



## Annotated Assessment Bibliography

### DIAGNOSTIC ASSESSMENT

The following sections contain measures that can be used to evaluate the appropriateness of potential clients for your DBT program.

#### *Diagnostic Assessment - Axis I*

##### Clinical Interview

- **Structured Clinical Interview for DSM-IV, Axis I (SCID)**

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1995). Structured Clinical Interview for Axis I DSM-IV Disorders - Patient Edition (SCID-I/P). New York: Biometrics Research Department, NY State Psychiatric Institute.

Contact Biometrics Research for a research version of the SCID: 212-960-5524.

- **Use DSM IV criteria, observations, informants; Use consensus diagnosis**

The SCID is the standard in the field for DSM diagnoses. Training tapes are available by contacting author directly.

- **Longitudinal Interview Follow-up Evaluation - Psychiatric Status Ratings (LIFE)** Keller, M. B., Lavori, P. W., Friedman, B., Nielsen, E. C., Endicott, J., McDonald-Scott, P., & Andreasen, N. C. (1987). The longitudinal interval follow-up evaluation: A comprehensive method for assessing outcome in prospective longitudinal studies. *Archives of General Psychiatry*, 44, 540-548). Contact: Claire Walker c/o Martin Keller's office at 401-444-1943.

This measure evaluates the presence and severity of psychiatric diagnoses over time. The LIFE can be used as a measure of quality-of-life-interfering behavior because, in addition to substance abuse, psychiatric symptomatology also represents quality of life interfering behavior and is common in women with BPD. High interviewer-observer reliability has been shown for the change points in diagnostic criteria as well as for the level of psychopathology.

#### *Diagnostic Assessment - Axis II (for Diagnosis of BPD)*

##### Axis II: Structured Interview

- **Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II)**

First, M.B. Gibbon, M., Spitzer, R.L., Williams, J.B.W., & Benjamin, L. (1996). User's guide for the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II). New York: Biometrics Research Department, New York State Psychiatric Institute.

Contact: American Psychiatric Press, Inc. 800-368-5777; <http://www.appi.org/index.html>.

This diagnostic interview can be used to obtain Axis II diagnosis of BPD. Previous studies with the DSM III-R version of the SCID have shown reliabilities by diagnosis over .60. This is the best scale for clinician use; it is easier, briefer, but does require clinical expertise in noticing clinically relevant criteria.

- **International Personality Disorders Examination (IPDE) (research)**

Loranger, A. W. (1995). International Personality Disorder Examination (IPDE) Manual. White Plains, NY: Cornell Medical Center.

Contact: Armand Loranger @ NY Hospital, White Plains, NY. 914- 997-5922.

This measure obtains Axis II diagnoses including BPD. The IPDE is the most widely established measure of personality disorders currently available and is used by the World Health Organization. Inter-rater reliability for BPD diagnosis on the IPDE has been found to be from .73 to .89 and temporal stability from .56 to .84, clearly in the acceptable range. Reliabilities for other disorders are .81 to .89 for inter-rater reliability and .67 to .75 for temporal stability. This measure may not be useful for clinicians; it is long and somewhat cumbersome, and requires more training than the SCID. It is however, the accepted research instrument for those interested in publishing.



## Axis II: Paper & Pencil

### ▪ **Personality Interview Questionnaire II (PIQ II)**

Widiger, T. A. (1987). *Personality Interview Questionnaire II (PIQ II)*. White Plains, NY: Department of Psychiatry, Cornell Medical Center, Westchester Division.

### ▪ **Personality Diagnostic Questionnaire-Revised (PDQ-R)**

Hyder, S.E., Oldham, J.M., Kellman, H.D., & Doidge, N. (1992). Validity of the Personality Diagnostic Questionnaire-Revised: A Replication in an Outpatient Sample. *Comprehensive Psychiatry*, 33, pp. 73-77.

To order, call: 800-424-9537

The Personality Diagnostic Questionnaire-Revised is a 99 item, self-administered, true/false questionnaire that yields personality diagnoses consistent with the DSM-IV diagnostic criteria for the axis II disorders. It takes approximately 20-30 minutes to complete. It is widely used in clinical and research settings. It is known for its sensitivity in detecting a particular personality disorder and has been criticized for its high false positive rates (overdiagnosing the presence of a PD). Due to its high false positive rates, it may be more appropriately used as a screening tool, rather than a standalone diagnostic tool.

### ▪ **Millon Clinical Multi-axial Inventory II (MCMI-II); MCMI-II Manual 4**

Millon, T. (1977). *MCMI-II Manual*. Minneapolis, MN: National Computer Systems.

Contact: NCS Assessments (800-627-7271, Ext. 5151); <http://assessments.ncs.com>; Email: [assessment@ncs.com](mailto:assessment@ncs.com)

This instrument is designed to help assess both Axis I and Axis II disorders.

### ▪ **Wisconsin Personality Disorders Inventory (WISPI)**

Smith, T.L., Klein, M. H., & Benjamin, L. (1996). The Wisconsin Personality Disorders Inventory: I. Development, Reliability, and Validity. *Journal of Personality Disorders*, 7 (4), 285-303.

Contact: Madison, WI: Department of Psychiatry, University of Wisconsin.

This is a self-report questionnaire derived from an interpersonal perspective on the Diagnostic and Statistical Manual of Mental Disorders-III-Revised (DSM-III-R) personality disorders (PDs). Internal consistency for 11 PD scales was very high in a sample of 1,230 psychiatric patients and normal disorders (PDs). Internal consistency for 11 PD scales was very high in a sample of 1,230 psychiatric patients and normal non-patient control Ss. Two-week test-retest reliability in 80 additional patients and non-patients was also high. Another study found good convergent and discriminant validity between the SCID-II, the PDE, and the WISPI (Barber & Morse, 1994).

### ▪ **Schedule for Normal and Abnormal Personality (SNAP)**

Clark, L. A. (1989). *Preliminary manual for the Schedule for Normal and Abnormal Personality*. Dallas, TX: Department of Psychology, Southern Methodist University.

Contact publisher: University of Minnesota Press, Test Division, 800-621-2736; Email: [Ump@tc.umn.edu](mailto:Ump@tc.umn.edu).

## SCREENING

### ▪ **Demographic Data Schedule (DDS)** Linehan, M. M. (1982). Unpublished manuscript. University of Washington, Seattle.\*

This measure obtains a wide range of demographic data. High concurrent validity was established by comparing DDS responses to hospital chart data for a sample of psychiatric inpatients.

For a copy of the screening measure, see: <http://depts.washington.edu/btrc/files/DDS.pdf>

### ▪ **Peabody Picture Vocabulary Test - Revised (PPVT-R)** Dunn, L. M. (1981). *Peabody Picture Vocabulary Test-Revised*. Circle Pines, MN: American Guidance Service. Contact: American Guidance Service.

This brief measure of verbal intelligence identifies mental retardation. Unlike many other brief instruments, it has the advantage of low sensitivity to learning disabilities (high rate of false positives) which are seen frequently among BPD



# Behavioral Tech

clients. It results in an IQ score comparable to those of other intelligence tests such as the WAIS-III and Stanford-Binet. This measure is best used if you don't have time or training for use of the WAIS.

- **Borderline Symptom Checklist-23 (BSL-23)** Bohus et al. (2009) The short version of the Borderline Symptom List (BSL-23): development and initial data on psychometric properties. *Psychopathology*, 42(1): 32-39.

The Borderline Symptom List (BSL-95) has initially been developed as a self-rating instrument for specific assessment of borderline-typical symptoms. In order to reduce patient burden and assessment time we developed a short-version of the BSL. Twenty-three of the original 95 BSL-items were included into the short-version (BSL-23). The evaluation was based on five different samples with borderline patients (n=694). The internal consistency of the BSL-23 was high: Cronbach's  $\alpha$ : 0.94-0.97. The remaining results regarding test-retest-reliability, validity, ability to discriminate between patient groups and sensitivity for change according to therapy were very satisfactory throughout. The results indicate that the BSL-23 is an efficient and convenient self-rating instrument that displays very good psychometric properties comparable to those of the full version of the BSL.

- **Difficulties in Emotion Regulation Scale (DERS)** Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment*, 26, 41-54.

The DERS is a 36-item self-report measure that assesses difficulties in regulation emotion, amongst both adults and adolescents. Constructs assessed include: nonacceptance of emotional response, difficulties engaging in goal-directed behavior, impulse-control difficulties, lack of emotional awareness, limited access to emotion regulation, and lack of emotional clarity.

## MEASURING CHANGE ON STAGE I TARGETS

Once clients have been determined as meeting criteria for inclusion in, or exclusion from, your program, the following sections contain measures that can be used to evaluate client and therapist change

### Suicidal/Life-Threatening Behaviors

*Adult (UW Measures): Measures used in University of Washington clinical trials; those followed by an \* can be requested by contacting Thao Truong at the BRTC; University of Washington, Dept of Psychology; Seattle, WA 98195; (206) 685-2037. Recipient must pay for copying and mailing of materials.*

#### Paper-and Pencil and/or Self-Report

- **University of Washington Risk Assessment Protocol/Risk Assessment & Management Protocol (UWRAP/UWRAMP)**

Reynolds, S.K., Lindenboim, N., Comtois, K.A., Murray, A., Linehan, M.M. (2006). Risky Assessments: Participant Suicidality and Distress Associated with Research Assessments in a Treatment Study of Suicidal Behavior. *Suicide and Life-Threatening Behavior*, 36(1), 19-33.

Linehan, M.M. (2009) University of Washington Risk Assessment Action Protocol: UWRAAP, University of WA, Unpublished Work.

For a copy of the UWRAP see: <http://depts.washington.edu/brtc/files/UWRAP.pdf>

Linehan, M. M., Comtois, K.A., & Ward-Ciesielski, E. F. (2012). Assessing and managing risk with suicidal individuals. *Cognitive and Behavioral Practice*, 19 (2), 218-232.

For a copy of the UWRAMP see: <http://depts.washington.edu/brtc/files/UWRAMP.pdf>

- **Suicide Attempt Self-Injury Interview (SASII)** Linehan, M.M., Comtois, K.A., Brown, M.Z., Heard, H.L., Wagner, A. (2006). Suicide Attempt Self-Injury Interview (SASII): Development, Reliability, And Validity of A Scale To Assess Suicide Attempts And Intentional Self-Injury. *Psychological Assessment*, 18(3), 303-312.

This measure assesses the topography, intent, medical severity, social context, precipitating and concurrent events, and outcomes of nonsuicidal self-injurious behavior during a target time period. Each episode of nonsuicidal self-injurious behavior is coded separately and details of each episode are obtained. Major PHI outcome variables are the



frequency of nonsuicidal self-injurious behavior behaviors (single acts as well as clusters of acts), medical treatment for the behaviors, and a set of four factors for each nonsuicidal self-injurious behavior episode: medical risk, suicide intent, instrumental intent, and impulsiveness. The factor scales are internally consistent, with alpha coefficients ranging from .64 to .86. Three of the factors (suicide intent, medical risk, and impulsivity) represent characteristics commonly associated with the lethality of nonsuicidal self-injurious behavior. The fourth factor, instrumental intent, represents behaviors labeled by others and DSM-III-R as "suicide gestures." In order to obtain summary information from this measure, it is recommended that the clinician create rational subsets based on the information obtained (e.g., "most serious," "most recent," "first," "number of different methods").

- **Suicidal Behaviors Questionnaire (SBQ)** Linehan, M. M. (1981). Unpublished manuscript. University of Washington, Seattle).\*

This brief questionnaire assesses subject's suicidal behaviors such as suicide threats and suicidal ideation, as well as range of methods used over the past year and semantic differential scale of perceived results of nonsuicidal self-injurious behavior. This measure can be included to assess suicidal behaviors other than nonsuicidal self-injurious behavior.

- **Reasons for Living Inventory: RFL** Linehan, M.M., Goodstein, J.L., Nielsen, S.L., Chiles, J.A. (1983). When You are Thinking of Killing Yourself: The Reasons for Living Inventory. *Journal of Consulting and Clinical Psychology, 51(2)*, 276-286.

This is a 45-item self-report questionnaire, which taps expectancies about the consequences of living versus killing oneself and assesses the importance of reasons for living. The measure has six subscales: Survival and Coping Beliefs, Responsibilities of Family, Child-Related Concerns, Fear of Suicide, Fear of Social Disapproval, and Moral Objections. The instrument has been found to be negatively and uniquely related to suicidal behavior, independent of its relationship to depression and hopelessness, and not related to general psychopathology.

- **Lifetime Parasuicide Count** (Linehan & Comtois, 1996. Unpublished manuscript. University of Washington, Seattle).\*

This measure obtains a lifetime overview of parasuicidal behavior (does not include ideation or threat). Provides brief information on 1<sup>st</sup> incident, most recent incident, and most severe parasuicidal behavior, as well as intent, and medical severity. Most useful for the clinician in that it provides a chart of all methods, and gives numbers by intent, as well as highest medical severity, providing a visual summary of the severity of parasuicidal behavior. This measure was designed for use with adults but has also been used with adolescents.

## OTHER ADULT MEASURES

### Other possible measures of suicidal/life-threatening behavior in adults

#### Interviews

- **SAD PERSONS Scale** Juhnke, G.A. (1994). SAD PERSONS Scale review. *Measurement & Evaluation in Counseling & Development, 27(1)*, 325-327.

Reviews the SAD PERSONS Scale, a suicide risk scale intended to assess immediate probability of suicidal behaviors. The scale's name is an acronym, each letter standing for 1 of the 10 risk factors of suicide, easily guiding clinicians through a thorough assessment. One point is scored for each risk factor present. Suggested clinical actions for varying scores are listed. The scale has been found to be useful, especially because it encourages a semi-structured interview format vital to accurate risk assessment, but it does have a lack of supporting reliability and validity.

- **Scale for Suicide Ideation (SSI)**; Beck, A.T., Brown, G.K., Steer, R.A.(1997). Psychometric characteristics of the scale for suicide ideation with psychiatric outpatients. *Behavior Research & Therapy, 35(11)*, 1039-1046. Contact: Psychological Corporation at 1 800-228-0752.

These 19-item clinician-administered scales measure current suicide ideation (SSI-C) as well as suicide ideation at its worst point in the patient's life (SSI-W). Developed for use with adults but has also shown to be reliable and valid for use with adolescents (DeMan, A.F., Leduc, C.P. (1994). Validity and reliability of a self-report suicide ideation scale for use with adolescents. *Social Behavior & Personality, 22(3)*, 261-266).



## Paper-and Pencil, Self-Report

- **The Brief Reasons For Living inventory (BRFL)** Ivanoff, A., Jang, S. J., Smyth, N. J., & Linehan, M. M. (1994). Fewer reasons for staying alive when you are thinking of killing yourself: The brief reasons for living inventory. *Journal of Psychopathology & Behavioral Assessment*, 16, 1-13.
- **Beck Hopelessness Scale (BHS)**; Beck, A.T., Weissman, A., Lester, D., & Trexler, L.D. (1974). The measurement of pessimism: The hopelessness scale. *Journal of Consulting and Clinical Psychology*, 42(6), 861-865. Contact publisher: The Psychological Corp: 1-800-228-0752.

## ADOLESCENT MEASURES

### Suicide and Other Life-Threatening Behaviors

#### Interviews: Adolescent Suicide

- **Suicidal Behaviors Interview (SBI)**; Reynolds, W.M. (1990). Development of a semi-structured clinical interview for suicidal behaviors in adolescents. *Psychological Assessment*, 2(4), 382-390. Contact: William Reynolds by email: william.reynolds@ubc.ca.  
  
This is a semi-structured clinical interview measure of suicidal behaviors designed for use with adolescents. Research suggests this may be a psychometrically sound clinical interview for the evaluation of suicidal behaviors in adolescents.
- **Kiddie-SADS (Kiddie- Schedule for Affective Disorders and Schizophrenia)**  
  
The K-SADS (or Kiddie-SADS) is a version of the SADS designed for school-aged children of 6–18 years. The K-SADS-PL (Present and Lifetime version) is administered by interviewing the parent(s), the child, and gaining an estimate of ratings which may include parent, child, school and chart-based ratings.  
  
Endicott J, Spitzer RL (1978). A diagnostic interview: the schedule for affective disorders and schizophrenia. *Archives of General Psychiatry*, 35(7), pp. 873-43.  
  
K-SADS-PL version 1.0, at National Institute of Neurological Disorders and Stroke. Version 1.0 of October 1996.

#### Paper-and Pencil, Self-Report: Adolescent Suicide

- **Harkavey Asnis Suicide Survey (HASS)**; Harkavy-Friedman, J.M. & Asnis, G.M. (1989). Assessment of suicidal behavior: A new instrument. Special Issue: Depression. *Psychiatric Annals*, 19(7), 382-387.  
  
Asarnow J, McArthur D, Hughes J, Barbary V, Berk M.(2012). Suicide attempt risk in youths: utility of the harkavy-arnis suicide scale for monitoring risk levels. *Suicide & Life Threatening Behavior*, 42(6):684-98.  
  
This is a self-report instrument designed to gather detailed information regarding demographics, past suicidal behavior (SB) in patients as well as their family and associates, and current SB. The HASS is helpful in assessing the whole spectrum of SB (from ideation to attempts) in psychiatric patients of all diagnoses (e.g., alcoholism, schizophrenia). The HASS Suicide Attempts items have also demonstrated excellent sensitivity (100%) and good overall classification accuracy (72%) among a sample of suicidal youth in an emergency department setting (Asarnow, McArthur, Hughes, Barbary, & Berk, 2012)
- **Suicide Ideation Questionnaire--Junior** (Siemen, J.R., Warrington, C.A., Mangano, E.L. (1994). Comparison of the Millon Adolescent Personality Inventory and the Suicide Ideation Questionnaire--Junior with an adolescent inpatient sample. *Psychological Reports*, 75(2), 947-950. Contact: Psychological Assessment Resources at 1 800-331-8378.  
  
Assessed the correlation of scores on the Millon Adolescent Personality Inventory (MAPI) and the Suicide Ideation Questionnaire--Junior. Nine adolescents (aged 15-27 yrs) were given the 2 inventories within 48 hrs after being admitted to an inpatient psychiatric facility. Of the 20 categories on the MAPI, scores on 10 were significantly correlated with scores on suicide ideation. High suicide ideators tended to experience school-related problems, report poor self-concept, have poor family rapport, and be overly sensitive.



- **The Reasons for Living Inventory for Adolescents (RFL-A);** Osman A, Downs WR, Kopper BA, et al (1997). The reasons for living inventory for adolescents (RFL-A): Development and psychometric properties.
- **The Brief Reasons for Living Inventory for Adolescents (BRFL-A).** Osman, A., Kopper, B.A., Barrios, F. X., Osman, J. R., Besett, T. & Linehan, M. M. (1996). The brief reasons for living inventory for adolescents (BRFL-A). *Journal of Abnormal Child Psychology*, 24 (4), 433-443.

A 14-item adaptation of the Reasons for Living Inventory, which has reasonable psychometric data to support its use with adolescents.

## THERAPY INTERFERING BEHAVIORS/COMPLIANCE BEHAVIORS

- **Treatment History Interview (THI)** Linehan, M. M., & Heard, H. L. (1987). Unpublished manuscript. University of Washington, Seattle.\*

This instrument is divided into three sections. Section 1 describes the subject's involvement with professional psychotherapy, comprehensive treatment programs (e.g., substance abuse programs, day treatment), case management, self-help groups and other non-professional forms of treatment. The following information is collected for each individual provider or comprehensive program: dates of treatment, number of sessions attended and missed, length of sessions, number and length of phone calls to providers for therapeutic reasons, types of techniques used by the therapist, and the subject's satisfaction with therapy. Section 2 describes involvement with inpatient units, emergency treatment and medical treatment. In its previous version, Section 2 measured number of emergency room visits, number of psychiatric and medical hospital days, physician and clinic visits, and phone calls to the crisis clinic. To insure a comprehensive assessment of costs typically incurred by BPD subjects specifically with drug abuse problems, several variables have been added to this section, including use of drug and alcohol residential programs, detox centers, ambulance and paramedics, police wellness checks and visits by Mental Health Professionals (MHP's) who visit individuals at their homes in psychiatric emergencies to determine whether or not they require hospitalization. Section 3 describes medications and dosage prescribed and dates of use.

- **Alcohol Anonymous Involvement Scale (AAI)** Tonigan, J. S., Connors, G. J., & Miller, W. R. (1996). Alcoholics Anonymous Involvement (AAI) Scale: Reliability and norms. *Psychology of Addictive Behaviors*, 10, 75-80). Contact: J. Scott Tonigan c/o CASSA (Center on Alcoholism, Substance Abuse and Addictions), 2350 Alamo SE, Albuquerque, NM 87106.

This is a 13-item self-report inventory examining lifetime as well as recent Alcoholics Anonymous attendance. It also includes items relating to involvement in the 12-step fellowship including premises such as "90 meetings in 90 days" and "working the steps." The AAI has been shown to have adequate test-retest reliability (.59 to .91) and good internal consistency (.85).

- **Structural Assessment of Social Behavior (SASB)** Benjamin, L. S. (1979). Use of structural analysis of social behavior (SASB) and Markov chains to study dyadic interactions. *Journal of Abnormal Psychology*, 88, 303-319. Contact: Intrex Interpersonal Instruments, Inc.; c/o Lorna Smith Benjamin, PhD; 677 N. Cortez St.; Salt Lake City, UT 84103; ph: (801) 363-6236.

The SASB has shown high reliability and validity across various studies and is becoming a widely used measure of the therapeutic relationship. The SASB has been used to measure dialectical behaviors as postulated by DBT theory. The SASB classifies interpersonal behavior as to type of focus (other, self, and own behavior), and along the dimensions of affiliation (hostile versus friendly) and interdependence (autonomy versus control).

It is suggested that clients and therapists fill out a short form of the SASB at the end of each group and/or consultation meeting. The SASB is scored using computer programs developed by Dr. Lorna Benjamin

Benjamin, L. S. (1982). Use of structural analysis of social behavior (SASB) to guide interventions in psychotherapy. In J. Anchin & D. Kiesler (Eds.), *Handbook of Interpersonal Psychotherapy*. New York: Pergamon Press.



- **Maslach Burnout Inventory (MBI)** Maslach, C., & Jackson, S.E. (1984). Burnout in organizational settings. *Applied Social Psychology Annual*, 5, 133-153.  
Contact: Consulting Psychologists Press, Inc. (1-800-624-1765).  
  
This questionnaire assesses burnout of counselors. It focuses on problems such as the absence of positive feedback, lack of control, lack of role clarity, and unrealistic personal expectations about the job. It has demonstrated acceptable reliability and validity.
- **Therapist Session and Phone Logs; Crisis Clinic Reports.**  
  
It is recommended that following each interaction, therapists complete a structured log that documents attendance, timeliness to sessions, and any incidence of suicidal behaviors and drug use reported by the client. You can also document strategies used and conduct a suicide risk assessment. The following forms are used in research and clinical work at the UW: DBT Session Notes, DBT Phone Notes, DBT Skills Consultation Notes, DBT Pharmacotherapy Notes, DBT Pharmacotherapy Phone Notes, DBT Imminent Risk Assessment, and DBT Crisis Planning Sheet. In addition, the Group Session Log is used by coders watching the DBT group skills training to record skills training information. The following forms are used in TAU: Case Management plus Counseling (CMC) session notes, CMC phone notes, CMC pharmacotherapy notes, CMC Imminent Risk Assessment, and CMC Crisis Planning Sheet.
- **Expectancies Questionnaire** (both therapist and patient versions/E-T and E-C), modified from the NIMH Treatment of Depression Collaborative Research Program's expectancy questionnaires (Elkin, I., Shea, M. T., Watkins, J. T., Imber, S. D., Sotsky, S. M., Collins, F. L., Glass, D. R., Pilkonis, P. A., Leber, W. R., Doherty, J. P., Fiester, S. J., & Parloff, M. B. (1989)). NIMH Treatment of Depression Collaborative Research Program: I. General effectiveness of treatments. *Archives of General Psychiatry*, 46, 971-982. Contact: Irene Elkin at 773-702-9419.  
  
Modifications include additional items relevant to DBT and other therapies for BPD. They can be administered at pretreatment and 4-month intervals. Both the therapist (E-T) and patient versions (E-C) assess general expectancies about level of therapeutic progress and how treatment will work. In addition, the patient version asks questions about what they expect their therapist to do in treatment, while the therapist version asks questions about what the therapist expects to do in treatment with their patient.

## QUALITY OF LIFE INTERFERING BEHAVIORS

### Substance Abuse

- **Addiction Severity Index (ASI)**; McLellan, A. T., Luborsky, L., Woody, E. G., & O'Brien, C. P. (1980). An improved diagnostic evaluation instrument for substance abuse patients: The addiction severity index. *Journal of Nervous and Mental Disease*, 168, 26-33.  
Contact: Dr. A. McLellan; Bldg. 7; PVA MC; University Ave.; Philadelphia, PA 19104.  
  
This is a widely used structured clinical interview designed to assess the severity of and problems caused by substance abuse. The full instrument assesses six different areas: drug and alcohol abuse, medical, psychiatric, legal, family/social and employment/support. For each area, the interview obtains objective information and the subject's judgments of severity and allows the assessor to produce severity ratings. It has demonstrated both high reliability and validity. (Note, the psychiatric section is duplicative with the SCID and its follow-up, the LIFE; however, this measure is the research standard for severity of addiction.)
- **Timeline Follow-back (TLFB)**; Sobell, L.C. & Sobell, M.B. (1992). Timeline Follow-back: A technique for assessing self-reported alcohol consumption. In R. Z. Litten & J. Allen (Eds.), *Measuring alcohol consumption: Psychosocial and biological methods* (pp. 41-72). Towota, NJ: Humana Press.
- **Substance Abuse History Interview (SAHI).**  
  
This measure was developed at the UW to assess substance abuse patterns and severity. It is a combination of the ASI and the TLI, and eliminates potential redundancy in using the measures separately.



## Other

- **SCL-90-R** (Maruish Mark Edward (Ed). et al. (1994). SCL-90--R, Brief Symptom Inventory, and matching clinical rating scales. In: The use of psychological testing for treatment planning and outcome assessment. Erlbaum Associates, Inc).  
Contact: NCS Assessments; 1-800-627-7271, ext. 5151; <http://assessments.ncs.com>;  
E-Mail: [assessment@ncs.com](mailto:assessment@ncs.com)

The SCL-90--R is a 90-item self-report that yields information related to psychopathology.

- **Brief Symptom Inventory-Short Version (BSI)**; Derogatis. L.R. & Melisaratos, N.  
The Brief Symptom Inventory: An introductory report. *Psychological Medicine*. 13(3), 595-605.  
Contact: NCS Assessments; 1-800-627-7271, ext. 5151; <http://assessments.ncs.com>;  
Email: [assessment@ncs.com](mailto:assessment@ncs.com)

The BSI represents the brief form of the SCL-90--R, is 53-items long, and has been shown to be a reasonable alternative to its parent measure.

- **Social History Interview (SHI)** was developed at the UW by adapting and modifying the psychosocial functioning portion of both the Social Adjustment Scale-Self Report (SAS-SR; Weissman, M. M., & Bothwell, S. 1976. Assessment of social adjustment by patient self-report. *Archives of General Psychiatry*, 33, 1111-1115) and the Longitudinal Interview Follow-up Evaluation Base Schedule (LIFE; see above).

This measure is used to assess the variability and frequent change typical in BPD. Events (e.g., jobs, moves, and relationship endings) are documented since the last assessment. Using the LIFE, functioning is rated in each of 10 areas (work, household, social interpersonal relations with partner, children, parents, friends, and others, global social adjustment and GAS) for the worst week in each preceding month and for the best week overall. Self-report ratings in these areas using the SAS-SR are used to corroborate interview ratings. Additional items regarding legal involvement were included from the Addiction Severity Index. Average inter-rater reliabilities on the LIFE combined over four-month periods ranged from .59 to .91, with an overall average of .80.

- **Daily Diary Cards**. Diary cards collect self-reported instances of nonsuicidal self-injurious behavior, alcohol consumption, illicit drugs used, prescription and non-prescription medications used, other risk or problem behaviors, and ratings of "misery" and efforts to cope. The latter ratings are on five-point scales. In addition to recording outcomes, the cards also help the therapist to organize the session. Each session begins with the therapist asking for the card and assessing the subject's urge to use drugs, urges for self-harm, and the urge to quit therapy before the session began. These questions are also asked at the end of each session before the subject leaves. To date, we have had a very good compliance record with these cards ranging from 53% of all possible cards for those who drop out of therapy to 62% for those who stay in therapy.

**For pdfs of daily diary cards, see:** <http://blogs.uw.edu/btrc/publications-assessment-instruments/>

## Skillful Behavior

- **Revised Ways of Coping Checklist - Drug abuse (RWCCCL)**; Vitaliano, P. P. (1985). The Ways of Coping Checklist: Revision and psychometrics. *Multivariate Behavioral Research*, 20, 3-26.  
Contact: P.P. Vitaliano; Director of Stress and Coping Project; University of Washington; Box 356560; BB-1504; Health Sciences Bldg.; Seattle, WA 98195. Ph: (206) 543-8397.

This self-report measure is a revision of the Ways of Coping Checklist developed by Folkman and Lazarus. The measure assesses different methods of coping with stress including problem-focused, seeking social support, blaming self, wishful thinking, avoidance, blaming others, counting your blessings, and religiosity. All subscales show excellent internal consistency. In addition, items related to the skills taught in DBT-S groups (mindfulness skills, distress tolerance skills, interpersonal effectiveness skills and emotion regulation skills) were included to determine whether those skills are used by subjects.





## POSSIBLE MODERATORS AND MEDIATORS OF THERAPEUTIC CHANGE: DBT SECONDARY TARGETS

### Emotional Vulnerability

(There are no direct measures of this construct, but the following traditional treatment outcome measures of emotion can be utilized as indirect measures.)

- **Beck Depression Inventory (BDI)** Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571., Contact: Beck Institute for Cognitive Therapy & Research; GBS Building; Suite 700; City Line & Belmont Aves.; Bala Cynwyd, PA; 19004-1610.
- **State-Trait Anger Expression Inventory (STAXI)** Spielberger, C. D., Jacobs, G. A., Russell, S., & Crane, R. S. (1983). Assessment of anger: The state-trait anger scale. In J. N. Butcher & C. D. Spielberger (Eds.), *Advances in Personality Assessment, 2*(2) (pp. 1-47). Hillsdale: LEA. Contact: Amy Powell, Yanessment Resources; Ph: (813) 968-3003.

- **Personal Feelings Questionnaire (PFQ)**shame; Harder, D. W., & Zalma, A. (1990). Two promising shame and guilt scales: A construct validity comparison. *Journal of Personality Assessment, 55*, 729-745. Contact: David Harder at 617-627-2523; fax 617-627-3181; email dharder@emerald.tufts.edu.

A number of studies have demonstrated test-retest and internal consistency for each subscale as well as construct validity.

- **Dissociative Experiences Scale DES**) Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociative scale. *Journal of Nervous and Mental Disease, 174*, 727-735.

This is a 28 item self-report questionnaire that was developed to offer a reliable measure of dissociation in normal and clinical populations. Good test-retest and split-half reliability have been shown as was the scale's ability to distinguish between people with a dissociative disorder and all other subjects.

- **Positive and Negative Affect Schedule-Revised (PANAS-R)** Watson, D., & Clark, L. A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology, 54*, 1063-1070. Contact: David Watson at University of Iowa 319-335-3384.

This questionnaire measures self-reported emotional states of distress, anger, and fear/anxiety on five-point Likert scales. PANAS and modified PANAS are collected at two times. Suicidal and para-suicidal ratings are obtained before the Nonsuicidal self-injurious behavior History Interview (PHI) and again after the patient reports the details of their most recent suicide/nonsuicidal self-injurious behavior episode. Before and after each PHI, the clinical assessor giving the interview also rates the patient on the same emotion adjectives. A shame summary score is computed by adding the seven shame items.

### Adolescent

- **Life Problems Inventory (LPI)** Rathus, J., Wagner, D. & Miller, A.L. Self-report assessment of emotion dysregulation, impulsivity, interpersonal chaos, and confusion about self: Development and psychometric evaluation of the Life Problems Inventory. (Manuscript in preparation).

For use with adolescents, this measure assesses the four problem areas among borderline adolescents: confusion about self, impulsivity, emotional dysregulation, and interpersonal problems.

- **UCLA PTSD Reaction Index** Steinberg, A., & Brymer, M. (2008). The UCLA PTSD Reaction Index. In: G. Reyes, J. Elhai, J. Ford (eds.) *Encyclopedia of Psychological Trauma*, (pp. 673-674) John Wiley & Sons, Ltd.



## Self-Invalidation

- **Multidimensional Perfectionism Scale (MPS)** Hewitt, P. L., & Flett, G. L. (1991). Perfectionism in the self and social contexts: Conceptualization, assessment, and association with psychopathology. *Journal of Personality and Social Psychology*, 60, 456-470. Contact: Multihealth Systems, Inc in Toronto.

This questionnaire measures three constructs that overlap with Linehan's concept of self-invalidation: self-oriented, other-oriented, and socially prescribed perfectionism. Rating is made on a 7-point scale. The reliability and validity of the scale have been demonstrated in clinical and non-clinical samples.

## Active-Passivity

- **Situational Competency Test (SCT)** Chaney, E. F., O'Leary, M. R., & Marlatt, G. A. (1978). Skill training with alcoholics. *Journal of Consulting and Clinical Psychology*, 46, 1092-1104. Contact: Edmund Chaney; University of Washington; VA Medical Center; 116-B; Ph: (206) 764-2165 (x 2165); Voice mail: (206) 764-2815; Fax: (206) 764-2652.

This is a verbal role-playing instrument measuring responses to situations associated with dysfunctional behaviors and relapse. It measures four different situation areas: frustration and anger, interpersonal temptations, negative emotions state and intrapersonal temptation. Responses can be scored for problem solving skill. They can also be scored for active problem solving (the problem is solved by behavior of the protagonist) versus passive problem solving (the problem is solved by behavior of another person, not the protagonist).

## Unrelenting Crisis

- **Psychiatric Epidemiology Research Interview and Contextual Rating System** (Hirschfield, R. M. A., Lerman, G. L., Schless, A. P., Endicott, J., Lichtenstaeder, S., & Clayton, P. J. (1977). Modified Life Events sections of the Psychiatric Epidemiology Research Interview (PERI-M). Bethesda, MD: National Institute of Mental Health.).

This is a structured interview which asks subjects to note the occurrence of 133 life events. Each identified event is rated on multiple ratings of valence, threat, and intensity. Crisis generating behaviors is the sum total of those crises events that are rated by the interviewer as highly under the control of the stressed individual.

## Inhibited Grieving

- This is a construct very similar to Steve Hayes's idea of emotional avoidance and can be measured by his **Experiential Avoidance Scale** (EAS; Hayes, unpublished manuscript).

This 17 item self-report scale which assesses the degree to which a subject is emotionally avoidant. The scale performed well on both confirmatory factor analysis and cross-validation.

## Apparent Competence

*(This is a complex construct and there is no standard measure for it. The following are two ways we've chosen to measure the extent that observers underestimate patients' emotions).*

- The first is the **discrepancy between subject self-ratings minus assessor ratings of emotion when discussing a shameful event.**
- The second is the **discrepancy between self-reported shame minus observer coded Shame Duration.**

To explore the likelihood of finding apparent competence effects, correlations are examined between shame coding and shame rated by the PANAS (10 PHI segments are coded with the shame frequency method and shame duration is coded for 12). We believe that the count of brief shame behaviors (frequency coding) was more associated with self-report than total duration of shame behavior because shame is as likely to be counted when patients are masking the emotions they are experiencing as when not. In contrast, masked shame reduces the duration score. In support of this possibility, shame duration did not correlate with assessors' report of a subsequent suicide attempt ( $r = .04$ ) but did correlate with patients' report of a suicide attempt ( $r = .33$ ).



## WEB SITES OF INTEREST: ASSESSMENT INSTRUMENTS

- <http://www.nimh.nih.gov/> -- Web site for the National Institute of Mental Health (NIMH)--this site is a good resource for those looking for information on the latest research and knowledge related to mental illness. Also contains links to other sites of interest to those in the mental health professions.
- <http://blogs.uw.edu/brtc/publications-assessment-instruments/>- Web site of assessment instruments commonly used in the UW Behavioral Research and Therapy Clinics, clinic of Dr. Marsha Linehan.
- <http://www.borderlinepersonalitydisorder.com/>