Do Parents Use of DBT Skills Change After a 12 Week Parent/Adolescent DBT Skills Group?

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Abstract

The following research looks at the results of a pre and post assessment of parents' DBT skills use after completing a 12 week DBT skills group. The research design compared individual and group raw score means of the pre and post assessment data. It was hypothesized that caregivers' post DBT-WCCL scores would indicate more use of DBT skills following the intervention. The data showed a decrease in dysfunctional coping and an increase in DBT skills on post assessments. The magnitude of decrease in dysfunctional coping was greater than the increase in use of DBT skills. Clinicians need to ensure that their DBT groups teach skills to caregivers along with their teen.

Do Parent's Use of DBT Skills Change After a 12 Week Parent/Adolescent DBT Skills Group?

Adolescence is a time of cognitive and emotional development which can result in stress to the individual (Quinn, 2009). During adolescence individuals develop ways to cope with stress. Adolescents may develop dysfunctional behaviors to cope with stress, such as self-harm. Choate (2012) estimated that between 13 and 45% of adolescents use self-harm as a way to cope. More research is needed for an evidence based treatment approach for adolescents who exhibit dysfunctional behaviors. One treatment that has been adapted and used to treat adolescents who exhibit self-harming behavior is Dialectical Behavioral Therapy (DBT) (Woodberry & Popenoe, 2008).

In 1997, Miller and colleagues created the original adaptation of DBT for treatment with adolescents (Groves, Backer, van den Bosch, & Miller, 2012). In this adaptation, Miller and colleagues emphasized incorporating the adolescent's family and caregivers into treatment. The families could be included in treatment through family therapy or in DBT skills groups. Miller, Glinski, Woodberry, Mitchell, & Indik (2002) believed that by the caregiver's participating in treatment, s/he could gain a better understanding of DBT skills. This would allow the adolescent's caregiver/s to utilize the skills themselves to better attend to the adolescent's needs, model the appropriate use of skills, and encourage the use of DBT skills outside of therapy (Choate, 2012; Miller, et. al., 2002; Neece, Berk, & Combs-Ronto, 2013).

Use of DBT skills training has been shown to be an essential part of effective DBT treatment (Lynch et al., as cited in Choate, 2012). Furthermore, Miller et al. 2002 argue that there are multiple benefits of having adolescent caregivers involved in DBT treatment and learning DBT skills. However, there is a lack of research investigating if caregivers involved in DBT

skills groups are actually learning DBT skills, utilizing and modeling them, and encouraging their adolescents to use them outside of treatment. Further research in this area would be important to insure that DBT treatment with adolescents is being delivered in the way originally intended by Miller et al.

The current study addresses whether or not caregivers, after completing a 12 week DBT skills group, utilize DBT skills and encourage their adolescents to use them. Quantitative data will be collected. Caregivers will be given a pre and post assessment of the DBT Ways of Coping Checklist (DBT-WCCL) and asked to answer a Patient Satisfaction Survey at the completion of the group.

Previous studies that investigated use of DBT skills typically assessed only the identified client's use ofthe skills. To date, there is a lack of research in the literature where caregivers' use of DBT skills is assessed. Additionally, there is a lack of research as to whether caregivers encourage the use of DBT skills in their adolescents. The current research aims to answer these two questions. The researcher hypothesized that caregivers' DBT-WCCL results would show an increase in DBT skills on the post assessment. Furthermore, it was hypothesized that caregivers would indicate that they had encouraged their adolescents to use the DBT skills outside of the therapeutic setting.

The research findings would either confirm or deny that the DBT parents and adolescents skill group is achieving what Miller et al., 1997 (as cited in Groves et al., 2012) initially intended for DBT treatment with adolescents. Miller and colleagues (2002) intended for adolescents caregivers' to be involved in treatment in order to learn and utilize the DBT skills as well as encourage their use in adolescents outside of treatment. Furthermore, the research findings can

be shared with adolescents' primary clinicians and aid in discovering areas to focus on in family therapy.

In this paper a review of the literature surrounding what DBT is, the population it treats, along with parents involvement in the treatment of their youth will be discussed. Additionally, the current study's method and results will be explored. Lastly, a discussion of the findings of the study, limitations, and areas of future research will be addressed.

Review of the Literature

Adolescence is often a time of change and growth. Much of this growth is related to cognitive functions and emotional development (Quinn, 2009). Adolescents may have many different stressors and they learn to develop ways to cope with these stressors. Adolescents may be stressed regarding school, family trouble, peer relationships, intimate relationships, changes in their bodies, and thoughts of the future. Because of the many stressors and the significant changes going on throughout adolescence, some adolescents develop dysfunctional coping skills, such as self harming behaviors (Choate, 2012; Woodberry & Popenoe, 2008). Self-harming is a dysfunctional coping skill estimated to be used by 13-45% of adolescents (Choate, 2012). Furthermore, Neece, et al., (2013) reported that recent research has suggested that adolescents who have engaged in self-harm and have depressive symptoms, are at a greater risk for future suicide attempts. Some studies found that 50-70% of individuals with a history of self harming behaviors have at least one suicide attempt (Nock & Favazza as cited in Choate, 2012). Self-harming behavior and suicide is a significant health concern for adolescents, yet to date, there has not been a great amount of research regarding a treatment approach that is evidence based,

for this population (Choate, 2012; Neece et al., 2013; Quinn, 2009; Woodberry & Popenoe, 2008).

Dialectical behavior therapy (DBT) has been shown to help treat suicidal, non-suicidal self injurious behaviors, and other impulsive behaviors in individuals (Groves, Backer, Bosch, & Miller, 2012; Linehan, 1993; Quinn, 2009). Dr. Linehan developed DBT as a treatment option for individuals with Borderline Personality Disorder (BPD) (Choate, 2012; Feigenbaum et al., 2012; Rizvi et al., 2013). Adolescents have been shown to demonstrate similar behaviors to those individuals diagnosed with BPD. This would provide justification for why DBT has been adapted for treatment with adolescents who have behaviors similar to those adults diagnosed with BPD (Woodberry & Popenoe, 2008).

When trying to find a treatment for adolescents who struggle with self-harming behaviors, suicide, and other emotion regulation issues, it is important to remember the context that adolescents have grown up in and often are still living in. Adolescents spent a good portion of their time around their family members. Typically, adolescents caregivers still have an influence on them. Adolescents caregivers may still provide them their basic needs such as, supporting them financially, providing them shelter, transportation, and clothing (Baker-Ericzen, Jenkins, & Schlagel, 2012; Israel et al., 2007). Throughout their childhoods, caregivers have often provided them with examples of how to cope and handle different problems that may occur. The caregivers may also encourage adolescents behavior in certain situations (Neece et al., 2013). Therefore, the caregivers are providing much more than the basic living needs, they are providing information regarding how to cope and deal with emotions that the adolescents may learn and use the rest of their lives. Thus, it is beneficial to incorporate adolescents family

members into treatment. This would insure adolescents were getting support outside of treatment that helped encourage what they were learning during treatment.

For the above reasons, DBT that has been applied to work with adolescents, has incorporated families into the treatment (Choate, 2012; Miller, Glinski, Woodberry, Mitchell, & Indik, 2002; Neece et al., 2013; Quinn, 2009; Woodberry & Popenoe, 2008). The family's main involvement in the treatment includes learning the DBT skills (Miller et al., 2002; Neece et al., 2013). Miller et al. (2002) argued that caregivers' involvement in DBT skills training will allow them to model the DBT skills for the adolescents and encourage them to use the DBT skills outside of treatment. However, there is little to no literature reporting whether caregivers are learning and using the DBT skills. If caregivers are not learning the DBT skills enough to use them outside of treatment, then they cannot model them for their children or accurately encourage them to use the skills. Caregivers understanding of and modeling the DBT skills is seen as an important contributing aspect in DBT treatment with adolescents. It provides support to the adolescent outside of treatment and in one of their main environments. Additional support outside of treatment and in one of the adolescents main environments will provide adolescents DBT treatment as originally designed for them. Therefore, more research surrounding whether caregivers are learning and using the DBT skills is needed.

The following literature review will report on how the research defines DBT treatment and the mental health disorders that DBT is used to treat. Next, the literature of DBT with adolescents and how it was altered in order to treat adolescents, will be reviewed. The next topic reviewed will be caregivers involvement in treatment of youth and caregivers involvement in DBT treatment. Lastly, literature surrounding the development and use of an instrument to assess DBT coping skill use will be reported on.

Dialectical Behavior Therapy

Dialectical Behavior Therapy, more commonly referred to as DBT, was invented by Dr. Marsha Linehan. DBT is a modified form of cognitive behavioral therapy (CBT). The main goal of DBT is for individuals to gain a life worth living. Standard and Comprehensive DBT has four treatment modes that are aimed at addressing five different functions (Rizvi, S. L., Steffel, L. M., & Carson-Wong, A. 2013).

DBT treatment modes and goals.

The four different treatment modes include, (1) individual therapy which would involve the client and the therapist meeting weekly to work together on the clients identified problems. (2) Skills training, in the form of a DBT skills group. However, when a group is not an option, the skills training can be done during individual treatment. These skills help to replace dysfunctional coping skills, such as self-harm, and provide clients with new functional coping skills. (3) As needed consultation outside of sessions between counselor and client, such as the client calling the counselor to talk in order to get support during a tough situation. (4) Consultation team meetings for the DBT therapist. The team meetings allow the therapist to consult with other colleagues regarding the client's treatment. This is an important aspect for the therapist to maintain self care.

These four treatment modes are used to address the five functions or goals of DBT treatment (Chugani, Ghali, & Brunner, 2013; Rizvi, et al., 2013; Quinn, 2009). The five functions of DBT treatment are (1) to increase the client's motivation for change. This includes meeting the clients where they are regarding wanting to change, and helping to motivate them to want to change their dysfunctional behavior and coping skills. (2) Enhance their capabilities,

meaning to provide clients with more skills and knowledge to allow them to be able to deal with stressors and emotional dysregulation. (3) Generalize their gains to their larger environment, which would be helping the clients to realize that what they can accomplish in session or in treatment can be applied to the bigger picture of their lives and their involvements with their environments. (4) Structure the environment to reinforce the gains. In other words, making sure that clients environments are not setting them up for failures. Helping the client to be surrounded by a supportive environment and have the skills and supports in place for the client to be able to succeed. (5) Increase therapist motivation and competence which means helping the therapist to stay motivated to help their clients and not get discouraged if their clients do not want to change or struggle during therapy. Furthermore, helping the therapist to continue to be and feel competent in DBT and assuring he or she is carrying out the treatment in the correct way (Chugani, et. al., 2013; Quinn, 2009). In addition to these four modes of treatment and five goals of treatment that help clinicians to carry out DBT treatment, DBT was shaped and is guided by three theories. These included biosocial, behavioral, and dialectical philosophy.

DBT theories.

Biosocial.

The biosocial theory states that an individual's biology and social environment play a role in his or her development. In regards to individuals who are later treated with DBT, it is believed that they are biological predisposed to a heightened emotional sensitivity, greater emotional reactivity, and slower return to emotional baseline compared to other individuals (Neece et al., 2013; Rizvi et al., 2013). This biological predisposition would cause an individual to struggle in controlling their emotional responses to situations because they are already more emotionally sensitive than others. Being emotionally sensitive to situations can cause the

individual to react to a stressor more than what might be thought of as an appropriate reaction to that stressor. Even after the reaction to the stressor has occurred, these individuals take long to calm down and cope with their emotions and return to their baseline.

The social aspect of the biosocial theory is the role that the environment plays when individuals grow up. It is believed that some individuals learn that intense emotional expressions are necessary to communicate effectively. This is partly as a result of growing up in an unresponsive environment (Neece et al., 2013; Rizvi et al., 2013). Because their environment was not responsive to a typical emotional reaction, some individuals needed to have a greater emotional reaction in order for their emotional needs to be met. Since the need of a greater emotional reaction may happen multiple times throughout their lives, the individuals then learned that in order to communicate their emotions and get a response, they needed to have an emotional reaction great than normal. Furthermore, it is also believed that in this invalidating environment, essential skills to label, tolerate, or regulate emotions are not modeled or taught (Neece et al., 2013; Rizvi et al., 2013). This would set the stage for individuals to develop dysfunctional coping skills for the individuals to regulate their emotions because they were not being taught other healthy emotional coping skills.

Behavioral.

In addition to biosocial theory, DBT was also shaped from behavioral theory. Behavioral theory is based on the assumption that human behavior is learned and therefore dysfunctional behavior can be unlearned and replaced with new behaviors. Behavioral theory targets individuals' behaviors and focuses on creating new functional behaviors in treatment. Behavioral theory plays a role in DBT by shaping how problems are defined, behaviors are

assessed, interventions are chosen, and the entire case is conceptualized (Rizvi et al., 2013). In DBT the goal of interventions are to increase adaptive behaviors and decrease maladaptive behaviors. This goal was grounded in the behavioral theory belief that dysfunctional behaviors can be unlearned and replaced with functional behavior. Furthermore, behavioral theory contributes to DBT, the nonjudgmental belief that every behavior is learned. Therefore, DBT takes the blame off of individuals' as being the problem and instead focuses the attention on their behaviors as a problem. It allows individuals to not feel judged by their dysfunctional behavior because that behavior was learned as a way for them to survive.

Additionally, behavioral theorists believe that problem behaviors are a consequence of skills deficits, problematic contingencies, deficiencies in emotional processing, and cognitive factors. Therefore, individuals develop these problem behaviors because they were not modeled other behaviors, taught healthy coping skills, or ways to tolerate and express emotions. These beliefs, that the problem behaviors are a result of skills deficits, emotional processing, etc., is what shapes the behavioral treatment interventions (Choate, 2012; Miller et al., 2002; Rizvi et al., 2013). Some DBT interventions are based on the behavioral theory beliefs and intervention. For example, DBT borrows the behavioral belief that problematic behaviors are a result of skill deficits and to treat that problematic behavior, DBT teaches clients new DBT skills.

Dialectical.

The last theoretical influence on DBT is dialectical theory. Dialectical theory states that reality is interrelated and connected, it is made of opposing forces, and is always changing (Rizv et al., 2013). In other words, an individual can have two different beliefs at once that may be opposing and that their beliefs are able to change. This belief is utilized in DBT by showing that

it is possible to hold two opposing viewpoints at once. For example, an individual in DBT might have the two believes "I want to cut" and "I want to stop cutting." The dialectic in DBT used most commonly is change and acceptance. In DBT clients are taught skills to change and ways for accepting themselves and reality (Harvey & Penzo, 2009; Neece et al., 2013; Rizv et al., 2013).

Mental Health Issues Treated by DBT

Initially, Dr. Linehan developed DBT as a treatment option for individuals with Borderline Personality Disorder (BPD). DBT was used to treat, primarily women, who struggled with, emotional regulation, impulsivity and self-harming and suicidal behavior (Choate, 2012; Feigenbaum et al., 2012; Rizvi et al., 2013). American Psychiatric Association and the UK Department of Health and National Institute for Clinical Excellence have listed DBT as the recommended treatment for BPD (Feigenbaum et al., 2013). Although standard DBT treatment can be effective for BPD, it can also cause difficulty in being applied to different types of settings due to how intensive it can be. For example, in standard DBT clinicians need to be available by phone whenever clients may need them. This is not practical or desired by some clinicians who may have many additional obligations and are not always be available by phone. Therefore, standard DBT treatment has been adapted to be more practical, such as not having the therapist available by phone 24/7 for the client. The practicality of adapted DBT has allowed it to be implemented as a treatment option in a wide range of settings covering a wide span or mental health disorders.

DBT has now been utilized for other personality disorders, a broader range of problematic behaviors and mental health diagnoses, and multiple clinical environments. DBT has

been shown to be a treatment for other personality disorders apart from BPD, such as narcissistic and anti-social personality disorder (McCann, Ivanoff, Schmidt, & Beach as cited in Feigenbaum et al., 2012). DBT can be used to reduce anger, depression, hopelessness, suicidal ideations, and alcohol abuse (Rizvi et al., 2013). DBT has been adapted to treat individuals diagnosed with ADHD. DBT has also been used in forensic settings (Shelton, Sampl, Kesten, Zhang, & Trestman, 2009) and with the elderly (Rizvi et al., 2013). Furthermore, DBT has been used with family caregivers of individuals with Dementia and self-injuring adolescents and their parents (Chagani et al., 2013; Choate, 2012; Miller et al., 2002; Neece et al., 2013). Research suggests that DBT is an effective way to treat male and female adolescents struggling with impulsive behaviors and emotion deregulation (Chagani et al., 2013; Choate, 2012; Lopez & Chessick, 2013; Miller et al., 2002; Pistorello, Fruzzetti, MacLane, Gallop, & Iverson, 2012).

DBT with Adolescents

One aim of DBT treatment is a focus on emotional regulation and helping individuals to develop skills to cope with their intense emotions. The adolescent period is characterized by emotions that at times, can be intense. During the adolescent period, having the ability to cope and deal effectively with these emotions is important (Quinn, 2009). Emotional regulation and coping skills are typically developed and learned from infancy to adolescence (Neece et al., 2013). DBT treatment interventions are focused on helping individuals develop coping skills and helping them to deal with intense emotions through emotional regulation. DBT can help adolescents to manage their emotions and develop skills they have failed to develop previously. DBT treatment with adults teaches the same skills as DBT treatment with adolescents (Quinn,2009). By incorporating the DBT treatment in adolescence, the individuals can learn the coping skills early that most adults in DBT never learned. Therefore, applying DBT as a

treatment for adolescents would be appropriate developmentally, behaviorally, and psychologically (Neece et al., 2013; Quinn, 2009; Woodberry & Popenoe, 2008).

The literature reports numerous adaptations of DBT for treatment with adolescents. For example, DBT has been adapted and tested for the treatment of adolescents in outpatient and inpatient settings (McDonell et al., 2010), residential settings (Sunseri, 2004 as cited in Groves et al., 2012), and incarcerated juvenile offenders (Trupin et al., 2002 as cited in Groves, Backer, Bosch & Miller 2012). Furthermore, DBT has been used to treat adolescents with self-harming/suicidal behaviors (James et al., 2008; McDonell et al., 2010; Woodberry & Popenoe, 2008), eating disorders, bipolar disorder and oppositional defiant disorder (McDonell et al., 2010).

Miller and colleagues created the original adaptation of DBT for treatment with adolescents in 1997 (Grooves et al., 2012).The original adaptation is most closely related to Linehan's 1993 version of DBT for adults with BPD (Choate, 2012; Groves et al., 2012). The original adaptation and research of DBT for adolescents was treating adolescents with emotional dysregulation and self-harming behaviors (McDonell et al, 2010). The adapted DBT treatment for adolescents, altered the treatment to better represent the population it would be applied to. Specifically, treatment length was shortened, terminology was changed to be more appropriate for adolescents, family members were included in treatment, and the additional skill 'Walking the Middle Path' was introduced (Miller, Rathus, & Linehan, as cited in Groves et. al, 2012). The DBT treatment sessions focused on four main aspects. These include, (1) directly addressing skills for interpersonal effectiveness, (2) self-regulation and distress tolerance, (3) providing structure that is necessary to motivate, reinforce, individualize and generalize the new skills, and (4) identify the behavioral sequence that leads to self harming behaviors (Choate, 2012). DBT

treatment is delivered in multiple methods. These include individual therapy, multifamily training groups, family therapy, telephone consultation, and team consultation for counselors (Choate, 2012; Neece et al, 2013).

There has been limited research surrounding DBT's effectiveness as a treatment for adolescents. There are two quasi-experimental designs that evaluate DBT and outcomes for adolescents with self-harming behavior (Grooves et al., 2012; McDonell et al., 2010; Quinn, 2009). Overall, both studies found that individuals who received DBT treatment resulted in fewer psychiatric hospitalizations, compliance to treatment, and reduction in behavioral incidents, such as self-harming, (Grooves et al., 2012). James et al. (2008) looked at the effectiveness of DBT with female adolescents in a community sample and found that after treatment individuals who received DBT improved in their depression, number of times they engaged in self-harm, and their overall functioning. The measurements used for James et al., study included the Beck depression inventory, Beck hopelessness scale, episodes of deliberate self-harm and the global assessment of functioning (James et al., 2008). A 2010 pilot study of DBT for adolescents in long-term inpatient care supported that those who received DBT had significant improvements in global functioning and reduction in prescribed psychotropic medications (McDonell, et al., 2010). Neece et al. (2013) used a clinical case example to illustrate the application of developmentally appropriate DBT to a 16 year old female adolescent. Their findings suggested that the DBT treatment was effective for the individual and her family. Grooves et al. (2012) reviewed the literature for DBT treatment with adolescents. Their findings concluded that, to date of all the different forms of DBT treatment for adolescents, there were three main themes that related in the results. One, there was a wide range of improvement in functioning and these improvements occurred in a wide range of treatment facilities. Two, DBT

treatment appeared to be accepted by both adolescents and families. Three, there was treatment retention for the DBT programs. Although additional research to assess the effectiveness for DBT treatment with adolescents is still needed, the initial research and findings are promising.

Caregivers' Involvement in Treatment

The importance of incorporating family involvement into the treatment of an adolescent is an aspect that is gaining more notice. Caregivers involvement in the treatment of children and adolescents varies. Israel et al. (2007) found that typically parents were more involved in treatment if their children were younger and they had externalizing disorders. Regardless of the age of children, family based interventions are seen as important (Finsterwald & Spiel, 2012). Typically, minors who are in mental health treatment are still depended on their caregivers. Their environment is influenced by the interactions with their caregivers (Miller et al., 2002; Neece et al., 2013). They are still living at home, financially dependent, and reliant on caregivers for transportation to treatment (Baker-Ericzen, Jenkins, & Schlagel, 2012; Israel et al., 2007). One important reason to engage families in the treatment of adolescents is due to this dependence that most youth still have on their caregivers.

Some clinical professional groups believe that the importance of incorporating parents into treatment is so beneficial, that they made it mandatory by putting it in their code of ethics. The American Academy of Child and Adolescent Psychiatry, state in their code of ethics that it is sufficiently important to help both children and their families in treatment (Ruberman, 2009). Additionally, the American Psychological Association Working Group on Children's Mental Health has defined appropriate and effective treatment to include the aspect of being "family centered" (Baker-Ericzen et al., 2012). Furthermore, many of the evidence based practices for

disruptive behavior diagnoses include a family-focused intervention (Baker-Ericzen et al., 2012). The importance of family involvement in treatment is supported by the numerous family-oriented treatments already in existence, these include, parent management training, functional family therapy, family psychoeducation, and multi-systemic family therapy (Miller et al., 2002).

Another important reason to engage families in the treatment of adolescents is the growing body of research that reports on the positive benefits for youth when they have families or parents involved in their treatment. Podell and Kendall (2010) found that when parents were involved in CBT treatment for anxious youth, the individuals had more gains from treatment. Furthermore, another study of parental involvement in youth treatment found that those individuals who had both caregivers involved in treatment had significantly higher maintenance of treatment gains (Bagner & Eyeberg, 2003). Israel et al (2007) reported that family based interventions have also had positive outcomes for adolescents with anxiety disorders and depression. Additionally, research regarding DBT with adolescents highlights the importance of families involvement with the adolescents. The benefits of family involvement is thought to be so important, that family therapy and family involvement in DBT skills training groups, are part of the treatment procedure for DBT with adolescents (Choate, 2012; Chugani et al., 2013; Miller et al., 2002; Neece et al., 2013; Woodberry & Popenoe, 2008).

Caregivers and DBT.

Adolescent self-harm is often associated with family dysfunction (Kerfoot et al., 1996 as cited in James et al., 2008).Furthermore, part of the reason individuals do not develop healthy emotional regulation skills is due to an invalidating environment. An invalidating environment is an environment where the emotional needs of the individual and caregiver are inconsistent, inappropriate to the emotion expressed, or trivializing (Neece et al., 2013). This is important to

keep in mind because in most cases, the adolescents are still in the environment that is contributing to the self-harm and/or lack of health coping skills. Although clinicians can help adolescents to learn healthy coping skills, it may be difficult for these skills to be implementing successfully when one of the adolescents main environments is not changing. Miller et al., (2002) believed that when an adolescents environment plays such a large role in their life and progress in treatment, a more active environmental approach should be taken. A more active approach would be incorporating the families into the adolescents treatment. This would allow therapy to be focused on addressing the environment and the individuals that contributed to that environment and the emotional dysregulation and overall potential family dysfunction. Having the entire family involved in treatment can help create changes not only at the individual level, but also at the environmental and systems levels.

Importance of caregivers involvement.

Caregivers can play a large role in adolescents lives and therefore influence their treatment. The importance of caregivers involvement in treatment was recognized when DBT was first adapted to treat adolescents. Miller et al., (2002) incorporated the adolescent's family into DBT treatment, suggesting the importance caregivers have on their adolescents treatment. In addition to incorporating families as part of treatment, a new skill was added to DBT treatment for adolescents that related directly to the family. The skill that was added was labeled "Middle Path," or often referred to as 'walking the middle path'. This skill focuses on dialectics, validation, and behavior in the context of the caregiver-teen relationship (Neece et al., 2013). It is important to keep in mind that both teens and caregivers can be contributors to the presence or lack of emotional reciprocity (Miller et al., 2002). By having both involved in treatment, it can address this dual contribution, as opposed to only addressing the adolescents contribution.

Additionally, if a therapist can work on different aspects that affect caregiver-teen relationships, in the context of both individuals, it can help to increase the change of their interactions by providing both individuals the DBT skills. By incorporating families into treatment sessions, the adolescents and caregivers can learn the DBT skills in the context of their families personal struggles and apply them accordingly.

Furthermore, caregivers are often incorporated into the adolescents treatment by participating in a DBT skills group (Miller et al., 2002; Neece et al., 2013). By caregivers involvement in the DBT skills groups, caregivers can learn the skills themselves, utilize them, and become a model and coach for their adolescents (Neece et al., 2013; Miller et al., 2002). With the caregivers understanding of the skills, they can encourage their adolescents to use the skills at appropriate times outside of therapy. The caregivers can also utilize the skills to allow themselves to respond more effectively to their adolescents needs (Choate, 2012). Although families can contribute to some of the adolescents presenting problems, the families can also be a source of strength and change to help support the adolescents in treatment (Miller et al., 2002). The family being a source of strength and support for the adolescent is an additional reason to include the family in treatment. Miller et al. (2002) talked about four main targets of treatment for therapists when they are working with adolescents and their families.

Targets of treatment.

The first target in treatment for adolescents and their families is to decrease family interactions that contribute to the adolescents self-harming or suicidal behavior. In the context of the family, this relates to interpersonal skills between the adolescent and the other family members. This can include increasing skills within the family to improve communication and

decrease hostile or unhealthy conflicts. Increasing healthy interpersonal interactions between the adolescent and the family members is an important target in treatment because interpersonal conflicts are one of the most common factors associated with adolescent suicide attempts (Miller & Glinski as cited in Miller et al., 2002). Addressing interpersonal skills with not only adolescents but their family members too can help to decrease the risk factors associated with self-harm or suicidal behavior for the adolescent.

Adolescents are often dependent upon caregivers for a number of reasons. Two reasons that impact treatment the most are financial support for treatment and transportation to treatment. Therefore, Miller and colleagues (2002) second target when working with families and adolescents is to reduce families or caregivers behaviors that interfere with treatment. This includes discussing with family members aspects such as the financial responsibility that allows the adolescents mental health care and transportation to mental health care. Clinicians should have the conversation surrounding aspects that may interfere with treatment, early on when the family first engages in treatment. This second target for treatment would hopefully prevent drop out from treatment by providing caregivers and clinicians a chance to discuss and explore potential drop out reasons, and problem solve around them when necessary (Miller et al., 2002).

The third target is to help families as a whole to identify and reduce family interactions that interfere with their quality of life (Miller et al., 2002). A way to increase families quality of life would be having the family work together to identify areas of improvement and not just looking at areas to improve surrounding the adolescent. The third target relates to DBT's overall main goal of helping the individual to develop a life worth living, but applies it to the entire family. By addressing the interactions that create problems in the family, it can help families to

function in a way that is more effective, respectful and loving (Miller et al., 2002). The third target helps to create an overall more supportive family environment.

The fourth target when working with families is related to the first three targets. It focuses on increasing the families' behavioral skills when dealing with parent-adolescent dilemmas. This fourth target focuses specifically on communication and collaboration skills and helping families and adolescents find the "middle path" (Miller et al., 2002). Clinicians can achieve the fourth target by incorporating validation skills into treatment and suggesting caregivers' receive help in specific parenting skills that are applicable to common problems that occur between them and the adolescent. For example, parents may learn ways to use effective reinforcement/punishment (Miller et al., 2002).

Research has shown that DBT skills training, is essential for DBT's effectiveness as a treatment (Lynch et al., as cited in Choate, 2012). Therefore, DBT skills training, whether delivered in group or individual therapy, should always be a part of DBT treatment. Additionally, caregivers' involvement in treatment is typically encouraged during the DBT skills group (Miller et al., 2002). One benefit of having caregivers involved in learning the DBT skills is so they can then utilize the skills and help to model and encourage the use of the DBT skills in their adolescents. However, there is a lack of research in the literature assessing how well caregivers learn and utilize the DBT skills. It is important for further research to examine caregivers' utilization of DBT skills to be done. This would provide knowledge as to whether caregivers are using the DBT skills themselves and therefore modeling the use of the DBT skills to their adolescents.

Assessing DBT Skills

One part of DBT treatment is the different skills that individuals are taught. Recent studies are beginning explore how individuals who are treated with DBT learn and utilize those DBT skills (Lopez & Chessick, 2013). Until a few years ago, there was no psychometrically sound measure of DBT skills (Necsiu, et al., 2010a). In 2010, Neacsiu, Rizvi, Vataliano, Lynch and Linehan created and tested the validity and reliability of a measurement to assess DBT skills use. This measurement was called the DBT Ways of Coping Checklist (DBT-WCCL).

The DBT-WCCL was adapted from the Revised Ways of Coping Checklist (RWCCL). The DBT-WCCL is comprised of questions from the RWCCL and additional questions created to cover the skills taught specifically by DBT treatment. Identified DBT skills training experts were asked to evaluate the existing list of questions on the DBT-WCCL to determine which questions captured DBT skills use best. The end result yielded a 59-item self-report measure. Thirty-eight of these items measure the frequency of DBT skills used in the last month. The remaining items measure non-DBT, dysfunctional coping strategies (Neacsiu, et. al., 2010b). From these 59-items, three different factors emerged; DBT Skills Subscale (DSS), and two Dysfunctional Coping Subscale (DCS), DCS1 referred to general dysfunctional behavior and DCS2 referred to blaming others (Neacsiu et al., 2010a).

The DBT-WCCL has been used as a measurement of DBT skills in different studies (Chugani et al, 2013; Neacsiu et al., 2010b). The DBT-WCCL is a way to measure individuals use of the DBT and dysfunctional coping skills within the last month. The DBT-WCCL can help clinicians to determine whether their DBT skills groups are effective and if individuals are utilizing the skills taught. Furthermore, the DBT-WCCL can also target dysfunctional skills

being used by individuals. This may allow treatment to focus on what specific dysfunctional coping skills might need to be replaced with DBT coping skills. Learning DBT skills is crucial for DBT treatment to be effective. Utilizing the DBT-WCCL allows clinicians a way to determine if the individuals are utilizing the DBT skills; but also can be used to look at caregivers' use of DBT skills. As aforementioned, one of caregivers' main roles in treatment is to help model and encourage the use of DBT skills. With the DBT-WCCL clinicians can now see if they are helping caregivers' understand the skills enough to utilize them.

Since the development of DBT, DBT has been adapted to treat multiple different mental health issues, in numerous mental health environments, across a diversity of individuals. One of these DBT adaptations has been to apply DBT to the treatment of adolescents with mental health disorders. There is a need for more experimental research regarding the use of DBT with adolescents and its effectiveness. Preliminary quasi-experimental research highlights positive outcomes for adolescents treated with DBT. When DBT was adapted for work with adolescents, one aspect added to the treatment was the involvement of the family members.

The literature highlights the potential benefits of having family members involved with DBT treatment of adolescents. One of the main benefits is that caregivers can learn the DBT skills in order to utilize them and be models for the adolescents. Once caregivers learn and understand the DBT skills, they can encourage their adolescents to use the skills outside of therapy. What is still lacking in the research is the answer to the question of "are caregivers' using the DBT skills?" By measuring caregivers' utilization of DBT skills, it can better be determined if caregivers' are learning the skills enough to be able to utilize them, model them to their adolescents, and encourage their adolescents to use the DBT skills outside of therapy. The aim of the current study is to examine if caregivers who participate in a DBT skills group use

DBT skills before and after completing the 12 week group. Determining if caregivers are using the DBT skills will allow researchers a better idea regarding the utilization of the skills outside of treatment.

Method

The current research looked at parent use of DBT skills after a 12 week DBT skills group. The participants of this research were parents or caregivers who had participated in an adolescent and parent 12-week DBT skills group. The data for this research had previously been collected by the agency prior to the beginning of the research project. The parents and caregivers were given the DBT-WCCL to complete at the beginning and at the end of the 12 week group. The research design examines individual and group raw score means for the pre and post-assessment data. Additionally, participants completed the Patient Satisfaction Survey following the end of the 12-week group. The following section will address more fully the demographics, and inclusion and exclusion criteria, for the participants. The DBT-WCCL and Patient Satisfaction Survey will be more fully explained. Finally, an explanation of how the study was conducted and the data analyzed with be addressed.

Participants

Participants were those parents and caregivers who had recently completed an adolescent and parent DBT skills group at a child and adolescent outpatient mental health facility in western New York. Data were excluded from the study based on the following criteria: the client had previously participated in individual or group DBT, the pre or post DBT-WCCL was not completed within the first two or last two therapy hours, or the individual missed more than three of the 12 therapy hours. Participants who had previous DBT skills training or experience may

have come into the group with knowledge and utilization of the skills already. Therefore, those individuals might not accurately represent how well parents learned the DBT skills from the group. Participants who missed more than three treatment hours would have missed multiple DBT skills that were taught in those sessions, which might have skewed the results. Therefore, of the ten possible participants, data from six participants were utilized for the study.

Both males and females had the opportunity to have their data included in the study. However, there was the potential for more data to be from females due to mothers typically participating in the treatment of youths more than fathers (Podell & Kendall, 2010). Specific demographic information such as age, race, gender, etc. of participants was not collected in order to help participants' data be unidentifiable.

Instrumentation

The DBT-WCCL(which can be obtained at http://depts.washington.edu/brtc/files/DBT-WCCL.pdf) is a psychometrically sound instrument developed by Necsiu, Rizvi, Vitaliano, Lynch, & Linehan (2010)a, to assess the use of DBT skills. The DBT-WCCL is comprised of questions adapted from the Revised Ways of Coping Checklist (RWCCL) and additional questions that address specific DBT skills. Necsiu et al. 2010a identified DBT skills training experts to evaluate the additional questions in order to determine the items that best assessed DBT skills. The DBT-WCCL is a 59-item self-report measure to assess DBT skill use within the last month. Thirty-eight of the 59-items measure DBT skills. The remaining items measure dysfunctional coping strategies (Neacsiu, et al., 2010b).

The 59-items on the DBT-WCCL represent three different subscales. The first subscale is the DBT Skills Subscale (DSS). The additional two subscales are Dysfunctional Coping

Subscales (DCS). The DCS1 refers to general dysfunctional behavior while the DCS2 refers specifically to dysfunctional coping that relates to blaming others (Neacsiu et al., 2010b). Necsiu et al 2010a, assessed the psychometric properties of the DBT-WCCL. Reliability and validity analyses resulted in the DSS factor showing both internal and test-retest reliability. DCS and DSS factors showed good internal consistency. Content validity was average to high for general DBT skills. However, the content validity was not sufficient to capture the differences between the DBT skills (Neacsiu et al., 2010b). Overall, Neacsiu and colleagues developed a good psychometric instrument to be used to assess DBT skills.

In addition to the DBT-WCCL, the Patient Satisfaction Survey was given to participants at the completion of the 12-week groups. The Patient Satisfaction Survey was created by the researcher and asked participants questions regarding their participation in past DBT groups, four open ended questions regarding specific feedback about the DBT group, and one Likert scale question surrounding their encouragement of DBT skills for their adolescents. The Patient Satisfaction Survey is attached in appendix A.

Procedures

Participants' data were identified for the study based on their participation in a previous DBT skills group. The DBT group leaders had parents complete the DBT-WCCL pre and post assessments by providing them to parents during the first two treatment hours and the last two treatment hours. The researcher received a list of participants who had completed a DBT group at the agency between August 2013 and April 2014. The researcher, who was interning at the agency, had access to patient files and completed assessment data.

Participant's names or initials remained anonymous by assigning a research number to each individual who participated in the study. This information was kept on a spreadsheet that was password protected and only accessible by the researcher. Additionally, the researcher had not participated in the DBT skills groups so she was unable to associate names of the participants to specific individuals receiving treatment at the agency. Consent from participants was not obtained because the data used had been previously collected and the research was seen as a quality improvement project. Additionally, no identifying information was collected and research results will not be published.

The research hypothesis was that participants post assessment DBT-WCCL scores would show an increase of DBT skills compared to the pre assessment. After all data has been collected, the researcher analyzed the pre and post assessment scores using SPSS to compare individual and group means. Additionally a paired sample T-test was completed to determine if the results were statistically significant.

Results

Pre and post assessment means were calculated for all three subscales of the DBT-WCCL (Dysfunctional coping skills 1, Dysfunctional coping skills 2, DBT skills). Additionally a paired sample t-test was used in order to determine if changes in pre and post assessment means were statistically significant. The table shows the pre and post assessment individual scores (N=6), group means, and change score means.

Table. DBT-WWCL Pre Assessment, Post Assessment and Change Scores

Research ID	**DCS1 Pretest**	**DCS1 Posttest**	**DCS2 Pretest**	**DCS2 Posttest**	**DBT Skills Pretest**	**DBT Skills Posttest**
A1	1.27	1.67	0.67	.67	2.16	2.50
A2	2.4	2.33	1	1	1.37	1.74
B1	1.6	.67	1.17	.33	2.03	1.97
B2	2.67	1.67	1.5	.67	1.5	2.24
B3	1.53	1.80	1.84	1.83	2.13	2.21
B4	2.73	1.33	2.5	1	1.63	2.05
Group Mean	2.03	1.58	1.44	.92	1.80	2.12
Change Score Mean	**DCS1**		**DCS 2**		**DBT Skills**	
	.45		.52		-.32	

Higher scores represent that those coping behaviors were utilized more frequently. The table shows that at the time of the pre assessment the majority of individuals were utilizing dysfunctional coping more frequently than DBT skills. Four of six individual scores for the DCS1 decreased in the post assessment. Furthermore, four of six individual scores for the DCS2 also decreased in the post assessment whereas two remained the same. Additionally, five of the six individual scores for the DBT skills scale increased at the time of the post assessment.

The group means for both dysfunctional coping skills scales decreased on post assessments and the DBT skills group mean increased on the post assessment. This suggests that individuals were utilizing less dysfunctional coping skills and more DBT coping skills after they had completed the 12 week DBT group. The change scores show that DCS2 had the greatest difference in pre and posttest followed by DCS1 and then by the DBT skills scale.

Figure 1 shows the pre and post assessment means for the three subscales of the DBT-WCCL, Dysfunctional coping skills 1 (DCS1) Dysfunctional coping skills 2 (DCS2) and DBT

skills. Figure 2, 3, and 4 illustrate individual's pre and post assessments for the three subscales of the DBT-WCCL. Figure 2 shows that participants A1 and B3 had greater dysfunction at the time of the post assessment. Figure 3 demonstrates that all individuals post assessment scores for the dysfunctional subscale 2 either remained the same or decreased. Figure 4 illustrates that every individual, apart from B1, increased in their DBT skills on the post assessment.

Figure 1. Pre and post assessment group means

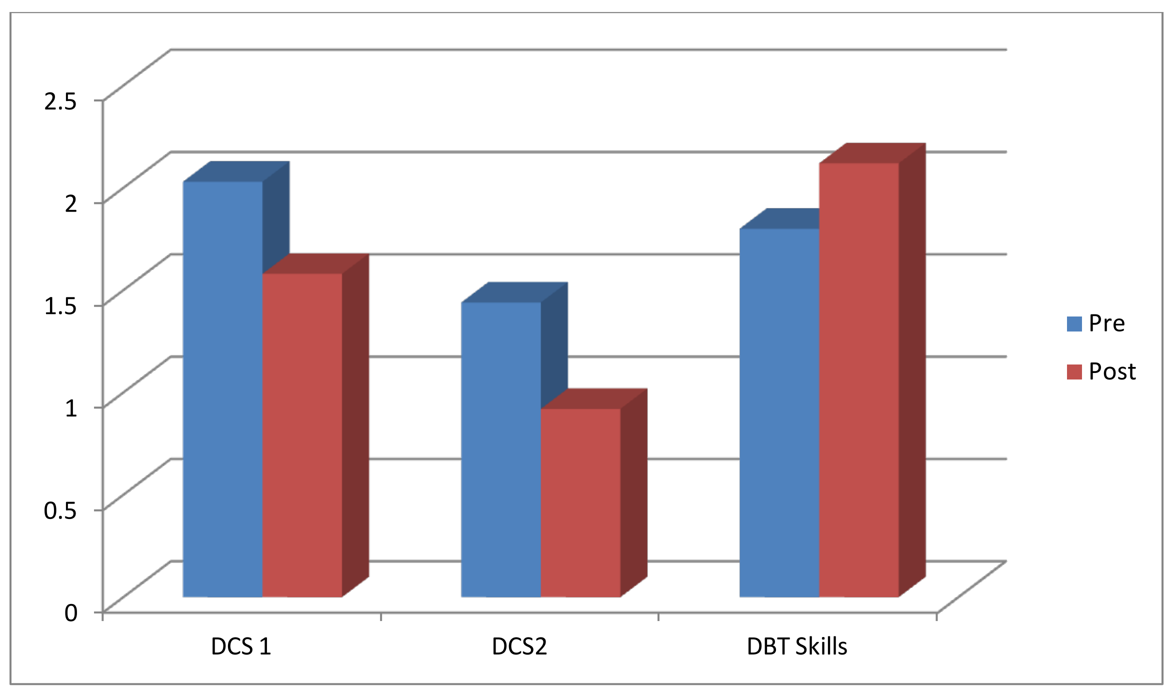


Figure 2 Dysfunctional Coping Skills 1 (DCS1) individual scores

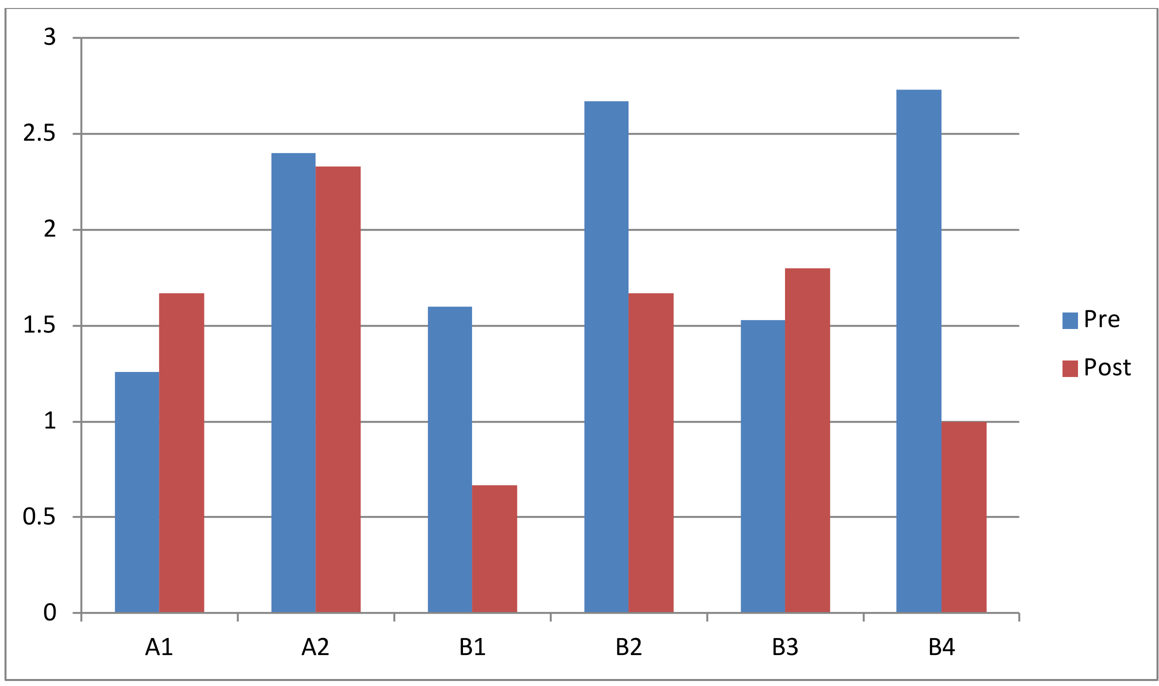
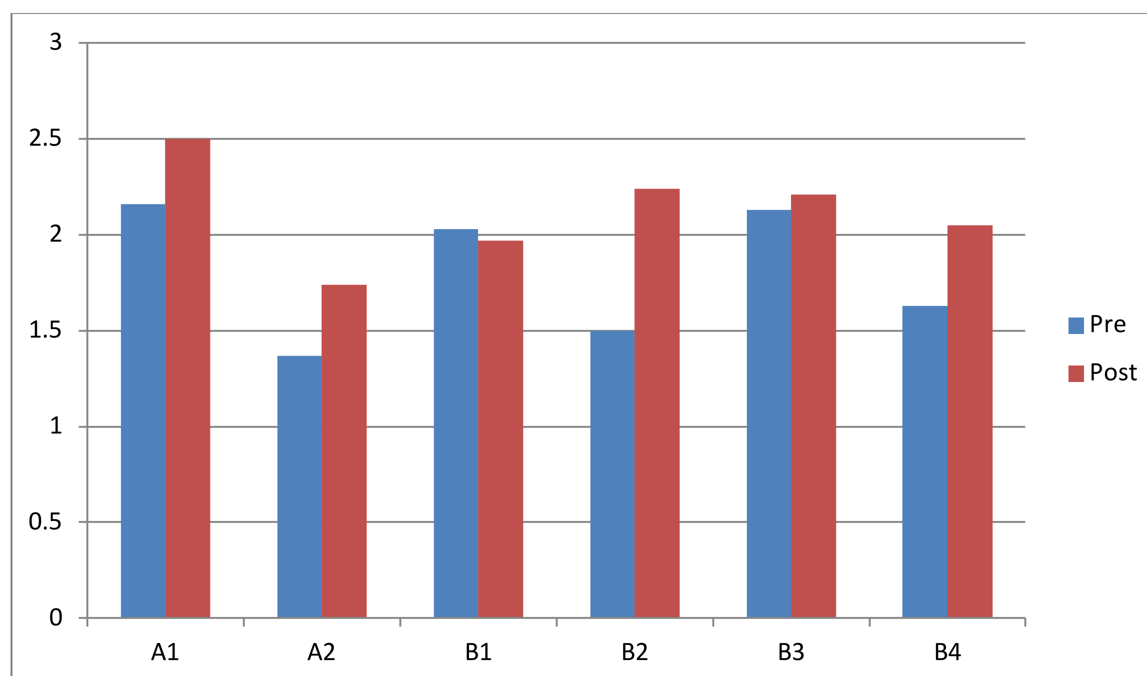


Figure 3. Dysfunctional Coping Skills 2 (DCS2) individual scores

Figure 4. DBT Coping Skills (DBT) individual scores



Paired sample t-tests were completed and showed that differences in the pre and post assessment means for the three subscales were not statistically significant. Furthermore, participants were given a post assessment survey which contained multiple yes/no, short answer questions, and a Likert question ranging from 1 (agree) to 5 (disagree) on their encouraging their adolescent to use DBT skills. Four out of six participants completed the Likert questions on the satisfaction survey. All individuals endorsed a 1 or 2 in relation to the question. Four of the seven survey questions were yes/no questions regarding experience with DBT in the past and DBT topics they wished were covered more/less. Four of the six participants fully completed the surveys and answered “no” for all four yes/no questions. The remaining two short answer questions addressed suggestions for improvement and what participants enjoyed most about the group. Three of the six participants answered the questions. Three of the six participants reported enjoying that the DBT group “discussed ways to handle certain situations,” “tools introduced to

deal with negative feelings," and "how to take a new look at it (a situation)." Three of the six participants responded to the question on suggestions for improvement with requesting more or longer group time and additional in group role plays of the different skills.

Discussion

When pre assessment and post assessment means for the three subscales were compared there was support for the hypothesis that parent's use of DBT skills would increase after the 12 week DBT skills group. The post assessment mean for the DBT skills scale was higher than the pre assessment, showing greater use of DBT skills. Furthermore, both Dysfunctional coping group means decreased on post assessments, indicating less dysfunctional attempts at coping. This suggests that individuals could have been applying the DBT coping skills they were learning through the group and replacing some of their dysfunctional coping skills with the new DBT skills.

The second hypothesis was supported as parents endorsed that they were encouraging their adolescents to utilize the DBT skills. A pre assessment value was not collected so it cannot be determined if this result is due to the DBT group or not. Due to parents' limited knowledge of DBT skills prior to participation in the DBT group, it can be suggested that parent encouragement of DBT skills improved following the DBT skills group.

Limitations of the Study

Limitations of the study include a small sample size. Only six participant's data were utilized in this sample. This is due partly to the nature and size of the DBT groups. The DBT groups tend to be small in size (four to six identified clients) due to the inclusion of parents. Therefore a group with four adolescents is a total group of eight or more. Furthermore, the DBT

groups last for 12 weeks and only two different DBT groups occur at the same time. Due to the length and size of the groups, only two groups' data were considered in this research leading to eight total participants. Two of those participants did not have sufficient data to utilize.

An additional limitation of this study is that it cannot be generalized to other settings. The researcher chose a convenience sample, which does not represent the entire population of parents taught DBT skills. Furthermore, the sample does not represent a wide range of gender. The nature of the group attracts a majority of female adolescents who are typically accompanied by female family members. Furthermore, the two DBT groups included in this study had different sets of group leaders. Although the topics covered and structure of the group were similar, the exact information delivered may have varied based on group leaders.

Due to the study not being a true experiment, the conclusions cannot be generalized. There were many external variables not controlled in the study. Although participants' DBT-WCCL results were only included if they had not had previous exposure to DBT skills through group or individual therapy, parents could still have learned additional or new coping skills outside of the DBT skills group. The DBT-WCCL requests that participants think back over the last month in order to complete the assessment. Participants could have been under different levels of life stress during the pre and post assessment, due to the group spanning over a three month period. The severity of stressful incidents could influence to the type of coping an individual utilizes, thereby impacting the individual's subscales on the DBT-WCCL.

Future Research

Areas for further research can include a larger sample size that covers a broader range of gender. An additional area to take into consideration for further research is collecting data from

participants who receive the DBT group from the same group leaders to account for more internal consistency. Furthermore, including a pre assessment Likert question regarding caregivers encouraging their adolescents to utilize the skills will provide more of a base line, allowing post assessment responses for the Likert item to demonstrate the amount the caregivers have increased in encouraging their adolescents to utilize DBT skills.

An additional area of research is the relationship between adolescents' DBT skill use and parents' DBT skill use. Furthermore, researchers could look at when caregivers utilize DBT skills, e.g., during interactions with their adolescent. This may shed light on whether or not parents are truly becoming role models of the DBT skills for their adolescents' and if the DBT skills are helping to make changes in interactions at the family level.

Conclusion

These findings are significant because caregivers are typically a large part of adolescents' lives. Providing not just the adolescent but also their caregivers with DBT skills may help to increase positive family interactions and decrease conflict between family members. Furthermore, the caregivers can help adolescents in their recovery by knowing the DBT skills, practicing and modeling them in front of the adolescents, and encouraging their adolescents to utilize the skills outside of treatment. Parental participation in DBT skills training allows the adolescents treatment to not just be at the individual level but also at the larger family environmental level. Change in the family system may help the adolescent's overall mental health and treatment.

The study findings suggest that parents learn and use the DBT skills. Further research with a larger number of participants is needed to determine if DBT groups help caregivers to

learn DBT skills and use them in a way that aids in the adolescent's treatment. DBT skills training should be on the individual and family levels. Helping to determine if interventions at the family level allow adolescents significant treatment success would be an important question to answer to help guide adolescent treatment in the future.

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Appendix A

Patient Satisfaction Survey

Participant Name ______________________________

Date __________________

Please answer the following questions:

1. Have you ever participated in a DBT skills group in the past? □ Yes □ No

2. Have you participated in or been exposed to DBT individual therapy in the past? □ Yes □ No

3. What did you enjoy regarding the DBT skills group?

4. What suggestions for improvement regarding the DBT skills group do you have?

5. Where there any DBT topics you wish had been covered less?

    □ No □ Yes

    If yes which ones?

6. Where there any DBT topics you wish had been covered more?

    □ No □ Yes

    If yes which ones?

7. I have found myself encouraging my adolescent to use DBT skills

Agree		Somewhat Agree		Disagree
1	2	3	4	5