. Clients learn to rely on themselves

instead of putting the solution on finding the perfect relationship, taking a pill, losing 20 pounds, going to therapy, etc.

5. The fifth assumption is *the lives of clients are often unbearable as they are currently being lived.* It is important to recognize and validate the pain the client is in before guiding the client toward change.
6. The sixth assumption is *clients must learn new behaviors in all relevant contexts of their lives.* The skills learned in therapy must be transferred to all areas of the client's life. The skills are meant for helping the client during times of extreme emotions and stress, not just for when the client is calm. Learning and using new skills in these times is how behavioral change is made. A goal is to reduce the pattern of avoiding, distracting, or escaping from feelings and replace it with a pattern of tolerating emotions without acting on impulses.
7. The seventh assumption is *there is no absolute truth.* This means DBT recognizes that each individual experiences reality in his/her own way.
8. The eighth assumption in DBT is *clients cannot fail in therapy.* If clients fail to make improvements, then the therapeutic process needs to be blamed --not the client or the therapist or the family.
9. Finally, the ninth assumption is *therapists treating the BPD population need support.* Research has shown that individuals with BPD are a challenging population to treat and often have poor therapeutic outcomes. Therapists often get caught between the demands for immediate relief from the intense emotional pain and building the skills and confidence needed for long-term

gains. To be supported through this demanding process, the therapist needs to have a consultation team as well as individual and group supervision throughout treatment (Linehan, 1993a).

Treatment Strategies in Dialectical Behavior Therapy

The core strategies in DBT are validation and problem-solving, which emphasize accepting the client where they are and also promoting change (Linehan, 1993a). The balancing of acceptance and change strategies helps clients feel understood for who they are and also helps them learn alternative adaptive behaviors. These DBT strategies are flexible in nature and are combined in a fluid manner so the therapist can meet the client's rapidly changing emotional and therapeutic needs (Rathus & Miller, 2002).

Validation strategies. Linehan and her colleagues (1991) found that when the therapist weaved validation in with the emphasis on change, clients were more likely to be collaborative and less likely to become agitated and withdrawn. The primary way DBT therapists communicate validation is by accepting the client where they are in the change process (Linehan et al., 1991). Validation provides an understanding of the client's behavior in response to his/her personal history and environment. The therapist searches for validation in even the most extreme behaviors. For example, cutting behavior might be valid in the short term because it relieves short-term painful feelings but it is invalid in the long term because it interferes with the goal of a life worth living. It is important to distinguish that acceptance does not equal agreement. A therapist might accept that a client abuses alcohol to overcome intense social anxiety and yet realize when drunk, the client makes impulsive decisions that lead to self-harm. The therapist could validate the behavior by acknowledging that (a) the behavior makes sense as it does

help the anxiety go down, (b) the client has witnessed her family getting drunk to cope, and (c) sometimes being drunk and impulsive is "fun." In this example, the therapist can validate that substance abuse is understandable given the client's history and point of view. However, the therapist does not have to agree that abusing alcohol is the best approach to solving the client's anxiety. Although the therapist looks for a function of the client's behavior, it is made clear that the behavior is maladaptive and the goal is to replace it with adaptive behavior.

Linehan (1993a) described seven levels of validation the therapist should follow sequentially. The first is active listening and observing in an effort to understand the client--the therapist is genuinely interested in hearing the client's story. The second level is reflective validation wherein the therapist reflects the client's feelings, thoughts, assumptions, and behaviors. The third level is "reading" the behavior to search for underlying functions. The therapist makes a link between the precipitating event and subsequent behavior and provides this explanation to the client. The therapist can articulate emotions and meanings of behavior the client cannot. The fourth level of validating the client is understanding his/her behavior in terms of causes. The therapist helps the client understand his/her behaviors are a result of contextual environmental factors, biological factors, and a combination of the two in the client's life. The fifth level of validation is communicating the client's behavior is justifiable, reasonable, and efficacious in his/her life as it is currently being lived. The sixth level of validation is recognizing and mirroring the clients as they are including acknowledging strengths in their capacities and areas of difficulties. The therapist does this without being taking an expert role or pathologizing the client. The final level of validation is using cheerleading

strategies. These acknowledge the client is doing his/her best and providing hope that he/she will eventually overcome his/her difficulties. Through the therapeutic relationship, the therapist offers reassurance and highlights evidence of client improvement (Miller et al., 2007).

Problem-solving strategies. A primary focus on change by the therapist can create a feeling of invalidation in the client; therefore, change strategies must be balanced with validation. In using the seven levels of validation, the therapist helps the client move toward change by implementing problem-solving strategies (Linehan, 1993a). This is done by first engaging in a behavioral analysis to understand the client's maladaptive behaviors and then generating and implementing alternative solutions through a solution analysis.

When faced with a problem behavior, the primary task of the therapist and client is to engage in a thorough behavioral analysis. To conceptualize a client's behavior through a DBT lens, a behavioral chain analysis of the emotional and cognitive events leading up to the behavior is conducted. The purpose is to empirically determine the cause of the behavior, what is preventing its resolution, and what aids are available for solving it. This involves questioning the client in a way that elicits a detailed account of the events of the day leading up to the problematic behavior. Through this review, the client and therapist identify the problem behavior (such as self-harm) and the presence of vulnerability factors that predisposed the client to act. The precipitating event is also reviewed. Once the problematic behavior is identified and the vulnerability factors are delineated, specific thoughts and feelings around that behavior are analyzed. Links between these thoughts, feelings, and behaviors are made to build a chain from the start

of the process to the ending at the problematic behavior. Through this detailed assessment, the therapist and client can identify points along the way where alternate choices could be made and where DBT skills could be implemented to avoid the problematic behavior. The behavioral chain analysis breaks down what can feel like an overwhelming event into opportunities for using new skills (Katz et al., 2004).

The ultimate goal of the behavioral analysis is to determine the function of the behavior by looking at the antecedents and consequences of the behavior (Linehan et al., 1991). By helping the client go through this process, the client is given a sense of hope, freedom, and mastery over his/her behavior. The consequence of the behavior is also important. The client is likely trying to avoid aversive emotional states; thus, seeking relief from emotional pain is often the primary motivator for self-harming behaviors. Mutual problem-solving with the client can be very validating and give him/her the experience of learning to tolerate his/her emotions.

At the end of the analysis, the therapist and client actively attempt to identify alternate solutions if they have not already been pointed out during the chain analysis (Katz et al., 2004). Solution analysis addresses two questions: Does the client have the skills to cope effectively? If the answer is no, then the DBT skills modules are used to enhance effective emotional, cognitive, behavioral, and interpersonal regulation. The client learns and then practices these skills. If the answer is yes, then the second question is: What are the impediments to using these skills effectively? To answer this question, four areas are examined. First, faulty beliefs are explored and cognitive restructuring techniques are used. Second, if conditioned emotional responses are blocking adaptive behavior, then exposure-based strategies are used. Third, the environment might not be

reinforcing functional behavior or alternatively be reinforcing dysfunctional behavior. If this is the case, contingency management strategies are used to increase the probability of functional behavior occurring again. Finally, if there are issues in the client-therapist relationship that are blocking change, relationship strategies are used including interpersonal effectiveness skills (Linehan, 1993a).

Change strategies model for the clients how to problem solve and think about causes and effects of their behavior. Although clients might effectively use problem-solving strategies and skills in the therapy room, they might not use these during times of crisis, e.g., when having thoughts of suicide. The ultimate goal is for the client to generalize the skills to the various contexts of his/her life. Case management strategies can help clients achieve this goal including communicating with other professionals on the client's treatment team, advocating for the client, providing resources for financial and supportive assistance, and, if necessary, brief hospitalization.

Characteristics of Dialectical Behavior Therapists

According to Miller et al. (2007), there are three main attitudes and interpersonal positions the therapist takes in relation to the client. In these positions, the therapist seeks to synthesize acceptance and nurturing strategies with change-demanding strategies in a clear manner. A useful metaphor to understand the therapist's role is the image of a seesaw; the goal is to balance between two opposing sides by adjusting the stance to facilitate change in the client's behavior while promoting self-reliance and growth.

Acceptance versus change. The therapist must be willing to find the inherent goodness and wisdom in the moment regardless of the situation. The therapist enters the experience fully without judgment or blame and, at the same time, realizes the purpose of

the relationship is change. The therapist must actively balance interventions of change (behavioral and CBT strategies) with interventions of acceptance (humanistic and Zen strategies).

Unwavering centeredness versus compassionate flexibility. Unwavering centeredness is the calmness in the middle of chaos; it is believing in the process and tolerating intensity and pain of clients in a calm and clear way. Compassionate flexibility is the quality of the therapist that is light, responsive, and creative. The therapist should stay centered by keeping their feet on the ground but remain flexible enough to get out of the client's way when necessary (Miller et al., 2007).

Nurturing versus benevolent demanding. Nurturing can take the form of teaching, coaching, encouraging, strengthening, and aiding the client from a position of believing in the client's ability to learn and change. Helping clients identify and verbalize their emotions and understand when hostility or aggression might really be fear and helplessness. Benevolent demanding is recognizing the client's existing abilities and reinforcing adaptive behavior. This is when the therapist acknowledges the client can take care of something on their own and to be careful not to do it for them. The dialectic balance here is between taking *care of* the client and taking *care for* the client. A metaphor to understand this stance is the therapist holds the client's hand alongside them while also gently pushing them forward with the other hand (Linehan, 1993a).

It is especially important to have compassion when working with suicidal clients with BPD features because this population can be emotionally restricted and sensitive. It is also important for therapists to acknowledge errors they have made and repair them through the therapeutic relationship. The clients must be able to see the therapist as

someone they can trust and the therapist models how to overcome conflict in a relationship without fleeing.

Adolescent Dialectical Behavior Therapy Treatment and Adaptations

While there is debate over the appropriateness of diagnosing an adolescent with a personality disorder including BPD (Meijer, Goedhart, & Treffers, 1998; Paris 2005), there is theoretical justification for adapting what was originally a BPD treatment for adults to an adolescent population (Katz et al., 2004; Rathus & Miller, 2002). Many of the similarities adolescents have with adults diagnosed with BPD can be somewhat explained by the understanding that personality disorders often begin in adolescence (Becker et al., 2002; Gould et al., 2003). Furthermore, the complexity of adolescents with suicidal ideation, parasuicidal behaviors, and multi-problem presentations makes DBT an appropriate therapeutic intervention based on research (Linehan et al., 1991; Woodberry & Popenoe, 2008).

According to Linehan (1993a), when working with parasuicidal adolescents from a DBT orientation, parasuicidal behavior is conceptualized using the biosocial theory. Specifically, the transaction of high emotional vulnerability (either biologically or triggered by major depressive disorder) with the experiences of invalidation (from self and/or others) help the therapist understand the function of the parasuicidal behavior in adolescents (Katz et al., 2004). Through the use of DBT, the therapist teaches the adolescent the skills needed "(a) to modulate extreme emotions and reduce maladaptive mood-dependent behavior and (b) to validate their own emotions, thoughts, and actions" (Koerner & Linehan, 2000, p. 30).

In 1997, Miller, Rathus, Linehan, Wetzler, and Leigh adapted Linehan's (1993a) original DBT treatment for adults with BPD for suicidal adolescents with BPD. Many studies investigated the use of DBT with adolescents and incorporated the changes made by Miller et al. (1997). Adolescent DBT has been researched with clients from various clinical settings and with various psychological disorders (Koons et al., 2001; Rathus & Miller, 2002; Robins & Chapman, 2004). Following the promising results of these studies, Miller et al. (2007) published *The Adolescent Adaptation of Dialectical Behavior Therapy*. Within this new model, several changes were made to be conducive to therapy with adolescents while still maintaining the integrity of DBT. This section described the use of DBT with adolescents and the changes to DBT for adolescents based on *The Adolescent Adaptation of Dialectical Behavior Therapy* (Miller et al., 2007). The adaptations described included changes to structure, an additional skills module, changes to the stage model, additional adolescent specific dialectics and language, and the addition of family therapy. Finally, the advantages and limitations of using DBT with suicidal or parasuicidal adolescents were discussed.

Changes to Structure

The first change to the DBT structure was reducing the length of the treatment from one year to 16 weeks. This shorter version of DBT is more intense and compact in order to fit with developmental and logistical issues of adolescence. Handouts, worksheets, and other material were modified for age-appropriate language. Examples used in the skills groups were modified to be more relevant to teenagers. Also, age-appropriate changes were made to the group guidelines (Rathus & Miller, 2002).

The Middle Path Module

A major change was the addition of a module called Walking the Middle Path, which targets highly dysregulated families with adolescents (Miller et al., 2007). The original four modules (mindfulness, emotional regulation, distress tolerance, and interpersonal effectiveness) are still used with the Middle Path, creating a total of five modules over 16 weeks for the adolescents and their families. The Middle Path module addresses dysregulation in families. In skills groups and family therapy, conflicts and dilemmas often found in parent-adolescent relationship are addressed (Katz et al., 2002). Adolescents and families learn skills to help them create balance in their lives. A primary focus of this module is learning how to balance acceptance and change and to understand dialectics. Dialectics teaches the importance of multiple points of view and emphasizes how change is the only constant in life (Miller et al., 2007). Thinking dialectically helps parents and adolescents find compromise in the middle path. For example, a parent should not be too strict/firm or too lenient/flexible with their adolescent but instead find a balance in the middle. An analogy of a spine is helpful in illustrating this dialectic. A spine needs to be firm enough to hold our body upright and flexible enough to allow us to bend and move in different situations. A spine that is overly rigid or overly soft will lead to discomfort and health problems.

Also in this module is the teaching of behavior modification techniques. Parents and caregivers learn to help promote change in their adolescents through the use of reinforcement, shaping, extinction of maladaptive behaviors, and increasing healthy behaviors and coping strategies (Koerner & Linehan, 2000). Family members improve

their relationships with each other by practicing validating themselves and others, active listening, tolerance of differences, and walking the middle path (Miller et al., 2007).

Areas of Dysfunction/Problem Areas

The five major areas of dysfunction for clients were adapted for the developmental aspects of adolescence (Katz et al., 2000). Instead of areas of dysfunction, they are labeled problem areas and include (a) confusion about self--not always knowing what you feel or why you get upset (dissociating), (b) impulsivity--acting without thinking it through, (c) emotional instability--fast intense mood changes with little control over them or a steady negative emotional state, (d) pattern of difficulty in finding and/or keeping relationships--getting what you want from others and keeping your self-respect (frantic efforts to avoid abandonment), and (d) adolescent/family dilemmas--polarized (black or white) thinking, feeling, or acting (dialectics; Miller et al., 2007).

Stage Model of Treatment

For adolescents, treatment is only comprised of Stage I with three primary targets as opposed to the four stages in the adult model (Miller et al., 2007). Stage I focuses on keeping the client safe, motivated, engaged in therapy, and committed to change (Rathus & Miller, 2002). The three targets are to (a) decrease life-threatening behaviors, (b) decrease therapy interfering behaviors, and (c) increase quality of life behaviors (Katz et al., 2000). Individual therapy, group therapy, and family therapy all seek to address these behaviors in adolescents.

Dialectical Dilemmas

Rathus and Miller (2002) proposed unique dialectical dilemmas for adolescents and families and three of them were included in the *Adolescent Adaption of Dialectical Behavior Therapy* manual (Miller et al., 2007). The first dialectical dilemma specifically for adolescents and their families is *excessive leniency versus authorization control*. Excessive leniency describes when parents are "too loose" with their adolescents because they are afraid of the ramifications if they do not want to take the path of least resistance. Authoritarian control is the opposite of this--parents are "too strict" and set unreasonable and overly restrictive limits for their adolescent. The second dialectical dilemma is *normalizing pathological behaviors versus pathologizing normal behaviors.* Sometimes parents will make light of a seriously problematic clinical behavior such as dependence on a substance. The opposite of this is making too much of typical adolescent behaviors such as changing self-image through clothing. The final dialectical dilemma for adolescents and families is *forcing autonomy versus fostering dependence.* Forcing autonomy is when the parent insists on separation and forces independence in the adolescent, often through excessive and age-inappropriate responsibilities. Fostering dependence on the other hand is when the parent is overly dependent on the child, is excessive in his/her control and caretaking, and reinforces the adolescent's clinginess to the parent.

The goal of addressing each of these dialectical dilemmas is to help adolescents and their families become unstuck from their maladaptive behavior patterns (Rathus & Miller, 2002). The therapist helps the families find a balance between these seemingly opposite poles of the same issue. Through the use of the Middle Path skills module,

adolescents and parents learn to find a healthy balance in each of these areas (Miller et al., 2007).

Family Therapy

Unlike adults, treating adolescents who still live within their original invalidating environment in which they learned their dysfunctional patterns requires involvement of the family members (Rathus & Miller, 2002). Family therapy combines family treatment and DBT to reduce invalidation within the family, which is a major contributing factor to emotional dysregulation in adolescents (Woodberry et al., 2002). A recently updated adaption of the DBT model specific for adolescents stated that family therapy in DBT is an essential component of treatment (Miller et al., 2007). The *Adolescent Adaption of Dialectical Behavior Therapy* model includes family therapy two to three times a month, telephone coaching as needed to help family members implement the skills in real life situations, integrating the family members into individual therapy sessions with the adolescents as needed, and monthly parent/caregiver groups (Miller et al., 2007).

Research showed that when adolescents are deficient in the types of skills taught in DBT, their families are highly likely to be deficient in the skills as well (Turner, Barnett, & Korslund, 1998). A unique challenge to adolescents is created when they try to practice their skills in a family setting not set up to support these new skills. Adolescents who are clients in DBT programs are often met with ineffective and invalidating responses from their caregivers (Woodberry et al., 2002). These responses can discourage the adolescent to continue using their newly acquired skills. Therefore, inclusion of family members in the program is very important. Whenever possible,

parents, caregivers, and family members should participate in learning DBT skills so the home environment is more conducive to using the skills (Woodberry et al., 2002).

The DBT family therapist is faced with the challenge of evaluating and understanding multiple, and often opposing, points of view (Katz et al., 2002). Through therapy, the adolescent and the family learn to integrate their opposing viewpoints and validate each other's experiences (Miller et al., 2007). Treatment targets in family therapy are to reduce skills deficits and increase effective DBT skills among family members. The first target is to decrease family risk factors including abuse, neglect, high levels of conflict, and parental psychopathology (Hoffman, Fruzzetti, & Swenson, 1999). Parents can be referred to their own individual therapist if additional mental health services are needed (Hoffman et al., 1999). Another target is to enhance protective factors in the family such as closeness, warmth, emotional involvement, stability, adaptability, and dialectical thinking (Miller et al., 2007). A final target is to improve interpersonal relationships in the family by enhancing mindfulness of interaction patterns, encouraging reciprocal validation between the adolescent and the family, increasing affection, and decreasing reactivity (Woodberry et al., 2002). Importantly, once families develop effective skills, family relationships can become a major source of strength for adolescents and a source of support for coping with emotional dysregulation (Miller et al., 2007).

Graduate Group

The *Adolescent Adaption of Dialectical Behavior Therapy* (Miller et al., 2007) includes a recommendation to provide an advanced skills graduate group for clients who have completed the initial course of treatment. The graduate group provides a second

phase of treatment that reduces the role of the clinician and emphasizes peer coaching, problem solving, and an opportunity for adolescents to practice teaching the skills they acquired in the initial 16 week program with their peers (Miller et al., 2007). Continuation of services is based on documented rates of relapse and recurrence among adolescents and recommendations by clinical researchers to provide either booster or continuation of treatment with this age group (Goldstein, Axelson, Birmaher, & Brent, 2007). Graduate groups can increase positive peer relationships between clients, which have been correlated with improved self-esteem, mitigation of stress, and an improved view of school (Berk, 2004).

Advantages of Dialectical Behavior Therapy with Adolescents

There are many advantages of using DBT with adolescents. The structure provided by DBT guides the therapist in the treatment plan for the adolescent. Stage I behaviors (suicidal and parasuicidal behaviors) are addressed as the first target and then the model provides a hierarchy of other treatment targets to help the therapist structure the sessions (Rathus & Miller, 2002). The strategies of diary cards, skills groups, and the stage model of treatment provide an organization of the client's problems for the therapist. The guidance provided by DBT reduces the therapist's anxiety around not knowing which simultaneously presenting problems to address first. The reduced anxiety of the therapist increases the likelihood the therapist will respond in a therapeutically helpful way to the adolescent in crisis (Stanley et al., 2001).

Dialectical behavior therapy also addresses treatment noncompliance and focuses on keeping adolescents engaged in treatment (Katz et al., 2002). The pretreatment stage emphasizes collaboration between therapist and client and targets commitment to change

(Katz et al., 2002). Additionally, DBT uses many worksheets, handouts, and activities that are appealing to adolescents. The skills groups provide an opportunity for adolescents to practice social skills with their peers and learn vicariously through the experiences of other adolescents to which they are much more likely to respond than experiences of adults (Miller et al., 2007; Steinberg, 2005). Finally, the areas addressed by DBT (emotional instability, impulsivity, interpersonal problems, and confusion about oneself) are consistent with the developmental tasks of adolescents (Katz et al., 2002).

Limitations of Dialectical Behavior Therapy with Adolescents

There are several limitations in using DBT with an adolescent population. A key limitation in implementing and running a full DBT program is resource intensive (Paris, 2005). Adolescents engage in weekly individual sessions, weekly group session, bimonthly family sessions, and have access to phone coaching outside of regular business hours. Not all adolescents and families are able to engage in such intensive services due to time constraints, lack of transportation, lack of childcare, and motivation (Theisen, 2007).

For therapists, there is intensive training and the addition of group supervision and a DBT consultation group meeting to their schedule. Supervisors must also be trained as the consultation group is facilitated using the DBT model. Some agencies might not have the funding to train therapists. Additionally, some regions might not have access to DBT training, which creates limitation in availability of treatment for adolescents.

Another major critique of DBT with adolescents exhibiting BPD features is the use of a short-term therapy in treating a personality disorder, which has been treated best

with long-term therapy (Paris, 2005). In the adult model of DBT, treatment is long-term with Stage I lasting one year (Linehan, 1993a). However, in the adolescent model, this stage has been shortened to 16 weeks. The primary goal of this stage for adolescents is stabilization, which includes control of suicidal and parasuicidal behaviors (Miller et al., 2007). Additionally, in this stage, adolescents and their families learn skills needed to decrease areas of dysregulation that contribute to the adolescent's problems. While DBT has been shown to be effective in achieving these goals, there have been no longitudinal follow up studies to determine if the adolescent model is as effective as the long-term adult model (Katz et al., 2002; Miller et al., 2007).

Outcome Research of Dialectical Behavior Therapy

This section of the literature review describes the outcome research in studies of DBT adapted for suicidal adolescents, DBT for adults with BPD, and the most up-to-date investigations of DBT in treating various mental health disorders in multiple clinical settings. Dialectical behavior therapy has been adapted for and evaluated in several adolescent populations and treatment settings such as community mental health centers, inpatient programs, and juvenile correctional facilities (Robins & Chapman, 2004). Dialectical behavior therapy has been trialed with success in populations with drug dependence, chronic suicidality, criminal behaviors, depressive disorders, eating disorders, and in adolescent and geriatric populations (Katz et al., 2002; Koons et al., 2001; Linehan, 1993a; Telch, Agras, & Linehan, 2001). A review of the current research included randomized control trials (RCT) and non-randomized or uncontrolled trials.

Adolescent Dialectical Behavior Therapy Outcome Research

In 1997, Miller et al. adapted DBT for suicidal adolescents. The primary modifications included (a) incorporating age appropriate language, (b) decreasing the length of treatment to 12 weeks, (c) adding family members in skills groups, and (d) including family members in adolescents' individual sessions as clinically indicated. The inclusion of family members was meant to help parents and caregivers coach their adolescents in using DBT skills and improving their own skills when interacting with their adolescents (Miller et al., 1997). Adding family members to the individual's treatment reduced the amount of conflict in the family and addressed common dialectical dilemmas in families. These modifications in standard DBT led to research on the effectiveness of DBT in treating suicidal and parasuicidal adolescents.

Miller, Wyman, Huppert, Glassman, and Rathus (2000) studied the overall effectiveness of DBT skills modules with adolescents: mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness. Participants included 27 adolescents from an adolescent depression and suicide program in New York. Adolescents were admitted to this program for self-harming behaviors, suicidal ideation, emotional dysregulation, and intra- and interpersonal dysregulation (Miller et al., 2000). Participants were selected for the DBT study if they had engaged in parasuicidal behavior within the last 16 weeks or reported current suicidal ideation and also met the diagnostic criteria for BPD (or a minimum of three BPD features). Diagnoses were determined using the structured clinical interview for DSM-IIIR Personality Disorders, Borderline Personality Module (SCID-II; APA, 1987). Participants were 85% female and 15% male, with a mean age of 16.7 years, and were 59% Hispanic, 33% African American,

3% Caucasian, and 5% self-identified as other. All participants received 12 weeks of DBT treatment including weekly individual therapy sessions and weekly multifamily skills training groups. These skills groups consisted of family members of the adolescent participants. Individual therapy sessions and skills group sessions covered each of the four DBT skills modules to treat the four problem areas addressed by DBT.

Participants were evaluated pre- and post-treatment utilizing the Life Problems Questionnaire (LPI)--a self-report measure consisting of 60 items designed to assess the severity of problems in the four treatment areas of DBT. The LPI has demonstrated internal consistency and validity (Miller et al., 2000). At the end of 12 weeks of treatment, the participants also completed the DBT Skills Rating Scale for Adolescents developed by Miller et al. (2000). Results indicated that the differences pre- and post-treatment as measured by the LPI scores demonstrated a significant reduction of symptoms in all four of the DBT problem areas: confusion about self, emotional instability, interpersonal difficulties, and impulsivity. This study demonstrated the effectiveness of DBT in a shortened 12-week version with parasuicidal and suicidal adolescents. However, limitations of this study included the small sample size, the lack of a control group, and the reliance on self-report measures developed by the researchers.

In 2002, Rathus and Miller addressed an area of need in the literature by researching treatment of adolescents with suicidal ideation and/or parasuicidal behaviors. The majority of previous research with depressed adolescents excluded participants with suicidal behaviors or severe self-harming behaviors. Using a quasi-experimental design, Rathus and Miller studied the adaptation of DBT for suicidal adolescents with borderline personality features. Participants were recruited from an adolescent depression and

suicide program in New York and were assigned to either the DBT treatment group or the TAU control group, which was outpatient community therapy. The treatment group (*n* = 82) was comprised of 93% female and 7% male participants with a mean age of 16.1 years. The TAU group (*n* = 29) was comprised of 73% female and 27% male participants with a mean age of 15 years. Both groups of participants were 67.6% Hispanic, 17.1% African American, 8.1% Caucausian, 6.3% self-identified as other, and 0.9% Asian.

Inclusion criteria for participants in the DBT group were (a) a suicide attempt within the last 16 weeks or current suicidal ideation as measured by the Harkavy-Asnis Suicide Survey (HASS) and the Scale for Suicidal Ideation (SSI), and (b) a diagnosis of BPD (or at least three BPD features) as measured by the SCID-II (Rathus & Miller, 2002). If participants met only one of these criteria, they were assigned to the TAU group; thus, the DBT group was comprised of adolescents with more severe symptoms. The treatment group received 12 weeks of DBT therapy, which consisted of weekly individual therapy sessions and weekly multifamily DBT skills groups. The TAU group received 12 weeks of weekly individual therapy sessions and weekly family therapy sessions, which utilized a supportive therapeutic approach with the goal of decreasing current problems for adolescents and their families (Rathus & Miller, 2002). Pre- and post-treatment measures included the HASS, Beck Depression Inventory (BDI), LPI, SSI, Symptom Checklist 90-Revised (SCL-90), Schedule for Affective Disorders and Schizophrenia-Child Version (K-SADS), SCID-II, number of psychiatric hospitalizations during treatment, number of suicide attempts during treatment, and treatment completion rate (Rathus & Miller, 2002).

Results of the study indicated the DBT group had significantly fewer psychiatric hospital admittances than the TAU group (0% vs. 13%). Sixty-two percent of participants completed treatment in the DBT group, which was significantly higher than the 40% completion rate of the TAU group (Rathus & Miller, 2002). Although there were no differences in suicide attempts between the DBT group and the TAU group, the DBT group reported a significant reduction in suicidal ideations. Additionally, the adolescents in the DBT group showed significantly reduced borderline personality features as well as less psychiatric symptoms overall. Pre- and post-treatment scores on the LPI indicated that within the DBT group, there were significant decreases in all four of the DBT problem areas: confusion about self, emotional instability, interpersonal difficulties, and impulsivity. These results suggested DBT as an effective treatment for suicidal or parasuicidal adolescents with BPD features. However, limitations in the design of the study decreased the generalizability of the results. While there was a control group, participants were not randomly assigned to treatment conditions, which resulted in non-equivalent groups. Additionally, the DBT group had a higher severity of symptoms at pre-treatment than the TAU group. Despite these differences in base rate symptoms, DBT still provided positive outcomes for the participants (Rathus & Miller, 2002).

Katz et al. (2004) conducted a controlled trial of DBT with hospitalized suicidal adolescents. Participants were randomly assigned to either the treatment condition of inpatient DBT group (n = 26) or the control condition of inpatient TAU (n = 27). Inclusion criteria included one or more psychiatric hospitalizations for suicidal ideation and/or parasuicidal behavior within the past 12 weeks. At a one year follow up to the

study, both groups showed highly significant reductions in suicidal ideation and depressive symptoms (Katz et al., 2004). However, DBT was superior to TAU in reducing the number of parasuicidal behaviors since treatment. The authors noted the lack of significant differences between the DBT and the TAU groups at follow up might be due to the high emphasis of preventing life-threatening behaviors across treatments in the context of a hospital setting (Katz et al., 2004). Another limitation of this study was adolescents in the DBT group were primarily being treated for suicidality and did not receive the recommended 12-week course (Rathus & Miller, 2002) of DBT treatment. Despite these limitations, this study contributed to the sparse follow-up DBT research with adolescents (Robins & Chapman, 2004).

Dialectical Behavior Therapy for Women Diagnosed with Borderline Personality Disorder

Dialectical behavior therapy has been empirically evaluated in several studies as a treatment for women diagnosed with BPD (Koons et al., 2001; Linehan et al., 2002, 2006; van den Bosch, Verheul, Schippers, & van den Brink, 2005). In 1991, Linehan et al. published a randomized control trial (RCT) with women diagnosed with BPD who had engaged in parasuicidal behavior. The treatment group (n = 24) received one year of DBT. The control group (n = 23) received one year of treatment as usual (TAU), which was community outpatient treatment. In comparison with those in the TAU group, participants in the DBT group engaged in a significantly lower number of parasuicidal behaviors (26% vs. 60%). Participants in the DBT group also had greater reductions in the frequency of admissions and number of days of inpatient psychiatric hospitalization. Compared to TAU, DBT was more effective at improving participants' social adjustment, global functioning, treatment compliance, anger, and treatment dropout rate (Linehan et

al., 1991). At 6- and 12-month follow-up studies, the DBT group maintained these treatment gains (Linehan et al., 1993). While both treatment groups showed improvements in depression, hopelessness, suicidal ideation, and reasons for living, there were no significant differences between the groups in those areas (Linehan et al., 1993).

Another RCT was conducted by a research group at Duke University on the efficacy of DBT with women veterans with BPD (Koons et al., 2001). Participants were assigned to either six months of DBT or TAU. The DBT group showed greater improvements in suicidal ideation, hopelessness, depression, and anger than did the TAU group (Koons et al., 2001). Also, only participants in the DBT group demonstrated significant improvements in parasuicidal behavior, aggressive behavior, and dissociation. There were no improvements in anxiety symptoms for either group. Because only 40% of the DBT participants had engaged in recent parasuicidal behaviors (as opposed to 100% in Linehan et al.'s 1991) study), the base rate of this behavior was lower; thus, the ability to demonstrate between group differences on reduction of parasuicidal behaviors was limited. However, because of the stage model of DBT, the Stage 1 behaviors (suicidal or parasuicidal behaviors) of Linehan et al.'s (1991) participants would be targeted first. The participants in Koons et al.'s (2001) study were able to focus on Stage 2 targets (quality of life behaviors), which might have accounted for the improvements in depression and hopelessness. These results suggested the effectiveness of expanding the use of DBT beyond outpatient clients with BPD to use with veterans with BPD (Koons et al., 2001).

A third RTC was conducted in the Netherlands with women diagnosed with BPD (Verheul et al., 2003). Participants (n = 58) were randomly assigned to 12 months of

either DBT or TAU. Results demonstrated a significant decrease in self-harming impulsive behaviors (i.e., substance use, binge eating, gambling, reckless driving) in the DBT group compared to the TAU group (Verheul et al., 2003). Dialectical behavior therapy was also more effective in reducing number of parasuicidal behaviors in participants with high levels of this behavior (14 or more parasuicidal acts in a lifetime) than for those with lower levels of this behavior (0 to 14 parasuicidal acts in a lifetime) but the differences were not significant. Neither group showed a significant reduction in frequency or amount of substance use. The DBT group did demonstrate significantly higher retention rates for the 12 months of treatment (63%) than the TAU group (23%; Verheul et al., 2003).

The results of these three independent RTC studies demonstrated the efficacy of DBT in treating adults with BPD. Overall, the clinical outcome data supported DBT as an efficacious treatment for women with BPD and was deemed an empirically supported treatment by the American Psychological Association (Robins & Chapman, 2004). Since the original study (Linehan et al., 1991), DBT remains the only outpatient psychotherapy with demonstrated efficacy for this population.

However, a limitation of these studies was only female participants were used; thus, generalizability to male clients was restricted. Furthermore, it was possible the effects of newly and intensely trained therapists in the DBT group might have contributed to the effectiveness of DBT. Linehan et al. (2002) addressed this possibility by conducting a study where both the DBT and comparison group therapists received rigorous training, regular supervision from expert psychologists, and participated in consultation groups. The comparison group was treatment by experts (TBE), in which

the therapists were predominantly trained in psychodynamic therapy. Findings from this study indicated clients in both the DBT and TBE groups improved significantly and there was no difference in rates of self-injury (Linehan et al., 2002). However, clients in the DBT group had significantly lower frequencies of suicide attempts, significantly lower rates of emergency room and inpatient services, and less than half the rate of treatment dropouts than clients in the TBE group (Linehan et al., 2002). This study indicated the effectiveness of DBT was unlikely due to treatment training, consultation, and supervision (Linehan et al., 2002).

While the existing research consistently pointed to the effectiveness of DBT in treating borderline personality disorder, little qualitative research has been conducted to ascertain the reasons for its success, especially from the perspective of those undergoing the treatment. One qualitative study sought to address this area of research with adults. Cunningham et al. (2004) interviewed female patients diagnosed with BPD (*n*= 14) undergoing DBT treatment. Results from this study indicated the women reported DBT had a positive impact on their lives (Cunningham et al., 2004). However, the interviews were conducted while the women were still in treatment (outpatient) and in varying stages of the DBT model. As described previously, symptoms of BPD included emotional dysregulation and an inability to identify and manage their feelings. Thus, if patients were still undergoing treatment, they might not have been able to identify what was unhealthy about their relationship and not have learned to regulate their emotions yet, making the self-reports more about their current mood rather than DBT as a treatment. Additionally, patients had been in DBT treatment in a range of six months to three years, creating very different types of experiences with DBT. The training of the

staff members in DBT also varied from a 10-day workshop to a two-hour training; thus, patients were receiving different levels of DBT treatment. The researchers also did not follow the DBT manual for treatment by leaving out several components such as phone coaching, family therapy, diary cards, and other aspects of DBT.

In my study, I addressed the limitations of this qualitative study. I waited to conduct interviews until the participants had completed the DBT program and had had a chance to use the skills in their daily lives to get a full understanding of their experience. This study also focused on adolescents instead of adults and included male and female participants to increase the diversity of the sample. Furthermore, the participants in my study had all have received the same level of treatment from therapists who followed a manualized treatment model.

Nock, Teper, and Hollander (2007) investigated the use of DBT modified for adolescents with one female adolescent client in a case study design (Miller et al., 2007). They found that using DBT skills led to decreased suicidal ideation, reduced frequency of self-harming incidents, and decreased substance abuse (Nock et al., 2007). Another finding from this case study was that the adolescent reported improvements in her relationship with her father as well as with her friends (Nock et al., 2007).

Another qualitative study examined two case studies of adult clients with trauma-related difficulties (Wagner & Linehan, 2006). These researchers found DBT treatment led to participants reporting significant decreases in PTSD symptoms. One participant also demonstrated a reduction in parasuicidal and suicidal behaviors but the other did not. Depression was reduced for one client but not for the other client (Wagner & Linehan 2006).

Dialectical Behavior Therapy in Different Clinical Settings

Adolescents and adults diagnosed with BPD are frequently referred to psychiatric hospitals or emergency services from other mental health agencies due to the severity of self-harming behaviors such as cutting, burning, branding, piercing, and head banging (Groves et al., 2012). The high level of referrals is partly due to a lack of resources in the community that can provide treatment for these behaviors (Aguirre, 2007). In the current mental health system, psychiatric hospitalization is the primary mode of treatment for self-harming adolescents (Katz et al., 2004). Future research is needed in other settings to assist mental health workers in treating adolescents with parasuicidal and suicidal behaviors so hospitalization is not the primary resource. Some of the clinical settings investigated included community mental health settings, inpatient settings, residential treatment settings, and correctional facility settings (Robins & Chapman, 2004). Other more recent studies have examined DBT being implemented in university settings (Pistorello, Fruzzetti, MacLane, Gallop, & Iverson, 2012). Research in each of these various clinical settings is described below.

Community mental health settings. One of the first community mental health centers to develop standardized DBT for BPD clients was the Mental Health Center of Greater Manchester in New Hampshire in 1998 (Robins & Chapman, 2004). Adult participants (n = 14) diagnosed with BPD completed a 12-month DBT program. In comparison with data from clients receiving TAI the previous year, the DBT clients demonstrated a 77% decrease in number of psychiatric hospital days, a 76% decrease in number of partial hospitalization days, a 56% decrease in crisis center services, and an 80% decrease in emergency room visits (Robins & Chapman, 2004). Another impressive

result was that despite an increase of three times as many scheduled outpatient visits, the Mental Health Center reported a total treatment cost reduction of 58% (Robins & Chapman, 2004).

These positive DBT treatment outcomes in community mental health settings have been replicated. Elwood, Comtois, Holdcraft, and Simpson (2002) published results of a 12-month DBT community mental health program for adults (n = 20) diagnosed with BPD with histories of chronic suicidal behavior and multiple treatment failures. The authors reported significant reductions in the frequency of parasuicidal behaviors, number of psychiatric emergency room visits, number of inpatient admissions, and number of psychiatric hospitalization days for DBT clients as compared to clients receiving TAU outpatient therapy from the previous year. The results showed that after completing the one-year DBT program, clients had significant reductions in the frequency of parasuicidal behaviors (Elwood et al., 2002).

An RTC study was conducted in a community mental health setting and demonstrated DBT to be superior to TAU for adults (n = 24) diagnosed with BPD and engaged in recent parasuicidal behavior (Turner et al., 1998). Participants were randomly assigned to one year of either DBT or TAU (weekly community outpatient therapy). Participants in both groups demonstrated significant improvement in overall functioning. However, the DBT treatment group had significant reductions in number of suicide attempts, number of deliberate self-harm behaviors, number of hospital inpatient days, frequency of suicidal ideation, and reduced impulsivity, anger, and depression (Turner et al., 1998). Like the findings of Koons et al. (2001), there were no group differences on levels of anxiety reduction.

These community mental health studies with adults diagnosed with BPD either did not have a control group or had small sample sizes; therefore, conclusions about the efficacy of the DBT programs were limited. However, the results did demonstrate that DBT implemented in a community mental health setting might have beneficial treatment outcomes for adults with BPD as well as financial benefits for mental health agencies.

University counseling centers. Pistorello et al. (2012) investigated the effectiveness of DBT for a university student population experiencing BPD symptoms, suicidal ideation, and at least one suicide attempt in a university counseling center (UCC). The authors were emphasizing the importance of the availability of DBT in UCCs to provide help to young adults before their symptoms worsened (Pistorello et al., 2012). The study compared DBT to an optimized treatment-as-usual and addressed several barriers UCCs experienced when implementing manualized DBT (e.g., provide brief psychotherapy, regular university breaks, trainee therapists; Pistorello et al., 2012). The study showed a positive outcome for participants in the DBT group compared to the TAU group. Improvement was seen in the following areas: depression, rates of suicidality, social adjustment, and symptoms of BPD. The authors conclude that DBT might be a feasible and effective treatment to implement with the population served in university settings (Pistorello et al., 2012).

Residential treatment centers. Along with inpatient and outpatient settings, another setting where DBT has been shown to be effective with adolescents is in residential care (Robins & Chapman, 2004). Dialectical behavior therapy was implemented in a residential treatment facility for adolescent girls to address suicidality and hospitalization due to parasuicidal behaviors (Sunseri, 2004). Dialectical behavior

therapy was effective at significantly reducing the number of days adolescents spent in psychiatric hospitals as well as decreasing self-injurious behaviors. Other changes noted in the residential treatment facility were a decrease in the length of time clients were held in restraints or put in seclusion as a means of preventing self-harm (Sunseri, 2004). Sunseri (2004) also noted that the staff of the treatment center found DBT to be a more supportive, well organized, validating therapeutic approach when working with adolescents.

Other studies have also found DBT to be effective in RTC settings. Researchers found that implementing DBT in an adolescent residential program improved the adolescents' ability to communicate more effectively and use skills to get their needs met (Wolpow, Porter, & Hermanos, 2000). It has also been demonstrated that DBT can be a more effective treatment for suicidal adolescents in RTCs than TAU (Wasser, Tyler, McIlhaney, Taplin, & Henderson, 2008).

Correctional facilities. A number of adult correctional facilities have documented positive results after incorporating DBT into their treatment using setting appropriate modifications (Berzins & Trestman, 2004; Cunningham et al., 2004; Laishes, 2002). However, only one study has been conducted investigating DBT in a juvenile correctional facility (Trupin et al., 2002). Trupin et al. (2002) conducted a controlled study to evaluate the effectiveness of DBT by comparing three different groups of incarcerated juvenile female offenders. Sixty participants were divided into three groups. The first group was a mental health unit receiving DBT, the second was a general population unit receiving DBT, and the third was a general population unit receiving TAU. The study followed a standard adolescent DBT format with the inclusion of

behavioral targets specific to the correctional setting such as unit-destructive behaviors and offense-related behaviors. The overall goal of the program was to decrease life-threatening behaviors and increase quality of life behaviors (Trupin et al., 2002).

The researchers found a significant reduction in problematic behaviors with the DBT groups and the rate of punitive actions by the staff was much lower (Trupin et al., 2002). The study also reported a significant decrease in aggressive behavior, suicidal attempts, parasuicidal behaviors, and disruptive behaviors. In the control group, no changes in participants or staff behaviors were found (Trupin et al., 2002).

One of the limitations of this study was unequal training for the staff on the two units receiving DBT treatment (Trupin et al., 2002). The mental health unit staff received approximately 80 hours of training while the general population unit received only the introductory 16 hours of training. While both groups demonstrated a reduction in parasuicidal and problematic behaviors, the unit receiving less training had much poorer outcomes than did the fully trained unit. This spoke to the importance of full adherence to the treatment model and necessary training for staff. It is important to address training as research studies might not report the exact amount of training the researchers had. While this study had a control group, the participants were not randomly assigned to a DBT or control group--another study limitation (Trupin et al., 2002).

Woodberry and Popenoe (2008) applied DBT to suicidal adolescents and their families in an outpatient community clinic in an uncontrolled study. Significant reductions in depressive symptoms, anger, dissociation symptoms, suicidal ideation, and an increase in overall functioning were reported. Parents/guardians of the adolescents also reported a decrease in depression and anxiety related symptoms in their children as

measured by the Child Behavior Checklist (Achenbach & McConaughy, 1987). These parent reports of positive change in their adolescents after DBT supported similar findings of improvement reported by parents in other studies (Goldstein et al., 2007; Nelson-Grey et al., 2006).

Additional Disorders Treated by Dialectical Behavior Therapy

The previous sections addressed the effectiveness of DBT with suicidal and parasuicidal behaviors among adults and adolescents. As mentioned in a prior discussion, a high rate of comorbidity exists between BPD and other psychological disorders (Linehan, 1993a). Research on the effectiveness of DBT has expanded to additional disorders and behaviors disorders.

Substance Abuse

Linehan et al. (1999) compared results from a DBT group and a treatment as usual (TAU) group of women with substance dependence, suicidality, and borderline personality disorder. A total of 28 participants were randomly assigned to DBT or TAU groups. The results showed a treatment dropout rate of 36% from the DBT group compared to 73% from the TAU group. Furthermore, according to urine analysis, the DBT group showed a significant reduction in substance abuse and significant improvements in social and overall adjustment compared to the TAU group. The results of this study suggested that DBT is an effective treatment for severely dysfunctional substance dependent women (Linehan et al., 1999).

Linehan et al. (2002) showed DBT to be a superior, comprehensive, validation treatment combined with a 12-step program for heroin dependent women. Participants were randomly assigned to either the DBT or therapy with a 12-step program group for a

12-month period. Both groups also received concurrent opiate agonist therapy (levomethadyl acetate hydrochloride oral solution; Linehan et al., 2002). Participants were assessed through urinalysis, interviews, and self-reports. Results showed that both treatment conditions were effective in reducing heroin use relative to baseline. The DBT group maintained fewer opiate-positive urinalyses at the four-month follow up whereas the 12-step group showed a significant increase in heroin use at the four month follow up. One critique of this study was only 64% of participants completed the DBT program while all of the participants in the 12-step group completed the full year of treatment (Linehan et al., 2002).

Eating Disorders

In one study, DBT was evaluated as a treatment for women with a binge eating disorder (Telch et al., 2001). Participants were randomly assigned to either the DBT group or to a wait-list control group. Outcome measures included an eating disorder examination pre- and post-treatment that measured weight, mood, and affect regulation. Compared with the control group, women in the DBT groups demonstrated significant improvement on measures of binge eating and eating pathology. At the end of treatment, 89% of women in the DBT group had stopped binge eating and at a six month follow up, the abstinence rate for binge eating remained high but dropped to 56% for the DBT group. Measures of weight, mood, and affect regulation were not significant (Telch et al., 2001).

Another eating disorder study examined the effects of DBT adapted for the treatment of bulimia nervosa with female participants (Safer, Telch, & Agras, 2001). Thirty-one participants were randomly assigned to either 20 weeks of DBT or 20 weeks

in the waitlist comparison condition. Dialectical behavior therapy skills groups emphasized training in emotional regulation skills. Compared to the wait list condition, the DBT group showed highly significant decreases in binging and purging behaviors. Overall, some promising preliminary findings suggested that DBT might be an effective treatment for eating disorders (Safer et al., 2001).

Bipolar Disorder

There has been an increase in attention to and treatment options for children and adolescents with bipolar disorder (Goldstein et al., 2007). As defined in the DSM-IV-TR (APA, 2000), bipolar disorder is attention deficit hyperactivity disorder (ADD). Research has shown that bipolar disorder affects approximately 6-15% of adolescents from clinical samples (Biederman et al., 1995). One of the core symptomatic features of adolescents with bipolar disorder is extreme emotional dysregulation (Leibenluft, Charney, & Pine, 2003). Emotional dysregulation is a main target of treatment in DBT (Linehan, 1993a). Goldstein et al. (2007) applied Rathus and Miller's (2002) adapted DBT model for adolescents with bipolar disorder. Their method of treatment was DBT interventions delivered over one year with two modalities: family skills training and individual therapy. There were 10 patients in their study; after the year of treatment, 9 out of 10 patients completed treatment with a 90% session attendance rate and high treatment satisfaction ratings (as rated by satisfaction survey post treatment). The results of the study found that all nine patients completing the study exhibited significant improvement from pre- to post-treatment in the following areas: suicidality, non-suicidal self-injurious behavior, emotional dysregulation, and depressive symptoms (Goldstein et

al., 2007). The results of this study indicated that DBT might be a promising treatment for adolescents with bipolar disorder.

Oppositional Defiant Disorder

Another disorder that has been treated with DBT is oppositional defiant disorder (ODD). According to the DSM-IV-TR (APA, 2000), ODD is characterized as a recurrent and developmentally inappropriate pattern of defiant, disobedient, negative, and hostile behavior toward authority figures that persists for at least six months and leads to significant impairment in academic, social, or occupational functioning. Adolescents with ODD are some of the most common clients in mental health clinics (Nelson-Gray et al., 2006). If left untreated, ODD is an antecedent to a child developing conduct disorder (Nelson-Gray et al., 2006). A treatment team used a modified version of adolescent DBT to treat ODD (Nelson-Gray et al., 2006). The modification made to the DBT program was the adolescents participated in the skills groups only and not in family or individual counseling sessions. The program included two hours of group therapy once a week for 16 weeks. Participants in the study (n = 32) were non-suicidal adolescents, had a mean age of 12.6 years, and had been diagnosed with ODD. All participants met the criteria for ODD and some had comorbid disorders; 34% also met criteria for conduct disorder and 31% for attention deficit hyperactivity disorder (Nelson-Gray et al., 2006).

After completion of the DBT program, the caregivers reported a significant reduction in negative behaviors and an increase in positive behaviors (Nelson-Gray et al., 2006). The adolescents themselves reported a decrease in depressive symptoms and externalizing and internalizing symptoms. Pre- and post-treatment measures included the Diagnostic Interview Schedule for Children, the Youth Self Report, the Behavioral and

Emotional Rating Scale, and the Child Depression Inventory (Nelson-Gray et al., 2006). Data analyses indicated that 77% of the participants who were in the clinically significant range of problematic behaviors on the measures pre-treatment were in the non-clinical range post-treatment. Although this study did not have a control group or waitlist group, it was consistent with the standard DBT manualized skills group and demonstrated DBT to be an effective intervention for non-suicidal adolescents with ODD (Nelson-Gray et al., 2006). No follow-up results were reported from this study.

Conclusion

Each of the studies described above contributed to understanding the effectiveness of DBT with adolescents diagnosed with various disorders and within different treatment settings. While the results of these studies were promising, some limitations included the frequent lack of a control/comparison group and lack of random participant selection and assignment. Despite some limitations, the evidence-based research overall provided positive outcomes associated with DBT for adolescents and warrants further investigation of this treatment modality with adolescent populations. To date, very few studies have followed-up with adolescents after DBT treatment. Thus, little is known about the experience of DBT after completing treatment.

There was also the limitation of dependence on self-report measures without the addition of qualitative data gained from in-depth interviews with the participants. Specifically, there was a lack of outcome research in understanding the effectiveness of DBT from adolescents' perspectives.

In the field of psychology, research has been predominantly positivist and has been associated with quantitative studies (Ponterotto, 2005). Positivist research focuses

on being able to predict and control phenomenon so the truth of the phenomenon becomes knowable (Ponterotto, 2005). In this philosophy of a knowable truth, there is the implication that there is one single reality and it can be objectively studied (Creswell, 2007). In contrast, constructivist qualitative research focuses on describing and understanding phenomenon from multiple perspectives (Ponterotto, 2005). The current study employed constructivist qualitative case study methodology to address the need for an in-depth understanding of *how* DBT is effective with adolescents in a community mental health setting. The following chapter describes the constructivist theoretical framework, qualitative case study methodology, and data collection methods utilized in this study.

Literature Review Limitations

The literature reviewed in this chapter and throughout the dissertation was acquired through the use of internet search engines, university library searches, from electronic journals and publication, and a review of completed qualitative dissertations. The following search engines were primarily used: Academic Search Premier, EBSCOhost, ProQuest Research Library, PsychINFO, PsychARTICLES, and Google Scholar. Information was also obtained through training manuals, professional presentations, and conference materials. My review of the literature might be missing information not available via the search engines I used or I might have limited my review by the choice of keywords I used to look for articles. Other studies might have been missed in my literature search due to the "file drawer" effect, which refers to unpublished studies or with negative outcomes. These studies were "filed" away and thus not available for researchers. This effect might have limited the types of studies I reviewed.

CHAPTER III

METHODOLOGY

To have a sound qualitative study, there must be rigor and consistency in the research design, which is ensured by congruency between the theoretical perspective, methodology, and procedural methods (Jones, Torres, & Arminio, 2006, p. 124). In this chapter, the constructivist theoretical orientation, case study methodology, and procedural methods of this study are described along with the researcher stance, multicultural issues, and ethical concerns.

The purpose of this constructivist qualitative case study was to understand how adolescents experienced dialectical behavior therapy (DBT) at a community mental health center and the impact it had on their lives. An "emic" perspective was a major component of this case study because the goal was "understanding the phenomenon of interest from the participants' perspectives, not the researcher's" (Merriam, 1998, p. 6).

The following primary guiding questions were explored:

Q1 How do adolescents experience DBT in a community mental health center?

Q2 How have the lives of adolescents been impacted by completing a DBT program?

Q3 How are the skills learned in DBT being used by adolescents?

Constructivist Theoretical Framework

Theoretical framework refers to the basic assumptions researchers have about the world they study (Bogdan & Biklen, 1998). Regarding theoretical perspectives of researchers, Crotty (1998) stated, "Different ways of viewing the world shape different ways of researching the world" (p. 66). Theory and epistemology provide a philosophical grounding for deciding what kinds of knowledge are possible and how researchers can insure they are both adequate and legitimate (Merriam, 1998).

Because I believe individuals experience the world in unique ways and there is no one "true" reality, I embraced the constructivist perspective for this study. Constructivism is an epistemology, a theory of knowledge and learning, that illustrates how we know what we know, what knowing is, and the possible scope of knowledge (Crotty, 1998; Fosnot, 1996). In constructivist theory, people construct their own realities based on their interactions with others and the world (Crotty, 1998). From a constructivist perspective, participants are able to bring their own meaning to their experiences (Crotty, 1998. The constructivist belief is an object or relationship itself that does not have meaning but instead is given meaning by humans. Furthermore, the meaning for the same object or relationship might differ depending on the individual (Crotty, 1998). Therefore, despite having shared experiences, participants will have had different interactions with the world, thus providing unique outlooks on the topic being studied. According to constructivist theory, individuals use "complex mental structures" to construct their own reality based upon previous knowledge, perception, and organization of their prior experiences (Braun & Clarke, 2006).

Crotty (1998) claimed that this theoretical perspective does not allow for "valid or invalid" or "true or false" viewpoints (p. 56), which is congruent with the methods of qualitative research. A key assumption of all qualitative research is researchers are

> interested in understanding the meaning people have constructed, that is, how they make sense of their world and the experiences they have in the world. Qualitative research implies a direct concern with *experience* as it is *lived* or *felt* or *undergone*. (Sherman & Webb, 1988, p. 7)

Constructivist theory focuses on the individual's experiences and context in his/her day-to-day life (Schwandt, 1994). Conducting research with a focus on experience and context allows for multiple qualitative methods such as observations, interviews, and artifacts to investigate the complexities of human relationships (Merriam, 1998).

The researcher is more interactive and becomes a researcher-participant in the study when conducting research from a constructivist viewpoint (Ponterotto, 2005). The relationship developed between the researcher and the participant(s) helps bring deeper meaning to the study. The researcher is the primary source of data collection in qualitative research (Merriam, 1998). In the interactive nature of constructivist research, the participants and researcher share experiences and examine what is being studied in the context of their shared reality (Ponterotto, 2005). There is no attempt by the researcher to be objective or to remain detached from the participants. Instead, the researcher acknowledges his or her role in the study and describes this for the readers in a section of the paper called personal stance (Merriam, 1998). As a qualitative researcher, I examined my role in the study and included this information in the researcher stance section of this chapter.

Constructivist Theory and Dialectical Behavior Therapy

Constructivist theory and dialectical behavior therapy (DBT) are compatible in many ways for conducting research. One connection between constructivist research and DBT is neither theory views the participant or client as having an objective truth to be discovered (Morrow, 2005). Reality is co-constructed in the constructivist research relationship with the understanding that multiple realities exist. Likewise, one of the basic assumptions of DBT is there is no absolute truth (Linehan, 1993a).

In DBT and qualitative research, the therapist/researcher is the primary instrument for gathering information and data collection. To be an effective researcher and therapist, one must be skilled at interviewing, listening, being in intimate relationships, tolerating ambiguity, and respecting the unique nature of the participant/researcher or client/therapist relationship (Morrow, 2005). Additionally, the clients and participants are the "experts" of their own lives and are in control of what information they choose to share with the therapist and researcher.

Another similarity between constructivist theory and DBT is the focus on building a trusting relationship. In DBT, the therapeutic relationship is a working alliance with open and honest communication and reciprocal vulnerability (Linehan, 1993a). Similarly, in constructivist research, the researcher seeks to build rapport and communication with the participants (Crotty, 1998). In both researcher and therapist roles, it is important to be aware of any potential power differential that accompany those roles and work toward developing a collaborative relationship.

Both constructivist research and DBT take the participant/client's cultural context into account. In constructivist theory, the researcher searches for meaning in people's

lives and examines the way their world is socially constructed (Creswell, 2007). In DBT, there is a focus on multicultural competency for therapists, which includes sensitivity, respect, and understanding client's worldviews within the context of their culture (Miller et al., 2007). The lives of people who seek services at a community mental health center are complex and many factors such as family background, ethnicity, culture, age, sexual orientation, socio-economic status, and life experience must be taken into consideration. A constructivist perspective allows for each of these factors to play a role in the participant's experience and acknowledges that each participant will have their own "reality."

Methodological Framework

Methodology represents the ideas behind a researcher's approach to answering a research question and the framework from which they conduct the study (Crotty, 1998). Case study methodology has been used across multiple disciplines including psychology, sociology, history, education, and anthropology (Merriam, 1998) and was employed for this study. Multiple researchers have provided conceptual frameworks for guiding case study research (Creswell, 2007; Merriam, 1998; Stake, 1995; Yin, 2014). Creswell (2007) described case study as an exploration of an issue through one or more cases within a bounded system. Yin (2014) defined case study as the *process* involved in conducting research, in that a case study is "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (p. 13). Contrastingly, Stake's (1995) definition focused on highlighting the complexity and uniqueness of a particular unit of study.

According to Merriam (1998), “As the product of an investigation, a case study is an intensive, holistic description and analysis of a single entity, phenomenon or social unit within a bounded system” (p. 34). The bounded system for this study was a specific intensive outpatient DBT program at a single community mental health center. Several cases (adolescents) within the same bounded system (community mental health DBT program) made the use of case study an appropriate methodology (Creswell, 2007, p. 74). This study is described as a cross-case design in which multiple cases within the same bounded system were used. Cross-case designs use multiple perspectives to explore the complexity of one bounded case (Braun & Clark, 2006). With cross-case methodology, the researcher focuses on one issue (understanding the experience of an adolescent DBT program) with multiple cases (multiple participants) to illustrate the issue (Creswell, 2007). In this design, the researcher looked for what was common across cases and what might be divergent and unique among the cases (Merriam, 1998). Cross-case designs strengthen the precision, validity, and stability of the finding by looking at a range of similar and contrasting cases (Miles & Huberman, 1994). Furthermore, including multiple adolescents in my study of DBT is a common strategy for enhancing the transferability of the findings (Merriam, 1998).

Case studies are an effective way to present participants’ stories by providing detailed, descriptive narratives and exploring multiple perspectives (Stake, 1995). As the researcher, my goal was to gain “an in-depth understanding of the situation and the meaning for those involved” (Merriam, 1998, p. 19). Through thick, rich description, I aimed to convey to the reader an empathetic understanding of the case and provide them

with the knowledge and information to connect to the participants' experiences (Stake, 1995).

Case study can be defined as instrumental or intrinsic (Merriam, 1998). Instrumental case studies seek to explore a case, or bounded system, when it provides insight into a particular phenomenon to be researched (Stake, 1995). This study was instrumental in nature because it sought to provide insight into the phenomenon of adolescents' experiences of DBT. In contrast, intrinsic case studies focus on describing the uniqueness of the case itself (Stake, 1995). Choosing an instrumental design for this study was appropriate because the findings from this study may provide insight and areas of further research in the area of adolescent DBT programs.

Qualitative case study can further be characterized as particularistic, descriptive, and heuristic (Merriam, 1998). This case study was particularistic as it focused on a particular community mental health center's adolescent DBT program. This case study was descriptive in that the findings of the phenomenon were presented through rich, thick description. According to Merriam (1998), "Thick description is a term from anthropology and means the complete, literal description of the incident or entity being investigated" (p. 29). Lastly, this case study was heuristic because the goal was to illuminate the reader's understanding of the phenomenon under study (Merriam, 1998).

Stake (1995) described four ways in which knowledge learned from case study is different than knowledge learned from other forms of research. Case study knowledge is

1. More concrete--case study knowledge resonates with our own experience because it is more vivid, concrete, and sensory than abstract.
2. More contextual--our experiences are rooted in context as is knowledge in case studies. This knowledge is distinguishable from abstract, formal knowledge derived from other research designs.

3. More developed by reader interpretation--readers bring to a case study their own experience and understating, which lead to generalizations when new data for the case are added to old data.
4. Based more on reference populations determined by the reader--in generalizing as described above, readers have some population in mind. Thus, unlike traditional research, the reader participates in extending generalization to reference populations. (Stake, 1995, pp. 35-36)

Finally, an advantageous outcome of qualitative case study methodology is that new meanings can be discovered, boundaries of the reader's experience may be expanded, or confirmation of what is already known may occur (Merriam, 1998). Furthermore,

> previously unknown relationships and variables can be expected to emerge from case studies leading to a rethinking of the phenomenon being studied. Insights into how things get to be the way they are can be expected to result from case studies. (Stake, 1995, p. 47)

Personal Stance

The research instrument used most often in case study methodology is the researcher who gathers, selects, and organizes data from multiple resources to further understand the bounded phenomenon (Merriam, 1998). As the researcher in this inquiry, I was the main instrument of data collection. This approach had the benefit of allowing me to be flexible in data collection and to adapt questions and methods to fit the specific circumstances of the case. As a human instrument, I also had the advantage of observing nonverbal communication, behaviors, and interactions with the environment, which added to the thick, rich description of the case (Merriam, 1998). However, any of my unexamined biases and values might have influenced the research (Creswell, 2007). To track my influence on the research process, I incorporated awareness of my own values, experiences, and decision-making by keeping a researcher journal and documenting these

observations in my field notes. In the following sections, I discuss what I brought to the study as a person and as the primary research instrument.

Choice of Topic

After graduating college, I found a job working at a residential treatment center (RTC) for abandoned, abused, and neglected youth. I took this job as a temporary position as I thought I would be immediately applying for graduate school. Three years later, I found myself not only still working at the RTC but was promoted to Assistant Program Director of the Acute Girls Unit. I had become deeply invested in the issues of adolescent mental health. It was during this time period in my life when I realized my passion for working with children and adolescents. I brought this passion with me to graduate school and have made issues of adolescent mental health the focus of my clinical work and research. I chose the topic of this study because I believe any psychological treatment that could be effective in preventing suicide and increasing mental health in adolescents deserves attention.

Personal Investment in Research Topic

On a spring night in 2003, I was conducting a routine check of residents in the residential treatment facility where I worked. In room 12, three beds were occupied but the fourth belonging to 14-year-old "Valerie" was empty. I checked the closet and then opened the bathroom door; initially, I heard nothing and prepared to conduct a house-wide headcount. As I closed the door, I heard a faint whimpering coming from the shower. I pulled back the shower curtain slowly and immediately saw bright drops of blood on the yellow tile floor. A razor lay beside Valerie; she was seated, motionless, with her eyes turned down, her wrists deeply wounded, and her pajamas stained red.

Inexperienced with suicide attempts, all I could think to say was “Why did you do this?” Valerie said, “I don’t know. I just don’t care.”

Sitting outside the emergency room a few hours later, I contemplated the contrast of this young girl’s traumatic childhood from my own experiences growing up. By no means were my teenage years perfect but any emotional pain or conflict took place in the context of a generally stable family and safe environment. As a child, I would often observe the differences between my family and my friends’ families, seeking to understand the interaction between our personalities and our surroundings. These early reflections and natural curiosity planted the seeds of my desire to study family dynamics and child development, in both intact families and divided, both supportive and abusive. Through my observations as a child and then later on the night of Valerie’s suicide attempt, I realized I wanted to further understand and assist children and families as a professional psychologist.

My clinical knowledge and therapeutic skills have come a long way since the night of Valerie’s suicide attempt. As part of a requirement for a doctoral course, I participated in an external practicum at a community mental health center where I co-ran dialectical behavior therapy (DBT) groups for suicidal and self-harming adolescents. The experience was supposed to last for one semester and I was supposed to learn about facilitating group therapy. What happened instead was I fell in love with the treatment approach of DBT and the impact it had on the adolescents so I chose to stay on at the center as an extern for almost two years. The first semester, I learned about facilitating groups from watching the group leaders; by the end of my experience, I was leading

multiple groups on my own and had joined the Adolescent Intensive Outpatient DBT team as a full time intern.

During my time as a therapist on the team, I became trained in DBT and conducted adolescent skills group therapy, parent/caregiver skills group, individual therapy, and family therapy. Throughout this experience, I was amazed at how well the adolescents were responding to DBT as a treatment. Adolescents actually wanted to repeat the program and parents requested more parent groups because they loved the DBT skills as well. Over time, my colleagues and I noticed the effectiveness of our program as reported by therapists, schools, parents, and the adolescents themselves. We shared stories of success and knew anecdotally that DBT was working. I saw teenagers go from cutting their bodies daily to learning new, alternate ways of coping with their distressing emotions so that they stopped cutting altogether. There were also many clients who struggled with managing their emotions unsuccessfully and continued to engage in destructive and self-harming behavior as a means of coping with their emotions. My work with these adolescents and their families using DBT was incredibly meaningful for me. As a result of this experience, I deepened my passion for doing clinical work with adolescents and families and developed a new passion for studying DBT as a treatment. I was curious as to why DBT was working for some adolescents and not for others. Although the team used pre- and post-treatment measures, the results did not go deep enough into understanding how change had occurred or not occurred. I wanted to know how the adolescents were experiencing with DBT, what they found helpful or useful, and their overall perception of the program. I realized answers to these questions could only come from the adolescents themselves. My dissertation was the

perfect avenue to explore these questions and to continue to contribute to the research on treating suicidal adolescents.

Theoretical Influences

Constructivist methodology and dialectical behavior therapy are both theories that speak to who I am as a researcher and a therapist. The emphasis on the central aspects of social and cultural context was one of the reasons I was interested in conducting qualitative research with these theories. The theories are similar in many ways and share important views on human nature and truth. I am drawn to these theories because they view adolescents within their context, which includes families and community systems. Additionally, I was influenced by these theories in my clinical work using the concept of dialectics and that there is "no one truth." The connections between theories allowed me to be congruent in both roles as a psychologist-in-training and as a qualitative researcher.

Involvement with the Setting

I was an employee of the community mental health center from where the participants were recruited for approximately a year and a half. My role at the center was as an intern therapist on the Adolescent Intensive Outpatient Dialectical Behavior team. This team utilized DBT as a treatment modality for adolescents with severe emotional and behavioral problems and their families by providing individual, group, and family therapy. During my experience as a DBT therapist, I became familiar with the DBT program as well as with the culture of a community mental health center. Through this past experience, I gained an understanding of the population served by community centers, the broad spectrum of disorders treated, the common interventions used, and the benefits and drawbacks associated with this type of setting.

Connection to the Participants

Three years have passed since I worked as a therapist in the adolescent DBT program at the community mental health center from which the participants were recruited. Although there was a slight possibility I might have known the participants through a previous therapeutic relationship, this did not occur. While I did not know the participants I interviewed, I did have an intimate understanding of the structure and content of the DBT program they experienced. Additionally, I also knew a few of the therapists still working at the center to whom the participants referenced in their interviews. This "insider information" can be advantageous in gaining trust with the participants (Fontana & Frey, 1994).

Role Clarity

I clearly distinguished my role of researcher from my role as a therapist-in-training during the data collection. Due to the personal nature of the research topic, it was at times challenging to keep my "researcher hat" on and not put on my "therapist hat." Having worked as a therapist on the DBT team, I had an understanding of the nature of the typical problems faced by the adolescents in this program. Frequently, there were histories of trauma, neglect, abuse, economic hardship, suicidal ideations, and interpersonal struggles among the DBT clients. Being in the field of psychology, I had an intense interest in and compassion for children and teenagers facing these problems. My awareness of the population I was studying prepared me for any difficult, painful, or sensitive information the participants shared. I was conscientious of remaining in the researcher role during interviews and avoiding the therapist role. However, I believe my

background training with this population and with DBT improved my effectiveness as an interviewer and was beneficial for the participants.

Multicultural Considerations

As a multiculturally competent researcher, I was aware of my own cultural impact on the study. To do this, I brought awareness to the inherent differences between the participants and myself. Being a Caucasian, middle-class, married, college-educated female, I differed from my participants in many ways. The participants in the study came from diverse ethnic and cultural backgrounds and the majority of them were from low socioeconomic status families. None of the participants was married or had been to college, primarily due to their age. Throughout the study, I cultivated sensitivity and awareness of the impact of my culture on the study, the impact of the participants' cultures on me, and I documented this in my researcher journal. Furthermore, I followed the *Multicultural Guidelines for Research* (American Psychological Association, 2003) for psychologists by conducting culturally informed and sensitive research.

It is my hope this brief introduction to my personal frame of reference and theoretical perspective might assist the reader in becoming aware of my potential biases as they might have impacted the findings of this study.

Description of the Setting and Program

The community mental health center where participants were recruited is a large agency in the Rocky Mountain region. The center provides outpatient psychological services, case management, community resources, home based services, and medications management. Infants, children, adolescents, and adults are seen at the center. Clients

come from diverse backgrounds and the primary source of payment for the center is Medicaid.

All participants in this study completed 16-weeks of dialectical behavior therapy (DBT) in the intensive outpatient program at the center. Participants recruited for this study had completed the DBT program within the last two to six months. The program followed the treatment model of the *Adolescent Adaption of Dialectical Behavior Therapy* manual (Miller et al., 2007). All of the treatment goals, modes of therapy, skill modules, and structure of the program described below were based on the DBT manaulized treatment (Miller et al., 2007)

Clients admitted to the DBT program were male and female adolescents ages 12 to 17 from culturally diverse backgrounds. While all clients did not meet the full criteria for borderline personality disorder (BPD), these adolescents presented with emotional, cognitive, and behavioral patterns consistent with the diagnosis of BPD including self-harming and suicidal ideation and attempts. The DSM-IV-TR (APA, 2000) allowed for an adolescent to be diagnosed with BPD if the pattern of pathology was pervasive, persistent, and unlikely to be limited to a developmental stage and/or Axis I disorder. Frequent comorbid diagnoses included substance abuse, mood disorders, anxiety disorders, conduct disorders, and background histories of trauma (APA, 2000). Clients were referred from other programs at the center as well as from psychiatric hospitals, inpatient programs, juvenile detention centers, the court system, and self-referrals through the center's intake process. To be admitted to the program, adolescents were required to have a funding source, usually Medicaid. Additionally, to receive the

intensive level of services provided by the DBT program, clients were screened for severity of problems through the intake process developed by the center.

Adolescents were provided with the following services by the Adolescent DBT program: one hour of individual therapy per week (more sessions if needed during a time of crisis), one and a half hours of group therapy twice a week, and one hour of family therapy two to three times per month. A parent/caretaker skills training group was conducted once every three weeks or when a date coincided with the beginning of a new DBT module. The parent groups were psycho-educational and focused on DBT skills the adolescents were learning for that module. Adolescents in this program did not receive the telephone coaching portion of DBT as this had not yet been implemented by the community mental health center. The clinical goals of the program were (a) to focus on preventing stage 1 behaviors (i.e., most severe and complex clinical behaviors such as substance abuse, suicidal and parasuicidal behaviors, criminal behaviors, and other high risk and therapy interfering behaviors); and (b) to allow adolescents to increase behaviors that improve the quality of life while decreasing behaviors that interfere with the quality of life and achievement of goals. All adolescents and their families participated in the pre-treatment stage of therapy where they made commitments to treatment and were educated about the DBT model before beginning the program.

The weekly skills groups covered each of the DBT modules: Mindfulness, Emotional Regulation, Distress Tolerance, Interpersonal Effectiveness, and the Middle Path. The therapists on the team received four weeks of DBT training prior to the start of the program and engaged in a two-hour weekly DBT consultation group, two hours of weekly group supervision, and one hour of weekly individual supervision.

Suicidal and parasuicidal behaviors were monitored through the use of diary cards and individual therapy throughout the program. The community mental health center's protocols were followed regarding any suicidal ideation and need for hospitalization. At the end of the 16-week program, participants either graduated from the program, were transferred to less intensive outpatient therapy, or were offered an opportunity to repeat the program if additional practice with the skills was needed.

Methods

Participants and Sampling

In case study methodology, there are two levels of sampling: selecting the case, or bounded system, to be investigated that best addresses the guiding questions and selecting the participants within the case who would provide the richest information (Merriam, 1998).

The most appropriate sampling method for understanding this case was purposeful, criterion-based sampling (Merriam, 1998). Patton (1990) made the case for purposeful sampling by arguing,

> The logic and power of purposeful sampling lies in selecting *information-rich cases* for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term *purposeful* sampling. (p. 169, italics in original).

Adolescent participants in this study were purposefully sampled using criterion-based selection in order to provide a thorough understanding of their experience with DBT (Patton, 1990). The following selection criteria were used because they "directly reflect the purpose of the study and guide in the identification of information-rich cases" (Merriam, 1998, p. 62). Participants must (a) be receiving treatment from the specific community mental health center--the bounded system in this study, (b) have completed

the full 16-week DBT program within the six months, (c) be willing and able to participate in one to two hours of research, (d) be between the ages of 12 and 17, and (e) be of any gender, race, ethnicity, socio-economic status, cultural background, sexual orientation, or religion to achieve diversity in the sample.

In qualitative research, there is no clear determination of the number of people in a sample (Merriam, 1998, p. 64). Lincoln and Guba (1985) recommended sampling until saturation was reached and no new themes emerged. In an emerging research design, it is also permissible to discuss a tentative number of participants to be sampled, knowing this number might be adjusted in the process of the investigation (Merriam, 1998). Patton (1990) recommended stating a minimum number of participants "based on expected reasonable coverage of the phenomenon given the purpose of the study" (p. 186). Nine participants were recruited for this study, which met the proposed goal of recruiting between 8 to 10 participants as a reasonable sample size. Saturation was reached with the information provided by nine participants (Lincoln & Guba, 1985; Merriam, 1998).

For participant recruitment, I consulted with current DBT therapists at the community mental health center in developing a recruitment flyer that was posted in the lobby of the center, in the group therapy rooms, and handed out by DBT therapists. The flyer provided information as to the purpose of the study, who qualified for the study, and the benefits of the research along with the compensation amount and my contact information (see Appendix A). Participants contacted me directly through phone calls or by email. Parental consent was obtained through a consent form from the parents or legal guardians of the adolescent due to them being under the age of 18 (see Appendix B). For thorough consent, the adolescents themselves signed an assent form (see Appendix C).

In addition to consent forms, participants were also given a referral form listing counseling services available to them if any issues arose during or after the study.

To ensure confidentiality, all participants were given a pseudonym to protect their identity (see Table 1). These pseudonyms were used during the interview so participants' real names were not used on the audio recordings. As a further step in protecting the participants' identities, the researcher used another set of pseudonyms in the write-up of the study. Additionally, identifying information from the interviews was removed and was not included in this write-up.

An appropriate incentive to participate in the study was offered in the flyer to increase the likelihood of participant response. A gift card to Target in the amount of $35 was offered at the completion of the study. This store was in close proximity to where the participants lived and offered a variety of merchandise of interest to adolescents.

Nine adolescents of varying cultural backgrounds participated in this study. Five of the participants were female and four were male; they ranged in age from 13- to 18-years-old. Participants in this study had diverse ethnic backgrounds including Caucasian American, Asian American, and Hispanic American. All participants completed a 16-week intensive outpatient DBT program at a community mental health center in the Midwest region of the United States.

Table 1

Participant Demographics

Participant Pseudonym	Age	Gender	Ethnicity	Living Situation	Maladaptive Behaviors
Anna	17	Female	Caucasian	Home with mother	Suicide attempt, cutting, substance use
Tara	14	Female	African American/ Caucasian	Therapeutic group home	Physical aggression, high risk behaviors
Davey	17	Male	Caucasian	Home with mother and step-father, primarily stays at friends' houses	Substance use, suicide attempt, arrests
Casey	16	Female	Caucasian	Home with adoptive parents, sibling, recent d/c from RTC	Cutting, suicide attempt
Adam	18	Male	Caucasian	Home with parents, sibling	Cutting, burning, head-banging, suicide attempt
Jade	15	Female	Korean American/ Caucasian	Home with parents, siblings	Burning, physical aggression
Jose	14	Male	Hispanic	Residential Treatment Center	Head-banging, physical aggression
Selena	16	Female	Hispanic	Home with mother and step-father, siblings	Cutting, substance use
Jeremy	15	Male	Hispanic/Caucasian	Home with mother, step-father, step-siblings	Court mandated treatment, arrests, substance use

Setting

The setting for data collection was in a private section of a cafe located within the participants' community. This setting was suggested by the first participant I interviewed because the location was convenient to where she lived. The location provided a semi-private space that was quiet, safe and comfortable; therefore, the researcher utilized this

location for the remaining interviews. Each participant was familiar with this location and identified it as convenient and easily accessible.

Interviews took place in a back corner of the café that was separate from the rest of the establishment. There were no nearby tables or customer traffic, making it highly unlikely that other people could overhear the interviews. The researcher was cognizant of protecting the participants' confidentiality and monitored the volume level of the interview. Additionally, the researcher used her counseling psychology skills to gently redirect the interviews toward experiences related to DBT and away from more personal disclosures by the participants. A benefit of the setting was the the relaxed atmosphere made it easier to quickly develop rapport with the participants. Participants appeared to be at ease in the interview setting as evidenced by the openness and honesty present in their interviews.

Data Collection Method

According to Merriam (1998), "Any and all methods of gathering data…can be used in a case study" (p. 28). However, the most commonly used forms of data collection in case study research are interviews, focus groups, observations, artifact examination, and document analysis (Merriam, 1998; Stake, 1995; Yin, 2014). To understand the experiences of the adolescent participants in this study, I used semi-structured interviews, observation, artifacts, field notes, and a reflexive journal, which are common forms of data collection in case study methodology (Merriam, 1998; Stake, 1995; Yin, 2014). In congruence with constructivism, I utilized in-depth, semi-structured interviews as the primary source of data collection. Interviews are an effective method for understanding the experience of others. Stake (1995) stated,

> We cannot observe how people have organized the world and the meanings they attach to what goes on in the world. We have to ask people questions about those things. The purpose of interviewing, then, is to allow us to enter into the other person's perspective. (p. 196)

After obtaining approval from the Institutional Review Board of the University of Northern Colorado (see Appendix D), I also obtained approval from the community mental health center where I recruited participants. All participants and guardians signed the consent and assent forms with the exception of one participant who was 18 and did not need a parental signature. I emphasized the confidentiality of the research and used pseudonyms to represent the participants.

Interviews. When using interviews as a source of data collection, the type of interview should align with the research questions being investigated (Merriam, 1998). In-depth interviews were used in this study to provide participants the opportunity to voice their thoughts, feelings, and experiences (Patton, 1990, p. 196). The semi-structured method of interviewing was used because it allowed for a standard set of questions to be asked of each participant to obtain certain information and also provided room for additional topics to be addressed. The semi-structured approach also allowed me to remain flexible with the questions and be open to exploring other questions or topics outside the ones I had pre-determined. This format also allowed for participants to expand on certain areas or bring up information not asked in the questions. In-depth interviews seeking participants' account of their subjective lived experiences require that researcher and the participant establish an empathic relationship (Creswell, 2007). The semi-structured interview format was less formal than a structured interview and helped foster an empathic relationship by permitting me to vary structured questions and obtain

data with a more conversational approach, which might have been more comfortable for the adolescent participants.

For case studies, Fontana and Frey (1994) recommend semi-structured interviews because they have enough structure to obtain the goal of the research and enough flexibility for free-flowing conversation to develop rapport with the participants. By having a less structured format, I allowed for the idea that participants could respond in a unique way and might steer the interview in a direction meaningful to him or her (Merriam, 1998). This format gave me the privilege of responding to the participants' actions and reactions to the process of being researched. These verbal and nonverbal responses provided opportunities for a more in-depth, rich understanding of the participants' experiences (Creswell, 2007).

While the interview guide was used with all participants, the order the questions were asked varied from participant to participant (see Appendix E). As the interviews were semi-structured, questions and topics of discussion were tailored to reflect the individual participants' experiences with DBT. The flexibility of a semi-structured interview was helpful if the participant steered the conversation in a different direction or if a more natural follow up question was appropriate. At the end of the interview, participants were given the opportunity to add anything that might have been overlooked or not addressed. They also had the opportunity to ask questions of me.

Each participant was interviewed in person for approximately one hour. All of the participants agreed to be contacted for a second interview if needed for expansion or clarification of the data (Merriam, 1998). However, after analyzing the data for themes, it was determined that all of the participants provided a thorough interview and no

additional interviews were deemed necessary. All interviews were recorded on a digital audio file for transcription at a later time. The digital files will be erased at the end of the research project.

The main focus of my research was to understand the experience of adolescents who had completed an intensive 16-week DBT program in a community mental health setting. Based on the major theoretical components of DBT, the following interview questions were developed:

1. Tell me about your experience in the DBT program.
2. What did you like most/least?
3. Describe any changes your friend, families or others have noticed in you since you completed the program.
4. Tell me a story about how the DBT has affected your life since the program.
5. How do you use the skills now? Most/least helpful?
6. Tell me about the impact has the DBT program had on your personal relationships.
7. Tell me about the impact DBT has had on your ability to control your emotions.
8. Tell me about the impact DBT has had on your ability to tolerate distress.
9. How are you using mindfulness in your life now? What is an example?
10. How has your experience with self-harming behaviors changed?
11. Describe the impact DBT has had on your experience in school? With teachers? At home? With parents/siblings/guardians?

12. If you could make changes to the program, what would they be? What would you keep the same?
13. What advice do you have for the therapists on how to run the program?
14. If you had to describe DBT to a friend, how would you do it?
15. Name one word that describes your experience with DBT.

Observations. Observations of the participants and their surroundings during the interviews contributed to the data collection process and complemented the data gained from interviews (Shank, 2002). Observation data might describe the setting of the interview and the nonverbal behavior of the participants (Merriam, 1998). Observation could provide knowledge about the context of the participants' stories, behaviors, and interviews, which would enrich the verbal information given (Merriam, 1998). I recorded my observations by taking notes during the interview and then again directly after the interviews to capture the data while still recent (Creswell, 2007). Observations of the participants added to the descriptive narratives provided in the findings section, which helped increase the transferability of the information to the reader (Merriam, 1998).

Artifacts. Artifacts include physical objects found within the study setting (Merriam, 1998). Artifacts for this study included past DBT diary cards, journals, DBT worksheets, artwork, songs, poems, or other items the participants felt were relevant to understanding their experience in the program (Shank, 2002). The use of art, writing, and music was emphasized in the DBT program the participants completed (Rathus & Miller, 2002). One participant brought an artifact that was a poem she had written during the DBT program. Another participant described a song he wrote during the DBT program

about the DBT concept of acceptance. A third participant described a painting she made in group therapy that exemplified one of the distress tolerance skills she learned. She put this painting on her bedroom wall and continues to use it for therapeutic purposes. More on the meaning these participants gave their artifacts is presented in their individual participant descriptions in Chapter IV.

Field notes. Field notes consist of researcher observations from the interviews including nonverbal behaviors of the participants (Merriam, 1998). During the interviews, I took notes in a paper notebook because it was less formal and distracting than using a laptop. However, after the interview, I immediately entered these notes on my computer and destroyed the paper copies. No identifying information was written on the paper version of my field notes. I also added any additional notes, impressions, or relevant information following each interview on my laptop. The field notes were saved in a password-protected file to ensure protection of the data. Information gained from field notes helped me establish context for the interviews and also helped with the interpretation of the data (Patton, 1990).

Reflexive researcher journal. A reflexive journal was kept for the duration of the research process. The goal of keeping a reflexive journal was to record any information that concerned my thoughts, feelings, reactions, values, potential biases, impressions, and insights about the study (Lincoln & Guba, 1985). The journal was also used for logging information about decisions in the methodology of the study and became part of the audit trail (Lincoln & Guba, 1985). Similar to the field notes, the reflexive journal was kept electronically on my laptop computer in a password-protected file and was electronically backed up.

Data Analysis

Data were analyzed according to the constant comparative method in conjunction with theoretical thematic and organizational analysis (Braun & Clarke, 2006; Merriam, 1998; Tesch, 1990). In qualitative research in counseling psychology, the researcher drives the theoretical thematic analysis based on the theory being studied. In this study, the emerging themes came from the data and were then organized into components of DBT in accordance with the research questions (Braun & Clarke, 2006). Because the intent of this case study was exploratory and descriptive, an inductive approach to analysis was first employed (Miles & Huberman, 1994).

According to Tesch (1990), there are three basic steps for analyzing data in qualitative analysis: development of an organizing system, segmentation of data, and making connections. An organizing system refers to seeing the data in the light of existing concepts and theories, which in this case was dialectical behavior therapy. In the segmentation phase, the researcher identified small sections of data that were meaningful, i.e., segments or analysis units. Tesch further defined a unit as "a segment of text that is comprehensible by itself and contains one idea, episode, or piece of information" (p. 116). Finally, making connections involved linking the emerging concepts and themes into a bigger picture. Data were organized, separated into segments, and finally categorized into themes by noting emerging constructs and themes in the transcripts of each interview for each participant (Tesch, 1990).

Merriam (1998) described a similar method called the constant comparative method, which was used in conjunction with Tesch's (1990) method for this study. The constant comparative method involved comparing one part of data to another to

determine similarities and differences. The data were then grouped together based on similar codes (Merriam, 1998). The grouping of codes eventually became categories and patterns among categories were identified and then arranged in relationship to one another to build themes (Merriam, 1998).

This procedure for analyzing the data evolved as the study was conducted. The evolution of codes and categories of the data analysis were documented by the researcher. In qualitative research, the data analysis and coding process occurred simultaneously with the data collection and continued throughout the research process (Merriam, 1998; Miles & Huberman, 1994; Stake, 1995). During the interviews, I began to hear common themes and unique experiences, which I made notes of in my field note journal (Merriam, 1998; Stake, 1995). Additionally, after each interview, I made notes of any overall themes from the interview and maintained a record of this as part of my audit trail.

Immersion in the collected data ensured familiarity with the experiences expressed by the participants (Stake, 1995). This immersion process involved transcribing the interviews, cross-checking the accuracy of the transcripts while listening to the digital recordings, reading and re-reading the transcripts and data from the interviews, and examining field notes and other written documentation gathered during the study (Merriam, 1998).

Data Representation

A case study narrative, which is a descriptive summary of each participant, was provided to give a "readable, descriptive picture of a person…making accessible to the reader all the information necessary to understand that person (Patton, 1990, p. 149). According to Patton (1990), each narrative could be presented alone and might be

presented chronologically, thematically (or both), and present "a holistic portrayal of a person" (pp. 148-149). For each participant, I wrote a short description of his/her background, behavioral observations, and a thematic summary describing his/her experience with DBT (Gordon & Shontz, 1990). Using cross-case analysis, the thematic summaries of the adolescents were compared for emerging common themes. Vignettes and extensive quotes were also used to illustrate the case and represent the data (Lincoln & Guba, 2000).

The main point of case study write ups was to provide enough description so the reader can assess the evidence the researcher used in analysis (Merriam, 1998). Patton (1990) stated that the case study report should provide enough rich, descriptive details to give the reader a vicarious experience. Donmoyer (1990) provided three advantageous reasons for giving the reader a vicarious experience of the case. First, case studies have the advantage of accessibility; they permit readers to experience situations and individuals in their own environment to which they normally would not have access. A second advantage is seeing the case through the eyes of the researcher allows readers to see familiar things in new and interesting ways. The third advantage of vicarious experiences is they provide decreased defensiveness and resistance to learning. Some readers might be more willing to learn vicariously through the case than from actual real life experience (Donmoyer, 1990).

Standards of Trustworthiness

Trustworthiness is how well the study does what it is intended to do (Creswell, 2007). Trustworthiness in qualitative research can be assured in five ways: credibility,

transferability, dependability, confirmability, and authenticity (Lincoln & Guba, 1985, 2000). Each of these areas is described below.

Credibility. Credibility refers to how accurately the researcher's portrayal of the participants' experiences matched the participants' perception of their experiences (Mertens, 2005). The use of reflexivity (the researcher's impact on the study and vice versa) is another way to implement credibility (Merriam, 1998). Reflexivity was demonstrated in the Personal Stance section of this chapter where I described my assumptions, biases, and experiences. Reflexivity was also used in the final write up of the results.

Triangulation is also an effective way to achieve credibility through multiple raters, multiple methods of data collection, and/or multiple methods of data analysis (Merriam, 1998). I used multiple forms of data collection (interviews, observations and artifacts) with semi-structured interviews being the primary method. I also conducted member checks after the data were analyzed. I emailed or spoke on the phone with the participants to check for accuracy of the themes that emerged from their experiences. I was able to contact eight of the participants who all stated that the data accurately reflected their experience and no changes were made. One participant was not reachable due to a disconnected phone line and gave no other means of contact.

I also utilized peer and expert reviewers as a form of triangulation to increase credibility of the study (Merriam, 1998). My peer reviewer was a professional colleague who had experience with qualitative research including writing a qualitative dissertation. She also had experience working with adolescents in a mental health setting and with self-harming and suicidal adolescents. This peer reviewer reviewed the transcripts and

developed categories and themes independent of my analysis. We then compared themes and discussed areas where themes overlapped or were discrepant and then reanalyzed the data. I went through several rounds of theme development, identifying data units that were redundant or could be compressed into one theme and also reorganized categories so themes from data were best represented. An organizational system was developed based on theoretical thematic analysis, so that the themes were reported following the structure of the DBT program.

My expert reviewer was my research advisor, who is highly experienced in qualitative research. She also reviewed and helped organize the themes. Additionally, the use of multiple participants in a case study is another way to triangulate data within the case as they provided reinforcement of the themes (Merriam, 1998). The nine participants in this study provided a saturation of themes.

Transferability. Transferability refers to how well the readers of the study can relate their experiences to the participants' experiences (Creswell, 2007). Transferability was achieved by providing thick, rich description of the process, the participants, the setting, and the data (Merriam, 1998). Detailed information and quotes from the participants were included to help the reader determine how closely the participants' experiences with DBT were similar to their own or to what had been reported in other studies. Thick, rich description also made the findings more transferable to mental health care providers working with adolescents and families using dialectical behavior therapy as their theoretical modality. Ultimately, it is the responsibility of the reader in constructivist research to determine the transferability of the research and how the findings would be beneficial to their situation (Creswell, 2007).

Dependability. Dependability involves the researcher making sure the process is logical, traceable, and documented (Merriam, 1998). Knowing how the data were collected and how decisions were made help future researchers understand the process I went through (Creswell, 2007). Dependability was ensured through audit trails wherein I kept track of the changes in the emergent design of the study, participant sampling, settings, interviews, the evolution of the codes, themes of the data, and the analysis procedures (Creswell, 2007). All field notes, transcriptions, and other documents were included in the audit trail.

Confirmability. Confirmability is the degree to which the study can be replicated by others (Creswell, 2007). According to Mertens (2005), it is important that "qualitative data can be tracked to its source, and the logic that is used to interpret the data [is] made explicit" (p. 257). The methodological techniques described above such as audit trails, reflexivity, and triangulation all served to support confirmability in this study.

Authenticity. Authenticity in constructivist studies is essential in establishing validity (credibility and transferability in qualitative work). Lincoln and Guba (2000) described five components of authenticity: fairness, tactical, educative, catalytic, and ontological authenticity. The inclusion of perspectives from each of the participants within this case study represented fairness as I endeavored "to act with energy to ensure that all voices in the inquiry effort [have] a chance to be represented in any texts" (Lincoln & Guba, 2000, p. 180). Tactically, the goal of this research was to share the findings with members of the professional psychological community through publications and conference presentations. This research has the potential to educate therapists and researchers in the effectiveness of DBT with adolescents. In the

implications section of this study, I provide information to stimulate further research and contribute to understanding mental health treatment of adolescents based on data that emerged directly from the participants, thus upholding catalytic authenticity. Ontologically, I included appropriate recommendations based on the findings (Shank, 2002).

Ethical Considerations

In qualitative research, the data collection methods are based primarily on the interactions between the researcher and the participants. Due to the nature of these interactions, ethical considerations need to be recognized throughout the inquiry process (Jones et al., 2006). Eisner and Peshkin (1990) encouraged researchers to possess "the sensitivity to identify an ethical issue and the responsibility to feel committed to acting appropriately in regard to such issues" (p. 244). The ethical considerations of this study are discussed in the following sections including protection of participants, concerns related to research in a known setting, dual relationships, and safety.

According to the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2003), when psychologists conduct research with clients/patients, they should "take steps to protect the prospective participants from adverse consequences' of declining or withdrawing from participation" (Standard 8.4). To protect the participants in my study, I made clear in the consent form that their participation was voluntary and they had the right to withdraw from the study at any time. Additionally, during the interviews, participants could elect not to answer questions they did not feel comfortable with and pause or end the interview session if any adverse reactions occurred (Fontana & Frey, 1994; Jones et al., 2006). I also emphasized to the participants the steps I would take to

ensure their confidentiality: keeping the data in a password protected file , assigning the participants pseudonyms to mask their identity, and altering any identifying statements from the interviews. Furthermore, any artifacts or specific observations about the participant or their surrounding that could be linked to their identity were removed.

Multiple relationships are not necessarily unethical or harmful but it is important to be especially prudent about informed consent and documentation as well as consult with supervisors during the research process (Yin, 2014). Although no multiple relationships occurred in this study, I was familiar with the setting and the therapists of the DBT program. No concerns presented themselves related to my previous experience with the program.

There are also potential ethical issues in conducting "backyard research" and challenges the researcher could face conducting a study in a known setting (Glesne, 1999). One of these potential challenges is that the researcher could have preconceived expectations about the participants or the study based on his or her prior experiences (Glesne, 1999). These expectations could create a bias in the data collection (Jones et al., 2006). I was aware of this possibility and employed the use of "bridling," a term developed by Dahlberg (2006), to address the impact my personal biases, preconceptions, or experiences might have on the study. This method allowed for the reality that forming connections with participants and their experiences was a unavoidable aspect of phenomenological qualitative research; instead of avoiding this, it should be acknowledged (Vagle, Hughes, & Durbin, 2009). Bridling was achieved in this study by describing my personal background and interest in the study as well as through the reflexive journal I kept and awareness during data analysis procedures.

A potential benefit for the adolescents in this study was they had the chance to reflect and gain new insights into their own experiences, beliefs, and personal growth. However, an ethical concern was the potential vulnerability of the population being studied. The adolescents in this study had a history of mental illness, specifically suicidal or parasuicidal thoughts and/or behaviors. If any of the participants happened to bring up current thoughts of hurting themselves, I had an ethical and legal obligation to notify their parents/guardians. If the participant was in imminent harm, I would have had to call a crisis service to ensure the participant's safety. Although difficult and or sensitive topics were addressed during the interview, none of the participants reported suicidal thoughts or intentions. All participants received a list of local mental health resources available to them regardless of what was discussed during the interview.

While some of these issues might have been unavoidable and other concerns might have been unforeseeable, throughout the research process, I gave "attention to ethical issues and [made] good judgments [to] increase the likelihood of behaving ethically" (Jones et al., 2006, p. 153). I documented any assumptions, expectations, and ethical concerns in my researcher's journal and shared these journal entries with my peer reviewer to decrease the possible impact they might have had on the findings.

Summary

This qualitative case study was designed to help understand how adolescents experienced DBT in an outpatient community mental health setting. This chapter described the constructivist theoretical orientation, case study methodology, and procedural methods utilized. Based on the research questions and the review of the literature, a constructivist theoretical orientation and case study methodology were

deemed appropriate approaches to this investigation. Findings from this study might benefit mental health professionals who work with suicidal or parasuicidal adolescents and could potentially guide future research of DBT as a therapeutic treatment for this clinical population. In the following chapter, I present the findings for each individual participant's experience of DBT including participant descriptions, themes related to their experience with components of DBT therapy, and themes related to their experiences with DBT skill modules.

CHAPTER IV

FINDINGS: ADOLESCENTS' INDIVIDUAL EXPERIENCES

The purpose of this constructivist, qualitative case study was to understand how adolescents experienced dialectical behavior therapy (DBT) in an outpatient setting. I utilized case study methodology because it was an effective way to present participants' stories through detailed, descriptive narratives and to explore meaning from multiple perspectives (Stake, 1995). Additionally, this research approach allowed for an in-depth understanding of both the individual and the shared experiences of the participants (Patton, 2002, p. 104).

The following research questions guided this study:

Q1 How do adolescents experience DBT in a community mental health center setting?

Q2 How have the lives of adolescents been impacted by completing a DBT program?

Q3 How are the skills learned in DBT being used by adolescents?

To answer these questions, I used semi-structured interviews to gather data from nine adolescent participants.

This chapter presents the research findings for each of the nine participants. Through thick, rich description, it was my goal to convey to the reader an empathetic understanding of the case and provide them with the knowledge and information to connect to the participants' experiences (Stake, 1995). The data for each participant are

organized into three sections. First, I provide demographic information, a brief social and psychological history, and behavioral observations. Then I present the participant's experiences with each of the three therapy components of DBT (skills group therapy, individual therapy, and family therapy). Finally, I present the experiences of the participant with the five skill modules of DBT (Mindfulness, Distress Tolerance, Emotion Regulation, Interpersonal Effectiveness, and Middle Path).

Jeremy

Background Information

Jeremy is a 15-year-old, Hispanic Caucasian male. He has a legal history including arrests for drug related offenses. Jeremy has spent time in juvenile detention and has been expelled from school numerous times. During the time of the program, Jeremy was living at home with his family. He presented with a tough exterior but he was well groomed, dressed in sagging khaki pants, long white tee shirt, and a large gold cross necklace. He seemed to take pride in his appearance and had a habit of shining the medallion of his necklace with the edge of his shirt while we were talking. Jeremy opened up to me that he has struggled with depression most of his life and he believes it is related to the physical and sexual abuse he suffered during his early childhood. This topic was not discussed in depth, as that was not the focus of the interview, but Jeremy stated this as if it was something he had become accustomed to telling adults in the mental health field. Jeremy told me the main problem he struggles with is marijuana. Based on his interview answers, Jeremy seemed to judge himself harshly and struggled with feelings of worthlessness. For example, he told me, "I'm my own worst enemy.

Like, I fucking critique everything I do. I used to get real sad sometimes because I'm real hard on myself."

During the interview, Jeremy was polite and cooperative but reticent. He gave short answers and initially seemed irritable and edgy like he wanted to leave the interview as soon as possible. As the interview progressed, he did open up and became more comfortable as evidenced by his relaxed physical posture, increased eye contact, and more detailed responses.

Jeremy's Experience with Dialectical Behavior Therapy Components

Skills group. Jeremy did not hide his disdain for DBT group therapy. He told me he thought it was a waste of time: "Um, at first I was pissed that I had to do it. The therapy. I mean my probation officer pretty much told the court I had to, so at first I was just like 'fuck this shit'. Oh, shit, I'm sorry." In fact, Jeremy was discharged from the program the first time around for missing too many therapy sessions. He told me he returned to the program because of his upcoming court dates and that DBT program therapists were flexible in letting him restart the program. When I asked what that was like for him, he responded,

> The program was like fucking forever. Like, almost the whole year but that's, that's cause I had to start over because I wasn't going enough in the beginning. I felt like a fucking reject starting over cuz some of the same people were in the group part.

Jeremy described having low participation in group: "Um, I didn't talk or anything at all. I got in trouble for sleeping once. Truth was I was high a lot but nobody really knew." Jeremy told me that going to group high on marijuana was the only way he could tolerate it and the other kids in group. He denied forming any connections with other group

members. He did not describe experiencing any positive changes as a result of DBT group therapy, although later in the interview he mentioned DBT skills he learned in group. When asked if there was anything he did like about the group, he replied, "Um, I guess some of the activities. Uh, the games and shit. I didn't do em or nothing. I slept in the corner but when they did do those games it was funny as hell so I watched those. It was stupid but sometimes it was kinda fun."

Individual therapy. Jeremy described a rocky start to his relationship with his first individual therapist. He told me he did not think he needed therapy and was only there because of his probation officer. Eventually he did develop a positive relationship with another therapist, Beth. He told me he developed trust with her, which helped him be more honest in therapy. He said, "She was always so nice, no matter how bad I fucked up. I mean I got locked up twice and she never gave me shit like everyone else." He was also able to relate to his therapist and she found ways to incorporate his interests into therapy such as music. Jeremy described the first time he felt a connection with Beth: "She had a poster of Bob Marley on her wall, which was legit. I like Bob Marley mostly cuz he smoked dank bud but we listened to his music and Beth always used to use his lyrics about being positive and true to yourself, so that was dope. I liked that."

In individual therapy, Jeremy focused on practicing being nonjudgmental toward himself and others. When asked what non-judgmental meant to him, Jeremy said, "Like, how she (Beth) didn't judge me for getting locked up or nothing. It didn't matter, and I wasn't used to that. We used that word, nonjudgmental all the time. I practiced not judging people right away." Jeremy described learning about *radical acceptance* in therapy and how his therapist helped him apply the concept to his life. He described

applying radical acceptance to the abuse he suffered in early childhood: “About when I was a little kid, what happened and everything. But I had to learn to accept it. It’s fucking impossible. But that’s what she said, and uh she was trying to get me to do that. I guess I did, kind of.”

Family therapy. Family therapy for Jeremy consisted mainly of his mother and himself; his younger sister and stepfather attended one or two sessions. Jeremy described having a difficult relationship with his mother, characterized by tension, verbal aggression toward each other, and strained communication. He told me sometimes he thought his mom did not really care what happened to him. When I asked him if people knew he was going to group therapy high, he said, “My mom did but she didn’t care because she just wanted me to go anyway. She doesn’t give a fuck, she just wants me and my…out of here, out of the house, as much as possible. So she knows, but doesn’t really care.”

Family therapy seemed to focus on improving the relationship between Jeremy and his mother. He described feeling judged by her. When I asked him to explain how he felt judged by her, he responded, “Um, I don’t know, like every time I fucked up she would just, like, that nothing I did, I could never do anything right. I was always never good enough.” He added that family therapy was difficult for him because he felt uncomfortable talking about his emotional struggles in front of his mother: “That was pretty fucked up too. I didn’t talk. I could only talk to Beth but not in front of my mom. Like, I’d talk and, um I didn’t want my mom to hear some of the stuff I was telling her.”

Jeremy said that in addition to working on being nonjudgmental, family therapy focused on teaching his mother the DBT skills he was learning. He described learning

the *interpersonal effectiveness* skills during one family therapy session and he noticed a change in their communication after that session. He described the positive change: "My mom and I talk better to each other, I guess. Like, more nice."

Jeremy's Experience with the Dialectical Behavior Therapy Modules

Mindfulness. Jeremy remembered learning the *mindfulness* skills and noted that he continued to use this skill in his life. He described how he used mindfulness: "Just learning how to relax. I learned to relax more with mindfulness. Like, I remember she said don't live in the past or the future, you just gotta live in the present." He told me this was his favorite skill and that talking about it in the interview made him want to start practicing mindfulness more.

Interpersonal effectiveness. Jeremy discussed the *interpersonal effectiveness* skills he learned as being helpful in improving his relationships with others. He told me he tried not to hold grudges against people who had let him down in the past, specifically his father: "Well, I guess with my dad. He just got back from Washington. He's been like spending a lot of time up there. And not hanging out. And, uh, now that he's back I guess it's helping me like forgive him, kinda." He could not recall using these skills in any other way.

Distress tolerance. Jeremy stated that he uses marijuana to cope with distressing situations and feelings. He did not recall the *distress tolerance* skills learned in group except to say, "We did stupid shit like hold ice cubes on one day but then another day we got candy. I don't really, I didn't really understand that one." When I reminded him of some of the skills, he repeated that he did not understand them and did not care to.

Emotion regulation. Jeremy said that during the program he had feelings of depression he had difficulty controlling. Again, he reported using marijuana as means of self-regulation. Jeremy was able to identify his emotions using *what* and *how* skills and was able to express these emotions to his therapist. He discussed how his negative thinking affected his emotions:

> I get real down on myself sometimes. I used to get real sad sometimes because I'm really hard on myself. And my mom? She always just gets on my back all the time too and even when she says the most mean things you could ever think of I, I still believe her.

He described his tendency to stay in *emotion mind* instead of *wise mind* and that this led to him making poor choices. It seemed that Jeremy and his therapist spent time working through the acceptance stage of DBT and he was slowly able to incorporate a few skills into his life.

Jeremy also returned to the idea of practicing being nonjudgmental toward others as a way to maintain being calm and non-reactive. I asked him to give me an example of how he practiced being nonjudgmental. He replied,

> Um, I mean I tried to get to know how people were. How or where they were coming from, ya know? Like I tried to think maybe I don't know about their life just like they don't know about mine, so ain't nobody can judge me and I tried to do that. To other people. Like if someone had an ugly look on their face not to think of it about me right away but to think about them. Like, um maybe they had a shitty day or something and that's why their face is like that.

Middle path. Jeremy did not have any recollection of the *middle path* skills and when prompted, he still could not make any statements about this module. Based on Jeremy' interview responses, it seemed he and his family might have used the *middle path* skills to find more balanced ways of communicating with each other.

Casey

Background Information

Casey is a 16-year-old Caucasian female. She came to the interview wearing distressed black jeans, a black netted long sleeve top over a neon tank top, and well-worn Converse shoes with ink pen writing on the white rubber parts. Casey's hair was cut in a choppy pixie style and was dyed a bright color. Casey's wrists and forearms were covered with dozens of colorful rubber bracelets and bangles.

Casey lives at home with her adoptive parents and younger sister. At the time of the DBT program, Casey had been recently discharged from a residential treatment center (RTC) back into the care of her family. She told me she was in the RTC because of the severity of her depression, which led her to engage in self-injurious behaviors. Casey described having a history of depression for most of her teenage years and childhood. She told me,

> Well, I got into therapy because I was really depressed. I guess my depression started like two years ago, maybe? That's when I noticed that, like I was having more bad days than good days. Just down. All the time. I didn't feel anything. That's also when I started scratching myself with pins. But when I really look back, I think I was unhappy way before that. Like, all of my childhood.

Casey openly discussed her history of depression and self-harm, which she said was the focus of her treatment in DBT. She described problems with tolerating painful emotions and poor impulse control. Early in the interview, Casey told me she attempted suicide once in her life: "Yeah. I mean, I did try suicide. And it was hard. But I don't really want to talk about it." I respected this request and emphasized again that she did not have to go into any personal history she did not want to. Casey replied, "No, it's

alright. It just triggers me. I get down thinking about it. But I guess I could tell you about it."

Casey reported that DBT helped reduce her self-injurious behaviors and gave her skills to cope with distress in a healthy way. She also stated she gained support and understanding from the group therapy component, which was what stood out to her most about DBT. She is a creative, artistic person and this was reflected in her interview. Casey incorporated her creativity into the DBT program. She said,

> The skills I use for distress tolerance are doing creative things, like my writing. Or I do some sculptures sometimes. Poems, drawing, artistic stuff, that kind of thing. It's calming, it calms me down. And even if I'm still sad, I can be sad but in a way that's not going to do damage. I can be sad on paper instead of on my skin.

During the interview, Casey's demeanor was relaxed and she displayed low energy. She spoke in a calm, even tone and her body language was languid. Casey provided thorough, thoughtful answers to my questions and appeared invested in the project. The first thing she told me after she sat down was how happy she was to be participating in research that might help other teenagers like her. Casey seemed comfortable discussing sensitive issues but occasionally became tearful. At times, her tone was dejected and the sadness emanating from her was palpable. Casey spoke to me in a way that demonstrated both her emotional vulnerability and her resilience. Her responses reflected a high level of self-awareness and insight.

Casey's Experience with Dialectical Behavior Therapy

Skills group therapy. Casey had a positive experience in skills group therapy. She reported feeling validated by the other group members: "Well, I think with group therapy it helped a lot because I was with people who understood where I was coming

from. So, I just felt content all the time." Casey told me she thought she was able to connect with these adolescents more than other people in her life: "They were going through a lot of the same things I was. So they didn't judge me about it. It was comfortable and not bad."

She reported the support she felt from the group members was different than what she had experienced before:

> Um, other people in my life really didn't want to hear about my depression. Like, they just got sick of it all the time. They just tuned it out or would nod their head and like "okay" and pretend to listen. But I know they didn't care. Or if they do care, they're just like, "what am is supposed to do?" It got old really fast. Nothing helps me and they get sick of that.

I asked Casey for an example of how she felt supported by the group. She told me she did not feel understood by her boyfriend at the time and that is where the group members really stepped up. Casey described this support:

> My depression, he was like I can't take this anymore. And that's what I really liked about the group, because we were all connected. They never got sick of me. They never like, judged me. They were there for me. Maybe they weren't? Maybe they did get sick, but I don't' know, they were just there for me when my boyfriend wasn't.

Casey stated in addition to receiving support, she was also able to give support back to the group. She did this by sharing some of her personal journal entries in group. I asked what the group's reaction to this was and she said, "They thought it was cool. And I think it might have helped some of them. To start finding other ways to get things out.

A negative part of Casey's experience was the large amount of paperwork involved in skills group therapy. She shared,

> Yeah, we had like a million handouts at each group. And they were dumb so I just really threw them away mostly. It didn't make that much sense and it was

> pretty pointless. Sometimes though, one of the papers would be good and I would save that one.

Individual therapy. Casey experienced validation and acceptance from her individual therapist: "Well, my therapist was helpful. And she was really nice and she listened. But I know that's what therapists are for." I asked her to elaborate on what was helpful about therapy and she said, "I don't really know. It was just someone to talk to. To get it out. Instead of keeping it inside me all the time. Just floating around."

Casey told me her individual therapy focused on learning and practicing distress tolerance skills to reduce her self-injurious behaviors. She said, "Well, when I started DBT I wasn't even really cutting. It was just scratching. I mean, most of the time I didn't even bleed. But I think I cut for the first time in, around December. And I was only cutting for a few months." She recalled she had difficulty handling distress and used cutting as her coping mechanism when she felt overwhelmed. Casey explained with teary eyes what this was like for her: "I hit rock bottom a lot. Several times. And I let myself do it. Even though I knew it was bad while I was doing it. I still just let it happen. Because there was nothing else I could or wanted to do." I asked what "bottom" was for Casey and she answered, "It was just how I was feeling. Like there was nothing I had to lose. I just kept going deeper and deeper and eventually it stops and I just kinda got stuck there."

I asked Casey if her experience of being "stuck" and feeling hopeless changed after therapy. In her answer, Casey continued to describe her depression using the visual metaphor of being in a hole:

> Like I still get depressed. And I go down towards bottom. But now I know I how to stop myself before I get to a place where I can't come back. It was sort of like that when I tried to kill myself. I was all the way at the bottom, just stuck there.

> Like, my therapist helped me recognize when I was heading that way and I have skills now. It was sort of like a hole. Like a depression hole. And now I know how to climb out of that hole when I get stuck in it.

In individual therapy Casey learned to be mindful of her triggers and to notice when she was going down her "depression hole." She acquired new, adaptive skills to help her climb out of that hole so that she does not reach the bottom again. Casey said one of the healthy coping skills she learned was to write in a journal when she was feeling overwhelmed: "Yeah. I wrote in it a lot and I shared it with my therapist every week. Sometimes I would write like a poem or a special entry. And it was good so I would share it with the group." I asked her what was helpful about journaling and she replied, "I guess I can express myself better when I can put everything on paper. It helps to journal to get stuff out. And it's sort of taking the place of cutting."

Family therapy. Casey told me that her experience in family therapy was difficult because her parents had a hard time understanding what she was going through. She reported that her parents did not validate her experience of being depressed. For example, she said her father told her "it is just a phase. You're fine. You just have to cheer up." Casey described not feeling understood by her parents but also not wanting to hurt their feelings.

> My dad, he really wants me to be great. He keeps saying, he asks me like once a week probably, "Well, you sure do seem better. You are, aren't you?" And he always tries to talk to me and see how I am. But all he says is "You're doing so much better, right?" I can't bring myself to say I'm not (she became teary) because I can see that it hurts them, almost as much as it's hurting me. And it's so obvious that he just wants me to be happy. Of course he does, that's what parents do. So, I say I'm fine, and I smile and he smiles and he's relieved. And I don't want to take that away from him.

I reflected back to her that it seemed like she and her family had a tough time talking about painful emotions including her depression. She agreed: "Yeah, no one

really knows what to say about it." Casey said her suicide attempt was especially shocking for her parents: "It was surprising for them I think. Because I was fine and then I wasn't. And it came out of nowhere and they didn't know what to do."

I asked Casey how DBT skills were incorporated into therapy and she said that her therapist focused on improving the family's communication skills. Casey told me she tried to communicate her feelings to her family by sharing some of her poetry with them during sessions. She described that experience: "It helped me a lot but I don't know if it helped them. I wrote some pretty dark stuff. And I think it scared my family. To hear that that was what was going on inside of my head."

When I asked Casey if she thought DBT had an impact on her family or if she thought things were different after therapy, she shook her head no. She stated that her family did not practice the skills outside of therapy. With a heavy sigh, she added, "My family, they weren't ready to deal with how depressed I had been. We still go to see a therapist but it's a different one. It's a dude and he's pretty cool."

Casey's Experience with Dialectical Behavior Therapy Skills Modules

Mindfulness. Casey learned to be mindful of what her triggers were and to notice when she had the urge to engage in self-harming behaviors. She practiced mindfulness skills to calm herself down when she felt emotionally overwhelmed. Casey told me, "I like things that are calming" such as meditation, which she reported doing often. However, Casey said that meditation occasionally backfired. She explained, "And I can't be too mindful, because after that place of calm then it leads into darker thoughts and they start coming back and I start thinking too much and I end up in that same place." Casey described how meditating on her emotions could turn into ruminating instead:

"Yeah, like there's too much of a good thing sometimes. If you go too far in it, it ends up badly. You have to know when to stop yourself." Casey mentioned being mindful in her creative activities like journaling, drawing, and sculpting.

Distress tolerance. Casey shared that she had made a suicide attempt on her life but that she did not want to talk about it. She explained that talking about that event was a trigger for her. We did not discuss her suicide attempt but she did speak openly about her self-injurious behaviors. Casey told me, "Well, when I started DBT I wasn't even really cutting. It was just scratching. I mean, most of the time I didn't even bleed. But I think I cut for the first time in, around December. And I was only cutting for a few months." She described positive and negative aspects to her experience with distress tolerance skills: "I kinda think the DBT helped. But it also sort of made it worse, too. It brought up a lot of things from my past that I couldn't handle talking about."

Casey described difficulty coping with distress in healthy ways. She used cutting as a maladaptive coping mechanism. She explained with teary eyes what this was like for her: "I hit rock bottom a lot. Several times. And I let myself do it. Even though I knew it was bad while I was doing it. I still just let it happen. Because there was nothing else I could or wanted to do." I asked what "bottom" was for Casey and she answered, "It was just how I was feeling. Like there was nothing I had to lose. I just kept going deeper and deeper and eventually it stops and I just kinda got stuck there."

I asked Casey if her experience of being "stuck" and feeling hopeless changed after DBT. In her answer, Casey continued to describe her depression using the visual metaphor of being in a hole. She said:

> Like I still get depressed. And I go down towards bottom. But now I know I how to stop myself before I get to a place where I can't come back. It was sort of like

> that when I tried to kill myself. I was all the way at the bottom, just stuck there. Like, my therapist helped me recognize when I was heading that way and I have skills now. It was sort of like a hole. Like a depression hole. And now I know how to climb out of that hole when I get stuck in it.

I asked Casey to tell me about the distress tolerance skills she learned from DBT. She shrugged and said, "Well there was a lot of them. And it was hard to keep track. There was just so many that I couldn't really remember specifically. I just sort of took them in as it happened." But then she perked up as she remembered a skill focused on distracting herself from her urges to self-harm. She explained,

> A really good one, was I learned that if you wait something out it usually will pass. So instead of going straight to cutting, wait 10 minutes and if you still feel like that, wait 10 more minutes. Even though most of the time I didn't feel like it was going to work.

I reflected back to Casey that she said the skills helped her climb out of her "depression hole" without resorting to cutting and asked her to elaborate on those skills. She eloquently explained,

> The skills I use for distress tolerance are doing creative things, like my writing. Or I do some sculptures sometimes. Poems, drawing, artistic stuff, that kind of thing. It's calming, it calms me down. And even if I'm still sad, I can be sad but in a way that's not going to do damage. I can be sad on paper instead of on my skin.

Casey told me she also relied on her friends for support when she was in crisis: "Yeah, they helped me stay strong." She explained that her friends reminded her of all the positive things in her life. She said this gave her hope: "Yeah, even if the big picture is bad. If there's just a couple good things. And you can hold onto those and hope that there's just gonna be more." Casey also relied on herself for support by using positive self-talk:

> I've gone through a lot. And whenever I feel like I can't go on. I just remind myself that I can. I'll never take the easy way out because short cuts don't always

> lead to the right thing. And I just couldn't do that to my family. Like, suicide is a short cut. It hurts more people than it does heal.

Emotion regulation. Casey openly shared she is an emotional person and always has been. She said she has experienced symptoms of depression since her early childhood and had difficulty regulating her emotions. Casey explained, "My moods are all over the place, ups and downs. And I wish that happiness was more permanent than the darkness. And sometimes the happiness just slips away and I don't even remember what it felt like." She described what was going on for her before she started the DBT program:

> It was just really my thoughts that were harmful and then I ended up turning them into action. And I got stuck in that. Cause those were the only ways I knew how to deal with it. So it was just a loop, over and over again. And I couldn't get out of it and everything was the same every day.

Casey said DBT taught her to manage her emotions better so that she does not "hit rock bottom" or get stuck in the hopelessness. She told me, "I learned to control my emotions better. And that it didn't always have to be ups and downs. And I got that from DBT."

The emotion regulation skills of "what and how" were helpful for Casey. These skills taught Casey to observe what emotion she was feeling without judgment and then to notice how the emotion was serving a purpose. Casey told me how she used this skill: "Like I can be sad. That's okay. But not so sad that I want to die." She said she learned to identify her emotions better, such as sadness, hopelessness, and loneliness, and that she had an easier time accepting them.

Casey also used journaling as a creative, healthy outlet for her painful emotions instead of cutting. During the program, she used poetry as a medium to express some of her pain. She told me about this process:

> I just sort of realized I had a lot to say and it was all just floating around me. And I couldn't always tell it to someone because I felt like they would judge me. But paper doesn't judge you. You can just get it out without hurting anyone or yourself.

Interpersonal effectiveness. Casey discussed how her emotional dysregulation and self-harming behaviors negatively impacted her relationships with others. She told me her friends and family did not know how to handle her depression. Casey gave me a disheartening example of how this played out in her personal life with an ex-boyfriend:

> I actually, I had a boyfriend and I lost him because I was depressed and he couldn't handle it. He said he loved me and I'm pretty sure he did. But it was like he couldn't handle it. It was like, I was his chore. That's what he said. I was his chore.

I asked Casey if DBT had any impact on other relationships in her life. She told me she had better control over her emotions and this had helped with her personal relationships, although she was not sure this was a result of being in DBT. She explained,

> Well, my relationship with my last boyfriend was bad because he couldn't handle me or do anything. And I guess, now I feel less depressed. I mean, I have a new boyfriend and he's really supportive of me and my depression. And that was cool but I don't know if the DB, helped. uh the DBT helped or not. And I don't know if it was related.

Tara

Background Information

Tara is a 14-year-old female who identifies as African American and Caucasian. She has a large stature, tall with wide shoulders and hips, and appeared older than her actual age. Tara wore heavy makeup and tight clothing. She styled her hair in a high ponytail and when she turned her head, the long weave she was wearing whipped around her face. Although it was apparent Tara put effort into looking attractive, there was something about her appearance that made me think of a little girl playing dress-up with

her mother's makeup and clothes. She exuded a sense of imitated confidence I guessed was part of the armor she wore to protect her vulnerabilities.

Tara is in the custody of the state and has a social worker as her legal guardian. During the time of the DBT program and interview, she lived in a therapeutic foster home with several other girls and a foster parent. Tara described her childhood as chaotic, having lived in shelters, foster homes, group homes, and residential treatment centers. Tara tried to recall the number of placements she has been in over her life; her best guess was eight different facilities over the last five years. She remembered living with her mother and her maternal aunt in early childhood but said she was removed from the home due to her mother's drug use. She said she still sees her mother but the visits are supervised and infrequent. Tara told me frankly that she was abused when she was little because her mother was a prostitute and had men come and go from the apartment. Tara began to tell me nonchalantly about the abuse and I gently stopped her and redirected her to the focus of my research--understanding her experience in the DBT program. I did this to protect Tara from disclosing personal information that might have led her to feel exposed or uncomfortable as well as to reinforce my role as researcher and not therapist**.**

High-risk behaviors such as sexual promiscuity, running away, and frequent fighting were some of the reasons Tara was in the DBT program. She told me she was put in the program by her last social worker, Ester, because she had been discharged from a group home due to her problematic behaviors. Tara said her main problem was losing control of her anger and becoming physically and verbally aggressive toward other kids, teachers, and adults. With a laugh she said, "Yeah, I used to be fightin' all the time." Tara denied any history of suicide attempts or self-injurious behaviors: "I don't do

nothing to hurt myself. Not like some of those other girls that were in group, they be cuttin on themselves and shit. I ain't never got like that. I never really did that."

During the interview, Tara was friendly but never truly let her guard down. She cooperated by answering the questions but her responses were often detached and flippant, conveying a lack of interest in the process. Her eye contact varied from poor to blatantly staring at me. Often, Tara said something she perceived as provocative; she would shoot me a sideways glance as if checking for a reaction. Tara left me with the impression that part of her callousness and detachment stemmed from having repeatedly shared deeply personal aspects of her life with adults she barely knew, likely due to have been moved around from placement to placement. I felt a deep sense of compassion toward Tara and admired her inner strength and resiliency. I enjoyed the lightheartedness and laughter she brought to the interview.

Tara's Experience with Dialectical Behavior Therapy Components

Skills group. Tara initially expressed a great deal of resentment about being in the DBT program. She expressed this by actively not-participating in the skills group. I asked her what her non-participation looked like and she told me she would often sleep during group therapy, say rude things to the other group members, or talk back to the therapists. She added defiantly,

> Or sometimes I just refused to go, and missed a lot of group. I was like, uh-uh (said in a sassy voice with wagging index finger), make me (laughs). I mean, I just was so mad, I was like "fuck you" to everyone at that group. Especially those bitchy therapists.

Due to these absences, Tara had to restart the program: "Yeah, but they made me start over. Well, not start over but I had to repeat the parts I missed. Like make up stuff." I

asked how she was able to motivate herself to go the second time around and she replied, "Well, I just said to myself I have to do this so, so just do it. Get it over with already, ya know?"

On her second time in the program Tara began to participate in the group activities. She enjoyed the hands-on aspect of skills group: "Umm, I liked it when we could draw and make posters. I love to draw and I always raised up my hand for drawing on the posters." She also formed positive relationships with some of the group members stating, "Um, I got to meet a lot of cool people. Cute boys sometimes. Some of the bitches weren't cool at first but then we were friends. I'm still friends with most of them."

Tara told me she liked skills group best when they broke into smaller groups because she felt more comfortable sharing with fewer people. The small group format allowed her to experience trust and connection with some of the adolescents in group:

> Umm. When we did small groups, I would sometimes give my problem for the group to work. That was cool I guess. Cause a lotta kids there knew what it was like to have a messed up family. I mean, I left some parts out but I would tell em most of it. Like the parts. Like, if my mom and I were fighting. That was really the main thing. I talked to the group about it, not at first but once I felt like I could trust them. Those other people.

Tara also described a feeling a sense of safety in the anonymity of the DBT group as opposed to the group therapy at her therapeutic foster home where everyone knew her. She told me,

> But for real, it was just good to be with other kids that could, like, understand you but didn't really know you. Like groups at the group home were real weird cause you didn't want everyone knowing all your shit, or problems I mean. But at DBT I could talk about it 'cause nobody knew me or my mom.

Individual therapy. Tara's individual therapy focused on identifying and understanding how her emotions were connected to her behaviors. She reported that her target behaviors were verbal and physical aggression toward others, running away, and acting out sexually. Tara reported that her individual therapist used the DBT technique of a *behavioral chain analysis* in her sessions. Although she had difficulty articulating this in language of DBT, she gave me an example:

> Um, well, she was real big on doing the charts. The ABCs she called 'em. I never really understood those charts, it seems like a big fucking pain, but she always made me do em. Sometimes it was good 'cause we'd work out some bad situation that I had that like that week. Like a fight with some bitch at school or something. Like I'd like figure out like what made me do it and how to not do it next time.

Tara said her therapist also taught her to identify emotional triggers that made her angry: "The stuff that sets me off. Like what sets me off. Like how to know what my buttons were, right? Then I'd be practicing my coping skills." Tara told me conversations with or about her mother were a major trigger for her and she worked on this in individual therapy:

> But nah, sometimes it was about how when I talked to my mom on the phone I would get real mad. Yell some fucked up stuff to her. I always felt real sad after that. We talked about that. About my mom? It was about her a lot too. She was the one who messed me up.

Tara also said she had difficulty comprehending most of the DBT concepts taught in skills group: "I mean I know I learned stuff, but the DBT words never really stuck in my head. Like we had all these papers with them on it, but I still couldn't remember." So Tara asked her individual therapist to explain them to her in their sessions. Regarding the DBT phrases, she said, "Yeah. I'd be dumb sometimes. I'd be like what's that? (Laughs) She'd break it down, so I got it. Fucked up weird words in that kind of

therapy." When I asked if what she learned in DBT had been helpful in her life, Tara answered, "Um, I feel better. I don't know how but…it's just all good right now. I don't know if it was the therapy or but what. I guess it was just helpful. It helped me. It helped me with my anger."

Family therapy. Tara described a negative and incomplete experience with family therapy. With palpable disappointment, Tara told me her mother's participation was infrequent and unpredictable. She said she had family therapy sessions "only when my mom was on parole. She's locked up now, she's a stupid bitch, but when she was living at my aunt's house she would sometimes come over with my caseworker. But that only happened a few times." Tara had no further comments about her experience with family therapy.

Tara's Experience with Dialectical Behavior Therapy Modules

Mindfulness. Tara did not recall learning about mindfulness. However, she described noticing how her body and mind became more relaxed after using some of the other DBT skills such as *imagery* (picturing herself on a beach) and *engaging the five senses* (smelling a candle). This increased awareness of self is a form of mindfulness.

Distress tolerance. The majority of skills Tara discussed in the interview were distress tolerance skills. She had many examples of how these skills helped her manage painful emotions and events in her life. Tara successfully used distraction skills by engaging in a calming activity to distract her from negative thoughts. Specifically, she would distract herself by listening to music on her headphones. Tara said she would listen to songs by Beyoncé to lift her self-confidence if she was having negative thoughts about herself.

Tara used distress tolerance skills of imagery when she felt herself getting angry or wanting to engage in negative behavior. She gave me an example of this:

> When we had to practice the skill where you imagined yourself somewhere else or thought of something good or funny, I'd write it down. I always pictured myself somewhere like in the tropical islands on a big beach with coconuts and blue blue water and real soft sand. That made me relax. Like I was on a postcard, like a model or something! HA, aint' no way I'm getting in a bikini though! (laughs) Naw, for real. It was real soothing. To be on the beach, in my mind, get it?

Self-soothing was another skill that resonated with Tara. This skill involved doing things that had an immediate relaxing and calming effect. Tara told me she found scented candles to be soothing but since she was not allowed to have candles at her group home, she used scented lotions: "I like the ones from Victoria Secret, they smell real good. I made my therapist get me those. I used to make her get me the nice ones, that's just how I do."

I asked Tara for an example of how she used distress tolerance skills in her life. She gave me this detailed example of how she was able to turn her mind away from negativity in her group home by practicing distraction, imagery, and self-soothing skills:

> When I'm mad I feel like I'm gonna pop off at all those girls, so I try to go to my relax place. I mean it's just my room, but I actually have a picture I drew from DBT on my wall, the tropical island one. I look at that and my new therapist got me this Caribbean Coconut lotion from Bath and Body Works I can smell. I just put it on my hands or my legs and it smells just like the beach! I guess I can pretend I'm somewhere different or pretend I'm really relaxing. Calm beach and I feel it calm me down, like I'm there.

Emotion regulation. Dialectical behavior therapy taught Tara how to identify and better control her emotions. Tara worked with her therapist toward experiencing anger or sadness without becoming overwhelmed by the emotion, which was what led to her impulsive behaviors. Although she denied engaging in self-harming behaviors, she

did experience poor impulse control when upset such as physical aggression or engaging in sexualized behaviors. When asked if any of these behaviors changed after being in the DBT program, she said, "Um, yeah. I mean I got calmer, not more angry and didn't want to fight."

Interpersonal effectiveness. Tara did not discuss interpersonal effectiveness skills during our interview. The skills taught in this module involved clients learning to express their needs more effectively, set personal limits, and improve relationships through validation. It is possible Tara has improved personal relationships in her life by having better control over her emotions and behaviors.

Selena

Background Information

Selena is a 16-year-old Hispanic female. She has a slight build, pretty face, and wavy black hair that flowed over her shoulders. Selena appeared "put together" dressed in a fashionable outfit with heavy eye makeup and dark lip liner. She had a small scar on her left cheek where she said she had a gang-related tattoo removed a few years ago. Selena seemed to take pride in her looks but also seemed self-conscious as evidenced by her repeated looks into the mirror on the wall where she adjusted her makeup and habitually smoothed her hair with her small manicured hands. Selena lives at home with her mother, her younger brother, and her step-dad. In an exasperated tone, she told me if she could move out of her house she would but her mother would not let her.

When I asked what brought her to DBT, Selena replied "Um, my mom made me go. I was like getting in trouble at school for skipping and I got caught smoking weed. I guess I needed some help and she used to go to that place for therapy." Selena told me

that at school she felt insecure and judged by her friends, which was one of the reasons she was frequently truant. She said it was easier to hide parts of herself because "I don't like to stand out" and explained, "I hide stuff. I mean I could get way better grades if I wanted to but like I feel stupid for being the smart one in my friends. And, and I don't like it. "

Selena also described being depressed in the past and engaging in self-injurious behaviors as a coping mechanism. She told me cutting herself was how she managed her feelings when she was "overwhelmed" or "numb." At the time of the interview, Selena reported she still experienced sadness but not full depression and no longer cuts herself. Selena reported past suicidal ideation but denied any suicide attempts. She stated,

> Um, yeah like, I had those thoughts, but it like, I never really got to a point where I wanted to kill myself. I guess I maybe thought about it but I never really tried suicide or anything. It was only cutting, but it wasn't like a deep like I wanted to slit my wrists. It was just light, like slow marks on my legs. And I don't do that kind of thing anymore.

During the interview, Selena spoke softly with a slight Spanish accent. She was cooperative and gave genuine, sincere responses. I found myself impressed with the self-awareness and bravery she possessed at such a young age. Her answers expressed a depth of meaning and personal insight into her experience with DBT.

Selena's Experience with Dialectical Behavior Therapy Components

Skills group therapy. Overall, Selena described her experience with DBT as helpful and reported several positive changes in her life as a result of going. However, she told me that during the program she felt self-conscious: "I didn't like going to the group sometimes and it was pretty, pretty embarrassing. Like I lied to my friends about where I was going. And, I didn't want everyone to know that I was in therapy. I felt

stupid because I had to go." Beyond the embarrassment, Selena said she liked "some of the kids in the group" and enjoyed "when people shared their stories" and "when they, um, told stuff about themselves."

Selena seemed to respond well to interactive aspects of skills group. Several times in the interview, Selena mentioned utilizing the DBT worksheets and handouts as part of her therapy. She also recalled learning skills through activities in skills group. She gave me an example:

> I mean the main one I remember was the skill where, the skills were we had to like name an emotion. We learned in group about how to do that. Like we played this game called charades. You had to like draw a card and then act out whatever emotion was on the card and then the other kids would like have to guess.

She went on to explain how this activity taught her about emotions: "And, um, some of the emotions were easy but some were pretty hard. And like I knew them but I didn't really understand them. And like now I can, like now I know that I feel disappointed a lot."

Individual therapy. Selena stated that she liked individual therapy because "just that I like, I had someone who would listen to me. I liked that I could talk about the things that I was having a hard time with." Specifically, Selena talked about her relationship with her father in individual therapy. She reported he had recently reentered her life and she was having a difficult time with that. I asked if DBT was helpful with this and she said,

> Um, I think I can talk to him better. I, um, know how to talk to him better. Because I used to be afraid of him. Not because he would hurt me or nothing ,but it was like I could never say what I was really feeling because I feel like he, he would think of me as weak. I had to pretend all the time that I was fine or he would get mad.

Her therapist, “Beth,” used interpersonal effectiveness skills to help Selena balance being respectful toward her father while also learning to stand up for herself. Selena explained how they worked on this in therapy:

> So in my sessions I practiced how to talk to him in a way that he would listen. I had to learn how to like stand up for myself with him, and it was kinda weird but I could practice saying the things that I would want to say to him. And then I would say them to Beth and then when I got comfortable I would say the things to him.

I asked Selena if she noticed any change after learning these skills and she answered, “Um, I don’t know. I mean, like, I think that I can stand up for myself a little more.”

Individual therapy also targeted Selena’s self-injurious behavior. I asked her if she thought DBT helped with those behaviors and she said, “Um, well I don’t, I don’t think I’m really depressed anymore. I don’t feel like I used to, so I don’t have to cut or anything.”

Family therapy. Selena described her experience with family therapy as “weird.” She attended family therapy with her mother, younger brother, and occasionally her mothers’ boyfriend who she calls “step-dad.” She told me, “I was always real uncomfortable when my step-dad was there. I didn’t care about my brother or mom being there because they are my real family. We’re blood.” Early in the interview, Selena described a hurtful relationship with her family. She said they often made fun of her weight and said mean things to her, such as calling her “gordita.” Selena reported that she felt her family was not a source of support for her.

When I asked Selena how things were different after going through family therapy, she reported that her relationship with her family improved. She explained, “Um, for me it’s just, I feel like my family understands me better.” Selena described

learning about middle path skills during family therapy. She noted that she felt she should be allowed more independence but her parents had stricter rules than she liked. She said they worked toward a compromise and gave me this example: “Like they had to give me my own space because I am growing up. But I like had to follow their rules better.” Selena also noted that they worked on communication skills to “talk nicer to each other.”

One major finding from Selena’s case was the impact of culture on her family therapy experience. She described the role her Mexican heritage had in family therapy:

> Well, it’s like in Mexico there’s this kind of different way to, to be with your family. It’s like you don’t really talk much about your family problems with anyone. It’s like we don’t really believe in therapy that much. I remember when, when one time I mentioned something, about our family. And, uh, afterwards my mom got really mad at me.

She went on to explain that her mother wanted her to use “Indescreta,” which she defined as “It’s just like, you shouldn’t, you shouldn’t, it basically means you should keep your stuff to yourself.” I asked her if there was something her therapist could have done to be more sensitive to her family’s culture and she shook her head and said, “Like I don’t really know. It’s just like uh, we just don’t talk about it much. It’s, we don’t talk about it much with strangers. It’s just like part of being Mexican.”

Not having a bilingual therapist was another cultural factor in Selena’s family therapy experience. She reported, “Um. I think that you need to have more Spanish speaking therapists for my family, for like families that don’t speak English.” Selena described how the language negatively impacted her experience: “My abuelita was going to do some therapy with me, she’s the person who loves me no matter what, but she doesn’t speak English.” Selena noted the DBT program would be improved by providing

bilingual therapists “because I think that there’s a lot of families that speak Spanish that need help.”

Selena’s Experience with the Dialectical Behavior Therapy Modules

Mindfulness. Selena described using mindfulness skills to slow herself down and notice what she was feeling. She used mindful breathing exercises to stay in the moment instead of acting impulsively. Selena gave this example of using mindfulness in her life: “I just like try to like, uh, breath slow, take deep breaths. And I think that I try to think before I act now. Like running away used to be my first reaction to everything.”

Distress tolerance. In the past, Selena engaged in self-injurious behavior as a means to cope with distress in her life. She said, “Um, like I used to be a cutter and like, cutting was so many ways, so many things for me. I, it was like a release of pressure, and feeling alive, and remembering I’m human.” Distress tolerance skills taught Selena to find positive ways to take control over her life when she experienced a crisis or felt overwhelmed. For example she noted, “I just joined my church choir and I get a lot of support there. Ah, singing is a way for me to release those kinds of things in my life.” I asked her to explain how singing was a positive coping skill and she replied,

> I don’t really know but I think it has to do with something like being in control. Like when things are, like out of my control in my life I can always sing. I kinda like this sense of like power. Or control, like I can be in charge of my life. I felt like when I first used that paper clip to scratch my leg., like I was the only one who could control that piece of metal. Like, it was like my little secret. With singing it’s like I can be in control, too. And nobody can take my voice away.

Selena has also found meaning in the pain of her past, which is a distress tolerance skill. She thoughtfully explained to me,

> I mean I still have my scars and it'll always be like a part of me. But it's not what defines me, you know. It's just one part of who I am and I have many parts. Like other people maybe smoke or drive really fast or do those things to feel alive and I don't have to cut myself to feel alive anymore.

Emotion regulation. Emotional regulation skills taught Selena how to identify her emotions and understand the purpose of her emotions. She stated, "I guess DBT taught me how to learn more about my emotions." Selena told me she used to not be able to identify her emotions or just ignored them because they were too painful. In therapy, Selena learned to identify a feeling of disappointment. She was then able to understand how this emotion played a role in her depression. She explained, "Um, it's just that like, I felt like people disappointed me. I think that I expect too much of people and then I get like, like sad when they hurt me."

Selena also told me she has an easier time identifying and understanding emotions in other people. She noticed that when her mother was yelling about how messy the house was, Selena saw another emotion behind her mother's anger. She explained, "Like I can tell she feels disappointed and kind of sad that our house is so small. Like I know she wants to live in a better place but she just yells instead of like saying that. And I can say, Mom, you're just disappointed."

Selena told me that in the past, she felt overwhelmed by her emotions and had difficulty identifying what she was feeling. She elaborated,

> I mean, um, it's hard to explain. Um, I think, I think it was because I used to be numb. Like one of those worksheets we did in therapy, about the uh, emotions. Like I had to list every different emotion I felt for each little, like situation they gave us. Like, for example, if you were dumped by your boyfriend, what would you feel? Things like that. I remember that for that I like wrote down numb for every single thing. Just numb for the whole page, every, every single answer. I had to cut myself if I wanted to feel something. Like, I think that I'm not, I'm just not numb anymore so I don't have to do those things to remind myself.

Instead of only being able to feel numb, emotion regulation skills taught Selena to identify her emotions by nonjudgmentally observing them. She described being able to experience her emotions without becoming overwhelmed by their intensity and becoming numb or needing to engage in self-harming behavior. I asked Selena if learning DBT skills helped in her life currently. She told me,

> Um, I feel like I'm a more positive person. I'm not depressed anymore. It's just, I like used to think that I wasn't real. Nobody was real. Like I was floating around invisible to everyone and now I know that what I am feeling is real. I'm a person and I'm able to kind of lift myself up now. I think that before I thought nobody could do that but I did it for myself.

Interpersonal effectiveness. Selena told me she applied the interpersonal effectiveness skills with her parents by learning to express her needs more effectively. She told me she had a hard time standing up for herself, especially with her father. By practicing skills with her individual therapist, Selena was able to assert herself and maintain self-respect.

Davey

Background Information

Davey is a 17-year-old Caucasian male. He arrived at the interview slightly out of breath, having ridden his skateboard from school. He carried himself with confidence but once he sat down, he appeared nervous as evidenced by chewing on the strings of his hooded sweatshirt and looking around the room. Davey clutched his skateboard at his side in a way that suggested its proximity was a source of comfort.

Davey began the interview by telling me how he ended up in the DBT program. He said he was referred for treatment because of his depression, substance abuse issues, and arrests for drug-related charges. Throughout the interview he referenced his drug use

and stated that smoking marijuana was his primary coping skill. He told me, “I’ll end up in rehab someday.”

Davey lives with his mother, stepfather, and two half-sisters but told me he spends most of the time at friends’ houses. He described a dysfunctional family environment in which he did not feel included. Davey reported that he was often told he “wasn’t part of the real family” by his stepfather and felt alone in the family. His dysfunctional relationship with his mother and stepfather contributed to his depressive feelings.

Davey denied any self-injurious behaviors. He said, “I don’t do that shit.” Davey also denied any suicidal ideation or attempts: “I don’t even consider suicide as an option. It’s a weak option. I don’t want to die. I’ve got things to do in life. Like, I’ve got really big plans.” However, during the interview, he spoke about being in group therapy at a hospital. When I inquired about this, Davey looked down and whispered, “Yeah, um, my, uh, stepdad, he uh, caught me with, uh, a rope around my neck in the garage. I was, like, testing it out like a noose. I wasn’t really going to do it but I guess he didn’t know that.”

During the interview, Davey was cooperative but nervous. He looked out the window and did not make eye contact for the first 10 minutes of the interview. At one point, Davey was having a hard time getting his answer out and said, “Sorry, I’m nervous. I don’t like interviews to be honest. That’s why I don’t do well in therapy.” He explained that he did not like all the questions in therapy and said, “Yeah, I don’t know how to answer them.” Davey was initially curt when answering questions but he eventually opened up and gave more descriptive responses. He became animated, using

metaphors and vivid imagery, when expressing the meanings of the songs he wrote during DBT.

In general, Davey reported that DBT was not a good fit for him and he did not find it beneficial: “I don’t really know. I feel like it’s not really a therapy for kids like me.” I asked Davey what impact DBT had on his life and he answered dejectedly, “Probably none, to tell you the truth. I still feel like the same person.” Despite these negative statements, Davey reported positive changes such as a sense of normalization from group therapy and increased mindfulness skills.

Davey’s Experience with Dialectical Behavior Therapy Components

Skills group therapy. Davey described his experience in skills group therapy as “chill.” I asked him to elaborate and he said group therapy was, “Like no big deal, sit there and talk or don’t talk, get something to drink, do some silly games sometimes. That was always real embarrassing but it wasn’t so bad (laughing to himself).”

He reported liking the group leaders: “Everyone there, the therapists and the doctors and the counselors or whatever, they were all nice. Nobody made you feel stupid or messed up, like you had a mental problems or something.” Davey also told me he made connections with some of the group members: “Yeah, there was some pretty okay people. Like these two girls? They were pretty cool. We hung out a lot.” However, he was bothered by other members: “Some of those guys were crazy or just weird. Like this one guy cried like every group and then would be like laughing the next minute (laughs). It was funny, but the dude was crazy.”

Davey said his experience of DBT was different than his experience in other group therapies. He described this difference: “Um, it didn’t feel like I was going into

some group where everyone was like messed up. Like at the hospital, it was when I was 14. Those people were seriously messed up. Like, I felt like I was in an insane asylum." Davey reported feeling a sense of normalization in the DBT group that he did not experience in the hospital group. He said, "I guess the kids in DBT were normal, so you feel more normal. I guess that's what I liked about DBT."

Davey appreciated the structured skills-focused approach of DBT versus an interpersonal approach. He explained, "The skills were lame but it was better than just, um, sitting around talking about all of our, like, personal problems. Like, all the deep shit." He added, "I think that's just sad. Like when kids just cry and tell their sob stories. I don't think that's like helping anybody. But that didn't happen too much in DBT with the group."

In group therapy, Davey preferred problem-solving to talking. When I asked how the group problem-solved without talking about their problems, he answered,

> Well, we did talk about our problems, but it wasn't like go around the circle and tell your sob story. If someone wanted to talk about their problems we'd like, try to problem solve them together. We wouldn't just be like "oh, poor me", and let's everybody hug and cry. We'd be like, shit that sucks! And then one of the therapists would have us figure out what that person could have done differently.

Davey summarized his opinion: "I think what I'm trying to say is that the DBT isn't just sit around. It's do stuff."

A negative part of Davey's experience in group therapy was he found it "really boring." He explained, "It was like a second school. We had to sit there and listen." Additionally, Davey became frustrated by the amount of paperwork he had to do in group therapy. He told me, "When we had to fill out these worksheets, like, it was hard." Davey added it was especially difficult for him because he has dyslexia. However, he

received help from another group member and said he did not mind because “she was like, really hot!”

Individual therapy. Davey reported his experience in individual therapy was not helpful. He stated, “Well I feel like the therapy didn’t really do anything for me. I don’t feel like I’m any less of an angry person than I used to be.” Davey said the focus of individual therapy was regulating his anger and replacing his drug use with adaptive coping skills. He explained, “My therapist and I spent most of the time trying to figure out what things we could do to calm me down… besides drugs. It’s hard for me to be sober. I feel like I can’t handle life when I’m not high.”

In individual therapy, Davey identified which emotion regulation skills worked best for him. He told me playing the guitar was a skill he used to manage painful emotions. He did this in session: “I used to bring my guitar to therapy and we’d play some. That always calms me down.” Davey said music was incorporated a lot into his therapy: “I’ve actually starting writing my own songs. I suppose there’s one thing I did learn from therapy.”

During the interview, Davey became the most animated when he spoke about his experience with radical acceptance in individual therapy. Dialectical behavior therapy teaches adolescents to use radical acceptance to accept themselves, their lives, and their past before they can learn to change (acceptance does not equal agreeing with or approving). I asked Davey to describe his experience with this DBT concept and he thoughtfully replied:

> It’s like life will be painful but it’s stupid to just ignore it or only to get mad about it. You have to first realize what’s going on before you can do anything. I feel like you’re hurting anyway just ignoring all the pain you’ve been through in your

> life. Things that happened to you, like abuse and stuff, those things, those things will never go away. As much as I want them to change, they won't.

Family therapy. Davey reported a dysfunctional family environment. He became emotional when he told me about being sent to the psychiatric hospital after his stepfather found him putting a rope around his neck. Davey said his stepfather "just wanted me out of his life and wished I could have stayed at the hospital. I think he wished that it was just him, my mom and their kids." I reflected back to Davey that it sounded like a painful time in his life and he looked at me, nodded, and tearfully said, "Yeah. It was."

When I asked Davey about his experience in family therapy, he grimaced and said, "It was terrible." He explained, "I only did two sessions. My stepdad got arrested for beating my mom and that made us stop." When I asked Davey about the two sessions he did have, he shrugged and replied, "I don't know. I don't remember anything to tell you about. Not much to say about my "family therapy" (used air quotes) in my family."

Davey's Experience with Dialectical Behavior Therapy Modules

Mindfulness. Davey told me he learned to be mindful when he became angry. He said before DBT he did not notice when his anger was starting to build but only noticed after it had already escalated. He described this: "Like I got real mad real quick. I go from zero to 60 in like 10 seconds." Davey mentioned a mindfulness exercise in group therapy that demonstrated how different types of breathing led to different sensations and emotions in the body. During this exercise, he noticed how shallow, short breaths made him feel anxious and "revved up" and that this was how he felt "right before I lose it. Like it felt like when I was mad." He reported learning to take deep

breaths and noticing the calming effect it had on his body. Davey reported he also practiced mindfulness by staying in the moment when he was writing song lyrics, playing guitar, and listening to music.

Distress tolerance. Davey told me song writing was the only distress tolerance skill he learned from DBT. Besides music, he said drug use was still his primary coping skill: "I just, I feel like I need them. Like I can't stop." Davey reported that when he was "overwhelmed with life," he smoked marijuana because "weed is the only medicine that's ever helped me."

Emotion regulation. Davey discussed problems regulating his emotions, especially anger. He described his anger: "I hold it in. Until I get really mad." Davey said he tends to ignore his feelings until he is ready to explode. He gave an example:

> Like people can get me mad but I hold that anger in and when the wrong person comes up and says something that I don't like, I blow up and it's like hell just broke loose. And I kind of black out and I don't know what really happens after that.

When I asked Davey about emotion regulation skills, he expressed his disdain for talking about emotions. He said, "It's messed up. Life. But nothing changes when you cry about it and wish it would go away." Instead of talking, Davey preferred practicing emotion regulation skills in group therapy. When the group was learning about using *wise mind*, he volunteered an example from his life to be role played:

> One time I got in trouble for cussing out my teacher and we acted that one out. (laughs) It was me and this girl (she was the teacher) and we role-played what happened and the group would be like "what were the other choices?" or something. And then I did the other choices in the role play, to see like what might have been different.

Davey said the role-play helped him realize he had been acting out of *emotion mind* instead of *wise mind*. I asked Davey if learning new skills helped him manage his anger.

He replied with a shrug, “Well I feel like the therapy didn’t really do anything for me. I don’t feel like I’m any less of an angry person than I used to be.”

Interpersonal effectiveness. Interpersonal effectiveness skills teach adolescents about increasing their self-worth, which has a positive impact on their relationships. Davey described a difficult time finding value in himself and being able to believe others saw value in him. He remembered learning interpersonal effectiveness skills through role play in group therapy and found them helpful. I asked him to describe his experience and he said,

> Uh, two people would get up and act out our problems or whatever. I mean not act like it was acting class but like role play or whatever. That way the person could think about the situation and, you know, see it differently. It was like a chance to like change how you saw stuff or whatever. I think it was maybe to give you an idea for what to do next time.

Davey stated he did not have any positive relationships in his life and the only dependable relationship he has had was with drugs. He explained, “Drugs have always been there for me. When my family wasn’t, or my friends, or my girlfriend, nobody was gonna be there… or help me. But I mean, the drugs did. They were always there for me.” When I asked Davey how DBT impacted his interpersonal relationships, he told me it did not. He said, “Nothing’s changed. Nobody’s changed. I haven’t. Not really. Maybe people know I’ve changed because I write songs now. But that’s it.”

Middle path. Davey strongly identified with the middle path concept of finding balance between acceptance and change, in the dialect of “both and,” and the DBT assumption that you are doing the best you can AND you need to do better. He described a song he wrote about this experience:

> So, life it’s like an ocean. It’s big and vast and there’s always going to be something that’s happening. And there’s stuff inside it, that’s keeping it from

> actually, being beautiful. Like, oil or you know seaweed. The seaweed being the drugs and the oil being abuse. It really messes you up and like the seaweed is there just to numb the abuse, to take you away from that oil and to drag me under. And I'll be away from it all. But eventually I mean, I need to breath, I, I could die. And it's hard to stop, I , like the drugs really help and it keeps me away from all that oil on the surface but what I really need to do is clear the oil out myself and just accept that it'll be there. And well, once I open my eyes and see the drugs aren't helping and get away from all that seaweed, um, I metaphorically need to teach myself to swim again so I can get up to the surface and face my problems. And take that breath of life that will move me forward.

Anna

Background Information

Anna is a 17-year-old Caucasian female. She is tall, athletically built, with dark blond hair and blue eyes. She was dressed casually in jeans, a high school sweatshirt, and flip flops (despite the cold weather). Anna carried herself with confidence and came across as an energetic and feisty girl. We comfortably engaged in small talk about sports and her plans for college; I could see that relating to adults came naturally for Anna.

Anna told me she lived at home with her mother and was an only child. She said she had a close relationship with her mother and her mother was her primary support system. Anna saw several therapists during her childhood for what she described as mild depression and behavioral problems in school. She said it was not until last year that her problems became serious. With narrowed eyes, she looked at me and said, "It was a rough time in my life because that was when my father abandoned me and my mom." She did not expand on the situation but said, "I was um, like pretty depressed and down. Around the time my dad left us and I was having, um like a hard time coping with it." Anna told me she had been cutting herself with a broken CD case she had hidden in the bathroom. When her mother noticed the scratches and found out that Anna, who describes herself as "a B student," was failing her classes, she set up counseling sessions

for Anna at school. Then, a few weeks later, Anna was hospitalized for attempting suicide by swallowing pills. Anna was enrolled in the DBT program soon after she was released from the hospital. According to Anna, this was her first and only suicide attempt and she reported she has not engaged in self-harming behaviors since that time.

During the interview, Anna was friendly and cooperative but also somewhat reserved emotionally. She was forthcoming in her description of the less personal components of her experience with DBT such as disagreeing with the length of the program. However, it seemed she was unwilling or uncomfortable discussing the more personal aspects of her experience. This was exemplified in her short, incomplete responses that lacked detail or depth. For example, Anna often replied with an aloof shrug and "I don't know" or "It was okay."

As I listened to Anna, I got the impression she felt shame and embarrassment about her past depression and self-harming behaviors. She seemed to block those parts of her life and focus on the positive changes she has made in her life. When asked her if the DBT program had any impact on her life, she emphatically replied, "Oh yeah, totally. It like totally changed me. It was like a major wakeup call or something. It was like, wake up! Hello! Do you really want to do this with your life? Do you want to die? I'm like, no." Anna summarized her general experience with DBT:

> Um, well, it was good I guess but it was kind of annoying. I mean would I do it again? No because it was a major time suck. But would I do it again if I needed to? Yeah, totally. I could do a shorter one, I think. Like, shorter than the whole thing I mean.

Anna's Experience with Dialectical Behavior Therapy

Group therapy. Anna responded well to the group component of DBT, especially her interactions with other group members. Before DBT, Anna felt "like something has to be wrong with me. Like, I'm totally not normal." I asked her to explain what "not normal" meant and she replied, "Like, no normal person would like think like I did or feel like I did, I thought I was just super fucked up." But in group therapy, Anna met adolescents with similar thoughts, feelings, and behaviors. Listening to their stories she began to feel less alone. She explained, "But like after the program? It's like it's not just me. Other people had those fucked up thoughts too. And like, like sometimes even more than me." This experience provided Anna with a sense of normalization. She found comfort knowing she was not the only one going through what she was going through.

With the support of the group, Anna also learned self-acceptance and how to be less judgmental of herself. She told me, "Other people helped me see that I wasn't a total freak or anything. Like, I'm still weird but that's because I like to be.(laughs)." Anna told me the younger participants in skills group made her experience uncomfortable. She thought having young members made the group "too immature" and limited the topics the group could comfortably discuss. She earnestly explained, "I mean they weren't that young but like I'm 17 and my two friends in the group were uh, 16 and 15 so we had more like adult stuff to talk about, you know? And the 12- and 13-year-olds were not as appropriate, you know?" She also expressed a sense of responsibility for the younger kids:

> Like there was this boy that was like 12 and it was weird or something when we talked about stuff that was like, pretty adult. Like we were talking about this one kid who would always get into fights and really mess the person up. And I felt bad for the kids to hear that. I mean, they shouldn't have to hear this! I mean I feel like it was too mature for him.

Individual therapy. Individual therapy did not particularly resonate with Anna. When I asked about her experience in individual therapy, she said, "Um, it was pretty normal I guess. Like, go talk. Pretty natural, I've done it before, so like pretty easy." She did not have any feedback about things she liked or did not like about individual therapy. Anna told me she did not think DBT individual therapy was any different than other types of therapy she has been in. Anna's target behaviors were her self-injurious behaviors and her therapy focused on learning adaptive coping skills to replace harmful behaviors. Anna stated she found the practical skills more helpful than talking to her therapist.

Anna expressed a complaint about the time commitment required of her by the program. In an exasperated tone, Anna said, "Um, like, like no offense but it was like really long! Super long. Um, it felt like the entire time I was just there. And like, it was really annoying I guess but to do it practically like every day." She participated in group therapy twice a week, individual therapy twice a week, and family therapy once a week or every other week.

Family therapy. Anna attended family therapy with her mom. She described her experience by saying, "Um, well that part was easy." I asked why it was easy and she shrugged and said, "My mom and I don't really have any problems." However, when I inquired further, Anna noted tension in their relationship. She described the problem between them as "she just feels like I'm out of control and she doesn't know how to

control me." Anna and her mother learned middle path skills during their family therapy sessions. Anna discussed finding a middle path with trust and safety in their relationship. She said they had to work on regaining trust in Anna that she would not hurt herself. I asked Anna if she still used these skills in her life and she reported, "I still talk to my mom about it and stuff, so it's pretty natural."

In family therapy, Anna and her mother worked on improving communication and trust. Anna also told me her mother did not know how to respond when Anna was engaging in self-injurious behaviors: "I used to do stuff that like freaked her out but it was never about her." She said the family therapist taught her mother some of the same distress tolerance skills Anna was learning. I asked Anna if she thought anything had changed after being in DBT family therapy and she gave a short laugh and replied, "Um, like I said, the family therapy stuff was like really easy for me. And like honestly, I've been to therapy before and you can never really pull anything new on me in therapy, it's like been there done that."

Anna's Experience with Dialectical Behavior Therapy Skills Modules

Mindfulness. Anna described using mindfulness skills to monitor her reactions when she felt herself becoming upset. She described mindful breathing: "I like to use the one where I take deep breaths and try to calm myself before I react." Anna also used mindfulness to notice when her body became tense and it was difficult for her to relax. She gave me an example of using her skills to relax: "It's like, just like hey take a chill pill and finally relax. I just need to chillax. That's what my boyfriend tells me to do." (Laughs).

Anna also told me she became mindful of the effect her cutting behavior and suicide attempt had on others around her. She explained she used to be "in a daze all to myself" but now has a greater awareness of how her behavior was viewed by people in her life. She said, "And like, I feel like, like people being like, look at what you're doing with your life! Like, hello?"

Distress tolerance. Anna had a history of engaging in self-injurious behaviors when she felt emotionally overwhelmed. She told me she used to cut herself frequently and attempted suicide one time, for which she was hospitalized. Anna denied cutting herself in last six months and she attributed this change to DBT saying, "Um, yeah, it was like the therapy, being in therapy, like helped a lot." Anna was enrolled in the DBT program as a step-down plan after being discharged from the hospital. Anna said that after being in the hospital, she took a hard look at her life and wanted to change her destructive patterns. She realized, "It's like do you really want this? It just made me think, you know, like where I want to go with my life and everything." Anna seemed to benefit greatly from the distress tolerance skills. I asked her what about DBT she found most helpful and she replied, "Mostly, like skills, like coping skills. Like, instead of this I can do x, y, and z instead of cutting. Like, getting all worked up or freaking too much."

The distress tolerance skill of *distraction* resonated with Anna. She told me that when she noticed herself feeling down, she would distract herself by surrounding herself with other people: "Um, yeah, it's like I finally realized other people go through the same things I do. And it's not just me. So, like I can learn things to like help with that, by being around other people, like that's really helpful for me."

Anna did not provide specific examples of the skills she practiced, citing difficulty remembering the DBT terminology as the reason. She told me, "Like, to be honest, I don't really remember what they are called or anything. Like, the names were all crazy like MAN and other letters that I'm supposed to like help us remember, but I guess it was pretty dumb, no offense." She was referring to the numerous acronyms taught in each of the skills modules such as DEARMAN.

Anna told me she would use DBT in the future: "Well, like if I started cutting again or something or got back into my suicidal ways, I would do it again." I asked if she would recommend this program to other teenagers going through a tough time and she said she would. She stated, "As kind of an intervention I guess. I think it's good for that, like anyone who's' thinking about cutting or anything like that. Or like wanting to kill themselves. I would tell them to do DBT."

Emotion regulation. Emotion regulation skills teach adolescent to observe their emotions nonjudgmentally and experience them without losing control of their thoughts, feelings, and behaviors. Anna told me she is an emotional person by nature: "Like I get super emotional sometimes? You know? It's probably just me being a girl. (laughs) But I try to not be a basket case of emotions." She said she use to have "super dark thoughts" and could not tolerate the pain without engaging in self-harming behaviors. Anna learned her emotions were temporary and they would pass with time. She told me she learned to control her emotions instead of them controlling her. I asked her if these skills had an impact on her life and she said, "Like for me, I feel like it's just more normal than I thought. Like, um learning new skills to cope with my feelings so I didn't do the stuff I used to."

Other emotional regulation skills Anna learned were *turning away* from negative thoughts and feelings and *turning toward* positive ones. Practicing these skills changed her outlook on life into a more positive one. She reported, "Uh, yeah, I guess I changed how I see myself. Like I'm not hopeless anymore. There's a change in me, in my emotions, and I see things brighter."

Interpersonal effectiveness. Anna reported that interpersonal relationships were never a problem for her. When I asked about her experience with the interpersonal effectiveness skills, she remembered them but said, "Um, yeah but I never really had a problem with that before so." When we discussed her problems at school, she admitted she had poor relationships with her teachers. She explained, "Yeah, um, it's like I got in a lot of trouble for my mouth, for like saying things. But I doubt that's ever going to change. That's just me." I asked if DBT interpersonal effectiveness skills helped her relationships with teachers. She replied, "Like, I still talk pretty bad to my teachers. And like, it's, I'm getting better at it I guess, but I'm not going to ever love school." I asked if DBT helped her problems at school. Anna shook her head and with a sneer, she answered, "Uh, like a little. Like I said I'm kind of getting better, but no."

Adam

Background

Adam is an 18-year-old Caucasian male (17 during the DBT program). He was dressed in black clothing and wore dark black eyeliner smudged around his eyes.. Adam's dark ensemble and disheveled appearance contrasted sharply with his bright smile and polite manners.

Adam lived in an apartment with his mother, father, and an older brother. He told me he was completing his high school degree online: “I do better when I can excel and utilize the computer.” He added that he was taking a few pre-college courses at a local community college but said he was not doing well with the exception of one class. Adam said he had struggled academically and socially for most of his life and left the public school system in early high school. This was in part due to the extensive bullying he experienced throughout his childhood and teenage years: “I’ve been bullied since I was in the first grade. Probably earlier than that but I can’t recall right now.”

Adam stated his social and academic difficulties were in part due to his diagnosis of Asperger’s Syndrome. Early in the interview, he remarked, “I’m not sure if anyone’s told you but I have Asperger’s, I mean on top of everything else; the bipolar disorder, the social anxiety, and the depression. I have Asperger’s. You name it--I’ve been diagnosed with it.” Adam believed his peers saw him as a “freak” and judged him for his appearance as well as his behaviors. He told me, “Being judged for what I look like, or how I talk or what I do has always been a huge part of my life. I mean, like I said, it’s part of my personality at this point. My identity.” Adam added, “What I haven’t told you, is that I am also, I’m also gay. I’ve been very, very highly persecuted for that. And with my bipolar disorder, I just, I couldn’t, because of all of that, I could not handle public school very well at all.” He said his sexual orientation was another source of social isolation and feeling different from other teenagers.

Adam spoke openly about his mental health history and reported, “Well, first off I’ve quite a bit of experience with DBT, most types of therapy for that matter. I’ve been seeing a psychologist or psychiatrist since I was around seven years old.” Adam reported

two suicide attempts for which he was hospitalized: “The first time I took all of my Celexa and my mood stabilizer. Anyways, my mother found me before anything really took effect. So, and she was able to drive me to the hospital. The second time was more simplistic. I, I just cut my wrists.”

He also reported a history of self-injurious behaviors:

> Well, uh, actually, yes. I did do self-harming on the side as well. I always preferred burning myself to cutting myself. Strangely enough. I’ve tested many alternatives to cutting. For instance, when I was little, I banged my head on walls. But, I would say I prefer burning. It was always a little more, I’ll say satisfying.

When I asked if he was currently experiencing suicidal ideation or engaging in self-harming behavior, he answered,

> No, not anymore. That’s uh, I’ve moved past that phase of my life now. Dialectical behavior therapy taught me to learn new skills instead of burning, or cutting myself. So, no I have not had any additional thoughts or any other thoughts of suicide. That, that again like I said, was all in the past.

During the interview, Adam was cooperative, engaged, and eager to provide information. He appeared to have given thought to the meaning of his experience with DBT as evidenced by his honest and insightful answers. Adam demonstrated strong verbal abilities and a more adult vocabulary than might be typical of other 18-year-olds. This statement provides an example of his speech pattern: “It was an unusual method of conveyance but it was effective nonetheless.” Overall, Adam reported a positive and helpful experience with DBT including reduced self-injurious behaviors and improved self-esteem.

Adam’s Experience with Dialectical Behavior Therapy

Group therapy. In group therapy, Adam had difficulty connecting with other adolescents and found the format to be restrictive. He stated that part of the problem was

"because I have Aspergers I have significant difficulty relating to other people." Adam described himself as "a mature young adult" and was distracted by some of the younger adolescents in the group. He said, "I felt like I was not able to fully express my issues in the group because there was some very, very immature people in there."

Adam stated the format of the group was more effective when they were split into smaller groups based on age: "We told the therapists that we wanted our own group with the other, with the other older kids." I asked if there was anyone in the group he connected with and he stated he did form one meaningful relationship: "Oh, well, actually, yes, to an extent. There was this girl, Cassidy, who totally, she totally got me. She was gay as well and was also older." Adam said he found support in talking with this group member because she was gay and could relate to the issues he was struggling with. Adam added that he thought group therapy could be helpful for adolescents struggling with issues related to their sexual identity: "To feel like they're not alone and they're not isolated. Especially, I mean, especially gay teenagers who think they're alone in the world. They're not!"

Individual therapy. Adam reported his experience in individual therapy was the most valuable part of DBT:

> Oh, actually I got most of my DBT in my individual sessions. Family therapy, like I told you was, I mean honestly it was just a complete waste of everyone's time. Group was obnoxious, I can tell you about that later. But therapy with Alison is really what saved me.

When I asked Adam what he liked best about individual therapy, he expressed feeling validated and accepted by his individual therapist: "She fully accepted me for who I was. For example, she brought me a nice eyeliner she got for free in a gift basket or something of that caliber. It was incredibly meaningful to me." He also learned from Alison how to

accept and find value in himself. Adam explained, "Alison did not see me as a freak and in fact she told me I was a valuable human being. I remember that phrase quite well. Because, you see I never thought I had value. I suppose it's a matter of self-esteem.

Along with validation and acceptance, Adam's individual therapy targeted his self-injurious behaviors. He explained, "Alison was a person who did not seem to be scared of my burn marks. She simply accepted that, without flinching or anything of that caliber. And said that we need to work on something different, don't we? And I agreed." Adam described learning distress tolerance skills: "Basically, we worked on skills that helped me calm down so I don't reach the point of no return. Which I would have ended up harming myself."

Adam also responded well to the structured, skill-based, behavioral approach of DBT individual therapy. He told me he appreciated how this was different than other types of "talk therapy" he had been in that were more process oriented. Adam said, "Alison also knew that I did not do too well with talking about how I felt. She was not one of those therapists who is always 'How does that make you feel?"

Familytherapy. Adam told me his experience in family therapy with his mother and father was painful and not helpful. When I asked him to elaborate, he let out a deep sigh and then explained:

> It was…quite awkward at times, I'm not going to lie. It was…(sigh) discussing my suicidal attempts and that I was gay. My parents have known this for two years but they did not comprehend the gravity of the situation for myself. I would say I was having an identity crisis at the time. For example, the eyeliner that I wear is something that disturbs my father to no end. I don't believe that he's homophobic. But he does not accept me. That is something that I also have to accept.

Middle path skills help adolescents and their families find a balance through acceptance and change**.** When I asked Adam about these skills he responded, "Yeah, that is something that is brought up in family therapy. You know, honestly, I believe that compromising is difficult for everyone. But it is also very important. I believe, I recall that we discussed those skills with my parents." Adam described wanting to find a middle path in being accepted by his parents and also understanding their point of view.

Adam also reported not feeling supported or understood by the therapist. Adam said, "In family therapy, we had a male therapist and I quite honestly believe that he did not know what to really do with me. With my whole identity crisis thing." I asked Adam if DBT skills were incorporated into family therapy and he responded, "Well, realistically, not, very little. It was mostly my mother talking, me crying, and my father…sitting in stalk silence. That was a time I could have done without."

Adam's Experience with Dialectical Behavior Therapy Skills Modules

Mindfulness. When I asked Adam about mindfulness skills, he gave an unclear response. He reported that he tries to incorporate mindfulness into his life by practicing meditation, although he added that he seldom did this. Adam stated he did not actively use other mindfulness skills such as breathing or relaxation because he did not find them helpful. He did say that during DBT, he worked on being mindful of his interpersonal skills.

Distress tolerance. Adam described maladaptive coping skills for handling distress in his life. He reported having made two suicide attempts and engaged in self-injurious behaviors. Adam noted a history of depression and said, "To be honest, I believe I've wanted to die since a young age. And I never really had the will power or

the strength to go through with that, of course." He shared an experience with me about his self-injurious behaviors: "I've burned myself twice, once on each shoulder. It left me with scars. And those scars are my reminders. They remind me of a time in my life. And, it's a time in my life that I do not and cannot go back to." In DBT, he learned distress tolerance skills to replace his harmful behaviors with healthy coping skills. Adam said, "DBT was actually highly focused on my hurting, the hurting of myself. Dialectical behavior therapy taught me to learn new skills instead of burning, or cutting myself" Adam learned and practiced these skills in individual and group therapy.

Adam described his experience with distress tolerance skills as helpful in finding more adaptive ways to cope with negative feelings: "I learned to recognize what my triggers were and then to replace the destructive behaviors with more, uh appropriate ones." With the help of his individual therapist, he learned to identify skills that would decrease his urge to self-harm. One of these skills was engaging the senses by listening to music. He said, "I learned that what calmed me down was music" and this eased the desire to act impulsively.

The skill of self-soothing was also helpful for Adam. He said he used this skill "if I felt like I was spinning out of control and want to punch something or punch my own head or burn myself, which I have done, mind you." Adam described his self-soothing to me:

> Well, I have this real down blanket, you see. Made of real down feathers. Those are from geese, actually. And it's heavy. I would go to my closet, go into the back where it was dark and cover myself with the blanket. I believe it calms me down. The heavy blanket and the dark space.

With an awkward laugh, he added, "Just so you know, I completely see the irony of me being in the closet as a gay man.

Emotion regulation. Adam admitted that identifying and understanding emotions was a challenge for him. Emotion regulation skills teach adolescents about the three states of mind: emotion mind, rational mind, and wise mind. Adam identified most with rational mind: "I also learned that I can at times be too rigid and too rational. Like a, like a robot, to be more precise in my wording. I believe this is, again, part of my Asperger's." A positive aspect of using his rational mind was he resonated with DBT:

> The thing about DBT was that it appealed to my logical side of my mind. It was like here are the steps you should take, A followed by B followed by C. I can tell you that DBT, that it makes sense. It's a logical type of therapy that I can understand.

The emotion regulation skills helped Adam to also use his *emotion* mind and ultimately his *wise mind*. He explained, "I did learn to use my emotions and also to recognize emotions of others. To be honest, that is something I still struggle with."

He described his experience with the *what* and *how* skills taught in group therapy:

> In group we did things to learn about emotions. Yeah. For example, we played a checkers (he means charades) game where we had to act out an emotion. It was an unusual method of conveyance but it was effective nonetheless. Anyway, the group had to guess what the emotion was. I believe that the point was to learn about different types of emotions. And like, like you said what they do for you.

I asked Adam what he learned about his emotions and what they did for him. He told me, "In, in my life, I often feel anger. But I learned that anger is only masking my real emotion. Sadness. Which, when I ignore that sadness it only becomes more and more intense. And it grows. That is what leads to my suicidal thoughts." Adam was able to use emotion regulation skills to non-judgmentally observe, describe, and participate in his emotions. He explained how he used this skill now and the impact it had on his life: "I simply notice my sadness, welcome it and not ignore it. Then I feel more in control. Not

it. DBT taught me to control my emotions like that. Not to ignore them but to accept them. “

Interpersonal effectiveness. Adam told me he had had difficulty relating to his peers for most of his childhood. In DBT, Adam learned interpersonal effectiveness skills that helped him communicate easier with his peers. He found the skill of active listening to be helpful, which teaches adolescents to respond to the speaker with verbal feedback and body language such as eye contact. He also described learning keeping the relationship skills, which taught him about validating the other person in a relationship. Self-validation of his own feelings, opinions, and values was also something Adam learned from interpersonal effectiveness skills. When I asked Adam what stood out the most in his experience of DBT, he answered, “Well, to be honest, I would say that learning to accept who I am and learning skills with others was most definitely what stood out in my mind.”

Adam reported that he still uses these skills in his life currently. I asked for an example and he said,

> Actually, I was not “speaking” (he used air quotes) to my best friend before DBT. And after I graduated I reached out to her and now we are best friends again. It was a long story and I won’t bore you with the details, let’s just say we were both at fault. And I suppose maybe I learned. I learned something in DBT that helped me talk to her.

Jade

Background Information

Jade is a 15-year-old female who identified as Korean American and Caucasian. She is of average build, dressed in jeans, high top shoes and a punk rock band tee-shirt.. Jade came to the interview laughing and talking on her cell phone and appeared reluctant

to end the conversation. She continued to check her phone throughout the interview, often interrupting our conversation laughing in response to the texts she received.

Jade did not disclose many details about her personal life. She told me she lives at home with her parents and siblings but did not spend a lot of time with her family. Jade said she did not like school and has always had a hard time academically. Jade described a history of emotional dysregulation. Her inability to manage her emotion, especially anger, contributed to her behavioral problems. Jade talked about her "short fuse," which typically resulted in physical aggression toward others. She has been suspended from school several times; when I asked for what, she said, "Mostly just fighting and stuff." Jade also described explosive arguments with her mother.

Jade denied any history of suicidal ideation or attempts, saying, "I never even thought about killing myself or anything." She did acknowledge engaging in self-harming behaviors. She told me, "I mean like, I never really hurt myself that bad. I just, just when I smoked I would burn my arm sometimes with the cigarette. See?" (She shows me her arm). Jade reported she still does this but less frequently than she used to.

During the interview, Jade was cooperative but appeared distracted, checking her phone often and looking around the room. Her speech was rapid and spontaneous, sometimes making her mumbled words difficult to decipher. She answered my questions nonchalantly and impulsively, often blurting out answers without pausing for thought. Jade discussed her experience in DBT in a less personal way than most of the other participants, focusing mostly on the structure of the program and less on the impact the program had on her. She spoke openly about what she disliked about the program including finding some of the skills "dumb" and family therapy a "waste of time."

Regarding changes in her life after DBT, Jade stated she was "less sad and less mad" than she used to be, fights with her mom less, and has reduced the frequency of self-harming. I appreciated Jade's friendly, laid-back, and sometimes funny personality. For example, when we got to the end of the interview and I asked if she had any questions for me, she pretended to be the interviewer and started asking me questions in a playful way.

Jade's Experience with Dialectical Behavior Therapy

Skills group. Jade said group therapy was her favorite part of DBT. When I asked her why, she said, "It was pretty good for a therapy group. I liked the therapists and some of, some other kids." She said the leaders made group fun, which helped her feel comfortable around the other group members. Jade described how the group leaders created an atmosphere that made her experience in group therapy better. For example, she appreciated that the therapists were not "too strict" and "always made sure we laughed and stuff."

The skills component of group therapy stood out as meaningful for Jade. She liked that the main focus of groups was learning about skills and not on interpersonal discussions. In her words, "I guess I also liked the groups because they were different than just talking about what's our shitty life. The skills we practiced in groups were good." Jade appreciated that by focusing on DBT skills, there was less focus on the individual problems of the group members: "I've been in groups at school and we just share about our lives and it gets too depressing for me. I mean, I don't want to hear about other kids' shit. And I don't think they need to know all my business." I asked her if the

skills she learned in group had impacted her in anyway and she replied, “I feel like I get less angry.”

Jade also appreciated the format in which the skills were taught. She did not have to share examples from her own life if she did not want to. Instead, Jade preferred to learn the skills using the fictitious vignettes provided on the DBT worksheets. She explained, “Um, well you know how we had to use other examples from other kids right? Like other kids’ life, right? Not like our stuff. But you know other fake kids’ stuff, or maybe it was based on real kids, I don’t know.” I asked what was better about this and she replied, “It’s just easier sometimes to think about what skills to do when it’s not about your problem, you know? Like-oh I can help this person- or I know what to do. But for me, it’s harder sometimes.”

One aspect of group therapy that was frustrating for Jade was the groups were co-ed. She reported liking some of the group members: “Although most of the guys were just annoying. It woulda been good if it was just a girls or just a boys group.” She said this was “cause the boys were too damn distracting” and because the girls wanted attention: “I mean, they got all stupid, I mean I did too sometimes but not like those other girls.” Jade described what sounded like typical adolescent behavior but it had a negative effect on her experience in group therapy: “No, but it’s just like, it was, I don’t know, it’s hard to explain, but. I mean it was crazy, I mean the leaders had to try to get us to be quiet. I mean at first it was funny, but later on it got really annoying.”

A negative part of her experience was the homework assigned in groups, which was usually to practice a skill or to complete a worksheet about the skill. Jade found this aspect to be both overwhelming and confusing. She said, “Yeah. I don’t know, just

having homework was really stupid. I mean we have so much stuff to do. It's just too much." I asked if she found any of the homework helpful and she replied:

> Hell no! It's just, I mean, it's just I didn't mind it too much. It's just like I didn't like how there was a lot. And sometimes I'd get it into groups, you know? But then I'd have to fill out all the charts and papers and I couldn't really remember how to do it.

She said part of her confusion stemmed from not understanding some of the DBT language:

> Oh my god. It was like a new language we had to learn. I just did not like that part. It's like, just speak English to us, you know? Maybe I'd change that. Like, no, like make it more real, you know? Like for us to actually understand, not for the people who wrote the books and stuff cause they obviously weren't in high school. (laughs). Stupid people. Like if it's actually meant for teenagers, like write in a language we can actually understand.

Individual therapy. Jade described her experience in individual therapy as "Mm, it was okay." Therapy focused on decreasing her self-harming behaviors and physical aggression, which she called her "mess-ups." She learned to connect her emotions, thoughts, and behaviors through the use of DBT worksheets. Jade remarked, "I had to do a lot of skills and charts. It was different than other therapy in that way. Julie was all about those charts! (laughs)" Jade described using the chain analysis worksheet to understand her antecedents, behaviors, and consequences. She said, "And also sometimes in session we did this thing called a chain thingy and it could get, it gets pretty old. But I guess it helped me. Like, like it helped me notice about my triggers and where I see how it happened. My mess-ups." I asked how it helped and she gave me this example:

> Well there's this one time Julie made me chart why I got suspended at school. I thought I knew cuz I hit this girl. But she made me go way back and we figured it out that I got real mad even before I got to school cuz my mom, she yelled at me about some shit I didn't even do. So I was mad and looking to fight someone, to

> like relieve my stress. But I didn't know that when I hit her, I just got pissed and she was all up in my face by the door, that kind of stuff. If she didn't make me do the chart I wouldn't have known about my trigger with my mom. That morning.

Jade also described using behavioral report cards to track when she hurt herself or had thoughts of hurting herself: "Like, every time I went in and I had to fill out a thing about how I was doing. Like did I want to hurt myself and stuff like that. The ones where you had to mark your mood and whether you cut." Jade's form of self-harming was burning her arm with a cigarette.

She also utilized individual therapy to review the skills homework assigned in group therapy that week. Jade explained:

> Oh. My. God. I HATED that we were supposed to do homework and charts and stuff. I always got in trouble with Julie, my individual therapist, cause I didn't do the stuff so we would do it in my therapy session. It was easier when she helped me, so I just let her do it that way.

Family therapy. Jade expressed ambivalence about her experience with family therapy in DBT. She told me her experience was "shitty, at first. Mom came to me and then didn't come and then came and I was like what's your deal? If I have to go then you have to go. (laughs). But we saw Mary for family and she was ok." Jade said family therapy consisted of herself and her mother. It seemed that Jade and her mother used middle path skills to find compromises and some common ground during their disagreements, which led to an improved relationship.

I asked Jade how their relationship was after DBT and she said, "Mostly it was, it was the same as before but I guess we try to get less angry at each other." I asked if family therapy was helpful and she replied, "Honestly, not really. No, it's just. I don't know. I just felt like why go if it's not going to change anything." However, later in the interview, Jade spoke about the constructive changes she and her mother have made in

their relationship and how these changes have positively influenced other parts of her life:

> Umm. It's changed my life with my mom. She used to, me and my mom used to fight really bad. But now we just fight normal. I mean, we still get mad at each other and stuff. But she doesn't run out of the house all the time and not come back.

Jade's Experience with Dialectical Behavior Therapy Skills Modules

Mindfulness. Jade learned to use mindfulness skills to notice when she was becoming emotionally dsyregulated. She learned how to use deep, mindful breathing to relax her mind and body when she felt herself getting upset. Jade described how she incorporated these skills into her life: "It, just that it taught me that we should calm down before we lose our temper. So, I just make sure I don't get as out of control. So, I just don't even talk. I just try to breath and shit before I lose it."

I asked her if there were any other mindfulness skills she used and she said,

> To be honest, I don't really do it all the time but, I mean, I liked the yoga part. Like, for example, sometimes before bed I try to do the pose where you lie on your back and relax all the muscles slowly in your body. I mean I should do it more often cause it helps me sleep. But I forget, so I don't really do it that much.

Jade told me her mother learned mindfulness skills as well: "She does that too, some but not as much when we were in the therapy."

Distress tolerance. Jade described using distress tolerance skills when she felt herself wanting to act impulsively and harmfully. She learned to use the skill of "walking away," which is when a person feels the urge to self-harm, they engage in an alternative activity for 10 minutes such as walking, drinking a large glass of water, or counting to 100. Jade told me, "Well, it's just like whenever I get really real mad or sad, instead of just doing something right away I wait a little bit. And I'd be like, less mad." Jade stated

that practicing distress tolerance skills had helped her reduce how often she self-harmed. I asked if she still burned herself when she was upset and she said, “Not really. I mean I did like a few weeks ago but it’s not all that bad as it used to be. I used to do it like every day.

She did not think all of the skills were helpful. Regarding other distress tolerance skills, she said, “I don’t think I use some of the other ones, like the one where we hold ice in our hand or can’t eat the M&M till they tell us.” The M&M example she referred to was about having the adolescents experience a “distressing” situation (not being able to eat the candy when they wanted) without acting on their impulses (eating the candy anyway). The holding ice exercise taught adolescents to find alternate behaviors to replace their self-harming behaviors. Instead of burning or cutting themselves, a person squeezes ice in their hand as a way to experience physical discomfort without doing damage. I asked her what she did not like about these skills and she answered, “It’s just, it’s just not really practical. It’s not like you’d do that in real life. Like where would you get the ice? So, that was really stupid.”

Emotion regulation. Jade described learning ways to manage her emotions. She recalled using the “riding the emotion wave” skill, saying, “The one about the wave, something about riding a wave or surfing but it was like you just have to ride it and wait.” This skill teaches adolescents that emotions are temporary and they will pass. She explained further, “I guess I like to picture the wave part and I just ride it on till it gets soft and fades away. Like my anger gets softer, you know?”

Jade described learning about emotions, how to identify them, and what purpose they served. She talked about understanding that her anger was mostly a mask for her

sadness. I asked her if learning about emotions was helpful and she replied, “Uh, yeah I guess so. It made me like less angry and sometimes like less sad. Well, I mean. I mean it would still be the same sad but less than I used to be. I don’t cry as much as I used to. I mean, I still get angry though.”

Interpersonal effectiveness. Interpersonal effectiveness skills help adolescents improve their relationships. Jade described improved communication in her relationship with her mother. I asked if these skills had an impact on other relationships in her life. She answered, “Uh, no. Maybe just not fighting with everyone as much. That’s probably about it.” She told me, “When I fight, I fight less than I usually do. I feel like I get less angry.” Jade attributed this to the changes she has experienced at home with her mother: “I mean, it’s probably because my mom, like me and my mom don’t fight as much at home. So I guess I feel like I don’t want to fight that much at school, too.” Jade told me she still fights at school but “yeah, it’s so much better. But not 100%. It’s starting to get better.” Then in a joking tone, she said, “I haven’t been suspended once this year!”

Jose

Background Information

Jose is a 13-year-old Hispanic male. When he walked into the interview room, he appeared younger than his actual age, wearing baggy athletic clothes over his small, slightly pudgy frame. Jose was immediately endearing in the shy way he constantly flicked his dark brown hair from his forehead where it was covering his dark brown eyes, only to have it immediately flop back down again. He gave me the impression of wanting to come across to others as tough and hardened only to be betrayed by his handsome, babyish, dimple-cheeked face.

Jose lives in a residential treatment center (RTC) where he receives therapeutic care and attends a public school. Currently, Jose is living in a less restrictive unit than the one he lived in while attending the DBT program. Jose has limited contact with his family members and said that some family members visit him but only on the holidays. He told me he has been in and out of treatment facilities since about the age of seven. During early childhood, Jose lived with various family members, moving from place to place. He stated that he does not know the whereabouts of his mother, father, or his siblings and this is a source of sadness for him.

Jose described his main behavioral problem as trouble controlling his anger. He mentioned that when he was younger, he would often be put in a "confinement room" at the RTC until he could calm down and manage his anger. He denied any history of suicidal ideation or attempts. His self-injurious behaviors included punching walls and head-banging, although he reported he had reduced these behaviors significantly in the last six months. He seemed to take great pride in the progress he has made in managing his anger and his success in moving to a less restrictive placement. He proudly told me he now has greater privileges such as playing his X-BOX, which is his most favorite possession.

During the interview, he was initially nervous as evidenced by his constant fidgeting in his chair, lowered eyes, and short, soft-spoken answers. However, as the interview progressed, a natural rapport easily developed between us. Eventually, Jose began to joke with me, moved around the room freely, and shared more about his experience. However, even though he was cooperative, his answers were brief, and he would often just shrug or say "I don't know." Jose spoke in a serious tone about his

family and background but he was generally in a pleasant mood and was friendly with me.

Jose's Experience with Dialectical Behavior Therapy

Group therapy. Jose described having an overall positive experience in group therapy. He appreciated being with other adolescents and seemed to look up to the kids who were older than him. Jose especially connected to group members who had a similar background to his with regard to growing up apart from their families. He reported feeling a kinship with another boy in group: "Like this one kid, James, we both lived in a group home so we kinda felt each other." Jose also noted that along with a sense of connection, he also was able to learn from the other kids in the group. When I asked what he learned from the other kids, he stated:

> Well, like, um I wasn't the only messed up kid, there were like other kids who had to go through bad stuff… but they were okay. Sometimes I learned that other kids have it way worse than me. But at the same time, I felt like they had it the same.

He described a sense of relief that he was not the only kid going through a difficult time and he saw hope in the resilience of other group members. Jose also mentioned he liked the group therapy leaders because they were "nice and funny, like joking with us and making us laugh."

In addition to what he gained therapeutically from the DBT group, Jose also seemed to appreciate his time away from the RTC and the small benefits that came with that. With a big smile, he told me about his absolute favorite thing about group: "Well, the snacks were just good cause they bought like the name brand stuff, like Cool Ranch Doritos and good sodas. Not like at the group home where we always get the generic

stuff, like I don't know Mr. Fizz or something." At the end of the interview, Jose and I visited the vending machines where I happily bought him a Sprite and a bag of Hot Cheetos.

Individual therapy. Jose described his experience in the individual therapy portion of the DBT program as "a lot of work!" Jose told me he liked his individual therapist because "she helped me" and "she was nice." He said most of what he learned about DBT came from practicing skills in his individual sessions. Jose reported his therapy focused on learning new techniques and adaptive skills to manage his anger and decrease his disruptive behaviors. He talked about his volatile temper and his history of escalating to a point where he lost control of his emotions and his actions. He called these explosive anger outbursts his "freak-outs," which resulted in self-harming behaviors such as head-banging, destruction of property, and physical assaults to the staff. When I asked Jose to describe these "freak-outs," he replied,

> Like when I got real mad I would usually just start yelling and then throwing things and then it was like I blacked out. I didn't know what I was doing anymore. Staff would tell me after about the stuff like hitting them or kicking them and I was like, what? I don't even remember doing that. I just went all black with rage and was like a tornado. Even the littlest thing could set me off.

Jose described learning and practicing emotion regulation and distress tolerance skills in individual therapy to address these target behaviors. He reported that although he still gets angry, he uses his learned DBT skills to manage his anger more appropriately.

Jose had difficulty recalling the names of specific DBT skills he learned but he was able to describe how he used them. He told me he practiced the skills he learned in DBT group the next day; if he had difficulty with a skill, he would bring it up in his individual therapy session. Jose seemed to have an earnest desire to learn and utilize the

DBT skills in an effort to regulate his emotions and decrease his "freak-outs." When I asked how DBT helped with this, he reported, "Well I guess DBT taught me to be less out of control with my anger. I can control myself better now, you know. Less freak-outs."

Family therapy. Jose' experience with family therapy was limited by the lack of family members involved in his life. In a sad and serious voice, he told me he did not attend family therapy very often because he did not live with any of his family. Per the DBT manual, caregivers and guardians are also encouraged to be involved in the child's treatment if family members are not available or appropriate. Jose reported that a few staff members from his group home sometimes attended family therapy with him but with a sigh, he said, "It wasn't the same."

Despite his disappointment, he went on to explain it was beneficial to have the RTC staff become familiar with the language of DBT and the specific skills he was learning. Jose felt it was easier for him to use his new DBT skills at the RTC when staff members could support him with DBT prompts when they saw his negative behaviors escalating. He said, "…only like two staff knew it but they'd always be like 'Jose, use your wise mind!' (laughs) They were funny, they got into some of that stuff." Jose reported that middle path skills he learned in DBT helped him compromise when he was negotiating with his staff members at the RTC.

Jose's Experience with Dialectical Behavior Therapy Skill Modules

Mindfulness. Jose's experience with mindfulness involved learning to pay attention to how his emotions were expressed in his body. He recalled learning to notice how his body felt in certain situations. Jose was able to connect how when he was angry,

his body responded with clenched fists. He told me this became his "tell-tale" or his signal he was becoming angry. When Jose was mindful of his body changing, such as his fists beginning to clench, he used mindfulness skills to calm himself down. One skill he mentioned was "taking really big deep breaths." He eagerly demonstrated this for me, holding his breath in with full cheeks, placing his hand over his belly, and then releasing with a long, deep sigh. He seemed to take pride in his mastery of this skill and the chance to showcase it. When Jose was mindful of his fists beginning to clench, he was able to use deep breathing to calm himself down.

Distress tolerance. Jose explained to me that since the DBT program, he has found healthier ways to respond to distressing situations. He denied any history of suicidal attempts or ideation. When asked about self-injurious behaviors, he said, "Well, for me I never cut or anything" but he did describe a history of head-banging and punching walls until his hands bled. He reported his typical reaction to distressing situations was to have a "freak-out," which involved becoming physically and verbally aggressive toward others and/or engaging in property destruction. I asked if he still responded to distressing triggers that way and he said, "Nah. Not really, there was one like two months ago but it never got bad like it used to, I just punched a wall but it didn't make a hole or anything, I kinda punched it light." He said DBT helped him decrease the number of incidents he had at his RTC but also attributed this change to getting older: "Also I just grew up some. I'm older now and that helps."

Interpersonal effectiveness. Jose reported that interpersonal effectiveness skills had an impact on his life by improving relationships with staff members at his RTC. He cited his improved ability to use DBT skills to regulate his emotions and express himself

more effectively as the reason for this improvement: “I guess I don’t get in trouble as much, so that helps with my staff. They don’t get so frustrated with me because I don’t have the big blowups like I used to. So I guess those relationships are better.”

Emotion regulation. Jose learned skills to help him manage his emotional reactions when he experienced negative life events. He told me using skills had increased his sense of control over his life: “Um, I just feel more in control of my life. Like it’s not all spinning and crazy, like before. Like, like I think it was a good program and I learned stuff.” He added with a laugh, “And also I am just more mature now.” When I asked Jose to give me an example of using these skills, he told me about a specific strategy he and his individual therapist came up with in DBT:

> I learned about controlling your emotions so, um, they don’t control you. I practiced having a remote control for myself so if I got too mad I could just turn it down with my remote, well, like using buttons. (Laughs) I just learned that it’s like a volume on a TV. Like you can make an emotion louder or quieter so I just try to do that when I feel myself getting angry. So, I turn the anger volume down.

He said he also learned to understand that his feelings are normal:

> I just know that it’s normal to get mad at stuff that happens to you but it’s like not normal to totally freak out and like throw chairs or something. Well, uh, the part where it’s like normal to get angry, because like everyone does get angry. But, uh, well what like you do with anger and emotions can be bad. So it’s normal to be angry but you have to learn how to handle it.

Summary

In this chapter, I presented each of the individual participant’s experiences with DBT. I described their experiences with the three treatment components as well as the five skill modules. Additionally, I provided background information and behavioral observations to aide in the thick, rich description of the narrative. In the next chapter, I present the overall experience of adolescents in DBT. Findings are presented as themes

that emerged from the participants' shared experiences and are organized following the DBT structure.

CHAPTER V

FINDINGS: SHARED EXPERIENCES

The purpose of this qualitative study was to understand how adolescents experienced dialectical behavioral therapy (DBT) in a community mental health setting. The following research questions guided this study:

Q1 How do adolescents experience DBT in a community mental health center?

Q2 How have the lives of adolescents been impacted by completing a DBT program?

Q3 How are the skills learned in DBT being used by adolescents after treatment?

I investigated these questions through a constructivist lens, allowing each participant to bring their own unique meaning to the experience of DBT (Crotty, 1998). Chapter IV presented the research findings of each participant's individual experience of DBT. In this chapter, I present the research findings of the nine adolescent participants' shared experiences of DBT. The findings are organized into themes related to the three therapy components, the skill modules, and negative experiences / suggestions for improvements (see Table 2).

Table 2

Themes Related to Components of Dialectical Behavioral Therapy and Negative Experiences

Component	Themes
Skills Group Therapy	Benefits From Group Members • normalizing effect • support, • parallel experiences. Valued Elements of Group Therapy • group leaders • confidentiality • emphasis on skills
Individual Therapy	The Therapeutic Relationship Validation and Acceptance Change-Oriented Techniques
Family Therapy	Invalidating Environment Inconsistent Involvement Benefits and Use of Skills
Mindfulness Module	Mindful breathing Noticing the Body/Mind Connection Participating in the Moment
Distress Tolerance Module	Crisis Survival Skills Radical Acceptance
Emotion Regulation Module	Understanding Emotions Skills to Decrease Emotional Vulnerability and Distress
Interpersonal Effectiveness Module	Improved Relationships
Themes Related to Negative Experiences or Suggestions for Improvement	Difficulty with DBT Terminology Group Demographics Duration and Frequency

Themes Related to Treatment Modality

Themes from Group Therapy

The participants in this study all described skills group therapy as a significant part of their experience of DBT. Two major themes emerged from the data. The first theme was Benefits From Group Members with three subthemes of *normalizing effect, support,* and *parallel experiences*. These themes were all related to the participants' experiences with other adolescents in the skills group. The second major theme was Valued Elements of Group Therapy with three subthemes of *group leaders, confidentiality* and *emphasis on skills*. These themes were related to how the participants experienced specific elements and components of DBT group therapy.

Benefits from group members.

Normalizing effect. The experience of DBT skills group was normalizing for many participants. Six participants described a sense of relief knowing they were not alone in their negative thoughts, depressive feelings, and dysfunctional behaviors. Casey shared her experience: "It's like I finally realized other people go through the same things I do. And it's not just me." Hearing group members describe emotional difficulties helped Davey "feel more normal." Jose felt less like "a messed up kid" when he learned other adolescents had similar thoughts and feelings to his own: "I would be like, that's what I feel! Or like, he does the same as me! So it's not just me." Adam said knowing other people had experienced suicidal thoughts made him feel "less alone" and less "like such a freak." Anna experienced normalization as comforting:

> Like with my thoughts and stuff before, I was like something has to be wrong with me. Like, I'm totally not normal. Like, no normal person would like think like I did or feel like I did, I thought I was just super fucked up. But like after

> the program? It's like it's not just me. Other people had those fucked up thoughts too. And like, like sometimes even more than me.

Receiving and providing support. All of the participants experienced group therapy as a source of emotional and behavioral support. When Selena doubted her ability to use interpersonal effectiveness skills with her father, the group provided her with encouragement and confidence. The group supported Tara when her mother was incarcerated. Four participants described depending on the group when they could not find support anywhere else in their lives. Casey told me "other people in my life really didn't want to hear about my depression. Like, they just got sick of it all the time." She turned to the group for support: "They were there for me. They would just remind me that I have enough strength to fight through my darkness. They helped me stay strong."

Five participants stated they were a source of support for other group members and found it to be a rewarding part of their DBT experience. Casey told me about sharing her journal entries with the group: "They thought it was cool. And I think it might have helped some of them. To start finding other ways to get things out." Adam said he used his "own experience to help others so they don't have to go through what I've gone through."

Parallel experiences. Another subtheme of benefits from other group members was participants were more likely to form connections with other adolescents who came from similar backgrounds or had parallel experiences to their own. Six participants found it easier to talk about their problems with group members who could identify with their life experiences. These participants described a feeling of kinship and unique understanding with group members with personal backgrounds and histories comparable to their own. For example, Tara related to other group members who also experienced

unstable childhoods and had lived with many different relatives growing up: “A lotta kids there knew what it was like to have a messed up family.” Jose described how having another adolescent from a residential treatment center was helpful: “Like this one kid, James, we both lived in a group home so we kinda felt each other.” He described the shared experience of not living with parents: “Like, we didn’t talk about our moms and dads that much cause we lived with a bunch of other kids. And he kinda got me. He knew what it was like for me kinda, and I kinda knew what it was like for him, so that made it better.”

Group leaders. Five of the participants reported the therapists (group leaders) contributed positively to their experience of DBT. Jade explained, “Lots of therapists are either annoying or the groups are really boring and strict. These therapists were kind of funny, especially Sarah, she always made sure we laughed and stuff. Not too strict on us. You know?” Davey also experienced DBT differently than other groups he had been in:

> I’ve had other groups where the leaders were real strict and yelled at you anytime you talked or whatever, like you were in school or prison or something. But these ladies were really cool. They didn’t yell or anything. And they didn’t make you feel too dumb about the therapy stuff.

Tara, Selena, and Jose agreed that “fun” and “nice” therapists made a difference in their experience of group therapy.

***Confidentiality*.** Several participants described a sense of safety and trust in group therapy because of the policy of confidentiality. Selena described this policy: “One of the group rules was what was said in group stayed in group.” Four participants reported feeling safe discussing their problems in group therapy because of the nonjudgmental environment. Five participants reported that confidentiality contributed to

an atmosphere of trust and an increased willingness to share personal aspects of their lives.

Tara was more comfortable discussing her personal her problems, knowing that what she said would remain confidential: “But for real, it was just good to be with other kids that could, like, understand you but didn’t really know you. Like groups at the group home were real weird cause you didn’t want everyone knowing all your shit, or problems I mean. But at DBT I could talk about it ‘cause nobody knew me or my mom.” I asked Tara what was helpful about this and she answered, “It felt a little safer, I guess. Like, if my mom and I were fighting. I talked to the group about it, not at first but once I felt like I could trust them. It felt safe.”

Emphasis on skills. One theme that emerged from the data was participants responded positively to the skills-based format of group therapy, especially the opportunity to practice new skills. Seven of the participants seemed to appreciate the focus of the group was on learning and practicing new skills as opposed to discussing their problems in an interpersonal group format. For example, Jeremy was wary of bringing a personal problem to the group for fear the leaders would “go all deep and shit into my problems. I really didn’t want that.”

Four participants stated practicing skills with other group members was the only way they understood how the skill worked and was more effective than the didactic portion of group where the leaders taught the skill because just hearing about it from the group leaders was not as effective. Anna highlighted the importance of learning new skills and said it was the most helpful aspect of group therapy: “It was mostly about, like, coping skills. Like, instead of this I can do x, y, and z instead of cutting. Like doing

something new instead of getting all worked up or freaking too much. That helped more than talking did."

Adam expressed his appreciation of the skills-based format of DBT:

> Well, you see, some, most therapies, they mostly involve talking. Communication. I don't do well in that type of therapy. But the thing about DBT was that it appealed to the logical side of my mind. It was like here are the skills and here are steps you should take: A followed by B followed by C. That worked better for me personally.

Themes from Individual Therapy

Themes that emerged from experiences with individual therapy included the Therapeutic Relationship, Validation and Acceptance, and Change-Oriented Techniques.

Therapeutic relationship. The majority of participants experienced positive change through the relationship with their individual therapist. Casey, Selena, Jose, Adam, Jeremy, and Anna described feeling "understood" by their therapists and said the therapeutic relationship contributed to their ability to change. Casey experienced growth in therapy because her therapist was engaged and invested in her progress. She said, "It was nice to actually be heard. Like, I knew she truly cared about me, and that made all the difference."

Jeremy appreciated that his therapist did not judge him for his mistakes, which allowed him to be more honest in therapy. He stated, "She was always so nice, no matter how bad I fucked up. I mean I got locked up twice and she never game me shit like everyone else." Adam's experience in DBT was positive, largely because of his relationship with his individual therapist: "To be honest, it was mostly Alison. She was the best therapist I have ever had. And I've had many." Adam reported that individual therapy was the most meaningful part of his DBT experience.

Acceptance and validation. All of the participants experienced acceptance and validation in individual therapy. Adam experienced acceptance by his therapist as significant. He said, "Alison did not see me as a freak. She fully accepted me for who I was. For example, she brought me a nice eyeliner she got for free in a gift basket or something of that caliber. It was incredibly meaningful to me." Casey said her feelings were validated and not dismissed. Jeremy was surprised to experience nonjudgmental acceptance from his therapist: "Like, how she didn't judge me for getting locked up or nothing. It didn't matter. And I wasn't used to that." Davey told me acceptance played a large role in his experience of DBT: "That's where I think DBT helped me, with the accepting my life."

Change-oriented techniques. Every participant described their experience with DBT change-oriented assessments and techniques with varied reactions. Many participants found the therapeutic tools, such as the charts, diagrams, and worksheets, to be frustrating but also helpful. For example, Jade described her experience completing a behavioral chain analysis with her therapist: "We did this thing called a chain thingy a lot and it could get…it gets pretty old. But I guess it helped me. It helped me notice about my triggers. If she didn't make me do the chart I wouldn't have known about my trigger with my mom." Tara said her therapist used DBT materials in therapy to focus on decreasing physical aggression. She explained, "Julie was real big on doing the charts. I never really understood those charts, it seems like a big fucking pain, but she always made me do em." Despite her dislike of the exercise, Tara admitted, "Sometimes it was good 'cause we'd work out some bad situation that I had that like that week. Like a fight with some bitch at school or something. It'd, like, help me understand about my anger."

Four participants said they filled out diary cards to monitor their suicidal thoughts and self-harming behaviors. If they engaged in self-harming behaviors, they then completed a behavioral chain analysis. Jade said her therapist was "all about those things" and she completed a chain analysis almost every session. Selena's therapist used a life worth living worksheet with her in individual therapy, which she described as "weird" but useful "if I need to make myself feel happier." Jose said that charting the antecedents, behaviors, and consequences of his "freak-outs" was tedious but helpful because it led to fewer incidents at his group home.

Themes from Family Therapy

Themes that emerged from experiences with family therapy were Invalidating and Uncomfortable Experiences, Inconsistent Involvement, and Benefits and Use Of Skills.

Invalidating and uncomfortable experience. Six participants described invalidating home environments and high levels of conflict in their families. Four of the six participants who attended therapy with their families regularly described their experience as "uncomfortable," "terrible," and a "time I could have done without." Casey told me her family had a tendency to ignore negative emotions and "just hope things get better." She said it was awkward discussing her self-injurious behaviors in family therapy because

> no one really knew what to say about it. Everyone was just numb. There was no feeling. Everyone sort of had dead eyes. Like no one knew what to do. It was just a hard time. My family, they weren't ready to deal with how depressed I had been.

Family therapy was uncomfortable for Jeremy because he had difficulty being honest and open with the therapist in front of his mother. He explained, "Like, I'd talk and, um I didn't want my mom to hear some of the stuff I was telling her. I didn't want

her to like judge me, or anything." Adam described a negative experience in family therapy because he felt his parents, especially his father, did not accept who he was, including his sexual orientation. He added that it was uncomfortable for everyone when they discussed his past suicide attempts: "It was mostly my mother talking, me crying, and my father…sitting in stalk silence. That was a time I could have done without." Adam and three other participants said that discussing suicide and self-harming behaviors was difficult in family therapy.

For Selena, family therapy was uncomfortable for two reasons. The first was her level of discomfort when her step-father attended the sessions: "It was weird. Because like I was always real uncomfortable when my step-dad was there. I didn't care about my brother or mom being there because they are my real family. We're blood." The second reason was related to the cultural values of her traditional Hispanic family: "Well, it's like in Mexico there's this kind of different way to, to be with your family. It's like you don't really talk much about your family problems with anyone. It's like we don't really believe in therapy that much." As an example of her uncomfortable experience with family therapy, Selena told me her mother got angry with her after one session because she shared something personal about the family: "It's like, something that my mom calls *indescreta*. It basically means you should keep your stuff to yourself."

Inconsistent involvement. Four of the participants' experiences of DBT were impacted by infrequent family therapy sessions or no sessions with family due to lack of involvement in the participants' treatment program. For varying reasons, these participants did not receive much of the family therapy component. Davey reported his family sessions were terminated due to domestic violence between his parents. Jade's

mother was inconsistent in her attendance to family therapy, thus Jade only experienced a few sessions. She explained, "Mom came with me and then didn't come and then came and I was like what's your deal? If I have to go then you have to go." Two participants did not live with family members, thus their programs were adapted. Jose lived in a residential treatment center and his family was not involved in his treatment. He told me some of the staff members came to family therapy occasionally. Tara lived in a group home and reported going to family therapy about two times "only when my mom was on parole. She's locked up now. She's a stupid bitch, but when she was living at my aunt's house she would sometimes come over with my case worker." These four participants experienced a different DBT program than other participants because of infrequent or absent family involvement.

Benefits and use of skills. Six participants stated they experienced positive changes from family therapy. They found it helpful when their caregivers learned DBT skills and aspects of the program. Jeremy said his family therapist taught his mother some of the DBT skills. He said this improved their communication: "My mom and I talk better to each other, I guess. Like, more nice." Selena stated her family had a better understanding of her self-injurious behaviors once they learned about distress tolerance skills. Jose reported it was helpful for his staff members to be familiar with DBT because they reminded him to use his skills at the RTC. He reported being prompted to use his emotion regulation skills when his negative behaviors were escalating: "They'd always be like 'Jose! Use your wise mind!' I mean it helped so I wouldn't forget to do it. They'd just keep reminding me." Jade and her mother learned emotion regulation skills in family therapy to diffuse the level of hostility in their arguments. She said using these

skills improved their relationship: “It’s changed my life with my mom. She used to, me and my mom used to fight really bad. But now we just fight normal. I mean, we still get mad at each other and stuff. But it’s way better.”

Themes Related to Skill Modules

Themes that emerged from experiences with the mindfulness module included Mindful Breathing, Noticing the Mind/Body Connection, and Participating in the Moment.

Mindfulness Module

Mindful breathing. Eight participants found the mindful breathing skills to be helpful in regulating their emotions. They reported a decrease in their anger when they focused on their breath. For example, Jade used the skill by counting her in-breaths and out-breaths during arguments with her mother. She said the breathing helped calm her down: “I just try to breath and shit before I lose it.” Selena used this skill when she herself becoming overwhelmed with emotions: “I just like try to like, uh, breath slow, take deep breaths. And pay attention to them. It helps calm me down.”

Noticing the mind/body connection. Five participants described a mind/body connection in their experience of mindfulness. Jose said mindfulness was “paying attention to what my body is doing when I get mad.” He used mindfulness to observe the physical signals his body was giving him about his emotions: “Well, my fists get balled up when I’m mad. I learned to notice it when it happens so it tells me I’m getting mad.” Casey used mindfulness in meditation, which calmed her mind and body down. However, she admitted that mindfulness without judgment could be difficult: “I can’t be

too mindful, because after that place of calm then it leads into darker thoughts and they start coming back and I start thinking too much and I end up in that same place."

Three participants described mindful physical exercises, such as yoga or progressive muscle relaxation, to be helpful in decreasing their stress. Jade said, "Like, for example, sometimes before bed I try to do the pose where you lie on your back and relax all the muscles slowly in your body. I mean I should do it more often cause it helps me sleep."

Participating in the moment. Seven participants described using the mindfulness skill of participating in the moment, which teaches adolescents how to increase awareness and be fully engaged in the present moment. Jeremy described participating in the moment: "Don't live in the past or the future, you just gotta live in the present." Reminding himself of this helped Jeremy let go of painful experiences from his past and eased his fears about the future. For Casey, focusing on the present moment helped decrease her urge to self-harm when she was emotionally dysregulated. Selena said participating in the moment decreased her impulse to flee from distressing events in her life: " Mindfulness helps because I try to think before I act now. Like running away used to be my first reaction to everything."

Distress Tolerance Module

Two themes emerged from experiences with the distress tolerance module: Crisis-Survival Skills and Radical Acceptance.

Crisis survival skills. Seven participants used distress tolerance skills to replace self-injurious behaviors with healthier coping skills. Casey discovered that keeping a journal during her DBT program was a way to manage the urge to self-harm. She said

journaling was “sort of taking the place of cutting” because it was another form of release. She added it was safer too: “You can just get it out without hurting anyone or yourself.” Casey also engaged in creative activities to tolerate distress: “Poems, drawing, artistic stuff, that kind of thing. It’s calming. It calms me down. And even if I’m still sad, I can be sad but in a way that’s not going to do damage. I can be sad on paper instead of on my skin.”

Selena said she no longer cuts herself because she uses alternative coping strategies: “I just joined my church choir and I get a lot of support there. And singing is a way for me to release those kinds of things in my life. I don’t need to cut to feel anymore.” Adam and Tara used self-soothing techniques to prevent impulsive behaviors when they were experiencing a crisis. Tara was able to block thoughts of self-injury by engaging her senses with scented lotions and Adam covered himself with a heavy comforter. Anna shared a distress tolerance skill she used: “A really good one, was I learned that if you wait something out it usually will pass. So instead of going straight to cutting, wait 10 minutes and if you still feel like that, wait 10 more minutes. Even though most of the time I didn’t feel like it was going to work, it helped.”

Four participants used the reaffirming personal values skill as a way to combat suicidal ideations or urges to self-harm. For example, Selena created a list of reasons to live and what she valued in life so she could review them when she had the urge to cut herself. Three participants reported using diary cards in therapy to track self-injurious behaviors and suicidal ideations.

Radical acceptance. Five participants discussed the concept of radical acceptance in their experience of DBT. Radical acceptance helped these participants

non-judgmentally accept (but not condone) emotional pain from situations they could not change. For example, Jeremy described accepting the abuse he experienced in childhood: "I get real down on myself sometimes, about when I was a little kid, what happened and everything. But I had to learn to accept it. It's fucking impossible but I had to." Selena and Tara were able to cope more effectively with their environment by accepting the situation instead of struggling against it. Adam practiced radical acceptance of his father's disapproval of homosexuality. Although he did not agree with how his father treated him, Adam realized wishing things were different was only contributing to the emotional pain that led him to engage in self-injurious behaviors. Davey vividly described what radical acceptance meant to him:

> It's like life will be painful but it's stupid to just ignore it or only to get mad about it. And that's the thing about acceptance. It's two parts. First it's the noticing, the seeing what's going on with you cause you can't just stay blind, with your eyes closed, ears shut and all that, you have to open up and look around. But that is really hard, especially when you've had the fucked up childhood like I did. I mean it can suck, like really suck and be painful and hurt but it's the first step. I feel like you're hurting anyway just ignoring all the pain you've been through in your life. Things that happened to you, like abuse and stuff. Those things, those things will never go away. Trust me, I've spent many years staying high trying to forget what happened to me but when I sober up, it was still there. You can't change the past or anything at all. Really shitty things that may have, that happened to you, like things that happened to me. (Sigh.) As much as I want them to change, they won't. So then the second step is that you should stop self-destructing and move on.

Emotion Regulation Module

Themes that emerged from experiences with the emotion regulation module included Understanding Emotions and Skills to Decrease Emotional Vulnerability and Distress.

Understanding emotions. Five participants learned how to more effectively identify, understand, and experience their emotions non-judgmentally. Selena said,

"DBT taught me how to learn more about my emotions. And other people's emotions, too." Adam also reported an improvement in his ability to correctly label emotions but added, "To be honest, that is something I still struggle with." Three participants found the group therapy game *emotion charades* to be a challenging but helpful activity in labeling different emotions. Tara learned she was more emotionally vulnerable after conversations with her mother and identified her feelings as disappointed and rejected.

Along with identifying emotions, five participants described the skills of observe emotions, which is acknowledging and experiencing feelings without judgment. For example, both Davey and Jose found the exercise of simply experiencing their emotion without judging themselves for having the emotion to be internally validating. Adam described his experience of non-judgmentally observing and experiencing sadness:

> Which, when I ignore that sadness it only becomes more and more intense. And it grows. That is what leads to my suicidal thoughts. However, I simply notice my sadness, welcome it and not ignore it. Then I feel more in control. Not it. DBT taught me to control my emotions like that. Not to ignore them but to accept them.

Skills to decrease emotional vulnerability and distress. All nine participants described using emotion regulation skills to decrease their emotional vulnerability and distress. Jose described his experience: "We learned about controlling your emotions so they don't control you. I practiced having a remote control for myself so if I got too mad I could just turn it down with my remote." I asked him to explain how this skill was helpful and he replied, "Well, it's like using the buttons. (laughed) It's like a volume on a TV. Like you can make an emotion louder or quieter. So I just try to do that when I feel myself getting angry. Turn the anger volume down." Jade said she liked the riding

the wave skill, which teaches adolescents that emotions are temporary and they will eventually pass. She explained,

> Well, it's just like whenever I get really real mad or sad, instead of just doing something right away I wait a little bit. I guess I like to picture the wave part and I just ride it on till it gets soft and fades away. Like my anger gets softer, you know?

I asked Jade if using this skill helped regulate her emotions and she replied, "Uh, yeah I guess so. It made me like less angry and sometimes like less sad. Well, I mean, I mean it would still be the same sad but less than I used to be. Like, I don't cry as much as I used to. I mean, I still get angry though."

When Selena was feeling emotionally vulnerable, she used skills to increase positive emotions such as the fake it til you make it skill. She said, "I just kinda picture myself being happy. Like even if I have to fake being happy I just try to feel happy. Or I like tell myself things that are positive in my life." Tara used the imagery skill to increase her positive mood. She elicited feelings of happiness and relaxation by looking at the picture of a tropical island she drew during DBT skill group and imagining she was on a vacation from her problems. Casey also improved her mood by using the skill of focusing on the positive emotions. She explained, "I can cling to that tiny bit of light and the small moments when I can feel, like happy or just bliss. Even if the big picture is bad. If there's just a couple good things. And you can hold onto those and hope that there's just gonna be more."

Interpersonal Effectiveness Module

Eight participants reported an improvement in their relationships due to having more effective communication skills. Four of these participants said their relationships with their parents/caregivers improved. For example, Selena used interpersonal

effectiveness skills to improve communication with her stepfather. She said by utilizing self-respect, assert, and express skills, "I learned how to talk to him in a way that he would listen."

Adam used interpersonal effectiveness skills to repair a relationship with his best friend: "Actually, I was not "speaking" (he used air quotes) to my best friend before DBT. And after I graduated I reached out to her and now we are best friends again. I learned something in DBT that helped me talk to her." Adam described using the skills of validating the other person and having an easy manner. Jeremy focused on improving relationships in his life by being nonjudgmental and not jumping to conclusions about them. He explained,

> I mean I tried to get to know how people were. How or where they were coming from, ya know? Like I tried to think maybe I don't know about their life just like they don't know about mine. So ain't nobody can judge me and I tried to do that to other people.

Anna and Jade both described using interpersonal effectiveness skills in school. Anna said she had poor relationships with her teachers because she "got in a lot of trouble for my mouth, for like saying rude things." Using the GIVE skills, she was working on improving these relationships: "I 'm getting better at it." When I asked Anna if she noticed a change at school, she said, "Like a little. But, like, I still talk pretty bad to my teachers." Jade reported she is fighting less at school because of improved relationships in her life. She explained, "It's probably because my mom, like me and my mom don't fight as much at home. So I guess I feel like I don't want to fight that much at school, too." Like Anna, Jade said fighting at school was still an area she was working on: "It's starting to get better, so much better than it was, but still not 100%."

Middle Path Module

Only three participants recalled the Middle Path module and only one participant described using skills from this module. Selena described examining the dialectical dilemma of "too loose or too strict" during a family therapy session. She reported that she and her parents worked toward a compromise: "Like they had to give me my own space because I am growing up. But I like had to follow their rules better." I discuss possible reasons for the lack of themes related to this module in the next chapter.

Suggestion for Improvement/Negative Experience Themes

Problems with Dialectical Behavior Therapy Terminology

Seven participants had difficulty with the terminology used in DBT. Casey said, "It was hard to keep track" of the skills taught in group therapy because the acronyms were confusing. When I asked Anna about using DBT skills, she shared, "Like, to be honest, I don't really remember what they are called or anything. Like, the names were all crazy like MAN and other letters that I'm supposed to remember." Jose told me, "I don't really know the names of any of those skills. I couldn't really remember them, they had hard names to remember." Jade described being frustrated by the DBT terminology:

> It was like a new language we had to learn. I just did not like that part. It's like, just speak English to us, you know? Maybe I'd change that. Like make it more real, you know? Like for us to actually understand, not for the people who wrote the books and stuff cause they obviously weren't in high school. Yeah, like if it's actually meant for teenagers, like write in a language we can actually understand.

Five of the participants needed help to understand the ideas, skills, and theories taught in group therapy. These participants had difficulty comprehending or were confused by certain DBT concepts but were too embarrassed or shy to seek clarification

during group therapy. Instead they relied on their individual therapist for help. For example, Jade explained, "I'd get it (the skill) in the groups, you know? But then I'd have to fill out all the charts and papers and I couldn't really remember how to do it. But Julie reminds me and I get it. It was easier when she helped me."

Group Demographics

Five participants stated their experience was negatively impacted by the demographics of the adolescents in skills group therapy. For three participants, having younger adolescents (age 12 or 13) in the group was distracting. Adam shared his experience: "I felt like I was not able to fully express my issues in the group because there were some very, very immature people in there." Anna said that some of the discussions in group therapy "about, like, adult stuff "were not appropriate for the younger adolescents and suggested separating into smaller groups based on age. Two participants said they wished the group was comprised of just their own gender because it was distracting having members of the opposite sex there.

Duration and Frequency

Six participants thought the duration of the DBT program was too long and the frequency of therapy sessions interfered with other parts of their lives. Jeremy said, "The program was like, fucking forever!" Anna stated, "Like, no offense but it was like, really long! Super long." Tara said she was not able to do things with her friends because of the time commitment required of the DBT program: "I had to go there all the time. It felt like I was always at the Center." According to Jade, attending individual, family, and group therapy was "a major time suck" because it cut into her time for extracurricular activities. When I asked Jose if he had any suggestions to improve the program, he

replied, “I’d probably make it shorter and go less often. It was like I was there every day. It was like I felt like I was there all the time.”

Summary

In this chapter, I presented findings from the participants’ shared experiences of DBT. I reviewed themes from each treatment modality (group, individual, and family) and themes from each skill module (Mindfulness, Distress Tolerance, Emotion Regulation, Interpersonal Effectiveness, and Middle Path). Additionally, I presented themes related to the participants’ suggestions for improvement of the DBT program. In the next chapter, I provide a discussion of the findings, review the implications and limitations, and suggest directions for future research.

CHAPTER VI

DISCUSSION

The purpose of this qualitative study was to understand, through a constructivist lens, how adolescents experienced a dialectical behavior therapy (DBT) program in a community mental health setting. This chapter contains a summary of the study, discussion of the findings, implications and limitations of the study, as well as directions for future research.

Summary of the Study

Adolescents are increasingly seeking psychological treatment for recurrent suicidal ideation, suicide attempts, and self-harming behaviors (Grunbaum et al., 2004). These dangerous behaviors along with trouble regulating emotions, poor interpersonal skills, and difficulty tolerating stress are common symptoms among adolescents receiving intensive outpatient services in a community mental health setting (Becker et al., 2002; Gould et al., 2003).

Clients presenting with self-harming behaviors and suicidality can be a challenge for therapists in community mental health settings because of the complexity of symptoms, likelihood of hospitalization, and the lack of empirically supported treatment interventions available (Koons et al., 2001; Miller et al., 2007). The treatment approach with the most empirical support for treating suicidal and self-harming adolescents is dialectical behavior therapy (DBT; Linehan, 1993a). In 2007, Miller et al. created a

standardized manual, *The Adolescent Adaption of Dialectical Behavior Therapy*, as a modified treatment for suicidal and self-harming adolescents.

Using this manual, several studies have found DBT to be an effective treatment for adolescents with suicidal and self-harming behaviors (Groves et al., 2012; Linehan, 1993b; Robins & Chapman, 2004). While these studies are promising, a lack of research remains that investigates DBT from the subjective experience of adolescents (Katz et al., 2004). Therefore, this qualitative case study explored how adolescents experienced a DBT program in a community mental health setting.

Nine adolescents of varying cultural backgrounds participated in this study. Five of the participants were female and four were male; they ranged in age from 13- to 18-years-old. The participants in this study had diverse ethnic backgrounds including Caucasian American, Asian American, and Hispanic American. All participants completed a 16-week intensive outpatient DBT program at a community mental health center in the Midwest region of the United States.

The following research questions guided this study:

Q1 How do adolescents experience DBT in a community mental health center?

Q2 How have the lives of adolescents been impacted by completing a DBT program?

Q3 How are the skills learned in DBT being used by adolescents after treatment?

Overview of the Dialectical Behavior Therapy Program

All participants in this study completed a comprehensive, multimodal, 16-week DBT program in an intensive outpatient setting, comprised of three treatment modalities: skills group therapy twice a week, individual therapy once a week and family therapy

approximately twice a month. The structure of the program was based on the manualized treatment approach for suicidal adolescents, *The Adolescent Adaptation of Dialectical Behavior Therapy* (Miller et al., 2007).

Discussion of the Findings

In Chapter IV, I presented the findings of individual participant experiences and in Chapter V, I presented the shared experiences of the participants. In this section, I provide a discussion of these findings, focusing on the participants' overall experience of DBT including experiences related to treatment modalities, skill modules, and negative experiences/ suggestions for improvement. Throughout the discussion section, I relate findings from the adolescents' experiences to back research and theories of DBT including the biosocial theory of borderline personality disorder, adolescent development, and self-harming behaviors.

Experiences Related to Treatment Modalities

Experiences in skills group therapy. The participants in this study all described skills group therapy as a significant part of their experience of DBT. Two major themes emerged from the data. The first theme was Benefits from Group Members with three subthemes of normalizing effect, support, and parallel experiences. These themes were all related to the participants' experiences with other adolescents in the skills group. The second major theme was Valued Elements of Group Therapy with three subthemes of group leaders, confidentiality, and emphasis on skills. These themes were related to how the participants experienced specific elements and components of DBT group therapy.

Benefits from group members.

Normalizing effect. Six participants experienced a normalizing effect from skills group therapy. These adolescents described normalization as knowing they were not alone in their negative thoughts, depressive feelings, and/or dysfunctional behaviors. This finding was similar to research with adult DBT groups in which participants found the group therapy component to be normalizing (Koerner & Linehan, 2000; Safer et al., 2009). According to Yalom's (2005) theory of group therapy, this experience was labeled as universality because the problems individuals were experiencing were often universal human concerns. Several participants experienced a sense of relief in expressing their emotional struggles to the group. It has been suggested that the act of sharing painful emotions with a supportive group and realizing others share that pain can be cathartic (Linehan, 1993a; Yalom, 2005).

This finding of normalization supported research demonstrating that the act of disclosing self-injurious and/or suicidal behaviors to other suicidal adolescents could be therapeutically beneficial (Katz et al., 2004). Conversely, research has shown that withholding this information only contributed to the intense isolation and loneliness often felt by adolescents who self-harm (McDermut, Miller, & Brown, 2001).

Participants reported that talking about suicidal ideation and self-harming behaviors was challenging. This finding fits with the literature identifying these areas as sensitive topics that are socially stigmatized (Nock et al., 2007). Research indicated that adolescents who engaged in self-harm or who had made suicide attempts were reluctant to talk about those behaviors because it brought up feelings of guilt, shame, and negative

self-esteem (Nock, 2010). Participants in this study reported experiencing all of these feelings when discussing their suicidality.

*Support***.** Receiving and providing support among group members was an experience all participants reported as meaningful. These adolescents said that group therapy was a unique source of emotional, behavioral, and social support. Most of the participants stated their families and communities were not available, willing, or able to provide them with the support they needed. Research has shown that this experience is common among adolescents being treated within a community setting (Theisen, 2007).

Participants reported they received emotional support from group members when they were not able to receive it from others in their lives. The theme of support was also identified in a qualitative study investigating the experience of DBT with adult women diagnosed with borderline personality disorder (BPD) in Australia (Cunningham et al., 2004). Participants in this study consistently expressed the support they received in group therapy was one of the most helpful aspects of DBT (Cunningham et al., 2004).

In alignment with the principle of altruisim, five participants also described the experience of wanting to support other adolescents in group therapy (Yalom, 2005). The participants described this experience as "give something back" to the group, either through encouraging words, sharing helpful advice, reading their poems, or "just being there." Participants described the experience of supporting other group members as a "rewarding" experience that often improved their self-esteem. For example, Jose told me that helping other adolescents who were having a "rough time" made him "feel good about myself."

Researchers have demonstrated similar findings--having a positive impact on a peer can increase self-esteem for adolescents (Chang, 2002). Roepke et al. (2011) investigated changes in global self-esteem among adult participants who had participated in a DBT group. They found that engaging in helpful interactions with other group members was associated with improvements in social and emotional self-esteem (Roepke et al., 2011).

Parallel backgrounds. Another subtheme of benefits from other group members was participants were more likely to form connections with adolescents from similar backgrounds. Six participants found it easier to talk about their problems with group members who could identify with their life experiences. For example, Tara related to other group members who had incarcerated parents because they could empathize with her experience in a unique way.

Participants seemed to place more value on the input of group members with similar problems or backgrounds to their own than other members. Other researchers have found that even when adolescents reported having a support system, the support they received was limited by the lack of first-hand knowledge of their problems (Comtois et al., 2007). A Hispanic participant said it was more meaningful when she received feedback or support from other Hispanic adolescents because they understood her culture. Jose valued the input of another group member from an RTC because of their shared experience of not living with their parents. This finding of parallel experiences is congruent with research indicating relationships during adolescence are often based on commonalities between peers (Chang, 2002).

Valued elements of group therapy.

Group leaders. In DBT, two therapists facilitated the skills group as co-leaders (Linehan, 1993a). Five of the participants reported that the therapists (group leaders) contributed positively to their experience of skills group therapy. The positive impact of group leaders made the experience of group therapy "easier to tolerate," "better," "less sucky," and "kind of fun at times." Several adolescents appreciated how relatable and humorous their group leaders were. This finding might be related to the training DBT therapists received in methods for engaging adolescents in therapy, encouraging participation through the use of humor, and an approachable, non-authoritative stance (Koerner & Linehan, 2000).

In DBT, group leaders use "cheerleading" to validate the client's ability to use the skills (Linehan, 1993a). Participants described receiving encouragement and praise from the group leaders when they used skills, which contributed to their positive overall experience in DBT. These participants reported they were more likely to practice the skills they learned when they were praised for doing so. This finding supported the use of "cheerleading" in group therapy as an effective tool with adolescent clients (Katz et al., 2004; Woodberry & Popenoe, 2008).

In general, getting adolescents to engage and participate in a group format can be difficult due to the influence of peers, desire to conform, or fear of negative stigmas (Woodberry & Popenoe, 2008). However, the relationship these participants had with their group leaders appeared to have a positive impact on their willingness to attend group therapy. For example, Jeremy told me the "laid-back, chill" atmosphere provided by the group leaders had a part in his continued attendance in group therapy. Davey also

appreciated the relatable and relaxed approach of his group leaders and said it was one of the reasons he gave DBT "a chance."

While the theme of appreciating group leaders was shared with another qualitative study of adult women's experiences of DBT, the reasons for appreciation were different (Cunningham et al., 2004). Adolescents seemed to value the personality and relational style of the group leaders. Contrastingly, the adult clients reported the most important characteristic of a group leader was proficiency in teaching skills and knowledge of the skills (Cunningham et al., 2004). These results highlighted a difference between how adolescent clients and adult clients experienced DBT.

*Confidentiality***.** Several participants described a sense of safety and trust in group therapy because of the policy of confidentiality. This finding was consistent with other theories of group therapy that emphasized the importance of confidentiality for group cohesiveness and member safety (Linehan, 1993a; Yalom, 2005). Five participants reported that confidentiality, along with the nonjudgmental environment, contributed to an increased feeling of trust and a willingness to share personal aspects of their lives. This theme was congruent with research indicating an increased participation in groups where members perceived a high level of trust (Woodberry & Popenoe, 2008; Yalom, 2005).

Research showed that maintaining confidentiality could be challenging for adolescents (Koerner & Linehan, 2000). Reasons for breaching confidentiality among adolescents were peer pressure, poor impulse control, difficulty with social skills, and a desire to please (Choate, 2012). Additionally, the setting of a community mental health center presents specific challenges to confidentiality because of the confined

geographical area served by these centers (Comtois et al., 2007). For adolescents, this includes the possibility of attending the same school or community youth events as other group members (Choate, 2012).

Emphasis on skills. One theme that emerged from the data was participants responded positively to a skills-based format of group therapy, especially the opportunity to practice new skills. Seven of the participants seemed to appreciate that the focus of the group was on learning and practicing new skills. Participants preferred the focus on problem-solving techniques to discussing their problems in a more process-oriented group format. Additionally, some participants expressed an adverse reaction to spending too much time processing negative emotional experiences of other group members. This finding aligned with the characteristic of DBT group therapy being psychoeducational in nature and not process oriented (Groves et al., 2012; Koerner & Linehan, 2000; Linehan et al., 2006).

Research indicated that youth group programs provide an effective environment for acquiring and practicing skills among other adolescents because this is their primary social learning group (Chang, 2002). Four participants stated that practicing skills with other group members was the only way they understood how the skill worked. They reported that practicing skills was more effective than the didactic portion of group where the leaders taught the skill. This finding was congruent with studies showing that having regular opportunities to practice skills with peers in a therapeutic setting increased adolescents' comprehension of the skills (Koerner et al., 2007; Koerner & Linehan, 2000; Miller et al., 2007).

It was theorized that when clients learn and rehearse adaptive coping skills, they are better able to interact assertively, label and modulate emotions, endure distress, and inhibit dysfunctional behavior (Robins & Chapman, 2004). Anna highlighted the importance of learning new skills and said it was the most helpful aspect of group therapy: "It was mostly about, like, coping skills. Like, instead of this I can do x, y, and z instead of cutting. Like doing something new instead of getting all worked up or freaking too much. That helped more than talking did."

The participants might have been responding to the discouragement provided by the group leaders of in-depth discussion or focus on intense emotional dysregulation, suicidal, or parasuicidal behaviors (Miller et al., 2007). Several studies found there might be a contagion effect in groups when adolescents discussed these behaviors (Aguirre, 2007; Choate, 2012; Linehan et al., 1999). One study of inpatient hospitalized adolescents compared DBT to a control group receiving treatment as usual (TAU) and found an increase in self-mutilating acts among adolescents who had no prior history of such behavior before beginning DBT (Linehan et al., 1999).

Experiences with individual therapy. Adolescents received one hour of individual therapy a week in the DBT program. Three themes emerged from the data related to the participants' experiences in individual therapy including the therapeutic relationship, validation and acceptance, and change-oriented techniques.

The therapeutic relationship. *A*ll of the participants in this study identified the relationship with their individual therapist as an important part of their experience in DBT. Participants described their therapeutic relationship as "helpful," "meaningful," "good to have someone to trust," "liked that she was always there," "I felt cared for," and

"someone who actually didn't judge me for all my messups." This finding supported the emphasis DBT placed on a strong therapeutic relationship as a crucial element in providing effective therapy with suicidal adolescents (Goldstein et al., 2007; Linehan, 1993a; Rathus & Miller, 2002). Additionally, the therapeutic relationship between the client and therapist was the most frequently mentioned effective common factor in psychotherapy literature (Wampold, 2001).

While numerous DBT studies have explored the subjective therapeutic relationship with adult participants in DBT, little is known about how adolescents experienced the therapeutic relationship in DBT (Choate, 2012; Cunningham et al., 2004; Goldstein et al., 2007; Linehan et al., 1999). In a study of 14 adult women diagnosed with BPD, qualitative researchers found that participants overwhelming agreed the therapeutic relationship impacted their ability to make positive changes in their lives (Cunningham et al., 2004). Similar to these results, four participants in this study reported the therapeutic relationship was a contributing factor in making progress toward their treatment goals. For Adam, the relationship with his therapist was a key component in his ability to change his negative self-perception: "It was mostly Alison, she made all the difference. I wouldn't be the person I am today without her."

Adam described his positive relationship with his therapist (Alison) allowed him to address how his negative self-talk and cognitive schemas were influencing his mood and behavior. Jeremy also reported he felt a connection with his therapist because she did not judge him and this was therapeutic in itself. Similarly, Kazdin, Marciano, and Whitley (2005) found a positive therapeutic alliance was associated with greater

therapeutic change, fewer perceived barriers, and greater treatment acceptability for adolescents with behavior problems.

Dialectical behavior therapy shares many common therapeutic elements and techniques with cognitive behavioral therapy (CBT; Linhean, 1993a). Therefore, research on adolescents and CBT might be relevant to the findings of this current study. For example, researchers investigated adolescents who were receiving (CBT) and found the participants valued a trusting, collaborative relationship with their therapist (Messari & Hallam, 2003). Several studies found that a positive therapeutic relationship positively influenced outcomes in mental health among children and adolescents receiving CBT for anxiety disorders (Chiu, McLeod, Har, & Wood, 2009; Liber et al., 2010).

This theme was also noted in other areas of adolescent treatment such as assessment (Binder, Moltu, Sagan, Hummelsund & Holgersen, 2013). A qualitative study examining adolescents' experiences of psychotherapy assessments found similar results regarding the importance of the therapeutic relationship with adolescents (Binder et al., 2013). In this study, adolescents reported that of all the factors that contributed to a positive experience with assessment in therapy, the therapeutic alliance was the most impactful (Binder et al., 2013).

The majority of the adolescents I interviewed reported not wanting to attend therapy at the beginning but were motivated to continue by their individual therapists. Similarly, other studies with suicidal adolescents in DBT programs have shown that building and maintaining a positive therapeutic relationship decreased client attrition (Rathus & Miller, 2002; Robins & Chapman, 2004; Woodberry & Popenoe, 2008). Casey said her individual therapy sessions were the main reason she continued to stay in

the DBT program. This was because her individual therapist helped her "make healthy choices instead of harmful ones. And I needed that in my life at that time."

Acceptance and validation. In DBT, individual therapy sessions focus on balancing change and acceptance (Linehan, 1993a). All of the participants experienced acceptance and validation in individual therapy. The participants in this study described validation as feeling understood, hearing that their behaviors made sense given their backgrounds, not being judged for mistakes, and having their feelings and thoughts reflected back to them in a genuine manner. Research indicated that adolescents were more likely to collaborate and less likely to become agitated when their therapist integrated validation into therapy (Miller et al., 2007).

Results from a qualitative study investigating the experiences of 14 women diagnosed with BPD contrasted with the results of this study (Cunningham et al., 2004). For adult participants, the experience of acceptance in individual therapy was not as important as the experience of equality between therapist and client (Cunningham et al., 2004). The difference between these studies highlighted the need to not uniformly apply treatments empirically supported with adult populations to adolescent populations without including developmentally specific adaptations (Choate, 2012; Goldstein et al., 2007; Groves et al., 2012).

These findings were consistent with research indicating clients in DBT experienced individual therapy as a less judgmental environment than family or group therapy (Crowell, Beauchaine, & Lenzenweger, 2008). Several participants said the experience of validation was new for them because they were accustomed to having their feelings dismissed or ignored by friends and family members, which was congruent with

the biosocial theory of DBT (Linehan, 1993a). For Casey, this occurred when her father dismissed her sadness by continually telling her she was not actually depressed and she should "just be happy," which only exacerbated sadness and increased her self-doubt. Woodberry and Popenoe (2008) found the validation provided in individual therapy could help decrease emotional dysregulation in adolescents coming from invalidating home environments.

Four participants mentioned that when they displayed the scars or wounds from their self-inflicted injuries, they were met with nonjudgmental acceptance by their therapists. Tara said she was usually met with a response of "shock or horror." Selena told me the accepting stance her therapist took toward her self-harming behaviors made it easier to talk about them. Selena's experience fits with research showing that clients were more likely to disclose information about suicide and self-harming behaviors when their therapist responded with interest but without alarm (Klaus, Mobilio, & King, 2009). Furthermore, Muehlenkamp (2006) emphasized the importance of accepting clients by taking them seriously, validating their pain, and acknowledging their choices to engage in self-harming behaviors as coping skills were highly effective though maladaptive. This validation provided adolescents with the motivation for change, which is the complementary component of DBT (Linehan, 1993a; Groves et al., 2012; Muehlenkamp, 2006).

Change-oriented techniques. In addition to validating clients, DBT therapists also helped clients change their maladaptive thoughts and behaviors (Miller et al., 2007). Change was facilitated through specific DBT techniques as well as traditional cognitive behavior therapy approaches such as addressing cognitive distortions, skill deficits, and

vulnerability factors (Katz et al., 2004). Participants in this study had mixed reactions to the techniques and strategies for change used in individual therapy.

Several adolescents in this study described the use of behavioral and cognitive assessments, such as a behavioral chain analysis, to be both frustrating and helpful. A behavioral chain analysis is a tool used to understand the cause of the behavior, what is preventing its resolution, and what skills are available for solving it (Linehan, 1993a). Tara said her therapist used a behavioral chain analysis to decrease her targeted problematic behavior of physical aggression: "I never really understood those charts. It seems like a big fucking pain, but Julie always made me do em." Despite her dislike of the technique, Tara admitted it was helpful: "Sometimes it was good 'cause we'd work out some bad situation that I had that like that week. Like a fight with some bitch at school or something. It'd, like, help me understand about my anger."

Jose also reported positive changes from completing a behavioral chain analysis in therapy. He said charting the antecedents, behaviors, and consequences of his "freak-outs" was tedious but helpful because it led to fewer aggressive incidents at his group home. This finding was similar to the decrease in aggression and irritability found among adult females diagnosed with BPD receiving change-oriented aspects of DBT in an outpatient setting (Linehan, McDavid, Brown, Sayrs, & Gallop, 2008). Additional research showed that change-oriented techniques used in DBT had a significant impact on client outcome, specifically decreases in suicidal attempts and depression and increased control over anger and aggression (Luoma & Villatte, 2012; Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006).

Four participants said they filled out weekly diary cards to monitor their suicidal thoughts and self-harming behaviors. Diary cards were a tool used daily by clients to record their emotion ratings, problem behaviors, and use of DBT skill (Miller et al., 2007). When clients indicated self-harming on the diary card, then their therapist facilitated a chain analysis to examine the antecedents and consequences of that behavior (Linehan, 1993a; Miller et al. 2007). Jade stated she completed a chain analysis with her therapist almost every week with the goal of decreasing her cutting. Neacsiu, Rizvi, and Linehan (2010) found use of diary cards was crucial in identifying non-suicidal self-injury in clients and that use of behavior tracking techniques might contribute to the decrease in this behavior over time.

Often the task of targeting self-harming behaviors can feel overwhelming for adolescents (Chang, 2002). Behavioral chain analyses have been shown to be helpful in breaking the behavior down into manageable pieces they can understand (Katz et al., 2004). For example, Selena reported this exercise helped her identify the links between her thoughts, feelings, and actions. Specifically, she learned that altercations with her mother in the morning created an emotional vulnerability she carried with her the rest of the day. This vulnerability combined with being triggered by a negative comment from a male peer led to feelings of worthlessness; ultimately, she sought relief by cutting herself in the school bathroom. Once this detailed assessment of the problematic behavior was completed, the therapist and adolescent identified points along the way where alternate choices could have been made and where DBT skills could be implemented to avoid the problematic behavior (Katz et al., 2004; Linehan, 1993a; Miller et al., 2007).

Three participants in this study reported they found the diary cards, skills homework, chain analysis, and other change-oriented techniques to be burdensome and not helpful. Davey said he refused to do the exercises related to his negative behaviors because it was "a waste of time." He added, "Why would I spend time talking about not doing drugs when I know very well that drugs are the only thing that help me?" Casey said she found the diary cards to be negative reminders of her depression and self-harming behaviors and "would rather not spend any more time on those." This finding might be related to research indicating that many adolescents will give up a behavior that is harmful but effective (Choate, 2012). These clients might need to spend several sessions using change-oriented techniques before they see them as beneficial (Rizvi, Steffel, & Carson-Wong, 2012).

Experiences with family therapy. In DBT, adolescents are conceptualized within the context of their family, living environment, and community (Katz et al., 2004). To address this adolescent-specific need, the addition of a family therapy component was included in the manual adapted for use with adolescents (Miller et al., 2007). In this study, seven participants lived at home with their families. The other two participants lived in a residential treatment center and a group home. Themes that emerged from experiences with family therapy were an Invalidating Environment, Inconsistent Involvement, and Benefits Gained/Use of Skills.

Invalidating and uncomfortable experiences. While research questions were not directed at participants' family dynamics or histories, most of the adolescents in this study disclosed some of this information when discussing their experience in family therapy. This finding was not surprising because unlike adults, most adolescents are still

surrounded by the invalidating environment in which they developed the dysfunctional behaviors for which they are in treatment (Rathus & Miller, 2002).

Four participants who attended therapy regularly described their experience as "uncomfortable," "terrible," "bad for everyone," and a "time I could have done without." A characteristic of adolescents enrolled in DBT programs was they were often met with ineffective and invalidating responses from their caregivers (Woodberry et al., 2002). Casey told me her family had a tendency to ignore negative emotions and avoided addressing her self-harming behaviors and depression. She said it was awkward discussing her self-injurious behaviors in family therapy because "no one really knew what to say about it. Everyone was just numb. There was no feeling. Everyone sort of had dead eyes. Like no one knew what to do. It was just a hard time." Adam described talking about his suicide attempts in family therapy: "It was mostly my mother talking, me crying and my father…sitting in stalk silence. That was a time I could have done without."

Although research indicated most parents of suicidal adolescents are afraid to bring up the topic for fear of making the situation worse, some studies showed this was not the case and in fact raising concerns about suicide with adolescents could be a preventative factor (Duckworth & Freedman, 2013).

Six participants described invalidating experiences with their families that contributed to their emotional problems. Jeremy described being invalidated by his step-father who treated him differently than his biological children. This exclusion was part of the reason Jeremy was hospitalized for a suicide attempt and then referred to the DBT program. Casey experienced invalidating responses from her parents, boyfriend, and

friends, which increased her feelings of depression and led to cutting herself. This finding aligned with research citing invalidation within the family was a major contributing factor to emotional dysregulation and suicide attempts in adolescents (Woodberry et al., 2002).

Invalidating responses from family members discourage adolescents from using their newly acquired skills and thus maladaptive patterns are perpetuated (Woodberry et al., 2002). Jeremy felt judged by his mother and so was reluctant to participate in family therapy when she was present. Adam described a negative experience in family therapy because he felt his parents, especially his father, did not accept his sexual orientation. This invalidating response to his identity was emotionally overwhelming for Adam and was one of the reasons he cited for his past suicide attempts. Adam's experience was supported in research citing that gay and lesbian youth often struggle with their sense of self and experience invalidation from their support system (Legate, Ryan, & Weinstein, 2012).

According to the biosocial theory of DBT, this finding reinforced the idea that invalidating environments inhibit a person's ability to identify and communicate their emotions effectively (Linehan, 1993a). Alternative explanations for why an environment might be perceived as invalidating are a person might be so emotionally sensitive to begin with that even effective parenting would not lower emotional vulnerability to levels where healthy coping skills could be used (Crowell et al., 2008). Another explanation was adolescents might require more time, attention, and help than their parents have to give them due to situational demands, job schedules, other children, or their own problems (Crowell et al., 2008).

Inconsistent involvement in therapy. Four of the participants' experiences of DBT were impacted by infrequent family therapy sessions or no sessions with family due to lack of involvement in the participants' treatment program for varying reasons. Davey reported his family sessions were terminated due to domestic violence between his parents. Jade's mother was inconsistent in her attendance to family therapy so Jade only experienced a few sessions: "Mom came with me and then didn't come and then came and I was like what's your deal? If I have to go then you have to go." Jose lived in a residential treatment center so his family was not involved in his treatment. He told me some of the staff members occasionally came to family therapy occasionally. Tara lived in a group home and reported going to family therapy about two times "only when my mom was on parole. She's locked up now. She's a stupid bitch, but when she was living at my aunt's house she would sometimes come over with my case worker."

Because of the inconsistent involvement of caregivers, these four participants experienced a different form of DBT than did other participants in this study. These participants did not receive the skill training or therapeutic effects that occur in the family therapy component, thus they did not receive DBT in its entirety according to the standards of the treatment manual (Miller et al., 2007). Furthermore, the absence or limited experience of family therapy for four participants might have negatively impacted other areas of their treatment because research showed parental involvement in an adolescent's treatment tends to improve dysfunctional and invalidating home environments, enhance generalization and maintenance of skills, and help family members to act as coaches (Miller et al., 2007).

Although studies have shown adaptations of the standard version of DBT can be effective with adolescents, such as a shorter 12-week program, there is a large body of research focusing on the importance of including family members when treating suicidal or self-harming adolescents (Klaus et al., 2009; Koerner & Linehan, 2000; Lynch, Morse, Mendelson, & Robins, 2003; Robins & Chapman, 2004; Telch et al., 2001; Woodberry & Popenoe, 2008). In addition to research findings, there was also a theoretical emphasis in DBT, as well as other theories such as family systems, for the involvement of families when treating adolescents (Miller et al., 2007; Stanley et al., 2001).

Furthermore, the absence or limited experience of family therapy for four participants might have negatively impacted other areas of their treatment because research showed that parental involvement in the adolescent's treatment tended to improve dysfunctional and invalidating home environments, enhance generalization and maintenance of skills, and help family members to act as coaches (Miller et al., 2007).

Benefits and use of skills. Family therapy is an important component of therapy with adolescents because family conflict is often a source of distress that triggers suicalidty (Choate, 2012). Six participants stated they experienced positive changes in their home environment from family therapy. These changes included receiving help from caregivers, family members learning skills, and increased communication.

Adolescents found it helpful when their caregivers learned the same skills DBT they did. This was consistent with the emphasis DBT places on reducing skill deficits and increasing effective among family members (Groves et al., 2012). Jose reported he had fewer incidents of physical aggression when his staff members used the DBT terminology and skills they learned. Jeremy said his family therapist taught his mother

interpersonal effectiveness DBT skills and using those skills improved their communication: “My mom and I talk better to each other, I guess. Like, more nice.”

Jose reported it was helpful for his staff members to be familiar with DBT because they reminded him to use his skills at the RTC. He reported being prompted to use his emotion regulation skills when his negative behaviors were escalating: “They’d always be like ‘Jose! Use your wise mind!’ I mean it helped so I wouldn’t forget to do it. They’d just keep reminding me.” Jose’s experience of DBT skills being helpful in his RTC was supported in the research.

While Jose did not have a family member participate in group therapy, it is often the case that children in RTCs do not have contact with family members (Sunseri, 2004). However, DBT has been studied in RTCs with promising results. For example, Sunseri (2004) found that adolescents in RTCs, like Jose, had reduced psychiatric hospitalizations after completing DBT. Other researchers also investigated DBT being used as a treatment for adolescents in RTCs and have found it helped reduce suicidality, depression, and self-injurious behaviors (Wasser et al., 2008; Wolpow et al., 2000).

Research showed that when adolescents are deficient in the types of skills taught in DBT, their families are highly likely to be deficient in the skills as well (Turner et al., 1998). Several adolescents described their family members as lacking in the skills they learned in DBT. When several family members are familiar with DBT skills and language, the home environment becomes more conducive to using the skills (Woodberry et al., 2002). Jade reported family therapy was helpful because she and her mother learned new emotion regulation skills. She said utilizing these skills decreased the intensity and frequency of their arguments and improved their relationship: “It’s changed

my life with my mom. She used to, me and my mom used to fight really bad. But now we just fight normal. I mean, we still get mad at each other and stuff. But it's way better." Researchers found that teaching family members basic DBT skills, such as how to identify and label emotions, increased the frequency and effectiveness of using validation techniques with adolescents (Klaus et al., 2009).

Adolescents who display suicidal and self-harming behaviors have a higher level of family conflict than is typical of normal adolescent development, which is a risk factor suicide attempts (Chang, 2002). Along with Adam, four other adolescents described difficulty discussing their suicidal and self-injurious behaviors with family members because dysfunctional family dynamics was a major contributor to these behaviors. Miller et al. (2007) recognized the crucial role family members play in an adolescent's inability to regulate his or her emotions and emphasized the importance of addressing family interactions that contribute to self-harming behaviors. A study of adolescents in an inpatient treatment center found that when family members were included in DBT, adolescents experienced a more significant decrease in depression compared to adolescents who received DBT without family therapy (Wasser et al., 2008).

One of the challenges adolescents face is when they try to practice their skills in a family setting not set up to support these new skills (Miller et al., 2007). Selena's experience with family therapy was uncomfortable because the cultural values of her traditional Hispanic family were not supportive of therapy. She described her experience: "Well, it's like in Mexico there's this kind of different way to, to be with your family. It's like you don't really talk much about your family problems with anyone. It's like we don't really believe in therapy that much." As an example of her

uncomfortable experience, Selena told me her mother got angry with her after one session because she shared something personal about the family during the session: “It’s like, something that my mom calls *indescreta*. It basically means you should keep your stuff to yourself.”

Selena voiced a concern she had with her family therapy experience related to a lack of multicultural accessibility. Specifically, she was disappointed her family therapist only spoke English because this prevented some of her Spanish speaking family members from participating due to a language barrier. Selena’s experience highlighted the importance of researching DBT with culturally diverse populations in order to understand if the effectiveness of the treatment translates and to identify potential adaptations that need to be made (Choate, 2012).

Experiences from Skill Modules

Mindfulness module. Mindfulness skills are used to help adolescents increase attentiveness to their emotions without evaluating them (i.e., without judging the emotion as good or bad, right or wrong) or impulsively acting upon them (Linehan, 1993a; Miller et al., 2007). This module is the first one taught to adolescents because it is incorporated into all of the other modules (Linehan, 1993a). Themes that emerged from experiences with mindfulness included mindful breathing, noticing the mind/body connection, and participating in the present moment.

***Mindful breathing*.** Mindfulness skills teach adolescents to control their attention by focusing by approaching tasks *one-mindfully*, which means focusing on one thing at a time instead of multitasking in order to increase awareness (Linehan, 1993a). The adolescents in this study reported the skill they used the most from this module was

mindful breathing, which is purposefully paying attention to and observing your breath in a nonjudgmental manner. Eight participants described using the mindful breathing skill as a means to exert more control over their emotions.

Mindful breathing could be practiced in several ways: paying attention to your in-breaths and out-breaths and repeating those words as the breath takes place; observing whether your breathing is shallow or deep, smooth or jagged; or observing the rise and fall of your chest and stomach as you breathe. Several adolescents in this study said they found mindful breathing helped in decreasing the emotion of anger, which decreased the maladaptive behaviors resulting from anger. Not only does mindful breathing distract the mind from negative thoughts or emotions, deep breathing has a physiological calming effect that can sometimes stop an adolescent's emotions from escalating beyond their control (Miller et al., 2007).

Jade often experienced an inability to control her emotions during arguments with her mother. She said their altercations typically ended in both of them being emotionally dysregulated, which was often a trigger for Jade to cut herself in order to reregulate. When she felt herself becoming increasingly angry, she practiced breathing in to the count of four and then breathing out to the count of four and this calmed her down "before I lose it."

Mindful breathing provided adolescents with an emotional "timeout" to observe the moment they were experiencing and regain emotional control (Linehan, 1993a). Selena used mindful breathing when she felt herself becoming overwhelmed by feelings of anxiety or depression: "I just like try to like, uh, breath slow, take deep breaths. And pay attention to them. It helps calm me down." She reported that simply attending to her

breath was an immediate source of relaxation. The finding that breathing mindfully is helpful is also common to several theoretical orientations in counseling such as cognitive behavioral therapy and trauma focused therapy as well as being a skill learned in areas outside of therapy (Katz et al., 2004).

***Noticing the body/mind connection*.** Five participants described a mind/body connection in their experience of mindfulness. Jose said mindfulness was "paying attention to what my body is doing when I get mad." He used mindfulness to observe the physical signals his body was giving him about his emotions: "Well, my fists get balled up when I'm mad. I learned to notice it when it happens so it tells me I'm getting mad." Noticing the physical reactions to emotional states could be important clues for adolescents to identify what they are feeling and thinking (Linehan, 1993a).

Suicidal and self-harming clients have been shown to have difficulty identifying what they are feeling; thus, they resort to finding a physical sensation for relief such as cutting, substance abuse, or disordered eating (Linehan, 1993a). All of the participants in this study reported a history of self-harming behaviors, suicidal ideation, or suicidal attempts. Four of these participants stated their senses were heightened during self-harming and breathing helped them return to a normal level of sensation. This finding aligned with research on the physiological experiences of individuals who self-injure (Nock, 2010). For example, adolescents who self-injure display higher physiological reactivity during distressing tasks than adolescents who do not self-injure (Nock & Mendes, 2008). Mindful breathing might contribute to decreasing physiological reactivity (Linehan, 1993a).

Linehan (1993a) advocated for clients to practice Zen meditations as a way to increase their awareness and acceptance of reality. Casey practiced mindful meditation as a way to calm her mind and body. However, she admitted that mindfulness without judgment could be difficult and during meditation, she had a hard time ignoring negative thoughts: “I can’t be too mindful, because after that place of calm then it leads into darker thoughts and they start coming back and I start thinking too much and I end up in that same place.” Mindfulness skills, like other coping skills, take practice and habitual use to be the most effective (Koerner & Linehan, 2000).

Three participants described practicing mindfulness through physical exercises. Vast amounts of research have been done on the beneficial and therapeutic effects of yoga on psychological disorders. Beginning DBT with a yoga pose is one way adolescents learn about the mind/body connection; adolescents in an inpatient unit reported decreased anxiety after practicing yoga as part of DBT (Katz et al., 2004). Jade reported progressive muscle relaxation techniques were helpful in decreasing stress at nighttime: “Like, for example, sometimes before bed I try to do the pose where you lie on your back and relax all the muscles slowly in your body. I mean I should do it more often cause it helps me sleep.” Lack of sleep has been identified as a risk factor for increased emotional vulnerability and research indicated that restful sleep was crucial for brain and body development in adolescents (Steinberg, 2005).

Participating in the moment. Mindfulness consists of paying attention to one's emotions, thoughts, and physical experiences just as they are in the present moment without trying to avoid, alter, or end them (Linehan, 1993a). For many adolescents in this study, focusing on the present moment brought an increased awareness of their

emotional and cognitive patterns**.** Seven participants described using the mindfulness skill of participating in the moment, which taught them how to increase awareness and be fully engaged in the present moment. Jeremy described participating in the moment as "don't live in the past or the future, you just gotta live in the present." Reminding himself of this helped Jeremy with his emotional control because he could let go of painful experiences from his past. Van Dijk, Jeffrey, and Katz (2012) researched adult participants with bipolar I or II disorder participants receiving DBT compared to a control group receiving TAU. They found the treatment group showed more control of emotional states, an increased ability to use mindfulness based skills, and fewer emergency room visits and admissions at a six-month follow up (Van Dijk et al., 2012).

Practicing mindfulness skills helps adolescents become aware of what they are experiencing so they can make "wise mind" decisions to use a skill instead of self-harming (Groves et al., 2012). For Casey, focusing on the present moment helped decrease her urge to self-harm when she was emotionally dysregulated. Mindfulness slows down the sequence of thoughts, feelings, and behaviors adolescents typically engage in, which creates room to practice new skills and behaviors (Linehan, 1993a). Selena said when she experienced overwhelming emotions, she usually tried to avoid them or had an impulse to escape from any distressing life circumstances but focusing on the present moment slowed this pattern down: "Mindfulness helps because I try to think before I act now. Like running away used to be my first reaction to everything." This finding was congruent with other studies indicating that mindfulness skills helped with emotion regulation (Cunningham et al., 2004; Lindenboim, Comtois, & Linehan, 2007; McCabe, LaVia, & Marcus, 2004).

Distress tolerance module. This skill module of distress tolerance addresses adolescents' behavioral and cognitive dysregulation in two ways: the first is to teach them skills focused on surviving crises in their lives and the second is to help adolescents accept their personal reality including painful experiences (Koerner & Linehan, 2000; Linehan, 1993a). Two themes regarding both of these areas emerged from the participants' experiences: crisis survival skills and radical acceptance.

. ***Crisis survival skills*.** Survival strategies help clients cope with crises in their lives by learning to develop resiliency for painful emotions and events as well as identifying healthy alternatives to their harmful or ineffective coping methods (Groves et al., 2012). All nine participants admitted to engaging in maladaptive coping methods for managing distress in their lives such as drug abuse, cutting, burning, and high risk behaviors.

Although not explicitly asked if DBT helped reduce these behaviors, several participants reported stopping or reducing their self-harming. Research indicated DBT is an effective treatment for reducing suicidality and self-harming behaviors in adolescents (Groves et al., 2007; Linehan et al., 2006; Rathus & Miller, 2002). For example, McDonnell et al. (2010) studied adolescents with histories of suicidality and self-injuring behaviors in long-term inpatient care; they compared a DBT group to a TAU group. The researchers found adolescents in the DBT group demonstrated significant reductions in psychiatric medications upon discharge and significant reduction in self-harming over time (McDonnell et al., 2010). Participants in the DBT group also demonstrated significantly lower rates of self-harming behaviors than did the control group (McDonnell et al., 2010).

Four participants said they no longer had suicidal ideations or attempts since completing DBT. This finding supported literature citing DBT to be effective with suicidal adolescents (Katz et al., 2004). Dialectical behavior therapy likely contributed to this change; however, other factors could be responsible such as the passing of time or the participants were only in partial remission--the period after treatment when high risk behaviors are absent before relapse occurs for some adolescents (Comtois et al., 2007). Jose said he no longer did head-banging when he was upset but he remarked this was because he "was older and more mature now."

Although these methods might provide immediate relief and improve the moment in some way, the effects were short lasting and usually made the problem they were trying to escape worse (Aguirre, 2007; Linehan, 1993a). The majority of participants stated this was true for them. The exception was Davey who claimed that even though he was aware of the harmful effects of drug abuse, he still considered it to be the most effective coping skill he had. This experience is not uncommon among adolescents in treatment in part because the maladaptive behaviors they developed had served them in the past and had become ingrained in their emotional dysregulation cycle (Groves et al., 2012; Miller et al., 2007).

The distress tolerance skills the participants described included distraction techniques, self-soothing, using imagery, finding meaning in the crisis, and creating lists of the pros and cons of tolerating the distress (Linehan, 1993a). Four participants described self-soothing techniques to be helpful. For example, Adam was soothed by covering himself up with a heavy blanket in a dark space. Tara found scented lotions and candles to be soothing and decreased her anger and urge to physically act out. Casey

discovered that keeping a journal during her DBT program was a way to manage the urge to self-harm. She said journaling was "sort of taking the place of cutting" because it was another form of release. She added it was safer, too: "You can just get it out without hurting anyone or yourself." Casey also engaged in creative activities to tolerate distress: "Poems, drawing, artistic stuff, that kind of thing. It's calming. It calms me down. And even if I'm still sad, I can be sad but in a way that's not going to do damage. I can be sad on paper instead of on my skin."

Participants were able to use these skills to prevent themselves from acting impulsively when they were experiencing a crisis. Four participants used the reaffirming personal values skill as a way to combat suicidal ideations or urges to self-harm. For example, Selena created a list of reasons to live and what she valued in life that she could review when she had the urge to cut herself. This finding was consistent with research indicating that focusing on reasons for living, especially the impact suicide would have on family members, was a helpful skill for combating suicidal ideations (Choate, 2012).

Anna described her experience with skills she used for distress tolerance that were unhealthy. She said that in the past, she would become so emotionally overwhelmed by sadness she would impulsively seek any type of mood-altering drug available and take it without consideration of consequences. This maladaptive coping strategy was ineffective in reducing negative feelings and actually made them worse when the effect of the drug wore off. Anna reached a point of helplessness and hopelessness that she attempted suicide by overdosing on pills. She said it was a major wakeup call for her and she entered the DBT program being receptive to learning more adaptive and effective coping skills. Anna reported that finding meaning in her experience and improving the moment

with positive thoughts were skills she used when she was feeling depressed, which have been shown to be effective with suicidal adolescents (Groves et al., 2012). She practiced this skill by reminding herself of the strength she had gained by her experience and engaged in positive self-talk about the progress she has made.

These findings were consistent with research that distress tolerance skills were perceived as helpful by clients in DBT (Lindenboim et al., 2007; Miller et al., 2000). At a one year follow up study, adults tended to practice mindfulness and distress tolerance skills more often than other skills (Wagner & Linehan, 2006). A qualitative study with adults found participants reported self-soothing, distracting, and one-mindfulness to be the most helpful of the distress tolerance skills (Cunningham et al., 2004). Distress tolerance skills and mindfulness skills were the highest rated skills among adolescents receiving DBT as a treatment in an outpatient setting (Miller et al., 2000).

The adolescents in this study who engaged in self-harming behaviors were not alone as research indicated this to be a trend among adolescents (Centers for Disease Control and Prevention, 2013). In the United States, it is estimated that one in every 200 adolescents cut themselves frequently and among adolescents receiving mental health services, self-injurious behaviors were one of the most common symptoms (Grunbaum et al., 2004; Robins & Chapman, 2004). Although DBT research with adolescents is promising, there is still much to be learned because even after treatment, many adolescents continue to self- harm (Rizvi et al., 2012). However, studies indicated that without any treatment, there is a greater likelihood self-injurying will continue into adulthood (Rathus & Miller, 2002; Wagner & Linehan, 2006).

Radical acceptance. Group members were also taught to accept what they could not change in a non-judgmental manner. Acceptance did not equal agreement with what had happened to them in their lives in the past or currently, only that a stance of non-acceptance was contributing to their pain (Linehan, 1993a). Five participants discussed the concept of radical acceptance in their experience of DBT. Radical acceptance helped these participants non-judgmentally accept (but not condone) emotional pain from situations they could not change (Miller et al., 2007). For example, Jeremy described accepting the abuse he experienced in childhood: "I get real down on myself sometimes, about when I was a little kid, what happened and everything. But I had to learn to accept it. It's fucking impossible but I had to." This skill provided adolescents with a catharsis related to separating themselves from abuse they endured in childhood (Robins & Chapman, 2004).

Accepting reality skills helps adolescents accept life in the moment, just as it is, even when it is painful or uncomfortable so they can move forward instead of being stuck in negativity (Linehan, 1993a; Miller et al., 2007). Selena and Tara used the skill of turning the mind, which helped them cope more effectively with their environment by accepting the situation instead of struggling against it. Adam practiced radical acceptance of his father's disapproval of homosexuality. Although he did not agree with how his father treated him, Adam realized wishing things were different was only contributing to the emotional pain that led him to engage in self-injurious behaviors.

Davey vividly described what radical acceptance meant to him:

> It's like life will be painful but it's stupid to just ignore it or only to get mad about it. And that's the thing about acceptance. It's two parts. First it's the noticing, the seeing what's going on with you cause you can't just stay blind, with your eyes closed, ears shut and all that, you have to open up and look around. But that

> is really hard, especially when you've had the fucked up childhood like I did. I mean it can suck, like really suck and be painful and hurt but it's the first step. I feel like you're hurting anyway just ignoring all the pain you've been through in your life. Things that happened to you, like abuse and stuff. Those things, those things will never go away. Trust me, I've spent many years staying high trying to forget what happened to me but when I sober up, it was still there. You can't change the past or anything at all. Really shitty things that may have, that happened to you, like things that happened to me. (Sigh.) As much as I want them to change, they won't. So then the second step is that you should stop self-destructing and move on.

Emotion regulation module. This module addressed emotional dysregulation by giving the client a non-judgmental place to experience and then decrease emotional distress (Linehan, 1993a). Emotional regulation skills teach clients how to identify emotions, understand the purpose of emotions, and control their emotions. The goal is to decrease emotional vulnerability and suffering and increase the ability to identify and experience emotions without becoming overwhelmed by their intensity, which can lead to acting impulsively in a self-harming manner (Koerner et al., 2007). Group members learned to notice early physical signs associated with emotions such as clenching of the jaw when becoming angry. Skills for this module included strengthening ability to have positive experiences; being mindful of both positive and negative emotions; observing, describing, and accepting the emotions; and understanding that emotions are temporary (Koerner & Linehan, 2000).

Understanding emotions. Five participants learned how to more effectively identify, understand, and experience their emotions non-judgmentally. Selena said, "DBT taught me how to learn more about my emotions. And other people's emotions, too." Participants described they often did not know what emotion they were experiencing or they did not allow themselves to experience the emotion because it was too painful. This finding fit with research on emotion dsyregulation and the emphasis

placed on understanding, observing, and describing emotions in DBT (Linehan et al., 2006).

Several participants reported DBT helped them pay attention to their emotions instead of ignoring them. For example, Selena recalled only being able to put down "numb" for what she was feeling on an emotion regulation worksheet during group therapy. Adam also reported an improvement in his ability to correctly label emotions but added, "To be honest, that is something I still struggle with." Three participants found the group therapy game emotion charades to be a challenging but helpful activity in labeling different emotions.

In addition to labeling emotions, participants learned to identify emotion triggers. Tara reported she was more emotionally vulnerable after conversations with her mother and identified her feelings as disappointed and rejected. She said that before understanding what her emotions were, she just labeled them as "dumb" and "bad." When adolescents are taught to respond to uncomfortable or negative emotions with an approach of trying to understand them, they often experience less emotional intensity from them (Safer, Telch, & Chen, 2009).

. Along with identifying emotions, five participants described the skills of observe emotions, which is acknowledging and experiencing feelings without judgment. For example, both Davey and Jose found the exercise of simply experiencing their emotion without judging themselves for having the emotion to be internally validating. Adam described his experience of non-judgmentally observing and experiencing sadness:

> Which, when I ignore that sadness it only becomes more and more intense. And it grows. That is what leads to my suicidal thoughts. However, I simply notice my sadness, welcome it and not ignore it. Then I feel more in control. Not it.

> DBT taught me to control my emotions like that. Not to ignore them but to accept them.

Similar to these findings, Kostiuk and Fouts (2002) interviewed adolescent females with conduct problems and found they were unable to constructively manage their negative emotions because they had very few strategies for regulating their emotions and the ones they had were destructive.

Skills to decrease emotional vulnerability and distress. Several of the participants engaged in maladaptive coping skills such as drug or alcohol use to manage overwhelming or negative emotions. Additionally, eight of the participants expressed that self-harming behaviors were the method they preferred to reregulate their emotions. This finding fit with the literature stating that self-inflicted injury is a more rapid and effective pathway to emotional relief than other maladaptive behaviors such as alcohol use, food binges and purges, and drug abuse (Safer et al., 2009). These results also aligned with Linehan's (1993a) research-- adolescents who often demonstrated difficulty in regulating emotions often manifested symptoms of parasuicidal behaviors.

All nine participants described using DBT emotion regulation skills to decrease their emotional vulnerability and distress, which decreased their impulsivity. Jose described his experience: "We learned about controlling your emotions so they don't control you. I practiced having a remote control for myself so if I got too mad I could just turn it down with my remote." I asked him to explain how this skill was helpful and he replied, "Well, it's like using the buttons. (laughed) It's like a volume on a TV. Like you can make an emotion louder or quieter. So I just try to do that when I feel myself getting angry. I turn the anger volume down." Before using this skill, Jose would engage in head-banging as his coping mechanism.

Jade said she liked the riding the wave skill, which teaches adolescents that emotions are temporary and they will eventually pass:

> Well, it's just like whenever I get really real mad or sad, instead of just doing something right away I wait a little bit. I guess I like to picture the wave part and I just ride it on till it gets soft and fades away. Like my anger gets softer, you know?

I asked Jade if using this skill helped regulate her emotions and she replied, "Uh, yeah I guess so. It made me like less angry and sometimes like less sad. Well, I mean, I mean it would still be the same sad but less than I used to be. Like, I don't cry as much as I used to. I mean, I still get angry though."

When Selena was feeling emotionally vulnerable, she used skills to increase positive emotions, such as the *fake it til you make it* skill. She said, "I just kinda picture myself being happy. Like even if I have to fake being happy I just try to feel happy. Or I like tell myself things that are positive in my life." Other participants also said they used emotion regulation skills to improve their mood and thus experienced less depression. Anna reported an excess of negative emotional arousal. She said she was often "an emotional basket case when I feel depressed", although she attributed this to her thought that girls are generally emotional. Anna reported using emotion regulation skills to manage her feelings of depression. This experience supported the theory that emotion regulation skills are change-oriented skills and help clients increase their capacity for managing negative emotions (Miller et al., 2007).

Similar to this finding, Goldstein et al. (2007) researched DBT with adolescents diagnosed with bipolar disorder who displayed a lack of control over excess emotions. The results of the study found adolescents being treated with DBT exhibited significant improvement from pre- to post-treatment in the following areas: suicidality, non-suicidal

self-injurious behavior, emotional dysregulation, and depressive symptoms (Goldstein et al., 2007). The results of this study indicated DBT might be a promising treatment for adolescents with bipolar disorder (Goldstein et al., 2007).

Tara used the imagery skill to increase her positive mood. She elicited feelings of happiness and relaxation by looking at the picture of a tropical island she drew during DBT skill group and imagined she was on a vacation from her problems. Casey also improved her mood by using the skill of focusing on the positive emotions. She explained, "I can cling to that tiny bit of light and the small moments when I can feel, like happy or just bliss. Even if the big picture is bad. If there's just a couple good things. And you can hold onto those and hope that there's just gonna be more." Similarly, Nock (2010) identified several emotion regulation skills, such as imagery, to be helpful in adolescent affect regulation.

Interpersonal effectiveness module—Improved relationships. One theme of improved relationships emerged from the participants' experience with the interpersonal effectiveness module. Eight participants reported an improvement in their relationships due to having more effective communication skills. The participants attributed these improvements to their greater ability to control their emotions and react with less emotional intensity. According to the theory of DBT, because emotionally vulnerable persons are often not able to correctly identify and regulate their emotional experiences internally, their ability to communicate their feelings to others and effectively seek support is greatly reduced (Linehan, 1993a; Linehan et al., 2006).

Four of these participants said their relationships with their parents/caregivers improved. For example, Selena used interpersonal effectiveness skills to improve

communication with her stepfather. She said by utilizing *self-respect, assert, and express* skills, "I learned how to talk to him in a way that he would listen." This was similar to the case study of a female adolescent who also reported improvements in her relationship with her father (Nock et al., 2007). One study found that improving communication between adolescents and parents enhanced the safety of the adolescent because parents were more likely to have information that might help them identify if their child was at risk for suicide (Klaus et al., 2009).

Adam used interpersonal effectiveness skills to repair a relationship with his best friend: "Actually, I was not 'speaking' (he used air quotes) to my best friend before DBT. And after I graduated I reached out to her and now we are best friends again. I learned something in DBT that helped me talk to her." Adam described using the skills of *validating* the other person and having an *easy manner*. Jeremy focused on improving relationships in his life by being nonjudgmental and not jumping to conclusions about them:

> I mean I tried to get to know how people were. How or where they were coming from, ya know? Like I tried to think maybe I don't know about their life just like they don't know about mine. So ain't nobody can judge me and I tried to do that to other people.

The theme of improved relationships with peers was also found in a qualitative case study of one adolescent receiving DBT (Nock et al., 2007).

The primary social environment adolescents need to use their skills in is school (Gould et al., 2003). Anna and Jade both described using interpersonal effectiveness skills in school. Anna said she had poor relationships with her teachers because she "got in a lot of trouble for my mouth, for like saying rude things." Using the GIVE skills, she was working on improving these relationships but still faced challenges in this area. She

said, “I’m not perfect. I don’t think I will ever like my teachers but I’m getting better at it.” When I asked Anna if she noticed a change at school, she said, “Like a little. But, like, I still talk pretty bad to my teachers.” Jade reported she is fighting less at school because of improved relationships in her life. She explained, “It’s probably because my mom, like me and my mom don’t fight as much at home. So I guess I feel like I don’t want to fight that much at school, too.” Jade said fighting with peers at school was still an area she was working on: “It’s starting to get better, so much better than it was, but still not 100%.” Impaired relationships with others was a consistent finding among adolescents demonstrating BPD characteristics because their feelings vacillated frequently and they also switched between avoiding conflict with caregivers and then engaging in intense conflict (Miller et al., 2007).

Themes Related to Negative Experiences or Suggestions for Improvement

Difficulty with Dialectical Behavior Therapy Terminology

While DBT was adapted to include language that was developmentally appropriate for adolescents, the results from this study were contradictory (Miller et al., 2007). Seven participants had difficulty with the terminology used in DBT. Casey said, “It was hard to keep track” of the skills taught in group therapy because the acronyms were confusing. When I asked Anna about using DBT skills, she shared, “Like, to be honest, I don’t really remember what they are called or anything. Like, the names were all crazy like MAN and other letters that I’m supposed to remember.” Jade described being frustrated by the DBT terminology:

> It was like a new language we had to learn. I just did not like that part. It’s like, just speak English to us, you know? Maybe I’d change that. Like make it more

> real, you know? Like for us to actually understand, not for the people who wrote the books and stuff cause they obviously weren't in high school. Yeah, like if it's actually meant for teenagers, like write in a language we can actually understand.

This finding was similar to a qualitative study investigating adult clients' perceptions of DBT (Cunningham et al., 2004). Participants reported the terminology used on the DBT handouts was "over their head" and it was unrealistic to expect them to memorize all of the acronyms they were taught (Cunningham et al., 2004). These researchers noted that clients had difficulty implementing the skills they did not understand due to the" strangeness of the DBT vocabulary" (Cunningham et al., 2004). They also found the skills of distract and self-soothe were easier for the clients to talk about because they were words commonly used, whereas words such as radical acceptance were more difficult because they were less common (Cunningham et al., 2004).

Five of the participants needed time in individual therapy to review the ideas, skills, and theories taught during group therapy because they found them confusing. Although skill training was part of individual therapy, the focus was different than skills training in group therapy. Some participants reported difficulty comprehending a skill or concept when it was taught by the group leaders and were only able to understand when they reviewed it with their individual therapist.

These adolescents noted they did not admit confusion or seek clarification during group because they felt shy or embarrassed in front of other group members. It appeared the participants sought clarification from their individual therapists in part because they felt it was a less judgmental environment. This finding fit with the idea that individual therapy is the treatment mode of DBT that provides adolescents with the opportunity to

express themselves without fearing judgment from peers or family members (Miller et al., 2007).

Group Demographics

Five participants stated their experience was negatively impacted by the demographics of the adolescents in skills group therapy. For three participants, having younger adolescents (age 12 or 13) in the group was distracting. Adam shared his experience: "I felt like I was not able to fully express my issues in the group because there was some very, very immature people in there." Anna said some of the discussions in group therapy "about, like, adult stuff "were not appropriate for the younger adolescents and suggested separating into smaller groups based on age. Two participants said they wished the group was comprised of just their own gender because it was distracting having members of the opposite sex there. While research exists on the developmental differences between adolescent males and females, no research has been done to date on how gender plays a role in DBT (Steinberg, 2005). Additionally, the majority of DBT research stems from work with women diagnosed with BPD, thus skewing the results and possibly limiting the generalizability for male adolescents (Robins & Chapman, 2004).

Duration and Frequency

One of the adaptations of DBT for adolescent clients was shortening the duration of treatment from one year to 16 weeks (Miller et al., 2007). However, despite this change, many participants felt the program was too long. Six participants thought the duration of the DBT program was too long and the frequency of therapy sessions interfered with other parts of their lives. Several participants reported that having to

attend individual therapy once a week, group therapy twice a week, and family therapy about every other week impeded their involvement with extracurricular activities. Several studies have shown that DBT can be effective in modified time formats, such as a brief program (12 weeks) or a 10-week skills only program (Lynch et al., 2006).

Middle Path Module

Middle path skills are designed to help adolescents and family members address their unbalanced, polarized thoughts and behaviors negatively affecting the emotional functioning of family members (Miller et al., 2007). This study found that adolescents did not report meaningful experiences with the Middle Path skill module. Only one participant reported the use of middle path skills with her family and she had limited memory of these skills.

The Middle Path Module was one of adaptations made to DBT specifically for working with adolescents (Miller et al., 2007). Dialectical behavior therapy conceptualizes clients within their environment, which for adolescents is primarily their families (Rathus & Miller, 2002). Because these skills were addressed primarily in family therapy, adolescents not receiving family therapy had less exposure to these skills (Woodberry & Popenoe, 2008). Several participants in this study had limited or no family therapy sessions; thus, it made sense they had difficulty recalling their experiences with the middle path module.

Middle path skills were also taught in group therapy (Miller et al., 2007). However, one explanation for a lack of findings in this area was this was the last module taught in group and less time was allocated to it in the program schedule (Miller et al., 2007). One of the reasons for the limited emphasis on these skills was because it

assumed adolescents would receive these skills in family therapy sessions (Woodberry & Popenoe, 2008).

Another possible reason for the finding that participants had more difficulty recalling and reported fewer skills for the middle path module was this was where the concept of dialectics received the most attention. Dialectics teaches the importance of multiple points of view, both/and thinking, and emphasizes how change is the only constant in life (Miller et al., 2007). Thinking dialectically helps parents and adolescents find compromise in the middle path. The theory of dialectics can be confusing and foreign to many participants (Rizvi, 2012); therefore, participants in this study might not have comprehended or integrated dialectics into their experience of DBT.

Clinical Implications

The clinical implications of this study added further support to a growing area of research. The current study is the first of its kind to explore how adolescents experience DBT in a community mental health setting. This was an exploratory study; therefore, caution should be taken when applying the findings to clinical settings. The reader must determine the transferability and relevance of the findings for his/her particular setting, population, or situation (Merriam, 2009). However, through thick, rich description, it was the goal of this study to provide information on how adolescents experienced DBT in a way that was useful for the reader. The findings from this study have also been compared and supported with current literature and research on DBT, adolescence, and suicidality.

This aim of this study was not in measuring outcomes or specifically looking at the participants' symptoms. However, the skills in DBT address self-harm and

suicidality; therefore, improvements in these areas were discussed during the interviews. The present findings that adolescents reported a decrease in self-harming behavior and a reduction of depressive symptoms added to the literature demonstrating the effectiveness of DBT in these areas (Linehan, Bohus, & Lynch, 2007; Miller et al., 2007; Nelson-Gray et al., 2005; Rathus & Miller, 2002; Robins & Chapman, 2004). These findings pointed to the clinical utility of DBT as an intervention with adolescents struggling with mental health difficulties.

Adolescents in this study reported the focus on learning and practicing skills during group therapy was beneficial to them. Furthermore, they identified a preference for the solution-oriented, problem-solving approach to personal problems shared with the group versus a process-oriented approach. Given these findings, a practical implication of this study would be for psychologists to implement a focus on acquiring and rehearsing new skills in adolescent group therapy.

One finding of this study was adolescents identified the support they received from DBT to be a beneficial part of their experience. This was in part because their home, school, and communities were not supportive. This finding was congruent with other research demonstrating that populations served by community mental health centers typically have limited resources for support (Comtois et al., 2007). Given this finding, along with the growing trend toward implementing DBT in community mental health centers, psychologists should emphasize the role support in working with adolescents in this setting (Choate, 2012; Theisen, 2007).

Another finding from this study was the therapeutic relationship in both individual and group therapy had a positive impact on adolescents' experience of DBT.

Adolescents reported being more motivated to attend therapy and engage in sessions because of the positive rapport with their therapists. This finding of willingness to engage in treatment was contradictory to research that indicated self-harming and suicidal adolescents have a high-rate of treatment noncompliance and therapy dropout (Groves et al., 2012; Koerner et al., 2007). Secure and positive attachments to therapists have also been linked to treatment gains as well as improved global functioning post-treatment (Lilliengren, Falkenstrom, Sandell, Mothander, & Werbart, 2014). Therefore, a clinical implication of this study was the therapeutic relationship should be considered a key factor in the treatment of suicidal and self-harming adolescents (Choate, 2012).

Adolescents in this study seemed to value the validation and acceptance they experienced in individual therapy, often because they did not experience this in other areas of their lives. Validation was identified as more meaningful than change-oriented skills, although these were reported to be helpful. Participants who did not report using many change-oriented skills still responded positively to the validation skills, which might have signified they were not ready for change (Robins & Chapman, 2004). Additionally, adolescents were likely to still be living in an invalidating environment; thus, they were more receptive to validation in therapy (Groves et al., 2012; Miller et al., 2007; Sunseri, 2004). This finding underscored the clinical importance of balancing validation and acceptance skills when working with adolescents.

Difficulty understanding the language and terminology was a common theme among participants including confusion about DBT concepts and difficulty remembering acronyms. This theme has been identified in other DBT qualitative research findings (Cunningham et al., 2004). Adolescents reported they often needed extra time in

individual therapy to clarify and learn the skills because they were unsure or embarrassed in group therapy. It might be important for psychologists using DBT to treat adolescents to regularly check for skill comprehension among group members in a nonthreatening way.

A finding from this study was that adolescents' experience of DBT was impacted by the consistency and frequency of their family's involvement. There are implications in this finding for psychologists working with adolescents and families in a DBT program. Given the backgrounds of the participants in my study, it might be unrealistic to assume that families in a community health center could attend the additional family therapy sessions. Reasons for low involvement could be related to the research, indicating families with lower socioeconomic status had less access to transportation, unavailability of childcare for younger children, and fewer resources (Theisen, 2007).

Additionally, most of the participants in this study who engaged in suicidal or self-harming behaviors reported invalidating family environments and dysfunctional family patterns. One implication for counseling psychologists is there may be a need to focus on resiliency in adolescents despite their dysfunctional family environments (Fine & Sung, 2014). Resiliency literature pointed to understanding factors within the individual, such as competence and self-efficacy, as well as external resources such as parental support and community organizations (Fergus & Zimmerman, 2005). It is important for psychologists to nurture the adolescent's strengths and positive adaptive behaviors to build resiliency regardless of their maladaptive family functioning (Fine & Sung, 2014).

Limitations and Future Directions

One limitation of this study was the small number of participants (n = 9). Despite this sample size, multiple cultural, family, and situational backgrounds were represented. For example, two participants were living in a group home setting and four of the participants were male. The majority of research on DBT has been done with adult Caucasian women diagnosed with borderline personality disorder, thereby limiting the generalizability of treatment effects to other populations (Rizvi et al., 2012). Gender is not specifically accounted for in the treatment model of adolescent DBT, yet research indicated the needs of male and female adolescents will differ based on the social pressures and biological stressors (Nolen-Hoeksema, 2012). Future research should expand on the present study by replicating the methodology with a larger sample size and include participants from varying backgrounds.

While this study included participants from diverse backgrounds, no specific questions were asked about the role of multicultural factors in their experience of DBT. Selena's experience of frustration at not having a bilingual family therapist highlights the importance of researching DBT with culturally diverse populations. Furthermore, minority populations often seek services through community mental health centers (Ben-Porath et al., 2004). Therefore, research on DBT in community settings needs to include minority participants (Ben-Porath et al., 2004). This research might help psychologists to understand how the effectiveness of DBT with adolescents translates across cultures and to identify potential areas where adaptations are needed (Choate, 2012).

Another limitation of this study was the time gap between when the adolescents completed the DBT program and when they participated in the interview. The

participants might have had difficulty recalling their experiences because of memory loss or lack of relevancy. Research indicated that a retrospective approach might create biases in what and how participants described their experiences (Nisbett & Wilson, 1977). However, one aim of the study was to explore how adolescents used skills after DBT and what impact this had on their lives. Therefore, the passing of time was a variable I expected to encounter and was included in the design of this study. Participants interviewed with me between two and six months after completing the program, which might account for differences in their experiences.

A desire to produce positive responses might have also led participants to over-report positive improvements or provide fewer negative experiences. The participants in this study described an overall positive experience with DBT but also provided examples of negative experiences and areas of the program they did not like. The results of this study should also be viewed within the limitation that the adolescents were volunteer participants and they might have had different experiences than adolescents who did not volunteer for the study. It is the responsibility of the reader to decide whether or not the results would be applicable to their own situation (Merriam, 2009).

Another limitation of this study was the interviews were conducted in a semi-private setting. The location allowed for a more relaxed, conversational approach to the interviews and the participants appeared to respond positively to the setting. Several participants commented on being glad the interviews were not held at the community mental health center because they felt they would be identified there. Because the adolescents associated the center with therapy, the location of the café allowed for a separation between therapy and research. However, the experiences the participants

recalled might have been limited by not being in a completely confidential environment. Future research might explore conducting qualitative interviews with adolescents in a private setting to understand if they would be more comfortable discussing personal information in that setting.

According to Linehan (1993b), DBT is most effective when all components of the manualized treatment are present. In the DBT treatment manual for adolescents, including family members in therapy is seen as an important part of treatment to address the developmental needs of adolescents compared to adults (Miller et al., 1997). However, several of these participants were not able to experience the family therapy component of DBT to address those areas of dysfunction. One limitation of this study was adolescents who did not receive family therapy might not have gained the full benefits of DBT and therefore had different experiences than other participants. Future DBT studies should examine the importance of family therapy with suicidal adolescents from dysfunctional families and its role in DBT. More research is also warranted in the area of improving family member participation and engagement in therapy.

Many of the therapeutic components, skills, and assumptions are based on the notion that an adolescent lives with their parent, which was not the case for two participants in this study. Although I did not ask Jose or Tara specifically about their experience of discussing skills that focused on parent-child interactions, I would imagine there would be a level of discomfort for them. Besides having an obvious impact on the family therapy component of their treatment, adolescents not living with parents might have experienced differences in other areas of DBT. More research is needed to

understand how adolescents not living with parents, such as group or foster homes, experience the parent focused skills of DBT.

The number of studies on DBT with adolescent populations is increasing (Wasser et al., 2008). However, caution should be taken when using a treatment empirically supported for adults with adolescent clients because of the developmental and social differences. For example, one finding of this study was adolescents valued the approachable, engaging styles of their group leaders, whereas adults valued the knowledge base and skill proficiency in their group leaders (Cunningham et al., 2004). These results highlighted a difference between how adolescent clients and adult clients experience DBT. Further research is needed to understand the differences in how adolescents and adults experience DBT.

This study found that adolescents did not report meaningful experiences with the Middle Path skill module. Reasons for limited experiences with the Middle Path skills might include (a) these skills were addressed primarily in family therapy so adolescents not receiving family therapy would have had less exposure to these skills and (b) these skills received less attention in group therapy, thus the concept of dialectics in these skills could be perceived as challenging (Woodberry & Popenoe, 2008). Because the Middle Path module was one of adaptations made to DBT specifically for working with adolescents, more research should be done to explore the lack of themes in this study related to this module (Miller et al., 2007).

As research has demonstrated that DBT is an effective treatment for adolescents with suicidal and self-harming behaviors, counseling psychologists should continue to study and train in DBT (Choate, 2012; Kazdin & Whitley, 2006; Rizvi et al., 2012). This

is because of the core belief that counseling psychology helps individuals alleviate distress in their lives, improve overall functioning, and increase well-being (APA, 2002). Furthermore, qualitative research is seen to be congruent with the beliefs and goals of counseling psychology (Morrow, 2005). Wertz (2005) stated that qualitative research, such as this current study, contributes to the field of counseling psychology by providing methods to capture important insights into sensitive human experiences both through triumphs and struggles.

Finally, this study demonstrated that adolescents experience DBT in many ways; by giving them the opportunity to voice their experiences, many important findings emerged. However, this was the first and only qualitative study of the subjective experiences of DBT from the voice of adolescent clients. Therefore, more qualitative studies are needed to further the understanding of how adolescents experience DBT. Additional research investigating adolescents' subjective experience with DBT in a variety of settings and across multiple disorders would greatly contribute to the current literature.

Conclusion

Despite growing evidence that dialectical behavior therapy (DBT) is an effective treatment for suicidal and self-harming adolescents, there is a lack of knowledge on how adolescents experience DBT. The goal of the current study was to address this lack of knowledge by providing readers with an understanding of how adolescents experienced DBT including the treatment components and skill modules in a community mental health setting. The participants in this study reported an overall positive experience in DBT and described beneficial results such as decreased suicidality and self-harming

behaviors, improved ability to tolerate distress, increased mindfulness and emotion regulation, and healthier relationships with others.

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APPENDIX A

RECRUITMENT FLYER

You Could Be In A Research Study about Teens and Dialectical Behavior Therapy!

My name is Jessica Chenoweth and as part of my degree at The University of Northern Colorado I am researching how adolescents experience Dialectical Behavior Therapy. This research study is about teenagers who have been in a DBT program. **You could be a voluntary participant in my study!**

Teens who take part get a $35 gift card to Target or Wal-Mart to thank them for their time!

Would the study be a good fit for me? YES if:

- You are between the ages of 12-17
- You have been in a DBT therapy group
- You are willing to talk about your experience in DBT

What will happen in the study? You will:

- Meet with me for an interview (about an hour) in person or over the phone or via Skype
- This is not a therapy session-just a short interview
- I will use a fake name for you in the study so that your identity is unknown to others
- Possibly answer a few follow-up questions in a short second interview
- **Get a THANK YOU GIFT for your time!**

There may be possible benefits if you take part in the study.

- Your contribution to this research may help other kids
- You will get a chance to share your thoughts about DBT

To take part in this research study or for more information, please contact Jessica Chenoweth at 720-292-0182 or jesschenoweth@gmail.com

UNIVERSITY of NORTHERN COLORADO

APPENDIX B

CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH

UNIVERSITY of NORTHERN COLORADO

CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: Understanding Dialectical Behavior Therapy through the Voice of Adolescent Clients
in a Community Mental Health Center

Researcher: Jessica Riedel Chenoweth, Counseling Psychology Doctoral Student
Phone Number: (720) 292-0182 Email: ried4063@bears.unco.edu

Research Advisor: Mary Sean O'Halloran, Ph.D., Professor, Dept. of Counseling Psychology
Phone Number: (970) 351-1640 Email: mary.ohalloran@unco.edu

As part of a requirement of my doctoral degree in psychology, I will be conducting a research study that will investigate adolescents' experience of Dialectical Behavior Therapy (DBT). Your child has been recruited for this study because he or she completed a 16-week course of DBT treatment at the community mental health center and has unique insights into what it's like to experience DBT. If you grant permission and if your child agrees to participate, I will interview your child in person, over the phone, or via Skype for approximately 1 hour with the possibility of a second shorter (30 min or less) interview for follow-up questions or clarification. The topics of the interviews will be about your child's experience of DBT at the community mental health center where he or she completed the DBT outpatient program. I will be asking questions such as what impact DBT has had on their lives, what they thought of the program, what skills they are using now, any examples of how DBT has helped them and any improvements they would like to see made in the adolescent DBT program. The study will require participants to agree to complete the interview as well as a possible short follow-up interview, which may be several weeks later. In addition to the interview, your child may bring items such as drawings, poems, past DBT handouts they have used and any other material he or she feels will help explain their thoughts or feelings about DBT to the interview. The researcher may make copies or take pictures of these items as additional data with your child's permission. Observations of your child's nonverbal behaviors during the interviews, such as gestures or facial expressions, will also be noted by the researcher. Interviews will be conducted either at the community mental health center or at a public location, such as a coffee shop, that offers a quiet place to talk. I will

provide assistance with arranging and paying for transportation, such as reimbursing bus fares or gas money.

Your child will be given a pseudonym (fake name) to be used instead of their real name. The names of participants will not appear in any professional report of this research. Additionally, any other identifying information will be removed or changed to protect the privacy of participants. Interviews will be audio recorded so that the researcher may transcribe them at a later time. The audiotapes will be kept in a locked, secure place where only the researcher and her advisor has access to them and all data files will be password protected on a private computer and all identifying data will be destroyed after three years. The information that your child shares will remain confidential with the exceptions of reports of harm to themselves or to others, which I am legally mandated to report.

This research will contribute to the field of psychology in order to further educate mental health professionals about how adolescent clients experience DBT in a community mental health setting. Understanding how DBT is effective in treating psychological problems in adolescents will assist therapists and mental health agencies in developing the best treatment available. Furthermore, this study may contribute to research and therapeutic treatments to help troubled adolescents in the future.

While as an advanced psychology student I have experience in counseling adolescents and responding to emotional or behavioral issues that may arise, my role in this situation is limited to that of a researcher, not a therapist. If troubling issues arise and counseling is desired, I will provide a list of names and numbers of therapists who could provide counseling for your child.

As a thank you for participating in this study, your child will receive a $35 gift card for Target or Wal-Mart. Participants are free to withdraw from the study at any time and will still receive compensation.

Please feel free to phone me at (720-292-0182) if you have any questions or concerns about this research and please retain one copy of this letter for your records.

Thank you for assisting me with my research! I greatly appreciate you and your child's contribution to this important topic.

Sincerely,

Jessica Riedel Chenoweth

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research. A copy of this form will be given to you to retain for future reference. If you have any concerns about your

selection or treatment as a research participant, please contact the Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-2161.

_____	_____
Child's Full Name (please print)	Child's Date of Birth (month/day/year)

_____	_____
Parent/Guardian Signature	Date

_____	_____
Participant's Signature	Date

_____	_____
Researcher's Signature	Date

APPENDIX C

ASSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH

UNIVERSITY of NORTHERN COLORADO

ASSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: Understanding Dialectical Behavior Therapy through the Voice of Adolescent Clients
in a Community Mental Health Center

Hi,

I am a graduate student at the University of Northern Colorado and I am interested in studying teenagers who have completed a Dialectical Behavior Therapy (DBT) program at a community mental health center. I chose you to be a possible participant in this study because you have completed a DBT program and have lots of valuable thoughts, feelings and opinions about your experience with DBT.

If you agree to be in the study we will meet in person or over the phone for an interview that will be about an hour long. In the interview I will ask you questions about your experience with DBT. Some example questions are: How do you use DBT skills in your life now? What was your favorite and least favorite part of DBT? Your answers to these questions are important for helping understand DBT better. If necessary, I may contact you afterwards if I have any follow up questions.

To protect your privacy you will get a fake name to be used in the study. Your real name will not appear anywhere in the report so that no one could identify you, this will help ensure that what you tell me stays private. However, I am legally required to report if you have plans of harming yourself or someone else. Also, I will keep all the tapes of our conversations in a locked place that only my advisor and myself will have access to. I will erase all the identifying information I collect from this study after it is over.

During the interviews we will be talking about how DBT helped or didn't help with the problematic behaviors or feelings you were struggling with when you started the program. What you share with me is completely up to you and if you feel uncomfortable talking about something then we don't have to. This is different than therapy. This is a study where I want to find out from you what you thought of DBT by talking to you and asking you questions. This is a chance for you to share your experiences with DBT and give therapists some feedback. If what we talk about brings up some troubling issues for

you and you want counseling, I will give you and your parent/guardian a list of names and numbers for licensed counselors.

By assisting me with this research you are helping other teenagers struggling with life problems and are helping counselors and psychologists find out what the best kind of therapy is. Hopefully this study will benefit others in the future and you can help researchers and therapists to better understand DBT.

As a thank you for helping me with my research, you will get a $35 gift card to Wal-Mart or Target after the interview. If for any reason you want or need to stop participating in the study you will still get the gift card. Also, I may contact you again for a second short interview to double check any information you gave me or to clear up anything I am confused about from the interview if needed.

Your parent or guardian has given permission for you to be in this study so if you would like to participate please sign and date below. As a voluntary participant you have the right to change your mind and can withdraw from the study at any time.

Please feel free to contact me (720-292-0182) if you have any questions or concerns about this research and please save a copy of this form for yourself.

Thanks for thinking about helping with my research. I really appreciate it! If you would like to participate, please sign below.

Sincerely,

Jessica Riedel Chenoweth

_____ _____

Your Full Name (please print) Your Date of Birth (month/day/year)

_____ _____

Your Signature Date

_____ _____

Researcher's Signature Date

APPENDIX D

INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY of
NORTHERN COLORADO

Institutional Review Board

DATE:	August 27, 2013
TO:	Jessica Chenoweth
FROM:	University of Northern Colorado (UNCO) IRB
PROJECT TITLE:	[482841-2] Understanding Dialectical Behavior Therapy through the Voices of Adolescents
SUBMISSION TYPE:	Amendment/Modification
ACTION:	APPROVED
APPROVAL DATE:	August 26, 2013
EXPIRATION DATE:	August 26, 2014
REVIEW TYPE:	Expedited Review

Thank you for your submission of Amendment/Modification materials for this project. The University of Northern Colorado (UNCO) IRB has APPROVED your submission. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of August 26, 2014.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Sherry May at 970-351-1910 or Sherry.May@unco.edu. Please include your project title and reference number in all correspondence with this committee.

Jessica -

Hello and thank you for making the changes requested by Dr. Roehrs. I've reviewed all of your application materials and have no further requests for modifications or additional materials.

Please be sure to use all of the revised materials developed through the review process in your participant recruitment and data collection.

Best wishes with your research. Don't hesitate to contact me if any IRB-related questions or concerns arise.

Sincerely,

Dr. Megan Stellino, UNC IRB Co-Chair

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Northern Colorado (UNCO) IRB's records.

APPENDIX E

INTERVIEW TOPICS AND POSSIBLE QUESTIONS

Interview Topics and Possible Questions

The main focus of my research is to understand the experience of adolescents who have completed an intensive 16-week DBT program in a community mental health setting. Based on the major theoretical components of DBT, questions for the interviews may include:

1. Tell me about your experience in the DBT program.
2. What did you like most?
3. What did you like least?
4. Has the program changed any part of your life? And if so, how?
5. Which of the skills do you use?
6. Which skills were/are the most helpful?
7. Which skills were/are the least helpful?
8. Tell me about the impact has the DBT program had on your personal relationships.
9. Tell me about the impact DBT has had on your ability to control your emotions.
10. Tell me about the impact DBT has had on your ability to tolerate distress.
11. How are you using mindfulness in your life? Example?
12. Describe your experience with the Middle Path skills.
13. Describe the impact DBT has had on your experience in school? With teachers?
14. Tell me about your experience being in skills groups? What did you like/not like?
15. Tell me about your experience being in individual therapy? What did you like/not like?
16. Tell me about your experience being in family therapy? What did you like/not like?
17. Describe how your life is different after completing DBT.
18. If you could keep one thing the same about the program what would it be?
19. If you could make changes, what would they be?
20. What advice do you have for the therapists on how to run the program?
21. How has your experience with parasuicidal behaviors changed?
22. How has DBT impacted your relationships?
23. Describe any changes your friend, families or others have noticed in you since you completed the program.
24. What is an example of how you used a DBT skill?
25. If you had to describe DBT to a friend, how would you say it?
26. What stood out the most to you in your experience with DBT?
27. If the participant brings artifacts (to be described below) to the interview, I will ask the participants to describe what meaning the artifact(s) hold for them and how the artifact represents their experience with DBT.
28. At the end of the interview, participants will be given an opportunity to address any areas they feel are relevant that were not covered by the interviewer's questions.

APPENDIX F

MANUSCRIPT

UNDERSTANDING DIALECTICAL BEHAVIOR THERAPY THROUGH THE VOICE OF ADOLESCENT CLIENTS

Jessica Riedel Chenoweth

Abstract

Dialectical behavior therapy (DBT) has recently been shown to be an effective therapy for treating adolescents with suicidal and self-harming behaviors. Despite the growing interest of DBT, a lack of research remains on the subjective experiences of DBT from the perspectives of adolescent clients. Therefore, the purpose of this qualitative study was to explore how adolescents experience DBT in a community mental health setting. Using constructivist, case study methodology, semi-structured interviews were conducted with nine adolescent participants. Findings emerged from the shared experiences of the participants including themes related to treatment modality, use of skills, and the impact of DBT on their lives. Participants reported beneficial results such as decreased suicidality and self-harming behaviors, improved ability to tolerate distress, increased mindfulness and emotion regulation, and healthier relationships with others. Negative experiences included difficulty understanding DBT terminology, too broad of an age range in group therapy, and inconsistent family involvement. Clinical implications and future research directions for the use of DBT with adolescents were discussed.

Keywords: adolescent, dialectical behavior therapy, community mental health, self-harming behaviors, suicidality

Introduction

Recently, there has been an increase in the number of adolescents seeking psychological treatment for recurrent suicidal ideation, suicide attempts, and self-harming behaviors (Choate, 2012). In the United States, suicide is the third leading cause of death among persons aged 15-24 years (Centers for Disease Control and Prevention, 2013). In a 2011 nationally-representative sample of youth in grades 9-12, it was found that regarding the 12 months preceding the survey, 15.8% of students reported they had seriously considered attempting suicide; 12.8% of students reported they had made a plan about how they would attempt suicide; 7.8% of students reported they had attempted suicide one or more times; and 2.4% of students reported they had made a suicide attempt that resulted in an injury, poisoning, or an overdose that required medical attention (Centers for Disease Control and Prevention, 2011).

Clients presenting with self-harming behaviors and suicidality can be a challenge for therapists in community mental health settings because of the complexity of symptoms, likelihood of hospitalization, and lack of empirically-supported treatment interventions available (Groves, Backer, van den Bosch, & Miller, 2012; Koons et al., 2001; Miller, Rathus, & Linehan, 2007). Furthermore, treatment for suicide and self-harming behaviors is costly to treat due to the frequency of inpatient stays, emergency room visits, hospitalizations, and long-term psychotherapy treatment (Katz, Cox, Gunasekara, & Miller, 2004). Thus, research on less expensive, effective treatment alternatives to hospitalization for suicidal adolescents would be highly valuable to adolescents, their families, and the mental health care system.

The treatment approach with the most empirical support for treating suicidal and self-harming adolescents is dialectical behavior therapy (DBT), which was developed by Marsha Linehan for working with adults diagnosed with borderline personality disorder and then adapted for use with adolescents (Linehan, 1993a; Miller et al., 2007). The effectiveness of DBT has been demonstrated with multiple psychological disorders and across a variety of settings (Lynch & Cozza, 2009; Lynch, Trost, Salzman, & Linehan, 2007; Miller et al., 2007; Pistorello, Fruzzetti, MacLane, Gallop, & Iverson, 2012; Robins & Chapman, 2004). Dialectical behavior therapy research has primarily focused on adults, especially women with BPD. New studies have emerged that explore adults and DBT in the areas of geriatric psychology, forensic settings, substance dependence, veterans, and eating disorders (Choate, 2012; Woodberry & Popenoe, 2008). Given the promising results of these studies, DBT was adapted for use with adolescents.

An early study applied DBT to adolescents exhibiting BPD traits (Rathus & Miller, 2002) and was groundbreaking in that it targeted, rather than excluded, participants with high Axis I and Axis II comorbidity and suicidality. Traditionally, adolescent studies looking at Axis I disorders did not include suicidal participants or participants with Axis II features (Linehan, Heard, & Armstrong, 1993). Parents of the adolescents were also included in the DBT skills group to maintain the progress and enhance skill practice generalizability to the home, which was a new variation from Linehan's (1993a) DBT work with adults. Results of this study showed that DBT decreased psychiatric hospitalizations for adolescents and increased treatment compliance (Rathus & Miller, 2002). However, there were no significant differences in the number of suicide attempts made during treatment. Dialectical behavior therapy was shown to be

a promising treatment option for adolescents with BPD characteristics (Rathus & Miller, 2002).

Following this study, many other researchers began to adapt traditional DBT for treatment of adolescents. A review of 12 studies on DBT with adolescents found that the use of the adolescent adaptations of DBT might lead to better outcomes than treatment as usual (TAU) in reducing parasuicidal behaviors, depressive symptoms, days in psychiatric hospitalization, and in reducing conflict in families (Dimereff & Koerner, 2007). These studies were conducted in outpatient, residential, forensic, and inpatient settings with adolescents and their families (Choate, 2012; Groves et al., 2012; Dimereff & Koerner, 2007; Miller et al., 2007; Robins & Chapman, 2004).

While these studies are promising, there remains a lack of research investigating DBT from the subjective experience of adolescents (Katz et al., 2004). There is a need to understand *how* DBT might be effective in treating adolescents (Quinn & Shera, 2009; Woodberry & Popenoe, 2008). To date, there has been one qualitative study about how adults perceive DBT and none from the perception of adolescent clients (Cunningham, Wolbert, & Lillie, 2004). Therefore, this study explored how adolescents experienced a DBT program in a community mental health setting. This case study sought to contribute to the research by understanding *how* adolescents experienced DBT. The unique insights and meanings gained from the current study might benefit mental health professionals using DBT with adolescents, psychological agencies that have or are starting a DBT program, and provide feedback specific to community mental health settings. Along with clinical benefits, the findings of this study might contribute to much-needed research on suicide prevention, understanding borderline personality disorder in adolescents, and

decrease self-harming behaviors as well as provide possible directions for further research.

The following research questions guided this study:

Q1 How do adolescents experience DBT?

Q2 How have the lives of adolescents been impacted by DBT?

Q3 How are the skills learned in DBT being used by adolescents?

Methodology

Theory

This study was conducted from a constructivist theory (Crotty, 1998). Constructivist theory and dialectical behavior therapy (DBT) are compatible in many ways for conducting research. One connection between constructivist research and DBT is that neither theory views the participant or client as having an objective truth to be discovered (Morrow, 2005). Reality is co-constructed in the constructivist research relationship with the understanding that multiple realities exist. Likewise, one of the basic assumptions of DBT is that there is no absolute truth (Linehan, 1993a).

In DBT and qualitative research, the therapist/researcher is the primary instrument for gathering information and data collection. To be an effective researcher and therapist, one must be skilled at interviewing, listening, being in intimate relationships, tolerating ambiguity, and respecting the unique nature of the participant/researcher or client/therapist relationship (Morrow, 2005). Additionally, the clients and participants are the “experts” of their own lives and are in control of what information they choose to share with the therapist and researcher.

Another similarity between constructivist theory and DBT is the focus on building a trusting relationship. In DBT, the therapeutic relationship is a working alliance with open and honest communication and reciprocal vulnerability (Linehan, 1993a). Similarly, in constructivist research, the researcher seeks to build rapport and communication with the participants (Crotty, 1998). In both researcher and therapist roles, it is important to be aware of any potential power differential that accompany those roles and work toward developing a collaborative relationship.

Both constructivist research and DBT take the participant/client's cultural context into account. In constructivist theory, the researcher searches for meaning in people's lives and examines the way their world is socially constructed (Creswell, 2007). In DBT, there is a focus on multicultural competency for therapists, which includes sensitivity, respect, and understanding client's worldviews within the context of their culture (Miller et al., 2007). The lives of people who seek services at a community mental health center are complex so many factors such as family background, ethnicity, culture, age, sexual orientation, socio-economic status, and life experience must be taken into consideration. A constructivist perspective allows for each of these factors to play a role in the participant's experience and acknowledges that each participant will have their own "reality."

Design

Case study methodology, which has been used across multiple disciplines, including psychology, sociology, history, education, and anthropology (Merriam, 1998), was employed for this study. According to Merriam (1998), "As the product of an investigation, a case study is an intensive, holistic description and analysis of a single

entity, phenomenon or social unit within a bounded system" (p. 34). The bounded system for this study was a specific intensive outpatient DBT program at a single community mental health center. There were several cases (adolescents) within the same bounded system (community mental health DBT program), which made the use of case study an appropriate methodology (Creswell, 2007, p. 74). This study was instrumental in nature because it sought to provide insight into the phenomenon of adolescents' experiences of DBT (Stake, 1995). An advantageous outcome of qualitative case study methodology is that new meanings can be discovered, boundaries of the reader's experience may be expanded, or confirmation of what is already known may occur (Merriam, 1998).

Participants

Nine adolescents of varying cultural backgrounds participated in this study (see Table 1). Five of the participants were female and four were male; they ranged in age from 13 to 18 years old. The participants in this study had diverse ethnic backgrounds including African American, Caucasian American, Asian American, and Hispanic American. All participants completed a 16-week intensive outpatient DBT program at a community mental health center in the Midwest region of the United States.

Table 1

Participant Demographics

Participant Pseudonym	Age	Gender	Ethnicity	Living situation	Maladaptive Behaviors
Anna	17	Female	Caucasian	Home with mother	Suicide attempt, cutting, substance use
Tara	14	Female	African American/ Caucasian	Therapeutic group home	Physical aggression, high risk behaviors
Davey	17	Male	Caucasian	Home with mother and step-father, primarily stays at friends' houses	Substance use, suicide attempt, arrests
Casey	16	Female	Caucasian	Home with adoptive parents, sibling, recent d/c from RTC	Cutting, suicide attempt
Adam	18	Male	Caucasian	Home with parents, sibling	Cutting, burning, head-banging, suicide attempt
Jade	15	Female	Korean American/ Caucasian	Home with parents, siblings	Burning, physical aggression
Jose	13	Male	Hispanic	Residential Treatment Center	Head-banging, physical aggression
Selena	16	Female	Hispanic	Home with mother and step-father, siblings	Cutting, substance use
Jeremy	15	Male	Hispanic/Caucasian	Home with mother, step-father, step-siblings	Depression, arrests, substance use

Setting

The setting for data collection was in a private section of a café located within the participants' community. This setting was suggested by the first participant I interviewed because the location was convenient to where she lived. The location provided a semi-private space that was quiet, safe, and comfortable; therefore, the researcher utilized this

location for the remaining interviews. Each participant was familiar with this location and identified it as convenient and easily accessible.

Interviews took place in a back corner of the café that was separate from the rest of the establishment. There were no nearby tables or customer traffic, making it highly unlikely that other people could overhear the interviews. The researcher was cognizant of protecting the participants' confidentiality and monitored the volume level of the interview. Additionally, the researcher used her counseling psychology skills to gently redirect the interviews toward experiences related to DBT and away from more personal disclosures by the participants. A benefit of the setting was the relaxed atmosphere made it easier to quickly develop rapport with the participants. Participants appeared to be at ease in the interview setting as evidenced by the openness and honesty present in their interviews.

Data Collection Methods

Participants were recruited through a flyer posted at a community mental health center as well as through distribution of the flyer by the DBT therapists. An appropriate incentive of a $35 gift card was offered to increase the likelihood of participant response. Parental consent as well as participant assent were obtained from the parents or legal guardians of the adolescents who were under the age of 18. To ensure confidentiality, all participants were given a pseudonym to protect their identity.

The methods for data collection were semi-structured interviews, observation, artifacts, field notes and a reflexive journal. These are common forms of data collection in case study methodology (Merriam, 1998; Stake, 1995; Yin, 2014). In congruence with constructivism, I utilized in-depth, semi-structured interviews as the primary source of

data collection (Stake, 1995). Each participant was interviewed in person for approximately one hour. All interviews were recorded on a digital audio file for transcription at a later time. The digital files were erased at the end of the research project.

Trustworthiness

To enhance the trustworthiness and rigor of this study, I employed several methods: saturation, triangulation, member checks, peer reviewer, expert reviewer, researcher reflexivity, thick descriptions, and an audit trail (Lincoln & Guba, 1985; Merriam, 2009; Morrow, 2005). I used multiple forms of data collection (interviews, observations and artifacts) with semi-structured interviews being the primary method. I also conducted member checks after the data had been analyzed and no changes were made.

Reflexivity

I worked as a therapist in the adolescent outpatient DBT program in the community mental health center that the participants were recruited from. During my time there, my colleagues and I noticed the effectiveness of our program as reported by therapists, schools, parents and the adolescents themselves. We shared stories of success and knew anecdotally that DBT was working. I saw teenagers go from cutting their bodies daily to learning new, alternate ways of coping with their distressing emotions so that they stopped cutting altogether. There were also many clients who struggled with managing their emotions unsuccessfully and continued to engage in destructive and self-harming behavior as means to cope with their emotions. I was curious as to why DBT was working for some adolescents and not for others. Although the team used pre- and

post-treatment measures, the results did not go deep enough into understanding why change had occurred or not occurred. I wanted to know how the adolescents were experiencing with DBT, what they found helpful or useful and what their overall perception of the program was. I realized that the answers to these questions could only come from the adolescents themselves.

A reflexive journal was kept for the duration of the research process. The goal of keeping a reflexive journal was to record any information that concerns my thoughts, feelings, reactions, values, potential biases, impressions, and insights about the study (Lincoln & Guba, 1985). The journal was also used for logging information about decisions in the methodology of the study and became part of the audit trail (Lincoln & Guba, 1985). Similar to the field notes, the reflexive journal was kept electronically on my laptop computer in a password-protected file and will be electronically backed up.

Data Analysis

Data were analyzed according to the constant comparative method in conjunction with theoretical, thematic, and organizational analysis (Braun & Clarke, 2006; Merriam, 1998; Tesch, 1990). In qualitative research in counseling psychology, the researcher drives the theoretical thematic analysis based on the theory being studied. In this study, the emerging themes came from the data and were then organized into components of DBT, in accordance with the research questions (Braun & Clarke, 2006).

To enhance trustworthiness, a colleague with experience in qualitative research methodology reviewed the transcripts and developed categories and themes independent of my analysis. We then compared themes and discussed areas where themes overlapped or were discrepant and then reanalyzed the data. I went through several rounds of theme

development, identifying data units that were redundant or could be compressed into one theme and also reorganizing categories so that the themes of the data were best represented. My research advisor, who is well versed in qualitative research, also helped guide the data analysis and reviewed the themes. Additionally, the use of multiple participants in a case study is another way to triangulate data within the case as they provide reinforcement of the themes (Merriam, 1998).

Transferability and Dependability

Transferability was achieved by providing thick, rich description of the process, the participants, the setting, and of the data (Merriam, 1998). Detailed information and quotes from the participants was included to help the reader determine how closely the participants' experiences with DBT are similar to their own or to what has been reported in other studies. Thick, rich description also made the findings more transferable to mental health care providers working with adolescents and families using dialectical behavior therapy as their theoretical modality. Ultimately, it is the responsibility of the reader in constructivist research to determine the transferability of the research and how the findings would be beneficial to their situation (Creswell, 2007). Dependability was ensured through audit trails wherein I kept track of the changes in the emergent design of the study, participant sampling, settings, interviews, the evolution of the codes, themes of the data, and the analysis procedures (Creswell, 2007). All field notes, transcriptions, and other documents were included in the audit trail to support confirmability of the study (Creswell, 2007).

Ethical Concerns

Ethical considerations included protection of participants, concerns related to research in a known setting, dual relationships, and safety. Measures were taken to address ethical concerns for working with this population: Institutional Review Board approval was obtained for this study, pseudonyms were used to protect participants' identity, consent and assent forms were signed and participants were given a list of resources available to them if they desired counseling services.

In qualitative research, the data collection methods are based primarily on the interactions between the researcher and the participants. Due to the nature of these interactions, ethical considerations were recognized throughout the inquiry process (Jones, Torres, & Arminio, 2006). I employed the use of *bridling*, a term developed by Dahlberg (2006), to address the impact my personal biases, preconceptions, or experiences might have on the study. This method allowed for the reality that forming connections with participants and their experiences is an unavoidable aspect of phenomenological qualitative research; instead of avoiding this, it should be acknowledged (Vagle, Hughes, & Durbin, 2009.)

Overview of the Dialectical Behavior Therapy Program

All participants in this study completed a comprehensive, multimodal 16-week DBT program in an intensive outpatient setting comprised of three treatment modalities: skills group therapy twice a week, individual therapy once a week, and family therapy approximately twice a month. Phone coaching is another modality but it was not implemented in the program at the time of this study. The structure of the program was based on the manualized treatment approach for suicidal adolescents, *The Adolescent*

Adaptation of Dialectical Behavior Therapy (Miller et al. (2007). The DBT program focused on decreasing emotional, behavioral, cognitive, and interpersonal dysregulation in adolescent clients. These areas of dysregulation were addressed through the five DBT skills modules: Mindfulness, Distress Tolerance, Emotional Regulation, Interpersonal Effectiveness and Middle Path (Miller et al., 2007). The first two modules were related to validation and acceptance and the last three modules are related to motivation and change (Miller et al., 2007).

Findings

Major themes and subthemes emerged from the data of the nine adolescent participants' shared experiences of DBT. Findings are organized into themes related to the DBT components including treatment modalities, skills modules, as well as themes related to negative experiences/suggestions for improvement of the DBT program (see Table 2).

Table 2

Themes Related to Components of Dialectical Behavior Therapy and Negative Experiences

Component of DBT	Themes
Skills Group Therapy	Benefits From Group Members • normalizing effect • support, • parallel experiences. Valued Elements of Group Therapy • group leaders • confidentiality • emphasis on skills
Individual Therapy	The Therapeutic Relationship Validation and Acceptance Change-Oriented Techniques
Family Therapy	Invalidating Environment Inconsistent Involvement Benefits and Use of Skills
Mindfulness Module	Mindful breathing Noticing the Body/Mind Connection Participating in the Moment
Distress Tolerance Module	Crisis Survival Skills Radical Acceptance
Emotion Regulation Module	Understanding Emotions Skills to Decrease Emotional Vulnerability and Distress
Interpersonal Effectiveness Module	Improved Relationships
Negative Experiences or Suggestions for Improvement	Difficulty with DBT Terminology Group Demographics Duration and Frequency

Themes Related to Therapy Components

Experiences in skills group therapy. The participants in this study all described skills group therapy as a significant part of their experience of DBT. Two major themes emerged from the data. The first theme was Benefits From Group Members with three subthemes of normalizing effect, support, and parallel experiences. These themes were all related to the participants' experiences with other adolescents in the skills group. The second major theme was Valued Elements of Group Therapy with three subthemes of group leaders, confidentiality, and emphasis on skills. These themes were related to how the participants experienced specific elements and components of DBT group therapy.

Benefits from group members.

Normalizing effect. The experience of DBT skills group was normalizing for many participants. Six participants described a sense of relief knowing they were not alone in their negative thoughts, depressive feelings, and dysfunctional behaviors. Casey shared her experience: "It's like I finally realized other people go through the same things I do. And it's not just me." Hearing group members describe emotional difficulties helped Davey "feel more normal." Jose felt less like "a messed up kid" when he learned that other adolescents had similar thoughts and feelings to his own: "I would be like, that's what I feel! Or like, he does the same as me! So it's not just me." Adam said knowing that other people had had experienced suicidal thoughts made him feel "less alone" and less "like such a freak."

*Support***.** All of participants experienced group therapy as a source of emotional and behavioral support. When Selena doubted her ability to use interpersonal effectiveness skills with her father, the group provided her with encouragement and

confidence. The group supported Tara when her mother was incarcerated. Four participants described depending on the group when they could not find support anywhere else in their lives. Casey told me "other people in my life really didn't want to hear about my depression. Like, they just got sick of it all the time." She turned to the group for support: "They were there for me. They would just remind me that I have enough strength to fight through my darkness. They helped me stay strong." Additionally, five participants stated they were a source of support for other group members and found it to be a rewarding part of their DBT experience. Adam said he used his "own experience to help others so they don't have to go through what I've gone through."

Parallel experiences. Another subtheme of benefits from other group members was that participants were more likely to form connections with other adolescents that came from similar backgrounds or had parallel experiences to their own. Six participants found it easier to talk about their problems with group members that could identify with their life experiences. These participants described a feeling of kinship and unique understanding with group members with personal backgrounds and histories comparable to their own. For example, Tara related to other group members who also experienced unstable childhoods and had lived with many different relatives growing up: "A lotta kids there knew what it was like to have a messed up family." Jose described how having another adolescent from a residential treatment center was helpful.

Valued elements of group therapy.

Group leaders. Five of the participants reported that the therapists (group leaders) contributed positively to their experience of DBT. Jade explained, "Lots of

therapists are either annoying or the groups are really boring and strict. These therapists were kind of funny, especially Sarah, she always made sure we laughed and stuff. Not too strict on us. You know?" Davey also experienced DBT differently than other groups he had been in:

> I've had other groups where the leaders were real strict and yelled at you anytime you talked or whatever, like you were in school or prison or something. But these ladies were really cool. They didn't yell or anything. And they didn't make you feel too dumb about the therapy stuff.

Tara, Selena, and Jose agreed that "fun" and "nice" therapists made a difference in their experience of group therapy.

*Confidentiality***.** Several participants described a sense of safety and trust in group therapy because of the policy of confidentiality. Selena described this policy: "One of the group rules was what was said in group stayed in group." Four participants reported feeling safe discussing their problems in group therapy because of the nonjudgmental environment. Five participants reported that confidentiality contributed to an atmosphere of trust and an increased willingness to share personal aspects of their lives. Tara explained how confidentiality helped: "It felt a little safer, I guess. Like, if my mom and I were fighting. I talked to the group about it, not at first but once I felt like I could trust them. It felt safe."

Emphasis on skills. One theme that emerged from the data was participants responded positively to the skill-based format of group therapy, especially the opportunity to practice new skills. Seven of the participants seemed to appreciate that the

focus of the group was on learning and practicing new skills as opposed to discussing their problems in an interpersonal, process-oriented format.

Four participants stated that practicing skills with other group members was the only way they understood how the skill worked and was more effective than the didactic portion of group where the leaders taught the skill because just hearing about it from the group leaders was not as effective. Anna highlighted the importance of learning new skills and said it was the most helpful aspect of group therapy: "It was mostly about, like, coping skills. Like, instead of this I can do x, y, and z instead of cutting. Like doing something new instead of getting all worked up or freaking too much. That helped more than talking did."

Themes from individual therapy. Themes that emerged from experiences with individual therapy included the therapeutic relationship, validation and acceptance and change-oriented techniques.

Therapeutic relationship. The majority of participants experienced positive change through the relationship with their individual therapist. Casey, Selena, Jose, Adam, Jeremy, and Anna described feeling "understood" by their therapists and said the therapeutic relationship contributed to their ability to change. Casey experienced growth in therapy because her therapist was engaged and invested in her progress. She said, "It was nice to actually be heard. Like, I knew she truly cared about me, and that made all the difference."

Acceptance and validation. All of the participants experienced acceptance and validation in individual therapy. Adam experienced the acceptance by his therapist as significant. He said, "Alison did not see me as a freak. She fully accepted me for who I

was. It was incredibly meaningful to me." Casey said her feelings were validated and not dismissed. Jeremy was surprised to experience nonjudgmental acceptance from his therapist: "Like, how she didn't judge me for getting locked up or nothing. It didn't matter. And I wasn't used to that." Davey told me acceptance played a large role in his experience of DBT: "That's where I think DBT helped me, with the accepting my life."

Change-oriented techniques. Every participant described their experience with DBT change-oriented assessments and techniques with varied reactions. Many participants found the therapeutic tools, such as the charts, diagrams, and worksheets, to be frustrating but also helpful. For example, Jade described her experience completing a behavioral chain analysis with her therapist: "We did this thing called a chain thingy a lot and it could get…it gets pretty old. But I guess it helped me. It helped me notice about my triggers. If she didn't make me do the chart, I wouldn't have known about my trigger with my mom."

Themes from family therapy. Themes that emerged from experiences with family therapy were an invalidating and uncomfortable experiences, inconsistent involvement, and benefits and use of skills.

Invalidating and uncomfortable experience. Six participants described invalidating home environments and high levels of conflict in their families. Four of the six participants who attended therapy with their families regularly described their experience as "uncomfortable," "terrible," and a "time I could have done without." Casey told me her family had a tendency to ignore negative emotions and "just hope things get better." She said it was awkward discussing her self-injurious behaviors in family therapy:

> No one really knew what to say about it. Everyone was just numb. There was no feeling. Everyone sort of had dead eyes. Like no one knew what to do. It was just a hard time. My family, they weren't ready to deal with how depressed I had been.

For Selena, family therapy was uncomfortable because the cultural values of her traditional Hispanic family. She described her experience: "Well, it's like in Mexico there's this kind of different way to, to be with your family. It's like you don't really talk much about your family problems with anyone. It's like we don't really believe in therapy that much." As an example of her uncomfortable experience with family therapy, Selena told me her mother got angry with her after one session because she shared something personal about the family: "It's like, something that my mom calls *indescreta*. It basically means you should keep your stuff to yourself."

Inconsistent involvement. Four of the participants' experiences of DBT were impacted by infrequent family therapy sessions or no sessions with family due to lack of involvement in the participants' treatment program. For varying reasons, these participants' did not receive much of the family therapy component. Davey reported that his family sessions were terminated due to domestic violence between his parents. Jade's mother was inconsistent in her attendance to family therapy; thus, Jade only experienced a few sessions. Two participants did not live with family members so their programs were adapted. Jose lived in a residential treatment center so his family was not involved in his treatment. He told me some of the staff members came to family therapy occasionally. Tara lived in a group home and reported going to family therapy about two times.

Benefits and use of skills. Six participants stated it they experienced positive changes from family therapy. They found it helpful when their caregivers learned DBT skills and aspects of the program. Jeremy said his family therapist taught his mother some of the DBT skills. He said this improved their communication: "My mom and I talk better to each other, I guess. Like, more nice." Jade and her mother learned emotion regulation skills in family therapy to diffuse the level of hostility in their arguments. She said using these skills improved their relationship: "It's changed my life with my mom. She used to, me and my mom used to fight really bad. But now we just fight normal. I mean, we still get mad at each other and stuff. But it's way better."

Themes Related to Skill Modules

Mindfulness module. Themes that emerged from experiences with the mindfulness module included mindful breathing, noticing the mind/body connection, and participating in the moment.

Mindful breathing. Eight participants found the mindful breathing skills helpful in regulating their emotions. They reported a decrease in their anger when they focused on their breath. For example, Jade used the skill by counting her in-breaths and out-breaths during arguments with her mother. She said the breathing helped calm her down: "I just try to breath and shit before I lose it." Selena used this skill when she herself becoming overwhelmed with emotions: "I just like try to like, uh, breath slow, take deep breaths. And pay attention to them. It helps calm me down. "

Noticing the mind/body connection. Five participants described a mind/body connection in their experience of mindfulness. Jose said mindfulness was "paying attention to what my body is doing when I get mad." He used mindfulness to observe the

physical signals his body was giving him about his emotions: “Well, my fists get balled up when I’m mad. I learned to notice it when it happens so it tells me I’m getting mad.” Casey used mindfulness in meditation, which calmed her mind and body down. Three participants described mindful physical exercises such as yoga or progressive muscle relaxation to be helpful in decreasing their stress. Jade said, “Like, for example, sometimes before bed I try to do the pose where you lie on your back and relax all the muscles slowly in your body. I mean I should do it more often cause it helps me sleep.”

Participating in the moment. *S*even participants described using the mindfulness skill of participating in the moment, which teaches adolescents how to increase awareness and to be fully engaged in the present moment. Jeremy described participating in the moment as, “Don’t live in the past or the future, you just gotta live in the present.” Reminding himself of this helped Jeremy let go of painful experiences from his past and eased his fears about the future. For Casey, focusing on the present moment helped decrease her urge to self-harm when she was emotionally dysregulated. Selena said that participating in the moment decreased her impulse to flee from distressing events in her life: “Mindfulness helps because I try to think before I act now. Like running away used to be my first reaction to everything.”

Distress tolerance module. Themes that emerged from experiences with the distress tolerance module included crisis-survival skills and radical acceptance.

Crisis survival skills. Seven participants used distress tolerance skills to replace self-injurious behaviors with healthier coping skills. Casey discovered that keeping a journal during her DBT program was a way to manage the urge to self-harm. She said journaling was “sort of taking the place of cutting” because it was another form of

release." She added that it was safer, too: "You can just get it out without hurting anyone or yourself."

Selena said she no longer cuts herself because she uses alternative coping strategies: "I just joined my church choir and I get a lot of support there. And singing is a way for me to release those kinds of things in my life. I don't need to cut to feel anymore." Adam and Tara used self-soothing techniques to prevent impulsive behaviors when they were experiencing a crisis. Tara was able to block thoughts of self-injury by engaging her senses with scented lotions and Adam covered himself with a heavy comforter. Anna shared a distress tolerance skill she used: "

> A really good one was I learned that if you wait something out it usually will pass. So instead of going straight to cutting, wait 10 minutes and if you still feel like that, wait 10 more minutes. Even though most of the time I didn't feel like it was going to work, it helped.

Radical acceptance. Five participants discussed the concept of radical acceptance in their experience of DBT. Radical acceptance helped these participants non-judgmentally accept (but not condone) emotional pain from situations that they could not change. For example, Jeremy described accepting the abuse he experienced in childhood: "I get real down on myself sometimes, about when I was a little kid, what happened and everything. But I had to learn to accept it. It's fucking impossible but I had to." Selena and Tara were able to cope more effectively with their environment by accepting the situation instead of struggling against it. Adam practiced radical acceptance of his father's disapproval of homosexuality. Although he did not agree with

how his father treated him, Adam realized that wishing things were different was only contributing to the emotional pain that led him to engage in self-injurious behaviors.

Emotion regulation module. Themes that emerged from experiences with the emotion regulation module included understanding emotions and skills to decrease emotional vulnerability and distress.

Understanding emotions. Five participants learned how to more effectively identify, understand and experience their emotions non-judgmentally. Selena said, "DBT taught me how to learn more about my emotions. And other people's emotions, too." Along with identifying emotions, five participants described the skills of observe emotions. For example, both Davey and Jose found the exercise of simply experiencing their emotion without judging themselves for having the emotion to be internally validating. Adam described his experience of non-judgmentally observing and experiencing sadness: "Which, when I ignore that sadness it only becomes more and more intense. And it grows. That is what leads to my suicidal thoughts. However, I simply notice my sadness, welcome it and not ignore it. Then I feel more in control. "

Skills to decrease emotional vulnerability and distress. All nine participants described using emotion regulation skills to decrease their emotional vulnerability and distress. Jade said she liked the riding the wave skill, which teaches adolescents that emotions are temporary and they will eventually pass. She explained,

> Well, it's just like whenever I get really real mad or sad, instead of just doing something right away I wait a little bit. I guess I like to picture the wave part and I just ride it on till it gets soft and fades away. Like my anger gets softer, you know? It made me like less angry and sometimes like less sad. Well, I mean, I

mean it would still be the same sad but less than I used to be. Like, I don't cry as much as I used to. I mean, I still get angry though.

Interpersonal effectiveness module--Improved relationships. Eight participants reported an improvement in their relationships due to having more effective communication skills. Four of these participants said their relationships with their parents/caregivers improved. For example, Selena used interpersonal effectiveness skills to improve communication with her stepfather. She said by utilizing self-respect, assert and express skills "I learned how to talk to him in a way that he would listen."

Middle path module. Only three participants recalled the Middle Path module and only one participant described using skills from this module. Selena described examining the dialectical dilemma of "too loose or too strict" during a family therapy session. She reported that she and her parents worked toward a compromise: "Like they had to give me my own space because I am growing up. But I like had to follow their rules better."

Suggestions for Improvement/Negative Experience Themes

Problems with Dialectical Behavior Therapy Terminology

Seven participants had difficulty with the terminology used in DBT. Casey said "it was hard to keep track" of the skills taught in group therapy because the acronyms were confusing. When I asked Anna about using DBT skills she shared: "Like, to be honest, I don't really remember what they are called or anything. Like, the names were all crazy like MAN and other letters that I'm supposed to remember." Jose told me, "I don't really know the names of any of those skills. I couldn't really remember them, they had hard names to remember." Jade described being frustrated by the DBT terminology:

> It was like a new language we had to learn. I just did not like that part. It's like, just speak English to us, you know? Maybe I'd change that. Like make it more real, you know? Like for us to actually understand, not for the people who wrote the books and stuff cause they obviously weren't in high school. Yeah, like if it's actually meant for teenagers, like write in a language we can actually understand.

Five of the participants' needed help to understand the ideas, skills, and theories taught in group therapy. These participants had difficulty comprehending or were confused by certain DBT concepts but were too embarrassed or shy to seek clarification during group therapy. Instead, they relied on their individual therapist for help. For example, Jade explained, "I'd get it (the skill) in the groups, you know? But then I'd have to fill out all the charts and papers and I couldn't really remember how to do it. But Julie reminds me and I get it. It was easier when she helped me."

Group demographics. Five participants stated that their experience was negatively impacted by the demographics of the adolescents in skills group therapy. For three participants, having younger adolescents (age 12 or 13) in the group was distracting. Adam shared his experience: "I felt like I was not able to fully express my issues in the group because there was some very, very immature people in there." Anna said that some of the discussions in group therapy "about, like, adult stuff " were not appropriate for the younger adolescents and suggested separating into smaller groups based on age. Two participants said they wished the group was comprised of just their own gender because it was distracting having members of the opposite sex there.

Duration and frequency. Six participants thought the duration of the DBT program was too long and the frequency of therapy sessions interfered with other parts of

their lives. Jeremy said, “The program was like, fucking forever!” Anna stated, “Like, no offense but it was like, really long! Super long.” Tara said she was not able to do things with her friends because of the time commitment required of the DBT program: “I had to go there all the time. It felt like I was always at the Center.” According to Jade, attending individual, family and group therapy was “a major time suck” because it cut into her time for extracurricular activities. When I asked Jose if he had any suggestions to improve the program he replied, “I’d probably make it shorter and go less often. It was like I was there every day. It was like I felt like I was there all the time.”

Discussion

Six participants experienced a normalizing effect from skills group therapy. These adolescents described normalization as knowing that they were not alone in their negative thoughts, depressive feelings and/or dysfunctional behaviors. This finding is similar to the research with adult DBT groups in which participants find the group therapy component to be normalizing (Koerner & Linehan, 2000;Safer, Telch, & Chen, 2009) Several participants experienced a sense of relief in expressing their emotional struggles to the group. It has been suggested that the act of sharing painful emotions with a supportive group and realizing others share that pain can be cathartic (Linehan, 1993a; Yalom, 2005).

While these participants reported that it was normalizing to hear that other adolescents had suicidal ideation and self-harming behaviors, they also said talking about these areas was challenging. These experiences were understandable given the sensitive nature of the topic and the social stigma of suicide and suicidal ideation (Nock, 2010). Research indicated that adolescents who engage in self-harm or who have made suicide

attempts are reluctant to talk about those behaviors because it brings up feelings of guilt, shame, and negative self-esteem (Nock, Teper, & Holland, 2007). This finding of normalization supported research demonstrating that the act of disclosing self-injurious and/or suicidal behaviors to other suicidal adolescents can be therapeutically beneficial (Katz et al., 2004). Conversely, research has shown that withholding this information only contributed to the intense isolation and loneliness often felt by adolescents who self-harm (McDermut, Miller, & Brown, 2001).

Receiving and providing support among group members was an experience that all participants reported as meaningful. Most of the participants stated their families and communities were not available, willing, or able to provide them the support they needed. Research has shown this experience is common among adolescents being treated within a community setting (Choate, 2012; Groves et al., 2012, Theisen, 2007). In alignment with the principle of altruisim, five participants also described the experience of wanting to support other adolescents in group therapy (Yalom, 2005). The theme of support was also identified in a qualitative study investigating the experience of DBT with adult women diagnosed with BPD who expressed that the support they received in group therapy was one of the most helpful aspects of DBT (Cunningham et al., 2004).

Researchers have demonstrated similar findings in that having a positive impact on a peer can increase self-esteem for adolescents (Grunbaum et al., 2004). Roepke et al. (2011) investigated changes in global self-esteem among adult participants who had participated in a DBT group. They found that engaging in helpful interactions with other group members was associated with improvements in social and emotional self-esteem (Roepke, et al., 2011). Other researchers found that even when adolescents reported

having a support system, the support they received was limited by the lack of first-hand knowledge of their problems (Comtois, Elwood, Holdcraft, Smith, & Simpson, 2007). Furthermore, relationships during adolescence are often based on commonalities between peers; therefore the theme of parallel experiences found in the current study was not surprising (Steinberg, 2005).

Five of the participants reported that the therapists (group leaders) contributed positively to their experience of skills group therapy. This finding might be related to the training DBT therapists receive in methods for engaging adolescents in therapy and encouraging participation through the use of humor and an approachable, non-authoritative stance (Koerner & Linehan, 2000). "Cheerleading," a DBT term described as validating the client's ability to use the skills, is an effective tool with adolescent clients (Groves et al., 2012; Katz, Gunasekara, Cox, & Miller, 2001; Woodberry & Popenoe, 2008).

In general, encouraging adolescents to engage and participate in a group format can be difficult due to the influence of peers, desire to conform, or fear of negative stigmas (Groves et al., 2012; Woodberry & Popenoe, 2008). However, the relationship these participants had with their group leaders appeared to have a positive impact on their willingness to attend group therapy.

While the theme of appreciating group leaders was shared with another qualitative study of adult women's experiences of DBT, the reasons for appreciation were different (Cunningham et al., 2004). Adolescents seemed to value the personality and relational style of the group leaders. Contrastingly, the adult clients reported that the most important characteristic of a group leader was proficiency in teaching skills and

knowledge of the skills (Cunningham et al., 2004). These results highlighted a difference between how adolescent clients and adult clients experienced DBT.

Several participants described a sense of safety and trust in group therapy because of the policy of confidentiality. Five participants reported that confidentiality, along with the nonjudgmental environment, contributed to an increased willingness to share personal aspects of their lives. This theme was congruent with other research, indicating increased participation in groups where members perceived a high level of trust (Woodberry & Popenoe, 2008; Yalom, 2005). Jade was more comfortable discussing her personal problems in group therapy because of the atmosphere of trust.

Seven of the participants seemed to appreciate that the focus of the group was on learning and practicing new skills as opposed to discussing their problems in an interpersonal group format. Four participants stated that practicing skills with other group members was the only way they understood how the skill worked. This finding was congruent with research, indicating that youth group programs provided an effective environment for acquiring and practicing skills among other adolescents because this was their primary social learning group (Groves et al., 2012).

Additionally, some participants expressed an adverse reaction to spending too much processing the emotions of group members. This finding aligned with the characteristic of DBT group therapy being psychoeducational in nature and not process-oriented (Koerner & Linehan, 2008; Linehan et al., 2006; Miller et al., 2007).

All of the participants in this study identified the relationship with their individual therapist as an important part of their experience in DBT. This finding supported the emphasis DBT places on a strong therapeutic relationship as a crucial element in

providing effective therapy with suicidal adolescents (Goldstein, Axelson, Birmaher, & Brent, 2007; Rathus & Miller, 2002; Linehan, 1993a). Additionally, the therapeutic relationship between the client and therapist is the most frequently mentioned effective common factor in psychotherapy literature (Wampold, 2001).

Similar to these results, four participants in this study reported that the therapeutic relationship was a contributing factor in making progress toward their treatment goals. Similarly, Kazdin, Marciano, and Whitley (2005) found that a positive therapeutic alliance was associated with greater therapeutic change, fewer perceived barriers, and greater treatment acceptability for adolescents with behavior problems.

All of the participants experienced acceptance and validation in individual therapy. The participants in this study described validation as feeling understood, hearing that their behaviors made sense given their backgrounds, not being judged for mistakes, and having their feelings and thoughts reflected back to them in a genuine manner. Research indicated that adolescents are more likely to collaborate and less likely to become agitated when their therapist integrates validation into therapy (Miller et al., 2007).

In contrast, results from a qualitative study found that for adult participants, the experience of acceptance in individual therapy was not as important as the experience of equality between therapist and client (Cunningham et al., 2004). The difference between these studies highlights the need to not uniformly apply treatments that have been empirically supported with adult populations to adolescent populations without including developmentally specific adaptations (Choate, 2012; Goldstein et al., 2007; Miller et al., 2007).

Several adolescents in this study described the use of behavioral and cognitive assessments such as a behavioral chain analysis was both frustrating and helpful. This finding was similar to the decrease in aggression and irritability found among adult females diagnosed with BPD receiving change-oriented aspects of DBT in an outpatient setting (Linehan, McDavid, Brown, Sayrs, & Gallop (2008). Additional research showed that change-oriented techniques used in DBT had a significant impact on client outcome, specifically decreases in suicidal attempts and depression and increased control over anger and aggression (Luoma & Villatte, 2012; Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006).

Several participants said they filled out weekly diary cards in order to monitor their suicidal thoughts and self-harming behaviors and then completed behavioral chain analysis with their therapist. Neacsiu, Rizvi, and Linehan (2010) found use of diary cards was crucial in identifying non-suicidal self-injury in clients and that use of behavior tracking techniques might contribute to the decrease in this behavior over time. Behavioral chain analyses have been shown to be helpful in breaking the behavior down into manageable pieces they can understand (Groves et al., 2012; Katz et al., 2004).

Three participants in this study reported they found the diary cards, skills homework, chain analysis, and other change-oriented techniques to be burdensome and not helpful. This finding might be related to the research, indicating that many adolescents will not give up a behavior that is harmful but effective (Choate, 2012). These clients may need to spend several sessions using change-oriented techniques before they see them as beneficial (Rizvi, Steffel, & Carson-Wong, 2012).

Six participants described invalidating experiences with their families that contributed to their emotional problems. This finding aligns with research citing invalidation within the family is a major contributing factor to emotional dysregulation and suicide attempts in adolescents (Woodberry, Miller, Glinski, Indik, & Mitchell, 2002). Invalidating responses from family members could discourage adolescents from using their newly acquired skills and thus maladaptive patterns are perpetuated (Groves et al., 2012; Woodberry & Popenoe, 2008).

Four of the participants' experiences of DBT were impacted by infrequent family therapy sessions or no sessions with family due to lack of involvement in the participants' treatment program for varying reasons. Because of the inconsistent involvement of caregivers, these four participants did not receive the skill training or therapeutic effects that occur in the family therapy component; thus, they did not receive DBT in its entirety according to the standards of the treatment manual (Miller et al., 2007). Furthermore, the absence or limited experience of family therapy for the four participants might have negatively impacted other areas of their treatment because research showed that parent involvement in the adolescent's treatment tended to improve dysfunctional and invalidating home environments, enhance generalization and maintenance of skills, and help family members to act as coaches (Groves et al., 2012; Miller et al., 2007).

Six participants stated they experienced positive changes in their home environment from family therapy: receiving help from caregivers, family members learning skills, and increased communication. Adolescents found it helpful when their caregivers learned the same skills DBT they did. This was consistent with the emphasis

DBT places on reducing skill deficits and increasing effectiveness among family members (Groves et al., 2012; Miller et al., 2007).

Research showed that when adolescents are deficient in the types of skills taught in DBT, their families are highly likely to be deficient in the skills as well (Turner, Barnett, & Korslund, 1998). Several adolescents described their family members as lacking in the skills they learned in DBT. When several family members are familiar with DBT skills and language, the home environment becomes more conducive to using the skills (Woodberry et al., 2002). Researchers found that teaching family members basic DBT skills, such as how to identify and label emotions, increased the frequency and effectiveness of using validation techniques with adolescents (Klaus, Mobilio, & King, 2009).

Eight participants described using the mindful breathing skill as a means to exert more control over their emotions. Not only does mindful breathing distract the mind from negative thoughts or emotions, deep breathing has a physiological calming effect that can sometimes stop an adolescent's emotions from escalating. The finding that breathing mindfully was helpful is also common to several theoretical orientations in counseling, e.g., cognitive behavioral therapy and trauma focused therapy, as well as being a skill learned in areas outside of therapy (Katz et al., 2004).

Suicidal and self-harming clients have been shown to have difficulty identifying what they are feeling; thus, they resort to finding a physical sensation for relief such as cutting, substance abuse, or disordered eating (Linehan, 1993a). All of the participants in this study reported a history of self-harming behaviors, suicidal ideation, or suicidal attempts. Four of these participants stated their senses were heightened during self-

harming and that breathing helped them return to a normal level of sensation. This finding aligned with research on the physiological experiences of individuals who self-injure (Nock, 2010). For example, adolescents who self-injure display higher physiological reactivity during distressing tasks than adolescents who do not self-injure (Nock & Mendes, 2008). Mindful breathing may contribute to decreasing physiological reactivity (Linehan, 1993a).

Five participants also described a mind/body connection in their experience of mindfulness. Noticing the physical reactions to emotional states can be important clues for adolescents to identify what they are feeling and thinking (Linehan, 1993a). Participants described practicing mindfulness through physical exercises. Vast amounts of research have been done on the beneficial and therapeutic effects of yoga on psychological disorders. Beginning DBT with a yoga pose is one way adolescents learn about the mind-body connection and adolescents in an inpatient unit reported decreased anxiety after practicing yoga as part of DBT (Katz et al., 2004)

For many adolescents in this study, focusing on the present moment brought an increased awareness of their emotional and cognitive patterns**.** Seven participants described using the mindfulness skill of participating in the moment, which teaches adolescents how to increase awareness and to be fully engaged in the present moment. Van Dijk, Jeffrey, and Katz (2013) researched adult participants with Bipolar I or II disorder participants receiving DBT compared to a control group receiving TAU. They found that the treatment group showed more control of emotional states and an increased ability to use mindfulness based skills, and also had fewer emergency room visits and admissions at a 6 month follow up (Van Dijk et al., 2013).

All nine participants admitted to engaging in maladaptive coping methods for managing distress in their lives such as drug abuse, cutting, burning, and high risk behaviors. Although not explicitly asked if DBT helped reduce these behaviors, several participants reported stopping or reducing their self-harming. Research has indicated that DBT is an effective treatment for reducing suicidality and self-harming behaviors in adolescents (Katz et al., 2004; Miller et al., 2007; Rathus & Miller, 2002).

For example, McDonnell et al. (2010) studied adolescents with histories of suicidality and self-injuring behaviors in long-term inpatient care and compared a DBT group to a TAU group. The researchers found that adolescents in the DBT group demonstrated significant reductions in psychiatric medications upon discharge and significant reduction in self-harming over time (McDonnell et al., 2010). Participants in the DBT group also demonstrated significantly lower rates of self-harming behaviors than did the control group (McDonnell et al., 2010).

Four participants said they no longer had suicidal ideations or attempts since completing DBT. This finding was supportive of literature citing DBT to be effective with suicidal adolescents (Choate, 2012; Katz et al., 2004). Dialectical behavior therapy likely contributed to this change; however, other factors could be responsible such as the passing of time or the participants were only in partial remission, which is the period after treatment when high risk behaviors are absent before relapse occurs for some adolescents (Comtois et al., 2007).

Although these methods might provide immediate relief and improve the moment in some way, the effects are short lasting and usually make the problem they were trying to escape worse (Aguirre, 2007; Linehan, 1993a). The majority of participants stated this

was true for them. One participant was the exception and claimed that even though he was aware of the harmful effects of drug abuse, he still considered it to be the most effective coping skill he had. This experience is not uncommon among adolescents in treatment in part because the maladaptive behaviors they developed have served them in the past and have become ingrained in their emotional dysregulation cycle (McDonnell et al., 2010; Miller et al., 2007).

The distress tolerance skills the participants described included distraction techniques, self-soothing, using imagery, finding meaning in the crisis, and creating lists of the pros and cons of tolerating the distress (Linehan, 1993a). Participants were able to use these skills to prevent themselves from acting impulsively when they were experiencing a crisis. These findings were consistent with research, indicating that distress tolerance skills were perceived as helpful by clients in DBT (Lindenboim, Comtois, & Linehan, 2007; Miller, Wyman, Huppert, Glassman, & Rathus, 2000).

Wagner and Linehan (2006) reported that at a one year follow up study, adults tended to practice mindfulness and distress tolerance skills more often than other skills. A qualitative study with adults found that participants reported self-soothing, distracting, and one-mindfulness to be the most helpful of the distress tolerance skills (Cunningham et al., 2004). Distress tolerance skills and mindfulness skills were the highest rated skills among adolescents receiving DBT as a treatment in an outpatient setting (Miller et al., 2000).

The decrease in self-injurious or suicidal ideation and decrease in depressive symptoms the participants reported was congruent with research demonstrating the effectiveness of DBT in these areas (Linehan et al., 2006; Rathus & Miller, 2002; Robins

& Chapman, 2004). However, some studies have shown that these effects are temporary and are not maintained at follow-up studies (Wagner & Linehan, 2006).

Adolescents are also taught to accept what they cannot change in a non-judgmental manner. Acceptance does not equal agreement with what has happened to them in their lives in the past or currently, only that a stance of non-acceptance is contributing to their pain (Linehan, 1993a). Five participants discussed the concept of radical acceptance in their experience of DBT. Radical acceptance helped these participants non-judgmentally accept (but not condone) emotional pain from situations they could not change (Miller et al., 2007). This skill has been shown to provide adolescents with a catharsis related to separating themselves from abuse they endured in childhood (Robins & Chapman, 2004).

Five participants learned how to more effectively identify, understand, and experience their emotions non-judgmentally. Participants described they often did not know what emotion they were experiencing or they did not allow themselves to experience the emotion because it was too painful. This finding fits with research on emotion dysregulation and the emphasis placed on understanding, observing, and describing emotions in DBT (Linehan et al., 2006). In addition to labeling emotions, participants learned to identify emotion triggers. When adolescents are taught to respond to uncomfortable or negative emotions with an approach of trying to understand them, they often experience less emotional intensity from them (Safer et al., 2009).

Along with identifying emotions, five participants described the skill of observe emotions, which is acknowledging and experiencing feelings without judgment. Similar to these findings, Kostiuk and Fouts (2002) interviewed adolescent females with conduct

problems and found they were unable to constructively manage their negative emotions because they had very few strategies for regulating their emotions and the ones they had were destructive.

All nine participants described using DBT emotion regulation skills to decrease their emotional vulnerability and distress, which decreased their impulsivity. Similar to this finding, Goldstein et al. (2007) researched DBT with adolescents diagnosed with bipolar disorder who displayed a lack of control over excess emotions. The results of the study found adolescents being treated with DBT exhibited significant improvement from pre- to post-treatment in the following areas: suicidality, non-suicidal self-injurious behavior, emotional dysregulation, and depressive symptoms (Goldstein et al., 2007). The results of this study indicated that DBT might be a promising treatment for adolescents with bipolar disorder (Goldstein et al., 2007).

Eight participants reported an improvement in their relationships due to having more effective communication skills. The participants attributed these improvements to their greater ability to control their emotions and react with less emotional intensity. Similarly, Nock (2010) identified several emotion regulation skills, such as imagery, to be helpful in adolescent affect regulation.

Four of these participants said their relationships with their parents/caregivers improved. This finding was similar to the case study of a female adolescent who also reported improvements in her relationship with her father (Nock et al., 2007). One study found that improving communication between adolescents and parents enhanced the safety of the adolescent because parents are more likely to have information that might help them identify if their child is at risk for suicide (Klaus et al., 2009). Impaired

relationships with others is a consistent finding among adolescents demonstrating BPD characteristics because their feelings vacillate frequently and they also switch between avoiding conflict with caregivers and then engaging in intense conflict (Miller et al., 2007).

The finding that emerged from the data was that most participants did not recall meaningful experiences with the Middle Path module and the ones who did only had limited memory of the skills in this area. Only three participants recalled the Middle Path module and only one participant described using skills from this module with their family to be helpful. Because these skills are addressed primarily in family therapy, adolescents not receiving family therapy have less exposure to these skills (Woodberry & Popenoe, 2008). Several participants in this study had limited or no family therapy sessions; thus, it made sense they had difficulty recalling their experiences with the Middle Path module.

While DBT was adapted to include language that was developmentally appropriate for adolescents, the results from this study were contradictory (Miller et al., 2007). Seven participants had difficulty with the terminology used in DBT. Casey said "it was hard to keep track" of the skills taught in group therapy because the acronyms were confusing. When I asked Anna about using DBT skills she shared: "Like, to be honest, I don't really remember what they are called or anything. Like, the names were all crazy like MAN and other letters that I'm supposed to remember." Five of the participants needed time in individual therapy to review the ideas, skills, and theories taught during group therapy because they found them confusing.

This finding was similar to a qualitative study investigating adult clients' perceptions of DBT (Cunningham et al., 2004). Participants reported that the

terminology used on the DBT handouts was “over their head” and it was unrealistic to expect them to memorize all of the acronyms they were taught (Cunningham et al., 2004). These researchers noted that clients had difficulty implementing the skills they did not understand due to the” strangeness of the DBT vocabulary” (Cunningham et al., 2004).

Five participants stated that their experience was negatively impacted by the demographics of the adolescents in skills group therapy. For three participants, having younger adolescents (age 12 or 13) in the group was distracting. Two participants said they wished the group was comprised of just their own gender because it was distracting having members of the opposite sex there. While research exists on the developmental differences between adolescent males and females, no research has been done to date on how gender plays a role in DBT (Chang, 2002). Additionally, the majority of DBT research stems from work with women diagnosed with BPD, thus skewing the results and possibly limiting the generalizability for male adolescents (Robins & Chapman 2004).

One of the adaptations of DBT for adolescent clients was shortening the duration of treatment from one-year to sixteen weeks (Miller et al., 2007). However, despite this change, many participants felt the program was too long. Six participants thought the duration of the DBT program was too long and the frequency of therapy sessions interfered with other parts of their lives.

Middle path skills are designed to help adolescents and family members address their unbalanced, polarized thoughts and behaviors that might be negatively affecting the emotional functioning of family members (Miller et al., 2007). This study found that adolescents did not report meaningful experiences with the he Middle Path skill module.

Only one participant reported the use of middle path skills with her family and she had limited memory of these skills.

The Middle Path module was one of adaptations made to DBT specifically for working with adolescents (Miller et al., 2007). Dialectical behavior therapy conceptualizes clients within their environment, which for adolescents is primarily their families (Rathus & Miller, 2002). Because these skills are addressed primarily in family therapy, adolescents not receiving family therapy have less exposure to these skills (Woodberry & Popenoe, 2008). Several participants in this study had limited or no family therapy sessions; thus, it made sense they had difficulty recalling their experiences with the Middle Path module.

Middle Path skills are also taught in group therapy (Miller et al., 2007). However, one explanation for a lack of findings in this area is this is the last module taught in group and less time is allocated in the program schedule (Miller et al., 2007). One of the reasons for the limited emphasis on these skills was because it was assumed adolescents would receive these skills in family therapy sessions (Woodberry & Popenoe, 2008).

Another possible reason for the finding that participants had more difficulty recalling and reported fewer skills for the Middle Path module was this was where the concept of dialectics receives the most attention. Dialectics teaches the importance of multiple points of view, both/and thinking, and emphasizes how change is the only constant in life (Groves et al., 2012). Thinking dialectically helps parents and adolescents find compromise in the middle path. The theory of dialectics can be confusing and foreign to many participants (Rizdi & Linehan, 2011); therefore

participants in this study might not have comprehended or integrated dialectics into their experience of DBT.

Clinical Implications

The clinical implications of this study added further support to a growing area of research. The current study is the first of its kind to explore how adolescents experienced DBT in a community mental health setting. This was an exploratory study; therefore, caution should be taken when applying the findings to clinical settings. The reader must determine the transferability and relevance of the findings for their particular setting, population, or situation (Merriam, 2009). However, through thick, rich description, it was the goal of this study to provide information on how adolescents experienced DBT in a way that was useful for the reader. The findings from this study have also been compared and supported with current literature and research on DBT, adolescence, and suicidality.

This aim of this study was not in measuring outcomes or specifically looking at the participants' symptoms. However, the skills in DBT address self-harm and suicidality; therefore, improvements in these areas were discussed during the interviews. The present findings that adolescents reported a decrease in self-harming behavior and a reduction of depressive symptoms added to the literature demonstrating the effectiveness of DBT in these areas (Linehan, Bohus, & Lynch, 2007; Miller et al., 2007; Nelson-Gray et al., 2005; Rathus & Miller, 2002; Robins & Chapman, 2004). These findings pointed to the clinical utility of DBT as an intervention with adolescents struggling with mental health difficulties.

This study found that adolescents reported the focus on learning and practicing skills during group therapy to be beneficial to them. Furthermore, they identified a preference for the solution-oriented, problem-solving approach to their personal problems shared with the group versus a process-oriented approach. Given these findings, a practical implication of this study would be for psychologists to implement a focus on acquiring and rehearsing new skills in adolescent group therapy.

One finding of this study was that adolescents identified the support they received from DBT to be a beneficial part of their experience. This was in part because their home, school, and communities were not supportive. This finding was congruent with other research demonstrating that populations served by community mental health centers typically have limited resources for support (Comtois et al., 2007). Given this finding, along with the growing trend toward implementing DBT in community mental health centers, psychologists should emphasize the role support in working with adolescents in this setting (Choate, 2012; Theisen, 2007).

Another finding from this study was the therapeutic relationship in both individual and group therapies had a positive impact on adolescents' experience of DBT. Adolescents reported being more motivated to attend therapy and engage in sessions because of the positive rapport with their therapists. This finding of willingness to engage in treatment was contradictory to research that indicated self-harming and suicidal adolescents have a high rate of treatment noncompliance and therapy dropout (Groves et al., 2012; Koerner, Dimeff, & Swenson, 2007; Miller et al., 2007). Secure and positive attachments to therapists have also been linked to treatment gains as well as improved global functioning post treatment (Lilliengren, Falkenstrom, Sandell, Mothander, &

Werbart, 2014). Therefore, a clinical implication of this study is that the therapeutic relationship should be considered a key factor in the treatment of suicidal and self-harming adolescents (Choate, 2012).

Adolescents in this study seemed to value the validation and acceptance they experienced in individual therapy, often because they did not experience this in other areas of their lives. Validation was identified as more meaningful than change-oriented skills, although these were reported to be helpful. Participants who did not report using many change-oriented skills still responded positively to the validation skills, which might have signified they were not ready for change (Robins & Chapman, 2004). Additionally, adolescents are likely to still be living in an invalidating environment; thus, they are more receptive to validation in therapy (Miller et al., 2007; Sunseri, 2004). This finding underscored the clinical importance of balancing validation and acceptance skills when working with adolescents.

Difficulty understanding the language and terminology was a common theme among participants including confusion about DBT concepts and difficulty remembering acronyms. This theme was identified in other DBT qualitative research findings (Cunningham et al., 2004). Adolescents reported they often needed extra time in individual therapy to clarify and learn the skills because they were unsure or embarrassed in group therapy. It might be important for psychologists using DBT to treat adolescents to regularly check for skill comprehension among group members in a nonthreatening way.

A finding from this study was that adolescents' experience of DBT was impacted by the consistency and frequency of their family's involvement. There are implications

in this finding for psychologists working with adolescents and families in a DBT program. Given the backgrounds of the participants in my study, it might be unrealistic to assume that families in a community health center could attend the additional family therapy sessions. Reasons for low involvement could be related to the research indicating families with lower socioeconomic status have less access to transportation, unavailability of childcare for younger children, and fewer resources (Theisen, 2007).

Additionally, most of the participants in this study who engaged in suicidal or self-harming behaviors reported invalidating family environments and dysfunctional family patterns. One implication for counseling psychologists is there might be a need to focus on resiliency in adolescents despite their dysfunctional family environments (Fine & Sung, 2014). Resiliency literature pointed to understanding factors within the individual, such as competence and self-efficacy, as well as external resources such as parental support and community organizations (Fergus & Zimmerman, 2005). It is important for psychologists to nurture the adolescent's strengths and positive adaptive behaviors to build resiliency regardless of their maladaptive family functioning (Fine & Sung, 2014; Groves et al., 2012).

Limitations and Future Directions

One limitation of this study was the small number of participants (n = 9). Despite this sample size, multiple cultural, family, and situational backgrounds were represented. For example, two participants were living in a group home setting and four of the participants were male. The majority of research on DBT has been done with adult Caucasian women diagnosed with borderline personality disorder, thereby limiting the generalizability of treatment effects to other populations (Rizvi et al., 2012). Gender is

not specifically accounted for in the treatment model of adolescent DBT, yet research indicated the needs of male and female adolescents will differ based on the social pressures and biological stressors (Nolen-Hoeksema, 2012). Future research should expand on the present study by replicating the methodology with a larger sample size and include participants from varying backgrounds.

While this study included participants from diverse backgrounds, no specific questions were asked about the role of multicultural factors in their experience of DBT. Selena's experience of frustration at not having a bilingual family therapist highlights the importance of researching DBT with culturally diverse populations. Furthermore, minority populations often seek services through community mental health centers (Ben-Porath, Peterson, & Smee, 2004). Therefore, research on DBT in community settings needs to include minority participants (Ben-Porath et al., 2004). This research might help psychologists to understand how the effectiveness of DBT with adolescents translates across cultures and to identify potential areas where adaptations are needed (Choate, 2012).

Another limitation of this study was the time gap between when the adolescents completed the DBT program and when they participated in the interview. The participants might have had difficulty recalling their experiences because of memory loss or lack of relevancy. Research indicated that a retrospective approach might create biases in what and how participants described their experiences (Nisbett & Wilson, 1977). However, one aim of the study was to explore how adolescents used skills after DBT and what impact this had on their lives. Therefore, the passing of time was a variable I expected to encounter and was included in the design of this study. Participants

interviewed with me between two and six months after completing the program, which might account for differences in their experiences.

A desire to produce positive responses might have also led participants to over-report positive improvements or provide fewer negative experiences. The participants in this study described an overall positive experience with DBT but also provided examples of negative experiences and areas of the program they did not like. The results of this study should also be viewed within the limitation that the adolescents were volunteer participants and they might have had different experiences than adolescents who did not volunteer for the study. It is the responsibility of the reader to decide whether or not the results would be applicable to their own situation (Merriam, 2009).

Another limitation of this study was the interviews were conducted in a semi-private setting. The location allowed for a more relaxed, conversational approach to the interviews and the participants appeared to respond positively to the setting. Several participants commented on being glad the interviews were not held at the community mental health center because they felt they would be identified there. Because the adolescents associated the center with therapy, the location of the café allowed for a separation between therapy and research. However, the experiences the participants recalled might have been limited by not being in a completely confidential environment. Future research might explore conducting qualitative interviews with adolescents in a private setting to understand if they would be more comfortable discussing personal information in that setting.

According to Linehan (1993b), DBT is most effective when all components of the manualized treatment are present. In the DBT treatment manual for adolescents,

including family members in therapy is seen as an important part of treatment to address the developmental needs of adolescents compared to adults (Miller, Rathus, Linehan, Wetzler, & Leigh, 1997). However, several of these participants were not able to experience the family therapy component of DBT to address those areas of dysfunction. One limitation of this study was adolescents who did not receive family therapy might not have gained the full benefits of DBT and therefore had different experiences than other participants. Future DBT studies should examine the importance of family therapy with suicidal adolescents from dysfunctional families and its role in DBT. More research is also warranted in the area of improving family member participation and engagement in therapy.

Many of the therapeutic components, skills, and assumptions are based on the notion that an adolescent lives with their parent, which was not the case for two participants in this study. Although I did not ask Jose or Tara specifically about their experience of discussing skills that focused on parent-child interactions, I would imagine there would be a level of discomfort for them. Besides having an obvious impact on the family therapy component of their treatment, adolescents not living with parents might have experienced differences in other areas of DBT. More research is needed to understand how adolescents not living with parents, such as group or foster homes, experience the parent focused skills of DBT.

The number of studies on DBT with adolescent populations is increasing (Wasser, Tyler, McIlhaney, Taplin, & Henderson, 2008). However, caution should be taken when using a treatment empirically supported for adults with adolescent clients because of the developmental and social differences. For example, one finding of this study was

adolescents valued the approachable, engaging styles of their group leaders, whereas adults valued the knowledge base and skill proficiency in their group leaders (Cunningham et al., 2004). These results highlighted a difference between how adolescent clients and adult clients experience DBT. Further research is needed to understand the differences in how adolescents and adults experience DBT.

This study found that adolescents did not report meaningful experiences with the Middle Path skill module. Reasons for limited experiences with the Middle Path skills might include (a) these skills were addressed primarily in family therapy so adolescents not receiving family therapy would have had less exposure to these skills and (b) these skills received less attention in group therapy, thus the concept of dialectics in these skills could be perceived as challenging (Woodberry & Popenoe, 2008). Because the Middle Path module was one of adaptations made to DBT specifically for working with adolescents, more research should be done to explore the lack of themes in this study related to this module (Miller et al., 2007).

As research has demonstrated that DBT is an effective treatment for adolescents with suicidal and self-harming behaviors, counseling psychologists should continue to study and train in DBT (Choate, 2012; Kazdin & Whitley, 2006; Rizvi et al., 2012). This is because of the core belief that counseling psychology helps individuals alleviate distress in their lives, improve overall functioning, and increase well-being (American Psychological Association, 2002). Furthermore, qualitative research is seen to be congruent with the beliefs and goals of counseling psychology (Morrow, 2005). Wertz (2005) stated that qualitative research, such as this current study, contributes to the field

of counseling psychology by providing methods to capture important insights into sensitive human experiences through triumphs and struggles.

Finally, this study demonstrated that adolescents experience DBT in many ways; by giving them the opportunity to voice their experiences, many important findings emerged. However, this was the first and only qualitative study of the subjective experiences of DBT from the voice of adolescent clients. Therefore, more qualitative studies are needed to further the understanding of how adolescents experience DBT. Additional research investigating adolescents' subjective experience with DBT in a variety of settings and across multiple disorders would greatly contribute to the current literature.

Conclusion

Despite the fact that there is growing evidence that dialectical behavior therapy (DBT) is an effective treatment for suicidal and self-harming adolescents, there is a lack of knowledge on how adolescents experience DBT. The goal of the current study was to address this lack of knowledge by providing readers with an understanding of how adolescents experienced DBT including the treatment components and skill modules in a community mental health setting. The participants in this study reported an overall positive experience in DBT and described beneficial results such as decreased suicidality and self-harming behaviors, improved ability to tolerate distress, increased mindfulness and emotion regulation, and healthier relationships with others.

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