FEASIBILITY AND ACCEPTABILITY OF WEB-BASED COACHING IN DIALECTICAL

BEHAVIOR THERAPY FOR YOUTH SCHOOL REFUSAL

A DISSERTATION

SUBMITTED TO THE FACULTY

OF

THE GRADUATE SCHOOL OF APPLIED AND PROFESSIONAL PSYCHOLOGY

OF

RUTGERS,

THE STATE UNIVERSITY OF NEW JERSEY

BY

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IN PARTIAL FULFILLMENT OF THE

REQUIREMENTS FOR THE DEGREE

OF

DOCTOR OF PSYCHOLOGY

NEW BRUNSWICK, NEW JERSEY   OCTOBER 2015

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ABSTRACT

School refusal (SR) affects a substantial proportion of youth and is associated with a number of negative outcomes if left untreated. Research on treatments for SR suggests existing treatments are relatively effective, but there are a number of ways in which the efficacy of such treatments could be enhanced. Videoconferencing technology may enhance SR treatment while minimizing the additional burden on families seeking treatment. In a novel adaptation of Dialectical Behavior Therapy for youth with SR, videoconferencing was used to provide Web-Based Coaching (WBC) on school mornings. Establishing the feasibility and acceptability of WBC is an important step in the development of Dialectical Behavior Therapy for Youth School Refusal (DBT-SR). The focus of the current study was assessing the feasibility and acceptability of WBC as used in an open trial of DBT-SR. Therapists, youth, and parents completed questionnaires throughout treatment about the feasibility (e.g., ease of set up) and acceptability (e.g., utility, privacy concerns) of WBC. To assess the therapeutic functions WBC may serve, participants responded to open-ended questions inquiring about the ways WBC was helpful. Results showed that parents and therapists gave generally high ratings of feasibility and acceptability, demonstrating that WBC can be feasibly and acceptably implemented. Responses suggest that WBC may help families generalize therapy skills, help youth regulate sleep or routines, allow therapists to give real-time support, and give therapists ecologically valid assessment. Youth gave lower responses, and possible reasons for this are discussed. Recommendations are provided for future development of WBC. Future studies must examine WBC with a larger sample, use community clinicians, and incorporate objective data.

Keywords: School Refusal, Dialectical Behavior Therapy, telepsychology

ACKNOWLEDGEMENTS

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for Youth School Refusal (DBT-SR)

School refusal (SR) is child-motivated refusal to attend school or difficulty staying in

classes during the school day (Kearny, 2008). SR is a heterogeneous construct that can consist of

extended absences, missed classes, tardiness, dread about school, and pleas not to attend school

in the future (Kearny, 2008). SR may affect up to 28% of youth at some point in their lives

(Kearny, 2001), and youth with SR are at higher risk for many problems, including lower

academic achievement (Lamdin, 1996), school dropout (Kearny, 2008), and a number of

economic, psychiatric, social, and marital difficulties later in life (Kearny, 2008). SR is often

associated with emotional distress, such as anxiety or depression (King & Bernstein, 2001). The

majority of interventions for SR focus on reducing the associated symptoms of anxiety and

depression (Kearny, 2008), and research on psychosocial treatments for SR has been primarily

confined to cognitive-behavioral therapies (Kearny, 2008; King & Bernstein, 2001).

There are a number of ways in which the efficacy of SR treatments could be improved

(Pina, Zerr, Gonzales, & Ortiz, 2009), though cognitive-behavioral treatments for SR are

empirically supported and relatively effective (Kearny, 2008; Pina et al., 2009). Extant research

suggests that cognitive-behavioral treatments are successful at increasing school attendance and

decreasing the symptoms associated with SR, such as anxiety, depression, and disruptive

behavior (Pina et al., 2009). For example, in a review of studies evaluating psychosocial

interventions for SR (Pina et al., 2009), youth who received treatments using cognitive and

behavioral strategies generally demonstrated some improvement in attendance, such that school

attendance for SR youth averaged 30% of days before treatment and 75% of days after treatment.

However, average posttreatment attendance rates ranged broadly from 47%-100% and treatment

effect sizes varied significantly across studies. Thus, interventions could be improved by enhancing the consistency of school attendance following treatment and increasing the proportion of youth who have a robust response to treatment. It is also salient that cognitive-behavioral treatments primarily focus on youth who refuse school for anxiety-related reasons, though not all youth with SR refuse school for these reasons (Kearny, 2008). SR behavior may serve a number of functions that are not related to anxiety and may also be maintained by factors within the family or home environment (Kearny, 2001). Due to the possible role of the family and home environment in maintaining SR behavior, effect sizes in SR treatments may be improved by increasing the emphasis on family and contextual variables (Kearny, 2008).

Research on longer-term outcomes from CBT with SR also demonstrates a need for improvement in psychosocial interventions (Last, Hansen, & Franco, 1998). In one study, (Last et al., 1998), youth were youth were randomly assigned to receive cognitive-behavior therapy or an attention placebo control. By the end of treatment and at follow-up, both groups showed statistically and clinically meaningful improvements in school attendance and symptoms of anxiety and depression. However, approximately 30% of youth in each group reported moderate to extreme difficulty reentering school the following year. Results of this study suggest that CBT is somewhat effective, but it may not be more effective than attention-placebo control treatment. Further, the substantial number of participants who had difficulty reentering school the following year suggests that treatment may not sufficiently address the skills needed to prevent relapse in the long term.

In another study, authors highlighted a number of ways to address the problem of high dropout in treatment for SR (Beidas, Crawley, Mychailyszyn, Comer, & Kendall, 2010). The population for this study was youth who had a primary anxiety disorder and SR, and cognitive

behavior therapy targeting anxiety was used. Participants had significant reduction in anxiety symptoms and SR. Notably, in this study, only 44% of those who completed the intake assessment completed the treatment. Authors considered several hypotheses about the high dropout rate in this study, and they proposed several ways to improve SR treatment. First, authors hypothesized that the treatment's high dropout rate may have resulted from its indirect focus on SR. Second, they suggested that dropouts may have had more difficulty attending treatment due to significantly higher physiological symptoms of anxiety among those who dropped out. Third, they hypothesized that dropouts may have had more ingrained patterns of SR that required a more intensive treatment model. Finally, authors suggested that exposure therapy targeting SR may need to begin soon after initiation of treatment, instead of waiting to the eighth week of treatment as was done in this study. Outcomes in treatment for SR may be improved by more time-intensive treatment and a direct focus on SR processes.

Technology may help address several shortcomings of current SR treatments, and incorporating technology into treatment delivery is an exciting and budding area of health care research. Increasing access to psychotherapy is vital to reducing the personal and societal burden of mental illness (Kazdin & Blase, 2011). Interventions that capitalize on Internet and smartphone technology have the potential to improve treatment and its reach because technology allows patients to access care from outside the therapy office (Kazdin & Blase, 2011), and it can enhance access to psychotherapy and to providers with specialized expertise (Backhaus et al., 2012). Web-based interventions are often used to enhance access to specialized medical and psychotherapeutic services in rural communities, and technology can increase access to psychotherapy services for underserved populations who may have difficulty securing transportation to a psychotherapy clinic (Backhaus et al., 2012; Wade, Chertkoff, Walz, Carey,

& Williams, 2009). Using web-based interventions may reduce barriers to in vivo visits, such as travel time, distance to providers, and costs associated with travel to attending psychotherapy (Backhaus et al., 2012; Wade et al., 2009; Wade, Oberjohn, Conaway, Osinska, & Bangert, 2011). Decreasing barriers to care may be especially important when treating families and youth, who have the additional burden of coordinating schedules of multiple family members (Wade et al., 2009).

The promise of integrating technology with psychological interventions comes with challenges. The feasibility and acceptability of using technology in psychotherapy is a key concern as innovations develop in this exciting area. A treatment is considered feasible if it can be reasonably carried out as intended, given local resources and restrictions. Measurement of feasibility involves numerous aspects of an intervention, including whether an adequate number of consumers will be interested in receiving the intervention (recruitment), time demands on clients and providers, scheduling demands, and whether consumers consistently attend and complete the treatment. Several aspects of feasibility are uniquely important for interventions involving technology, including affordability, reliability, and ease-of-use of the equipment. A concept related to feasibility is acceptability, which refers to the extent to which a stakeholder evaluates an intervention as appropriate, fair, reasonable, and not overly intrusive (Kazdin, 1980). Acceptability is important to assess when developing any novel intervention due to its implications for implementation, particularly because treatments with higher acceptability are more likely to be initiated and adhered to by consumers and clinicians (Kazdin, 1980).

Research has supported the general use of telehealth interventions to treat psychological disorders. One survey of psychologists and psychology graduate students indicated that the majority of respondents held positive opinions toward computer-based treatments for

psychological disorders, and the majority agreed that computer-based interventions could be effective in treatment of psychological disorders (Perle et al., 2013). It is plausible that interventions involving the Internet are particularly feasible and acceptable for younger consumers given the large amount of time that youth spend online (Wade et al., 2009). Though consumers and practitioners are generally accepting of web-based interventions, some have raised concerns. For example, many practitioners have reservations about these interventions, including the relative dearth of research supporting its effects, protecting privacy and confidentiality, handling crisis situations remotely, and the lack of ethical clarity for using technology in practice (Perle et al., 2013). From the perspective of consumers, sources of dissatisfaction with treatments tend to relate to technical difficulties, though across studies dissatisfaction related to technical glitches does not impact general satisfaction (Backhaus et al., 2012).

Some of the earliest attempts to integrate technology with psychological interventions for youth focused on creating interactive web pages and CD-ROMs that provided therapy materials and supplemental materials and activities for clients to use outside of therapy sessions. Interventions have been designed to be delivered both entirely online and as a supplement to in-person therapy, and each format brings unique advantages and challenges. Compared to in-person interventions, CD-ROMs and web pages typically require less therapist time, are more cost-effective, offer greater anonymity and privacy, and are also more transportable since the treatments can be accessed from any computer (Khanna & Kendall, 2008). Clients may access and review treatment materials after sessions (Khanna & Kendall, 2008). The interactive nature of such programs allows some limited customization, and the standardized presentation may enhance treatment adherence (Khanna & Kendall, 2008). There are also several challenges in

implementing this treatment approach. For instance, reduced face-to-face time may interfere with fostering the alliance necessary to aid treatment engagement and compliance (Khanna & Kendall, 2008). In addition, though some customization is possible, individualization of the treatment is limited due to the standardized presentation of materials and absence of a therapist.

More recent efforts use Internet-based videoconferencing to supplement or deliver psychological treatments to youth. Videoconferencing takes advantage of the Internet's increasing bandwidth and computers' enhanced processing power to facilitate real-time, high definition conversations between therapist and client. A key advantage of videoconferencing is that it allows access to therapy from a client's home while therapists have the opportunity to converse with the client and simultaneously observe nonverbal behavior (Nelson & Velasquez, 2011). Videoconferencing allows relationship building that approximates that of in-person therapy (Nelson & Velasquez, 2011) and may facilitate building the therapeutic alliance more than static presentations that use technology (e.g., CD-ROM). An advantage of videoconferencing that is particularly salient when working with youth is that it can be flexibly used with individuals or families. Involving parents may be particularly important for youth with SR, since family involvement may facilitate a faster increase in school attendance (Heyne et al., 2002). Videoconferencing does not reduce time required by the therapist to meet with clients as web-based or CD-ROM supplements might. Videoconferencing also requires broadband Internet access and sufficient computer processing power and speed to support the type of video and audio quality required for real-time conversations.

Despite its novelty, videoconferencing has been viewed as an acceptable and feasible psychotherapy tool. A comprehensive review of 65 articles supported the use of videoconferencing in psychotherapy, indicating that videoconferencing was a feasible way to

deliver psychotherapy (Backhaus et al., 2012). Specifically, all reviewed articles noted that videoconferencing was feasible, and 38% of articles indicated that videoconferencing could help reduce costs or increase access to psychotherapy. Outcomes for the acceptability of videoconferencing also appeared positive. Over half of the reviewed studies examined patient or provider satisfaction, and users tended to be satisfied. In studies where a comparison group was used, studies reported similar satisfaction between videoconferencing and in-person psychotherapy. Dissatisfaction tended to be related to technical problems when it did occur, though these frustrations did not appear to impact overall satisfaction ratings (Backhaus et al., 2012). Despite the benefits of videoconferencing, telehealth research has been relatively unexplored with anxious and depressed youth (e.g., Gordon & Rolland Stanar, 2003; Khanna & Kendall, 2008; Spence, Holmes, March, & Lipp, 2006).

Few studies have examined use of videoconferencing with youth behavioral disorders, but one demonstrates that multiple forms of technology supplements can enhance treatment engagement and satisfaction (Jones et al., 2013). In this study, youth with early-onset behavior problems and their parents were randomly assigned to receive an in-person behavioral parent training program or the same program with a technology enhancement. The technology enhancement used smartphones to deliver between-session skills videos, daily surveys, text message reminders, recording videos of home practice for in-session review, and midweek video calls to reinforce progress and problem-solve challenges to implementing interventions. Treatment satisfaction was measured using a consumer satisfaction scale that was developed for the in-person treatment. This scale assessed satisfaction with the overall in-person program, the difficulty of the skills taught, and the efficacy of the therapist. Treatment engagement was measured using session attendance. Results showed that those in the technology-enhanced group

had higher treatment engagement and treatment satisfaction; this group also had higher

homework completion, and overall therapists spent less time with the technology-enhancement

group (Jones et al., 2013). This study demonstrates the capacity for smartphone adjuncts to in-

person psychotherapy to increase treatment engagement and satisfaction and to decrease

therapist time in a family-based treatment. Though video calls were used to troubleshoot barriers

to home practice, this study did not capitalize on the capacity of videoconferencing to provide

real-time feedback. Like the smartphone adjuncts used by Jones et al. (2013), videoconferencing

adjuncts could enhance session attendance and treatment satisfaction, and videoconferencing

offers the added benefit of real-time feedback.

No published youth studies have used videoconferencing for skills practice to supplement

in-person psychotherapy, but two studies have used videoconferencing as an adjunct to

psychotherapy delivered via interactive web pages (Wade et al. 2009; Wade et al., 2011). In one

study, videoconferencing was used to provide parenting skills coaching to children (ages 3 to 9)

with traumatic brain injury (Wade et al., 2011). Youth were randomly assigned to receive links

to resources relevant to traumatic brain injury or to receive I-InTERACT, a web-based parenting

skills program of self-guided web modules with live coaching by videoconference. I-InTERACT

used videoconferencing to provide parent coaching to address the common challenges in

scheduling weekly sessions with busy adolescents and their parents. Results highlighted the

acceptability of videoconferencing interventions to consumers. The majority of parents rated

videoconferencing sessions as "easy to use," "helpful," and helpful relative to in-person

psychotherapy. The treatment was also acceptable to therapists, and all therapists in this study

found the treatment to be beneficial for families. Moreover, parents described videoconferencing

sessions as reinforcing what they had learned in I-InTERACT's self-guided web modules, and

the authors noted that videoconferencing allowed therapists greater knowledge of the families'

day-to-day life. These findings highlight the potential for videoconferencing to enhance

ecological validity, practitioners' assessments, and consumers' skills acquisition and

generalization. This intervention was found to be generally feasible without specialized computer

equipment. Nevertheless, 69% of families reported one or more problems with technology, such

as difficulties with video and sound quality.

A study of adolescents with a traumatic brain injury and their families further supported

the feasibility and acceptability of videoconferencing as a treatment adjunct (Wade et al., 2009).

The intervention in this study consisted of 10 informational and interactive web-based sessions

followed by videoconferencing sessions with a therapist to review and apply skills. Consistent

with other research, authors concluded that this intervention was feasible (Wade et al., 2009). All

families completed the program, and clients reported high treatment satisfaction, wherein 90% of

participants indicated that they "Agreed" or "Strongly Agreed" that they would recommend the

program to a friend (Wade et al., 2009). Sixty-five percent of participants rated

videoconferencing as "Very" or "Extremely" easy to use, and 75% rated it as "Very" or

"Extremely" helpful. Encouragingly, 55% of participants rated videoconferences as "Very" or

"Extremely" helpful compared to face-to-face, and only 30% of participants indicated that they

"Agreed" or "Strongly Agreed" that they would rather meet in person.

Videoconferencing may address problems that have challenged successful treatment of

SR in youth. Youth with SR and their parents may require active coaching beyond what they

receive in traditional once weekly therapy sessions. Videoconferencing could be used to provide

parent and youth coaching to families on school mornings when distress is highest. In this way,

videoconferencing can increase the intensity and dose of the active intervention without having

to schedule families to attend extra sessions at the therapist's office or for the therapist to make

home visits. Scheduling videoconferencing in the mornings, when the youth is likely to exhibit

the majority of resistance, may enhance the ecological validity of the intervention because it

might enable therapists to provide direct coaching to parents or youth in the mornings when the

greatest refusal behavior is occurring. A web-camera can also be set up in any room giving the

therapist an opportunity to observe and intervene in the most relevant contexts for the family's

problematic interaction patterns.

The current study sought to evaluate the feasibility and acceptability of a web-based

component used in an adaptation of Dialectical Behavior Therapy (DBT) to treat youth with SR,

due to the shortcomings of existing SR treatments and the potential of technology to enhance

outcomes. Internet-Enhanced Treatment for Youth School Refusal (DBT-SR) is a 16 week

adaptation of DBT used with youth ages 12-17 with problematic SR. Standard DBT is a

psychosocial treatment that was designed to target emotional and behavioral dysregulation

(Linehan, 1993). DBT was chosen as the treatment to be adapted for youth with SR due to its

focus on decreasing emotion dysregulation, which was hypothesized by the developers of DBT-

SR to maintain SR behavior. Both standard DBT and its adaptation for adolescents emphasize

the importance of coaching clients in skills outside of therapy sessions, typically over the phone

(Linehan, 1993; Miller, Rathus, & Linehan, 2007). Like DBT for adolescents (Miller et al.,

2007), DBT-SR is a 16-week treatment that includes individual therapy, a multifamily group

focused on teaching skills, and a consultation team. Standard DBT and DBT for adolescents use

phone coaching to enhance clients' skills as needed when clients have difficulty (Linehan, 1993;

Miller et al., 2007), but DBT-SR uses scheduled videoconferencing sessions for skills coaching.

Web-Based Coaching (WBC) videoconferencing sessions used in DBT-SR were designed to

provide coaching in the skills learned in therapy to youth and their parents in the mornings when

youth with SR typically have the most difficulty.

WBC was designed to enhance treatment for SR in a number of ways. This treatment

model was thought to enhance the validity of therapists' assessments through direct observation

of youth and parents' behavior in the setting in which problematic behavior took place, rather

than relying on self-report during in-person sessions several days later. Videoconferencing was

used instead of other technology, such as the telephone, because it was thought to allow

therapists to view interactions among multiple family members and to visually assess

environmental variables that may contribute to the maintenance of SR behavior. It was also

believed that videoconferencing would enhance the intervention because therapists would

provide real-time coaching and corrective feedback. Real-time coaching was thought to allow for

immediate, in vivo practice of the skills learned in therapy during the week's most challenging

moments, rather than giving feedback about behavior in session several days following a

challenging situation. Scheduling WBC sessions in the mornings instead of providing as-needed

phone coaching stemmed from feasibility concerns regarding family and practitioner schedules,

and it is thought that for this population the morning is the most difficult time of day.

Videoconferencing also allows therapists the flexibility to intervene with one or several

members, or to provide more passive coaching as a family completes their morning routine.

Particularly because youth with SR can be a challenging population to treat, using

videoconferencing from a family's home was thought to make possible a more intensive

outpatient treatment model that minimizes the additional burden on families.

Establishing the feasibility and acceptability of WBC is an essential step in the

development of WBC as a potential treatment adjunct and in the development of DBT-SR

overall. WBC is novel and may pose feasibility and acceptability challenges. For the current

study, youth with clinically significant school refusal behavior were invited to participate in an

open trial of DBT-SR. In this trial of DBT-SR, WBC sessions were scheduled in the mornings

when family routines are typically busy. It was important to assess the ease or difficulty in

scheduling and completing these early morning coaching sessions. With minimal specialized

equipment provided by the researchers to the families, it was critical to evaluate the

technological ease and quality of conducting high definition videoconferencing sessions with

standard computer hardware and software. Privacy concerns were also assessed, as it was

important to detect any concerns that parents and clinicians might have in sharing private

information over the Internet.

A second aim of this study was to determine whether therapists and clients perceived

WBC to serve the expected function of aiding clients in generalizing skills learned in therapy, or

whether WBC served any unanticipated functions, such as holding parents and youth

accountable for implementing strategies learned in therapy. Consistent with similar interventions

that have employed videoconferencing, we hypothesized that WBC would be feasible, and that it

would be rated as feasible (e.g., easy to use and set up, more beneficial than difficult to schedule)

by parents, youth, and therapists across study assessments. Despite overall feasibility, we

hypothesized there will be some technical problems and concerns about technical problems. We

also anticipated some challenges fitting WBC into providers' and families' schedules,

particularly because WBC sessions took place in the mornings. We also hypothesized that WBC

would be rated as acceptable by parents, youth, and therapists across study assessments (e.g., low

privacy concerns, satisfaction with WBC, belief that WBC is important to the DBT-SR treatment

overall). Despite overall acceptability, we hypothesized that parents and therapists would have

some concerns about privacy and confidentiality. We expected that youth ratings would be lower than parent and therapist ratings because youth may not agree with the treatment goal of returning to school. Nevertheless, we expected youth to rate treatment as feasible and acceptable. Finally, we hypothesized that practitioners and clients would perceive WBC as helping clients generalize the skills learned in therapy because WBC involved in vivo practice of the skills taught in therapy during times we expected were challenging for the majority of families with youth who refuse school.

Method

Participants

Participants were three youth who sought outpatient care for anxiety- or depression-related school refusal problems, their parents, two licensed psychologists who served as DBT-SR group leaders, and four doctoral graduate students who served as individual DBT-SR therapists. Four families completed intake interviews and began therapy as part of an open trial of an experimental DBT-SR program. Two families dropped out of treatment between the first and second individual session, and one of these youth refused to complete the measures included in this study. Two families completed midtreatment, posttreatment, and follow-up assessments.

Of the youth included in the current study, two were boys and one was a girl (14 -16 years old; $M = 15.00$; $SD = 1.00$). Three mothers and two fathers were involved in the study (i.e., attended at least one individual session and completed study measures). All youth and parents identified as Caucasian. Inclusion criteria for families in the original open trial were: youth between the ages of 12 and 17, presence of significantly-interfering youth SR as indicated by parent and child interviews using the Anxiety Disorders Interview Schedule for Children (ADIS-IV-C/P; Silverman & Albano, 1996). The study also required that the child and at least one

parent were fluent in English, the family owned a computer, and the youth was on a stable dose of medication for at least four weeks prior to the start of treatment. Youth were not eligible if they had a principal diagnosis of conduct disorder or oppositional defiant disorder or if they had a diagnosis of intellectual disability, psychosis, bipolar disorder, or autism spectrum disorder.

Principal *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition, text revision (*DSM-IV-TR*; American Psychiatric Association, 2000) diagnoses for the two completing youth were Major Depressive Disorder and Generalized Anxiety Disorder. Secondary diagnoses included Social Anxiety Disorder ($n = 1$) and Generalized Anxiety Disorder ($n = 1$). Five of the therapists were female and one was male (ages 25-38; $M = 28.80$; $SD = 5.54$).

Measures

Clinical diagnoses were assessed using the ADIS-IV-C/P, a semistructured interview with good reliability in diagnosing childhood disorders according to *DSM-IV-TR* diagnostic criteria (Silverman, Saavedra, & Pina, 2001). Several measures, designed for the current study, were used to assess the feasibility and acceptability of the WBC component of this treatment.

Client Technology Attitudes and Expectations Questionnaire (CTAEQ). At the first session parents and youth completed the CTAEQ, a self-report measure that assessed attitudes and expectations about technology and its use in therapy (see Appendix A). This eight-item measure used a five-point Likert-type scale (with anchors ranging from 1= "Strongly disagree" to 5 = "Strongly Agree"). Questions assessed participants' comfort using technology, the frequency of their use of different technologies, and concerns about privacy and security over the Internet. Each item assesses a different aspect of acceptability.

Therapist Technology Attitudes and Expectations Questionnaire (TTAEQ). The TTAEQ is an 18-item self-report measure completed prior to the first session by individual and group therapists (see Appendix A). This measure was used to gather demographic information about therapists, the professional settings in which they work, and past experiences and training in the skills relevant to DBT-SR. This measure also contained several items that assessed attitudes and expectations about technology and its use in therapy using a five-point Likert-type scale (with anchors ranging from 1= "Strongly disagree" to 5 = "Strongly Agree"). Questions assessed therapists' concerns about privacy and confidentiality and their expectations about the extent to which WBC will help their clients.

Youth Feedback Questionnaire (YFQ). At midtreatment, posttreatment, and follow-up, youth completed a 28-item measure that used a five-point Likert-type scale (with anchors ranging from 1 = "Not at all" to 5 = "Very much") and open-ended questions that required a response of one sentence or less (see Appendix A). Items addressed both negative and positive aspects of the program. This questionnaire consisted of four subscales: Global Opinion (five questions), WBC (13 questions), Individual Counseling (two questions), and Group (eight questions). The current study used the WBC subscale, which assessed satisfaction with WBC, perceived utility of WBC, importance of WBC in the treatment package, potential concerns about WBC (e.g., difficulties with technology and privacy), and helpfulness of the format of WBC. This subscale also included open-ended items inquiring about the most helpful aspects of WBC and suggestions for improving the intervention.

Parent Feedback Questionnaire (PFQ). At midtreatment, posttreatment, and follow-up, parents completed a 28-item measure that used a five-point Likert-type scale (with anchors ranging from 1 = "Very dissatisfied" to 5 = "Very satisfied") and open-ended questions that

required a response of one sentence or less (see Appendix A). Items addressed both negative and

positive aspects of the program. This questionnaire consisted of four subscales: Global Opinion

(five questions), WBC (13 questions), Individual Counseling (two questions), and Group (eight

questions). The current study used the WBC subscale, which assessed satisfaction with WBC,

perceived utility of WBC, importance of WBC in the treatment package, potential concerns

about WBC (e.g., difficulties with technology, privacy, intrusiveness), and helpfulness of the

format of WBC. This subscale also included open-ended items inquiring about the most helpful

aspects of WBC and suggestions for improving the intervention.

Therapist Feedback Questionnaire (TFQ). At posttreatment, group and individual

therapists completed a 34-item measure that used a five-point Likert-type scale (with anchors

ranging from 1 = "Very dissatisfied" to 5 = "Very satisfied") and open-ended questions (see

Appendix A). This questionnaire consisted of four subscales: Global Opinion (15 questions),

WBC (13 questions), Individual Counseling (two questions), and Group (six questions). The

current used the WBC subscale, which assessed satisfaction with WBC, potential concerns about

WBC (e.g., difficulties with technology, privacy, intrusiveness), and feasibility of integrating

WBC into clinical practice. This subscale also included open-ended items inquiring about the

most helpful aspects of WBC and suggestions for improving the intervention.

WBC Quality Rating Form (WBC-QRF). During each WBC session, therapists

completed, with some input from clients, a 13-item measure that assessed the quality of the

videoconference (see Appendix A). This measure noted technical information about the

videoconferencing sessions (e.g., bit rate and packet loss), and therapists rated the quality of the

video and audio during the session on a six-point Likert-type scale (with anchors ranging from 0

= "Coaching could not be done at all because of technology problems" to 5 = "Flawless- like in

person"). During the sessions, therapists also asked participants their ratings of the video and audio quality using the same six-point Likert-type scale and noted it on this form. Space was provided to note any technological problems that arose during the session.

Procedure

The Rutgers Institutional Review Board approved the current study. Participants were community-referred treatment-seeking families recruited by conducting outreach (phone calls, fliers to nearby schools). A parent completed a brief phone screening to assess study eligibility, and then parent(s) and youth completed an intake assessment that consisted of the ADIS-IV-C/P and a battery of self-report questionnaires including those for the current study. Participants who met inclusion criteria were then invited to begin the 16-week DBT-SR treatment (see Chu, Rizvi, Zendegui, & Bonavitacola, 2014). Supplemental WBC sessions were individually scheduled for each family (see details below).

The current study used assessments at the first session, at midtreatment, at posttreatment, and at the three-month follow up assessment. Prior to the first session, therapists and clients completed the TTEAQ and CTEAQ, respectively. At midtreatment, posttreatment, and the follow-up assessments, youth and parents completed the YFQ and PFQ, respectively. Therapists completed the TFQ at posttreatment, and they completed the WBC-QRF following each WBC session.

Families received the following hardware to participate in videoconferencing: a high definition webcam (Logitech HD Pro Webcam C910, model #960-000597), a room microphone (Blue Microphones Snowball USB Microphone, model #SNOWBALL-BA), a USB hub, and a networking cable. Individual therapists used their personal computers for WBC, and they received a networking cable and a high definition webcam (Logitech HD Pro Webcam C910,

model #960-000597). The networking cable was used to connect directly to therapists' wireless

router to improve the quality of videoconferencing.

Cisco Jabber, a videoconferencing program, was downloaded by therapists and installed

on each therapist and family's computer. Calls with Cisco Jabber are encrypted and the

technology adheres to HIPAA regulations to maintain participant confidentiality. This program

was chosen because it delivers higher quality video and has fewer delays than Skype.

Videoconferencing allowed therapists and families to see and hear each other over a real-time

video. Therapists also downloaded and installed Snagit software (TechSmith) on their computers

to record and save WBC videos. Snagit was chosen over other screen capture programs for its

ease of use balanced with quality of video recordings.

When consenting to the study, families were educated about the possible confidentiality

risks of WBC. Prior to the first WBC session, study staff emailed families instructions to

download and install Cisco Jabber. Following the first session, study staff went to families'

homes to orient members to the technology used in the study and to deliver computer hardware.

Families were also provided with a technology guide that included step-by-step directions and

troubleshooting tips. No difficulties arose when participants installed software, when therapists

visited families' homes, or when orienting families to technology.

Web-Based Coaching Sessions. Individual therapists initiated WBC sessions according

to a plan made with families during individual sessions. Therapists conducted WBC sessions

from a private room in their homes because WBC sessions took place early in the morning.

Therapists had the flexibility to include the youth, parents, or both in sessions. The frequency of

WBC sessions was dependent on how many full days of school the child had attended the

previous week: daily for attending zero to two days, twice weekly for attending three days, and

once weekly for attending four days. No WBC was scheduled if the youth attended all days the previous week. Regardless of school attendance, two brief WBC sessions took place between the first and second individual in-person sessions. The first WBC session focused on testing the WBC equipment, and in the second WBC session, the therapist observed the family during their morning routine. WBC sessions took place in the room in which the most conflict typically occurred.

Analyses

Descriptives of WBC sessions were calculated from the WBC-QRF, providing details about number, frequency, times, and duration of WBC calls. Unexpected cancellations were also recorded and presented. Detailed information about specific problems with WBC was obtained from an open-ended question on the WBC-QRF that asked therapists to note any technology problems that arose during a WBC session. Specific problems noted here were reviewed, sorted, and categorized to identify themes. Frequency of each theme was tallied, and the percentage of WBC sessions in which each type of problem occurred was calculated in order to identify areas of concern.

Estimates of broad WBC feasibility and acceptability were obtained by calculating mean, standard deviations, and score ranges for individual items of the WBC-QRF, YFQ, PFQ, TFQ, CTAEQ, and TTAEQ at each assessment point. Estimates were calculated separately for youth, parents, and therapists. Given the lack of measure norms, mean scores were compared to threshold scores chosen *a priori* (e.g., a score of 4 = "probably appropriate" or higher) to determine whether each item met criteria for feasibility or acceptability.

Participants' perceptions of the utility or usefulness of WBC was evaluated based on parent, child, and therapist responses to open-ended questions that inquire about perceived

benefits of WBC (e.g., "What was the most helpful part about WBC?"). Responses were

examined for themes indicating perceptions of the utility of WBC, sorted into groups according

to their theme, and the number of participants who raised a particular area of usefulness was

tallied in order to identify areas of benefit.

Results

Of the four families that initiated treatment, two completed the 16-week program. Both

children who completed the program met for no *DSM-IV-TR* diagnoses at posttreatment and

follow-up assessments. Both of the families that dropped out did so prior to the second individual

session, and neither family set up or completed any WBC. Neither family cited concerns about

WBC as a primary reason for dropout. One youth dropped out primarily because she was

unhappy with the format of the group (e.g., she did not want parents involved), and the other

youth dropped out primarily because the family had recently started another mindfulness-based

treatment program that they wanted to continue in lieu of DBT-SR.

The families that completed treatment had an average of 38.50 WBC sessions (*Range*: 36

– 41; see Table 1 for WBC data for each family). Zero to five WBC sessions occurred each

week, with a mean of 1.97 WBC sessions per week (*Range* = 0 – 5). WBC sessions lasted an

average 16.60 minutes, ranging from 4.00 to 43.00 minutes in length. All WBC sessions took

place between 6:30 a.m. and 9:30 a.m., with 83.8% of WBC sessions beginning between 6:30

a.m. and 6:59 a.m. Of planned WBC sessions, 18.7% were cancelled on the morning of the

scheduled session. Sessions were missed for a variety of reasons (see Table 1). One family

primarily missed because the child refused to come to the computer when the therapist called for

WBC, often resulting in phone coaching with the parents or youth. The other family missed for a

variety of reasons, including not responding to the therapist's call, not having WBC equipment

set up or in the right place, Internet being unavailable as part of a contingency management plan,

and parents wanting to receive coaching by phone so as not to wake the child. One WBC session

was missed due to technical problems.

Feasibility: Technological Quality and Reliability

Of 77 total WBC sessions, therapists noted a total of 49 technical problems in 37 sessions

(49.3%) on the WBC-QRF. No technology problems occurred in 51.0% of all WBC sessions,

indicating that when problems did occur, multiple problems tended to co-occur in the same

sessions. The most common technical problems were audio or video lags, which took place in

17.3% of WBC sessions. Table 2 describes details of all types of WBC problems.

Participants reported that WBC video and audio quality was high on the WBC-QRF.

Parents and youth reported that WBC video quality was high, with a mean of 4.06 ($SD = 1.23$),

and a range of 0 ("Coaching could not be done") to 5 ("Flawless-like in person"). In 87.3% of

WBC sessions, clients rated video quality as 3 ("Acceptable") or better, and they rated video

quality as 2 ("Somewhat poor") or worse in 12.7% of WBC sessions. Clients reported similar

audio quality, with a mean of 4.10 ($SD = 1.22$), and a range of 0 to 5. In 90.3% of WBC sessions,

audio quality was rated as 3 or better, and in 9.7% of WBC sessions, it was rated as 2 or worse.

Therapists gave high ratings of video quality, with a mean rating of 4.21 ($SD = 1.16$), and a range

of 0 to 5. Video quality was rated 3 or higher in 93.0% of WBC sessions, and it was 2 or worse

in 7.0% of WBC sessions. Therapists also gave high ratings of audio, with a mean of 4.14 ($SD =$

1.07), and a range of 0 to 5. Therapists rated audio quality 3 or higher in 91.5% of WBC

sessions, and they gave ratings of 2 or lower in 8.5% of WBC sessions.

Parents, youth, and therapists provided overall ratings on the set-up and benefits of WBC

on five-point Likert-type scales (YFQ, PFQ, and TFQ). Results are summarized in Tables 3, 4,

and 5 for each source, respectively. Each youth rated ease of set-up and technology use as 4 or

"Moderately" easy or higher across all time points. At midtreatment, one parent rated ease of set-

up and technology use as 3 or "Somewhat" easy, while other parents rated it uniformly as "Very

easy." At posttreatment and follow-up, all parents rated ease of set-up and technology use as 5 or

"Very easy." All therapists rated ease of set-up and technology use as 4 or "Moderately" easy.

When asked whether the benefits of WBC outweighed the challenges of scheduling,

youth gave the lowest mean ratings. Across time points, one youth rated this item 1 or "Not at

all," whereas another youth consistently rated this item 5 or "Very much." Both parents and

therapists gave higher ratings to this item, with all adult participants indicating that the benefits

of WBC outweighed the challenges of scheduling "Moderately" or "Very much" (with ratings of

4 or 5, respectively). Therapists also rated the extent to which they agreed that the average

clinician has the time and resources to fit WBC into their schedule. Therapist ratings ranged from

2 "Mildly disagree" to 3 "Agree and disagree equally."

Acceptability

Parents, youth, and therapists rated 10 to 11 acceptability items on five-point Likert-type

scales, with lower numbers indicating less acceptability and higher numbers indicating greater

acceptability. Results are summarized in Tables 3, 4, and 5 for each source, respectively. Mean

Child CTAEQ and YFQ responses for individual items ranged from 2.50 to 4.50, with the rating

of whether DBT-SR needs WBC to be effective rated lowest in acceptability (at midtreatment)

and privacy protection during WBC rated as highest (at posttreatment and follow-up). Notably,

scores improved at posttreatment and follow-up assessments for whether DBT-SR needs WBC to

be effective. At pretreatment, youth rated one of four CTAEQ items above the determined

threshold for acceptability. The acceptable item was the degree to which youth agreed

videoconferencing was secure and confidential. Scores were consistently below the threshold for acceptability for satisfaction with the help youth got during WBC and how essential WBC was in helping with the problems that brought youth to counseling. Youth rated items consistently above the acceptability threshold for the helpfulness of having WBC at a set time and the helpfulness of having WBC in the mornings.

Parents reported higher treatment acceptability than youth ratings. The only CTAEQ or PFQ item below the determined acceptability threshold was the pretreatment CTAEQ item assessing whether parents agreed videoconferencing was secure and confidential ($M = 3.75$, $SD = 0.50$). In contrast, the highest-rated item was a similar PFQ question that asked how much parents felt their privacy was protected during WBC. For this item, parents uniformly rated 5 or "Very much" across midtreatment, posttreatment, and follow-up assessments.

Therapists gave generally high ratings of treatment acceptability on the TTAEQ and the TFQ. Like parents, therapists gave below threshold ratings for the pretreatment TTAEQ item that assessed the degree to which they agreed videoconferencing was secure and confidential ($M = 3.33$, $SD = 0.82$). One therapist selected 2 or "Disagree" when asked whether videoconferencing was secure and confidential, whereas the rest of therapists selected 3 or "Undecided" and 4 or "Agree." Therapists also gave ratings below the determined acceptability threshold on an TFQ item that assessed the intrusiveness of having WBC in their home or office. Scores for this item ranged from 2 or "Somewhat intrusive" to 4 or "Mostly not intrusive."

Functions of WBC

Participants rated the extent to which they agreed that WBC helped practice the skills learned in the skills group on a five-point, Likert-type scale, with higher numbers indicating higher agreement. Tables 3, 4, and 5, display Child, Parent, and Therapist responses,

respectively. Mean responses ranged from 3.00 ("Neutral") to 4.75. Therapists gave the lowest

ratings for this item ($M = 3.00$, $SD = 0.82$), with responses ranging from 2 or "Probably not" to 4

or "Probably." Therapists also rated the extent to which WBC helped them understand and assess

their clients' problems. Therapists rated this item on a five-point, Likert-type scale, with higher

scores indicating WBC helping more with assessing clients' problems. Therapists gave high

scores, with a mean of 4.75 ($SD = 0.50$, *range* = 4-5).

Youth and parents described the most helpful parts about WBC sessions during the

midtreatment, posttreatment, and follow-up assessments, and therapists noted the most helpful

parts at the posttreatment assessment. Six themes were identified by categorizing open-ended

responses. No notable changes were detected over time, and Table 6 presents the frequency and

percentage of parents, youth, or therapists that noted each theme at any assessment point.

Participants most commonly noted that WBC aided in generalizing therapy skills, routine or

sleep regulation, and giving or receiving real-time support or encouragement.

Discussion

This study examined the feasibility, acceptability, and perceived functions of WBC as

part of a novel treatment adapting DBT for SR. As hypothesized, WBC was feasible overall.

Technical problems occurred commonly, but did not significantly impact overall WBC quality

ratings. The benefits of WBC outweighed the challenges, though the average community

clinician might need to change their work schedules to make WBC more feasible. WBC was

acceptable overall, as hypothesized. However, WBC was less acceptable to youth participants

across a number of domains. Participants perceived WBC to help with generalizing therapy

skills, routine or sleep regulation, and support and encouragement. Together, results suggest that

WBC is a valuable adjunct to in-person psychotherapy.

Feasibility

Parent and youth reports of usability and feasibility showed promise, which is consistent with past research that supports the general feasibility of using videoconferencing in health care applications (Backhaus et al., 2012). Sessions averaged about 15 minutes, making the daily time commitment for WBC minimal. Despite the short duration, there were about 40 WBC sessions per client, and sessions tended to take place between 6:30 a.m. and 7:00 a.m. Numerous sessions and early timing underscores that WBC is a significant commitment for therapists and families. The frequency of WBC sessions suggests that families and therapists find value in the sessions and are willing to make use of this resource even as it can require additional time and effort on their parts. Finding value in WBC is consistent with high ratings of helpfulness in past studies using videoconferencing adjuncts (e.g., Wade et al., 2009), and it is consistent with our hypothesis that families would find WBC acceptable. Parents rated WBC as essential to DBT-SR and essential to helping their child, highlighting its value in parents' minds.

Cancellations and no-shows are a particular issue to consider in implementing WBC sessions. Close to 20% of WBC session were cancelled without notice. It is unclear how much of this is consistent with attendance problems that are endemic to youth with SR or specific to WBC sessions. Therapists will want to anticipate WBC refusal, by both parents and youth, and plan around its eventuality. When youth refuse WBC but parents do not, therapists have an opportunity to coach parents in using DBT skills to help their child engage in activities they are resisting. Parents can then generalize these same skills to help their child attend school. Missed WBC sessions, whether due to child or parent factors, should be targeted as therapy-interfering behavior and treated similarly to missed group and individual sessions. That is, therapists should address missed WBC sessions during the next individual session using behavioral chain analysis

and other DBT strategies (e.g., contingency management, radical genuineness). Additionally, therapists in this study anecdotally reported that missed WBC sessions, scheduled early in the morning, may lead to frustration with clients and contribute to burnout. Therapists' ideographic reactions to missed WBC sessions should be monitored and addressed in a DBT-SR consultation team, much like the consultation team is used in standard DBT.

Consistent with past research (Wade et al., 2011), technical problems were relatively frequent in WBC, occurring in about half of WBC sessions. However, technical problems proved to be minor because only one session was missed due to technical problems, and on average videoconferencing quality was rated highly. Audio or video lags occurred in about 15% of WBC sessions and were the most frequent technical problem. Based on the information in the present study, it is not possible to determine the exact cause of technical problems. Nevertheless, therapists and parents provided suggestions on open-ended items for improvements of WBC technology. For example, one therapist suggested, "something more portable and less complicated (i.e., only one device) like an iPad may be easier." Another therapist noted, "It may be easier for families with a lot of stress to use simpler technology. Using the family's computer and needing to be plugged into the Internet introduced difficulties in the morning since my clients had low knowledge of technology and high stress. It may be worth it to sacrifice video quality to increase simplicity."

To balance addressing technical problems and simplifying technology, we recommend additional pilot testing of several components of WBC. Audio or video lags may have been caused in part by participants using their networking cables incorrectly, such that videoconferencing quality decreased when computers used Wi-Fi instead of the networking cable. Additional pilot testing should include testing and revising instructions for using the

networking cable with naïve volunteers. Varying quality of participants' home networks could

have also contributed to varying quality experiences, particularly in light of the high definition

video resolution produced by Cisco Jabber. Further piloting of Cisco Jabber with various audio

and video settings is warranted. Further pilot testing might also include mobile devices, such as

iPads and tablets that are dedicated for WBC purposes. This may reduce any processing

interference contributed by other software on the computing device.

  WBC appeared feasible according to ratings by youth, parents, and therapists across time

points. This is consistent with ratings of videoconferencing in other studies (e.g., Wade et al.,

2009; Wade et al., 2011). Importantly, parents and therapists gave positive ratings of the cost

versus benefit of WBC, suggesting that WBC was a valued resource despite any difficulties that

accompanied WBC. Youth ratings of the cost-benefit of WBC were lower than hypothesized,

despite youth endorsing that the technology was easy to set up and their comfort with the

security of technology. Youth endorsed the benefits of WBC as "Somewhat" outweighing the

challenges of scheduling, on average and across time points. It is notable that two youth

responded to this question at each time point, and one primarily responded "Not at all," while the

other responded "Very Much." It is difficult to determine the validity of such responses given the

tendency for one youth to respond primarily positively and the other to respond primarily

negatively, and it is unclear how a larger group of youth would respond. Given that WBC takes

place in the morning when youth with SR do not want to go to school, a larger sample of youth

may give low ratings of the utility of WBC due to the inherent mismatch between youth and

adult treatment goals for SR.

  Therapists gave lower ratings than hypothesized about whether the average clinician

could fit WBC into their schedules. When asked whether the average clinician has the time and

resources for WBC, therapist responses ranged from mild disagreement to agreeing and disagreeing equally. Instead of logistical concerns, responses to open-ended questions suggested that therapist burnout, relating to WBC and DBT-SR more broadly, may underpin concerns about working WBC into clinicians' schedules. For example, one clinician reported that to improve DBT-SR she would "reduce my workload outside of this program to prevent burnout." Another clinician suggested sharing the burden of care with two therapists "partly to reduce therapist burnout." Despite the challenge of potential burnout, high satisfaction and utility ratings indicated that WBC is a valued addition to clinical practice.

WBC may require accommodations in clinicians' schedules to balance WBC with other demands and decrease potential burnout. In the future, clinicians should use information about WBC (e.g., number of sessions to expect; typical session length and times) to anticipate how WBC would affect their practice and their work-life balance; then therapists may choose to limit other commitments when adding WBC to their practice. Given that WBC typically took place before 7:00 a.m., therapists may limit late evening therapy sessions so that the whole workday is earlier.

Acceptability

WBC appeared acceptable, as evidenced by generally positive expectations about WBC, generally high treatment satisfaction, and primarily low concerns about confidentiality. Consistent with hypotheses, adult participants rated a number of aspects of WBC as acceptable. On average, parents and therapists believed that DBT-SR would be successful, believed the time commitment for DBT-SR was appropriate, were comfortable with the prospect of using videoconferencing for psychotherapy, were satisfied with WBC, believed WBC was specifically helpful for therapy targets, and believed WBC was necessary for making DBT-SR effective.

Therapists also believed that WBC would enhance clients' outcomes. These high ratings support

the notion that WBC is an acceptable way to increase the intensity of an outpatient treatment.

High satisfaction with videoconferencing for clients and providers is consistent with past

research, which found that users were generally satisfied with using videoconferencing for

psychotherapy (Backhaus et al., 2012). In both the current study and past research, nearly all

participants rated videoconferencing sessions as helpful (Wade et al., 2009; Wade et al., 2011).

Therapists' positive expectancies are consistent with research that has found that the majority of

therapists are accepting of videoconferencing as an adjunct to fact-to-face therapy (Perle, 2013).

In terms of scheduling WBC, parents tended to believe that it was helpful for WBC to take place

at a set time and in the mornings, as opposed to as needed or at other times of day. In the future,

WBC for SR should continue to be scheduled in the mornings before school.

Results supported the hypothesis that youth acceptability scores would be lower than

adult scores; however, youth rated several individual items below the hypothesized thresholds

listed in Table 3. Acceptability ratings mirrored feasibility ratings, with one youth consistently

giving positive ratings and the other negative ratings. Thus, youth self-report tells two stories of

acceptability and feasibility, and a larger sample of youth could as easily reflect high or low

ratings. As discussed above, youth ratings may be lower than adult ratings because youth and

adult treatment goals do not align in most treatment for SR (i.e., youth do not want to go to

school and adults want them to go). Youth also considered it helpful for WBC to take place at a

set time in the mornings. Despite frequent cancellations, therapists might wish to keep sessions

fixed in the mornings and actively problem-solve with families how to maximize attendance.

Treatment developers had hoped that, despite the potential aversiveness of coaching

during the challenging morning time, youth would see the value in live practice of skills during a

challenging time. With two discrepant youth reports, one cannot prematurely conclude how a

larger sample of youth would respond to WBC. In the future, there could be greater focus on

increasing youth engagement in WBC. Individual therapists may specifically elicit goals for

WBC from youth, draw out the connection between WBC and youth goals, use more

motivational interviewing techniques, and provide youth with greater orientation to the potential

benefits of WBC. Lower youth ratings of acceptability are not consistent with previous research,

which has demonstrated roughly equivalent parent and youth ratings of helpfulness and ease-of-

use of videoconferencing sessions (e.g., Wade et al., 2009); however, previous research

examining the acceptability of videoconferencing has not been conducted with youth with SR.

Parents and therapists endorsed mild concern about security and confidentiality at

pretreatment. One therapist reported disagreement with the statement "videoconferencing is

secure and confidential," and the remainder of adults selected agreeing with this statement or

being undecided. Practitioners' concerns about protecting privacy and confidentiality when using

telehealth interventions have been previously documented, though in past research a greater

number of practitioners were concerned about privacy (about half of practitioners; Perle, 2013).

While some concerns about the security of videoconferencing were hypothesized, therapists'

concerns were higher than anticipated. In contrast, youth endorsed the belief that

videoconferencing is secure and confidential. Despite adults' concerns about privacy at

pretreatment, they endorsed the belief that their privacy was protected at midtreatment,

posttreatment, and follow-up assessments. It is possible that adults had less experience with

videoconferencing or less understanding about how privacy could be protected during

videoconferencing. Adult perceptions about privacy changed after they had more exposure to

videoconferencing by participating in WBC. While there are inherent privacy risks any time

private information is transmitted over the Internet (Myers & Turvey, 2013), concerns could be

assuaged in future uses of WBC by giving increased education about steps taken to protect

security and confidentiality. Future uses of WBC, like other interventions using

videoconferencing, should continue to give thorough informed consent about privacy risks,

secure private information to the greatest extent, and make use of private rooms for sessions

(Myers & Turvey, 2013).

Consistent with hypotheses, parents endorsed little concern about the intrusiveness of

having WBC take place in their homes. However, therapists gave slightly higher than

hypothesized ratings of intrusiveness of WBC. When asked about how intrusive it was to have

WBC film therapists in their offices, on average therapists responded, "Neutral - possibly,

maybe, don't know" to "Mostly not intrusive." Conversations with therapists following the study

indicated that perceptions of WBC intrusiveness related to observing personal limits (e.g., clients

seeing therapists first thing in the morning, exposing parts of therapists' homes, clients knowing

when therapists are travelling, etc.). Personal limits must be reconsidered when a new form of

communicating with clients is introduced. Videoconferencing has the potential to expose aspects

of the therapists' personal life that are private when conducting in-person psychotherapy, such as

the therapists' homes. When using videoconferencing from home, therapists must carefully

consider what part of their homes they want to show clients, what attire they wear when

conducting psychotherapy from home, etc.

Observing limits is essential to DBT-SR, as it is in standard DBT (Linehan, 1993). Like

standard DBT, DBT-SR therapists must have limits, observe them, and treat limit threatening or

crossing as therapy interfering behavior (Linehan, 1993). Limits are unique to the therapist and

the clinical context (Linehan, 1993), but common examples of limit crossing involve session

rescheduling and the timing, length, and frequency of coaching phone calls. In DBT-SR, two

categories of personal limits might be common to WBC: limits related to the technology (e.g.,

location of computer terminal, times of day, frequency, etc.) and limits related to client behavior

(e.g., how to handle client no-shows, late cancellations, answering WBC calls late, etc.).

Observing limits related to WBC should be treated similar to phone coaching in standard DBT.

Therapists should carefully consider what parts of their home to expose, the type of attire to

wear, the time of day they are comfortable coaching, and the frequency and length of WBC

sessions. The consultation team can be used to monitor how a therapist is setting limits and

reacting to limit crossing, as it would in standard DBT.

Functions of WBC

In this early development phase we were eager to assess whether parents, youth, and

therapists perceived the utility of WBC as was intended by the treatment developers. As

hypothesized, therapists and parents perceived that WBC helped generalize DBT skills. Three

quarters of therapists noted that WBC was helpful for skills generalization (i.e., helping youth

practice skills during challenging times and outside the therapy office); however, on average

therapists responded "Neutral- Maybe, Possibly, Don't know" when they were asked whether

WBC helped youth practice the skills learned in skills group. It is possible that therapists

perceive skills generalization as the most helpful part about WBC, but they are unsure whether

WBC was successful in helping youth practice the skills learned in the skills group.

Parents endorsed agreement that WBC was helpful in practicing the skills learned in the

group, and all parents noted that skills generalization was a benefit of WBC. For example, one

parent commented, "[WBC helped my son] practice the skills learned in group at a difficult time

(early in the morning) when he felt tired and unable to get up." Contrary to hypotheses, youth did

not endorse agreement that WBC helped with skills generalization on open-ended items or when asked directly. Overall, it appears that WBC may have served the intended function of skills generalization, though more research is needed in this area.

Sleep or routine regulation was a frequently noted, if unanticipated, perceived function of WBC. All parents endorsed WBC as helpful for sleep or routine regulation, making comments such as, "[WBC] helped keep my son on a normal schedule so he couldn't stay up all night and sleep late everyday." Future uses of WBC for SR should capitalize on the potential for WBC to help with sleep and routine regulation, which is commonly related to SR (Hochadel, Frölich, Wiater, Lehmkuhl, & Fricke-Oerkermann, 2011), such that youth go to bed and wake at similar times each day. For example, therapists could specifically use WBC to target the "balancing sleep skill" within the Emotion Regulation component of skills group. Real-time support or encouragement was noted by half of participants, and one youth noted, "[The most helpful part of WBC is] seeing a friendly face when I feel sick."

WBC also appeared to help increase ecologically valid assessment. Therapists substantially agreed that WBC helped them understand and assess their clients' problems. Half of therapists (group and individual were included) noted that WBC was helpful for ecologically valid assessment. One parent also noted that WBC was helpful for assessment, noting, "It gave [the therapist] an un-edited, real-time view of the challenges we have been living with." Participants' perceptions of the functions of WBC may not reflect the actual functions of WBC, and future research should use objective data to examine the functions of WBC.

Because WBC appeared to serve broad functions, it may be used for problems other than SR to increase sleep regulation, generalize therapy skills, and demonstrate therapist support. Using WBC for sleep or routine regulation could be particularly helpful for sleep disorders, or it

may be helpful for psychiatric disorders associated with sleep dysregulation, such as depression or anxiety disorders (American Psychiatric Association, 2000). Using WBC to generalize therapy skills could be helpful for other DBT treatments or to facilitate in vivo exposures to settings inaccessible from the therapy office. Demonstrating therapist support could be used to increase alliance or to support clients through challenging life events.

Participant feedback highlighted the benefit of using videoconferencing instead of morning coaching by phone for coaching in DBT-SR. For both participating families, WBC focused significantly on coaching parents and youth in applying DBT skills with each other, particularly the Walking the Middle Path skills (e.g., Validation, contingency management). One parent noted that WBC helped her to generalize Validate and Cheerlead with her child by highlighting, "It taught me how to coach my child in a positive way." A therapist also highlighted the value of WBC in helping parents implement Walking the Middle Path skills when she noted, "WBC helped increase coaching for parents in implementing contingency plans in the mornings." Videoconferencing was also thought to be important because of the noted function of WBC in ecologically valid assessment. Having therapists view problematic interactions and child behaviors first hand was valuable to both parents and therapists. One parent noted that a benefit of WBC was that it gave the therapist an, "un-edited, real-time view of the challenges we have been living with." Another therapist noted that WBC was helpful for "assessing what really happens in the mornings."

There are several important limitations to the current study, though this study is valuable for the development of WBC and DBT-SR. Most salient is the study's small sample. Two families participated in the study, and feasibility and acceptability is evaluated on the experiences of those families and their therapists. This small sample may not be representative of

the SR population more generally, and a small sample may be particularly problematic for SR because of its heterogeneous presentation (Kearny, 2008). The data used for the current study is self-report, and much of it is retrospective in nature. Self-report and retrospective data may be subject or biases. Given the early stage of treatment development of DBT-SR, it seemed fair to allow a development period to hone WBC session content. Therefore, the treatment protocol of WBC was not firmly developed at the outset of the study. A loose protocol allowed therapists great flexibility to tailor WBC to each family's needs. Study therapists may have delivered WBC differently, and differences in delivery could account for differences between the perceptions of the two families and their providers. Additionally, individual therapists were advanced graduate students in clinical psychology whose work schedules are not representative of typical community clinicians conducted WBC. The responses of these therapists may have been different if they had more typical work schedules.

Concluding Remarks

Taken together, the results of this study support the use of coaching via videoconferencing instead of in-person morning visits. Though in-person visits would also allow for ecologically valid assessment and the flexibility to coach parents and youth, in-person morning visits are clearly not feasible, particularly given the high number of morning sessions, early session times, and the prohibitive expense of therapist travel. Many of the challenges of in-person visits are circumvented by videoconferencing, which allowed the flexibility of assessing and addressing multiple family members at once.

WBC is worthwhile and a uniquely valuable adjunct to in-person psychotherapy. WBC has potential to help generalize therapy skills to places and times that are not feasible for therapists to access in person. Using videoconferencing allows more intensive outpatient

treatment, while minimizing the additional burden on consumers. Moreover, WBC provides

flexibility that is particularly helpful for family-based treatments, when therapists want to assess

or intervene with one or several family members at once. These benefits appear to outweigh the

challenges that come with WBC, such as fitting WBC into busy therapist schedules and at times

engaging youth in WBC interventions. WBC appears worthwhile and uniquely valuable given

the apparent benefits of WBC along with its general feasibility and acceptability.

Results encourage optimism for future uses of WBC, though there are several

recommendations for WBC moving forward:

1. Before beginning WBC, therapists should work with clients to prevent no-shows
   at WBC sessions.

2. Additional pilot testing of technology should be conducted to optimize the
   technology used for WBC (e.g., revise instructions for using the networking
   cable, using iPads).

3. Clinicians should anticipate how early-morning WBC sessions would impact
   work schedules and consider personal limits. The DBT-SR consultation team
   should help therapists observe limits and avoid burnout.

4. Therapists should devise strategies to optimize youth engagement in WBC, such
   as specifically eliciting goals for WBC from youth and providing greater
   orientation to the potential benefits of WBC.

5. Before beginning WBC, therapists and parents should be educated about security
   and confidentiality.

6. Therapists should capitalize on the potential for WBC to help with routine or
   sleep regulation (e.g., using WBC to target the "balancing sleep" skill).

Future research should evaluate the feasibility and acceptability of WBC with a larger sample and with a well-developed treatment protocol for WBC to ensure unified delivery. Later study of WBC should include community clinicians in order to determine how WBC would fit with a typical clinical caseload. Future study should aim to examine whether WBC enhances treatment outcomes. Research should also use objective data to determine whether WBC actually increases skills generalization, sleep regulation, and rapport.

In summary, WBC has the potential to be feasibly and acceptably implemented. Early results suggest that WBC may help youth with SR generalize skills learned in therapy to a challenging time of day, regulate their sleep or routines, and feel real-time support from therapists when families are in need. Future development of WBC will include additional pilot testing to minimize technology problems and several steps to plan ahead to circumvent challenges in WBC. These additions have the potential to optimize WBC and maximize its benefits. Future studies must examine WBC with a larger sample, use community clinicians, and incorporate objective data.

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Table 1

Detailed WBC Information for Participating Families

WBC Information	Family 1	Family 2
Number of WBC sessions	36	41
Average WBC sessions per week (*SD*, *range*)	1.70 (1.45, 0-5)	2.28 (1.99, 0-5)
Average session length in minutes (*SD, range*)	19.45 (9.39, 4.00-43.00)	13.94 (8.06, 6.00-32.00)
% of planned sessions cancelled	20.6%	17.1%
Of sessions cancelled, percent cancelled due to a technology problem	0.0%	14.3%
Of sessions cancelled, percent cancelled due to family not responding	100.0%	28.6%
Of session cancelled, percent cancelled due to a miscellaneous reason[a]	0.0%	57.1%

Note: Data gathered from the Web-Based Coaching Quality Rating Form.

[a]Reasons included not having WBC equipment set up or in the right place, Internet being unavailable as part of a contingency management plan, and parents wanting to receive coaching by phone so as not to wake the child, etc.

Table 2

Problems Encountered during WBC

Problem Type[a]	Frequency in any WBC session	Percentage of sessions present
Internet Problems	6	8.0%
Computer Problems unrelated to WBC	0	0.0%
Cut out/froze/broken up video or audio	9	12.0%
Audio or video lag	13	17.3%
"Choppy" or video asynchronous with audio	7	9.3%
Jabber problem	7	9.3%
Other problem	7	9.3%

Note: Data gathered from the Web-Based Coaching Quality Rating Form.

[a]Multiple problems were tallied in some sessions.

Table 3

Youth Ratings of WBC Feasibility, Acceptability, and Functions

Question	Threshold (possible ranges = 1 - 5)	Pretreatment (n = 3)		Midtreatment (n = 2)		Posttreatment (n = 2)		Follow-Up (n = 2)	
		M (SD)	Range	*M (SD)*	Range	*M (SD)*	Range	*M (SD)*	Range
		Acceptability							
How successful to you think this program would be in helping you with the problems that brought you to counseling?	Mean of 4 (Somewhat successful) or higher	3.67 (1.15)	3-5	--	--	--	--	--	--
Is the amount of time you will spend on this program appropriate?	Mean of 4 (Probably appropriate) or higher	3.67 (1.15)	3-5	--	--	--	--	--	--
How much do you agree that videoconferencing is secure and confidential?	Mean of 4 (Agree) or higher	**4.33 (0.58)**	4-5	--	--	--	--	--	--
How comfortable are you with the idea of using videoconferencing with your therapist?	Mean of 4 (Mostly comfortable) or higher	3.00 (1.73)	2-5	--	--	--	--	--	--
How satisfied are you with the help you got during WBC?	Mean of 4 (Somewhat satisfied) or higher	--	--	3.50 (2.12)	2-5	3.50 (2.12)	2-5	3.50 (2.12)	2-5
How essential was WBC in helping you with the problems that brought you/them to counseling?	Mean of 4 (Moderately) or higher	--	--	3.00 (2.83)	1-5	3.00 (2.83)	1-5	3.50 (2.12)	2-5

Table continued on next page

Table 3 (Continued)

Would you say this program needs to have WBC to be effective?	Mean of 4 (Probably) or higher	--	--	2.50 (0.71)	2-3	**4.00** **(1.41)**	3-5	3.50 (2.12)	2-5
How much did you feel your privacy was protected during WBC?	Mean of 4 (Moderately) or higher	--	--	**4.50** **(0.71)**	4-5	**4.50** **(0.71)**	4-5	3.50 (2.12)	2-5
How helpful was it to have WBC take place at a set time (instead of as needed)?	Mean of 3 (Somewhat) or higher	--	--	**3.50** **(2.12)**	2-5	**3.00** **(1.41)**	2-4	**3.50** **(2.12)**	2-5
How helpful was it to have WBC take place in the mornings (instead of another time of day)?	Mean of 3 (Just a little bit) or higher	--	--	**3.00** **(2.83)**	1-5	**3.00** **(2.83)**	1-5	**3.50** **(2.12)**	2-5
			Feasibility						
How easy was it to set up and use the technology needed for WBC?	Mean of 4 (Moderately) or higher	--	--	**5.00** **(0.00)**	5-5	**4.50** **(0.71)**	4-5	**5.00** **(0.00)**	5-5
Did the benefits of WBC outweigh the challenges of scheduling?	Mean of 4 (Moderately) or higher	--	--	3.00 (2.83)	1-5	3.00 (2.83)	1-5	3.00 (2.83)	1-5

Table 3 (Continued)

		Functions						
Did WBC help you practice the skills you learned in the skills group?	Mean of 4 (Probably) or higher				3.50		3.50		3.50
		--	--	3.50 (2.12)	2-5	3.50 (2.12)	2-5	3.50 (2.12)	2-5

Note: Data gathered from the CTAEQ and the YFQ. Bold typeface indicates a mean above the feasibility or acceptability threshold determined *a priori*.

Table 4

Parent Ratings of WBC Feasibility Acceptability, and Functions

Question	Threshold (possible ranges = 1 - 5)	Pretreatment (n = 4)		Midtreatment (n = 4)		Posttreatment (n = 4)		Follow-Up (n = 3)	
		M (SD)	Range	M (SD)	Range	M (SD)	Range	M (SD)	Range
		Acceptability							
How successful to you think this program would be in helping your family with the problems that brought you to counseling?	Mean of 4 (Somewhat successful) or higher	**4.00 (0.00)**	4-4	--	--	--	--	--	--
Is the amount of time you will spend on this program appropriate?	Mean of 4 (Probably appropriate) or higher	**4.00 (0.82)**	3-5	--	--	--	--	--	--
How much do you agree that videoconferencing is secure and confidential?	Mean of 4 (Agree) or higher	3.75 (0.50)	3-4	--	--	--	--	--	--
How comfortable are you with the idea of using videoconferencing with your therapist?	Mean of 4 (Mostly comfortable) or higher	**4.50 (0.58)**	4-5	--	--	--	--	--	--
How satisfied are you with the help your child got during WBC?	Mean of 4 (Somewhat satisfied) or higher	--	--	**4.75 (0.5)**	4-5	**4.50 (0.58)**	4-5	**4.33 (0.58)**	4-5
How essential was WBC in helping your child with the problems that brought you/them to counseling?	Mean of 4 (Moderately) or higher	--	--	**4.75 (0.5)**	4-5	**4.25 (0.50)**	4-5	**4.33 (0.58)**	4-5
Would you say this program needs to have WBC to be effective?	Mean of 4 (Probably) or higher	--	--	**4.75 (0.5)**	4-5	**5.00 (0.00)**	5-5	**4.67 (0.58)**	4-5

Table continued on next page

Table 4 (Continued)

How much did you feel your privacy was protected during WBC?	Mean of 4 (Moderately) or higher	--	--	**5.00 (0.00)**	5-5	**5.00 (0.00)**	5-5	**5.00 (0.00)**	5-5
How intrusive was it to have WBC in your home?	Mean of 4 (Mostly not intrusive) or higher	--	--	**4.50 (1.00)**	3-5	**4.25 (0.96)**	3-5	**4.00 (1.73)**	2-5
How helpful was it to have WBC take place at a set time (instead of as needed)?	Mean of 3 (Somewhat) or higher	--	--	**4.50 (0.58)**	4-5	**5.00 (0.00)**	5-5	**4.33 (0.58)**	4-5
How helpful was it to have WBC take place in the mornings (instead of another time of day)?	Mean of 3 (Just a little bit) or higher	--	--	**4.50 (0.58)**	4-5	**5.00 (0.00)**	5-5	**4.33 (0.58)**	4-5
Feasibility								
How easy was it to set up and use the technology needed for WBC?	Mean of 4 (Moderately) or higher	--	--	**4.50 (1.00)**	3-5	**5.00 (0.00)**	5-5	**5.00 (0.00)**	5-5
Did the benefits of WBC outweigh the challenges of scheduling?	Mean of 4 (Moderately) or higher	--	--	**4.50 (0.58)**	4-5	**5.00 (0.00)**	5-5	**5.00 (0.00)**	5-5
Functions								
Did WBC help your child practice the skills learned in the skills group?	Mean of 4 (Probably) or higher	--	--	**4.25 (0.50)**	4-5	**4.50 (0.58)**	4-5	**4.00 (1.00)**	3-5

Note: Data gathered from the CTAEQ and the PFQ. Bold typeface indicates a mean above the feasibility or acceptability threshold determined *a priori.*

Table 5

Therapist Ratings of WBC Feasibility, Acceptability, and Functions

Question	Threshold (possible ranges = 1 - 5)	Pretreatment (n = 6)		Posttreatment (n = 3 - 4)	
		M	Range	*M*	Range
Acceptability					
How successful to you think this program would be in helping your clients with the problems that brought them to counseling?	Mean of 4 (Somewhat successful) or higher	**4.83 (0.41)**	4-5	--	--
Is the amount of time your clients will spend on this program appropriate?	Mean of 4 (Probably appropriate) or higher	**4.17 (0.41)**	4-5	--	--
How much do you agree that videoconferencing is secure and confidential?	Mean of 4 (Agree) or higher	3.33 (0.82)	2-4	--	--
How comfortable are you with the idea of using videoconferencing with your clients?	Mean of 4 (Mostly comfortable) or higher	**4.17 (0.41)**	4-5	--	--
How much do you think using WBC will enhance client outcomes?	Mean of 4 (A lot) or higher	**4.17 (0.41)**	4-5	--	--
How satisfied are you with the help your client got during WBC?	Mean of 4 (Somewhat satisfied) or higher	--	--	**4.25 (0.50)**	4-5
How essential was WBC in helping your client with the problems that brought them to counseling?	Mean of 4 (Moderately) or higher	--	--	**4.50 (1.00)**	3-5
Would you say this program needs to have WBC to be effective?	Mean of 4 (Probably) or higher	--	--	**4.50 (0.58)**	4-5
How much did you feel your clients' privacy was protected during WBC?	Mean of 4 (Moderately) or higher	--	--	**4.75 (0.50)**	4-5
How intrusive was it to have WBC in your home/office?	Mean of 4 (Mostly not intrusive) or higher	--	--	3.33 (1.15)	2-4

Table continued on next page

Table 5 (Continued)

	Feasibility				
How easy was it to set up and use the technology needed for WBC?	Mean of 4 (Moderately) or higher	--	--	**4.00 (0.00)**	4-4
Did the benefits of WBC outweigh the challenges of scheduling?	Mean of 4 (Moderately) or higher	--	--	**4.25 (0.50)**	4-5
The average clinician have the time and resources to reasonably fit WBC into their schedule.	Mean of 4 (Mildly agree) or higher	--	--	2.75 (0.50)	2-3
	Functions				
Did WBC help your clients practice the skills they learned in skills group?	Mean of 4 (Probably) or higher	--	--	3.00 (0.82)	2-4
How much did WBC help you understand and assess your clients' problems?	Mean of 4 (Moderately) or higher	--	--	**4.75 (0.50)**	4-5

Note: Data gathered from the TTAEQ and the TFQ. Bold indicates a mean above the feasibility or acceptability threshold determined *a priori*.

Table 6

Frequency and Percentage of Web-based Conferencing (WBC) Functions noted by Youth, Parent, and Therapist: How was WBC helpful?

Perceived Function	Youth (n = 2)		Parent (n = 4)		Therapist (n = 4)		Total (N = 10)	
	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Generalize skills[a]	0	0.0%	4	100.0%	3	75.0%	7	70.0%
Routine or sleep regulation[b]	1	50.0%	4	100.0%	1	25.0%	6	60.0%
Support and encouragement	1	50.0%	2	50.0%	2	50.0%	5	50.0%
Accountability for implementing strategies[c]	0	0.0%	2	50.0%	2	50.0%	4	40.0%
Ecologically-valid assessment	0	0.0%	1	25.0%	2	50.0%	3	30.0%
Modeling Reliability	0	0.0%	1	25.0%	0	0.0%	1	10.0%

Note: Data gathered from the YFQ, PFQ, and TFQ. Frequencies and percentages refer to the number of participants who endorsed this function (e.g., a 1 and 50% in the youth column represents that one of two children endorsed a function at any assessment point).

[a] Coaching sessions helped youth/parents use therapy skills well or in a new context.

[b] Coaching sessions helped "make" the youth get out of bed.

[c] Coaching sessions gave an occasion to practice skills, regardless of quality.

Appendix A
Measures

CLIENT TECHNOLOGY, ATTITUDES, AND EXPECTATIONS QUESTIONNAIRE

Please answer these questions related to our program, the technology you have in your home, and your attitudes about the use of technology in counseling. *We are working to improve this program so that we can help more people - we take your opinion seriously!*

1. Based on the initial description of our program, how successful do you think this program would be in helping you and your family with the problems that brought you to counseling?

1	2	3	4	5
Very unsuccessful	*Somewhat unsuccessful*	*Neither successful nor unsuccessful*	*Somewhat successful*	*Very successful*

2. Given the multiple components of the program (individual counseling, multi-family group, web-coaching), do you think the amount of time you will spend on this program is appropriate given the type of problems that brought you to counseling?

1	2	3	4	5
Definitely not appropriate	*Probably not appropriate*	*Neutral (possibly, maybe, don't know)*	*Probably appropriate*	*Definitely appropriate*

3. In general, how comfortable are you with using technology, such as computers, the internet, smart phones, and tablet devices (e.g., iPads)?

1	2	3	4	5
Not at all Comfortable	*A little comfortable*	*Somewhat comfortable*	*Mostly comfortable*	*Very comfortable*

4. Please rate how frequently you use each of the following technology devices for your _personal use_ (not exclusively at work):

Device:		How frequently?		
Desktop computer	Don't own	Not at all	Infrequently	Every day
Laptop computer	Don't own	Not at all	Infrequently	Every day
Tablet device (e.g., iPad)	Don't own	Not at all	Infrequently	Every day
Smart phone (e.g., Android, iPhone)	Don't own	Not at all	Infrequently	Every day
Videoconferencing (e.g., Skype, FaceTime)	Don't own	Not at all	Infrequently	Every day

5. How much do you agree that video-conferencing over the internet is secure and confidential?

1	2	3	4	5
Strongly Disagree	*Disagree*	*Undecided*	*Agree*	*Strongly Agree*

6. How concerned are you about protecting your privacy over the internet?

1	2	3	4	5
Not at all concerned	*A little concerned*	*Somewhat concerned*	*Very concerned*	*Extremely concerned*

7. How much does any concern about privacy stop you from doing anything online (e.g., using Facebook, paying bills online, using email to communicate private information, using apps)?

1	2	3	4	5
I don't limit any of my activities	*I limit a few activities*	*I limit some activities*	*I limit many activities*	*I limit most of my activities*

8. How comfortable are you with the idea of using video-conferencing with your therapist?

1	2	3	4	5
Not at all comfortable	*A little comfortable*	*Somewhat comfortable*	*Mostly comfortable*	*Very comfortable*

THERAPIST TECHNOLOGY, ATTITUDES, AND EXPECTATIONS QUESTIONNAIRE

Please answer these questions related to our program, the technology you have in your home, and your attitudes about the use of technology in counseling. *We are working to improve this program so that we can help more people - we take your opinion seriously!*

1. What is your gender? (Circle one)   Male   Female   Other

2. What is your age?   ------------------------

3. What is the highest educational degree that you have obtained? (Circle one)

                                            Undergraduate   Masters   Doctorate

4. What is your main *clinical* work setting? (Check all that apply)

- Private practice
- Outpatient community MH center
- Day treatment
- Inpatient unit
- Residential treatment facility
- Corrections facility
- Legal system
- Assertive community treatment team
- Drug treatment program
- Medical center
- Emergency room
- Nursing home
- Supportive housing
- School/university
- Other (Please specify) _____

5. In what parts of our study do you plan to work? (Check all that apply)

- Web-based coaching
- Individual therapy
- Consultation team
- Skills group

6. What is your theoretical orientation? (Check all that apply)

- Behavioral
- Cognitive
- Cognitive behavioral
- Psychodynamic
- Systems
- Integrative
- Other (Please specify): _____

7. Have you treated clients before using dialectical behavior therapy? (Circle one)   Yes   No

8. How much of your clinical training and experience has been with youth?

1	2	3	4	5
Minimal or none	*Some*	*About half*	*Most*	*Nearly All*

9. How much have you used telemedicine procedures before (i.e., using videoconferencing to communicate or hold sessions with clients)?

1	2	3	4	5
Never	*Rarely*	*Occasionally*	*Frequently*	*Very frequently*

10. Based on the initial description of our program, how successful do you think this program would be in helping your *clients* with the problems that brought them to counseling?

1	2	3	4	5
Very unsuccessful	*Somewhat unsuccessful*	*Neither successful nor unsuccessful*	*Somewhat successful*	*Very successful*

11. Given the multiple components of the program (individual counseling, multi-family group, web-coaching), do you think the amount of time *clients* will spend on this program is appropriate given the type of problems that brought them to counseling?

1	2	3	4	5
Definitely not appropriate	*Probably not appropriate*	*Neutral (possibly, maybe, don't know)*	*Probably appropriate*	*Definitely appropriate*

12. In general, how comfortable are *you* with using technology, such as computers, the internet, smart phones, and tablet devices (e.g., iPads)?

1	2	3	4	5
Not at all Comfortable	*A little comfortable*	*Somewhat comfortable*	*Mostly comfortable*	*Very comfortable*

13. Please rate how frequently you use each of the following technology devices for *professional purposes* (i.e., primarily for client-related work):

Device:	How frequently?			
Desktop computer	Don't own	Not at all	Infrequently	Every day
Laptop computer	Don't own	Not at all	Infrequently	Every day
Tablet device (e.g., iPad)	Don't own	Not at all	Infrequently	Every day
Smart phone (e.g., Android, iPhone)	Don't own	Not at all	Infrequently	Every day
Videoconferencing (e.g., Skype, FaceTime)	Don't own	Not at all	Infrequently	Every day

14. How much do you agree that video-conferencing over the internet is secure and confidential?

1	2	3	4	5
Strongly Disagree	*Disagree*	*Undecided*	*Agree*	*Strongly Agree*

15. How concerned are you about protecting your privacy over the internet?

1	2	3	4	5
Not at all concerned	*A little concerned*	*Somewhat concerned*	*Very concerned*	*Extremely concerned*

16. How much does any concern about privacy stop you from doing anything online (e.g., using Facebook, paying bills online, using email to communicate private information, using apps)?

1	2	3	4	5
I don't limit any of my activities	*I limit a few activities*	*I limit some activities*	*I limit many activities*	*I limit most of my activities*

17. How comfortable are you with the idea of using video-conferencing with your *clients*?

1	2	3	4	5
Not at all comfortable	*A little comfortable*	*Somewhat comfortable*	*Mostly comfortable*	*Very comfortable*

18. How much do you think using *web-based coaching* will enhance client outcomes?

1	2	3	4	5
Not at all	*A little bit*	*Somewhat*	*A lot*	*A great deal*

YOUTH FEEDBACK QUESTIONNAIRE

Please answer these questions related to each component of the DBT-SR program. Each component is distinct and we need your help in deciding which parts are better or worse. *We are working to improve this program so that we can help more people - we take your opinion seriously!*

Global Opinion: First, we would like to know what you think about the entire <u>program</u>. Think about everything you did – the individual counseling, the weekly skills group, and the web-based coaching sessions. Think, "If I were recommending this whole program to someone else, this is what I would say…"

1. <u>Overall</u>, how happy were you with the help that you got in this program?

1	2	3	4	5
Very Unhappy	*Somewhat Unhappy*	*Neither happy nor unhappy*	*Somewhat happy*	*Very happy*

2. Was the program helpful for you and your family?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral (possibly, maybe, don't know)*	*Probably*	*Definitely*

3. Is the overall time required for the program worth it?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral (possibly, maybe, don't know)*	*Probably*	*Definitely*

4. <u>Overall</u>, what was the most helpful part about this program?

_____

_____

_____

5. <u>Overall</u>, how would you improve this program?

_____

_____

_____

Web-based Coaching: Now we would like to know what you think about <u>web-based coaching</u> sessions. Think, "If I were recommending *only* the web-based coaching to someone else, this is what I would think…"

1. How happy were you with the help you got during <u>web-based coaching</u>?

1	2	3	4	5
Very Unhappy	*Somewhat Unhappy*	*Neither happy*	*Somewhat happy*	*Very happy*

2. Did <u>web-based coaching</u> help you practice the skills you learned in the skills group?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral* *(possibly, maybe, don't know)*	*Probably*	*Definitely*

3. How important was <u>web-based coaching</u> in helping you with any problems?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very important*

4. How easy was it to set up and use the technology involved in <u>web-based coaching</u>?

1	2	3	4	5
Not at all easy	*Just a little bit*	*Somewhat easy*	*Moderately*	*Very easy*

5. How private did you feel <u>web-based coaching</u> was?

1	2	3	4	5
Not at all private	*Just a little bit*	*Somewhat*	*Moderately*	*Very private*

6. Did you think it was good to have <u>web-based coaching</u> at one time every morning (instead of calling when needed)?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very much*

7. How good was it to have <u>web-based coaching</u> take place in the mornings (instead of another time of day)?

1	2	3	4	5
Not good at all	*Just a little bit good*	*Somewhat*	*Moderately*	*Very good*

8. Did the benefits of <u>web-based coaching</u> outweigh the time it took?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very much*

9. Would you say that this program needs to have <u>web-based coaching</u> to be useful?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral* *(possibly, maybe, don't know)*	*Probably*	*Definitely*

10. What was the most helpful part about web-based coaching?

_____

_____

_____

11. How would you improve web-based coaching?

_____

_____

_____

12. Please note any other thoughts you would like to share with us about the use of technology in web-based coaching.

_____

_____

_____

Individual Counseling: Now we would like to know what you think about *only* the weekly counseling you had with your therapist. Think, "If I were recommending the individual counseling to someone else, this is how I would think…"

1. How happy were you with individual counseling?

1	2	3	4	5
Very Unhappy	*Somewhat Unhappy*	*Neither happy nor unhappy*	*Somewhat happy*	*Very happy*

2. Was the individual counseling helpful for you and your family?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral (possibly, maybe, don't know)*	*Probably*	*Definitely*

Group Satisfaction Now we would like to know what you think about the weekly skills group meetings you had with your parent(s) and other families as well as the skills you learned in these meetings. Think, "If I were recommending the skills group to someone else, this is what I would think…"

1. How happy were you with the overall quality of the skills group?

1	2	3	4	5
Very Unhappy	*Somewhat Unhappy*	*Neither happy nor unhappy*	*Somewhat happy*	*Very happy*

2. Was the skills group helpful for you and your family?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral* *(possibly, maybe, don't know)*	*Probably*	*Definitely*

3. How much did having other families in the group help you learn the skills in the skills group?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very much*

4. How much did having your family at group help you learn the skills in the skills group?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very much*

5. How comfortable did you feel sharing thoughts and experiences in the skills group?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very comfortable*

6. Did the benefits of the skills group outweigh the time and hassle of attending our group?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral* *(possibly, maybe, don't know)*	*Probably*	*Definitely*

7. Please list the three skills that were most helpful to you (e.g., mindfulness, distress tolerance, walking the middle path, emotion regulation, interpersonal effectiveness).

1._____

2._____

3._____ _____

8. Please rank the parts of this program in order from 1, *most helpful*, to 3, *least helpful*.

_____ Individual treatment

_____ Web-based coaching

_____ Skills groups

PARENT FEEDBACK QUESTIONNAIRE

Please answer these questions related to each component of the DBT-SR program. Each component is distinct and we need your help in deciding which parts are better or worse. *We are working to improve this program so that we can help more people - we take your opinion seriously!*

Global Opinion: First, we would like to know what you think about the <u>entire program</u>. Think about your overall impression of the program including the individual counseling, the weekly skills group, and the web-based coaching sessions. Think, "If I were recommending this whole program to someone else, this is how I would rate it…"

1. <u>Overall</u>, how satisfied were you with the help that your child got in this program?

1	2	3	4	5
Very dissatisfied	*Somewhat dissatisfied*	*Neither satisfied nor dissatisfied*	*Somewhat satisfied*	*Very satisfied*

2. Did the program help your family to manage your problems better?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral (possibly, maybe, don't know)*	*Probably*	*Definitely*

3. Is the overall time required to participate in this program reasonable and worth it?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral (possibly, maybe, don't know)*	*Probably*	*Definitely*

4. <u>Overall</u>, what was the most helpful part about this program?

_____

_____

_____

5. <u>Overall</u>, how would you improve this program?

_____

_____

_____

Web-based Coaching: Now we would like to know what you think about <u>web-based coaching sessions</u>. Think about your impression of only web-based coaching. Think, "If I were recommending *only* the web-based coaching sessions to someone else, this is how I would rate it…"

1. How satisfied were you with the help that your child got during <u>web-based coaching</u>?

1	2	3	4	5
Very dissatisfied	*Somewhat dissatisfied*	*Neither satisfied nor dissatisfied*	*Somewhat satisfied*	*Very satisfied*

2. Did <u>web-based coaching</u> help your child practice the skills learned in the skills group?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral* *(possibly, maybe, don't know)*	*Probably*	*Definitely*

3. How essential was the <u>web-based coaching</u> in helping your child with the problems that brought your family to counseling?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very essential*

4. How easy was it to set up and use the technology involved in <u>web-based coaching</u>?

1	2	3	4	5
Not at all easy	*Just a little bit*	*Somewhat easy*	*Moderately*	*Very easy*

5. How much did you feel your family's privacy was protected during <u>web-based coaching</u>?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very much*

6. How intrusive was having the camera and <u>web-based coaching</u> film you and your family in your home?

1	2	3	4	5
Very intrusive	*Somewhat intrusive*	*Neutral* *(possibly, maybe, don't know)*	*Mostly not intrusive*	*Not intrusive at all*

7. How helpful was it to have <u>web-based coaching</u> take place at a set time (instead of as needed)?

1	2	3	4	5
Not at all helpful	*Just a little bit*	*Somewhat*	*Moderately*	*Very helpful*

8. How helpful was it to have <u>web-based coaching</u> take place in the mornings (instead of another time of day)?

1	2	3	4	5
Not at all helpful	*Just a little bit*	*Somewhat*	*Moderately*	*Very helpful*

9. Did the benefits of <u>web-based coaching</u> outweigh the challenges of scheduling time for coaching?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very much*

10. Would you say that this program needs to have <u>web-based coaching</u> to be effective?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral* *(possibly, maybe, don't know)*	*Probably*	*Definitely*

11. What was the most helpful part about <u>web-based coaching</u>?

_____

_____

_____

12. How would you improve <u>web-based coaching</u>?

_____

_____

_____

13. Please note any other thoughts you would like to share with us about the use of technology in <u>web-based coaching</u>.

_____

_____

_____

<u>Individual Counseling:</u> Now we would like to know what you think about *only* the weekly counseling you had with your therapist. Think, "If I were recommending the individual counseling to someone else, this is how I would rate it…"

1. How satisfied were you with the help that your child got during <u>individual counseling</u>?

1	2	3	4	5
Very dissatisfied	*Somewhat dissatisfied*	*Neither satisfied nor dissatisfied*	*Somewhat satisfied*	*Very satisfied*

2. How helpful was <u>individual counseling</u> in helping your child with the problems that brought you to counseling?

1	2	3	4	5
Very unhelpful	*Somewhat unhelpful*	*Neither helpful nor unhelpful*	*Somewhat helpful*	*Very helpful*

<u>Group:</u> Now we would like to know what you think about the weekly skills group meetings you had with your parent(s) and other families as well as the skills you learned in these meetings. Think, "If I were recommending the skills group to someone else, this is how I would rate it…"

1. How satisfied were you with the overall quality of the <u>skills group</u>?

1	2	3	4	5
ery dissatisfied	*Somewhat dissatisfied*	*Neither satisfied nor dissatisfied*	*Somewhat satisfied*	*Very satisfied*

2. Did the <u>skills group</u> help your family manage your problems better?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral* *(possibly, maybe, don't know)*	*Probably*	*Definitely*

3. How much did attending groups with <u>other families</u> help your child learn the skills taught in the <u>skills group</u>?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very much*

4. How much did attending groups with <u>your family</u> help your child learn the skills taught in the <u>skills group</u>?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very much*

5. How comfortable did <u>you</u> feel sharing in the <u>skills group</u>?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very comfortable*

6. Did the benefits of the <u>skills group</u> outweigh the logistical challenges of attending our group?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral* *(possibly, maybe, don't know)*	*Probably*	*Definitely*

7. Please list the three skills that were most helpful to your family (e.g., mindfulness, distress tolerance, walking the middle path, emotion regulation, interpersonal effectiveness).

1._____

2._____

3._____

8. Please rank the parts of this program in order from 1, *most helpful*, to 3, *least helpful*.

_____ Individual treatment

_____ Web-based coaching

_____ Skills groups

THERAPIST FEEDBACK QUESTIONNAIRE

Please answer these questions related to each component of the DBT-SR program. Each component is distinct and we need your help in deciding which parts are better or worse. *We are working to improve this program so that we can help more people - we take your opinion seriously!*

Global Opinion: First, we would like to know what you think about the entire program. Think about your overall impression of the program including the individual counseling, the weekly skills group, and the web-based coaching sessions. Think, "If I were recommending this whole program to someone else, this is how I would rate it…"

1. Overall, how satisfied were you with this program?

1	2	3	4	5
Very dissatisfied	*Somewhat dissatisfied*	*Neither satisfied nor dissatisfied*	*Somewhat satisfied*	*Very satisfied*

2. Did the program help your clients to manage their problems better?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral (possibly, maybe, don't know)*	*Probably*	*Definitely*

3. I like the procedures used in this program.

1	2	3	4	5
Strongly disagree	*Mildly disagree*	*Agree and disagree equally*	*Mildly agree*	*Strongly agree*

4. Implementing this intervention at my practice would make me a better therapist.

1	2	3	4	5
Strongly disagree	*Mildly disagree*	*Agree and disagree equally*	*Mildly agree*	*Strongly agree*

5. Is the overall time required to participate in this program reasonable and worth it?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral (possibly, maybe, don't know)*	*Probably*	*Definitely*

6. How challenging is it to learn this treatment relative to other treatments?

1	2	3	4	5
Much more challenging	*Somewhat more*	*About the same*	*Somewhat easier*	*Much easier*

7. In your practice, how difficult was it to coordinate with others on your consultation team to provide DBT-SR to your clients?

1	2	3	4	5
Very difficult	*Somewhat difficult*	*Neither difficult Nor easy*	*Somewhat easy*	*Very easy*

8. The average clinician in the community has the time and resources to reasonably fit provision of this treatment into their schedule.

1	2	3	4	5
Strongly disagree	*Mildly disagree*	*Agree and disagree equally*	*Mildly agree*	*Strongly agree*

9. There are few social barriers (e.g., administrative disapproval, colleague skepticism) that would prevent an average clinician from providing this treatment.

1	2	3	4	5
Strongly disagree	*Mildly disagree*	*Agree and disagree equally*	*Mildly agree*	*Strongly agree*

10. There are few organizational barriers (e.g., time, money, space) that would prevent an average clinician from providing this treatment.

1	2	3	4	5
Strongly disagree	*Mildly disagree*	*Agree and disagree equally*	*Mildly agree*	*Strongly agree*

11. I have the resources (e.g., time, space, money) necessary to provide this treatment.

1	2	3	4	5
Strongly disagree	*Mildly disagree*	*Agree and disagree equally*	*Mildly agree*	*Strongly agree*

12. Would you want to continue to use this treatment with other clients similar to those in this study?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral (possibly, maybe, don't know)*	*Probably*	*Definitely*

13. Overall, what was the most helpful part about this program?

_____

_____

_____

14. Please describe anything in this program that you believe is missing or unnecessary.

_____

_____

_____

15. Overall, how would you improve this program?

_____

_____

_____

Web-based Coaching: Now we would like to know what you think about web-based coaching sessions. Think about your impression of only web-based coaching. Think, "If I were recommending *only* the web-based coaching sessions to someone else, this is how I would rate it…"

1. How satisfied were you with the help that your client got during web-based coaching?

1	2	3	4	5
ry dissatisfied	*Somewhat dissatisfied*	*Neither satisfied nor dissatisfied*	*Somewhat satisfied*	*Very satisfied*

2. Did web-based coaching help your clients practice the skills they learned in the skills group?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral (possibly, maybe, don't know)*	*Probably*	*Definitely*

3. How essential was the web-based coaching in helping your clients with the problems that brought them to counseling?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very essential*

4. How easy was it to set up and use the technology involved in web-based coaching?

1	2	3	4	5
Not at all easy	*Just a little bit*	*Somewhat easy*	*Moderately*	*Very easy*

5. How much did you feel your clients' privacy was protected during web-based coaching?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very much*

6. How intrusive was having the camera and web-based coaching film you in your office?

1	2	3	4	5
Very intrusive	*Somewhat intrusive*	*Neutral (possibly, maybe, don't know)*	*Mostly not intrusive*	*Not intrusive at all*

7. The average clinician in the community has the time and resources to reasonably fit web-based coaching into their morning schedule.

1	2	3	4	5
Strongly disagree	*Mildly disagree*	*Agree and disagree equally*	*Mildly agree*	*Strongly agree*

8. How much did web-based coaching help you understand and assess your clients' problems?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very much*

9. Did the benefits of <u>web-based coaching</u> outweigh the challenges of scheduling time for coaching?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very much*

10. Would you say that this program needs to have <u>web-based coaching</u> to be effective?

1	2	3	4	5
Definitely not	*Probably not*	*Neutral (possibly, maybe, don't know)*	*Probably*	*Definitely*

11. What was the most helpful part about <u>web-based coaching</u>?

_____

_____

_____

12. How would you improve <u>web-based coaching</u>?

_____

_____

_____

13. Please note any other thoughts you would like to share with us about the use of technology in <u>web-based coaching</u>.

_____

_____

_____

<u>Individual Counseling:</u> Now we would like to know what you think about *only* the weekly counseling you had with your therapist. Think, "If I were recommending the individual counseling to someone else, this is how I would rate it…"

1. How satisfied were you with <u>individual counseling</u>?

1	2	3	4	5
Very dissatisfied	*Somewhat dissatisfied*	*Neither satisfied nor dissatisfied*	*Somewhat satisfied*	*Very satisfied*

2. How helpful was <u>individual counseling</u> in helping your clients with the problems that brought them to counseling?

1	2	3	4	5
Very unhelpful	*Somewhat unhelpful*	*Neither helpful nor unhelpful*	*Somewhat helpful*	*Very helpful*

Group: Now we would like to know what you think about the weekly skills group meetings you had with your parent(s) and other families as well as the skills you learned in these meetings. Think, "If I were recommending the skills group to someone else, this is how I would rate it…"

1. How satisfied were you with the overall quality of the <u>skills group</u>?

1	2	3	4	5
?ry dissatisfied	*Somewhat dissatisfied*	*Neither satisfied nor dissatisfied*	*Somewhat satisfied*	*Very satisfied*

2. Did the <u>skills group</u> help your clients manage their problems better?

1	2	3	4	5
?efinitely not	*Probably not*	*Neutral (possibly, maybe, don't know)*	*Probably*	*Definitely*

3. How much did attending groups with <u>other families</u> help your clients learn the skills taught in the <u>skills group</u>?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very much*

4. How much did attending groups with <u>their family</u> help your clients learn the skills taught in the <u>skills group</u>?

1	2	3	4	5
Not at all	*Just a little bit*	*Somewhat*	*Moderately*	*Very much*

5. Please rank the five skills in order from 1, *most helpful,* to 5, *least helpful.*

_____ Mindfulness

_____ Distress Tolerance

_____ Emotion Regulation

_____ Interpersonal Effectiveness

_____ Walking the Middle Path

6. Please rank the parts of this program in order from 1, *most helpful*, to 4, *least helpful.*

_____ Individual treatment

_____ Web-based coaching

_____ Skills group

_____ Consultation Team

DBT-SR WEB-BASED COACHING QUALITY RATING FORM
PLEASE COMPLETE THIS FORM DURING EACH WEB-BASED COACHING SESSION

Today's date	
Session start time	
Location of computer in Client's home. *If location has changed please clearly note reasoning.*	

Client ratings of session quality should be completed near the end of each session by the family member with whom you spoke most.

Quality ratings should be from 1 to 5, with anchors as follows:

0	1	2	3	4	5
Coaching could not be done at all because of technology problems.	*Audio or visual problems were present throughout. Web-coaching was very difficult*	*Somewhat poor: audio/video interfered several times with coaching*	*Acceptable. Small audio or video lags/glitches that did not interfere with coaching*	*Excellent, only minor glitches, easy to communicate; as good as web talking goes*	*Flawless – like in person*

Client rating of <u>video</u> quality *Ask, "How would you rate the quality of only the video you saw during today's session? Please rate only the quality of the video."*	
Client rating of <u>audio</u> quality *Ask, "How would you rate the quality of only the audio you heard during today's session? Please rate the only quality of the sound."*	
Therapist rating of <u>video</u> quality *Think, "How would you rate the quality of only the video you saw during today's session? Please rate the only quality of the video."*	
Therapist rating of <u>audio</u> quality *Think, "How would you rate the quality of only the audio you heard during today's session? Please rate only the quality of the sound."*	
Did any technology problems come up during today's session? (Client and Therapist complete):_____ _____ _____	
Session end time	