Enhancing the lives of adult women suffering from bipolar disorder by managing their depression through Dialectical Behavior Therapy as an alternative to Cognitive Behavior Therapy.

Abstract

This study examined the effects of Dialectical Behavioral Therapy (DBT) on Clinically Depressed bipolar suffering adult women as opposed to the simple Cognitive Behavioral Therapy most frequently used to treat women who fall into this category. The group of women that this study particularly targets is women who have experienced in their lifetime a Major Depressive Episode, so severe that they have, at some point, required hospitalization. DBT is a form of therapy that was originally designed to treat patients suffering from Borderline Personality Disorder (BPD). It was recognized that CBT alone was largely ineffective for BPD sufferers and thus DBT was created which has had far greater success with BPD sufferers since its commencement in 1993 (Linehan 1993a; Linehan, 1993b).

This study utilizes a multiple subject multiple baseline design which included a baseline phase and a treatment phase lasting ten weeks.

The Beck Depression Inventory-II as well as the Subjective Units of Distress Scale (SUDS) was used on a weekly basis at the beginning of each session. The sessions were structured so that some featured therapeutic activities typical of Cognitive Behavioral Therapy sessions, and others, of Dialectical Behavioral Therapy were employed. The therapy sessions are designed such that the subjects are unaware that different techniques are being utilized.

The subjects are given activities to complete at home subsequent to each session and are surveyed at the beginning of the next session as to the utility and effectiveness of these exercises. The subjects are also asked to keep a journal of both their feelings after each session and also their feelings in between sessions.

The subjects are also surveyed at the end of the 10 treatment phase as to the overall effectiveness of the different techniques employed by therapist and subject alike.

Results of analysis of the data are presented to assess symptoms of depression using graphs beginning with baseline BDI-II scores for each participant and then weekly scores during the treatment phase. Results of this study indicated that whilst the Beck Inventory and SUDS scores remained the same following the Cognitive Behavioral Therapy sessions, the Beck Inventory scores and SUDS scores actually decreased noticeably after the DBT

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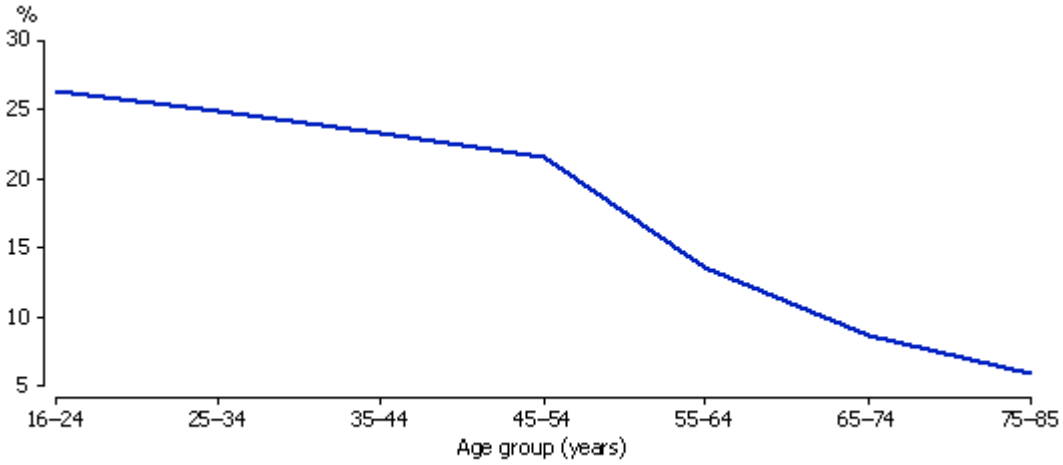
Introduction

The National Institute of Mental Health tells us that at least 18.8 million people in any given year in the United States suffer from Clinical Depression. It is also well established that women are twice as likely to experience depression as men, the crucial age group being for women between 25 and 44.



Source: 2007 National Survey of Mental Health and Wellbeing

Statement of the problem

Whilst there can be no doubt as to the efficacy of cognitive behavioral therapy, as its benefits and its success are constantly stated and re-affirmed in many areas of psychological treatment, it remains a fact that there are some people who are in effect "treatment resistant" when it comes to treating certain types of depression with cognitive behavioral therapy. It is not difficult to envisage that the groups of women that are more often than not, resistant to this type of therapy have particular attributes that make them or have made them resistant over the course of their illness and treatment. Women with Bipolar disorder, or in fact, anyone with bipolar disorder experiences a vast array of mood swings ranging from acute mania to chronic or severe depression.

Purpose of the Research

The purpose of this research is to determine the effectiveness of Linehan's Dialectical Behavioral Therapy on Clinically Depressed Bipolar female adults.

Given that there is such a high incidence of clinical depression both in the US and indeed worldwide, there is a need to develop and explore different long lasting treatments that can be used both in conjunction with and exclusive of drug therapy to enhance the quality of life for sufferers.

By treating clinically depressed patients with Dialectical Behavioral Strategies, it is hypothesized that there will be a reduction in depressive symptoms, more so than the reduction experienced when Cognitive Behavioral Strategies alone are employed. Changes are assessed both by improvement in the participants' BDI-II scores and in the recorded effectiveness of the activities determined by questionnaires designed for each participant to record their feelings as to the usefulness of different strategies and activities employed in each session.

The intent of this research is two-fold: to examine the underlying dynamics and challenges that can impact effective and lasting treatment, particularly when working with chronically depressed individuals and to investigate the components of DBT that contribute to its overall effectiveness and appeal when used to treat these clients. Because there are many challenges associated with providing treatment to these individuals, there is a strong need for treatment agencies to provide comprehensive and effective treatment that is both practical and concise. It is believed that DBT may be one such solution. In addition to DBT's guiding constructs and treatment application, this research looked to examine its effectiveness as an alternative to CBT.

Justification for the Research

While still in its infancy as a treatment model, DBT has received a great deal of empirical support for treating a growing range of severe and maladaptive behaviors. Due to the rapidly emerging collection of positive results and support obtained from a number of treatment outcome studies, it already appears that DBT is being actively utilized as a course of treatment for a wide variety of individuals. Despite its most common association with treating Borderline Personality Disorder, research shows that an increasing number of chronic and persistently mentally ill clients appear to be benefiting from DBT and that it is quickly becoming a primary treatment modality.(Weitzman, 2004)

Among all the adults in the United States who have experienced at least one Major Depressive Episode in the last year, only 65.1 percent received treatment. Whilst females who fall into this category are more likely than males to receive treatment for depression, still only 70.1 percent of those females received treatment. (National Institute of Mental Health, www.nimh.nih.gov)

The following graph indicates the prevalence of Major Depressive Episodes in specific populations during the year 2004.

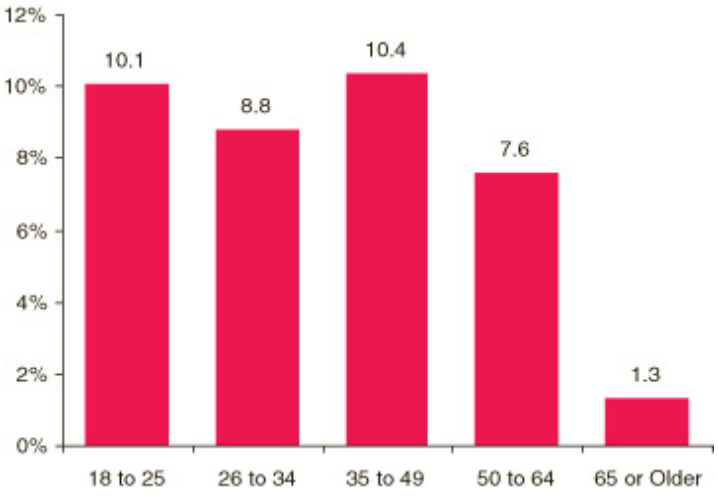


Figure 1. Percentage of Adults Aged 18 or Older Who Reported a Past Year MDE, by Age Group: 2004

Depression is considered to be one of the leading causes of disability in the United States today. (Murray, 1996) Up to 15% of those who are clinically depressed die by suicide. For each of these

suicides there are an estimated 8 to 25 attempted suicides and the ratio is higher in adult women. Adult women attempt suicide twice as often as men. (NIMH)

In 1997, suicide was the 3rd leading cause of death in 15 to 24 year olds in the US. Research has shown that 90 percent of people who kill themselves have depression or another diagnosable mental or substance abuse disorder. (NIMH)

More than 30 percent of patients suffering from major depression report suicidal ideation. (National Centre for Health Statistics, www.cdc.gov/nchs.org) Thirty percent of all clinically depressed patients attempt suicide; half of them ultimately die by suicide. (NCHS). More Americans suffer from depression than coronary heart disease (12 million), cancer (10 million) and HIV/AIDS (1 million). (NCHS)

Given the widespread suffering of depression and the high risk of suicide, depression that is untreated is likely to effect many Americans, and those who do not suffer from depression will more likely than not be effected by a friend or a loved one who is suffering from depression or who has indeed attempted or committed suicide. Thus, the quality of life of most Americans is effected one way or another by depression.

Not only is the cost to the population too grave to ignore but there are also many other hidden costs that often remain unthought-of of when determining the effect depression has on the population in general.

For example, depression has been found in the US to be one of the most common causes of extended work absences. (Stansfield, Fuhrer, Head, & Shipley, 1997 p64).

Depression is generally considered to be the most prevalent of all diagnosed mental disorders. (Gotlib, Roberts, and Gilboa, 1996; Moran and Lambert, 1983; Wolman and Stricker, 1990). The World Health Organization estimates that 340 million people currently suffer from some form of clinical depression, and that depression will become the leading cause of disability and the 2nd leading contributor to the global burden of disease by the year 2020 (WHO, 2001). In the USA it is estimated that 10 percent of the population has a depressive disorder (Rosenfeld, 1999), and that one out of every four Americans will experience symptoms of depression that are serious enough to warrant treatment at some time during their lives (Marsella, Hirschfeld and Katz, 1987). Given its widespread prevalence, it is not surprising that depression has been described as "the common cold of mental health problems that strikes the rich and the poor as well as the young and the old. (Rosenfeld, 1999, p10). Symptoms of depression vary in severity, from feeling sad or gloomy for a relatively short period of time, to deep despair, extreme guilt, hopelessness and thoughts of death that could result in suicide. Persistent depression can also produce behavioral and physical symptoms such as fatigue, insomnia, impotence, frequent crying, chronic aches and pain, and excessive gain or loss in weight (Rosenfeld, 1999 p20). Clearly depression is a complex, multifaceted syndrome that is comprised of a number of underlying dimensions. (Spielberger et al, 2003)

Given the effectiveness and success of Linehan's Dialectical Behavioral Therapy for treatment of patients with BPD, it is important to test the application of the same therapy to sufferers of other Mental Illnesses and particularly to those who are clinically depressed. If effective, and indeed the participants report marked improvement in their depressive symptoms subsequent to the sessions

employing DBT strategies, more so than the CBT strategies, the cost implications, both financial and life-enhancing could be significant.

Across studies DBT seems to reduce severe dysfunctional behaviors that are targeted for intervention (e.g. para-suicide, substance abuse and binge eating) enhance treatment retention and reduce psychiatric hospitalization. Evidence suggests that additional research is warranted to examine which components of DBT contribute to outcomes although preliminary skills coaching seems to be a crucial ingredient in producing reductions in para-suicidal behaviors and specific strategies (e.g. validation, balance of change and acceptance interventions) may play an important role in positive behavior change.(Kelly Koerner, 2000)

Limitations of the Research

There are several problems involved with the implementation of this methodology. Firstly there are many variables that cannot be controlled, the most obvious being that each subject is unique so it is impossible to suggest that any of the participants' backgrounds are similar and thus different outcomes may be as a result of the different experience of the participants or as a result of the therapy employed or a combination of both factors.

Similarly, whilst understanding the precepts of DBT and CBT is not overly difficult it has to be noted that the effectiveness of the therapist is always a consideration when assessing the effectiveness of a particular style of therapy.

There are also other factors and variables that could be said to account for changes in depression levels of the participants. For example: the nature of the therapeutic relationship, the truthfulness and openness of the participant when reporting his/her feelings on his/her levels of depression; outside influences such as family support networks or peer support; and just general changes in life circumstances.

The quantitative usefulness of the survey provided to the professionals as part of the mixed design research is most likely very limited. Whilst certain questions do lend themselves to a desire to draw quantitative conclusions, this is not really a viable possibility given the limited number of participants in this part of the design. Furthermore the qualitative nature of the majority of questions on the survey are inherent to the thesis design and have far more weighting that the quantitative data.

Chapter 1

Literature Review

History of Bipolar Disorder

Bipolar disorder is perhaps one of the oldest known illnesses. Research reveals some mention of the symptoms in early medical records. It was first noticed as far back as the second century. Aretaeus of Cappadocia (a city in ancient Turkey) first recognized some symptoms of mania and depression, and felt they could be linked to each other. His findings went unnoticed and unsubstantiated until 1650, when a scientist named Richard Burton wrote a book, The Anatomy of Melancholia, which focused specifically on depression. His findings are still used today by many in the mental health field and he is credited with being the father of depression as a mental illness.

Jules Falret coined the term "foliecirculaire" (circular insanity) in 1854 and established a link between depression and suicide. His work led to the term bipolar disorder, as he was able to find a distinction between moments of depression and heightened moods. He recognized this to be different from simple depression and finally in 1875, his recorded findings were termed Manic-Depressive Psychosis, a psychiatric disorder. Another lesser-known fact attributed to Falret is that he found the disease seemed to be found in certain families thus recognizing very early that there was a genetic link.

Francois Baillarger believed there was a major distinction between bipolar disorder and schizophrenia. He characterized the depressive phase of the disease. It was this achievement that allowed bipolar disorder to receive its own classification from other mental disorders of the time. In 1913, Emil Krapelin established the term manic-depressive, with an exhaustive study surrounding the effects of depression and a small portion about the manic state. Within fifteen years, this approach to mental illness was fully accepted and became the prevailing theory of the early 1930's.

In 1952, an article appeared in The Journal of Nervous and Mental Disorder, analyzing the genetics behind the disorder, and revealing the likelihood that manic depression ran in families already stricken with the disorder. Throughout much of the 1960's many with the disorder were institutionalized and given little help financially because of Congress's refusal to recognize manic depression as a legitimate illness. Only in the early 1970's were laws enacted and standards established to help those afflicted, and in 1979 the National Association of Mental Health (NAMI) was founded.

In 1980, the term bipolar disorder (1980) replaced manic-depressive disorder as a diagnostic term found in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-III). During the 1980's research finally was able to distinguish between adult and childhood bipolar disorder and even today, more studies are needed to find the probable causes and the possible methods to treat the illness. (http://www.caregiver.com/channels/bipolar/articles/brief_history.htm)

Bipolar Disorder

Bipolar disorder, also called manic depression, is a mental illness that is characterized by severe mood swings, repeated episodes of depression, and at least one episode of mania. Bipolar disorder is one kind of mood disorder that afflicts more than 1% of adults in the United States, up to as many as 4 million people. Here are some additional statistics about bipolar disorder:

- Bipolar disorder is the fifth leading cause of disability worldwide.
- Bipolar disorder is the ninth leading cause of years lost to death or disability worldwide.
- The number of individuals with bipolar disorder who commit suicide is 60 times higher than that of the general population.
- People who have bipolar disorder are at a higher risk of also suffering from substance abuse and other mental health problems.
- Males may develop bipolar disorder earlier in life compared to females. (http://www.medicinenet.com/bipolar_disorder/article.htm)

Bipolar disorder has a number of types, including bipolar type I and bipolar type II disorder. Depending on how rapidly the mood swings occur, the episodes of bipolar disorder can also be classified as mixed or rapid cycling. For every type and duration of the illness, the sufferer experiences significant problems with his or her functioning at school, at work, or socially, may require hospitalization, or may have psychotic symptoms (for example, delusions or hallucinations). The diagnosis of bipolar I disorder requires that the individual has at least one manic episode but does not require a history of major depression. Bipolar II disorder is diagnosed if the person has experienced at least one episode of major depression and at least one hypomanic (a milder form of mania) episode.

A mixed episode is defined as a period of time in which both the criteria to diagnose a major depressive episode and a manic episode are fully met, except for the duration requirements of each. The mood problem (manic alternating with depressive symptoms) takes place nearly every day for a total of at least a week.

The shift from depressed to manic affect is particularly confusing to the patient and to those with whom they can relate. Bipolar patients come to distrust their emotions, but because there is little they can do to control their feelings through simple psychological exertion, many bipolar patients distrust their emotions while they simultaneously surrender to them. They like the affect of the mania feeling safer when irritable because they protect themselves more (or alternately enjoy the euphoria of positive affect that makes normal life affect pale in comparison). They surrender to the depression due to its immediacy and apparent lack of connection to specific thoughts and experiences.(Mazza)

Patients experiencing mania engage in behavior similar to that observed with anxious patients, in that there is substantial flight. While the anxious person flees from perceived threat, the manic patient flees from their experience of intensity. The frequent sexualisation, intoxication and hyperactivity of the manic patient can be viewed as mood dependent behavior that serves to distract and fragment the otherwise observed emotional turbulence. While many bipolar patients look like they are seeking out arousal rather than avoiding it, the acting-out behavior serves to fragment and thus compartmentalize the arousal into more manageable and understandable urges.(Mazza)

In order to qualify for the diagnosis of bipolar disorder, a person must experience at least one manic episode. Symptoms of mania must last at least a week (unless it is a mixed episode) and include

- elevated, expansive, or irritable mood;
- racing thoughts;
- pressured speech (rapid, excessive speech);
- decreased need for sleep;
- grandiose beliefs (for example, feeling like one has super powers or superlative talents or faults);
- tangential speech (repeatedly changing topics to topics that are hardly related);
- increased goal directed activity;
- Impulsivity and poor judgment.

Symptoms of the manic episode of early onset bipolar disorder tend to include outbursts of anger and rage, as well as irritability, as opposed to the expansive, excessively elevated mood seen in adults. The adolescent with bipolar disorder is more likely to exhibit depression and mixed episodes,

with rapid changes in mood. Despite differences in the symptoms of bipolar disorder in children and adolescents compared to adults, many who are diagnosed with certain kinds of bipolar disorder before adulthood continue to have those symptoms as adults.

As is true with virtually any mental-health diagnosis, there is no one test that definitively indicates that someone has bipolar disorder. Therefore, health-care practitioners diagnose this disorder by gathering comprehensive medical, family, and mental-health information. The practitioner will also either perform a physical examination or request that the individual's primary-care doctor perform one. The medical examination will usually include lab tests to evaluate the person's general health and to explore whether or not the individual has a medical condition that might have mental-health symptoms.

In asking questions about mental-health symptoms, mental-health professionals are often exploring whether the individual suffers from depression and/or manic symptoms but also anxiety, substance abuse, hallucinations or delusions, as well as some behavioral disorders. Practitioners may provide the people they evaluate with a quiz or self-test as a screening tool for bipolar disorder and other mood disorders. Since some of the symptoms of bipolar disorder can also occur in other mental illnesses, the mental-health screening is to determine if the individual suffers from bipolar disorder, an anxiety disorder, schizophrenia, schizoaffective disorder and other psychotic disorders, or a substance abuse, personality, or behavior disorders like attention deficit hyperactivity disorder (ADHD). Any disorder that is associated with sudden changes in behavior, mood or thinking, like a psychotic disorder, borderline personality disorder, or multiple personality disorder (MPD) may be particularly challenging to distinguish from bipolar disorder. In order to assess the person's current emotional state, health-care providers perform a mental-status examination as well.

In addition to providing treatment that is appropriate to the diagnosis, determining the presence of mental illnesses that may co-occur (be co-morbid) with bipolar disorder is important in preventing bad outcomes. For example, people with bipolar disorder are at increased risk of committing suicide, particularly after engaging in previous episodes of self-harm. Individuals who suffer from this illness, in addition to either alcohol problems or borderline personality disorder, are also at particular risk of committing suicide. People with bipolar disorder are at higher risk of having an anxiety disorder like panic disorder, phobias, generalized anxiety disorder, or obsessive compulsive disorder (OCD).

History of Depression

In a comprehensive review of the history of depression and melancholia, Jackson (1986, 1995) traces the origins of these concepts to the 5th century B.C. writings of Hippocrates, the father of modern medicine. The Greek term “melancholia”, was used by Hippocrates to describe "black mood", which he attributed to excessive black bile in the brain. Melancholia was considered to be a mental disorder that involved prolonged sadness and fear along with sleeplessness, irritability, restlessness and aversion to food (Jackson, 1995, p8). In the 2nd century AD, Rufus of Ephesus and Galan described persons who suffered from melancholia as sad, gloomy and fearful with delusional ideas involving guilt and sin. Galan's restatement of Hippocrates description of melancholia consisting of affective feelings, self-deprecating cognitions, and somatic symptoms prevailed for the next 1500 years. During the 17th and 18th Century, Pinel and Greisinger considered depression to be synonymous with melancholia which Pinel defined as "characterized by great depression of spirits" that involved gloom, despair and suspicion (Jackson, 1995, p.7) These negative mood states were also emphasized by Greisinger (1845). In the 1980's Emil Kraepelin (1887) differentiated between melancholia which he regarded as a diagnostic entity or type of insanity, and depression, which he used mainly to describe dysphonic mood or affect. Although Kraeplin clearly distinguished between

depression and melancholia, subsequent ambiguity in the definition of depression appears to have resulted from differences in the emphasis on depression as an affective mood that varies in intensity and the diagnosis of depression as a psychiatric disorder (Neckham, Leber, and Youll, 1995; Jackson 1995, Koebler, Moul, and Farmer, 1995)

The systematic study of the efficacy of different treatments for depression is a relatively recent and underdeveloped field (Rehm, 1989). Diagnostic differentiation and detailed criteria for major depression, dysthymia, and bipolar states were not clearly established until 1980 with the publication of the Diagnostic and Statistical Manual of Mental Disorders. Prior to the establishment of this consensus definition, it would have been difficult to adequately research the unique needs of any depressed population. However, since 1980 and the establishment of clear diagnostic criteria, few outcome studies have compared treatment responses of men and women or have addressed treatment efficacy for women.("Treatment for Women with Depression,")

Depression

It is normal to feel down or sad at times during your life. If you have had to cope with a stressful event, you may need time to grieve and feelings of sadness may last for some time. The term depression is sometimes used to describe feelings of sadness. Depression is also the name for a group of illnesses, which affects the way someone feels and is characterized by a persistent lowering of mood.

When someone is depressed they may feel a range of things including: ·

- feeling hopeless or helpless
- losing interest in activities they usually enjoy
- a lack of energy
- changes in sleeping and eating patterns
- crying a lot or feeling agitated
- high use of alcohol or other drugs
- losing their temper
- withdrawing from the group
- headaches or stomach aches
- feeling empty
- Feeling anxious.

Sometimes people become depressed in response to something in particular and sometimes depression can occur for no apparent reason. Some of the things that can trigger depression include:

- a history of depression within the family
- a stressful event or chain of events such as a family break-up, child abuse, ongoing bullying at school, rape, a death, a relationship break up, family conflict
- Having a baby.

People experiencing depression may have suicidal thoughts.
(http://au.reachout.com/find/articles/depression)

Clinical depression is a state of extreme distress in which the sufferer feels empty or numb rather than merely sad. The depressed person is unable to enjoy life normally or have an emotional shift from the depressed state.

A persistent depressed mood may be the feature of a Mood Disorder when it is present all or most of the time for at least two weeks.

In a Major Depressive Episode, someone might also experience:

- either diminished appetite with weight loss or increased appetite with weight gain,
- either insomnia or increased sleep,
- either agitation or slowed movements,
- loss of all pleasure and enjoyment,
- tiredness and fatigue,
- feelings of guilt and worthlessness,
- Poor concentration and thoughts of death, including suicidal thoughts and plans. (http://www.health.qld.gov.au/mentalhealth/abt_mental/facts_depression.asp)

When depressed, a person will focus on minor negative aspects of what was otherwise a positive life experience. For example, after a vacation at the beach, the depressed person will remember the one day it rained, rather than the days of sunshine. If anything goes wrong, the depressed person evaluates the entire experience as a failure or as a negative life experience. As a result, memories are almost always negative. (A. Beck)

Automatic thoughts are repetitive, automatic self-statements that are said to ourselves in certain situations. They can be positive or negative. Psychological problems develop when automatic thoughts are consistently negative. They are automatic because they are not the result of an analysis of the problem; they are a knee-jerk reaction to specific situations. For example a person in social situations always presuming others dislike him/her or think he/she is stupid. (A. Beck)

Albert Ellis first presented the idea that irrational beliefs are at the core of most psychological problems. These beliefs could also be called unrealistic, incorrect or maladaptive. Psychologists have also suggested that these ideas are irrational because they are not logical or are based on false assumptions. The following are some examples of irrational beliefs:

I cannot be happy unless everyone likes me
If I do what is expected of me, my life will be wonderful
Bad things don't happen to good people
Good things don't happen to bad people
In the end, bad people will always get punished
If I am intelligent (or work hard) I will be successful. (A. Beck)

Cognitive distortions are another way of describing the irrational ideas, overgeneralizing of simple mistakes or developing false assumptions about what other people think or expect. (A. Beck)

Pessimism is the tendency to think that things won't work out as desired, that what is desired won't be obtained. Pessimism feeds the negative cognitive distortions and self-talk. (A. Beck)

Hopelessness and helplessness are both features of depression. Viewing the world as bad and filled with problems leads to a feeling of helplessness and a belief that life will never improve is hopelessness.(A. Beck)

Behavioral models of depression emphasize the importance of low levels of positively reinforced healthy behavior, high levels of avoidance and escape behaviors and reduced available reinforcing stimuli as causal factors in the etymology and maintenance of depression. Behavioral approaches focus on teaching strategies to modify the environment (e.g. increase in pleasant events, problem solving skills training), with the goal of increasing access to reinforcing events and activities and reducing behavioral avoidance coping.(Janice A. Blalock, 2008)

However few studies have addressed whether coping behavior mediates the treatment effects of cognitive behavioral therapies for depression.(Janice A. Blalock, 2008)

Supportive Criteria

Bipolar Depression

Not as prevalent as other forms of depression is bipolar depression. Bipolar Disorder is characterized by cycling mood changes: severe highs and lows. When in a depressed cycle, an individual can have any or all the symptoms of a depressive disorder.

Theoretically bipolar depression is exactly the same as unipolar or straight Major Depression. Theoretically, the two cannot be distinguished so it's difficult to determine tell if someone has bipolar disorder just by looking at their depression.

What constitutes bipolar disorder depression can be determined by the actions of the depressed person prior to becoming depressed. Usually energy and motivation start to decline. A person may lose interests in activities that were pleasurable before. Often times a bipolar depressed person will experience a change in libido, difficulty concentrating, worrying a lot, loss of interest in people, negative thinking, cannot face normal task, feeling tired and listless, wanting to be alone, anxiety and a slow down in terms of ideas.

The following symptoms are not necessarily required for the diagnosis of bipolar depression but may also be seen as secondary symptoms in some women within the age group.

- sleep disturbance and sleep EEG abnormalities
- instability
- substance abuse (not the cause of the mood disorder but used as self-medication
- suicidal ideation
- extreme fatigue
- extreme paranoia
- negative ruminations ("DSMIV,")

Diagnostic Criteria

The DSM IV states that for a diagnosis of Bipolar Depression the criteria of Major Depressive Disorder must be met.

Major Depressive Disorder

The essential feature of a Major Depressive Episode is a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities. The individual must also experience at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. To count towards a Major Depressive Episode, a symptom must either be newly present or must have clearly worsened compared with the person's pre-episode status. The symptoms must persist for most of the day, nearly every day, for at least 2 consecutive weeks. The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning. For some individuals with milder episodes, functioning may appear to be normal but requires markedly increased effort. (DSMIV)

1. Depressed mood: This means that most of the time a person feels down, sad, empty, discourages. S/he may cry a lot, or may be unable to cry. Feeling irritable is another common emotional symptom.

2. Loss of interest: A person may experience loss of interest or pleasure in life so that s/he has to push himself/herself to do things s/he used to enjoy. This often includes a loss of interest in sex. It becomes difficult for a person to anticipate that any activity might be pleasurable. (Sanderson, 2009 p73)

3. Change in appetite for food: The most usual picture is that a person loses his/her appetite. Food neither interests nor appeals to him/her. A person may have to push him/herself to eat, and may lose weight. Sometimes people eat more when they are depressed. They use food as a source of comfort.

The diagnosis for Bipolar Disorder 1 with most recent episode depressed requires the following:

Bipolar 1 Disorder most recent episode depressed

A. currently (or most recently) in a major depressive episode

B. there has previously been at least one manic episode or one mixed episode

C. The mood episode in criteria A or B are not better accounted for by Schizo-affective Disorder and are not superimposed on schizophrenia, Schizophreniform Disorder, Delusional disorder or Psychotic disorder not otherwise specified.("DSMIV,")

Bipolar II disorder is a common disorder with a prevalence of approximately 3 – 5%. Distinct clinical features of bipolar disorder have been described. The key to diagnosis is the recognition of past hypomania while depression is the typical presenting feature of the illness. (Dodd, 2005)

For Bipolar II Disorder the following is required:

Bipolar II Disorder

A. Presence (or history) of one or more Major Depressive Episodes

B. Presence (or history) of at least one hypomanic Episode

C. There has never been a manic or mixed episode

D. the mood symptoms in Criteria A and B are not better accounted for by Schizo-affective Disorder and are not superimposed on schizophrenia, Schizophreniform Disorder, Delusional disorder or Psychotic disorder not otherwise specified.("DSMIV,")

Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects and marked impulsivity beginning by early adulthood and present in a variety of contexts as indicate by 5 (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment

2. A pattern of unstable and intense interpersonal relationships characterized by alternatives between extremes of idealization and devaluation

3. Identity disturbance: markedly and persistently unstable self-image or sense of self

4. Impulsivity in at least 2 areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating)

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 dysphonia, irritability or anxiety usually lasting a few hours and only rarely lasting a few ways.

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 ("DSMIV,")

Genetics in Bipolar Disorder

Bipolar disorder (also known as manic depressive illness) is a complex genetic disorder in which the core feature is pathological disturbance in mood (affect) ranging from extreme elation, or mania, to severe depression usually accompanied by disturbances in thinking and behavior. The lifetime prevalence of 1% is similar in males and females and family, twin, and adoption studies provide robust evidence for a major genetic contribution to risk. There are methodological impediments to precise quantification, but the approximate lifetime risk of bipolar disorder in relatives of a bipolar proband are: monozygotic co-twin 40-70%; first degree relative 5-10%; unrelated person 0.5-1.5%. Occasional families may exist in which a single gene plays the major role in determining susceptibility, but the majority of bipolar disorder involves the interaction of multiple genes (epistasis) or more complex genetic mechanisms (such as dynamic mutation or imprinting). (Craddock & Jones, 1999)

There has long been a debate as to whether or not Bipolar Disorder is a genetic disorder. However the DSMIV states:

Major Depressive Disorder is 1.5 – 3 times more common amongst first degree biological relatives of persons with the disorder than among the general population. (DSM IV p373)

First degree biological relatives of individuals with bipolar disorder have elevated rates of Bipolar I Disorder (4% - 24%, Bipolar II Disorder 1% - 5%) and major depressive disorder (4% - 24%). Those individuals with mood disorder in their first degree biological relatives are more likely to have an earlier age of onset. Twin and adoption studies provide strong evidence of a genetic influence for bipolar disorder. (DSM IV p386)

Some studies have indicated that first degree biological relatives of individuals with Bipolar II disorder have elevated rates of Bipolar II disorder, Bipolar I disorder and Major depressive disorder compared to the general population. (DSM IV p395

Treatment Strategies

Current treatment strategies used to treat sufferers of bipolar disorder with major depressive disorder are 2 fold.

It is widely accepted that psycho pharmaceutical intervention is administered with co-junct therapy.

All treatment methods are intended at elevating an individual's quality of life through enhancing abilities and minimizing emotional distress.("DSMIV,")

Bipolar disorders have proved difficult to treat but a range of cognitive, behavioral and pharmacological interventions have been developed with some success. The treatments developed for bipolarity have been directed at the contributing factors implicated in the etiology of bipolar disorders including social rhythm regularity, sleep routines and circadian rhythms. For example a longitudinal study found that Bipolar I individuals who received inter-personal and social rhythm therapy experiences longer periods free from bipolar episodes. Fewer bipolar episodes were also found in another study of bipolar patients who received a CBT that emphasized routine and sleep. Other kinds of sleep intervention have also found some therapeutic effectiveness for bipolar patients. (Benedetti et al. 2001) found that the effectiveness of a sleep intervention was additionally enhances when participants were simultaneously treated with lithium. (Totterdell, 2008)

In terms of treating Bipolar Depression with therapy, there is no shortage of literature indicating that psychotherapeutic intervention is advantageous in the successful treatment of sufferers.

Widely used therapies include

- Cognitive Behavior Therapy (CBT)
- Gestalt Therapy
- Interpersonal Therapy

However it is generally accepted that CBT is the most beneficial and therefore most widely accepted used therapeutic intervention for depressed patients

Cognitive behavioral therapy (CBT) is a form of treatment that combines elements of both cognitive therapy and behavior therapy. Cognitive therapy examines the way people's thoughts about themselves, others, and the world affect their mental health. Behavior therapy investigates the way people's actions influence their own lives and their interactions with others. By combining the two, CBT examines the way people can change their thoughts and behaviors in order to improve their lives.

Despite the benefits offered by CBT, it's very important to remember that the primary treatment for bipolar disorder is medication. The skills taught in the CBT treatment are meant to enhance the medical treatment, not act as a substitute for it. Overall, the goals of the CBT treatment for bipolar disorder are to help people maintain their medication regimen and reduce stress in their lives in order to avoid triggering a manic episode.

The CBT treatment for bipolar disorder is often composed of six steps:

1. Conduct an assessment and provide education
2. Develop effective communication skills
3. Develop problem-solving skills
4. Develop stress reduction skills
5. Challenge and correct self-defeating thoughts
6. Prevent relapse

Psychotherapy

The 6 CBT steps can be broken down as follows:

1. Conduct an assessment of the person's symptoms in order to verify that he or she is struggling with bipolar disorder.

The first step of the CBT treatment for bipolar disorder is to conduct an assessment of the person's symptoms in order to verify that he or she is struggling with bipolar disorder and not some other similar problem. Before beginning treatment, it's essential to determine whether the person is struggling with bipolar I, bipolar II, or cyclothymia. For this reason, it's very important for the person to consult with a medical professional as soon as possible. Then, after being stabilized on medication, the person may find it helpful to use CBT skills to maintain a healthy lifestyle.

Once people have been diagnosed with bipolar disorder, it's important that they understand the basic nature and causes of the disorder, as well as the basic nature and causes of depression, which is frequently associated with bipolar disorder. One of the most important and difficult steps during this initial phase is helping the person with bipolar disorder recognize that the illness will be a lifelong struggle. Unfortunately, bipolar disorder does not go away no matter how well a person maintains his or her medication and therapy regimen. In this respect, the disorder is similar to diabetes and other medical illnesses that must be monitored and treated over the course of a person's lifetime. Therefore, part of the early stages of treatment is helping people accept the fact that they must rely on medication to stabilize their mood, just as insulin helps people with diabetes stabilize their blood sugar levels.

Since bipolar disorder frequently disrupts a person's family and social relationships, it's also very important to educate family and friends about the nature of the illness and the roles that they might

play in helping to stabilize the disorder. This includes understanding the nature of the illness and the events that trigger manic episodes, and learning how to communicate more effectively.

It's also important for everyone involved to understand that CBT is an active form of treatment that requires the person with bipolar disorder and his or her loved ones to do work outside of the therapy session.

2. Develop Effective Communication Skills

It has often been observed that frequent highly emotional conversations with others can lead to a person having a manic episode. Therefore, it's very important that the person with bipolar disorder and his or her family and friends learn to communicate with each other in ways that are more effective and less volatile. This is where effective communication skills can be helpful.

Many people with bipolar disorder have difficulty making requests to get their needs met in fair and reasonable ways. Assertive communication skills can be very effective for making these requests. In addition, problem-solving communication skills are excellent for helping people in the following situations: setting limits with others, listening to others in effective ways, interpreting others' body language, negotiating with others and dealing with criticism.

3. Develop Problem-Solving Skills

Often, the third step of the CBT treatment for bipolar disorder is to learn problem-solving skills. Sometimes people with bipolar disorder lack coping skills for handling difficult or uncertain situations. This can lead to feelings of anxiety and hopelessness that then trigger manic episodes. Problem-solving skills can help the person identify and select healthy solutions to difficult, anxiety-provoking situations. The steps to problem solving include defining the problem, outlining the desired goals, brainstorming possible solutions, evaluating the possible consequences, putting the chosen plan into action, and evaluating the results. This is a very effective skill when used alone by the person with the disorder, and it can be even more powerful when used cooperatively with the person's family and friends.

4. Develop Stress Reduction Skills

Many people experience stress in their daily lives, but for people with bipolar disorder, stress can sometimes trigger manic episodes. This is because stress, particularly chronic stress, takes a very heavy toll on a person's body, mind, and relationships. Relaxation exercises can help reverse some of these effects, but more importantly, they can also prepare a person to confront the causes of stress in a much healthier way. For example, suppose a woman's relationship with her husband has been problematic. For the last few years, she has avoided dealing with the conflicts and as a result she has developed many physical symptoms of stress, such as tight muscles and high blood pressure. Practicing relaxation techniques in a consistent way can help ease these problems. In addition, they can also help if she chooses to address the relationship issues with her husband. Relaxation techniques can prepare a person for confronting stressors and help the person deal with problems in a more effective way.

Typically, relaxation exercises begin with building body awareness to help people scan their bodies for signs of stress and muscles tension.

Next, it's very important to learn proper breathing techniques. Many people who are under stress breathe in a very constricted way. Some of them breathe very rapidly. Either of these types of

breathing can make a person more vulnerable to stress. Learning proper breathing technique, using long, slow breaths, can help a person relax quickly and easily.

Progressive muscle relaxation is also a very important exercise. Many people experience stress as muscle tension. Progressive muscle relaxation helps people relax the entire body. Then, once this basic technique is established, people can learn to relax even more quickly by using cue-controlled relaxation and other rapid relaxation techniques.

Meditation is also helpful for many people. Learning how to stay focused in the present moment is a healthy alternative to being overwhelmed by stress-provoking thoughts. Meditation, or mindfulness, can take many forms, none of which have to be spiritual. People can learn to be mindful of their breathing, to meditate while walking or eating, or to use visualization to meditate.

Effective relaxation also includes developing good nutritional habits and engaging in healthy physical exercise. Therefore, people coping with stress should make time in their lives to address these issues, too.

Visualization techniques use the power of the imagination to help people relax and create mental space for evaluating stressful situations. Techniques such as special-place visualization can help people relax by imagining a safe place in their mind where they can completely relax.

5. Challenge and Correct Self-Defeating Thoughts

The next step of the CBT treatment for bipolar disorder is to challenge and correct self-defeating thoughts. This is a very important step for three reasons: First, self-critical thoughts can often lead to feelings of sadness, hopelessness and anxiety, which can then trigger manic episodes. Second, self-defeating thoughts often play a large role in the development of depression. Therefore, this step is at the core of the CBT treatment for depression. And third, self-defeating thoughts often cause a person to stop taking medications. For example, a person might think “Why bother taking them if I’m going to have the problem for the rest of my life anyway?” or “I’m feeling better now, so I don’t have to take my medications anymore.” For all of these reasons, challenging and correcting self-defeating thoughts is a crucial step in the CBT treatment for bipolar disorder.

Automatic thoughts are the most observable form of self-defeating thoughts. These are critical thoughts that people think and say to themselves that sabotage success and happiness. Two examples of automatic thoughts might be “I don’t deserve anything good happening to me” and “Why bother trying? I’m just going to fail.” A person can be either aware or completely unaware of having a thought like this. However, in both cases the result is that the person feels sad or hopeless.

Much of the CBT treatment for bipolar disorder will be spent identifying and re-evaluating these types of thoughts. This can be done with the use of a thought record. The thought record helps the person look for evidence that both supports and contradicts these thoughts. Then, most importantly, it helps the person create a more balanced thought. For example, if the person struggling with bipolar disorder had the thought “Why bother trying? I’m just going to fail,” the thought record would offer evidence of this thought being true and examples of it not being true in the person’s life.

The thought record also helps the person identify different types of cognitive distortions, unhelpful thinking styles that generate those automatic thoughts. For example, overgeneralizing involves making broad negative conclusions about life based on limited situations, and minimizing and magnifying involve discounting the positive and enlarging the negative aspects of life.

By evaluating the evidence and cognitive distortions, the goal of the thought record is to help the person find a new, more balanced thought and ease feelings of sadness and hopelessness. In this example, perhaps a more balanced thought would be “Even though I don’t do everything perfectly, I’m still capable of doing most things pretty well.” And instead of feeling excessively sad, such as 8 on a scale of 1 to 10, perhaps this newer thought will help the person feel less sad, say only a 5 out of 10.

As the work on challenging automatic thoughts continues, a person using a thought record will usually begin to notice common themes among his or her thoughts. These themes often point to deeper, more firmly entrenched core beliefs about one’s self that make a person more vulnerable to manic episodes and depression. These core beliefs, often called schemas, include thoughts like “I’m a failure,” “I’m worthless,” and “I’m unlovable.” When these core beliefs are encountered, they too need to be challenged and modified using the thought record and other techniques.

6. Prevent Relapse

Finally, the last step of the CBT treatment for bipolar disorder is preventing relapse after treatment is complete. The key to relapse prevention is for the person to continue using the cognitive and behavioral skills learned in treatment and to recognize the early signs of returning manic and depressive episodes in order to take steps to prevent them. When needed, people should always consider seeking additional help from medical and mental health care professionals.

Psychopharmacology

Because of the strong biological factors associated with the disorder, the primary treatment for bipolar disorder is medication. Currently, the first line of mood stabilizing medications for manic symptoms includes lithium (Eskalith), valproic acid (Depakote), carbamazepine (Tegretol), olanzapine (Zyprexa), risperidone (Risperdal), ziprasidone (Geodon), quetiapine (Seroquel), and aripiprazole (Abilify). The second choice for medications includes the antipsychotic medications haloperidol (Haldol), chlorpromazine (Thorazine), and clozapine (Clozaril), as well as the anticonvulsant medications clonazepam (Klonopin) and lorazepam (Ativan). Although some evidence suggests that lithium might lower a person’s risk of suicide, the use of lithium also requires the person to undergo regular blood tests to prevent the buildup of toxins.

Certain antidepressants are also used to control depressive symptoms related to bipolar disorder. Those more commonly prescribed include fluoxetine (Prozac), bupropion (Wellbutrin), paroxetine (Paxil), venlafaxine (Effexor), sertraline (Zoloft), fluvoxamine (Luvox), and citalopram (Celexa), as well as the anticonvulsant medication lamotrigine (Lamictal).

Lithium is the medication used most often to treat bipolar disorder. This medication evens out mood swings. It is used not only for manic attacks or flare-ups of the illness, but also as an ongoing maintenance treatment for bipolar disorder. Lithium will usually reduce severe manic symptoms in one to two weeks. It may take weeks to several months before the condition is fully controlled.

Some people have a single episode of mania that is not repeated. Most have more frequent episodes, however, and continued treatment with lithium or another mood stabilizer is advised to keep moods stable. Some people respond to lithium and have no further episodes. Others may have milder mood swings, or less frequent mood swings. Some people with bipolar disorder may not be helped at all by lithium. There's no way to tell without trying it, though.

People taking lithium must have regular blood tests. If too little is taken, lithium will not be effective. If too much is taken, severe side effects may occur. The range between an effective dose and a toxic

one is small. Blood lithium levels are checked frequently at the beginning of treatment. Once a person is stable on a maintenance dosage, the lithium level is checked every few months. How much lithium people need to take may vary over time, depending on how ill they are, their body chemistry, and their physical condition.

Antipsychotic medications are sometimes used in the initial phase of treatment for mania and may be able to be discontinued over time as the lithium takes effect. Some of the newer antipsychotic medications are also approved for longer-term use in bipolar disorder. Antidepressants may also be added to lithium during the depressive phase of bipolar disorder. Care must be taken with the use of antidepressants in bipolar disorder, as they can potentially increase switches into mania, particularly without adequate mood stabilization.

The type of medication, or the combination of medications, a person receives will depend on the type of mania experienced, the stage of the problem, and any hallucinatory or delusional symptoms. Unfortunately, the use of any of these medications will result in some accompanying side effects that might make the person want to quit using them. However, stopping the use of medication, no matter how good or bad the person feels, almost always leads to the reoccurrence of manic symptoms.

The Research

The following illustrate the different types of studies that have been conducted using both CBT and DBT mindfulness based therapy to treat a variety of mental illnesses.

In **Mindfulness, Meditation and Cognitive Behavioral Therapy for Insomnia**, a unique intervention combining mindfulness meditation with cognitive behavioral therapy for insomnia (CBT-I) has been shown to have acute benefits at post treatment in an open label study. The aim of the study was to examine the long-term effects of this integrated intervention on measures of sleep and sleep-related distress in an attempt to characterize the natural course of insomnia following this treatment and to identify predictors of poor long-term outcome. Analyses were conducted on 21 participants, who provided follow-up data at six and 12 months post treatment. (Ong, 2008, p43)

In **Mindfulness & Psychosis Chadwick, Newman –Taylor & Abba (2005),Mindfulness Groups for People with Psychosis** research cites the outcome of a 6 session mindfulness program for 10 people with unremitting distressing psychotic symptoms of at least 2 years duration. Participants: 11 people - 7 men, 4 women (1 later dropped out). All had paranoid beliefs, 6 auditory hallucinations, 5 other hallucinations (4 visual, 1 tactile). All had negative self-schema and symptoms of anxiety and depression. 9 met criteria for paranoid schizophrenia, 2 for schizoaffective disorder

In **The Effect of Mindfulness based Therapy on Anxiety and Depression A Meta: Analytic Review, Hofmann**, Sawyer, Witt and Oh **(2010),** 39 studies examining a range of disorders – e.g., depression, generalized anxiety disorder, social anxiety disorder, panic disorder, bipolar affective disorder, chronic pain, diabetes, cancer, fibromyalgia, chronic fatigue syndrome, arthritis, stroke, organ transplant, binge eating disorder

In **Responding Mindfully to distressing psychosis: A grounded theory analysis, Abba**, Chadwick and Stevenson (2008)**, a** more of a theoretical examination of the psychological process involved in mindfulness and psychotic symptoms were analyzed. 16 participants were interviewed after completing a mindfulness group program. Participants: 12 men, 4 women, all experiencing paranoia. 11 with auditory hallucinations, 5 other hallucinations concurrent symptoms of anxiety and

depression. 13 met criteria for paranoid schizophrenia, 2 for psychotic depression, 1 a psychotic episode

In the **Impact of Mindfulness on Cognition and Affect in Voice Hearing: Evidence from Two Case Studies Newman**–Taylor, Harper and Chadwick , examined if mindfulness training alone would lead to change in distress and cognition (belief conviction) in people with distressing voices.

Participants included: 2 men, both met the criteria for paranoid schizophrenia with current auditory hallucinations. One was aged 51and the other 63 both with a history of psychosis since their 20's. Both experienced associated anxiety.

Finally in **Mindfulness Groups for Distressing Voices and Paranoia: A Replication and Randomized Feasibility Trial,** Chadwick, Hughes, Russell, Russell & Dagnan (2009), trialled 22 participants - people all experiencing distressing auditory hallucinations for at least 2 years, 19 held paranoid beliefs, all met criteria for schizophrenia, average duration of illness 17.7 years.

The Methods utilized were:

1. Decentered Awareness: Clear, open, and gentle awareness of whatever is present, marked by acceptance and an absence of reaction (avoidance, struggle, rumination). Practised in formal sitting, and;

2. Metacognitive Insight: A focus on reflective learning about the nature of the experience. Often on reflection, important metacognitive insights are made rather than during the practice itself.

Chapter 2

History of CBT

CBT is relentlessly structured, methodical, and involves an enormous amount of tedious paperwork. All that structure is what enables it to help a person who it too anxious to get anything useful out of any kind of meditation, but it is hard to imagine that anyone without serious problems would want to stick to doing CBT work every day for the rest of his/her lives. Mindfulness meditation, on the other hand is something that many people choose to do in order to enhance their lives, even when things are basically "OK". Whilst there are no philosophical clashes between the two approaches it is arguable that they are generally appropriate for different circumstances.

"Cognitive behavioral therapy proposes that our thoughts, behavior, and emotions influence each other, which means that distorted thinking can create negative emotions or unwanted/unhelpful behavior (and vice versa). CBT encourages the use of talk therapy and systematic exercises to identify distorted thoughts and behaviors and replace them with more realistic/supportive/helpful/balanced thoughts and behaviors, in order to improve our emotional state."

CBT is similar to mindfulness as it is focused on what is going on in the mind but uses the discoveries made differently. The idea is that the mind comes up with all sorts of weirdness, people latch onto that weirdness, latching onto that weirdness creates overwhelming emotions, overwhelming emotions cause the mind to come up with more weirdness (stories) to explain them, and people find themselves back on the never-ending wheel of unhappiness (aka depression or anxiety). CBT generally advocates writing down the weirdness, rationally asking, "Is that really true? Do I really believe that? Do I really *need* to believe that? Is there a more balanced way of looking at this?"

and then learning to recognize the distorted thought when it comes up, and learning to let it go rather than get emotionally caught up in it.

CBT

In a broad sense, as its name suggests, CBT involves both 'cognitive therapy' and 'behavior therapy'. Cognitive therapy focuses on an individual's pattern of thinking while behavior therapy looks at associated actions. When combined skillfully, these two approaches provide a very powerful method to help overcome a wide range of emotional and behavioral problems in children, adolescents and adults. Depending on the problem, CBT may involve a mix of both therapeutic modalities, so some issues are better treated with more behavioral methods and some with more cognitive methods. One of the strengths of CBT is that it aims not just to help people overcome the symptoms that they are currently experiencing, but it also aims to teach the person new skills and strategies that they can apply to future problems. It focuses on the 'here and now' whilst developing an understanding of past styles of thinking and behavior that have developed over time. (Australian Association for Cognitive Behavioral Therapy, Victorian Branch, http://www.aacbtvic.org.au/content.asp?topic_ID=621)

Cognitive therapy is a goal-directed problem solving therapy that focuses on teaching specific cognitive and behavioral skills to improve current functioning. The therapeutic aim is to define the patient's presenting problems, to set goals and to modify dysfunctional thinking and associated behaviors which prevent adaptive functioning. The clinicians role is to teach the patient to identify and modify dysfunctional thoughts and beliefs.(Bateman, 2004)

Generally speaking, cognitive behavioral interventions emphasize the complex interaction among cognitive events, processes, products, and structures, affect, overt behavior, and environmental context and experiences as contributing to various facets of dysfunctional behavior.

Although cognitive-behavior therapy encompasses a variety of strategies and procedures, all share the tenet that learning plays a central role in the acquisition and maintenance of behavior, whether adaptive or dysfunctional. Further, cognitive-behavioral approaches recognize that learning involves more than just the environmental consequences of behavior: learning involves the manner in which the individual processes information cognitively. (Finch, 1993, p40)

Cognitive variables (beliefs, cognitions, attributions, expectancies, images), are considered legitimate, and, in fact, necessary concerns of the cognitive behavioral clinician. There are several sources of empirical work that have influenced this trend, including data indicating that cognitions influence behavior and the behavior change process (Bandura, 1969, 1977b, 1986; Mahoney, 1974, p72).

A characteristic is the consensus that the most appropriate methodology with which to consider and to examine unobservable private events is a behavioral one – that is cognitions should be analyzed in the same empirical fashion that characterizes the investigation of motor behaviors in the behavior modification literature. (Finch, 1993, p72)

Another characteristic of a cognitive-behavioral approach is the explicit acknowledgement of a meditational viewpoint in cognitive-behavioral analyses – a contention that cognitive events mediate behavior and learning (Bandura, 1977a; Karoly, 1977; Meichenbaum, 1977). As a

consequence, cognitions themselves become appropriate targets for intervention and can be deliberately and systematically altered to produce behavior change. (Finch, 1993, p73)

The cognitive behavioral therapist systematically attempts to alter both internal and external environments to produce desired behavior change, with the belief that the "reciprocal determinism" (Bandura, 1969, 1986) that characterizes human functioning can best be served by this combination. (Finch, 1993)

The assertion that cognitions and behaviors influence one another reciprocally is the fifth characteristic of the approach. The frequent claim of behavior therapists that changes in behavior lead to changes in attitudes, beliefs and emotions has ample supporting evidence, as reviewed by Bandura (1969), 1986). However, as Mahoney (1974) emphasized, other evidence demonstrates that cognitive changes can produce behavioral ones. Cognitive-behavioral theorists comfortably assert that both strategies have credence. (Finch, 1993, p73)

The Cognitive Model

Not every depressed patient is an appropriate candidate for short-term cognitive-behavioral treatment. Mild-to-moderately depressed patients might be suitable. Patients with severe depression (i.e. a score of 20 or higher on the Beck Depression Inventory) will probably require longer-term treatment. Further, patients who have additional axis I or axis II disorders are less likely to benefit than patients who do not have additional disorders. Patients with psychotic features, bipolar disorder, current substance abuse, or severe personality disorder diagnoses (such as borderline personality disorder) are not appropriate candidates for this treatment and should be screened out. (Klosko, 1999, p81)

The central idea of the cognitive model is that thoughts affect feelings. How we think about things affects how we feel about them. (Klosko, 1999)

Depressed people tend to think about reality in negatively distorted ways. Beck noticed that depressed patients tend to make certain characteristic cognitive distortions. Specifically they make logical errors, such as jumping to conclusions or all-or-nothing thinking, and they fail to evaluate evidence objectively. They see the world through dark-colored glasses, thus increasing the likelihood that they will remain depressed. (Sanderson 2008)

The study of automatic thoughts constitutes one of the most common areas of research in the field of cognitive therapy. According to Beck (1967) automatic thoughts are images or cognitions presented by subjects as a result of the cognitive schema or core belief that is activated in a particular moment. Thus automatic thought reflect the content of the more central and tacit structures of the cognitive system. These images and thoughts reflect the meaning subjects are assigning to a given situation and are deeply associated with the emotional and behavioral response to that event. Moreover automatic thoughts play an important role in the cognitive system and helping to understand the core beliefs underlying the several psychological disorders. (Beck 1995)… Beck (1996) suggested that specific phobia is characterized by thoughts about specific dangers, general anxiety disorders by general and mid to long term danger, whereas depression is characterized by thoughts about loss.(Pedro J. Nobre, 2008)

Distorted negative thinking is a core feature of depression. Beck discussed the "cognitive triad of depression," in which depressed patients have a negative view of the self, the world and the future. The self s worthless, the world is overwhelming, and the future is hopeless. The cognitive triad serves as schemas for processing information. Since reality is filtered through these schemas for processing information, depressed patients consistently distort their interpretations of events to maintain the negative view of self, world and future. (Sanderson, 2008)

The general assumptions on which cognitive therapy is based include the following

1. Perception and experiencing in general are active processes which involve both inspective and introspective data.
2. The patient's cognitions represent a synthesis of internal and external stimuli
3. How a person appraises a situation is generally evidence in his cognitions (thoughts and visual images)
4. These cognitions constitute the person's "stream of consciousness" or phenomenal field which reflects the person's configuration of himself, his world, his past and future.
5. Alterations in the context of the person's underlying cognitive structures affect his/her state and behavioral pattern.
6. Through psychological therapy a patient can become aware of his cognitive distortions
7. Correction of these faulty dysfunctional constructs can lead to clinical improvement.

The cognitive model of depression (Beck 1976) postulates 3 concepts to explain the psychological sub state of depression.

1. cognitive model
2. schemas
3. Cognitive errors (faulty information processing).

The "Cognitive Triad" consists of 3 cognitive patterns used by the patient to regard him/herself. The first refers to the patient's negative view of him/herself as defective, inadequate, diseased or deprived. He/she tends to attribute his unpleasant experiences to a psychological, moral or physical defect in him/herself. The patient believes that because of his/her presumed defects, he/she is undesirable and worthless.

The second component refers to the depressed person's tendency to interpret his/her ongoing experiences in a negative way. He/she sees the world as making exorbitant demands on him/her and/or presenting insuperable obstacles to reaching his/her life goals.

The third component refers to his/her negative view of the future. As the depressed person makes long-range projections, he/she anticipates that his/her current difficulties or suffering will continue indefinitely.

A second major ingredient in the cognitive model consists of “Schemas”. This concept is used to explain why a depressed person maintains his/her pain-inducing and self-defeating attitudes despite objective evidence of positive factors in his/her life.

Any situation is composed of a plethora of stimuli an individual selectively attends to specific stimuli, combines them in a pattern and conceptualized the situation. A particular person tends to be consistent in his responses to similar types of events. Relatively stable cognitive patterns form the basis for the regularity of interpretations of a particular set of situations. The term ‘schema’ designates these stable cognitive patterns.

When a particular person faces a particular circumstance, a schema related to the circumstance is activated. The schema is the basis for molding data into cognitions. Thus a schema constitutes the basis for screening out, differentiating and coding the stimuli that confront the individual. He/she categorizes and evaluates his/her experiences though a matrix of schema.

The kinds of schemas employed determine how an individual will structure different experiences. A schema may be inactive for a long period of time but can be energized by specific environmental factors (for example, stressful situations). The schemas activated in a specific situation directly determine how the person responds. In psychopathological states such as depression, patient’s conceptualizations of specific situations are distorted to fit the prepotent dysfunctional schemas. The orderly matching of an appropriate schema to a particular stimulus is upset by the intrusion of these overly active idiosyncratic schemas. As these idiosyncratic schemas become more active they are evoked by a wider range of stimuli which are less related to them. The patient loses much of his voluntary control over his thinking processes and is unable to invoke other more appropriate schemas.

The 3rd aspect is “Faulty Information Processing”. These systematic errors in thinking of the depressed person maintain the patient’s belief in the validity of his negative concepts despite the presence of contradictory evidence (Beck 1967)

1. Arbitrary inference (a response set) refers to the process of drawing a specific conclusion in the absence of evidence to support the conclusion or when the evidence is contrary to the conclusion.

2. Selective Abstraction (a stimulus set) consists of focusing on a detail taken out of context, ignoring other more salient features of the situation and conceptualizing the whole experience on the basis of this fragment.

3. Overgeneralization (a response set) refers to the pattern of drawing a general rule or conclusion on the basis of one or more isolated incidents and applying the concept across the board to related and unrelated situations.

4. Magnification and minimization (a response set) are reflected in errors in evaluating the significance or magnitude of an event that are so gross as to constitute a distortion.

5. Personalization (a response set) refers to the patient’s proclivity to relate external events to himself when there is no basis for making such a connection.

6. Absolutistic, dichotomous thinking (a response set) is manifested in the tendency to place all experiences in one of two opposite categories; for example, flawless or defective, immaculate or filthy, saint or sinner. In describing himself, the patient selects the extreme negative categorization. (Beck 1967)

Cognitive Behavioral Therapy Treatment for Depression

According to theories of depression, maladaptive cognitive styles play a role in the etymology and maintenance of depression. Cognitive interventions that change maladaptive cognitions and processes have been shown to reduce depressive symptoms and the risk for relapse and recurrence. (Janice A. Blalock, 2008)

One study comparing differential change in cognitions in combined therapy, cognitive therapy and pharmacotherapy found that combined therapy produced the largest change in maladaptive cognitions.(Janice A. Blalock, 2008)

A variety of cognitive and behavioral strategies are utilized in cognitive therapy. Cognitive techniques are aimed at delineating and testing the patient's specific misconceptions and maladaptive assumptions. This approach consists of highly specific learning experiences designed to teach the patient the following operations

1. To monitor his/her automatic thoughts (cognitions)

2. To recognize the connections between cognitions, affect and behavior

3. To examine the evidence for and against his distorted automatic thought

4. To substitute more reality-oriented interpretations for these biased cognitions

5. To learn to identify and alter the dysfunctional beliefs which predispose him/her to distort his experiences.

Various verbal-techniques are used to explore the logic behind and basis for specific cognitions and assumptions. The patient is initially given an explanation of the rationale for cognitive therapy. Next he learns to recognize, monitor and record his/her negative thoughts on the daily record of dysfunctional thoughts.

The cognitions and underlying assumptions are discussed and examined for logic, validity, adaptiveness and enhancement of positive behavior versus maintenance of pathology.

Self-questioning plays a major role in the generalization of cognitive techniques from the interview to external situations. Examples of self-questioning include: "What is the evidence for my conclusion?" "Are there any other explanations?" "How serious is the loss?" "How much does it actually subtract from my life?" "What is the degree of harm to me if a stranger thinks badly of me?" "What will I lose if I try to be more assertive?"

Therapy generally consists of 12 – 25 sessions at weekly intervals. The moderately to severely depressed patients usually require interviews on a twice weekly basis for at least 4 – 5 weeks and then weekly for 10-15 weeks. The frequency is then tapered to once every 2 weeks for the last few

sessions and booster therapy is recommended after the completion of the regular course of treatment.

Each session contains the following standard cognitive-behavioral treatment components.

1. Setting the agenda for the session
2. Reviewing homework assignments completed since the last session
3. Assigning new homework
4. Asking for feedback about the session

Outline of Treatment

Session 1

1. Education about depression
2. Suicide assessment and contract
3. Scheduling pleasurable activities
4. Establishing a basic structure for each day

Session 2 + 3

1. The cognitive model of depression
2. Self-monitoring of automatic thoughts

Session 4 + 5

1. Examining the evidence
2. Generating alternatives

Session 6 + 7

1. Cognitive Distortions
2. Introduction of appropriate behavioral treatment

Session 8 & 9

1. Hypothesis testing
2. Problem solving
3. Continuing appropriate behavioral treatment

Session 10 - 11

1. Summary of the steps of cognitive therapy
2. Relapse prevention (for treatment responders)
3. Continuing appropriate behavioral treatment

Session 12 & 13 (for treatment responders)

1. Plan for maintenance and generalization
2. Termination (Blalock, 2008)

Although the cognitive approach has been slow to give systematic attention to many psychological disorders, the application of cognitive explanations to depression represents one of the most thoroughly researched areas of psychopathology. (Atwood, 1993)

In line with the ideas of cognitive psychology, cognitive perspectives of depression are all similar in they assert that depression results from negative cognitive structures that distort an individual's experience in a negative manner.

Beck has proposed a theory of depression based on cognitive schemata. The central tenet of Beck's theorizing was that depressed individuals feel as they do because they commit characteristic errors in thinking that cause them to evaluate themselves, their work and their future negatively (Atwood, 1993)

According to Beck, these characteristic ways of thinking are produced by enduring maladaptive cognitive schema that the depressed individual acquired through early negative consequences in childhood. Examples of such experiences that Beck believed were implicated in the development of these negative schemata include the loss of a parent, or parents who were critical or disapproving, an unrelentless succession of tragedies or the social rejection of peers. (Atwood, 1993)

In one respect the depressed person is like a purely "cerebral" being: He/she can see the point of a joke but is not amused. He/she describes the appealing features of his partner or child without a sense of satisfaction. He/she can recognize the appeal of a favorite food or musical piece – but without experiencing a sense of relish. Paradoxically, although the depressed person's capacity to resonate with positive feelings is dulled, he experiences extreme vibrations of unpleasant emotions. It is though his entire reservoir of feelings is channeled through the sluices of sadness, apathy and unhappiness. (Beck, p21)

The patient is encouraged to view homework as an integral vital component of treatment (Beck, 1967)

Patients may be told that cognitive therapy like science is concerned with converting mysteries into problems because problems, unlike mysteries are designed to be solved. The steps to problem solving are spelled out to the patient.

1) specify the problem
2) identify a hypothesis about the cause of the problem
3) design a test for the hypothesis
4) evaluate the results of the test
5) Accept, reject or modify the hypothesis to account for the results of the test. (Beck, 1967)

The following is an example activity that might be used with a patient engaging in CBT.

Firstly explain to the patient that there are helpful and unhelpful ways of reacting to most situations, depending on how s/he thinks about them. It is good practice to give examples to the client as to what constitutes an unhelpful thought as opposed to a helpful one.

Provide a hypothetical situation to the client:

Situation:	*You've had a bad day, feel fed up, so you go out shopping. As you walk down the road, someone you know walks by and, apparently, ignores you.*

You instruct the	**client to form 2 columns** **Unhelpful**	**and to complete both**. **Helpful**
Thoughts:	He/she ignored me - they don't like me	He/she looks a bit wrapped up in themselves - I wonder if there's something wrong?
Emotional: Feelings	Low, sad and rejected	Concerned for the other person
Physical:	Stomach cramps, low energy, feel sick	None - feel comfortable
Action:	Go home and avoid them	Get in touch to make sure they're OK

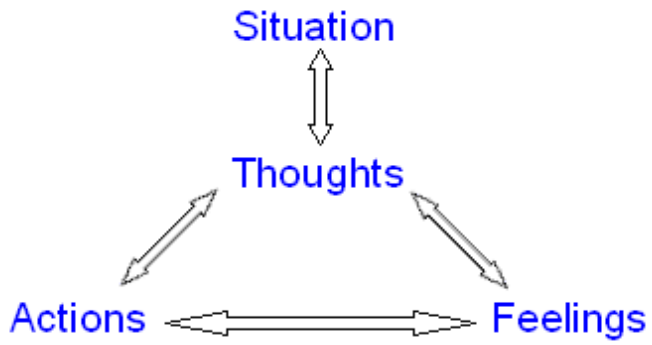
The same situation has led to two very different results, depending on how the client thought about the situation. How s/he thinks it has affected the way he/her feels and what s/he did.

In the example in the left hand column, you've jumped to a conclusion without very much evidence for it - and this matters, because it's led to:

- a number of uncomfortable feelings
- an unhelpful behavior.

The following is also a useful, simple, diagrammatical tool to explain to a patient how his/her actions or feelings can depend very much on the thoughts experienced.

This is a simplified way of looking at what happens. The whole sequence, and parts of it, can also feedback like this:



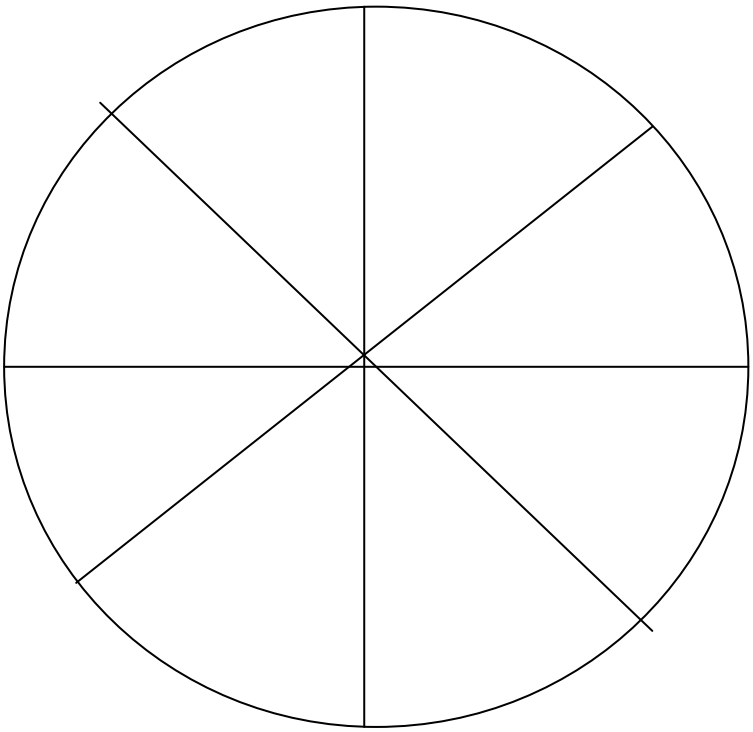
This then has the potential to become a vicious cycle because negative thoughts trigger negative feelings and actions which in turn then present you with another negative situation and so on.

This "vicious circle" can make you feel worse. It can even create new situations that make you feel worse. You can start to believe quite unrealistic (and unpleasant) things about yourself. This happens because, when distressed, people are more likely to jump to conclusions and to interpret things in extreme and unhelpful ways.

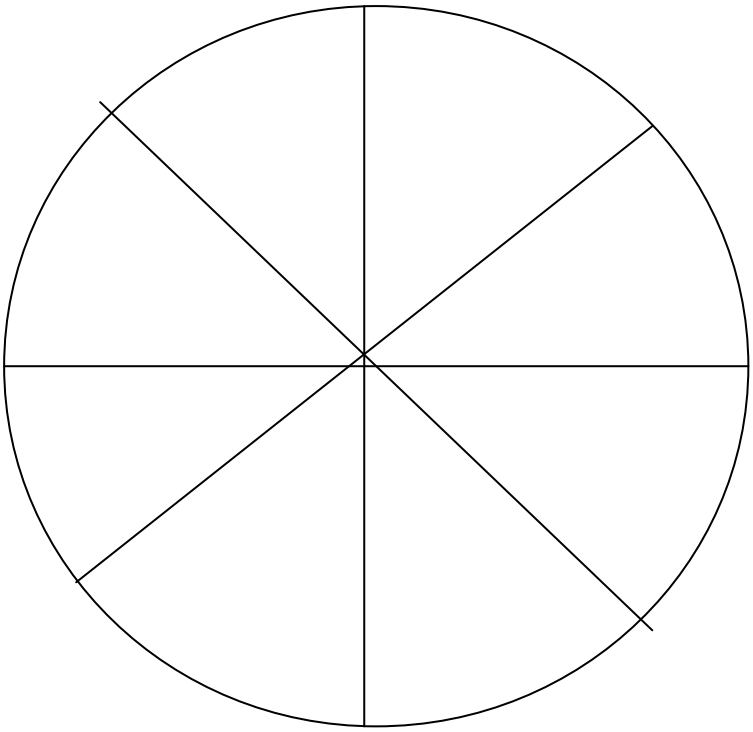
CBT can help break this vicious circle of altered thinking, feelings and behavior. When parts of the sequence are seen clearly, then they can be change them - and subsequently change the associated feeling. CBT aims to get patients to a point where they can "do it themselves", and work out their own ways of tackling these problems.

"**Five areas" Assessment**

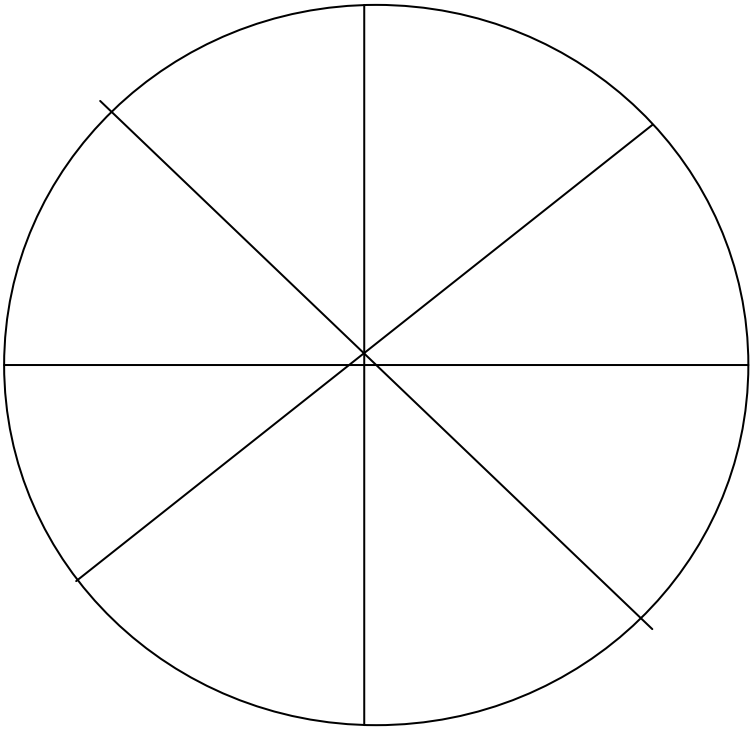
The Five Areas assessment is another technique frequently used in CBT training. Basically it involves identifying a patient's level of satisfaction (or dissatisfaction) with the 5 main areas of life, these being: family, friends, work, spirituality and finances. In doing so this can be represented diagrammatically by using the wheel of life. Patients are asked to plot a circle like so:



It is explained to the patient that each line represents an aspect of his/her life. The middle of the circle where all the lines meet is 0. The outside of the circle where each of the lines touch the outer part of the circle is 10. Clients are then asked to place dots along each line where he/she feels his/her level of satisfaction is, 0 being completely unsatisfied and 10 being completely satisfied. A patient might have developed a circle that looks like this:



It is then the therapist's job to join the dots so that the circle looks something like this:



Explaining that the wheel is not really a wheel but rather a misshapen object that probably wouldn't be able to roll much at all. The objective for the patient, with the help of the therapist, is to bring at least 2 or 3 of the dot points further out from the center. In doing so it has the effect of pulling some of the other areas out with them.

This is another way of connecting all the 5 areas mentioned above. It builds on relationships with other people and helps patients see how these can make them feel better or worse. Issues such as debt, job and housing difficulties are important to a patient's state of mind. If a patient improves one area, then it is likely that the other parts of his/her life will improve as well.

What does CBT involve?

The sessions

CBT can be done individually or with a group of people. It can also be done from a self-help book or computer program. In England and Wales two computer-based programs have been approved for use by the NHS. Fear Fighter is for people with phobias or panic attacks, Beating the Blues is for people with mild to moderate depression.

In individual therapy:

- A client will usually meet with a therapist for between 5 and 20, weekly, or fortnightly, sessions. Each session will last between 30 and 60 minutes.
- In the first 2-4 sessions, the therapist will check that CBT is the sort of treatment the patient wants to receive and with which s/he feels comfortable.
- The therapist will also ask questions about a patient's past life and background. Although CBT concentrates on the here and now, at times it is necessary to talk about the past to understand how it is affecting the present.
- The client then decides what he/she want to deal with in the short, medium and long term.
- The client and the therapist will usually start by agreeing on what to discuss that day.

The work

- With the therapist, a client breaks each problem down into its separate parts. To help this process, the therapist may ask the client to keep a diary. This may help the client identify individual patterns of thoughts, emotions, bodily feelings and actions.
- The client and therapist together will look at the thoughts, feelings and behaviors to work out:
  - if they are unrealistic or unhelpful
  - how they affect each other, and the client.
- The therapist then helps the client to work out how to change unhelpful thoughts and behaviors
- Often though, it's easier to talk about doing something, but much harder to actually do it. After the client has identified what can be changed, the therapist will recommend "homework" – that allows the client to practise these changes in his/her everyday life. The objective then are for the client do develop their own skills of:

a. Questioning a self-critical or upsetting thought and replace it with a positive (and more realistic) one.

b. Recognizing when he/she is about to do something that will make him/her feel worse and, instead, do something more helpful.

- At each meeting therapist and client discuss progress since the last session. The therapist can help with suggestions if any of the tasks seem too hard or don't seem to be helping.

- The therapist will not ask the client to do things he/she don't want to do – the client decides the pace of the treatment and what he/she will and won't try. The strength of CBT is that a client can continue to practise and develop his/her skills even after the session has finished. This makes it less likely that the symptoms or problems will return. (The Royal College of Psychiatrists, http://www.rcpsych.ac.uk/mentalhealthinformation/therapies/cognitivebehaviouraltherapy.aspx)

Therapeutic benefits derived from the use of CBT

How does it work?

CBT (Cognitive Behavioral Therapy) is "a system of psychotherapy that attempts to reduce excessive emotional reactions and self-defeating behavior by modifying the faulty or erroneous thinking and maladaptive beliefs that underlie these reactions" (Beck et al, 1993)

CBT encourages clients and patients to become aware of their thoughts, to concentrate on their thinking patterns so that they can begin to learn how to take control of the unhelpful thoughts and eventually introduce more helpful thoughts into their minds. (Counseling Directory, http://www.counselling-directory.org.uk/counselloradvice9644.html)

People suffering from depression - particularly 'non-melancholic depression' - will often have an ongoing negative view about themselves and the world around them. This negative way of thinking is often not confined to depression, but is an ongoing part of how the person thinks about life. Many or all of their experiences are distorted through a negative filter and their thinking patterns become so entrenched that they don't even notice the errors of judgment caused by thinking irrationally.

Cognitive behavior therapy aims to show people how their thinking affects their mood and to teach them to think in a less negative way about life and themselves. It is based on the understanding that thinking negatively is a habit, and, like any other bad habit, it can be broken.

CBT is conducted by trained therapists either in one-on-one therapy sessions or in small groups. People are trained to look logically at the evidence for their negative thoughts, and to adjust the way they view the world around them. The therapist will provide 'homework' for between sessions. Between 6-10 sessions can be required but the number will vary from person to person.

CBT can be very beneficial for some individuals who have depression but there will be others for whom it is irrelevant. (Black Dog Institute, http://www.blackdoginstitute.org.au/public/depression/treatments/psychological.cfm)

When a client comes for CBT their natural disposition is to analyze and interpret their negative thoughts. They want to find a solution to problems in their thinking in the same way as they would want a practical solution to the problems faced in everyday life, i.e. career, health, financial, external conditions in the world around them.

However, thinking problems do not always lead themselves to a mechanistic, pragmatic problem solving exercise. This is generally because these negative thoughts and the emotional pain are initially caused by events which happened long ago, in childhood, or at least have their roots or point of origin there. This makes them less amenable to standard CBT, where negative thoughts can be identified, and reframed in an alternative and more balanced way. (Centre for CBT counseling, http://www.centreforcbtcounselling.co.uk/mindfulness_cbt.php)

The normal thinking process reacts to a negative thought, image or feeling which presents itself to the mind, by engaging with that thought. In CBT the term MAGNIFICATION is used as an error in logic which means that, as one thought comes into the mind, we associate and chain it with another thought until it gets bigger and bigger.

For example:

If a student thinks that s/he is going to fail a forthcoming exam, or make a fool of him/herself while making a presentation, or be rejected by someone s/he asks out on a date, the mind will act like a computer in a negative feedback loop and give him/her all of the similar situations in my life when similar things have happened. This has a snowball effect because s/he then fixes the mind on these until these thoughts seem like an obstacle as big as Mount Everest would be to climb.

The alternative to fixing and magnifying negative events would be to DISTRACT myself from them by doing something different to try to escape from them. The problem with this is that, consistent with the literature of avoiding negative thoughts, the more we try to escape from them the more prevalent they become in our minds.

The following is a thought record that could have been presented as homework to a female age 42 alcoholic.

Thought Record
(Steps 1-2) 42 y/o female alcoholic

Situation/Event	Automatic Thought	Related Feeling	Rating Mood and Desire/Craving (1-10)
I fought with my husband over missing our son's basketball game to attend an AA meeting.	"He is not supporting my recovery."	Anger Frustration, Misunderstood	6
My husband invites me to his holiday work party; I remember last year's party when I had leave because I was so intoxicated.	"I am an embarrassment to my husband and a bad wife.	Guilt, Depression	8
My sister is hosting the holiday dinner this year and asks me to make a run to the liquor store to buy the supplies for the event.	"She is insensitive and Putting me in a bad position for a relapse."	Anger, Hurt	6
I tell me boss I've been struggling with my recovery and he really wants to help me get sober.	"I am a bad employee for letting my drinking affect my work."	Frustration, Guilt	8
I'm celebrating my son's birthday, and realize I've missed many of his achievements and milestones because of my drinking	"I am a bad mother for letting him down for so long."	Guilt, Depression	10

Extracted from, *Cognitive Behavioral Therapy and Mindfulness in Addiction Treatment*, Tony Pacione, LCSW, CSADC

Chapter 3

Limitations of CBT

Traditional cognitive therapy models attempt to alter maladaptive behavior by modifying its concomitant dysfunctional thoughts and underlying assumptions. However, there is empirical evidence that attempts to actively change aversive internal experiences (e.g., thoughts, emotions, body sensations) often multiplies problems (e.g., in PTSD, GAD, pain etc.). Consistent with Einstein's opinion that we cannot change a problem with the means that created it, mindfulness and

acceptance-based approaches take the view that attempting to change the content of incapacitating thoughts is less productive in the long term than learning to develop control over the processes that maintain them.

Mindfulness is a way of observing thoughts, images and feelings in an accepting way without either:
a)engaging with them, stepping back to interpret them in the traditional way.

CBT steps back into an observer hypothesis testing position to reality - test and challenge negative automatic thoughts
or
b) using distraction techniques to try to suppress and/or escape from them.
Previous studies indicate that suppression is a counterproductive mechanism of thought control.(Juan V. Luciano, 2008)

A recent study comparing formerly depressed patients with and without a history of suicidal ideation during past episodes of depression (Williams, Barnhofer, Crane and Beck, 2005) found that previously suicidal participants showed significant decreases in interpersonal problem-solving ability following induction of sad mood. By contrast problem solving performance in those without a history of suicidal ideation remained relatively unchanged. These data suggest that small changes in mood may reinstate cognitive deficits that are thought to contribute to escalation of suicidal crises.(J. M. G. Williams, 2008)

The question is whether such increases in hopelessness are simply a reaction to the negative life events that are almost always present in the recent history of those who attempt suicide or whether there is an underlying factor that reflects a latent disposition to react with hopeless cognitions to even relatively mild changes in mood.(J. M. G. Williams, 2008)

It appears that CBT is no better than a variety of manualized psychotherapies in reducing binge eating, including focal psychotherapy, supportive-expressive therapy and IPT.(Fairburn)
CBT is not for everyone. From studies CBT has been found to be one of the most successful therapies ever developed (including drug therapy). However, it is still a product of the social sciences and has about an 80% success rate (that is, in significantly reducing the disorder if it is administered by a competent practitioner). CBT seems to be a success story. Even drug therapies for psychological disorders rarely see an 80% success rate. Furthermore, there doesn't seem to be many negative side effects from CBT. It has been quite successful for the most part. However there will always be that 20% who are not helped at all or much by CBT.

Recent innovations in psychological treatments have integrated mindfulness meditation techniques with traditional cognitive and behavioral therapies, challenging traditional cognitive and behavioral therapists to integrate acceptance- and change-based strategies. In a study, 2 treatments: mindfulness-based cognitive therapy and dialectical behavior therapy, were utilized. It sought to review the integration rationale underlying the 2 treatments, how the treatments combine strategies from each modality to accomplish treatment goals, the implications for therapist training, and treatment effectiveness. In addition, the challenges of assessing the benefits of incorporating acceptance-based strategies were discussed. Both therapies have integrated acceptance-based mindfulness approaches with change-based cognitive and behavioral therapies to create efficacious treatments. (Joaquim, Juan Carlos, Josefa, Judith, & et al., 2005)

This study addressed the specific challenges faced by traditional cognitive and behavioral therapists when integrating mindfulness meditation techniques. ·The primary challenge is the integration of acceptance, as opposed to change-based, strategies. ·In both MBCT and DBT, adding mindfulness

meditation techniques to traditional cognitive and behavioral therapies resulted in the creation of efficacious treatments. However, there were limitations to this study. ·This discussion of integrating mindfulness meditation with cognitive and behavioral therapies is limited to 2 treatments for specific clinical presentations. ·Only the challenges faced by traditional cognitive and behavioral therapists are discussed. ·Future research is required to determine the specific contribution of the mindfulness meditation component to therapeutic outcome.

In practice, CBT focuses on the person's current issues and symptoms. "Painful emotional states," says Dr. Irene, "are often the product of irrational beliefs or faulty logic." Cognitive psychologists seek to "change the person's thinking to minimize these symptoms." Usually, the therapist sees the patient weekly, and these sessions are supplemented by daily practice exercises that help them apply CBT skills in their daily lives. "Individuals," Dr. Irene continued, "are rarely aware that their thoughts are destructive, but almost always experience relief as they change their thinking patterns."

By comparison, "Mindfulness is based on Eastern philosophy," said Dr. Irene. "For us in the West, it's the 'new kid' on the block." Rather than dealing with thinking, mindfulness addresses problems in psychological function that occur because painful emotions are avoided.
Again, patients are not aware of avoiding their feelings, but the objective of therapy is to "help the person experience all emotions, especially negative ones, in the here and now." Emotions are viewed as a normal and inevitable part of life. Avoidance of emotions leads to more avoidance, more symptoms, and a tendency to "wallow in pain instead of moving on to the next moment and the next feeling life brings." (The Cam Report, http://www.thecamreport.com/2010/07/comparing-mindfulness-and-cognitive-behavioral-therapy/)

The thought processes

Long term follow-up studies have shown that recovered depressed patients are at high risk for recurrences (Mueller et al., 1999). Furthermore evidence suggests that later episodes of depression require less activation from negative life events than earlier episodes – in other words sensitization may occur. From a cognitive science perspective, it has been suggested that sensitization (and increased risk of relapse and recurrence) is brought about by increased cognitive reactivity to small changes in depressed mood.

Repression and suppression are currently conceptualized as automatic (unconscious) and voluntary (conscious) processes respectively.(Juan V. Luciano, 2008). Whilst some of CBT emphasizes thought changes, a large part does also rely on repression and suppression. Whilst this is sometimes and effective technique, many times it can equally be as counter-productive: actually ignoring (or attempting to ignore) a normal thought or feeling can create more distress in the patient, resulting in the client interpreting that there is something wrong with his/her thoughts and that they should be suppressed. However DBT and mindfulness seeks to focus on and deal with these issues as one would any normal everyday problem.

Mindfulness cognitive therapy (or mindfulness-based cognitive therapy, MBCT) is a blend of two very different approaches — cognitive behavioral therapy (CBT) which focuses on changing our thoughts in order to change our behaviors, and the meditative practice of mindfulness, a process of identifying our thoughts on a moment-to-moment basis while trying not to pass judgment on them. While cognitive behavioral therapy has always emphasized the end result of change of one's thoughts, mindfulness really looks at how a person thinks — the process of thinking — to help one be more effective in changing negative thoughts.

Coelho et. al. (2007) looked at the research into mindfulness-based cognitive therapy (MBCT), and found only four relevant studies that examined the effectiveness of this approach. The current evidence from the randomized trials suggests that, for patients with 3 or more previous depressive episodes, MBCT has an additive benefit to usual care. However, because of the nature of the control groups, these findings cannot be attributed to MBCT-specific effects. (Psych Central, http://psychcentral.com/blog/archives/2008/02/12/is-mindfulness-based-cognitive-therapy-effective/)

Through mindfulness the practitioner becomes less identified with the contents of consciousness. Segal, Williams & Teasdale (2002 p.38, 39) name this process as "decentering". In metaphorical terms it is as if a practitioner is watching the stream of consciousness rather than swimming in it and being buffeted by its eddies and currents.

Segal et al (2002 p.38, 39) postulate that this decentering may also be a component of the effectiveness of traditional CBT. Indeed, the importance of such distancing or decentering had previously been recognized in discussions of cognitive therapy (Beck, Rush Shaw & Emery 1979). Rick Ingram and Steve Hollon (1984 p.272) suggested that cognitive therapy relies on helping individuals switch to a controlled mode of processing that is metacognitive in nature and focuses on depression-related cognition...typically referred to as distancing. The long term effectiveness of cognitive therapy may lie in teaching patients to initiate this process in the face of future stress.
It is thought that this decentering allows practitioners to develop a tolerance of unpleasant affect and a concomitant reduction in avoidance behavior. (Breslin et al 2002, p289)

There is now also a body of evidence that demonstrates the problems created by dealing with unpleasant feelings or thoughts by avoidance. We can now say fairly confidently that suppressing a thought feeling or sensation, including pain ultimately increases it. (Clark Ball & Pape 1991, Gold & Wegner 1995, Wegner, Schneider, Carter & White, 1987, Wegner, Schneider, Knutson & McMahon 1991, Cioffi & Holloway 1993)

For example Wegner et al (1987) compared the thought reports of two groups during a period when each had been instructed to think aloud about a white bear. One group focused on the target (white bear) from the outset, whereas the other first spent a period of time suppressing white-bear thoughts. Compared with the group that thought about a white bear at the outset, the initial suppression group reported a higher rate of target thoughts during a subsequent expression period. (Mindfulness, http://www.mindfulness.org.au/AACBT2005.htm)

We can all get a taste of the effects of attempted thought avoidance simply by trying not to think of something. For example try not to think of the taste of a lemon in your mouth. Try not to think of its slight acidity and of how it causes your saliva to flow. Of course the paradoxical trap is that in order not to think of something you have to think of it first in order to define what it is that you are going to avoid thinking about.

Unfortunately the news about thought suppression gets even worse. It is accepted that rebound is greatest in the situational context of the original suppression. (Wegner, et al 1991) So if the desire for a cigarette is suppressed after a satisfying meal, that same desire is likely to return with a vengeance after the next satisfying meal. Moreover, recurrence of the mood alone causes rebound of the suppressed thought. (Wenzlaff et al 1991) So the feeling of satisfaction in a different context would be enough to re-elicit the desire for the cigarette in the above example.

Mindfulness allows a patient to bypass these problems associated with avoidance and disputation. Instead of trying to distract from or argue with the unpleasant thoughts,

mindfulness simply makes the thought less important. When a person uses mindfulness he/she stays exposed to the thought for its natural duration without feeding or repressing it.

Also mindfulness reduces the magical power that we unwittingly give to language. In order to understand this, a simple mental exercise can be undertaken, where we consider the meaning of the sentence:

Mindfulness is the opposite of avoidance.

Using the normal rules of logical language we could deduce from this statement that mindfulness must mean "facing fear". It is a small step then to interpret mindfulness as being counter phobic behavior like taking up hang-gliding when you have a fear of heights. This in fact is engaging in an internal struggle which is not part of mindfulness. Rather, mindfulness is staying with what arises, without trying to control it. Again this statement could be logically misinterpreted to mean that mindfulness means being out of control! In fact people usually feel much more in control when practicing mindfulness. So in mindfulness there is **control of attention** without trying to control the contents of attention, such as thoughts feelings and physical sensations. Mindfulness remains open & non-judgmental.

Making the normal abnormal

"Dirty Guilt" & "Clean Guilt"

Another default of CBT can be expressed in terms of Dirty Guilt v Clean Guilt. Many clients suffering with depression often describe feelings of immense guilt: they are somehow responsible for the harm that has been created or experienced. This can be referred to as "clean guilt". However, once a client practising CBT realizes that he/she is having negative thoughts, then this can sometimes lead to the client feeling guilty about having those negative thoughts – and this can be referred to as "Dirty Guilt". It is basically feeling guilty about feeling guilty.

These thoughts can be classified as rumination – behaviors and thoughts that focus ones attention on one's depressive symptoms and on the implications of these symptoms.(Nancy L. Kocovski, 2008)

Experimental evidence for the harmful effects of emotional suppression is not yet as great as that for thought suppression, but there seem to be many examples of these vicious cycles. For instance, suppose a person is extremely distressed about anxiety and tried to do everything to eliminate it because of its awful meaning and potentially terrible consequences. In this case a small bit of classically conditioned anxiety may cue both purposeful attempts to avoid and reduce the anxiety and additional anxiety associated with the verbal constructing of highly aversive consequences. In essence the person may become anxious about being anxious. (Hayes, 1996)

The paradoxical effects of suppression have also been demonstrated in a study examining somatic sensation (Cioffi & Holloway, 1993). Participants in a cold-pressor air induction procedure were given one of three sets of instructions. They were told to think about their room at home (distraction) focus on the sensations in their hand, or eliminate thoughts about pain entirely. Recovery on discomfort ratings was slowest for the suppression instructions and most rapid for the focusing instructions. Later in the experiment they were asked to rate the unpleasantness of an innocuous vibration. Participants from the suppression condition rated it more unpleasant than did those with other instruction sets. This suggests that part of the unpleasantness of avoided emotions comes from the very process or avoidance, not from the emotions themselves.(Hayes, 1996)

Chapter 4

History of DBT

In order to understand the evolution of DBT, we first need to define it. Dialectics refers to the process of change, whereby an idea or an event (thesis) generates and is transformed into its opposite (antithesis) and is preserved and fulfilled by it, leading to a reconciliation of opposites (synthesis).(C. Hutton, 2007)

DBT is a treatment protocol which has been partially influenced by both Hayes', and Kohlenberg and Tsai's work. It was developed specifically to treat and target the behaviors exhibited by women who were self-mutilating and suicidal. Linehan's work began by focusing on suicidal behaviors using a treatment utility method of assessment which looks at outcomes according to how clients were classified and treated in terms of target behaviors. In this evaluation process, Linehan recognized the overlap of coinciding factors for this suicidal population and those meeting criteria for borderline personality disorder. Among the common behavioral problems were high levels of misery, chaotic interpersonal patterns, and extremely maladaptive resistant behaviors even in the context of supportive psychotherapy relationships. Therefore, Linehan noted a target area, ubiquitous to these cases, of willfulness or resistance to life in general and to therapy in particular.(Nelson, 2004)

"Dialectical behavior therapy (DBT) is a comprehensive cognitive-behavioral treatment for complex, difficult-to-treat mental disorders Linehan, 1993). Originally developed for chronically suicidal individuals, DBT has evolved into a treatment for multi-disordered individuals with borderline personality disorder (BPD). DBT has since been adapted for other seemingly intractable behavioral disorders involving emotion dysregulation including substance dependence in individuals with BPD, binge eating, depressed suicidal adolescents, depressed elderly and to a variety of settings, including inpatient and partial hospitalization, forensic settings." (Dimeff, 2001)

DBT combines the basic strategies of behavior therapy with eastern mindfulness practices, residing within an overarching dialectical world view that emphasizes the synthesis of opposites. The term dialectical is also meant to convey both the multiple tensions that co-occur in therapy with suicidal clients with BPD as well as the emphasis in DBT of enhancing dialectical thinking patterns to replace rigid, dichotomous thinking. The fundamental dialectic in DBT is between validation and acceptance of the client as they are within the context of simultaneously helping them change. Acceptance procedures in DBT include mindfulness (e.g. attention to the present moment, assuming a non-judgmental stance, focusing on effectiveness) and a variety of validation and acceptance based stylistic strategies. Change strategies in DBT include behavioral analysis of maladaptive behaviors and problem solving techniques including skills training, contingency management (i.e. reinforces, punishment) cognitive modification and exposure based strategies.(Dimeff, 2001)

DBT has engendered considerable interest around the Americas, Europe and elsewhere because it was the first psychotherapy shown in a randomized controlled clinical trial to have effects on the symptoms of Borderline Personality Disorder. DBT, a broad-based behavioral treatment is founded on a dialectical and biosocial theory of BPD that determines the form and content of interventions.(Bateman, 2004)

Marsha Linehan was the founder of this technique of therapy. During the late 70's and early 80's Linehan was a CBT practitioner, however at that time, she and her team were trying to find techniques to better help with suicidal and para-suicidal clients. Through collaboration and observation, Linehan and her team discovered that she had been applying a number of interventions that were not traditionally associated with CBT. It was discovered that many of the techniques she was using, were closer to paradoxical therapy approaches than to CBT ones. These methods include

techniques such as matter-of-fact exaggerations, use of double-bind statements, and encouraging clients to accept feelings and situations rather than trying to change them. Linehan and her team observed that the use of paradoxical therapy practices were useful and had distinctive results. Despite the nature of these techniques, she was reluctant to identify this newly developing theory approach with a paradoxical framework because she feared that inexperienced therapists might mis-interpret or over-generalize the paradoxical intent of the therapy and prescribe suicide to clients as an intervention which should not be done under any circumstances. Instead Linehan began to use "dialectical" as a way to describe this new therapy approach as a result of her experiences working with chronically suicidal and para-suicidal clients. It is noted that the term "dialectical" was not only used because it prevented misuse of the treatment but because in hindsight it also highlighted the greatly opposing viewpoints experienced by clients and therapists throughout the treatment. (Weitzman, 2004)

Linehan compared one group of twenty-two females (ages 18 – 45) with BPD who underwent DBT for one year and twenty-two matched females with DBT who underwent treatment as normal in the community. The subjects were assessed before treatment and at four, eight and twelve months after treatment. There was a significant reduction in the frequency and medical risk of para-suicidal behavior among subjects who received DBT compared with subjects who received treatment as usual. The number of days of inpatient psychiatric hospitalization was fewer for subjects who received DBT than for controls, resulting in greater cost-effectiveness for DBT in spite of DBT's intensive treatment design, which includes both individual and group psychotherapy as well as accessibility for telephone consultation between sessions for one year.(Marra, 2005)

DBT grew out of a series of failed attempts to apply the standard cognitive and behavior therapy protocols of the late 1970's to chronically suicidal client. These difficulties included

c. focusing on change procedures was frequently expressed as invalidating by the client and often precipitated withdrawal from therapy, attacks on the therapist or vacillations between these two poles

d. teaching and strengthening new skills was extraordinarily difficult to do within the context of an individual therapy session while concurrently targeting and treating the client's motivation to die and suicidal behaviors that had occurred during the previous week

e. Individuals with BPD often unwittingly reinforced the therapist for iatrogenic treatment (e.g. a client stops attacking the therapist when the therapist changes the topic from one the client is afraid to discuss to a pleasant or neutral topic) and punishes them for effective treatment strategies (e.g. a client attempts suicide when the therapist refuses to recommend hospitalization stays that reinforce suicide threats.)

The first randomized clinical trial compared DBT to a treatment-as-usual (TAU) control condition. DBT subjects were significantly less likely to para-suicide during the treatment year, reported fewer para-suicide episodes at each assessment point, and had less medically severe para-suicides over the year. DBT was more effective than TAU at limiting treatment drop out, the most serious therapy interfering behavior. DBT subjects tended to enter psychiatric units less often, had fewer inpatient psychiatric days per client and improved more on scores of global as well as social adjustment, DBT

subjects showed significantly more improvement in reducing anger than did TAU subjects.(Dimeff, 2001)

In a more recent study, one hundred and one clinically referred women with recent suicidal and self-injurious behaviors meeting DSM IV criteria, matched to condition on age, suicide attempt history, negative prognostic indication, and number of lifetime intentional self-injuries and psychiatric hospitalizations were observed.(M.M. Linehan)

The results from this study showed that Dialectical behavior therapy was associated with better outcomes in the intent-to-treat analysis than community treatment by experts in most target areas during the 2 years treatment and follow-up period. Subjects receiving DBT were half as likely to make a suicide attempt, required less hospitalization for suicide ideation and had lower medical risk across all suicide attempts and self-injurious acts combined. Subjects receiving DBT were less likely to drop out of treatment and had fewer psychiatric hospitalizations and psychiatric emergency department visits.(M.M. Linehan)

DBT

DBT is an effective, new school of psychotherapy and psychopathology that has wide applicability to many patients. (Marra, 2004)

DBT is a new theoretical school that accepts many of the philosophical assumptions of approaches that preceded it, yet combines these assumptions and treatment strategies into a theoretically coherent model of mankind that provides both understanding of emotional pain and strategies to reduce such pain. (Marra, 2004)

Client with BPD are often considered overwhelmingly difficult and are sometimes thought to be 'treatment resistant'. DBT is an approach that blends emotion regulation, interpersonal systems and cognitive behavioral approaches. Added to the mix is Linehan's personal experience with Eastern philosophies and religions as well as the ideas of entering the paradox and extending that is from Aikido, a Japanese form of self-defense.

The humanistic hypothesis is that if the therapist is able to obtain genuineness, empathetic understanding, and positive regard, then positive personality change will occur in the client. (Rogers, 1957). Rogers proposes seven behavior strands within which behavior changes can be described in the client: feelings and personal meanings, manner of experiencing, degree of incongruence, communication of self, manner in which experience is construed, relationship to problems, and manner of relating. (Marra, 2004)

As a whole DBT attends to five functions of comprehensive treatment: capability enhancement (skills training) motivational enhancement (individual behavioral treatment plans), generalization (in vivo assignments, phone consultation), structuring of the environment (programmatic emphasis on reinforcement of sobriety and adaptive behaviors) and capability and motivational enhancement of therapists (therapist team consultation group). The treatment has 2 major characteristics: a behavioral, problem solving focus blended with acceptance strategies and an emphasis on dialectical processes. The term dialectical is meant to convey both the co-existing multiple tensions that must be dealt with in treating the multi-disordered patients, as well as the thought processes and behavioral styles employed and targeted in the treatment strategies. DBT is defined by its emphasis on behaviorally explicit targets and treatment strategy groups. The conduct of the therapist is guided by a detailed manual of procedures. (Linehan 1993a; Linehan et al., 1997).

DBT's treatment approach allows clinicians to reframe and validate client behaviors and reduce the likelihood of anthologizing inappropriate actions or intent on the part of the client through reframing problem behaviors into emotion regulation and skill deficit issues(Weitzman, 2004).

DBT has been described as 'the single most remarkable entry into therapeutic strategies for borderline patients' (Gunderson 2001:329) to appear since 1987 not the least for its capacity to invigorate and sustaining enthusiasm for treating a group of patients who have often demoralized prior generations of clinicians.(M Hazelton, 2006)

DBT can be employed with diverse clientele well beyond the original trials with adult suicidal women with borderline personality disorder – and that it can be modified with due caution in regard to adherence.(Alec L. Miller, 2006)

It is an empirically validated cognitive behavioral treatment informed by the mindfulness practices of Zen Buddhism. It has four major components: weekly, highly structured individual therapy (using a hierarchy of behavioral targets and diary cards); weekly group skills training that focuses on four major skill area as: mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness; as needed coaching between sessions to assist clients with skill acquisition and generalization and a weekly consultation meeting for the treatment team, designed to enhance learning of DBT and to provide peer support and supervision.(Alec L. Miller, 2006)

The authors indicate that DBT is the only treatment that has been replicated in demonstrating effectiveness in reducing suicidal and self-injurious behavior of adults. They add that a number of these DBT studies have included older adolescents : 18 – 21 year olds.(Alec L. Miller, 2006)

The dialectics are framed as transactional paradoxes that parents, therapist and youths need to understand and balance. The dilemmas are choosing between excessive leniency and authoritarian control, normalizing pathological behaviors versus anthologizing normal behaviors and forcing autonomy versus fostering dependence.(Alec L. Miller, 2006)

Most definitions emphasize 2 points. The first is that a mindful state is characterized by full attention to and awareness of the internal and external experience of the present moment. Second this awareness is employed equanimously in that whatever arises is acknowledged and examined without judgment, elaboration or reaction. Mindfulness therefore incorporated elements of both attention-regulation and an open, accepting orientation to experience. It is important to note that mindfulness refers to a particular quality of attentional focus, mindful awareness rather than to any particular practice or technique.(Richard Chambers, 2008)

DBT cannot reasonably be attributed to general factors associated with expert psychotherapy. DBT appears to be uniquely effective in reducing suicide attempts.(M.M. Linehan)

Treatment strategies in DBT focus on an acceptance/change dialectic. Change-oriented techniques draw heavily on behavioral and cognitive therapy and psychological principles and research in areas such as learning, emotions, social influence and persuasion. Acceptance techniques, (for both consumers and therapists) are based on client-centered and emotion focused therapies and Zen principles and practice. The following outlines a treatment program developed by Linehan.

Individual Therapy

1 hour per work: Focusing on negotiating and contracting about treatment, motivational interviewing and problem solution and analysis.

Group Skills Training

2.5 hours per week: focusing on the development of mindfulness skills (reducing impulsiveness by improving observing, describing and participating); distress tolerance skills (learning to more effectively deal with distress by acquiring and using distracting, self-soothing; improving the moment, thinking of pros and cons and radical acceptance); emotion regulation skills (addressing myths about emotions and learning to observe and describe emotions); an interpersonal effectives skills (learning to say no to unwanted requests and to ask for what is wanted).

Telephone Coaching

Encouragement to make brief appropriate telephone calls to practice overt rather than covert communication such as self-harm; to seek assistance with using skills learned in therapy; to assist with the repair of therapeutic engagement.

Therapist Consultation Meeting

Peer group supervision and support using the same strategies used to support consumers Is based on behavioral theory, cognitive theory, and mindfulness practice

DBT Treatment Priorities

1. Suicide and self-harm behaviors
2. Therapy Interfering behaviors – both consumers (e.g.. missing appointments) and therapists (e.g. resenting seeing consumers)
3. Behaviors interfering with quality of life (e.g. substance abuse, staying in abusive relationships)

Combining mindful awareness with cognitive behavioral therapy yields an intervention characterized by a focus on the present moment (as with CBT) but with an emphasis on accepting thoughts emotions and behaviors rather than actively trying to change them. This forms the underpinning of Mindfulness-Based Cognitive Therapy, which has been shown to prevent relapse in individuals who have suffered multiple previous episodes of depression.(Richard Chambers, 2008)

Mindfulness-based psychological interventions have been drawn largely from Buddhist insight meditation techniques known as Vipassana. These aim to foster the development of insight into the nature of mind, through developing mindful awareness of our present moment, psychological responses.(Richard Chambers, 2008)

It is a "stages of treatment model with hierarchies of treatment at each stage.

It seeks to problem solve by Behavior Analysis and Insight. It uses didactics and contingency as strategies to achieve Cognitive Restructuring and it utilizes Behavioral Rehearsal and Exposure Therapy as management strategies. (Hutton, 2007)

Dialectics can be described as: the process of change whereby an idea or event (thesis) generates and is transformed into its opposite (antithesis) and is preserved and fulfilled by it, leading to a reconciliation of opposites (synthesis). (Hutton, 2007)

The use of Dialectics in the name of the therapy refers to a process whereby clients are helped to find true balance in their emotions, thoughts, and behaviors/choices. It also seeks to teach clients how to live in balance by modeling both how to "live in balance" and "push" for change.
There are various strategies that are used when applying Dialectical Behavior Therapy and these include but are not limited to:

f. Devil's Advocate
g. Calling the client's bluff
h. Carefully timed confrontation
i. Irreverence
j. Humor
k. Metaphors
l. Paradox
m. Silence Intensity
n. Consultation to patient

Dialectical Behavioral Therapy is a therapy which was originally designed by Marsha Linehan to treat patients suffering from Borderline personality Disorder.

There are four aspects to DBT Therapy:

Core Mindfulness Skills
- These are derived from Buddhist meditation techniques to enable the client to become aware of the different aspects of experience and to develop the ability to stay with that experience in the present moment.

The purpose of mindfulness is to increase the sense of self and decrease emptiness through learning to observe and describe on-going experience. Mindfulness helps increase control over thoughts/emotions by learning to suspend judgment and watching thoughts pass and emotions ebb and flow. (Hutton, 2007) Finally it should help increase spontaneity and personal decision making by learning to participate skillfully in the moment, integrating emotion and reasoning ability. (Hutton, 2007)

Interpersonal Effectiveness Skills
- These focus on effective ways of achieving one's objectives with other people: to ask for what one wants effectively, to say no and be taken seriously, to maintain relationships and to maintain self-esteem in interactions with other people (comparable to assertiveness training).
Interpersonal effectiveness involves:

1. learning to say no and make requests affectively while maintaining self-respect and important relationships.

2. learning how to balance over-commitment and involvement with under-commitment and isolation

3. learning how to balance assertiveness and joining with others to increase interpersonal relationships and self-acceptance (Hutton, 2007).

Emotion Modulation Skills
- These skills are ways of coping with intense emotional experiences and their causes. They also allow for an adaptive experience and expression of intense emotions.

- decrease or increase physiological arousal associated with emotion
- re-orient attention
- inhibit mood dependent behavior
- experience emotions without escalating or blunting
- Organize behavior in the service of external, non-mood-dependent goals.

Distress Tolerance Skills
- These include techniques for putting up with, finding meaning for, and accepting distressing situations if there is no conceivable solution at present. This can be done in two ways…

1. replace maladaptive coping that works in the moment with non-destructive in the moment coping devices
2. learn to accept on-going events and discomfort in order to reduce severe misery (Hutton 2007)

Therapeutic strategies of DBT include both acceptance of the patient's experiences (validation of their emotional pain and suffering) and offering new psychological coping strategies that include a refocus on meaning and substance in their life, exposure to previously intolerated emotions, prevention of emotional escape and introduction of a behavior focus (a new goal orientation that appreciates and acknowledges emotional pain and suffering but demands new and different solution-focused strategies to deal with them. (Marra 2004)

DBT postulates that emotions are more likely to spur certain thoughts rather than thoughts growing emotions. (In direct opposition to CBT which assumes that thoughts lead to emotions.)
DBT thus assumes that emotions themselves (their intensity, duration, and perceived non-specific manifestation) are the primary causative factor in psychopathology. (Marra, 2004)

DBT also presumes, paradoxically, that while the goal of the patient is to escape and avoid their affect, their very focus on such processes make them increasingly attentive to (and thus more likely to respond to) affective stimuli. The more they avoid and escape their emotions, the more they experience them. A central principle of DBT, therefore is the acceptance of emotional pain decreases it. (Marra, 2004)

DBT differs from previous therapeutic approaches in that psychotherapy is oriented around validation (acceptance of the patient's perspectives on their own experience) of the emotional pain the patient suffers and assisting the patient to differentiate acceptance of their pain from approval of it. (Marra, 2004)

DBT is thus about balancing therapeutic strategies: some strategies promote change, some practices promote acceptance of experience as it is, some promote exploration of feelings and history, some promote distraction and arousal reduction, and some strategies are designed to promote the commitment and endurance required to undergo the arduous path of the previous strategies. (Marra, 2004)

Emotional acceptance technologies… empower the patient to attend to new clues in problem solving their emotional arousal. (Marra, 2004)

The skill sets (meaning making, mindfulness, emotion regulation, distress tolerance, strategies behavior skills) (Marra, 2004) all play an important part in DBT practice.

DBT shares the rich intellectual tradition of psychoanalytic approaches by embracing the notions of compromise formation, the pleasure principle, cathexis and anticathexis (redefined as attachment and aversion), emotional trauma as requiring extreme psychological defensive mechanisms, and the role of transference in psychological healing. DBT rejects the central notions of a dynamic psychology (one that studies transformations and exchanges of energy within the personality, such as id, ego, and superego), the central role of the unconscious developmental stages (oral, anal, etc.) in predicting lifelong deficits, and the primitive role of sexuality in explaining pathology. (Marra, 2004)

DBT embraces the central role of compromise formation in defining human suffering, as did Freud (Hall, 1954). Life involves a series of competing, contradictory, and irreconcilable differences in demands, expectations and desires. Dialectics are the continua that define such competing and contradictory demands upon the person. For example, people in critical emotional pain frequently live out the dialectic that they both want to embrace life and feel that they cannot tolerate what life brings to them. They want to both live and to die. These are incompatible desires, but they are experienced simultaneously in the moment by the person who suffers such a dialectic conflict. A compromise must be formed between the two competing demands, and the adequacy of the formed compromise will define the health and the "dis-ease" of the person. (Marra, 2004)

Adler defined the goal of therapy, unlike the Freudian notion of rescuing the patient from illness, as liberating the patient's social interest by changing faulty social values such as overgeneralizations, false or impossible goals of "security," misperceptions of life and of life's demands, minimization or denial of one's worth, or faulty ethical values such as "Be first even if you have to climb over others" (Dreikurs, 1957). (Marra, 2004)

DBT also embraces Freud's pleasure principle. Simply put, people try to increase their pleasure and to decrease their pain. People do not consciously and deliberately put themselves in situations and circumstances that are painful. (Marra, 2004)

In the late 1800's Freud wrote about cathexis and anticathexis. The underlying notion is about urges. "Want" and "need" have a force. Urgency is the sense of desperation that satisfying a need or want is critically important. DBT, along with Eastern meditative traditions, embraces the notion that people become "attached" to either a person, thing, or process and begin to live their lives as if this attachment is more important than other values. Attachment (defined as a deep desire to keep something or someone) causes the person to sustain environments that may have outlived their usefulness. The reverse, aversion (similar to Freud's anticathexis) causes the person to avoid or repel situations that otherwise might continue to be useful to them. (Marra, 2004)

Moreover, DBT assumes that our behavior is operant. No matter how chaotic and misunderstood behavior may be, it probably represents frantic attempts to operate on the environment to reduce perceived threat and increase perceived pleasure. DBT endorses the role of trauma in producing long-lived ineffective strategies to cope with emotional pain. (Marra, 2004)

DBT's Application

DBT is designed to be a comprehensive therapy for BPD patients at all levels of severity and complexity of disorder and is conceptualized as occurring in stages based on the severity and complexity of the disorder. As a comprehensive treatment DBT serves five functions

1) it enhances patient capabilities
2) it improves patient motivation to change.
3) It ensures that new capabilities generalize to the natural environment
4) It structures the environment in the ways essential to support patients and therapist capabilities
5) It enhances therapist's capabilities and motivation to treat patients effectively.

In DBT these functions are divided among modes of service delivery (e.g. psycho educational skills raining, individual psychotherapy.(Linehan)

DBT addresses specific treatment targets in a hierarchical order of importance

1) decreasing life threatening and suicidal behaviors including para-suicide episodes[1]
2) decreasing behavior that interferes with treatment
3) decreasing patterns that have a severe effect on quality of life (including in-patient psychiatric care
4) increasing behavioral skills. Subsequent to achieving behavioral control, it becomes possible to work on other important goals including
5) increasing emotional experiencing and resolving post-traumatic stress responses
6) enhancing self-respect
7) resolving problems in living
8) enhancing the capacity for joy

DBT has been rapidly adapted in community mental health settings. (Linehan)

Extreme emotional vulnerability is rarely the sole cause of psychological problems. An invalidating environment is also a major contributing factor. What is an invalidating environment? The "environment" in this case is usually other people. "Invalidating" refers to a failure to treat a person in a manner that conveys attention, respect and understanding. Examples of an invalidating environment can range from mismatched personalities of children and parents (e.g. a shy child growing up in a family of extroverts who tease her about her shyness) to extremes of physical or emotional abuse. In DBT it is thought that borderline personality disorder arises from the transaction between emotional vulnerability and the invalidating environment. (Hutton, 2007)
As outlined the DSM IV definition Borderline Personality Disorder is characterized by:

- Emotional Vulnerability
- Rapidly shifting moods
- Anger problems
- Chaotic relationships
- Fear of being left alone/abandoned
- Desperate Behaviors
- Experiencing unrelenting Crises

[1] Para-suicide is any acute intentional self-injurious behaviour with or without the intent to die

- Pushing down/denial of feelings
- Self-Invalidation
- Mask (both physical and Mental)
- Disassociation
- Paranoid thinking
- Over personalization
- Self-harming behavior (Hutton, 2007)

Clients with BPD experience Emotion Dysregulation, this meaning that their emotions are out of control and are characterized by feelings that the behavior cannot be controlled and as a result the behavior becomes mood driven. (Hutton 2007)

A sufferer of BPD may experience innate sensitivity to external stimuli. He/she may have an extremely low threshold for emotional arousal and will have extreme reactions to these external stimuli. This is then often characterized by a slow return to baseline behavior as the highly sensitized emotional reaction lingers and thus he/she may be already below baseline by the time the next external stimulus occurs. (Hutton 2007)

Quite frequently the environment that BPD sufferers have experiences is one where expressiveness is not tolerated – nor are displays of emotions or expressions of needs and wants. It is common that the responses to any of these emotional displays are dismissed trivialized and or criticized. (Hutton, 2007)

DBT is based on a dialectical worldview that emphasizes wholeness, interrelatedness and process (change) as fundamental characteristics of reality.(Hutton)

The relationship between the individual and the environment is a process of reciprocal influence and that the outcome at any given moment is due to the transaction between the person and the environment. Within social learning theory this is the principle of reciprocal determination. (Hutton)

Treatment of BPD has received increasing attention from cognitive theorists. The cognitive approach views the problems of the client with BPD as residing within both the content and the process of the individuals thoughts.(Hutton)

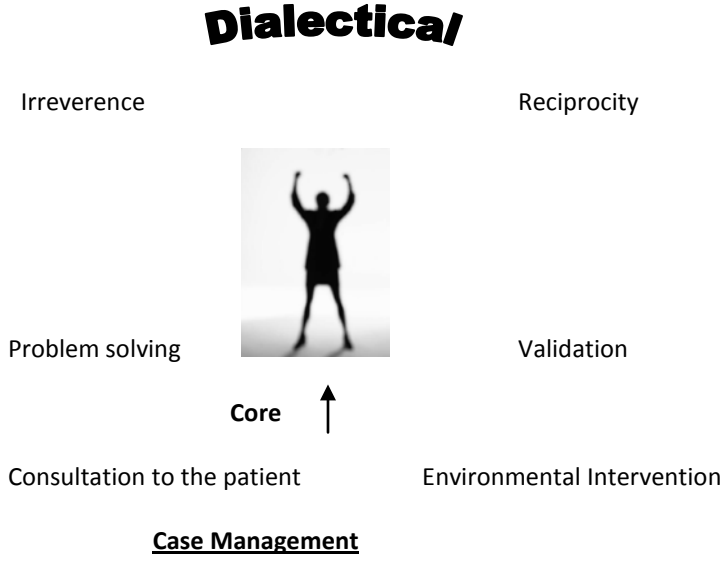


Figure 9.2 Treatment Strategies in DBT. From Linehan (1993b). Copyrights 1993 by the Guilford Press.

Within an individual session, with a given client certain strategies may be used more than others and all strategies may not be necessary or appropriate.(Hutton)

Dialectical strategies permeate the entire therapy and their use provides the rationale for adding the term dialectical to the title of the therapy. There are 3 types of dialectical strategies: those having to do with how the therapist structures interactions, those pertaining to how the therapist defines and teaches skillful behaviors and certain specific strategies used during the conduct of treatment.(Hutton)

Three primary characteristics are needed to maintain a dialectical stance in the therapeutic relationship: movement, speed and flow. Movement refers to acting with certainty, strength and total commitment on the part of the therapist. If the therapist only moves half- heartedly the client will only move half-heartedly. Speed is of the essence and entails keeping the therapy moving so that it dos no become rigid or stuck. Finally flow refers to being mindful to the moment to moment unfolding of a session and responding smoothly and with apparent effortlessness.

Dialectical thinking is emphasized throughout the entire treatment. Not only does the therapist maintain a dialectical stance in his/her treatment of the client but he/she also focuses on teaching and modeling dialectic thinking to the client. The therapist helps the client move from an “either-or” position to a “both and” position.

There are 8 specific dialectical treatment strategies

1. entering and using the paradox
2. using metaphor
3. playing devil’s advocate
4. extending
5. activating the client’s “wise mind”
6. making lemonade out of lemons
7. allowing natural change (and inconsistencies even within the therapeutic milieu)
8. assessing dialectically by always asking “What is being left out here?”

The essence of entering the paradox is the therapist’s refusal to step in with rational explanation. The client’s attempts at logic are met with silence, a question or a story designed to shed light. The client is pushed to achieve understanding to move towards synthesis of the polarities and to resolve the dilemma him/herself.(Hutton)

Behavioral extremes and rigidity, whether cognitive, emotional or overtly behavioral, are signals that synthesis has not been achieved: thus they can be considered non-dialectical. Instead a “middle path” similar to that activated in Buddhism is advocated and modeled. The important thing in following the path to enlightenment is to avoid being caught and entangled in any extreme and always follow the middle way((Hutton 2007)

The use of metaphors, stories, parables and myth is extremely important in DBT and provides an alternative means of teaching dialectical thinking. Stories are usually more interesting and easy to remember and encourage the search for other meanings of events under scrutiny. Metaphor also allows clients to distance themselves from the problem discussed and can therefore feel less threatening. (Hutton)

The devil’s advocate technique is a method of addressing a client’s dysfunctional belief or problematic rules. With this strategy a therapist presents a propositional statement that is an extreme version of the clients own dysfunctional beliefs then plays the role of devil’s advocate to

counter the client's attempts to disprove the extreme statement or rule. For example a client may state that "Because I'm overweight, I'd be better off dead". The therapist argues in favor of the dysfunctional belief, perhaps by suggesting that because this is true for the client, it must be true for others as well, hence all overweight people would be better off dead. The therapist may continue along the lines: and since the definition of what constitutes being overweight varies so much among individuals, there must be an awful lot of people who are better off dead.

The term extending has been borrowed from aikido, a Japanese form of self-defense. In that context, extending occurs when the student of aikido waits for a challenger's movement to reach his/her natural completion, then extends the movement's endpoint slightly further than what would naturally occur leaving the challenger vulnerable and off balance. In DBT extending occurs when the therapist takes the verity or gravity of what the client is communicating more seriously than the client intends.

Validation and problem solving strategies (activating the wise mind) together with dialectical strategies make up the core of DBT and form the heart of the treatment. Validation strategies are the most obvious acceptance strategies whereas problem solving strategies are the most obvious change strategies.(Hutton)

Making lemons out of lemonade is a strategy that involves taking something that is apparently problematic and turning it into an asset. Problems become opportunities to practice skills, suffering allows others to express empathy: weaknesses become one's strength. To be effective this strategy requires a strong relationship between client and therapist. The client must believe that the therapist has a deep compassion for his/her suffering. The danger in using this strategy is that it is easily confused with the invalidating refrain repeatedly heard by clients with BPD. The therapist should avoid the tendency to oversimplify a client's problems and refrain from implying that the lemons in the client's life are really lemonade.(Hutton)

Allowing natural change: Unlike CBT there is no right or wrong way of thinking or one right or wrong path for the therapy session. The therapist encourages the patient to appreciate the natural changes in their life/thinking/feeling and to accept them as a normal, valid progression.

Assessing dialectically: by always asking "what's being left out here? " is helpful technique for when patients are caught up in extreme emotion arousal about a life event. It is almost always the case that there is something the patient is not seeing or is subconsciously leaving out of the equation. Sometimes shifting the focus automatically affects the intensity of the arousal.

The Clinical Handbook of Psychological disorders explains in detail how the process of therapy plays out.

First the client and therapist must arrive at a mutually informed decision to work together. Typically the first one to four sessions are presented to the client as opportunities for client and therapist to explore this possibility. Diagnostic interviewing, history taking and formal behavioral analyses are of high priority. Targeted behaviors can be woven into initial therapy sessions or be conducted separately.

Secondly the client and therapist must negotiate a common set of expectancies to guide the initial steps of therapy. Agreements outlining specifically what the client and therapist can expect from each other are discussed and agreed to.

When necessary the therapist attempts to modify the client's dysfunctional beliefs regarding the process of therapy.

Issues addressed include the rate and magnitude of change that can reasonably be expected, the goals of treatment and general treatment procedures and various myths the client may have about the process of therapy in general.

Orientation covers several additional points. First, DBT is presented as a supportive theory requiring a strong collaboration between client and therapist. DBT is not a suicide prevention program but a life enhancement program, in which client and therapist function as a team to create a life worth living.

Thirdly DBT is described as a cognitive behavioral therapy with a primary emphasis on analyzing problematic behaviors and replacing them with skillful behaviors and on changing ineffective beliefs and rigid thinking patterns.

Finally the client is told that DBT is a skills oriented therapy with special emphasis on behavioral skills training. The commitment and orienting strategies are the most important strategies during this phase of treatment. The therapist places a strong effort in getting the client to commit to not engaging in suicidal or non-suicidal self-injury behaviors for some specified period of time before allowing the client to leave the session. It can be for 1 year, 6 months, until next session or until tomorrow.(Hutton)

Dialectics is the art of logical discussion but unlike cognitive behavioral strategies the focus is not on logic at all but on dialogue. The DBT therapist develops a dialogue about meaning and purpose in life. The dialogue centers on the fundamental nature of reality which involves thesis and anti-thesis, balance and imbalance. Each imbalance offers an opportunity for rebalance. Psychological dialectics involve conflict and opposition as the needs and desires of the person are frequently in conflict with the demand characteristics and contingencies of the environment at the moment. (Marra, 2005)

Linehan's clinical response to resistance is consistent with her "dialectical" approach. A unique aspect of DBT, that of balancing acceptance and change in the therapy process, attempts to address the client's experience of therapy as either overly accepting and non-productive, or overly change oriented and invalidating. By addressing directly what Linehan calls the fundamental dialectic in psychotherapy, that of acceptance versus change, DBT simultaneously accepts and respects the client's experience while insisting on the possibilities for changing maladaptive patterns of behavior. This is done strategically through weaving into therapy a combination of both change and validation strategies. DBT emphasizes the need for clinicians to be aware and take responsibility for imbalances in the acceptance and change dialectic in the psychotherapy. This is done through in-session assessment of client responses, discussion of both client and therapist perception and genuine attempts to rectify an unbalanced environment.(Nelson, 2004)

Similarly, in a randomized controlled trial conducted by Linehan et al. (1999), women meeting criteria for BPD and polysubstance use disorder or substance use disorder for amphetamines, anxiolytics, cocaine, cannabis, hypnotics, opiates or sedatives had significantly greater reductions in drug use throughout the treatment year and at follow up than did the treatment as usual subjects.

Further those assigned to DBT had significantly better treatment retention (64% retention in DBT: 27% in TAU).

Mindfulness

Mindfulness is one of the core principles of DBT. There is an important distinction to be made between mindfulness and CBT.

A basic description of Mindfulness is: whatever thoughts, feelings or sensations arise in the mind, observe them as the Impartial Observer, and as a result such 'disturbances' fall away and lose their power over a person.

A basic description of Cognitive Behavioral Therapy is: the individual analyses their thoughts and determines those which are 'irrational' and then substitutes such 'irrational' thoughts with 'rational' ones. (Mindfulness, http://forums.philosophyforums.com/threads/cbt-vs-mindfulness-25569.html)

Mindfulness is a simple yet complexly implemented intervention to decrease avoidance and escape responses. It's simple because it involves only 3 principles of attention: attending to only one thing at a time, adopting a non-judgmental attitude and describing from experience rather than through constructs or pre-defined categories. These simple notions are quite difficult to implement because they go against the grain of out typical observational processes. Most of us have been trained to multi-task to evaluate and to categorize or analyze our observations simultaneously. To turn off the analytical skills that have been over learned and the habitual parts of our observation process is quite difficult. (Marra, 2005)

To learn to precisely reorient our attention in a mindful way is a powerful strategy to decrease acute emotional disorders. Mindfulness can assist patients with several aspects of acute mental disorders. Attention and concentration decrease with increased anxiety or depression and mindfulness increases attention and concentration. Acute mental disorders predispose the individual to self-absorption; mindfulness increases attention to the environment. Acute mental disorders often involve a loss of attention to senses.; mindfulness involves heightened sensual activity. The ability to shift attention away from thoughts and rumination is difficult with high emotional arousal; mindfulness is about turning the mind away from thoughts and to experience. Mindfulness is thus about increasing observational skills themselves thus exposing the individual to their emotions (decreasing the avoidance and escape responses typically used in acute mental disorders) Mindfulness increases contact with the world in the moment, thus offering new environmental prompts to grow new emotions rather than focusing on old experiences that generated the negative affect. Mindfulness is thus about living more experientially. (Marra, 2005)

Teaching patients how to be mindful is easier and more effective if they understand the rationale for the practice. The rationales is to increase the scope and accuracy of attention, assist in shifting focus of attention, increase the effectiveness of the use of our senses in experiencing the world, become less ruminative and judgmental in our information acquisition, reduce the role of self-consciousness and decrease emotional escape and avoidance, and develop additional calm and inward peace by relinquishing aversion and attachment. (Mazza)

In DBT, a Zen Buddhist perspective has been integrated as part of the acceptance/change process. The acceptance/change dialectic is used throughout treatment to promote a non-judgmental, empathetic attitude toward self, balanced by a fiercely persistent and goal-oriented therapy agenda.

Acceptance is tied to willingness in several ways. When the clinician works to accept some of the symptoms and experiences and the life of the client, he/she models a willing attitude for the client. The client is in turn encouraged to be willing with both self and life events in order to overcome blocks in emotional experiencing and shift long-standing destructive patterns in living (i.e. being willing to “accept” strong emotions rather than fighting to control or avoid them).(Nelson, 2004)

In her comparative text on DBT method Linehan adopts the following spiritual definition of willingness which gives some phenomenological indication of the nature of the process.

Willingness implies a surrendering of ones self-separateness, and entering-into, an immersion in the deepest processes of life itself. It is a realization that one already is a part of some ultimate cosmic process and it is a commitment to participation in that process. In contrast, willfulness is the setting of oneself apart from the fundamental essence of life in an attempt to master, direct, control or otherwise manipulates existence. More simply, willingness is saying yes to the mystery of being alive in each moment. Willfulness is saying no, or perhaps more commonly “yes, but…”(Nelson, 2004)

Therapeutic benefits

Mindfulness, primarily a meditative skill in many schools of Buddhism, is based on the idea that the activity of the mind itself, regardless of the content of thoughts, leads to dissatisfaction (sometimes called "suffering"). Thoughts, be they positive or negative, can trick clients into assigning permanence to an ever-changing, ever-fading reality. Mindfulness, a disciplined activity that usually occurs in meditation, is a system whereby clients observe the thoughts in their minds without judging them. In doing so, they gradually learn to separate from and let go of the thoughts. (Mindfulness, http://ask.metafilter.com/80646/Integrating-CBT-and-mindfulness)

Mindfulness has to do with seeing thoughts *as* thoughts, rather than identifying with them as "reality"; Buddhism (as I understand it) teaches that suffering arises from this identification (attachment). Buddhist teachers are often at pains to stress that meditation is not about stopping or squashing or reducing the incidence of thought, but rather relating to thoughts in a fundamentally different way.

Learning to be 'mindful' of automatic thoughts and previously unquestioned explanatory styles, etcetera, is of course an essential first stage in CBT — the very idea that thinking can be readjusted first requires an understanding that they are thoughts, not a simple reflection of the world — this is how patients can begin to learn to "see" thoughts. Likewise, once a patient begins to see that thoughts can be adjusted, and that they can thereby affect your emotional state, a more non-attached approach to any specific thoughts seems to be bound to follow.

DBT is based on a combined capability deficit and motivational model of BPD which states that:

1) people with BPD lack important interpersonal, self-regulation (including emotional regulation and distress tolerance skills and
2) personal and environmental factors often both block and or inhibit the use of behavioral skills that clients do have and reinforce dysfunctional behaviors.(L. A. a. L. Dimeff, M.M, 2001)

The different stages of DBT are designed to have the following impacts

- dramatically reduce suicide attempts and Para suicidal behaviors
- decrease anger and anxiety related impulsive behaviors
- reduce hopelessness
- improve coping skills (Hutton, 2007)

The following is a summary of how the different stages achieve the different desired outcomes

Stage 1

The first step involves an attempt to decrease life-threatening behaviors and or quality of life threatening behaviors i.e. joblessness, homelessness, relationship chaos.
It also attempts to Increase Behavioral skills through mindfulness, interpersonal effectiveness, emotion regulation, distress tolerance and self-management.

Stage 2

This stage seeks to Reduce Quiet Desperation whilst at the same time Increase Emotional Experiencing

Stage 3

Aims to Decrease problems in living while increasing the acceptance of ordinary happiness and unhappiness

Stage 4

This last step endeavors to Decrease incompleteness and increasing a patient's capacity for joy
This can be done by increasing community involvement, focus on career relationships and focusing on spirituality. (Hutton, 2007)

Patients who present for treatment have powerful ad frequent early experiences of pain. Issues of attachment primarily occur in early infancy. Trauma, loss and emotional invalidating can occur throughout the life cycle. Once these psychological issues occur, the person is pre-disposed towards high emotional arousal. Neurological and neurotransmitter neural net firings then take over sustaining high emotional arousal over long periods of time. The central dialectic between one's own experience in compassion with the experience of others (who are fortunate not to have the attachment trauma, or loss experience or genetic predisposition toward negative kindling effects) results in conflict. "I don't seem to experience the world in the same way others who are happy and care free" is a frequently unarticulated but fundamental conclusion of the person in chronic emotional pain. This dialectic conflict between self-experience and comparison with others increases arousal as the patient blames themselves (as inadequate, faulty, depraved or defective) for the very problems they wish to solve. Shame, anxiety, fear and anger frequently result from this, adding additional emotional load to the problems these people face. The environment itself (happy others)

becomes invalidating as the person compares their own experience to the perceived experiences of others. One results of this dialectic is that the patient is less likely to use reward rather than punishment when facing life's difficulties. The self-hatred or self-blame following failure to achieve these goals results in the self-punitive response further increasing already high emotional arousal. Rather than a cognitive focus the DBT therapist targets the high sensitivity to emotional stimuli resulting in emotional vulnerability in order to decrease emotional intensity, speed return to emotional baseline and decrease need for social avoidance. The DBT therapist increases solution focused coping and decreases emotion-focused coping that fails to recognize the role of dialectic failure in patients' lives.(Marra, 2005)

The following is a table that demonstrates the issues clients may have and the strategies adopted in DBT to deal with each of those issues.

Summary of DBT General Strategies	
Pathotopology	**DBT Strategies**
High emotional arousal	Identify and label affect Mindfulness (acceptance) Stress-management and self-soothing techniques Redeploy attention to external rather than internal cues Redeploy problem solving to long-term objectives.
Slow return to emotional baseline	Shift attention between affect, cognition, physiology, behavior and environment Decrease mood dependent behaviors Reduce arousal through stress management Identify secondary emotional reactions and reframe
Emotional sensitivity	Mindfulness (acceptance) Redirect to solution-focused strategies Move between short-term and long-term objectives
Hyper vigilance	Reduce avoidance and escape strategies Cognitive reframing Attend to safety cues.
Emotional avoidance and escape	Exposure (acceptance) Identify and label affect Mindfulness (acceptance) Reduce mood-dependent behavior Teach emotion regulation and distress tolerance skills Coach application of skills to daily living (generalization) Increase solution-focused coping

Chapter 5

Alternative Applications of DBT

Dialectical Behavior Therapy is a comprehensive cognitive-behavioral treatment for complex, difficult to treat mental disorders (Linehan, 1993a.b.) Originally developed for chronically suicidal individuals, DBT has evolved into a treatment for multi-disordered individuals with borderline personality disorder. DBT has since been adapted for other seemingly intractable behavioral disorders involving emotion dysregulation, including substance dependent individuals with BPD, binge eating, depressed, suicidal adolescents, depressed elderly and to a variety of settings, including inpatient and partial hospitalization, forensic settings.(L. a. L. Dimeff, MM, 2001)

Linehan originally developed DBT for the treatment of borderline personality disorder. However the theory of DBT is comprehensive and represents a global school of psychotherapy. DBT is applicable to a variety of classes of emotional disorders. DBT does not simply attend to chief complaints or primary symptoms but rather it attends both to the symptoms that cause immediate distress to patients and to identifying and targeting issues that are long term and enduring maladaptive patterns to which the patient may have habituated but that are nevertheless evident. The therapist cannot adequately attend to most acute disorders by applying only one set of treatment targets as many patients will present with a mixture of issues.(Marra, 2005)

“The benefits of the mindfulness training were reflected in significantly enhanced self-reported levels of mindfulness, significantly reduced self-reported depressive symptoms, reflective rumination, and negative affect and improvement on some indices of executive cognitive function.”(Richard Chambers, 2008)

Depression involves an element of brooding – being a tendency to ruminate on the meanings of one’s own actions and feelings. Such rumination is particularly inconsistent with the focus on here and now bodily sensations that is at the core of Vipassana practice. The basis of mindfulness in DBT.(Richard Chambers, 2008)

Dialectics with mood disorders

Mood disorders involve central concerns with shame and feelings of emptiness, meaninglessness, boredom, despair, guilt, sin, hunger and self-loathing. The depressed patient feels guilty and culpable, frequently with feelings of incompleteness. By punishing themselves (with judgmental thoughts that turn criticism against the self) they decrease perceived anxiety and increase perceived power – at least they can do something to change the feared hopelessness. Individuals with depression will at times idealize others then feel diminished in comparison to those they idealize.(Mazza)

The catastrophic thinking of depressed patients is not without evidential merit, as studies have shown that even among depressed patients who receive treatment that alleviates their depression, a chronic course of depression predicted persistent social maladjustment, even among those who were depression free for 6 months.(Mazza)

Because the depressed person feels empty, their feelings themselves are defined as dangerous, since they bring hurt into focus. Most of the dialectics with mood disorders thus have to do with content themes of self-loathing, distrust of emotions, prediction of disaster and abandonment fears.

However the most central dialectic is loss of energy versus desire for joy. The depressed person has desires but fears them resulting in struggles with hope. When the depressed person is feeling less hope, they become increasingly passive.(Marra, 2005)

According to Linehan dialectical thinking is a middle ground between 2 opposite ways of thinking and acting. One way is thinking in terms of absolutes, this is called Universalistic thinking and it means that the belief is that, in an argument or discussion, one person is right and the other person is wrong.

Relativistic thinking, according to Linehan assumes that there is no universal truth and that in an argument the truth is in "the eye of the beholder".

Linehan then reports that dialectical thinking requires that the thinker transcend polarities. The thinker must look at each of the polarities and ask about what may have been left out of each argument. In terms of dialectical behavior therapy, the goal becomes that the patient comes to accept the existence of two poles and many details.

In these terms it means the patient comes to understand and accept that both black and white exist. Therefore it is not necessary to abandon one way of thinking or one point of view.

Thinking in dialectic terms is liberating because it becomes possible to take in many truths, many realities without rejecting any persons who hold to these opposites or varied opinions, views and realities.

Dialectics and Bipolar Disorder

Bipolar disorder is a special case because in bipolar disorder, emotions are especially prone to be prompted due to neurochemical influences rather than environmental ones.(Mazza)

While the bipolar patient is a stylized example of distrust of emotions and the bipolar patient has even more reason to distrust their emotions due to the known genetic and biochemical genesis of the disorder, dialectic psychotherapy in conjunction with medications can be helpful. With the bipolar patient, the therapist helps the patient to identify incongruence between their affect and their environment in the moment. The dialectic between focus on self versus focus on environment is particularly important work with the bipolar patient. Improving the bipolar's observational skills with mindfulness is especially important, and helping them to navigate the passivity versus activity dialectic is equally critical. Shifting from emotion-focused coping to solution focused coping can help them improve their strategic behavior even in the face of uncontrollable affect.(Marra, 2005)

Dialectic psychotherapy is thus applicable to bipolar disorder in spite of the known evidence that affect is at times beyond the control of the patient. In fact DBT assumes that affect frequently is kindled neurologically with most acute emotional disorders and precisely this contributes to their high emotional arousal. DBT is designed to treat such conditions as it helps the patient to make sense of their feelings even those not under the conscious control and to engage in coping responses based upon this knowledge.(Marra, 2005)

Dialectics and Anxiety

The central dialectics with anxiety is the desire for safety in the face of perceived threat. Inadequate synthesis of this, results in the loss of freedom as the patient places increasing restrictions on what they can and cannot do. Anxiety disorders have prominent content themes of threat, dependency, inadequacy, shame and somatization. Emotional escape and avoidance are high-probability problems with all of the anxiety disorders. While self-focus increases (with attention to physiology and affect being prominent), anxious patients also have a fear of being observed and humiliated in the public eye.

This can lead to inconsistency in the dialectics of activity versus passivity. The anxious person decreases their trust in their own body, their own competence to control their body and their competence to function in interpersonal environments. Anxious patients thus can become quite secretive, avoiding the perceived humiliation that would be forthcoming if others could transparently observe their internal experience. Anxiety disorders along with mood disorders offer the greatest challenge for the patient who is fearful of their own affect, since their affect indeed can be overwhelming and threatening. Behavioral approaches have thus increasingly embraced the need for training in emotion regulation skills in these disorders.(Marra, 2005)

Dialectics and Eating Disorders

Eating disorders involve central issues of identity, acceptability, indulgence or urge versus inhibition, self-control versus helplessness and the fundamental acceptability of the individual to self and society. The patient acts as if their hunger will destroy them as well as others. The conflict is between urge and self-control with less attention focuses on solution-focused coping. High emotional arousal results from their self-loathing rather than from food or eating food. Food is simply the focus of attention around which the underlying emotional dread and want dance.(Marra, 2005)

The role of maladaptive regulation in eating disorders has been well researched and specific application of dialectical behavior therapy to the issue of eating disorders has been made. Eating disorders can be characterized as a way of avoiding affect by redirecting attention to less personally threatening stimuli and like food and using binge or purge behaviors to modify affect through both positive and negative reinforcement. Individuals who present for treatment of eating disorders frequently have comorbid anxiety disorders and patients with both eating disorders and anxiety disorders have been found to have higher maladaptive emotion regulation strategies.(Marra, 2005)

The goal of the treatment of eating disorders using a DBT approach involves increasing the variety of emotional inputs available in the environment (training in emotion regulation skills) increasing the variety of need fulfillments in the environment (meaning making skills),validating the worth of the individual and regardless of met or unmet needs, increasing the frustration tolerance of the patient (distress tolerance skills) shifting contextual variables from short term to long term (Strategic behavior skills) and most importantly increasing sensory input (mindfulness skills) to substitute sensual activities for food satiety.(Marra, 2005)

Adaptations of DBT for other clinical issues such as suicidal and self-harming behaviors in adolescents, chemical dependence in women, depression in adults has also undergone clinical trials. DBT relies on a close theory relationship in the context of a biosocial and skill-deficit model and

seeks to remediate cognitions and behaviors through cognitive and interpersonal behavioral processes. The concept of willingness and techniques for developing willingness in both therapist and clients is important in DBT due to the pervasiveness of resistant or unwilling patterns in this population.(Nelson, 2004)

The differences between CBT and DBT

Rather than being a contradictory perspective, DBT is an outgrowth of behavior therapy in that it fully embraces behavior therapy principles. However DBT is less cognitive than traditional cognitive behavioral perspectives since DBT posits that thoughts are less important than affect regulation. (Marra, 2005)

Most newer psychotherapies following the cognitive behavior model place great emphasis on thoughts, as in Acceptance Commitment Therapy. ACT assert that "language itself enables humans to struggle with their own private experiences in a way that fosters the ubiquity of human misery". Thus even the "third wave" of behaviorism, encompassing acceptance and mindfulness principles, tends to support the primacy of cognitive events as the cause of major emotional dysfunction although the goals are much the same. DBT on the other hand diminishes the role of cognition as the primary causative factor in major mental disorders. Fundamentally DBT differentiates itself from the standard cognitive behavioral therapy by placing the emphasis on emotion regulation rather than maladaptive thought processes.(Marra, 2005)

DBT proposes that the ability to sustain attention to affect is more important than the ability to change simple behavioral contingencies. DBT is thus different from standard behavioral therapy approaches because it places major responsibility for behavioral change closer to the emotions themselves. Cognition is not a necessary mediating factor. Emotions hurt and emotional factors including the behavioral principles of avoidance and escape are critically important in defining the therapeutic focus of attention.(Marra, 2005)

So DBT borrows from many intellectual traditions of the past but is differentiated from those same schools of philosophy by assuming that emotional conflict itself creates psychopathological responses. Inadequate compromise formation, the dialectics upon which DBT rests, defines its uniqueness. Emotional conflict and fear of one's emotional arousal result in avoidance and escape behaviors. Yet in complex human beings, the avoidance and escape apply to internal processes rather than external environments and effectively avoiding or escaping oneself is difficult indeed.(Marra, 2005)

Given DBT's treatment focus and application, it is seemingly straightforward to classify it as a cognitive behavioral approach. However this is an inaccurate description. DBT is a dynamic and eclectic treatment model that incorporates concepts and techniques from many different treatment approaches, including client centered, psychodynamic, Gestalt, strategic, systems paradoxical and Eastern/Zen therapies. Also while DBT did develop out of a cognitive-behavioral background, it is strongly influenced by dialectical philosophy and a biosocial theory of personality functioning which continue to shape the theory and practice of DBT.(Weitzman, 2004)

As a result of these alternative origins Linehan describes at least four main differences that set DBT apart from other standard cognitive behavioral therapies including:

1. The need to develop a collaborative therapeutic relationship with the client which is viewed to be an essential component to treatment
2. the therapists use of acceptance and validations of client behaviors as they occur from moment to moment
3. developing and maintaining a focus on the dialectical process
4. the importance of specifically addressing and treating "therapy interfering" behaviors.

Dialectical thinking encourages clients to see reality as complex and multifaceted: to hold contradictory thoughts simultaneously and learn to integrate them and be comfortable with inconsistency and contradictions. For individuals who are extreme and dichotomous in their thinking and behavior, this is very important. A dialectical emphasis applies equally to a client's behavior, because the client is encouraged to integrate and balance emotional and behavioral responses. In particular dialectical tensions arise in the area of skills enhancement versus self-acceptance; problem solving versus problem acceptance and affect regulation versus affect tolerance.

In DBT Diary cards are kept and record instances of suicidal or NSSI on a daily basis including urges to engage in suicide or NSSI on a 0 – 5 point scale. Use of substances is also recorded. The therapist during DBT must develop the pattern of routinely reviewing the card at the beginning of each session. The card acts as a road map for each session. Therefore a session cannot begin unless the card has been completed. Failure to complete or bring the card is considered therapy-interfering behavior and should be addressed as such.(Hutton)

This is somewhat dissimilar to CBT sessions which do incorporate homework but only as a small part of the therapeutic process, not so pivotal.

Mindfulness skills are viewed as central in DBT thus they're labeled "core skills". These skills represent a behavioral translation of meditation (including Zen and contemplative payer) practice and include observing, describing, spontaneous participating, being non-judgmental, focusing awareness and focusing on effectiveness.

Unlike standard behavior and cognitive therapies which ordinarily focus on changing distressing emotions and events, a major emphasis of DBT is on learning to manage pain skillfully. Mindfulness skills reflect the ability to experience and observe ones thoughts, emotions and behaviors without judgment or action. (Barlow p383)

Although direct cognitive restructuring procedures such as those advocated by Beck and colleagues are used and taught as part of emotion regulation, they don't hold a dominant place in DBT.(Hutton)

"In contract contingency clarification strategies are used relentlessly by highlighting contingency relationships operating in the here and now. Emphasis is placed on highlighting immediate and long term effects of client's behavior (both on themselves and others) clarifying the effect of certain

situations on client's own responses and examining future contingencies that clients are likely to encounter."(Hutton) p398

Exposure procedures of the DBT therapist involve first orienting the client to the techniques and to the fact that exposure to cues is often experienced as painful or frightening. Thus the therapist does not remove the cue to emotional arousal and at the same time he/she blocks both the action tendencies (including escape responses) and the expression tendencies associated with the problem emotion. In addition the DBT therapist works to assist the client in achieving enhanced control over aversive events. A crucial step of exposure procedure is that the client be taught how to control the event. It is critical that the client have some means of titrating or ending exposure when emotions become unendurable. The therapist and client should collaborate in developing positive, adaptive ways for the client to end exposure voluntarily, preferably after some reduction in the problem emotion has occurred.(Hutton)

Generally speaking both CBT and DBT practice engage in reciprocal communication. Reciprocal communication involves responsiveness, self-disclosure, warm engagement and genuineness. It also involves attending to the client in a mindful manner and taking the client's agenda and wishes seriously. (Hutton)

However irreverent communication is a communication style pertaining specifically to DBT. It is a communication technique used to push the client "off balance", get the client's attention, present an alternative viewpoint, or shift affective response. It is a highly useful strategy when the client is immovable or when therapist and client are "stuck". It has an "off-beat" flavor and uses logic to weave a web the client cannot escape. Although it is responsive to the client, irreverent communication is almost never the response the client expects. For irreverence to be effective is must be both genuine (versus sarcastic or judgmental) and come from a place of compassion and warmth towards the client. Otherwise the client may become even more rigid. When using irreverence, the therapist highlights some unintended aspect of the client's communication or reframes it in an unorthodox manner. For example if the client says "I am going to kill myself, the therapist might say, "I thought you agreed not to drop out of therapy?"(Hutton)

The following table shows a comparison of traditional cognitive reframing and DBT style framing to cognitions. The DBT informed reframing connects the thought process to underlying affect, thus providing validation through demonstrating to the patient that the therapist understands the foundation for the thought process. DBT attempts to stay closer to the affect generating the thoughts rather than attacking the thought process itself.

Comparison of CBT and DBT Reframing Strategies		
Dysfunctional thought	**CBT-Style Reframing**	**DBT-Style Reframing**
Everyone must love me or I feel horrible	It is impossible for everyone to love anyone. Rejection and disapproval are part of life. Having just a few	Of course you want everyone to love you. That would increase your sense of safety and security. We all want that. You've felt

	people love you is more important than striving for the impossible goal of having uniform and unending love from everything you encounter	rejected so often and it hurts so much, desiring universal approval would go a long way toward reducing your pain. But it hurts you to want this love because it sets you up for disappointment
Negative feelings are bad and destructive and I should avoid them at all costs	Negative feelings like sadness and disappointment are a part of life. You can't avoid them so you might as well accept them as normal aspects of human living. You can't have the good without the bad.	You're right. Negative feelings like sadness and disappointment hurt badly. We all want to avoid them. No one has found an acceptable way to throw out the bad feelings and trying puts tremendous pressure on you.
Others don't approve of my feelings. I shouldn't feel the way I do	Seeking others' approval makes you dependent on others for your happiness. Values and opinions vary so greatly from person to person, seeking their approval will lead to frustration and disappointment. Revise your "should" rules and you'll feel better. Say to yourself, "It would be nice if others approve, but I can't expect others will always agree with me.	Of course you seek the approval of others for the feelings you have. Most of us do so. We want to be affirmed – this is natural. But when you begin to negate your feelings because the approval you want doesn't come, it makes you feel bad. Your feelings are yours, and just because others don't have the same feeling does not mean that your feeling is wrong.
The world is a very dangerous place. People can be cruel and hurtful. I need to avoid them.	The world is neither dangerous nor supportive. It is neutral. Sometimes we get what we want and sometimes we don't. Sometimes people can be nice, sometimes hurtful. It depends on the situation. Avoiding others or stressful events deprives you of what possible good could come your way. So say to yourself instead, "The world is neutral. It is my job to avoid harm while seeking pleasure. I Deserve as much as is available to me."	You're right. The world can be a dangerous place and your depression and anxiety are results of this danger. No one wants to feel that kind of hurt. I certainly don't. I try to avoid hurt too. But you also feel lonely when you avoid people. It's a balancing act between avoiding hurt yet not feeling alone and afraid. Compromises must be made between being safe and being happy and that is hard for all of us.
I must be bad because I frequently don't get what I want. There is something wrong with me.	Just because you don't get what you want does not mean that you're bad. You may be frustrated, but that doesn't mean that you're bad. It may be the tools and strategies you are using that keep you from accomplishing your goals, and that doesn't mean there is anything fundamentally wrong with you. We just need to improve your tools and strategies. Then you will more frequently accomplish your	I can understand why you feel that there is something wrong with you. Your feelings are so intense and seemingly unending. You try so hard to change what's going on but it hasn't worked yet. Most of us would feel bad given what you've experienced. Blaming yourself hurts though. It adds to your pain rather than relieving it.

	objectives.	
I'll be humiliated in public if others see how vulnerable I feel.	Most people are so self-absorbed that they don't see or even try to see what you are experiencing. They are concerned with themselves. Why try to please people you don't even know? Focus on your own objectives and stop worrying what others think and feel.	You feel vulnerable and concerned about others' judgments of you. Most of us want approval and when we feel vulnerable this need increases. Of course you're anxious. Let's work at decreasing your sense of vulnerability, then others' judgments of you will be less important.
I'm hopeless and I'll never get well	Nobody is hopeless. There is tremendous evidence that depression, phobias, PTSD, BPD, Bipolar disorder, GAD are all curable with the appropriate treatment strategy. There is hope. You can get better. Stick with our treatment plan and look for improvement in small increments	Of course your hope is low. You have been feeling like this for a long time. Most people with this problem feel just like you do. How could you feel any differently? What we will do together is change strategies so that different feelings occur

*(Marra, 2005)

The goal in cognitive behavioral therapy is to change dysfunctional thought processes. The goal in DBT is not simple agreement with the patient but rather assisting the patient to see how their underlying thought process is a natural consequence of their underlying strong emotional arousal. By connecting the thought process to the actual emotional process, the therapist aids the patient to understand their emotion-focused rather than solution-focused strategies. The patient is not wrong in having the thought processes they have as these thoughts are predictable outcomes of strong affect. However they lead to strategies that increase rather than decrease emotional pain. DBT strategies work on changing the cognitive schemas, rather than the use of logic in order to reduce functional outcomes of pain. Validation of emotion and affect allows the patient to accept new ways of coping without increasing underlying feelings of inadequacy.(Marra, 2005)

While the DBT therapist may focus on thoughts that increase emotional pain in their patients, this is not the primary focus of treatment. Dialectic conflict (compromise formations in Freud's language) results in heightened emotional arousal. A primary focus of DBT is assisting the patient to increase emotion management. The major emphasis is on self-management of affect rather than cognitions. Affect self-management can occur through acceptance based technologies such as mindfulness skills or through dialectical analysis.(Marra, 2005)

DBT therapy is thus unlike cognitive or behavioral approaches in that attention to affect is not simply symptom focused but involves recognition of the substantial strain being placed on the patent to form compromised between competing and frequently contradictory demands of the environment and personal wishes and wants.(Marra, 2005)

While cognitive approaches to anxiety emphasize the Socratic Method, an education model, DBT invites the patient to first accept their feelings as real, understandable and valid. Exposure to anxiety precedes any cognitive reframing, as the patient is invited to first experientially challenge the notion

that their anxiety is intolerable. Experiential avoidance and escape is explained to the patient and validation of their emotions precedes any attempt to modify the cause of the emotion. The DBT premise is that avoidance and escape of emotion per se is a more powerful predictor of symptom maintenance than cognitive processes(Marra, 2005)

Anxious patients tend to be self-absorbed with physiological and mental representations of their anxiety. The DBT therapist does not reinforce this perseverative focus on the body by asking the patient to engage in recording of the anxiety experiences. This reinforces the self-absorption. Rather the DBT therapist helps the patient to identify specific areas of physiological arousal within psychotherapy session. Mindfulness of anxiety preceded instruction in relaxation techniques so that the patient first experientially confronts the intolerability of their anxiety. Acceptance precedes change strategies when using a DBT approach to anxiety disorders and validation precedes the acceptance strategies.(Marra, 2005)

Lastly a further differentiation between the two therapies lies within each one's homework demands. As demonstrated previously CBT homework consists largely of identifying and tracking negative thoughts and sequences and replacing them with more positive one. Alternatively DBT homework may focus around the most dialectic statement in any given situation. For example, the following worksheets may be provided for homework following DBT sessions: focusing less on thoughts and more on dialectics and linking behavior and emotional experience.

Chapter 6

Method

Subjects

There are 3 groups of subjects in this study:

1. Five young women with a Bipolar II Diagnosis currently experiencing major depressive episode. These women are the case studies for this thesis. The women selected were aged between 18 and 30 and had been diagnosed with Bipolar Disorder (major Depressive episode). They were referred through GROW[2].

2. Ten young women currently without mental health issues who have in the past had treatment for depression. These women were interviewed regarding their past experiences with therapy. These women responding to an advertisement asking women to engage in an interview regarding their past experiences in the mental health system

3. Ten therapists currently practising treatment of depression who use Cognitive Behavior Therapy in their practice. Contact was made with many therapists and ten willing to complete a survey were found.

Instruments

[2] Grow is a community based support centre that provides group therapy and support for people with mental disorders

The study participants in group 1 initially took a number of psychometric tests which are attached in Appendix 1.

Different scales were used at different times partially because one was therapeutically preferable over the other but also to avoid over familiarization of the client with any one questionnaire.

These are:

The Beck Depression Inventory (Beck II), The Positive and Negative affect Scale (PANAS) (Appendix 2), The Suicide attempt Self Injury Interview (SASII) (Appendix 3), The Subjective Units of Disturbance Scale (SUDS) (Appendix 4), The Mindfulness Attentions Awareness Scale (Appendix 5),The Dysfunctional Attitude Scale (DAS) (Appendix 6), The Leids R (Appendix 7), The Hamilton Rating Scale for Depression (HRSD) (Appendix 8), The Therapist History Inventory (THI) (Appendix 9) and the Suicide Behavior Questionnaire (Appendix 10). At the beginning of each session the therapist completed a Mental Health Assessment form for each client.(Spielberger)

The Beck Depression Inventory

The Beck Depression Inventory was used in this study to assess cognitive-affective, behavioral and somatic symptoms of depression. The participants were instructed to respond to the BDI items by choosing one of four statements of varying severity that "best describes the way you have been feeling the past week including today." Each item is scored on a 4-point rating scale with values ranging from 0 (no depression) to 3 (maximum depression). The 13 items comprising the BDI Cognitive-Affective subscale evaluate sadness, pessimism, guilt feelings, irritability, suicidal thoughts and other affective and cognitive symptoms of depression. The BDI Somatic Performance Subscale consist of 8 items that assess sleep-disturbance, loss of appetite, fatigue, work difficulty, and other somatic and performance decrements. The reliability and validity of BDI scores based on all 21 items have been established for psychiatric and medical patients and normal adults in a number of studies.(Spielberger)

The Positive and Negative affect Scale (PANAS),

The goal in developing this scale was to create reliable and valid measures that were also brief and simple to administer. The primary concern was to select descriptors that were relatively pure markers of either Negative Affect or Positive Affect; that is, terms that had a substantial loading on one factor but a near-zero loading on the other. The positive and negative affect schedule is a 20 item self-report measure of Positive and Negative affect developed by Watson, Clarke and Tellegen (1988b).NA and PA reflect dispositional dimensions, with high NA epitomized by subjective distress and unpleasurable engagement, and low NA by the absence of these feelings. By contract PA represents the extent to which and individual experiences pleasurable engagement with the environment.

The Suicide Attempt Self Injury Interview (SASII)

The Suicide Attempt Self Injury Interview is used to collect details regarding the time, circumstances, motivations and treatment of each Intentional Self Injury (ISI) that a subject can recollect.

Intentional Self Injury (ISI), as measured here, is defined in question S1 of the SASII. The SASII's structure consists of a Dateline, Appendices, Cards and an interview for each ISI episode.

The SASII can either be answered in numerical order (preferred for research) or the interviewer can move freely around within the interview, following subject cues (preferred for clinical use). The phraseology is designed to provide flexibility and aid communication. Data is collected for either a "lifetime" history (as far back as a subject can recall up to the present) or an "interval" history (covering the intervening time between scheduled assessments or some other arbitrary time span determined by the interviewer). Many subjects refer to specific ISI events as "overdose' or "suicide attempt" so terminology reflects their vocabulary. When a question requests that the interviewer record the subject's response "verbatim", it does not imply that the interviewer should not probe the subject for a more detailed answer or clarify the answer. Instead, the interviewer is encouraged to probe, to clarify and to obtain as detailed of an answer as is necessary for making clinical ratings. For each question that requires an interviewer's rating, the interviewer should base the rating on clinical judgment based on the entire interview, not simply on the subject's verbatim response. Generally speaking, text that is to be read to the subject is in upper and lower case letters, while instructions to the interviewer or coder are in capital letters. Directions to use "-8" often appear in the interview instructions. "-8" is a code for "Not Applicable." Vocabulary: An "episode" is the word used to describe a "single event or act" or to describe a "cluster." A "cluster" is a group of "single events/acts." "clusters." "Cards" refer to attached lists that should be given to the subject according to instructions in the interview

The Subjective Units of Distress Scale (SUDS),

A Subjective Units of Distress Scale (SUDS - also called a Subjective Units of Disturbance Scale) is a scale of 0 to 10 for measuring the subjective intensity of disturbance or distress currently experienced by an individual. The individual self-assesses where they are on the scale. The SUDS may be used as a benchmark for a professional or observer to evaluate the progress of treatment. In desensitization-based therapies, such as those listed below, the patients' regular self-assessments enable them to guide the clinician repeatedly as part of the therapeutic dialogue.

The SUD-level was developed by Joseph Wolpe in 1969. It has been used in EMDR, Trauma-Focused Therapy (TFT), EFT, Anxiety Disorders and for research purposes.

The Mindfulness Attentions Awareness Scale (MAAS)

The MAAS s a 15 item scale designed to assess a core characteristic of dispositional mindfulness, namely open or receptive awareness of and attention to what is taking place in the present. The scale shows strong psychometric properties and has been validated with college, community and cancer patient samples. Correlational quasi-experimental and laboratory studies have shown that the MAAS taps a unique quality of consciousness that is related to and predictive of a variety of self-regulation and well-being constructs.

The Dysfunctional Attitude Scale (DAS)

The Dysfunctional Attitudes Scale (DAS – Weissman, 1979; Weissman& Beck, 1978) is a self-report instrument for assessing attitudes associated with depressive symptoms. Originally a 100-item scale, it was later transformed into two 40-item parallel forms (DAS-A and DAS-B).

Using a group of 2,023 psychiatric outpatients diagnosed mainly with affective and anxiety disorders (less than 1.0% were diagnosed with a psychotic disorder), Beck, Brown, Steer and Weissman (1991) examined the factor structure of the original 100-item DAS and found that 66 of the 80 items retained loaded on nine first-order factors. The factors reflected themes of vulnerability, approval, perfectionism, need to please others, imperatives, need to impress others, avoidance of weakness, control over emotions, and disapproval. The factor solution was stable on cross-validation and invariant with respect to gender.

Factor analyses performed on the two 40-item parallel forms revealed different structures, for different target populations. For example, Cane, Olinger, Gotlib and Kuiper (1986) factor analyzed form A of DAS using a non-clinical group of 664 students and found just two factors, which they named "performance evaluation" and "approval by others". A year earlier, in 1985, Oliver and Baumgart have administered both forms of DAS (A and B) to a group of 275 persons formed by hospital workers and their spouses and found a lack of factorial equivalence between the two forms. In 1984, Parker, Bradshaw and Blignault had administered DAS-A and DAS-B to two samples of Australian general practice patients (*N* = 117 and 126) and found four factors, which they named "*Externalized Self-Esteem", "Anaclictic Self-Esteem", "Tentativeness",* and "*Need for Approval". Results obtained with samples of older adults indicate* the *factor structure established with younger adults does not replicate with this age group. Moreover,* the factor structure with older adults seems to be uncertain: a single factor structure, two-factor structure, and three-factor structure are essentially of equal validity *(*Floyd, Scogin, & Chaplin, 2004*).*

While the factor structure of DAS-A and DAS-B remains uncertain, pending future investigation, reliability coefficients (Alpha Cronbach = .89) are good (Weissman & Beck, 1978), as well as the correlation between the two forms (r=.81).

All things considered, DAS-A is one of the most efficient instruments for measuring the cognitive distortions associated with clinical depression.

Design

Designs are transformative in that they offer opportunities for trans-configuring the dialogue across ideological differences and, thus, have the potential to restructure the evaluation context. Diverse methods most importantly serve to include a broader set of interests in the resulting knowledge claims and to strengthen the likely effectiveness of action solutions.(John W. Creswell)

Mixed method design is fast becoming a well-used and recognized form of research methodology especially in the areas of social sciences. The benefits of this methodology include the ability to interpret and analyze data either generally or specifically (quantitative research) whilst also having the flexibility to perform some in depth study and investigation into individual cases with specific outcomes (qualitative).

Mixed method design can involve any number of combinations of assorted methods of investigation, data, outcome derision and response analysis and they can occur in varying orders.
The commonality across transformative studies is ideological such that no matter what the domain of inquiry, the ultimate goal of the study is to advocate for change.

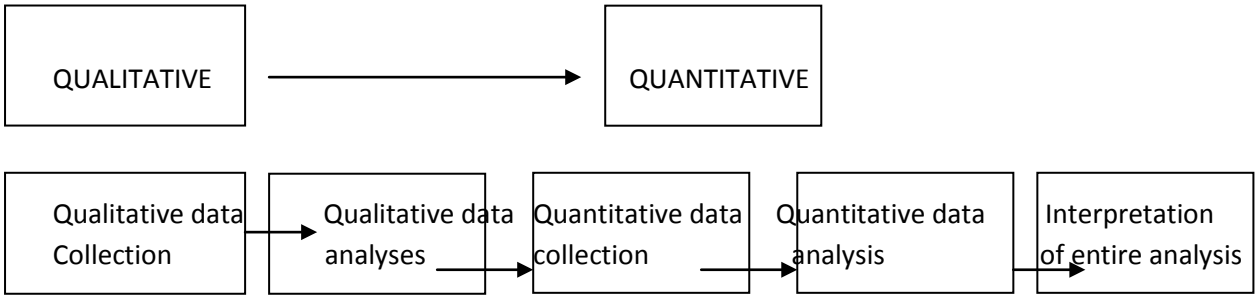
Transformative designs are found in evaluative research as well as in health care. To illustrate how this design might work, a researcher might examine the inequity that exists in an organization's salary structure that marginalizes women in the organization. The issue of inequity frames the study, and the inquirer proceeds to first gather survey data measuring equity issues in the organization. This initial quantitative phase in which several in-depth case studies are developed to explore in more detail the quantitative results.(John W. Creswell)

There are 6 major mixed method designs
1. Sequential Explanatory
2. Sequential Exploratory
3. Sequential Transformative
4. Concurrent triangulation
5. Concurrent Rested
6. Concurrent Transformative

Sequential Explanatory Design

The sequential explanatory design is the most straightforward of the six major mixed method designs. It is characterized by the collection and analysis of quantitative data followed by the collection and analysis of qualitative data. Priority is typically given to the quantitative data and the two methods are integrated during the interpretation phase of the study.(John W. Creswell)

This design can be reported in two distinct phases with a final discussion that brings the results together.(Creswel J W, 2003)



(Creswel J W, 2003)p180

A multiple case, multiple therapy session design was used to evaluate individual responses to different types of therapy. The methodology involves a multiple base line design enabling the comparison of behaviors and responses to the two different types of therapy to determine which enabled more positive responses in each case. The experimental investigation lies within approach to each individual subject. (Cooper, 1987)

In both qualitative and quantitative research multiple case study designs have achieved much recognition in a variety of fields such as: clinical psychology, special education, social work and research into communication disorders.

In order to completely assess the impact and efficacy of a treatment, determining via self-report what aspects of the treatment clients find appealing or helps them stay engaged becomes as relevant as treatment outcomes explaining how a treatment works or what was changed, especially as it related to working with difficult to treat clients. The intent of this research is to explore individuals' ratings of the appeal and efficacy of their primary treatment course in an effort to develop a deeper understanding of its operating components and to both assess and enhance the value of DBT as a treatment.(Weitzman, 2004)

The author collected "Mixed" forms of data including quantitative survey data and qualitative open-ended interview data.((John W. Creswell)

The interviews permitted the ability to look for emerging themes from both the survey and from previous interview data, which would then be explored in more depth in subsequent interviews.(John W. Creswell)

Mixing quantitative and qualitative research in this study makes it a mixed methods research report. More specifically with information from recent literature on mixed methods design used by Hosler and Vesper (1993) it could more specifically be described as what is talked about in their study as being a "concurrent triangulation method design" indicating a triangulation of data collecting, separate data analysis and the integration of databases at the interpretation or discussion stage of the report. Furthermore their concurrent triangulation method design gave priority to quantitative research as does this one.

It is advisable to conduct the qualitative research prior to the quantitative research for a number of reasons.

Qualitative research is about exploring. The results are not numbers or "yes" or "no" but rather gain insight about needs wants goals aspirations etc. Qualitative measures provide the "why" and "how" questions you need answered before the right quantitative questions can be formulated.

Because all methods of data collection have limitations, the use of multiple methods can neutralize or cancel out some of the disadvantages of certain methods. (e.g. the detail of qualitative data can provide insights not available through general quantitative surveys)

A mixed method study involves the collection or analysis of both quantitative and/or qualitative data in a single study in which the data are collected concurrently or sequentially, are given a priority, and involve the integration of the data at one or more stages in the process of research.(John W. Creswell)

When qualitative data collection precedes quantitative data collection the intent is to first explore the problem under study and then follow up on this exploration with quantitative data that are amenable to studying a large sample so that results might be inferred to a population.(John W. Creswell)

The implementation decision also calls for clearly identifying the core reasons for collecting both forms of data in the first place and understanding the important inter-relationship between the quantitative and qualitative phases in data collection. These reasons need to be clearly articulated in any mixed method report.(John W. Creswell)

The design used in this study is a mixed method design involving the use of a survey. A survey with fixed questions was distributed to a number of professionals practising specifically in the area of providing services to clients within the specified age bracket and with a bipolar disorder major depressive episode) diagnosis. The survey (Appendix 11) contains questions, the outcome of which would provide both qualitative and quantitative data. The quantitative data consists of very limited specific data that is collected by the survey. The data that could be interpreted as quantitative data is data ascertained in response to questions such as the first question. However as stated in the limitations section, the data is limited in its application. Whilst it is desirable to attempt to draw formulaic conclusions from the responses to these questions i.e. no professionals expressed a tendency towards using CBT as a principal method in treating clients, given the limited number of participants and the qualitative nature of the following and inherently linked responses to subsequent questions the quantitative quality of the data is low. The qualitative nature of the responses to the subsequent questions linked to the initial question in the survey is what carries substance and weight in assessing the efficacy and utility of the different therapies in practice. So whilst the design is a mixed design that does entail both qualitative and quantitative measures in the methodology, it is largely the qualitative data that allows for meaningful and veritable understanding and appreciation of the differing methods employed by professionals in dealing with bipolar clients in the relevant age group.

Another qualitative aspect of the research includes responses to short interview questions conducted with subjects who had previous exposure to mental health systems. These subjects, like the previous needed to be female and between the age of 21-28 and needed to have been hospitalized for bipolar depression at least once in their life time. The manuscript of questions asked can be found in (Appendix 12).

The questions involved were about the types of therapy they had been treated with over their time of exposure to the mental health system. It was initially thought that if the subjects were not familiar with the types of therapies they had been exposed to, that the therapist could deduce the type/s from their recall and description of questions they had been asked and the activities they were asked to perform. However, as it turned out, all the subjects had been informed of or otherwise had come to know the types of therapies that had been employed during their treatment.

The interviews were conducted with the purpose of discovering which of the techniques they were exposed to were considered more effective or helpful.

The current study is a mixed transformative design using both quantitative and qualitative data to advocate for change in practice the change being implementation of DBT across a broader range of settings and more specifically in bipolar disorder (major depressive episode) patient.

In this study the quantitative data consists of the surveys conducted by counselors or psychologist in order to determine how often CBT is used in practice, whether it is effective for that particular practitioner or what alternatives they use if CBT is not employed at all.

The qualitative data in this study consists of 5 case studies of patients experiencing bipolar disorder (major depressive episode) and 10 interviews conducted with people who have had previous experiences within the mental health system.

The principle methodology of this study was qualitative with a strong quantitative complement. Patient data garnered from a study involving multiple case studies over a 1 year period was used to identify the efficacy of both CBT and DBT in practice in clients with bipolar depressions. Additional insight into the efficacy of each treatment was garnered by interviews with a sample of ex-patients and their experiences with the mental health system for their depressive episode. Interviews were used both to explore emerging themes in greater detail and to triangulate findings.

Components of data collection

A total of 5 case studies were conducted. All participants completed 10 – 12 sessions over a 6 month period. Development of the CBT and DBT methods used in the patient sessions was left to the therapist only and the different techniques were not described as being techniques used more frequently in either therapy in order not to bias clients who may have had a pre-existing like or dislike for one or the other types of therapy. The 5 cases were given the Beck Inventory, SUDS scale test and the Mindfulness Attention Awareness Scale, test at the beginning of each session to monitor their progression over the week or fortnight. Their results are tabulated further on.

As stated previously, at different times it was beneficial to ask the clients to undertake other psychometric tests such as SASII, DAS and PANAS which were used when needed but more to ensure the safety of the clients and the adequacy of their care, rather than to contribute to the final results.

The clients were also asked to evaluate their homework activities each week. Clients were asked to rate their homework on a scale of 1 to 5: with 1 being not at all helpful, 2 being slightly helpful, 3 being adequately helpful, 4 being very helpful and five being extremely helpful. If any of the clients did not undertake the homework at all they were asked to give an explanation as to why for example, too busy, didn't understand, forgot, didn't like I, too hard etc… These results are represented in the results section.

A total of 10 therapists were surveyed regarding the uses of particular types of therapy in their practices.

A total of 10 ex-patients with previous involvement with mental health care due to depressive episodes were surveyed regarding what techniques they found particularly helpful or unhelpful.

Data Analysis

Qualitative data were analyzed via thematic analysis, with data being unitized and categorized. Quantitative data were statistically analyzed via logistic regression with significant discussion of coding of independent and dependent variables.

Discussion and Inferences

Both quantitative and qualitative results are discussed jointly in the discussion section. Significant factors identified by the case studies were corroborated with the theme that had emerged from the logistic regression.

Triangulating the results from the case studies and the surveys has allowed for the positing of more broad and extensive uses of the techniques specific to DBT in practice.(Creswel J W, 2003)p180

In order to determine any solid conclusions based on the information and efficacy of the therapy sessions of the case studies participants, it is necessary to further explore the opinions of practising professionals in the field thus enabling not only a comparison between therapeutic methodologies but also to make a determination on the basis of experiences of professionals and their success rates during their practice of differing therapies and their perception of the utility of both methods

Participants

Women with a Diagnosis of Bipolar Disorder II experiencing major depressive episode aged between 18 – 30 years residing within a 40km circles centered in Brisbane who were referred by a psychologist or psychiatrist and were willing to sign an agreement expressing the commitment to attend 10 – 12 sessions of treatment were considered for recruitment.

The exclusion criteria were a DSMIV diagnosis of Borderline Personality Disorder or chronic psychotic disorder, insufficient command of the English language and/or severe cognitive impairment.

The diagnosis of Bipolar has to have been previously established in prior psychiatric treatment as did the diagnosis of current major depressive episode. However the major depressive episode was re-established in the pre-clinical trial interview by the use of the Beck Inventory. Whilst the participants were not required to have shown recent para-suicidal behavior, recent suicidal ideation was required and also needed to be established by the Beck inventory in the pre-trial interview and also established in prior treatment with psychiatric professionals.

Throughout the psychological community, chronic and persistently mentally ill clients are one of the most difficult to treat effectively in regard to creating both significant and lasting behavior changes. For the purposes of this research individuals were chosen if they had at least three of the following criteria:

1. multiple mental health diagnoses (bipolar depression being one)
2. the use of prescribed psychiatric medications
3. coping skills deficits manifested as emotional or behavioral dysregulation (e.g. substance abuse, increased suicidal thoughts, acts or gestures, self-harming behaviors, hyper sexuality, ongoing legal or financial problems and engaging in aggressive or violent behaviors)
4. social skill deficits, interpersonal difficulties and/or a general lack of social support
5. a history of multiple treatment episodes
6. increased community services involvement including emergency room visits, calls to 000, day treatment admittance and/or involvement with intensive case management.(Weitzman, 2004)

The structured clinical interviews for Axis and Axis II DSM IV and the Beck Inventory along with the Subjective Units of Disturbance Scale were employed. The Dysfunctional Attitude Scale was also used as the initial screening and diagnostic instruments.

Confounding by Medication

Medication use was monitored at weeks 2 and 11. The greater improvement with dialectical behavioral therapy techniques cannot be explained by the use of medication as at all times both in prior interviews and during treatments, ¾ of the patients reported use of medication from one or more of the following categories: Benzodiazepines, selective serotonin reuptake inhibitors, mood stabilizers and neuroleptics. No changes to medication or dosage were made during treatment and no changes had been made in the 3 months prior to the study treatment.

Sarah

Sarah is a 32 year old woman living in a defacto relationship with no children. She was first diagnosed with Bipolar Disorder and was receiving treatment for depression at the time of joining the study

Paula

Paula is a 22 year old Tafe student who is single and has only recently been diagnosed as experiencing Bipolar Disorder. Previously she had been diagnosed and treated for major depressive disorder.

Georgia

Georgia is a 27 year old single mum of one boy, who lives with her parents. She was first diagnosed as having Bipolar Disorder in her teens. Her condition was exacerbated following the birth of her child – it manifested in post-natal depression which ultimately led to her marriage breakdown, she is currently being treated for Major Depressive Disorder.

Amy

Amy is a 23 year old university student who has currently had to defer her studies due to her depression. Her diagnosis occurred 2 years prior.

Carly

Carly is a 29 year old single person who has just recently returned to live with her mother as she lost a job due to her depression and can no longer afford to live in an apartment on her own. Carly was first diagnosed with bipolar Disorder when she was 21.

The Therapists

Therapists whose practice was identified as being with a 40km distance of Brisbane and who advertised their practice as dealing with depression specifically with Cognitive Behavior Therapy listed as one of their practices were approached for inclusion in the study.

Therapist 1

Gender	Female
Age	44
Profession	Psychologist
Years in Mental Health	15
Place of Work	Mermaid Beach
Specialization	Anxiety, depression, family therapy

Therapist 2

Gender	Female
Age	34
Profession	Psychologist
Years in Mental Health	7
Place of Work	Brisbane
Specialization	Anxiety, depression, cross-cultural psychology

Therapist 3

Gender	Male
Age	49
Profession	Psychologist
Years in Mental Health	20
Place of Work	Noosa Heads
Specialization	Anxiety, depression, separation and divorce

Therapist 4

Gender	Female
Age	51
Profession	Psychologist
Years in Mental Health	24
Place of Work	Cairns
Specialization	Anxiety, depression, grief and loss

Therapist 5

Gender	Male
Age	45
Profession	Counselor
Years in Mental Health	14
Place of Work	Brisbane
Specialization	Anxiety, depression, eating disorders

Therapist 6

Gender	Male
Age	31
Profession	Counselor
Years in Mental Health	5
Place of Work	Clear Island Waters
Specialization	Anxiety, depression, stress management

Therapist 7

Gender	Female
Age	37
Profession	Psychologist
Years in Mental Health	7
Place of Work	Nambour
Specialization	Anxiety, depression, eating disorders

Therapist 8

Gender	Male
Age	39
Profession	Psychologist
Years in Mental Health	10
Place of Work	Brisbane
Specialization	Anxiety, depression, trauma counseling

Therapist 9

Gender	Female
Age	45
Profession	Psychologist
Years in Mental Health	8
Place of Work	Brisbane
Specialization	Anxiety, depression, separation and divorce

Therapist 10

Gender	Female
Age	46
Profession	Psychologist
Years in Mental Health	12
Place of Work	Indooroopilly
Specialization	Anxiety, depression, adult survivors of abuse

The Surveyees

Women with an historical diagnosis of major depressive episode aged between 18 – 30 years residing within a 40km circle centered in Brisbane who responded to an advertisement placed at one of 3 universities (Griffith University, Queensland University of Technology and University of Queensland) and at the Grow Centre at Holland Park and were willing to complete a survey relating to their past experiences with depression and their previous therapy sessions , were considered for recruitment.

Surveyee 1

Gender	Female
Age	26
Profession	HR
Time since last depression	2.5 years

Surveyee 2

Gender	Female
Age	27
Profession	Education
Time since last depression	10 years

Surveyee 3

Gender	Female
Age	30
Profession	Retail
Time since last depression	9 years

Surveyee 4

Gender	Female
Age	33
Profession	Unemployed
Time since last depression	Less than 1 year

Surveyee 5

Gender	Female
Age	23
Profession	student

Time since last depression	1.5 years

Surveyee 6

Gender	Female
Age	29
Profession	Administration
Time since last depression	2 years

Surveyee 7

Gender	Female
Age	25
Profession	unemployed
Time since last depression	1 year

Surveyee 8

Gender	Female
Age	30
Profession	Child care
Time since last depression	4 years

Surveyee 9

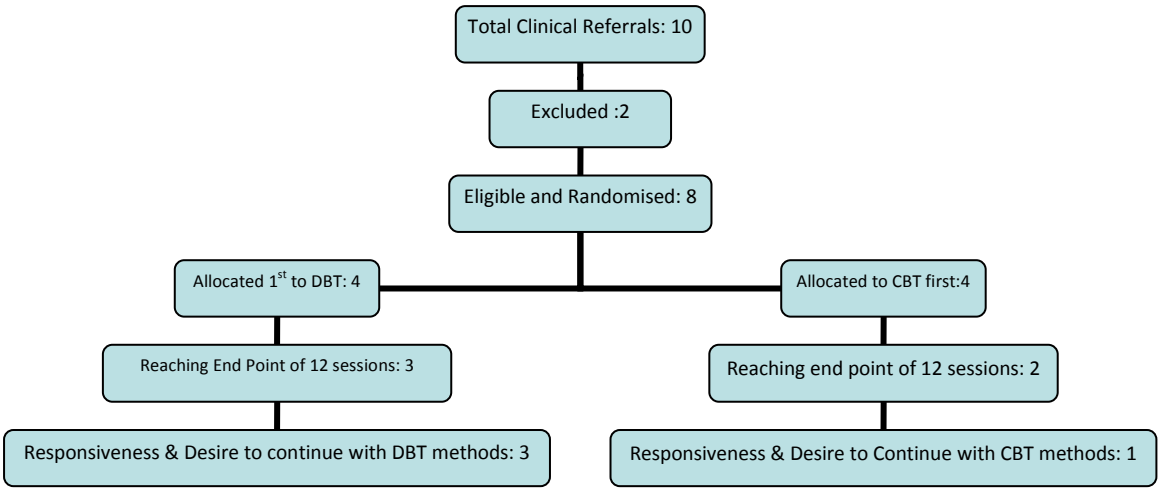
Gender	Female
Age	26
Profession	HR
Time since last depression	2.5 years

Surveyee 10

Gender	Female
Age	26
Profession	unemployed
Time since last depression	2.years

Setting and Material

The following is a diagrammatical representation of the recruitment processes involve in the selection of those suitable for case studies.



Once selected then orientation took place.

During the baseline case study period, all participants took part in a one-hour orientation interview conducted by the therapist. During this orientation, each participant read and signed a consent form which included a description of the research purpose and design. (Appendix 13). Each participant was also required to complete the BDI-II. This was administered to identify depression levels and to serve as the first baseline measure.

As this is a staggered design, the therapist checked in weekly with each of the participants before his or her initial treatment phase, to assess for crisis and to ensure continued compliance and participation with the study. This was done via the phone and also in person. The therapist was also available to participants throughout the study to answer questions about the study. Participants were not allowed to be in concurrent treatment while waiting for their treatment phase to begin.(Chew, 2006)

CBT Treatment Conditions

The treatment conditions involved the administration of a progression of cognitive behavioral therapy techniques designed to focus on thought identification and regulation. The first 3 sessions involved the introduction of the thought changing process and an exploration about how clients can with the appropriate skills bring into their conscious whatever negative thoughts are harbored in order to be able to deal with the using CBT. The following 3 sessions were more about follow-up rather than explanation. The sessions become client directed as the client is asked to demonstrate their understanding and the use of their CBT techniques in real life situations and report on their experiences. All sessions included the administration of the BDI-II at the beginning of each session.

DBT Treatment Conditions

The treatment condition involved the administration of two of the four modules of DBT. These modules were entitled Mindfulness Training, and Distress Tolerance Training (Linehan, 2001). Each module had three to five paradigms, designed to be implemented on a weekly basis. All sessions included the administration of the BDI-II at the beginning of each session and using the appropriate intervention of Distress Tolerance Training. The treatment interventions were used in a typical individual therapy format, with the first part of the hour being focused on the homework and the new information for that week and the second part of the hour being designated as time for the client to process issues, discuss challenges and to process ways in which to apply DBT to each participant's life issues.

The use of self-report measures in examining clients' usefulness and satisfaction ratings with their therapy is an important part of this study.

This research investigated clients as they self-report the appeal and efficacy of their first group of first therapy session (CBT model) and the second therapy sessions (DBT model). In an attempt to avoid risking that clients found the 2nd group of therapy more satisfying only because this was a natural course of progression after having received CBT primarily, the order was switched for half the clients so that half of them received the DBT sessions first and the other half, the CBT.

The following hypothesis was proposed:

H: Clients would identify as being more satisfied with the DBT treatment sessions than their experiences with CBT both in regards to appeal as well as efficacy

Procedure

The Suicide Attempt and Self Injury Interview measures the typography, suicide intent and medical severity of each suicide attempt and non-suicidal self-injury. The Suicidal Behaviors questionnaire was used to discover the client's scores both before and after treatment (and at various times during the treatment if it was deemed appropriate).

The Treatment History Interview measured each subject's experience with professional psychotherapy, comprehensive treatment programs, case management programs, inpatient units, emergency treatment and other crises services and medication use. The Hamilton Rating Scale for Depression was used to evaluate the severity of depressive symptoms.(M.M. Linehan)

The patients chosen were assigned to 6 sessions of treatment of each type. That is:

Six sessions based on the principles used in therapy relating specifically to cognitive behavioral methods; and 6 sessions of therapy centering on Dialectical Behavior techniques.

The patients were not informed about the type of therapy they would be receiving. They simply understood that they would attend sessions with a frequency of between once a week and once a fortnight, until the completion of 12 sessions.

CBT Procedure

As a clinically derived self-report measure, the Beck Depression Inventory which consists of 21 items assesses cognitive affective, motivational and physiological symptoms of depression. The total BDI score indicates the number of symptoms categories endorsed along with the severity of those particular symptoms.(Hodgson, 1994)

The therapist should be as clear and specific as possible when giving the assignment. It is preferable to say "write down 10 – 20 automatic negative thoughts", than “just record some of your negative thoughts”.

The Daily Record of Dysfunctional thoughts is an integral part of cognitive therapy. Initially patients are asked to complete the first 3 columns of the record. Situations that precede unpleasant emotions are recorded along with the emotions and the automatic thoughts. This assignment helps the patient learn to self-monitor affect changes, learn to correctly label emotions and learn to recognize automatic thoughts and their relations to emotions.

In an attempt to teach clients to identify and their automatic dysfunctional thoughts, various CBT techniques are employed. The following is an example of how CBT might be used in session.

Example

Therapist: I'd like to have you count on a wrist counter the number of times you say "should" to yourself this week. What do you think of the idea?

Patient: It sounds a little stupid to me. Why would I want to do that?

Therapist: We've found that counting automatic thoughts makes one more aware of them and thus easier to answer. Also, merely counting tends to decrease their influence. (The therapist might also say, "Recording helps put distance between yourself and your thoughts, and gives you feedback and evaluation in changing thoughts.")

Patient: I don’t think this will work for me.

Therapist: I'm glad you are questioning me. This shows that you are using your reasoning powers. There is no reason you should automatically believe something just because I say it. I'm not positive this will work in your case, but I have a hunch – or a hypothesis, to give is a scientific sound – that it will work. I'd like to test this hypothesis out.

Patient: What do you mean "test your hypothesis?”

Therapist: I have a hypothesis that it will help you and you have a hypothesis that it won't work. I don’t know for sure who is right. Do you?

Patient: No I don’t

Therapist: I suggest we run an experiment for a week, gather some data, and see which point of view conforms more closely to the facts. How does that sound to you?

Clients, for homework are asked to identify negative thoughts as they come to mind and keep a record of when the thought occurred and how it made clients feel. The following session then looks at

these automatic thoughts – identifying where they might have come from and testing evidence to see whether or not the thought can be substituted by a newer and healthier one.

DBT Procedure

As previously stated, 2 modules of DBT training were used in this study. The first module (weeks 1 – 3) was Core Mindfulness. These skills are psychological and behavioral versions of meditation practices from Eastern spiritual training. The focus of this training was to present the participant with the idea of three states of minds: "reasonable mind," emotional mind," and "wise mind" (Linehan, 1993). "Wise mind" is the combination of both the "reasonable mind" and the "emotional mind" and is essentially the state of "mindfulness." The goal was to develop a lifestyle of participating with awareness. Participants were instructed in this practice, and during this three week module they participated in a variety of educational and practical skills. The practical skills included encouragement to reflect about their "wise mind" by doing some basic meditation practices such as deep breathing and relaxation. Participants were also instructed to be more aware of themselves and their environment by noticing thoughts, feelings and behaviors without judgment or application of "good" and "bad" labels.(Chew, 2006)

The second phase or module (sessions 4 – 6) of treatment, Distress Tolerance Skills, was implemented after the introduction and practice of Core Mindfulness Skills. The essential goal of this module was for participants to be able to tolerate and accept distress as an essential mental health goal. There are 2 primary reasons for this:

1. pain and distress are a part of life, and
2. distress tolerance therefore is essential to being able to overcome and attempt change with oneself (Linehan, 1993).

Distress Tolerance Skills are a natural follow-up to Mindfulness Skills as they stress ability to accept, in a non-judgmental way, both oneself and one's situation as it is without labeling. This module targets tolerating and surviving crises, along with accepting life as it is at the moment. Participants were taught this skill by the use of "distracting," "self-soothing," "improving the moment,' and "thinking of the pros and cons of situations. Homework was also assigned between each weekly meeting to further participants' skills in tolerance. Homework was in the form of relaxation and meditation and continued awareness of self and the environment.(Chew, 2006)

Chapter 7

Results

This chapter will report the results of a study of the effects of Dialectical Behavior Therapy on participant's levels of depression symptoms. DBT was the independent variable and depression symptoms served as the dependent variable. Each participant completed the Beck Depression inventory II (Beck, 1979) on a weekly basis across both DBT and CBT treatment conditions. The following statements and conclusions regarding the effect of the DBT treatment on depression symptoms versus CBT treatment were based on visual analysis of the weekly recorded BDI-II scores.(Chew, 2006)

A randomized trial was conducted to evaluate whether dialectical behavior therapy (DBT) a treatment that synthesizes a behavioral change with radical acceptance strategies would be more effective for bipolar women with major depressive disorder than Cognitive Behavioral therapy, a manualized approach that provided the major acceptance based strategies used in DBT in combination with mindfulness based techniques. Treatment lasted for 6 months. First results indicate that DBT treatment conditions were effective in reducing the problematic symptoms associated with major depressive disorder episodes.

Data obtained by the Beck Depression Inventory and the Daily Record of Dysfunctional Thoughts suggest that in the treatment of women with Bipolar Disorder (major depressive episode), DBT is more effective than treatment-as-usual for reducing the frequency and medical severity of suicidal ideation, ideation and attempts at self-injury, treatment drop-out, social adjustment ratings, and self-reported anger.

Figures 1a, 1b, 1c, 1d and 1e are visual representations of each participant's weekly scores for the 6 weeks of CBT treatment.

Figures 2a, 2b, 2c, 2d and 2e are visual representations of each participant's weekly scored for the 6 weeks of DBT treatment.

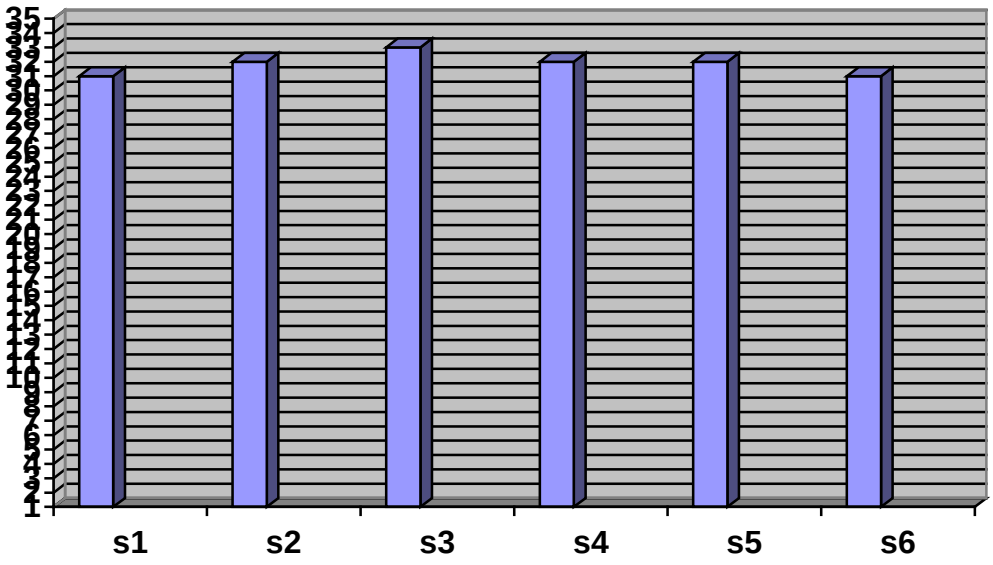
Figures 3a, 3b, 3c, 3d and 3e are visual representations comparing the scores for both therapies for each participant.

Pseudonyms were used to protect confidentiality and identity of each participant.

CBT sessions

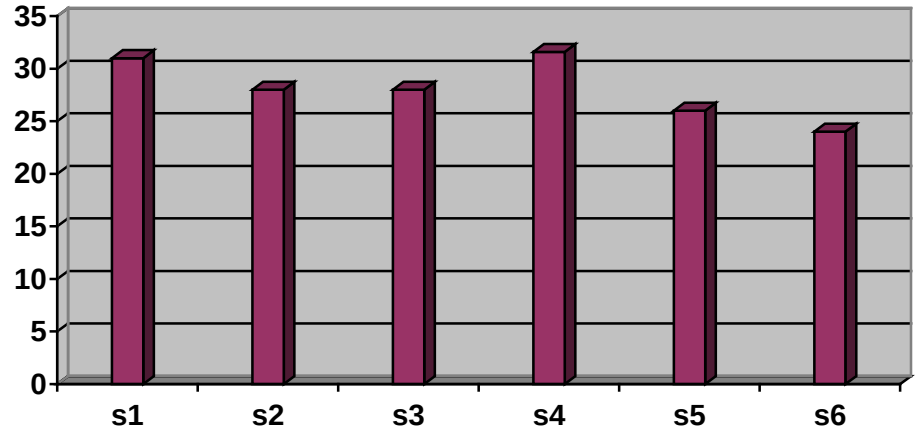
Sarah. As shown in table 1a, Sarah's weekly depression level during CBT treatments was in the severe range (M= 31.2) across the time period of 6 weeks. At the onset of treatment she showed a marked increase in symptoms (following sessions 1 and 2). For session 3 and 4 the scores stabilized and at the end of session 6 her symptoms were the same as they were at onset.

1a Cognitive **Behavior therapy sessions** (x = session y = beck scores)



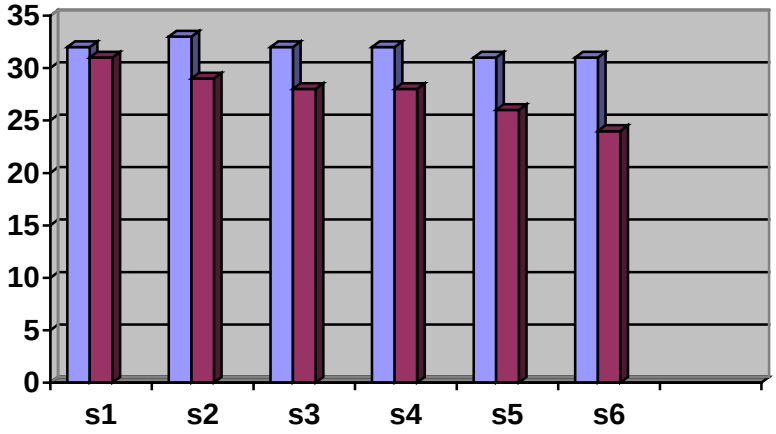
As shown in table 2a, her initial depression level was severe (31.2). However she did evidence a decrease in symptoms immediately at the onset of treatment. Following session 1 she showed a marked decrease in symptoms from a high score of 31.2 to a less severe score of 28. From sessions 2&3 Sarah's score stabilized at 28 and then in weeks 4 – 6 her score further dropped to her lowest score of 24.

2A **Dialectical Behavioral Therapy sessions (**x = session y = beck scores)



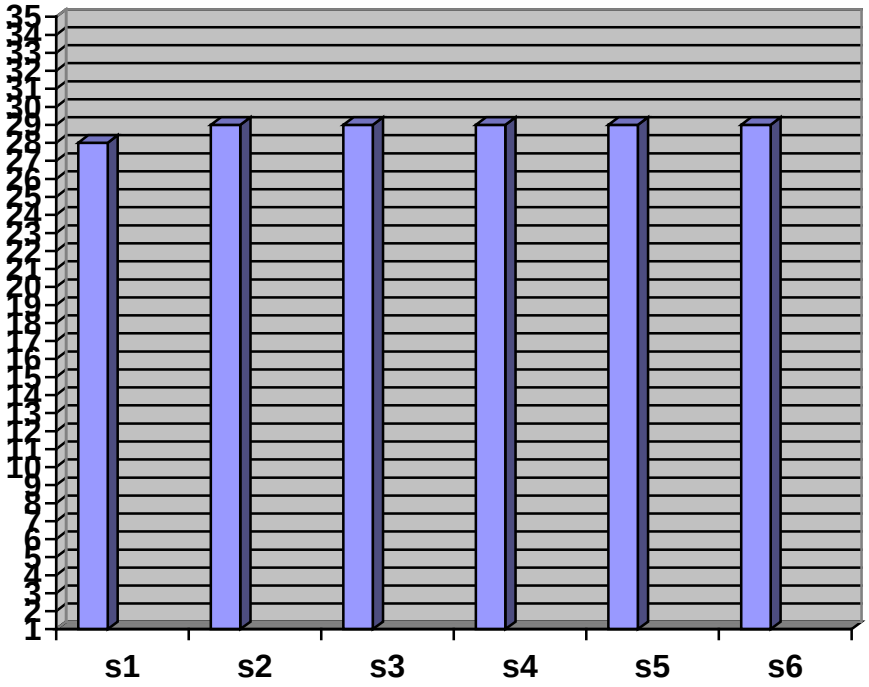
The following is a graph comparing the scores for each type of therapy.

3A **CBT and DBT sessions compared (x=session y=Beck score)**



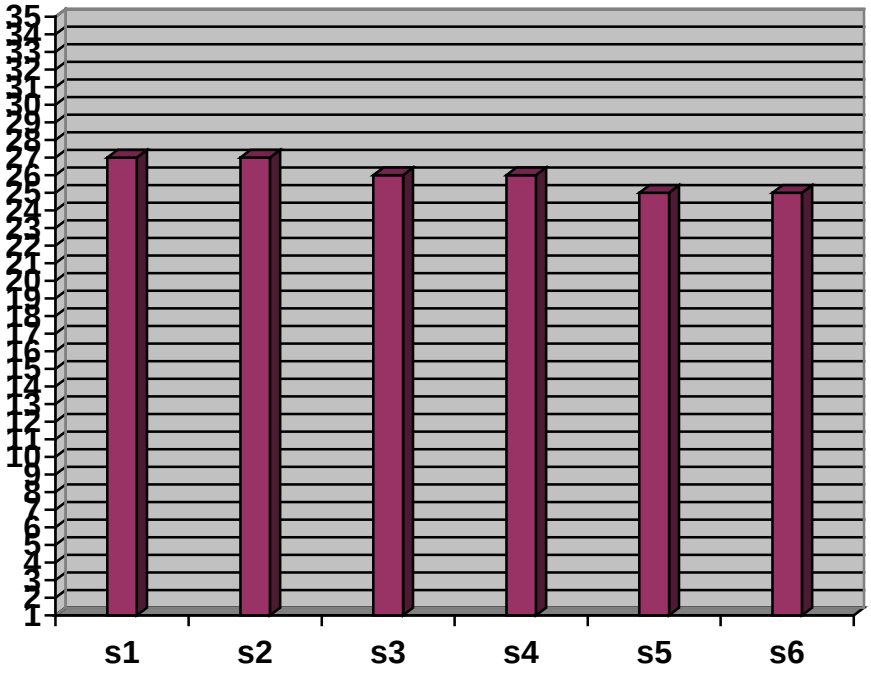
Carly. Carly's depression levels prior to treatment were just in the severe range (M= 29). On the first day of CBT treatment Carly's scores increased. From the 2 session through to the 6th session Carly's score stabilized at 29. Therefore no decrease in depressions symptoms was established.

1B Cognitive Behavior therapy sessions (x = session y = beck scores)



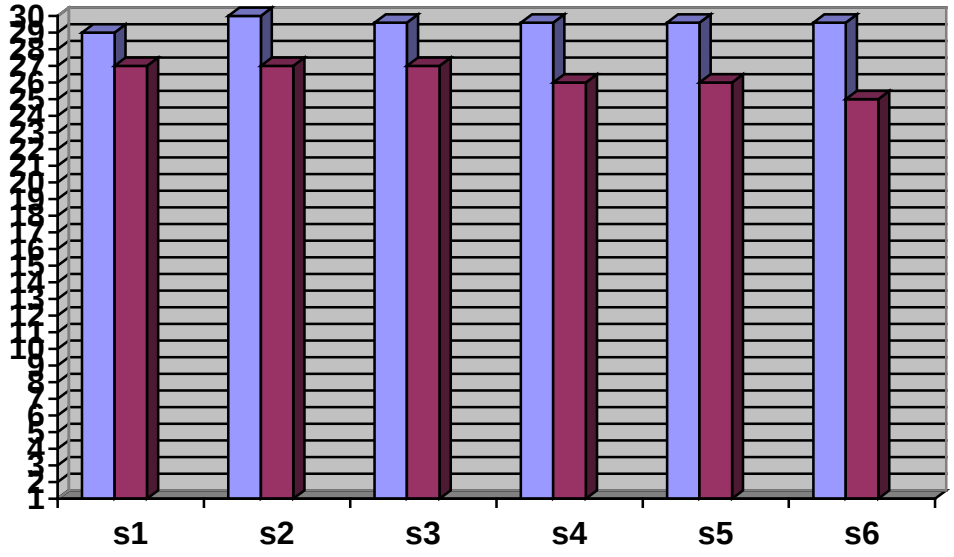
On the first day of DBT Treatment, Carly's depression symptoms slightly decreased to 27. From the beginning of DBT treatment though to week 5, Carly's self-reported weekly scores of depression symptoms continually decreased. At week six her BDI-II score had dropped to 25.

2B Dialectical Behavioral Therapy sessions (x = session y = beck scores)



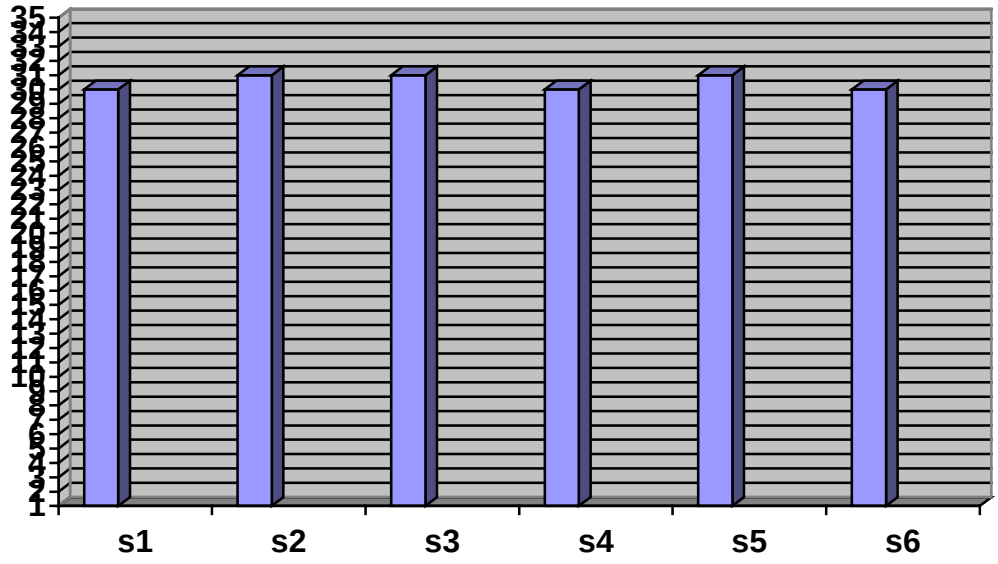
The following is a graph that compares the scores for each type of therapy.

3B CBT and DBT sessions compared (x=session y=Beck score)



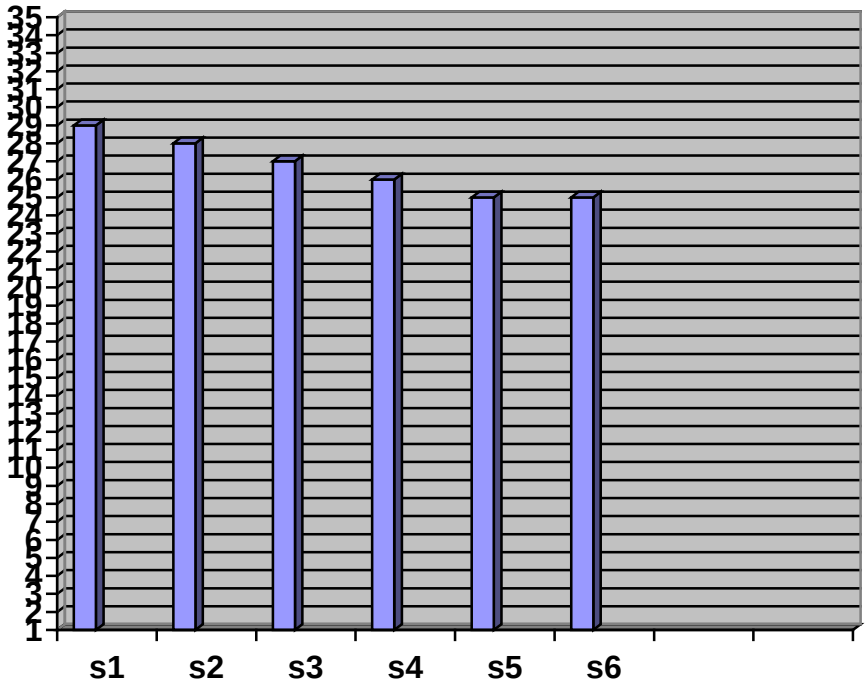
Amy. Amy's depression levels prior to treatment were just in the severe range (M= 30). On the first day of CBT treatment Amy's scores increased. From the 2nd session through to the 6th session Amy's score stabilized at 31. Therefore no decrease in depression symptoms was established.

1C Cognitive Behavior therapy sessions (x = session y = beck scores)



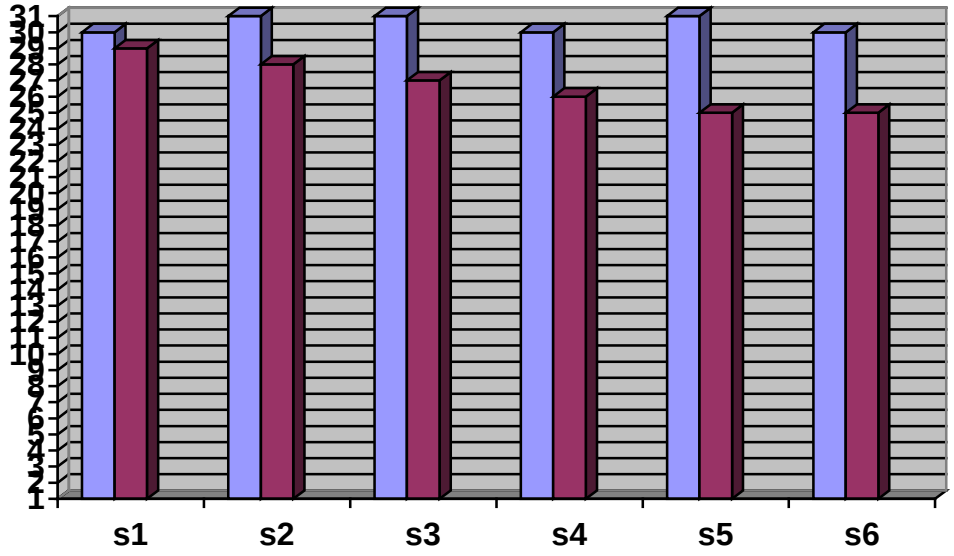
On the first day of DBT Treatment, Amy's depression symptoms slightly decreased to 28. From the beginning of DBT treatment though to week 5, Amy's self-reported weekly scores of depression symptoms continually decreased. At week six her BDI-II score had dropped to 25.

2C Dialectical Behavioral Therapy sessions (x = session y = beck scores)



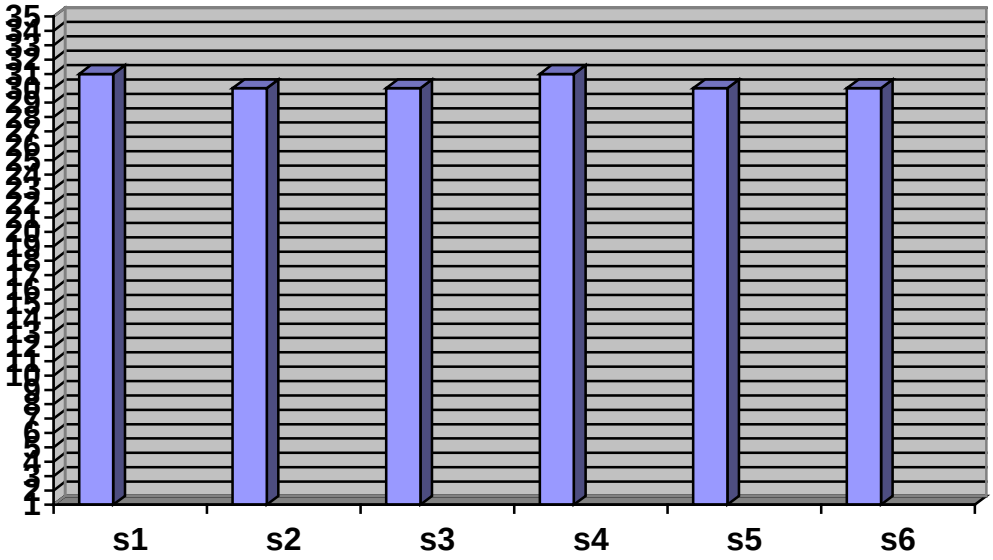
The following is a graph comparing the scores of each type of therapy.

3C CBT and DBT sessions compared (x=session y=Beck score)



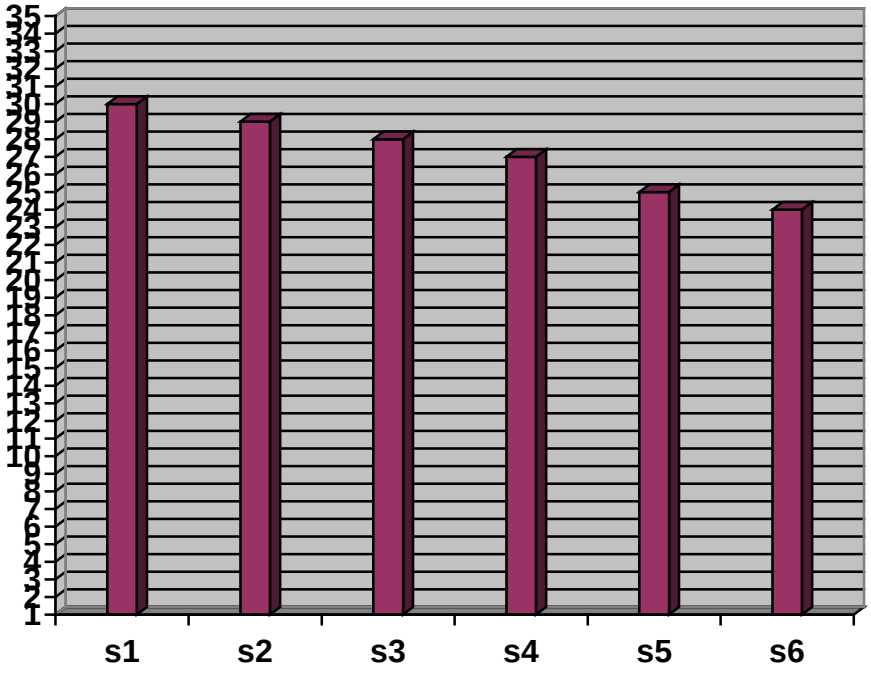
Georgia. Georgia's depression levels prior to treatment were in the severe range (M= 31). On the first day of CBT treatment Georgia's scores increased. From the 2nd session through to the 6th session Georgia's score stabilized at 3. Therefore no significant decrease in depression symptoms was established.

1D Cognitive Behavior therapy sessions (x = session y = beck scores)



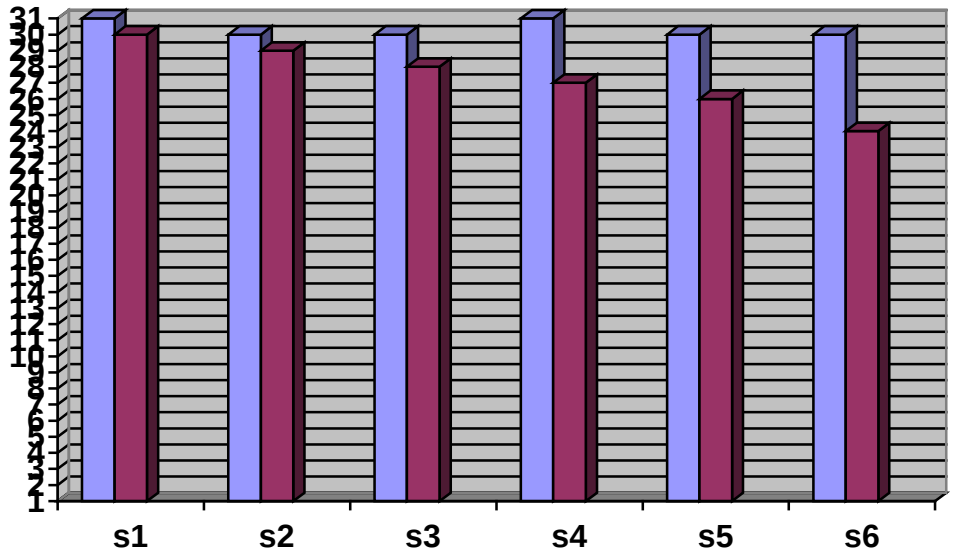
Georgia. On the first day of DBT Treatment, Georgia's depression symptoms slightly decreased to 29. From the beginning of DBT treatment though to week 5, Georgia's self-reported weekly scores of depression symptoms continually decreased. At week six her BDI-II score had dropped to 24.

2D **Dialectical Behavioral Therapy sessions (**x = session y = beck scores)



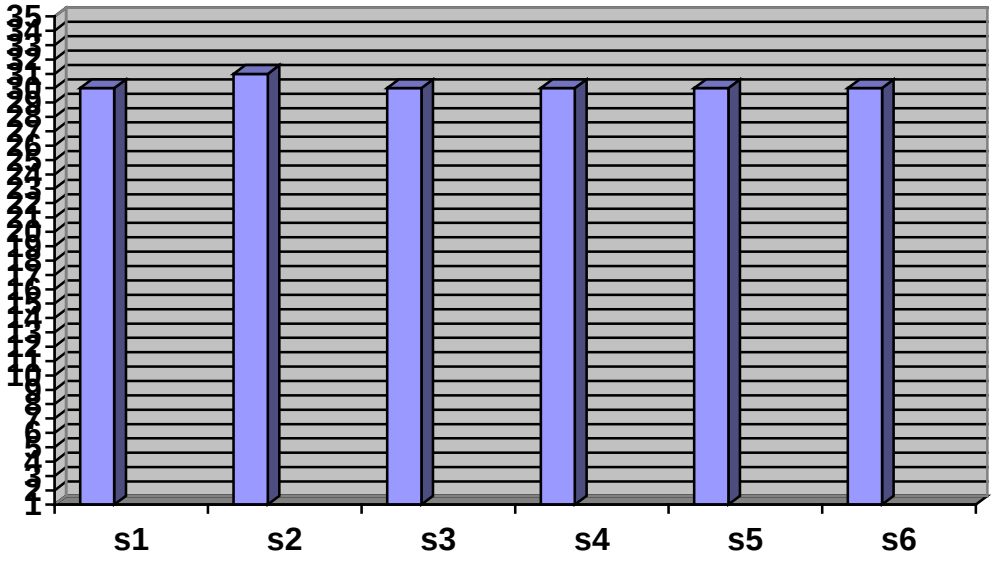
The following graph is a comparison of the scores for each type of therapy.

3D CBT and DBT sessions compared (x=session y=Beck score)



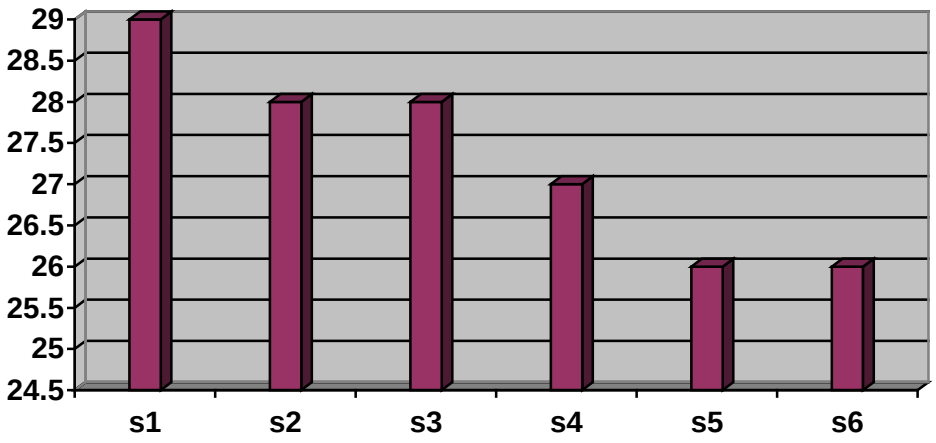
Paula. Paula's depression levels prior to treatment were in the severe range (M= 30). On the first day of CBT treatment Georgia's scores increased. From the 2nd session through to the 6th session Georgia's score stabilized at 30. Therefore no decrease in depression symptoms was established.

1E Cognitive Behavior therapy sessions (x = session y = beck scores)



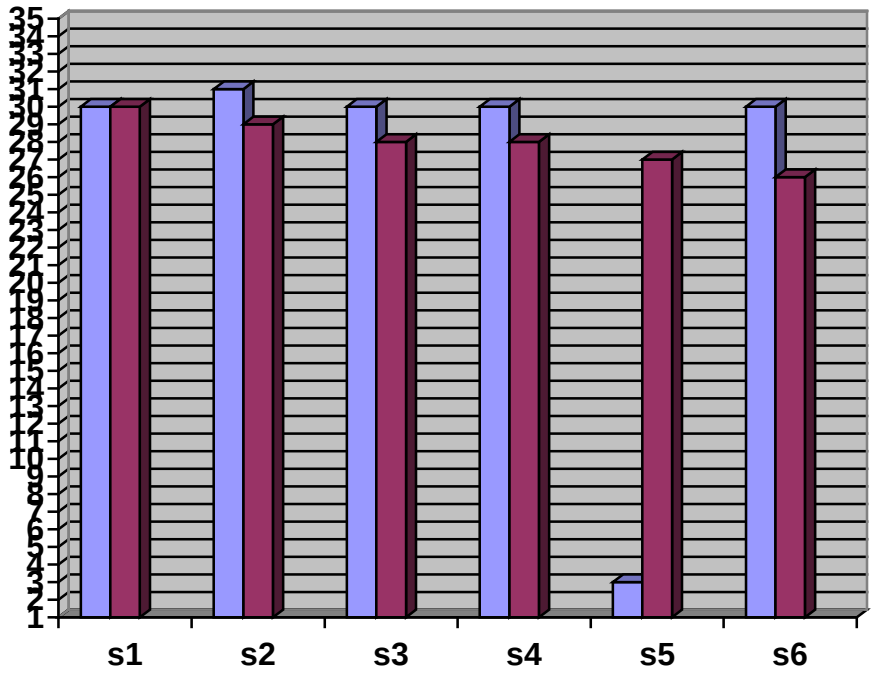
Paula. On the first day of DBT Treatment, Paula's depression symptoms slightly decreased to 29. From the beginning of DBT treatment though to week 5, Georgia's self-reported weekly scores of depression symptoms continually decreased. At week six her BDI-II score had dropped to 26.

2E Dialectical Behavioral Therapy sessions (x = session y = beck scores)



The following graph compares the Beck scores in response to the 2 different therapies.

3E CBT and DBT sessions compared (x=session y=Beck score)



There were no statistically significant differences in baseline demographic or clinical characteristics of the case studies. The sample was female and white. All participants had a bipolar II diagnosis and were currently experiencing a depressive episode the mean duration of the current major depressive episode being 3 months. Most of the sample was rated severely ill[3] on the Clinical Global Impression of Severity of Illness at baseline.(Janice A. Blalock, 2008)

[3] The Clinical Global Impression of Severity of Illness is a 7 point scale that requires the clinician to rate the severity of the patient's illness at the time of the assessment relative to the clinicians past experiences with patients who have the same diagnosis. Considering total clinical experience a patient is assessed on severity of mental illness at the time of rating: 1 = normal, 2 = borderline mentally ill, 3 = mildly ill, 4 = moderately ill, 5 = markedly ill, 6 = severely ill, 7= extremely ill.

The following tables represent the weekly SUDS and MAAS results for each client. Table 1a contains the results from these scales following the CBT sessions and Table 1b represents the results following the DBT sessions.

1a

	Sarah	**Amy**	**Georgia**	**Paula**	**Carly**
SUDS	7, 6,7,7,6,7	5,6,5,6,5,5	8,8,7,7,7,8,7	7,7,7,7,7,7,	6,7,6,6,6,7,6
MAAS	2.3, 2.2, 2.5, 2.4, 2.4, 2.4	1.2, 1.9, 2.1, 1.8, 2.1, 1.3	1.9, 1.9, 1.8, 1.8, 1.9, 1.8	1.7 1.8, 1.9, 1.8, 1.7, 1.7	2.2, 2.3, 2.2, 2.3, 2.2, 2.2

1b

	Sarah	Amy	Georgia	Paula	Carly
SUDS	7, 6,6,5,6,5	5,6,5,5,5,5	8,8,7,7,6,5,5	7,7,7,66,5,	6,7,6,6,5,5,4
MAAS	2.3, 2.5, 2.7, 3.1, 3.3 3.7	1.2, 1.9, 2.1, 2.8, 3.2 3.3, 3.4	1.9, 2.3, 2.4, 2.7, 2.9, 3.1	1.7, 2.2, 2.9. 2.9 3.1, 3.3	2.2, 2.8, 3.1, 3.5, 3.4, 3.5

Results – SUDS &MAAS

What became obvious through the responses received from the practitioners, from the subjects and from the activities and observations collected from the case studies, was that in these circumstances that whilst many are exposed to cognitive behavioral therapy which is widely considered the standard practice, its efficacy is generally not perceived in those bipolar subjects in the study.

Results from the practitioner's survey

Of the professionals interviewed, none of them expressed a specific liking for CBT or a tendency toward the everyday use of it. When questioned, many of the professionals stated that they had no one particular type of therapy that they felt could be applied.

Many reported using CBT and DBT at different times depending on the needs of the clients.

All reported that they use many CBT exercises like challenging thoughts and behavior, keeping a mood diary, exercising projections, negative thought identification, reframing and decatatrophising..

One particular therapist stated that when CBT doesn't work she uses more experiential exercises and/or some DBT skills.

Another stated that many clients are slack about record keeping and feel guilty about not doing it which will often cause them to cancel appointments. Some clients have even said that they feel that they are being administered a set program rather than having had their own issues identified and understood. The same clinician stated that she did not dwell on challenging irrational beliefs. Anything that focuses more attention on thee dysfunctional beliefs is counter-productive because the attention reinforces their significance and trains the mind to zoom in on them or magnify them

Results from the case studies

Not only did all patients respond more positively to the DBT sessions as opposed to the CBT (through self-reporting via the weekly questionnaires regarding the perceived efficacy of different tools and strategies) but all the patients experienced a marked decrease in their Beck scores when being treated with DBT type therapy and exercises whilst most scores in response to the CBT techniques did not change. Clients also received a better score both in their SUDS and in the MAAS.

Carly stated that the mindfulness tasks assigned for homework were beneficial in helping to "get hold of the present" and thus felt that her symptoms were reduced whilst attempting to practice mindfulness.

Amy stated that "finding the middle ground" was a useful tool when experiencing "emotional overload". Both these techniques were used as part of the DBT therapy sessions (without the subject's knowledge of course)

Amy Georgia and Sarah all agreed that the dysfunctional thoughts record was not so useful and both Sarah and Georgia did not complete their homework the second time they were asked to record their thoughts. Both reported it was too uncomfortable of an exercise to complete as it brought to the forefront all the irregularities in their thinking – furthering their view that their minds "were against them".

All except Carly completed all the homework set following the DBT sessions whilst all reported that the mindfulness mediation techniques were the most useful.

Carly missed her homework for 2 of the DBT sessions but stated her reason being that she had been too busy that week/fortnight.

All the activities are located in the (Appendix 14)

Results from the interviews

Whilst none of the interviewees suggested that they had an understanding of DBT, all of them understood what was meant by CBT. Six reported that engaging in CBT strategies such as thought recording and change alleviated some of their symptoms and that they continued to use some of the strategies learned. One felt that CBT had neither positive nor negative affect on her mood. Three stated that the CBT exercising involving homework of subconscious thought recording (DAS) actually worsened their symptoms, feeling that the concentration on changing the thought led to a belief that there was something fundamentally wrong with the mind, making their depression worse.

Chapter 8

Analysis of Results

Overall DBT resulted in self-reported better outcomes for the clients rather than CBT, the usual treatment employed being CBT .(R. Verheul, 2003).

It is also the case that many practitioners have already formed the view that, in many cases, CBT is not an effective method of treatment and so have turned to alternate therapies when dealing with such clients.

Having said that of course there is always a place for CBT, not only is CBT well researched and its application noteworthy but also the majority of the surveyees reported that CBT activities were useful in that they still employed them in their daily lives.

Whilst it is not being suggested that CBT should no longer be used but rather demonstrating that for young women with Bipolar Disorder (major depressive disorder) DBT might be more efficient and effective.

Chapter 9

Discussion of findings

This study tested the efficacy of DBT in treating major depressive episodes in young adult women with Bipolar I or II diagnosis. Five women were chosen and approached to participate in the 12 sessions to be offered to each woman, each session being between 1.5 – 2 hours. Regular telephone contact was encourage during the DBT phase of the treatment but was not mentioned by the therapist to the clients when in the CBT stage of treatment. Each client following a session was to complete a questionnaire to have ready for the next session thereby allowing the therapist to gauge whether the treatment style used was effective and to compare the CBT sessions perceived efficacy to that of the DBT sessions without the participants knowing which treatment encompassed more of CBT strategies or DBT ones. The results obtained from the study indicate that DBT is an effective and acceptable treatment for emotional problems experienced by young female adults with Bipolar major depressive episode.(Eskin, 2008)

Suicidal behavior is a major mental health concern among young adults. Therefore effective psychosocial treatment alternatives for the treatment of suicide problems are needed in this population. The results obtained in the present study are encouraging. Post-treatment suicide risk scores following the DBT sessions were significantly lower than the post-treatment scores following the CBT sessions.(Eskin, 2008)

Taken together the findings from this study make a strong case for the use of DBT for the treatment of depression and suicidal potential in young adult bipolar females.(Eskin, 2008)

Clinical applicability

The results of this study revealed that DBT can be a useful technique when treating young women with Bipolar Disorder and this should be taken into consideration by both clinicians in different disciplines and educators working with this particular population.

Implications

It is proven that the collaboration between therapist and client to actively identify the client's needs, wants and expectations means that the client is empowered as early as possible in the therapy process and is less likely to feel inadequate as might be the case when many negative thought processes are constantly being pointed out. Many clients found the DBT homework which focuses on treatment goals and actually forming concrete expressions of their feeling and wants along with the use of target cards, and telephone consultations more engaging and satisfying that the thought changing activities associated with the CBT sessions.

Limitations

While a number of results from this study did prove to be statistically significant, it is important to recognize that, given there was only a small sample size, the power of these analyses is relatively low.

Complications regarding the strength of this study's outcome include:

1. The size of the sample collected.

2. The fact that subjects were all volunteers and included a number of clients who reported actively experiencing psychotic and/or dis-associative symptoms.

3 Allowing surveyed subjects to refer to their diary which they kept either at home or to stay after the treatment and refer to and or make entries directly after any given session.

Despite these limitations, these results provide overwhelming support for the use of DBT as a treatment for use with clients suffering from severe clinical depression. The fact that DBT fosters collaboration between client and therapist seems to strengthen its applicability and heighten client engagement. This is significant in the sense that increased engagement most likely means smaller dropout rates for therapy which effects both the individual at a baseline level, but also the greater community logistically in the provision of its services. If clients feel engaged in their therapy then they are in turn more likely to return and take up their normal role in society without the need for reliance on hospitals and other centers and services and are less likely to need to rely on financial services such as disability pensions etc. which in turn means that there is less strain on the community which inadvertently effects the public at large. In terms of CBT, as a treatment it often re-iterates and re-enforces the clients engagement in what the therapy regards as "wrong processes" which in some circumstance can serve to, rather than improve a client's esteem, actually only serves to re-enforce their "sick" place in society, without really providing the ongoing support and the skill building that is really required in order to maintain their successes and foster higher rates of client recidivism. Providing CBT treatment in this way does not promote any sort of lasting beneficial change and this means that the clients will continue to burden the mental health system and this of course is at a cost to the community. Given that the clients in question often require immediate relief of the severe symptoms when sick, if they do not have the proper means to manage these symptoms, It is likely that they will find their way back into treatment services, whether it is returning to the treating agency, emergency hospital, psychiatric hospital or just psychiatric and medical specialists generally. More costly than this of course is the personal cost to the client. These costs including actions such as, returning to drugs, ending up in jail or injury or death by negligent, self-harming or suicidal behavior. DBT however may be a cost effective way of reducing these possibilities. When it is looked at closely in a cost effective way, it may be that the cost of training more staff in DBT could very well far out way the community costs already discussed: the treatment services, the support services, the treatment costs of repeated intakes, paperwork, billing hours and discharges, the potential costs could be far greater. DBT's success is largely due to its ability to be able to incorporate diverse techniques and methods whilst still adhering to a structure regimented enough to give clients security. It combines some of the best techniques from a variety of therapies but allowing enough emphasis still to be placed on the valuable flexibility of the dialectical philosophy that allows treatment to occur in a more accommodating manner. Rather than over-focusing on negative thought processes and behaviors, DBT looks to firstly engage clients, then teach clients how they can be their own case managers, encouraging clients to focus on identifying target behaviors rather than identifying negative ones.

Conclusion

Overall there appears to be support that DBT is an important therapy to consider when dealing with patients with Bipolar Disorder (major depressive episode) diagnosis. It is the core mindfulness and distress regulation that makes it unique in its application in a demographic that has previously been failed by CBT that did not live up to its well accepted standard. However the exact role in maintaining sound mental health for this particular group has yet to be analyzed. Based on the results of the present study, it does appear that DBT practices produce more desirable outcomes that those of CBT alone, however, further research may examine the specific role that DBT plays in the maintenance treatment of young women sufferers of Bipolar Disorder major depressive episode..(Nancy L. Kocovski, 2008)

Summary

In conclusion research has shown that DBT is effective not only with Borderline Personality Disorder, but also in a variety of other mental illness treatments, such as substance use and eating disorders. (Robbins & Chapman 2004). The research of Segal et al (2002) yielded some impressive results with regard to mindfulness being an effective treatment for depression as well. DBT is an effective treatment that helps self-regulate emotions by teaching specific skills so that a person can better cope with their emotionality and be better adjusted (Linehan, 1993). Seligman (1978) suggested that depression can be explained but the theory of learned helplessness. Learned helplessness suggests that depression ensues when a person feels they have no control over themselves or their environment. DBT would appear to be a very valuable treatment in addressing this as it teaches and encourage a person to develop and gain control. Individuals who are able to implement these tools may be able to prevent depressive symptoms, and consequently stave off relapse. Because the prevalence of depression is so wide spread, it is worthwhile to examine more effective means of treating the symptoms associated with this affliction.

This study was designed to evaluate whether DBT (specifically Mindfulness Skills training and Distress tolerance training) could offer some relief from depressive symptoms. The results of this study suggest that this intervention was successful and demonstrated a change in depression symptoms across all 5 participants. Each participant began with a diagnosis of Major Depressive Disorder in the severe range but the scores were markedly lower on the Beck scale following the DBT treatment sessions. While some methodological problems exist, the study nonetheless still points to some promising results

Future Research

The results also stimulate further questions; namely, are the effects of the treatment long lasting; and would it work with different types and ages of people. More research would help to enhance and support the result of this current study, with a larger sample size. With this research, a valuable tool could be provided for clinicians treating Bipolar depression with potentially longer lasting results for persons suffering from this debilitating mental illness.

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APPENDIX 1

Roche

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Beck Depression Inventory

CRTN: _____ CRF number: _____

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Baseline

patient inits: _____

BDI-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

Continued on Back

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Subtotal Page 1

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11. Agitation

0 I am no more restless or wound up than usual.

1 I feel more restless or wound up than usual.

2 I am so restless or agitated that it's hard to stay still.

3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.

1 I am less interested in other people or things than before.

2 I have lost most of my interest in other people or things.

3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.

1 I find it more difficult to make decisions than usual.

2 I have much greater difficulty in making decisions than I used to.

3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.

1 I don't consider myself as worthwhile and useful as I used to.

2 I feel more worthless as compared to other people.

3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.

1 I have less energy than I used to have.

2 I don't have enough energy to do very much.

3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.

1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.

2b I sleep a lot less than usual.

3a I sleep most of the day.

3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

Subtotal Page 2

Subtotal Page 1

Total Score

Mood/Depression Assessment Questionnaire

1. Since your last visit have you felt depressed, sad or blue much of the time?
   yes ☐
   no ☐

2. Since your last visit have you often felt helpless about the future?
   yes ☐
   no ☐

3. Since your last visit have you had little interest or pleasure in doing things?
   yes ☐
   no ☐

4. Since your last visit have you had trouble sleeping many nights?
   yes ☐
   no ☐

Are two (2) or more of the above questions marked YES while undergoing treatment in this protocol?

yes ☐ → *complete a Beck Depression Inventory. If score is 30 or less, patient may continue in the study. If score is ≥ 31, patient will need to complete all final assessments and be dropped from the study. The investigator may recommend that the patient be referred for a professional psychiatric assessment.*

no ☐

APPENDIX 2

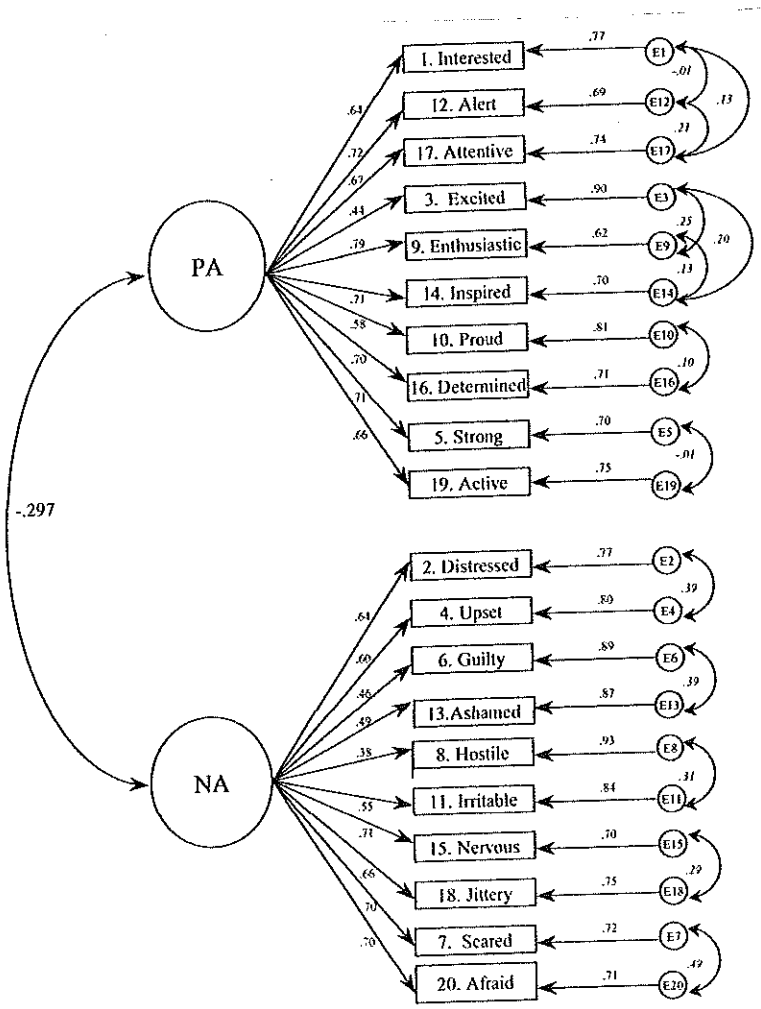

Figure 1. Graphical representation of the correlated two-factor model of the PANAS (Model 2d); the factor loadings are standardized loadings.

APPENDIX 3

INSTRUCTIONS FOR USE OF SUICIDE ATTEMPT SELF INJURY INTERVIEW (SASII-1 9/28/06)

Susan Bland, MSW
Angela Murray-Gregory, MA, MSW

Introduction

The Suicide Attempt Self Injury Interview (SASII) is used to collect details regarding the time, circumstances, motivations and treatment of each Intentional Self Injury (ISI) that a subject can recollect. Intentional Self Injury (ISI), as measured here, is defined in question S1 of the SASII. The SASII's structure consists of a Dateline, Appendices, Cards and an interview for each ISI episode.

The SASII can either be answered in numerical order (preferred for research) or the interviewer can move freely around within the interview, following subject cues (preferred for clinical us). The phraseology is designed to provide flexibility and aid communication. Data is collected for either a "lifetime" history (as far back as a subject can recall up to the present) or an "interval" history (covering the intervening time between scheduled assessments or some other arbitrary time span determined by the interviewer). Many subjects refer to specific ISI events as "overdose' or "suicide attempt" so terminology reflects their vocabulary.

When a question requests that the interviewer record the subject's response "verbatim", it does not imply that the interviewer should not probe the subject for a more detailed answer or clarify the answer. Instead, the interviewer is encouraged to probe, to clarify and to obtain as detailed of an answer as is necessary for making clinical ratings. For each question that requires an interviewer's rating, the interviewer should base the rating on clinical judgment based on the entire interview, not simply on the subject's verbatim response.

Generally speaking, text that is to be read to the subject is in upper and lower case letters, while instructions to the interviewer or coder are in capital letters. Directions to use "-8" often appear in the interview instructions. "-8" is a code for "Not Applicable."

Vocabulary: An "episode" is the word used to describe a "single event or act" or to describe a "cluster." A "cluster" is a group of "single events/acts." Please see question 3 of the SASII for a complete definition of "clusters." "Cards" refer to attached lists that should be given to the subject according to instructions in the interview.

Question S1.

The interviewer should be thoroughly familiar with the definition of Intentional Self Injury (ISI). Answers should be probed in order to be certain the subject understands what types of behavior the interviewer is inquiring about. The following definitions should be used:

Intentional Self Injury: Any overt, acute, nonfatal self-injurious act where both act and bodily harm or death are clearly intended (i.e., both the behavioral act and the injurious outcomes are not accidental) that results in actual tissue damage, illness, or, if no intervention from others, risk of death or serious injury.

Drugs: Any amount above the prescribed dose plus intent to harm one's self counts as an ISI. This means even taking two pills counts if two is above the prescribed dose and the subject was intending to hurt him/herself (e.g., kill, make sick, cause physiological damage). Drugs or medications must be INGESTED to count as an ISI. Therefore, if someone grabs the pills even as the subject was about to put them into his/her mouth, this does NOT count. Once the pills are swallowed or if put in mouth but forcibly taken out by someone else, count as an ISI. If drugs are taken simply to obtain a good night's sleep, do not count. Intentional sleep as a consequence counts only if it involves an excessive amount of sleeping (e.g., an entire week-end or much more than the individual's "normal" sleep pattern). Do not count if drugs are taken to get high, feel better or as part of a normal drug abuse pattern (exception for drug abuse would be taking more than one's regular "dose" with the expectation of harm).

Alcohol: Ingested alone, in absence of any other substance, does NOT count unless there is clear and incontrovertible evidence, such as a physicians warning, that ingesting that particular amount of alcohol would cause acute harm/death and subject did it knowingly with the intent to hurt him/herself in an acute manner (i.e., drinking with hope of getting cirrhosis of the liver and dying from that would NOT count).

Poisoning: Substance must have been INGESTED. As with drugs, if someone grabs the poison even as the subject was about to ingest it, this does NOT count. Once the poison is swallowed or if put in mouth but forcibly taken out by someone else, count as an ISI. Includes any food/substance subject knows or has been told would cause harm (e.g., a diabetic eating enough sugar to produce a noticeable, negative, immediate physiological response) and which the subject ingests with an intent to cause such harm.

Gunshot: Must have pulled trigger AND caused tissue damage, or Russian roulette if certain at least one bullet was present, aimed at body, with clear intent to risk harm.

Cutting: Skin must be broken, not just pushed or rubbed.

Burning Must be some damage to skin other than redness and/or pain. For example, burning arm hair with a lighter that leaves a red mark and causes sunburn like pain for an hour would NOT be counted.

Stabbing: To puncture, thrust or drive with a pointed weapon, as opposed to incise, gash or cleave as in cutting

Strangling: Tight enough to cause a physiological reaction such as dizziness, or the act of strangling presents a clear risk of known harm (i.e., if subject has epilepsy).

Hanging: Engaging in the act with intent to harm. Erotic hanging is not counted as an ISI. Putting noose around neck does NOT count unless it meets the criteria for strangling above.

Jumping: Must be belief or intent to harm. Dangling feet over a bridge or hanging on with hands but not jumping does NOT count.

Asphyxiation: Engaged in the act even if it did not cause damage. If subject had set up all necessary equipment, i.e., attached hose to exhaust pipe and turned on motor with nozzle end to mouth but something went wrong (such as the hose melting) this still COUNTS as an ISI.

Drowning: Counts if subject engages in act he/she has reason to believe will result in his/her demise whether or not it does. For example, swimming out to the middle of a large lake to drown but being picked up by the Coast Guard would count as would swimming out, turning back when exhausted and having extreme difficulty making it back to shore e.g. continuously sinking beneath water, taking water into lungs and/or attempt results in some physiological damage. Just turning back with no difficulty getting back to shore would NOT be counted.

Hitting Body Both intent to harm and noticeable tissue damage (bruise, lump) must be present. Banging fist (hitting/kicking something with a hand) in anger or frustration without any intent to cause harm does NOT count.

Bulimia Ordinarily does NOT count, unless there is a clear and convincing reason to believe damage has been done to the body (e.g., throwing electrolytes out of balance) was both the intent and the consequence.

Stop Eating Same as above. For example if a subject does not eat for 7 days with intent to cause harm but has no physiological effect such as dizziness, faintness or nausea, then act is NOT counted.

Stopped needed medical treatments or medications Ordinarily does NOT count, unless there is clear and convincing reason to believe acute damage to the body was the intent and the consequence. Count as a suicide attempt if there was clear intent to commit suicide and tissue damage or a negative, immediate physiological response was a result. If death is simply being allowed, i.e., the person was stopping medications for reasons other than to die even knowing that death would or could result, then it does NOT count.

Motor vehicle collision Vehicle collision must have had a reasonable chance of causing bodily harm.

Stepping into traffic Subject must have been hit by a car or situation must be similar to russian roulette if harm was intended but subject was not hit; subject must not have voluntarily left the road before being hit, and cars must have been going fast enough on the road that there would be little chance of avoiding being hit.

Driving off bridge or cliff If the car is headed off the road and then subject stops the car for any reason prior to the tires leaving the pavement, the act is NOT counted. However if the car is stopped physically by someone other than the subject (such as the police) it is counted.

Harming a wound Must be more than just "playing" with wound, picking at it, making it itch, etc. Must have opened wound and caused further bleeding.

Other Only count what would qualify as an ISI by itself. Do not count repetitive behaviors that cause harm but are better accounted for as OCD or other disorders like trichotillomania or skin picking disorders.

Also do NOT count intentionally self harming behavior that is done primarily to procure pain medications, recreational self mutilation (done for fun not in response to emotional pain), sadomasochistic behaviors (done for sexual pleasure not in response to

emotional pain) or self inflicted tattoos & brands (done for fashion/cultural/statement reasons not in response to emotional pain).

Question S2.

This total should include all single events and all events within a cluster. (See Question 3 for definition of clusters.)

Question S3.

S3 is answered by the interviewer at the end of the interview. The response is based on the interviewer's' evaluation of the subject' general memory acuity, effects of any medications on subject's memory, inconsistencies noted by interviewer, and the subject's professed difficulties remembering times or details. For example, a subject who brings a calendar documenting all episodes and has a clear memory of each episode would have a higher reliability rating than a subject who was heavily medicated, had no calendar, and could only recall that he/she "overdosed many times."

Question S4.

S4 will equal S2 if all events were single but will be less than S2 when at least some events are clustered. (See Question 3 for definition of clusters.)

Dateline.

The dateline is an extremely brief outline of ISI activity. Only the date, method, whether or not it was a suicide attempt and whether or not any medical treatment was received are recorded on all ISI's done during the time span under inquiry. Details of each ISI are recorded on individual SASII forms. If subject is having difficulty recalling ISI's during the time period, ask the subject to think about the most recent month and then work backwards month by month.

The dateline helps structure what can be a confusing mass of information, especially if a subject's memory is poor or inclined to change. Also, since subjects have difficulty talking about their ISI's, the dateline provides a basis for initiating conversation. Finally, it is useful for checking radical changes, e.g., a subject who had multiple ISI's in a previous time span now states he/she has none to report. By being aware of the previous number of ISI's, the interviewer can probe for the reasons for the abrupt change.

Question 1.

Start with the most recent ISI and work backward in time. This procedure is based on the literature in memory research which suggests that such a procedure will obtain the most detailed and accurate information.

Question 2.

Self-explanatory

Question 3.

#3 is the beginning of detailing each episode. If the subject can remember the specific act, it is considered a single event. If either interviewer or client can distinguish one act from another, whether by time or circumstance, or any other detail, each act is to be rated as a single event. Occasionally a subject cannot clearly recall details of a series of events. If a sequential series of ISI's, suicide attempts, or overdoses are too repetitive or too close together in time to discriminate as separate acts, they should be identified as a cluster. All questions in the SASII must be answered identically about each act in the series in order to be considered a cluster. Thus, clustering is rarely used because subjects can almost always recall some details of an event. It is rare that a series of events are identical. There is usually a difference in location, motivation, severity/frequency, type of medical treatment received, etc.

Isolate and record as separate events any instances wherein:

a) Subject receives medical treatment
b) There is a change in severity/frequency of self-harm
c) There is a change in level of impulsivity or probability of intervention
d) There is any change in reason(s) for engaging in the act
e) Subject moves in or out of an inpatient psychiatric unit

f) Basically, whenever there is any difference in the way any of the questions are answered

When a single event can be distinguished within a long cluster, end the first cluster, record the single event, and begin a second cluster.

If information on a cluster is taken and then the subject remembers details of one act within the cluster, that one act is recorded in detail on a separate SASII form and the previous cluster is broken into two clusters: one cluster prior and one cluster following the single event. Thus, what initially appears to be a cluster often breaks down into separate events as the subject's memory is prodded by the SASII questions. Or a large cluster breaks down into several short clusters interspersed with single events.

The most effective approach to #3 is to talk about single acts unless this becomes impossible, at which point one considers clustering. Probing for medical treatment is often an effective way of identifying single acts which may be separated from what initially appears to be a cluster. To begin with a cluster usually results in some waste of time and backtracking as the interviewer discovers many differences within an assumed "cluster."

When counting up the total number of SASII's in a time period, count each cluster as a single episode. EXAMPLE: 3 single events + 1 cluster of 5 overdoses = 4 SASII's total.

Additional Examples for Determining number of episodes/clusters

If a subject cuts twice in one day because of different triggers, it would be considered two episodes and separate SASII's would be completed for each episode.

If a subject cuts at 11:00 pm due to an argument and then cuts again at 4:00 am due to the same argument, both done with no intent, it would be considered one episode even though it occurred on two different days.

If, in the same scenario above, the 4:00 am act was an overdose with no intent, it would still be considered one episode even though the lethality was more severe than the cutting. In this instance the assessor would code for the highest level of lethality based on all ISI's within the episode.

If a subject tries to hang him/herself with intent but the rope breaks and he/she then cuts with no intent, it would be considered two episodes. If, though, the cutting was also with intent, it would be considered one event with two methods and coded for the highest lethality reached within that episode.

If a subject does not eat for two weeks and has physiological consequences, the episode is considered a single episode and NOT a cluster.

Question 4.

The focus here is on the initiation of the act itself. Falling off a ledge is accidental. Jumping off a ledge is deliberate. Balancing on a ledge on one foot and leaning over the edge hoping to fall is semi-deliberate. Do not infer unconscious motivation; stick to conscious motivation.

Question 5.

Frequencies of ISI acts within a cluster can be determined most easily by averages if the subject does not clearly recall the total number of acts. Did the acts occur on a daily basis? If so, how many times per day? If not daily, how often each week, on the average? The interviewer can then tally the total.

Questions 5a &5b.

If subject only remembers that the act was at the beginning of the month, enter "1" for the day, if at the middle of the month, enter "15" and if at the end enter "30". For example 01/01/2006 would be an example of a date for the beginning of a month. If the subject doesn't remember the date, but does remember the month, enter "15" for the day. Use the best estimate if the subject is not certain of the month. Asking if it was fall, winter, spring, or summer works as a good time reference.

Question 6.

Work with the client to estimate how accurate the date for that specific event is and record the estimate as a date that is "exact", "within two weeks", "within two months", or a date that could be "anytime in the last year".

METHOD AND MEDICAL RISK OF METHOD

Following question 7 is an **open-ended question** that asks the subject to tell the interviewer about the ISI. This question is designed to provide the interviewer with a general sense about the episode. Since the interviewer will not be coding any variables directly from this question, it is left to the interviewer to determine how much he/she wishes to probe the client for details at this point. If the interviewer already knows something about the ISI (e.g., the interview is being conducted in the emergency room following an overdose), he/she does not even need to ask the question.

Question 7.

Code the PRIMARY method here from the numeric list of methods listed under #7. For example if the primary method was the ingestion of drugs then the code would be **7.2**. If subject has used more than one method, code the more severe method, e.g., if the subject has used drugs and alcohol, generally code for the drugs since drugs are more likely to cause death than alcohol. Similarly if a subject attempts to hang themselves but the rope breaks and they cut afterwards, code hanging as the primary.

Questions 7.1 – 7.17

The codes for recording each method used are the numbers **7.1 – 7.17** in front of each method listed in #7. Specificity is the key to answering these questions.

The questions asking for verification by scars requires the interviewer to note whether or not they can observe scars from the ISI on the subject during the interview.

If two implements from the same category are used to cause harm within the same event or act code the implement that causes the most damage. For example a razor would generally cause more damage than a paper clip or butter knife.

When drugs or alcohol are consumed at the time of an ISI, the details of the amount and type should be noted in the verbatim section of #7, but recorded as an additional method on **7.1** or **7.2** only if they were intentionally part of the means of the ISI.

For SEC's on **7.1** code units of alcohol consumed. One unit of alcohol would be = a 12 oz. beer, 4 oz. wine or wine cooler, 1 oz. hard liquor or 1 standard cocktail.

Question 8.

The interviewer should use strictly the examples written (or methods similar in risk) and not use any personal interpretation of the descriptors "low," "very low", etc. Rate strictly on method alone; do not include information on location of act, other's presence, medical effects, or other aspects of the ISI. Superficial cuts on surface or limbs are cuts that ordinarily would not require sutures. Deep cuts are those that usually would require sutures. If unsure, use lower category.

If a subject drives after an overdose do not code at a higher level, but rate as noted above according to the method alone.

Question 9.

Write in the subject's answer to the open ended question verbatim, then code level of conscious intent to cause self injury based on subjects answer.

Question 10.

The question with options 0-6 should be read to the client verbatim and coded exactly as client answers without any interpretation by the coder.

Question 11.

Give card A to the subject, ask the question and code his/her answers.

Question 12.

To be read verbatim. Some, not all, subjects relate to the idea of attempting suicide without intending to die. For those who do not and resist this question in its entirety, they should be instructed to answer the question as if the phrase "even if you did not really intend to die" were not there.

Question 13

Use the same subject's definition of suicide attempt here as used in question #12. If subject's answer on #13 is different from that on #12, write in what accounts for that change on #13a.

Question 14.

Using all information gathered during the interview (or up to this point if questions asked in sequence) rate the subject's conscious expectation to die.

COMMUNICATION OF SUICIDE INTENT

Question 15.

This question should always be read completely verbatim. The temptations to paraphrase should be avoided strictly as it is easy to leave out key words. A communication of suicide ideation may or may not also be a threat. Code here both non-threatening and threatening communications. Examples of non-threatening direct communications include telling a therapist or relative that one is thinking of suicide when asked directly or saying "I can't stop thinking of killing myself." Examples of non-threatening indirect communications would be saying "I wish I were dead" or saying "I just feel like I can't go on any more.

Question 16.

As in #15, this question should always be read completely verbatim. The temptations to paraphrase should be avoided strictly. A threat is any direct or implied promise of self-injury or suicide or it is any act or statement that gives an appearance of or actually is calculated to instill fear in others that one might self-harm or suicide. It is often accompanied by a hostile tone. An indirect threat would be a statement to a therapist "I just wanted to call to say good-bye" or saying "I can't tell you" when asked why he/she might not come to the next session.

IMPULSIVITY AND PROBABILITY OF INTERVENTION

Question 17.

In addition to asking the question as written, the interviewer must also probe for resistance. Did the subject resist the impulse and, if so, for how long? The difference between an ISI done impulsively with and without overwhelming emotion is the difference between cutting with intense feelings of anger toward the therapist, sadness about ending a relationship, etc. vs. walking past a knife and suddenly having the urge.

Question 18.

The note should be written before or during the ISI and should indicate the subject's wish or intent to die. This item does not include notes which only describe the subject's unhappiness.

Question 19.

Record yes/ no/ somewhat answer verbatim, then record circumstances verbatim. For non-suicidal behavior, "save you" means "stop you".

Question 20.

The interviewer should code strictly according to the examples cited. Avoid interpreting the descriptors "certain intervention," "probable intervention," etc. Probing may be necessary if the interviewer is unfamiliar with the geography or setting referred to by the subject. Asking for more detail, rather than interpreting or assuming, is the correct approach.

If a subject has roommates or family in the same house, says goodnight to them and would not be expected to see them until morning and initiates self harming behavior afterwards, the chance of intervention would be "3" or ambiguous.

LEVEL OF MEDICAL TREATMENT

Question 21.

Give subject card B and probe for a "blow-by-blow" account of events immediately following the ISI. This should include where he/she went, what he/she did, to whom he/she spoke following his/her episode. Number of hours prior to treatment refers to the number of hours between the time the subject intentionally injured him/herself and the time treatment was received. These can also be coded in sequence by time of intervention or assistance.

Question 22.

Record answer verbatim and then code according to subject's answer. The interviewer should code according to the italicized definitions and the examples cited. Avoid interpreting the descriptors "hardly any effect," "moderate effect," etc. Focus instead on the specifics and severity of any physiological effect or damage. If the subject is uncertain about his/her condition, probe more and then code lower category. Medical records can also be used to determine the rating.

Question 23.

Using all information gathered throughout the interview, the interviewer should code for the type of medical treatment received. The interviewer should code the highest level of treatment.

Treatment must occur within 24 hours of an ISI in order to be counted on #23.

Question 24.

Probe the subject's self-report, using answers to previous questions if appropriate, to assess the subject's conscious suicide intent at the time of the ISI. Code from list and describe the reason for rating in 24a.

In order to code a "5", subject must have carefully planned act (at least one day of planning) AND have every expectation of death. If it is an impulsive act with every expectation of death, code a "4".

Question 25.

Code #1 is not ordinarily used because the accidental nature of the behavior would have stopped the interview earlier. However, the code is included if the interview is used with an accidental injury control condition.

Code #2 is also not used for the same reason as above. If used, code here if the injury is due to highly risky behavior, such as subway surfing, drunk driving, jumping off of high bridges for a thrill, etc.

Code #3 is rarely used.

Code #4 is rarely used. An example of when it is appropriate to use this code would be when a subject plans to go out get drunk and black out with the intent of being raped and killed and then does get drunk, blacks out and gets raped, but survives.

Code #9: Self Explanatory

Code #5 - #6: Self Explanatory

Code #7: Use if a subject had no ambivalence

Code #8 is rarely used and should only be coded in instances of near miracle survival following a suicide attempt. For example, when a subject survives after jumping in front of a train, speeding car on the freeway or jumping from a VERY high place or when a subject would not have survived without medical intervention and only got the intervention by a random chance. A good example of this is when a subject is found by a hiker in a remote spot and must be put on a ventilator following an overdose.

Supplemental and Experimental Questions for the SASII

TRIGGERS

Questions 26a & 26b

These questions focus on what precipitated the ISI. Some subjects will not be able to identify anything for # 26. If, after some probing, this is the case write in "no response" and code this item as -8 (non applicable).

Question 27.

This question focuses on what happened in the 24 hours before the ISI. The assessor will hand the subject the list (card D) of antecedents and will ask him/her to say the number of all items that apply. The antecedents don't necessarily have to be previously identified as "triggers" to the ISI. For question 13a write out the demand on the subject and for question 21a write out the negative event.

Question 28.

The intent here is to connect certain behaviors (alcohol, drugs, difficulty sleeping, not getting requested help, overeating & illegal behaviors) to ISI. Thus the effects of alcohol, etc., should be occurring in the 24 hours prior to the ISI. For drugs and alcohol code how much was used, over how many hours it was used and how many hours prior to the self injury the subject stopped using the substance. If alcohol and/or drugs were used as a method of ISI, code "-8" for the respective question(s).

If a subject has used drugs and/or alcohol as a method of ISI in the last 24 hours (an ISI counted on a previous SASII) it would be counted on #28 for the current SASII.

Question 29-30.

The intent of these questions is to assess dissociative experiences surrounding ISI behavior.

Question 31.

Be sure to probe for exactly what the voices were saying.

Question 32.

First determine if pain was experienced. Then, if yes, ask them to rate on the 5 point scale. Code appropriate rating or zero for no pain.

NON-MEDICAL CONSEQUENCES OF SASI

Questions 33.

This question is the same as #21 above with additional people/places listed that the subject may have had contact with. Give subject card C and follow the instructions in #21.

Question 34 (Part A).

For those people/places subject had contact with in #33, rate how helpful each was on the scale given.

Question 34 (Part B).

For those people/places subject had contact with in #21, rate how helpful each was on the scale given.

Questions 35 – 41

Read the question and then read each of the possible responses from 1 to 6, temporarily skipping 3 "No effect or overall neutral effect" and reading that last if subject has not chosen any of the others.

Question 40.

If money is lost from days missed from work then code according to the total cost to the subject.

Subject has no financial effect if parents or charity pay hospital bills. When a parent takes his/her own bankcard away from a subject, it is not considered a financial impairment unless the bankcard is in the subject's name.

Question 42.

This question focuses on what happened to the subject immediately following the ISI. The assessor will hand the subject the list (card E) of events and experiences and will ask him/her to say the number of all items that apply. For those that apply the subject should then be asked to rate to what degree each item occurred on the scale given.

If the subject loses consciousness immediately following their ISI, for example in an auto accident, then he/she should indicate the consequences immediately upon waking up. If, though, the subject recalls a time period after the ISI but prior to losing consciousness, for example after swallowing pills but before blacking out, then the subject should indicate the consequences immediately after the ISI.

APPENDIX 4

		This applies to me .....: (please circle)				
		not at all	*a bit*	*mode-rately*	*strongly*	*very strongly*
1.	I can only think positive when I am in a good mood.	0	1	2	3	4
2.	When in a low mood, I take fewer risks.	0	1	2	3	4
3.	When I feel sad, I spend more time thinking about what my moods reveal about me as a person.	0	1	2	3	4
4.	When in a sad mood, I am more creative than usual.	0	1	2	3	4
5.	When I feel down, I more often feel hopeless about everything.	0	1	2	3	4
6.	When I feel down, I am more busy trying to keep images and thoughts at bay.	0	1	2	3	4
7.	In a sad mood, I do more things that I will later regret.	0	1	2	3	4
8.	When I feel sad, I go out and do more pleasurable activities.	0	1	2	3	4
9.	When I feel sad, I feel as if I care less if I lived or died.	0	1	2	3	4
10.	When I feel sad, I am more helpful.	0	1	2	3	4
11.	When I feel sad, I am less inclined to express disagreement with someone else.	0	1	2	3	4
12.	When I feel somewhat depressed, I think I can permit myself fewer mistakes.	0	1	2	3	4
13.	When I feel down, I more often feel overwhelmed by things.	0	1	2	3	4
14.	When in a low mood, I am more inclined to avoid difficulties or conflicts.	0	1	2	3	4
15.	When I feel down, I have a better intuitive feeling for what people really mean.	0	1	2	3	4
16.	When in a sad mood, I become more bothered by perfectionism.	0	1	2	3	4
17.	When I feel sad, I more often think that I can make no one happy.	0	1	2	3	4
		not at all	*a bit*	*mode-rately*	*strongly*	*very strongly*

Please continue on the next page.

	This applies to me .....: (please circle)				
	not at all	*a bit*	*mode-rately*	*strongly*	*very strongly*
18. When I feel bad, I feel more like breaking things.	0	1	2	3	4
19. I work harder when I feel down.	0	1	2	3	4
20. When I feel sad, I feel less able to cope with everyday tasks and interests.	0	1	2	3	4
21. In a sad mood, I am bothered more by aggressive thoughts.	0	1	2	3	4
22. When I feel down, I more easily become cynical (blunt) or sarcastic.	0	1	2	3	4
23. When I feel down, I feel more like escaping everything.	0	1	2	3	4
24. When in a sad mood, I feel more like myself.	0	1	2	3	4
25. When I feel down, I more often neglect things.	0	1	2	3	4
26. When I feel sad, I do more risky things.	0	1	2	3	4
27. When I am sad, I have more problems concentrating.	0	1	2	3	4
28. When in a low mood, I am nicer than usual.	0	1	2	3	4
29. When I feel down, I lose my temper more easily.	0	1	2	3	4
30. When I feel sad, I feel more that people would be better off if I were dead.	0	1	2	3	4
31. When I feel down, I am more inclined to want to keep everything under control.	0	1	2	3	4
32. When I feel sad, I spend more time thinking about the possible causes of my moods.	0	1	2	3	4
33. When in a sad mood, I more often think about how my life could have been different.	0	1	2	3	4
34. When I feel sad, more thoughts of dying or harming myself go through my mind.	0	1	2	3	4
	not at all	*a bit*	*mode-rately*	*strongly*	*very strongly*

Please check whether all items are answered. Thank you.

APPENDIX 5

Mindfulness Attention Awareness Scale (MAAS)

Mindfulness Attention Awareness Scale (MAAS)

Please indicate the degree to which you agree with each of the following items using the scale below. Simply circle your response to each item.

1	2	3	4	5	6
almost always	very frequently	somewhat frequently	somewhat infrequently	very infrequently	almost never

1.	I could be experiencing some emotion and not be conscious of it until some time later.	1	2	3	4	5	6
2.	I break or spill things because of carelessness, not paying attention, or thinking of something else.	1	2	3	4	5	6
3.	I find it difficult to stay focused on what's happening in the present.	1	2	3	4	5	6
4.	I tend to walk quickly to get where I'm going without paying attention to what I experience along the way.	1	2	3	4	5	6
5.	I tend not to notice feelings of physical tension or discomfort until they really grab my attention.	1	2	3	4	5	6
6.	I forget a person's name almost as soon as I've been told it for the first time.	1	2	3	4	5	6
7.	It seems I am "running on automatic" without much awareness of what I'm doing.	1	2	3	4	5	6
8.	I rush through activities without being really attentive to them.	1	2	3	4	5	6
9.	I get so focused on the goal I want to achieve that I lose touch with what I am doing right now to get there.	1	2	3	4	5	6
10.	I do jobs or tasks automatically, without being aware of what I'm doing.	1	2	3	4	5	6
11.	I find myself listening to someone with one ear, doing something else at the same time.	1	2	3	4	5	6
12.	I drive places on "automatic pilot" and then wonder why I went there.	1	2	3	4	5	6
13.	I find myself preoccupied with the future or the past.	1	2	3	4	5	6
14.	I find myself doing things without paying attention.	1	2	3	4	5	6
15.	I snack without being aware that I'm eating.	1	2	3	4	5	6

APPENDIX 6

DAS

This questionnaire lists different attitudes or beliefs which people sometimes hold. Read *each* statement carefully and decide how much you agree or disagree with the statement.

For each of the attitudes, indicate to the left of the item the number that *best describes how you think.* Be sure to choose only one answer for each attitude. Because people are different, there is no right answer or wrong answer to these statements. Your answers are confidential, so please do not put your name on this sheet.

To decide whether a given attitude is typical of your way of looking at things, simply keep in mind what you are like *most of the time.*

1 = Totally agree
2 = Agree very much
3 = Agree slightly
4 = Neutral
5 = Disagree slightly
6 = Disagree very much
7 = Totally disagree

_____ 1. It is difficult to be happy unless one is good looking, intelligent, rich, and creative.
_____ 2. Happiness is more a matter of my attitude towards myself than the way other people feel about me.
_____ 3. People will probably *think less of me* if I make a mistake.
_____ 4. If I do not do well all the time, people will not respect me.
_____ 5. Taking even a small risk is foolish because the loss is likely to be a disaster.
_____ 6. It is possible to gain another person's respect without being especially talented at anything.
_____ 7. I cannot be happy unless most people I know admire me.
_____ 8. If a person asks for help, it is a sign of weakness.
_____ 9. If I do not do as well as other people, it means I am a weak person.
_____ 10. If I fail at my work, then I am a failure as a person.
_____ 11. If you cannot do something well, there is little point in doing it at all.
_____ 12. Making mistakes is fine because I can learn from them.
_____ 13. If someone disagrees with me, it probably indicates he does not like me.
_____ 14. If I fail partly, it is as bad as being a complete failure.
_____ 15. If other people know what you are really like, they will think less of you.
_____ 16. I am nothing if a person I love doesn't love me.
_____ 17. One can get pleasure from an activity regardless of the end result
_____ 18. People should have a chance to succeed before doing anything.

_____ 19. My value as a person depends greatly on what others think of me.
_____ 20. If I don't set the highest standards for myself, I am likely to end up a second-rate person.
_____ 21. If I am to be a worthwhile person, I must be the best in at least one way.
_____ 22. People who have good ideas are better than those who do not.
_____ 23. I should be upset if I make a mistake.
_____ 24. My own opinions of myself are more important than others' opinions of me.
_____ 25. To be a good, moral, worthwhile person I must help everyone who needs it.
_____ 26. If I ask a question, it makes me look stupid.
_____ 27. It is awful to be put down by people important to you.
_____ 28. If you don't have other people to lean on, you are going to be sad.
_____ 29. I can reach important goals without pushing myself.
_____ 30. It is possible for a person to be scolded and not get upset.
_____ 31. I cannot trust other people because they might be cruel to me.
_____ 32. If others dislike you, you cannot be happy.
_____ 33. It is best to give up your own interests in order to please other people.
_____ 34. My happiness depends more on other people than it does on me.
_____ 35. I do not need the approval of other people in order to be happy.
_____ 36. If a person avoids problems, the problems tend to go away.
_____ 37. I can be happy even if I miss out on many of the good things in life.
_____ 38. What other people think about me is very important.
_____ 39. Being alone leads to unhappiness.
_____ 40. I can find happiness without being loved by another person.

APPENDIX 7

LEIDS-R

Instructions

Below are a number of statements that may apply to you to a lesser or greater extent.

Almost every statement concerns your thoughts about a certain matter *at times when you feel down or when you are in a low mood.* This does not mean a seriously depressed mood or true depression.
Your task is to indicate the extent to which the statements apply to you when you feel somewhat sad.

Try to imagine the following situation when filling out this questionnaire:

> **It is certainly not a good day, but you don't feel truly down or depressed.**
> Perhaps your mood is an early sign of something worse to come, but things might also improve in the next day or two.
>
> On a scale ranging from 0 to 10 (0 = not at all sad; 10 = extremely sad; 6 and above = a truly depressed mood), you would choose a 3 or 4 to describe your mood.
> The scale looks like this:

0	1	2	3	(4)	5	6	7	8	9	10
not at all sad			somewhat sad			depressed			very depressed	

Please try to imagine yourself in the above situation, for instance by thinking back to the last time you felt somewhat sad (score 3 or 4).

{Now take some time to imagine such a situation.}

To what extent are you able to imagine such a situation?

- o well
- o somewhat
- o not at all

Now proceed to the next question (even if you find it difficult to imagine yourself in such a situation).

APPENDIX 8

THE HAMILTON RATING SCALE FOR DEPRESSION

(to be administered by a health care professional)

Patient's Name _____

Date of Assessment _____

To rate the severity of depression in patients who are already diagnosed as depressed, administer this questionnaire. The higher the score, the more severe the depression.

For each item, write the correct number on the line next to the item. (Only one response per item)

_____ **1. DEPRESSED MOOD** (Sadness, hopeless, helpless, worthless)

0= Absent
1= These feeling states indicated only on questioning
2= These feeling states spontaneously reported verbally
3= *Communicates feeling states non-verbally—i.e., through facial expression, posture,* voice, and tendency to weep
4= Patient reports VIRTUALLY ONLY these feeling states in his spontaneous verbal and non-verbal communication

_____ **2. FEELINGS OF GUILT**

0= Absent
1= Self reproach, feels he has let people down
2= Ideas of guilt or rumination over past errors or sinful deeds
3= Present illness is a punishment. Delusions of guilt
4= Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations

_____ **3. SUICIDE**

0= Absent
1= Feels life is not worth living
2= Wishes he were dead or any thoughts of possible death to self
3= Suicidal ideas or gesture
4= Attempts at suicide (any serious attempt rates 4)

_____ **4. INSOMNIA EARLY**

0= No difficulty falling asleep
1= Complains of occasional difficulty falling asleep—i.e., more than 1/2 hour
2= Complains of nightly difficulty falling asleep

_____ **5. INSOMNIA MIDDLE**

0= No difficulty
1= Patient complains of being restless and disturbed during the night
2= *Waking during the night—any getting out of bed rates 2* (except for purposes of voiding)

Adapted from Hedlung and Vieweg, The Hamilton rating scale for depression, *Journal of Operational Psychiatry*, 1979;10(2):149-165.

6. **INSOMNIA LATE**

_____ **0**= No difficulty
1= Waking in early hours of the morning but goes back to sleep
2= Unable to fall asleep again if he gets out of bed

7. **WORK AND ACTIVITIES**

_____ **0**= No difficulty
1= Thoughts and feelings of incapacity, fatigue or weakness related to activities; work or hobbies
2= Loss of interest in activity; hobbies or work—either directly reported by patient, or indirect in listlessness, indecision and vacillation (feels he has to push self to work or activities)
3= Decrease in actual time spent in activities or decrease in productivity
4= Stopped working because of present illness

8. **RETARDATION: PSYCHOMOTOR** (Slowness of thought and speech; impaired ability to concentrate; decreased motor activity)

_____ **0**= Normal speech and thought
1= Slight retardation at interview
2= Obvious retardation at interview
3= Interview difficult
4= Complete stupor

9. **AGITATION**

_____ **0**= None
1= Fidgetiness
2= Playing with hands, hair, etc.
3= Moving about, can't sit still
4= Hand wringing, nail biting, hair-pulling, biting of lips

10. **ANXIETY (PSYCHOLOGICAL)**

_____ **0**= No difficulty
1= Subjective tension and irritability
2= Worrying about minor matters
3= Apprehensive attitude apparent in face or speech
4= Fears expressed without questioning

11. **ANXIETY SOMATIC:** Physiological concomitants of anxiety, (i.e., effects of autonomic overactivity, "butterflies," indigestion, stomach cramps, belching, diarrhea, palpitations, hyperventilation, paresthesia, sweating, flushing, tremor, headache, urinary frequency). Avoid asking about possible medication side effects (i.e., dry mouth, constipation)

_____ **0**= Absent
1= Mild
2= Moderate
3= Severe
4= Incapacitating

12. SOMATIC SYMPTOMS (GASTROINTESTINAL)

_____ **0**= None
1= Loss of appetite but eating without encouragement from others. Food intake about normal
2= Difficulty eating without urging from others. Marked reduction of appetite and food intake

13. SOMATIC SYMPTOMS GENERAL

_____ **0**= None
1= Heaviness in limbs, back or head. Backaches, headache, muscle aches. Loss of energy and fatigability
2= Any clear-cut symptom rates 2

14. GENITAL SYMPTOMS (Symptoms such as: loss of libido; impaired sexual performance; menstrual disturbances)

_____ **0**= Absent
1= Mild
2= Severe

15. HYPOCHONDRIASIS

_____ **0**= Not present
1= Self-absorption (bodily)
2= Preoccupation with health
3= Frequent complaints, requests for help, etc.
4= Hypochondriacal delusions

16. LOSS OF WEIGHT

_____ **A.** When rating by history:
0= No weight loss
1= Probably weight loss associated with present illness
2= Definite (according to patient) weight loss
3= Not assessed

17. INSIGHT

_____ **0**= Acknowledges being depressed and ill
1= Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2= Denies being ill at all

18. DIURNAL VARIATION

_____ **A.** Note whether symptoms are worse in morning or evening. If NO diurnal variation, mark none
0= No variation
1= Worse in A.M.
2= Worse in P.M.
_____ **B.** When present, mark the severity of the variation. Mark "None" if NO variation
0= None
1= Mild
2= Severe

19. DEPERSONALIZATION AND DEREALIZATION (Such as: Feelings of unreality; Nihilistic ideas)

_____ **0**= Absent
1= Mild
2= Moderate
3= Severe
4= Incapacitating

20. PARANOID SYMPTOMS

_____ **0**= None
1= Suspicious
2= Ideas of reference
3= Delusions of reference and persecution

21. OBSESSIONAL AND COMPULSIVE SYMPTOMS

_____ **0**= Absent
1= Mild
2= Severe

Total Score _____

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APPENDIX 9

LIFE HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing these questions, as fully and as accurately as you can, you will provide your therapist with important information, without using your actual therapy time. Please answer these questions on your own time. The information in this questionnaire will be kept by your therapist and will not be disclosed to anyone without your written permission. Case records are strictly confidential. If you do not wish to answer a question, simply write, "Do not care to answer."

THERAPIST'S NAME: PETRA GUSTIN, CMH

CLIENT'S NAME: _____ AGE: _____

OCCUPATION: _____

By whom were you referred? _____

Who presently lives with you? _____

Marital status: (circle one) Single Engaged Married Separated Divorced Widowed

If married, how many times? _____ Do you live in a house, hotel, room, apartment, etc? _____

CLINICAL:

1. State in your own words the nature of your main problems and their duration:

_____

_____

_____

_____

_____

2. Give a brief account of the history and development of your complaints (from onset to present):

_____

_____

_____

_____

_____

3. On scale below please estimate the severity of your problems:

Mildly Upsetting Moderately Severe Very Severe Extremely Severe Totally Incapacitating

4. With whom have you previously consulted about your present problems?

OCCUPATIONAL:

1. What sort of work are you doing now?

2. What sort of work have you done in the past?

3. Does your present work satisfy you? (If not, why are you dissatisfied?)

4. Ambitions:

Past:

Present:

PERSONAL DATA:

1. Date of birth: _____ Place of birth: _____

Mother's condition during pregnancy (as far as you know:) _____

2. Underline any of the following that applied during your childhood:

Night Terrors	Bed Wetting	Sleepwalking
Thumb-sucking	Nail-biting	Stammering
Fears	Happy Childhood	Unhappy Childhood

3. Health during childhood (List illnesses):

4. Health during adolescence (List illnesses):

_____

_____

5. What is your height? _____ Your weight: _____

6. Any surgical operations? (Please list them and give age at time)

_____

_____

7. When were you last examined by a doctor? _____

8. Any accidents? _____

_____

9. List five main fears:

1. _____
2. _____
3. _____
4. _____
5. _____

10. Underline any of the following that apply to you:

Headaches	Financial problems	Fainting	Don't like vacations
Palpitations	Dizziness	No appetite	Can't make friends
Bowel Disturbances	Stomach trouble	Insomnia	Over Rambunctious
Nightmares	Fatigue	Alcoholism	Can't keep a job
Feel tense	Take sedatives	Tremors	Disoriented
Unable to relax	Suicidal ideas	Shy with people	Concentration difficulties
Depressed	Feel panicky	Take drugs	Memory Problems
Don't like weekends	Sexual problems	Can't make a decision	Unable to have a good time

11. Underline any of the following words, which apply to you:

Worthless	Useless	A 'nobody'	'Life is empty'
Inadequate	Stupid	Incompetent	Naïve
'can't do the right thing'	Guilty	Evil	Morally Wrong
Horrible Thoughts	Hostile	Full of Hate	Anxious
Agitated	Cowardly	Unassertive	Panicky
Aggressive	Ugly	Deformed	Unattractive
Depressed	Unloved	Misunderstood	Bored
Restless	Confused	Unconfident	In Conflict
Full of Regrets	Worthwhile	Sympathetic	Intelligent
Attractive	Confident	Considerate	Assertive

OTHER AREAS:

1. Present hobbies, interests, and activities:

2. How is most of your free time occupied?

3. What is the last grade of school you completed?

4. Scholastic abilities; strengths and weaknesses:

5. Were you ever bullied or severely teased?

6. Do you make friends easily? Do you keep them?

FAMILY DATA:

1. **Father**:

Living or deceased? _____

If deceased, your age at the time of his death? _____

Cause of death: _____

If alive, father's present age: _____ Occupation: _____

Health: _____

2. **Mother**:

Living or deceased? _____

If deceased, your age at the time of her death? _____

Cause of death: _____

If alive, mother's present age: _____ Occupation: _____

Health: _____

3. Give a description of your father's/ mother's personality and attitude towards you (past and present):

_____

_____

4. In what ways were you punished by your parents as a child?

_____

_____

5. Give an impression of your home atmosphere (the home in which you grew up). Mention state of compatibility between parents and between parents and children.

_____

_____

6. Were you able to confide in your parents? _____

7. If you have a stepparent, give your age when parent remarried: _____

8. Give an outline of your religious training: _____

9. If you were not brought up by your parents, who did bring you up, and between what years?

_____

_____

10. Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc.?

_____

_____

11. Who are the most important people in your life?

_____

_____

12. Does any of your family suffer from alcoholism, epilepsy, or anything, which can be considered a "mental disorder"? Give details.

_____

_____

13. Recount any fearful or distressing experience not previously mentioned:

_____

_____

14. List the benefits you hope to derive from therapy.

_____

_____

15. List any situations, which make you feel calm and relaxed.

_____

_____

16. Please add any information not mentioned by this questionnaire that may aid your therapist in understanding and helping you.

_____

_____

SELF-DESCRIPTION:

Please complete the following:

I am _____

I am _____

I am _____

I am _____

I am _____

I feel _____

I feel _____

I feel _____

I feel _____

I feel _____

I think _____

I think _____

I think _____

I think _____

I think _____

I wish _____

I wish _____

I wish _____

I wish _____

I wish _____

I would like to:

	NO	SOME	A LOT
Get advice on how to deal with my life and other people	0	1	2
Have my therapist respond to me on a person-to-person basis	0	1	2
Get better self-control	0	1	2
Get clarity regarding which things I think and feel are real and which things are mostly in my mind	0	1	2
Work out a particular problem that has been bothering me	0	1	2
Get my therapist to say what she really thinks	0	1	2

THANK YOU.

APPENDIX 10

SBQ-R Suicide Behaviors Questionnaire-Revised

Patient Name _____ Date of Visit _____

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (check one only)

- ☐ 1. Never
- ☐ 2. It was just a brief passing thought
- ☐ 3a. I have had a plan at least once to kill myself but did not try to do it
- ☐ 3b. I have had a plan at least once to kill myself and really wanted to die
- ☐ 4a. I have attempted to kill myself, but did not want to die
- ☐ 4b. I have attempted to kill myself, and really hoped to die

2. How often have you thought about killing yourself in the past year? (check one only)

- ☐ 1. Never
- ☐ 2. Rarely (1 time)
- ☐ 3. Sometimes (2 times)
- ☐ 4. Often (3-4 times)
- ☐ 5. Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)

- ☐ 1. No
- ☐ 2a. Yes, at one time, but did not really want to die
- ☐ 2b. Yes, at one time, and really wanted to die
- ☐ 3a. Yes, more than once, but did not want to do it
- ☐ 3b. Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (check one only)

- ☐ 0. Never
- ☐ 1. No chance at all
- ☐ 2. Rather unlikely
- ☐ 3. Unlikely
- ☐ 4. Likely
- ☐ 5. Rather likely
- ☐ 6. Very likely

APPENDIX 11

Questionnaire

1. Do you use CBT techniques in most of your sessions with clients? If yes with approximately what percentage of your clients?

2. Do you use DBT techniques with any of your clients? If yes with approximately what percentage of your clients?

3. Which techniques of CBT specifically do you use most often?

4. Why do you think these particular techniques are effective?

5. Can you give a practical example of how you use a CBT technique with clients?

6. In your practice with clients, when using CBT, do you set clients homework i.e. diary, automatic thought register etc

7. If so – do you find clients responsive to and motivated to complete the exercises?

8. Can you give an example of an exercise you might give for homework.

9. Are there any CBT techniques, exercises or strategies that you believe are ineffective? Which ones and why?

10. Do you use any other forms of therapy and if so which are they.

11. What are the aspects of those other therapies that you find effective and successful?

12. Do you ever encounter clients that are non-responsive to CBT? If yes how do you proceed from there?

APPENDIX 12

Questions

1. In your hospital stay what kinds of activities were encouraged as part of the treatment process
2. What strategies were taught to help avoid relapse
3. Which skills did you find the most beneficial
4. Were you able to continue using some of the strategies provided once back in the community
5. Are there any activities you use on a daily basis to help with your depression
6. Were any of the techniques unhelpful? If so which ones
7. At any time in the treatment processed were you even informed as to which therapy you were learning and using? If so which one?

APPENDIX 13

Consent Form

In signing this deed I irrevocably:

1. Consent to Fotina Riveros, using data and information obtained during our session for the purpose of her doctoral thesis.

2. Confirm that no reference to my name will occur and that the information presented will not identify me.

3. Release Fotina Riveros from any claim by me, or on my behalf, arising out of the publication of the thesis

4. Confirm that confidentiality and other professional requirements operate as in any other therapeutic session including compulsory referral in the case of violence against others or to self

Released by:	
Full name:	
Address:	
Postcode:	**Telephone:**
Mobile:	**Email address:**
DOB (Optional):	
Executed as a Deed	

APPENDIX 14

Reality Acceptance Worksheet

Realities that I am refusing to accept:

1. _____
2. _____
3. _____
4. _____
5. _____

Behaviors that I do when I am refusing to accept a reality (may look like a tantrum, giving up, manipulating, arguing, etc).

1. _____
2. _____
3. _____
4. _____
5. _____

How I experience SUFFERING when I refuse to accept reality:

1. _____
2. _____
3. _____
4. _____
5. _____

	Pro's	Con's
Cope	• Increased self respect • People around you will respect you • Will help you get what you want • Mastering Skills	• Can't speak my mind • Feel tense longer • Don't get to retaliate, just think about it • Give up a moment of power
Not Coping	• Hurt Someone • Some times it pays off • Protect yourself/others • Get satisfaction • You get to end it	• Lose privileges • Lose trust • Lose self-respect • Lose status

Distress Tolerance Pro's and Con's Worksheet

	Pro's	Con's
Cope		
Not Coping		

Thinking of Pros and Cons

Make a list of the pros and cons of TOLERATING the distress—coping by using skills. Make another list of the pros and cons of NOT TOLERATING the distress—that is, of coping by hurting yourself, abusing alcohol or drugs, or doing something else impulsive.

Focus on long-term goals, the light at the end of the tunnel. Remember times when pain has ended.

Think of the positive consequences of tolerating the distress. Imagine in your mind how good you will feel if you achieve your goals, if you don't act impulsively.

Think of all of the negative consequences of not tolerating your current distress. Remember what has happened in the past when you have acted impulsively to escape the moment.

Distress Tolerance Pros and Cons Example

When you have the urge for verbal retaliation:

	Pro's	Con's
Coping	• No fight • No argument • Maintain relationship • No infraction/consequences • Learn skills/mastery of skills • Increase self-esteem • Increase hope • Gain trust of others • Move toward less restrictive or increased privileges	• Don't get to fight or argue • Don't get to make your point • No immediate release • No instant gratification • No rush • Others won't be afraid of you
Not Coping	• Others will leave you alone • You get instant gratification • You main gain popularity • Get the rush/feel powerful • May feel in control of situation	• Lose self-esteem • Lose self-worth • Poor outcome/consequences • Lose motivation for treatment • May stop using skills all together/rebel • Stay at FSH longer

When you have the urge to fight/physically attack:

Mastering My World

A sense of accomplishment is a gift only I can give myself.

People in very desperate situations (concentration camps, prison, etc) find things to do on a daily basis that give themselves a sense of accomplishment and control. When we do something that is just a little bit hard for us, we gain a sense of mastery in the world, and our sense of hopelessness weakens.

Make a list of things that you can do in order to gain a sense of mastery. Make sure that the tasks are realistic goals for each mood state. Remember that it is harder to do everything when you are depressed, so pick small tasks for when you are in a low mood:

To Improve a Good Mood:

1.
2.
3.
4.
5.
6.
7.

To Challenge Medium Mood:

1.
2.
3.
4.
5.
6.
7.

To Raise a Low Mood:

1.
2.
3.
4.
5.
6.
7.

KNOWING THE DIFFERENCE:

Thought, Emotion, Event, or Behavior?

Read the items to the left. For each item, circle the correct category to the right.

Item	Thought	Emotion	Behavior	Event
1. We're going to be late to smoke!	Thought	Emotion	Behavior	Event
2. This group is a drag.	Thought	Emotion	Behavior	Event
3. Being afraid of a spider.	Thought	Emotion	Behavior	Event
4. Throwing a book.	Thought	Emotion	Behavior	Event
5. Having the urge to scream.	Thought	Emotion	Behavior	Event
6. Someone calls you a bad name.	Thought	Emotion	Behavior	Event
7. You pass room check!	Thought	Emotion	Behavior	Event
8. You are given passes.	Thought	Emotion	Behavior	Event
9. A peer tells a lie about you.	Thought	Emotion	Behavior	Event
10. A staff member is harsh.	Thought	Emotion	Behavior	Event
11. Someone takes your snack.	Thought	Emotion	Behavior	Event
12. Sad	Thought	Emotion	Behavior	Event
13. Crying	Thought	Emotion	Behavior	Event
14. Your aunt dies.	Thought	Emotion	Behavior	Event
15. Irritation with a peer.	Thought	Emotion	Behavior	Event
16. Worrying about your money.	Thought	Emotion	Behavior	Event
17. Nervousness about your TPR.	Thought	Emotion	Behavior	Event
18. Your favorite group is cancelled.	Thought	Emotion	Behavior	Event
19. Rage.	Thought	Emotion	Behavior	Event
20. I hate this food!	Thought	Emotion	Behavior	Event
21. You punch a wall.	Thought	Emotion	Behavior	Event
22. You yell at a peer.	Thought	Emotion	Behavior	Event
23. A patient is put in time out.	Thought	Emotion	Behavior	Event
24. You refuse your medications.	Thought	Emotion	Behavior	Event
25. You take your medications.	Thought	Emotion	Behavior	Event

VALIDATION PRACTICE

After reading each situation, circle all of the responses that are VALIDATING. Some of the responses may be skillful, but not validating. Remember to focus on reassuring self/other that their experience is real, important, and/or makes sense. Circle all of the validating responses for each question.

1. A friend has just thrown a chair down the hallway because a peer refused to let them use the phone. They have received a Major Infraction and are very angry. They are talking to you.

    a. You listen, nodding.
    b. You ignore them, because you don't want to give them attention for bad behavior.
    c. You state, "You were really frustrated, weren't you?"
    d. You say, "You're right! She never lets anyone else use the phone!"

2. A peer is having a lot of with symptoms lately. He is getting into trouble with staff, breaking rules. He asks you to lie for him so that he can stay out of further trouble.

    a. You say, "You're really worried about being in trouble, and I can understand that, but I can't lie, and get into trouble too. Let's find another solution."
    b. You immediately go tell staff on him.
    c. You try to avoid him. When he approaches you, you say, "I can't talk right now, I have to do my laundry."
    d. You say, "You want me to tell staff that you were with me and that you didn't do what they say you did."

3. You are feeling a lot of irritation and you don't know why. You snap at a peer who has done nothing wrong.

    a. You tell yourself, "I'm always irritable and drive people away."
    b. You force yourself to behave more patiently with others than you actually feel for the rest of the day.
    c. You talk to a friend and tell them, "I just snapped at someone, and I don't know why. I'm irritable and confused."
    d. You ask for a PRN.

Dialectics Homework Sheet

Circle the letter in front of the dialectical statement for each group of sentences:

1. a. It's hopeless. Why even try? I give up.
   b. My problems are gone, this is easy.
   c. This is hard for me, and I'm going to keep working at it.

2. a. I'm totally right about this—it's the truth!
   b. I'm stupid. Everyone else is always right about things.
   c. Well, I can see it this way, and you see it that way.

3. a. Everyone is always unfair to me.
   b. In some situations, I feel that I'm not being treated fairly.
   c. Everyone is always fair to me.

4. a. People should listen to me whenever I need to talk.
   b. I should be able to handle my own problems without bothering other people.
   c. Sometimes I need someone to listen to me. When they can't, it's frustrating.

5. a. It's my parent's fault that I have these problems, so I shouldn't have to work so hard to solve them.
   b. All of my problems are my own fault.
   c. I may not have caused all of my own problems, but I need to solve them anyway.

6. a. Other people always hurt me, so I don't trust anyone.
   b. I trust some people and I find it very difficult to trust others.
   c. If I were healthy I would be able to trust everyone.

7. a. I hate you for doing what you did. I am done being your friend.
   b. It shouldn't be any big deal if other people hurt me.
   c. You really hurt my feelings and we will have to work it out.

Finding WILLINGNESS Worksheet

What WILLFULNESS feels and looks like for me:

Willful *body and emotion* sensations:

1. 4.
2. 5.
3. 6.

Body and Facial Expressions (how my willfulness looks):

1. 4.
2. 5.
3. 6.

I notice that I become willful when (situations):

1.
2.
3.
4.
5.

My best strategies for ***Turning my Mind*** to **WILLINGNESS** include:

1. 4.
2. 5.
3. 6.

Practice these strategies and record on your diary card.