Helping Clients Heal from Self-Harm: A DBT Approach for Teens

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Objectives

Participants will learn:
- ✓How to define self-harm (or Non-suicidal Self-Injury – NSSI) and some of the statistics related to this
- ✓Tools to help you not freak out when you find out your client is self-harming
- ✓Reasons teens self-harm and ways to help yourself, your client, and their family understand the behaviour
- ✓How to effectively assess for self-harm and tools to help improve commitment to treatment, building rapport and trust
- ✓About the Experiential-Avoidance Model of NSSI
- ✓Strategies to increase understanding of self-harm and to work toward eliminate self-harming behaviours

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What is NSSI?

Self-Harm/Non-Suicidal Self-Injury (NSSI) refers to purposely inflicting damage on the body, in the absence of lethal intent, and not socially sanctioned

- Sometimes people will refer to other behaviours as self-harm (e.g. substance use, disordered eating), and while these behaviours are harmful and self-destructive, they are not the same.

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Common ways of self-harming:

1. Cutting
2. Head-banging
3. Extreme scratching
4. Punching/Hitting
5. Burning

Interference with wound-healing
Pinching
Puncturing
Biting
Extreme skin-picking
Ingesting dangerous substances (e.g. bleach)
Breaking Bones

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The Statistics

- Although listed as a diagnostic criterion for Borderline Personality Disorder (BPD) in the DSM-V, NSSI may also occur in individuals without BPD; and not everyone with BPD engages in self-harm

- Researchers have reported self-injurious behaviour in a wide range of other disorders, such as post-traumatic stress disorder (PTSD), dissociative disorders (including DID), conduct disorder, obsessive-compulsive disorder, intermittent explosive disorder, anxiety and mood disorders, substance use disorder, bulimia (Cipriani et al, 2017) and Bipolar Disorder (Esposito-Smythers et al, 2010)

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The Statistics

- NSSI is most common among adolescents and young adults; average age of onset is between 12 and 14 years.

- Although NSSI typically decreases in late adolescence, youth who engage in repetitive NSSI seem to be at high risk for continuing to use dysfunctional emotion regulation strategies, even after cessation of NSSI. One recent study found that adolescents who had ceased repetitive NSSI were very likely to show high levels of substance misuse.

- **Self-harm is one of the strongest antecedents of suicide in youth** (Aggarwal et al, 2017), with those who self-injure being 30-fold more likely to complete suicide (Cooper et al., 2005)

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The Statistics

Although there is little research on NSSI before the early 2000s, prevalence rates have been rather stable across publications from different countries within the past 15 years;

- NSSI is widespread among adolescents both in community as well as in clinical settings:
  - Rates of adolescents engaging in NSSI range from 1.5 to 6.7% in community samples;
  - In adolescent psychiatric samples, prevalence rates are as high as 60% for single-incident NSSI and around 50% for repetitive NSSI (Brown & Plener, 2017)

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The Statistics

- Within an ethnically diverse sample
  - multiracial college students reported high prevalence rates (20.8%), followed by Caucasian (16.8) and Hispanic (17%)
  - although research on non-Caucasian subjects was limited to a few countries, among Chinese students, prevalence rates ranged from 24.9–29.2%; and prevalence rates of Turkish adolescents was 21.4% (Cipriano et al, 2017); and evidence suggests that African American males are also at high risk of engaging in self-harm (Rojas-Velasquez et al, 2020).

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Non-Suicidal Self-Injury Disorder (NSSID): A New Diagnosis?

- In 2013, NSSID was included in section III of the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM5), as a condition in need of further study, making it a highly relevant research area.
- As currently proposed, NSSID is a dichotomous diagnosis consisting of six criteria that must be met in order for a diagnosis of NSSID to be applicable (still controversial).
- The potential diagnosis of NSSID is conceptualized as a condition that can occur with or without other comorbidities, such as BPD, as well as suicidality.
- Preliminary data show that NSSID prevalence rates range between 5.6% and 7.6% in non-clinical samples of adolescents, and 0.2–0.8% in young adults; in clinical adolescent self-injuring samples, between 74% and 78% meet full criteria

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NSSID: Proposed Criteria

A. In the last year, the individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of the body of a sort likely to induce bleeding, bruising, or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), with the expectation that the injury will lead to only minor or moderate physical harm (i.e. there is no suicidal intent. Note: The absence of suicidal intent has either been stated by the individual or can be inferred by the individual's repeated engagement in a behavior that the individual knows, or has learned, is not likely to result in death.)

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NSSID: Proposed Criteria

B. The individual engages in the self-injurious behavior with one or more of the following expectations:

1. To obtain relief from a negative feeling or cognitive state.
2. To resolve an interpersonal difficulty.
3. To induce a positive feeling state.

Note: The desired relief or response is experienced during or shortly after the self-injury, and the individual may display patterns of behavior suggesting a dependence on repeatedly engaging in it.

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NSSID: Proposed Criteria

C. The intentional self-injury is associated with at least one of the following:

1. Interpersonal difficulties or negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act.
2. Prior to engaging in the act, a period of preoccupation with the intended behavior that is difficult to control.
3. Thinking about self-injury that occurs frequently, even when it is not acted upon.

D. The behavior is not socially sanctioned (e.g., body piercing, tattooing, part of a religious or cultural ritual) and is not restricted to picking a scab or nail biting.

E. The behavior or its consequences cause clinically significant distress or interference in interpersonal, academic, or other important areas of functioning.

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NSSID: Proposed Criteria

F. The behavior does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal. In individuals with a neurodevelopmental disorder, the behavior is not part of a pattern of repetitive stereotypies. The behavior is not better explained by another mental disorder or medical condition (e.g., psychotic disorder, autism spectrum disorder, intellectual disability, Lesch-Nyhan syndrome, stereotypic movement disorder with self-injury, trichotillomania [hair-pulling disorder], excoriation [skin-picking] disorder).

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Risk Factors

- Identifying as LGBTQ+; females are more likely to self-harm than males (Brown & Plener, 2017)
- History of NSSI, cluster B personality disorders (borderline, antisocial, narcissistic & histrionic), and feelings of hopelessness (Brown & Plener, 2017)
- Dysfunctional relationships
- History of being bullied
- Childhood emotional abuse, strong association of increased parental critique or parental apathy (Brown & Plener, 2017)
- "Social Contagion": Initial engagement in NSSI may be very related to this, but continuation of the behaviour is more related to emotion dysregulation (Brown & Plener, 2017)

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Risk Factors

- A history of child maltreatment and stressful life experiences could create a vulnerability that disrupts emotional regulation function (Cipriani et al, 2017)

- Participants who began self-injuring at or before age 12 reported significantly more lifetime acts of NSSI, greater method versatility, and more medically severe NSSI than those who began NSSI at 17 or older; and the proportion of individuals reporting suicide attempts significantly increased as the age of onset became younger (Muehlenkamp, 2019)

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Protective Factors

- Unfortunately, few studies have directly examined barriers to NSSI
- Deliberto & Nock (2008) asked 94 adolescents why they would or would not like to stop self-harming; almost 79% identified at least one reason they'd like to stop, including:
  - NSSI is unhealthy
  - it attracts unwanted attention
  - to avoid causing problems in relationships with friends and family
  - to avoid scarring
  - to avoid or reduce feelings of shame

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Protective Factors

- Individuals diagnosed with BPD who self-harm but have a capacity to identify and label emotions accurately are more able to regulate emotions and less likely to self-harm (Zaki et al, 2013)

- We can also extrapolate from research that has looked at reasons for NSSI:
  - receiving treatment for an underlying condition such as mood, anxiety, SUD & eating disorders
  - learning healthier ways of managing emotions
  - having support people to discuss problems with
  - learning to problem-solve in healthier ways

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What To Do When Your Client Discloses NSSI?

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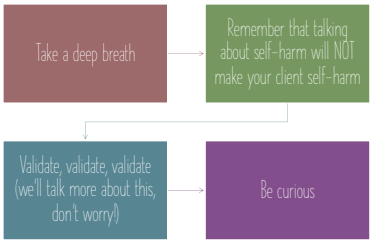
Step One: Don't Freak Out!



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Step Two: Assessing NSSI

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Why do Teens Self-Harm?

There are many reasons people engage in self-harming behaviour & it's important to explore this with your client. Be sure to confirm that the intention is to hurt themselves before labeling the behaviour as self-harming. Some clients will struggle to explain why they engage in this behaviour, so here are some possibilities (Van Dijk, 2021):

- A way of punishing self
- Helps to manage intense emotions
- Distracts from emotional pain
- Makes you feel in control
- Proves you're not invisible
- Is a way of avoiding suicide
- Validates emotional pain
- Attempt to change others' behaviour

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Why do Teens Self-Harm? (cont...)

- Helps you to avoid/escape painful feelings
- Lets you feel something other than "numb"
- Communicates to others that you need help
- Provides relief from your current situation or emotion
- Shows your desperation to others (i.e. it's proof of how bad things are)
- Creates pleasure: peace, calm, or even joy or euphoria (possibly related to "pain-offset relief"; or stimulation of endorphins: one study found reduced pain sensitivity and basal opioid deficiency to be independent biological correlates and potential risk-factors for NSSI (Van der Venne et al, 2020).

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Step Three: Ethical Considerations

- What are your obligations to report the self-harm to the parents or referrer (e.g. if referred by another healthcare provider)?
  - Context of your work (e.g. school SW versus private practice)
  - Age of the client
  - Privacy laws
- Is treating this person within your scope of practice?
  - e.g. a school SW or therapist working with a FHT may not have worked with self-harm before; if not, and if you plan to continue to work with this youth, be sure to seek consultation if necessary!

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One way of conceptualizing NSSI:

The Experiential Avoidance Model

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The Experiential Avoidance Model (EAM) of NSSI (Chapman et al, 2006)

- Experiential Avoidance (EA) includes any behaviour that provides avoidance/escape from unwanted internal experiences or the external conditions that elicit them (Hayes et al, 1996)
- Brown et al (2002) found that the most common reason for engaging in NSSI was emotional relief or emotion regulation; NSSI may be conceptualized as fitting within the broader class of experiential avoidance behaviours.
- According to this model, the immediate reduction of the unpleasant experience (thoughts, emotions, physical sensations, etc.) provides powerful reinforcement for NSSI (in other words, NSSI is negatively reinforced by the elimination or reduction of the adverse experience, which maintains the behaviour).

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The Experiential Avoidance Model of NSSI

A.L. Chapman et al. / Behaviour Research and Therapy 44 (2006) 371–394

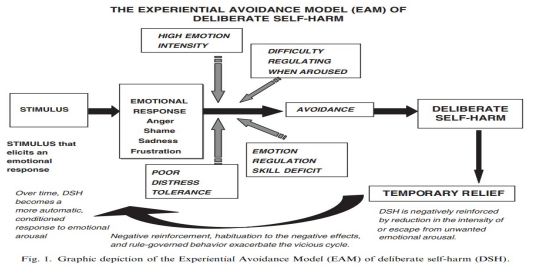

Fig. 1. Graphic depiction of the Experiential Avoidance Model (EAM) of deliberate self-harm (DSH).

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The Experiential Avoidance Model of NSSI

- Stimulus triggers an aversive emotional response.
- Individual experiences urge to escape distress; engages in NSSI, reducing/eliminating emotional arousal, thereby negatively reinforcing NSSI.
- In a vicious cycle, repeated negative reinforcement strengthens the association between emotional distress and NSSI, so that NSSI becomes an automatic escape response.

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The Experiential Avoidance Model of NSSI

- In a study by Sachsse et al (2002) high cortisol levels corresponded with high ratings of painful emotions and preceded episodes of NSSI; following NSSI, cortisol levels dropped dramatically and stayed low for the next few days
- Chronic use of EA strategies such as NSSI may prevent the extinction of unwanted emotions: modern therapies often include use of Exposure & Response Prevention (ERP) (interventions that expose the individual to emotionally evocative stimuli, while blocking the avoidance response), based on the assumption that repeated exposure to the stimulus that elicits a learned emotional response (in the absence of the feared outcomes) will weaken that emotional response. However, the use of avoidance and escape behaviours prevents this process from occurring.

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The Experiential Avoidance Model of NSSI

- Hayes et al. (1996) proposed that ruled-governed behaviour is often involved in EA: For example, either through the direct experience of NSSI leading to relief, or through hearing about or observing others' experiences of relief following NSSI, an individual may adopt the verbal rule, "If I cut, I will feel better", and may then choose to engage in NSSI, in spite of the fact that NSSI is associated with negative long-term consequences).
- Rule-governed behaviour may reduce an individual's sensitivity to, and ability to learn from, actual contingencies operating in the environment
- Contributing to the vicious cycle of NSSI, the NSSI may, over time, become linked with fewer punishing consequences; for example, in his model of the trajectory of suicidal behaviour, Joiner (2002) proposes that repeated suicidal behaviour causes habituation to the fear, pain, or negative social connotations associated with the behaviour

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Treating NSSI

- ✓DBT, CBT & Mentalization-Based Treatment for Adolescents (MBT-A) – none shown to be superior thus far
- ✓The evidence of psychiatric medication used for the treatment of NSSI in adolescents is still insufficient

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DBT for NSSI

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DBT for NSSI

- The EA model of NSSI highlights the utility of teaching skills for tolerating and regulating distressing emotions; Dialectical Behavior Therapy (DBT) for BPD includes skills focused primarily on enhancing distress tolerance and emotion regulation (Linehan, 1993)
- Short-term interventions developed for NSSI among individuals with and without BPD have incorporated elements of DBT with elements from other behaviour therapies (Chapman et al, 2006).

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Emotion Dysregulation in NSSI

- One key component in the development of maladaptive EA behaviours may be the failure to use more skillful emotion regulation behaviours in response to emotional arousal, such as:
  - (a) reducing intense physiological arousal associated with the emotion;
  - (b) turning attention away from emotional stimuli;
  - (c) inhibiting impulsive, mood-driven behaviour, and
  - (d) engaging in behaviour oriented toward achieving non-mood-dependent goals.
- Individuals with limited access to effective emotion regulation strategies are more likely to avoid emotions, and therefore may be at greater risk for behaviours such as NSSI

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The DBT Biosocial Theory applied to NSSI

Studies have found a significant association between emotional reactivity and EA; therefore Chapman et al (2006) postulate that, although emotional reactivity is not a sufficient factor for EA or NSSI, individuals with stronger emotional reactivity are more likely to use NSSI as a means of escaping distressing internal experiences.

This brings us to the biosocial theory in DBT that is used to explain the development of emotion dysregulation

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The DBT Biosocial Theory

Pervasive emotional dysregulation is the result of two main factors:

1. A biological predisposition to emotional vulnerability (high sensitivity): a. react to things others don't react to; b. reaction is seen as higher than warranted; c. longer to return to baseline; and d. higher level of emotional pain

AND

2. A pervasively invalidating environment: Where the individual's internal experiences are regularly judged, punished, minimized, ignored, etc. (e.g. the abusive home, the poor fit, the chaotic home, societal/systemic invalidation in the form of discrimination)

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The DBT Biosocial Theory

Consequences of the emotionally vulnerable child growing up in the invalidating environment:

- The child doesn't learn to label or trust private experiences, including emotions; instead, they learn to search their environment for cues on how to think, feel, and act
- They therefore don't learn to modulate emotional arousal; or how to respond appropriately to distress
- "Problem Behaviours" such as NSSI are the result of unhealthy attempts to regulate emotions
- You can teach this theory and use it as an intervention in and of itself, helping clients to understand their own behaviour (which often contributes to acceptance and subsequently increases readiness for change)

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Validation

What is validation?

- Communicating to the client that their responses make sense and are understandable within their current life context or situation
- Communicating acceptance of the client, taking the client's responses seriously and not discounting or minimizing them

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Why validate?

- *Invalidation* increases emotional arousal, which makes it difficult for clients to process information
- Validating the emotionally aroused client (e.g. "I know you're angry") helps to reduce the intensity of emotions, allowing for new learning and therapeutic change (balances the push for change)

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Benefits of Validation

- Enhances the therapeutic relationship
- Strengthens your empathy toward the client
- Encourages the client to keep going when they're ready to quit
- Teaches the patient through modeling, how to trust and validate themselves

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Levels of Validation (Linehan, 1997)

1. Listening & Observing (listen mindfully, active listening)
2. Accurate Reflection (so what you're saying is...)
3. Articulating the Unverbalized (I would imagine you'd be feeling...)
4. Validate the current state based on history or biology (e.g. of course you don't want to walk down the dark alley, you were assaulted in an alley)
5. Communicate the person's behaviour makes sense and is reasonable for anyone (e.g. Of course you don't want to walk down the dark alley, dark alleys are scary and dangerous)

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Levels of Validation

6. Radical Genuineness: treating the person as valid (matter of fact, not treating patient as fragile, direct and challenging)
   - This level of validation must come from the therapist's genuine self; at this level, almost any response by the therapist can be validating
   - Notice your natural, spontaneous reaction (versus the "Twilight Zone" therapist)
   - Not just verbal, but facial expressions and behaviour as well

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How to Validate

- Only validate the valid! - e.g. you need to validate the extreme emotional response without validating the problematic behavior
- Be descriptive and nonjudgmental in articulating how the client's response isn't effective or doesn't make sense

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NSSI: Collecting the Data

The Behavioural Analysis (BA)

- Helps to give us a better understanding of the behaviour, to increase overall awareness, and to identify reinforcers and triggers for the behaviour
- Provides a detailed account of each thought, feeling, and action that moved the client from the Prompting Event to a Problem Behaviour
- Done in partnership at first, then as homework
- Can be aversive for clients
- Emphasizes the client's responsibility

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The Behavioural Analysis (BA) Exercise

Considering the Case Example:

- What's the problem behaviour we're analyzing? (make sure this is clear!)
- What were the vulnerability factors - often biological, can also include learning (what made it more likely on that day that the individual engaged in that behaviour?)
- What was the prompting event or trigger?
- Describe the links in the chain from when the prompting event occurred to when the problem behaviour occurred
- What were the consequences (positive as well as negative)

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Monitoring NSSI

Research has shown that monitoring behaviours can often help us to change them in a positive direction; regardless of changing the behaviour, however, this will also be helpful in monitoring how you're doing in eliminating NSSI

Methods of monitoring:		
DBT Diary Card	Noting in phone/daytimer/calendar	Other options the client suggests

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DBT Diary Card/Tracking Sheet

Online through PsychSurveys: https://www.psychsurveys.com/

Paper DBT Diary Cards available: https://depts.washington.edu/uwbrtc/wp-content/uploads/NIMH4-S-DBT-Diary-Cards-with-Instructions.pdf

Behavior Tracking Sheets (Word)

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Getting Commitment

It can be difficult for clients to commit to letting go of the self-harming behaviour, even when they know it's in their best interest and they want to let go of the behaviour.

1. Start where the client is: provide lots of validation (we can validate the behaviour with regard to the function it serves, but of course we don't want to over-do this; we can also validate the intense emotion that caused the behaviour)
2. Help the client understand the function of their behaviour – it has served a purpose for them! Also reminding the client we're not going to take away their means of regulating without providing other, healthier ways of managing
3. The BA's will provide additional information that will help the client to see their NSSI in a new, more objective light – e.g. patterns of triggers (avoidance behaviour, interpersonal relationships, etc.)
4. Doing a pros and cons chart can also be helpful in highlighting the positives and negatives of the behaviour

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Pros and Cons Chart

Pro's and Con's: four columns; written out ahead of time while in Wise Mind (start this in session collaboratively)

- Four columns instead of two gives the client a broader perspective
- Written engages the frontal lobes
- Consider short-term as well as long-term
- Can then be used as a reminder as to why the person doesn't want to act on the problem behaviour

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Pros and Cons Chart Exercise

Pros of Cutting	Cons of Cutting
Pros of NOT Cutting	**Cons of NOT Cutting**

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Getting Commitment

Other DBT Commitment Strategies:

1. Devil's Advocate (e.g. you tell me you've seen three therapists before and you've always decided to continue with NSSI; what makes you think things will be different this time?)
2. Foot in the Door/Door in the Face (Asking for a tiny goal that almost anyone would agree to; asking for the moon so the client will readily agree to something less)
3. Freedom to Choose (highlighting that they are free to choose for themselves, but also highlighting that the therapist is free to choose to observe limits)
4. Shaping Behaviour (baby steps!)

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DBT Skills Modules

There are four skills modules in DBT:

1. Core Mindfulness Skills
2. Distress Tolerance Skills
3. Emotion Regulation Skills
4. Interpersonal Effectiveness Skills

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Distress Tolerance Skills

F-TIP Skills:

1. Forward Bend (baroreceptors activate PNS)
2. "TIP" the temperature of your face (mammalian dive reflex)
3. Intense exercise
4. Paced Breathing (PNS)

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Distress Tolerance Skills

Help your client make a personalized list of Distress Tolerance Skills:

What do they do already to cope in more effective ways?

What else could they be doing?

Help them brainstorm with the following sets of skills

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Distress Tolerance Skills

Distracting Skills: (ACCEPTS)

Activities (e.g. TV, reading, walking, Zentangle)

Contribute to others (e.g. volunteer, do something kind for someone else)

Comparisons (e.g. to others, to yourself)

Emotions (e.g. TV, music)

Pushing Away (e.g. with imagery – e.g. Container)

Thoughts (ie. Generate neutral thoughts, such as counting, singing a song, etc.)

Sensations (e.g. take a bath, elastic band, ice)

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Distress Tolerance Skills

Self-soothing with the 5 Senses:

1. Sight (e.g. flowers, clean room)
2. Hearing (another person's voice, nature, music)
3. Touch (e.g. clean sheets, pets)
4. Taste (e.g. herbal tea, a favourite food, mint)
5. Smell (flowers, perfume, etc.)

- Helpful during a crisis, and also as general self-care
- Note that some people over-use this; others feel guilt and so tend to avoid self-soothing; the challenge with both instances is to help the client find balance.

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Distress Tolerance: Alternate Rebellion

Satisfying an urge to act out in a way that doesn't do harm to self or others.

Share with your client: If you notice that your urge to self-harm is related to a desire to rebel (against your parents, or societal norms, or perhaps even pressure you've been putting on yourself to be successful, achieve, be perfect, etc.) you can turn to this skill. Here are some ways that you could express your desire to rebel without the negative consequences of NSSI:

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Distress Tolerance: Alternate Rebellion

- Wear crazy underwear
- Turn your music up loud
- Kiss your dog on the lips
- Get a piercing or tattoo
- Start a food fight
- Dye your hair a crazy color.
- Wear mismatched socks or shoes (or both).
- Go into your basement and scream as loud as you can.
- Put your pants on starting with the opposite leg.
- Express a viewpoint different to what's considered the norm.
- Throw your pillow (or something else that's soft) at the wall.
- Give an honest response instead of a polite one.
- Say no to someone's reasonable request, and don't give them an explanation.

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Distress Tolerance Skills

Urge Management: What to do when crisis strikes

1. Rate the intensity of the urge from 0 (no urge) to 10 (intense urge)
2. Set a timer for 15 minutes.
3. In the meantime…

- Re-regulate with F-TIP skills
- Mindfully distract yourself with distracting and self-soothing
- Read your pro's and con's list

When your 15 minutes is up, re-rate your urge & re-set timer if necessary

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Distress Tolerance Skills

Dialectical Abstinence:

- While eliminating NSSI is the goal, you're not going to be "perfect" at it; you will have lapses.

- When lapses happen, the idea is to radically accept that you've self-harmed, and then get back on track as quickly as possible (rather than ruminating, self-judging, triggering shame, etc.)

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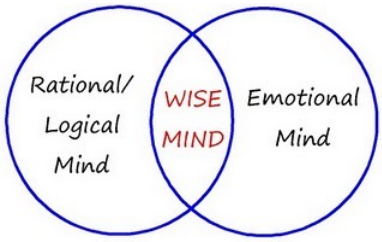
Core Mindfulness Skills: States of Mind



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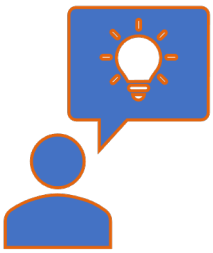
Core Mindfulness Skills: States of Mind

Reasoning Mind:

- Logical, practical, intellectual, rational, straight-forward thinking; may include "rule-governed behaviour" ("if I cut I'll feel better!")
- No emotions involved (or very minimal)
- Examples: making a grocery list; following instructions to bake a cake; balancing your chequebook (as long as there's no anxiety involved!)



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Core Mindfulness Skills: States of Mind

Emotion Mind:

- This is the part of us that often gets us into trouble!
- You know you're in emotion mind when your emotions are controlling your behaviours
- Examples: you're feeling anxious so you self-harm; your mood is depressed so you withdraw and isolate yourself; you feel angry and you lash out at the people around you
- Emotion mind also includes pleasant emotions

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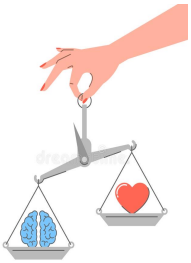
Core Mindfulness Skills: States of Mind

Wise Mind:

- It's not that RM and EM are bad and we want to get rid of them; rather, we want to be able to find a balance more often: this is Wise Mind
- Wise Mind = RM + EM + Intuition
- Also includes considering values
- You're in WM when you're thinking about the consequences of your behaviour and choosing how you want to act rather than reacting.



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Core Mindfulness Skills: States of Mind

Differences between EM and WM:

Both involve an element of emotion, so clients often confuse the two

In EM, the feelings are more intense, and are controlling behaviour; there's usually an uncertainty and going back and forth between two choices

In WM, there's a feeling of peace or calmness ("rightness") about a decision

EM can often "trick" us into thinking it's WM – we have to go within, this usually takes practice

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Core Mindfulness Skills: States of Mind

Exercises to help clients get to Wise Mind:

- "What does your Wise Mind tell you?"
- Turning inward exercises – e.g. Stone flake on a lake; going down a spiral staircase within yourself
- Breathing exercise: breathing in "Wise", out "Mind"

Also: Who represents each of these states for the client? Having a short-cut can help!

Activity: Careers? Famous People?

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Core Mindfulness Skills: States of Mind

Often just identifying what state of mind is there can help someone take a step back if they're in EM or RM

Help increase awareness of these states by having clients notice regularly

Mindfulness and many of the DBT skills will help people access WM

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Reducing Vulnerability to EM

STRONG:

Balancing Sleep

Treating physical and mental health problems as prescribed

Reducing (or eliminating) drugs and alcohol

One thing daily to build mastery

Balancing nutrition

Getting exercise

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Mindfulness in Emotion Regulation

1. Reducing dwelling or rumination
2. Helps in identifying and labeling the emotion
3. Increasing pleasurable emotions
4. Relaxation
5. Managing urges
6. Getting to know yourself

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Obstacles to Mindfulness

How do you get your client to buy in to mindfulness?

- Connect mindfulness to their goals
- Informal versus formal exercises
- Doing activities they're already able to engage in well
- Be flexible!

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Nonjudgmental Stance

Video

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Nonjudgmental Stance

- Often, people who self-harm struggle a lot with shame; this is often connected with self-judgments
- This skill is about semantics!
- Judgments often increase the intensity of emotions - we need to watch for the judgments that stick to us - reducing these judgments will help us to reduce the painful emotions we're experiencing
- Note that this isn't about stuffing emotions or opinions, but rather expressing these things more assertively

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Nonjudgmental Stance

- Think "inflammatory language" - if you can reduce the use of this language, you can reduce the intensity of emotions
- Takes the short-form out and says what we really mean
- Won't make the pain disappear, but will prevent extra emotions from arising
- Will be more effective in interpersonal situations

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Nonjudgmental Stance

Typical examples in NSSI:

- "What's wrong with me?", "I'm crazy", "I should be able to do this", "I'm a failure/defective/worthless", and so on.
- Steps:
  - Help the client identify the facts of the situation
  - Help the client name the emotion(s)
  - Put the two together for a nonjudgmental statement

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Nonjudgmental Stance

Help the client write out a list of nonjudgmental statements for one "theme" at a time:

e.g. "I'm bad" might look like this:

1. I'm frustrated with myself that I keep turning back to cutting.
2. I feel ashamed when I lose my shit on my parents
3. I'm disappointed in myself for not doing better in school

– Have the client practice with those statements - read them to themselves, proactively and reactively

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Nonjudgmental Stance

- What nonjudgmental stance isn't:
- It's not rationalizing, excusing behaviour, or providing reassurance (e.g. "It's okay that I cut myself because it kept me from killing myself"; "it makes sense that I burned myself because I know it helps me manage when I'm feeling really angry"; or "it's okay that I hurt myself, I know this is a process and I'll keep working on it")

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Nonjudgmental Stance

Some nonjudgmental words to consider:

- Helpful versus unhelpful
- Effective versus ineffective
- Safe versus unsafe or dangerous
- Satisfying versus unsatisfying
- Healthy versus unhealthy

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Radical Acceptance

- "It is what it is"
- "Acceptance" does NOT mean approval
- RA reduces the amount of suffering in our lives

Exercise: Think of a difficult situation in your life you've gotten to acceptance with

- Turning the Mind: This is how we radically accept: Notice you're fighting reality; turn your mind back to acceptance

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Radical Acceptance

Four steps to RA:

1. First step is deciding to practice this skill
2. Next, making the commitment to yourself: as of this moment, I'm going to work on accepting this situation
3. Notice when you're not accepting, but fighting reality
4. Turn your mind back to acceptance

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Radical Acceptance

Techniques to help your client get to Radical Acceptance:

- Breathing
- Taking an open posture
- Half-Smile

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Radical Acceptance

Don't just practice RA with "big", painful situations; daily practice helps us to be more accepting of the "little" things that will occur in our daily lives that trigger fighting reality and emotional suffering; for example:

- A below-average grade
- The weather
- Waiting in line
- Distracting noises while you're trying to do your homework

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Radical Acceptance

What does your client need to work on accepting?

- Past or recent trauma?
- Relationship issues?
- Gender/sexual identity?
- Other ideas:

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Willingness versus Wilfulness

Wilfulness is refusing to do your best with what you've got; sitting on your hands and refusing to try; giving up; "whatever"

Willingness is being open to the possibilities, doing your best to act skilfully; playing the cards you're dealt

When life gets difficult, our clients will often become wilful and want to resort to old habits rather than try to use skills – they (and we) need to accept that wilfulness has arisen and do their best to be more willing; you can't find wilfulness with wilfulness!

Also:

- Forward Bend!
- You can teach your clients the same 3 techniques to get to RA to help them get to willingness
- And asking "What's the threat?" – what are they afraid will happen if they become willing?

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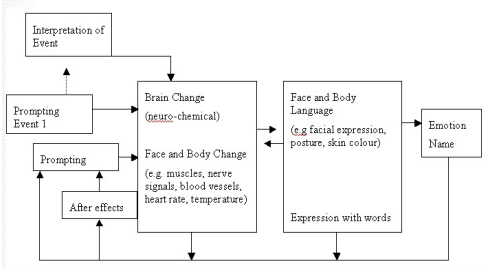
Emotion Regulation: Model of Emotions



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Emotion Regulation

1. Understanding and Naming Emotions

Increase awareness of all the components of the emotional experience (prompting event, interpretations, physical sensations, facial expression & body language, action urge and the actual action, and after-effects), which increases the individual's understanding of the emotion (including simply naming it) and allows for self-validation.

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Emotion Regulation Skills

2. Self-Validation:

The client must learn to validate themselves, accepting their emotions, thoughts and experience in general rather than judging these; and learning to trust that their response is valid even if it's not what others want or expect.

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Emotion Regulation Skills

Primary Emotions:

Situation – Interpretation – Primary Emotion

Secondary Emotions:

Situation – Interpretation – Primary Emotion – Interpretation – Secondary Emotion

- How you feel about your feelings
- Family of origin messages often feed into these patterns; identifying these messages can be helpful (reminder: emphasizing to the client that we're not blaming their family, but helping them understand; you may also bring family in to have these conversations together)

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Emotion Regulation Skills

There are three ways to self-validate (Van Dijk, 2012):

1. Acknowledging the presence of the emotion: for example, "I feel anxious."
- By just acknowledging the emotion and putting a period on the end of that sentence rather than going down the road of judging it, you are validating your anxiety.
2. Allowing: giving yourself permission to feel the feeling: for example, "It's okay that I feel anxious."
- Here, not only are you not judging the feeling, but you're going one step further and saying "this is okay" – again, not that you like it or want it to hang around, but that you're allowed to feel it.
3. Understanding: this is the highest level of self-validation and the most difficult.
- In this form of validating, not only are you not judging the emotion and saying it's okay to feel it, you're going one step further and saying you understand it: "it makes sense that I feel anxious going into situations with new people because I was bullied as a child."

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Opposite to Emotion Action

With Opposite Action, the idea is not to avoid the emotion, but rather to help reduce it so that it is more manageable. Once we have an emotion, we tend to act in ways that keep the emotion going (e.g. when we're angry, we might yell at the other person, which feeds our anger). By acting opposite to the urge attached to the emotion, the emotion is reduced in intensity and we can then access Wise Mind.

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Changing Unwanted Emotions with Opposite Action

1. Identify the emotion and the urge associated with it
2. Validate the emotion
3. Check the facts (is the emotion warranted or justified?)
4. If the emotion is not warranted (or if it is and you still want to reduce the emotion), act opposite to the urge in order to reduce the emotion.

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Changing Unwanted Emotions with Opposite Action

Figuring out if the emotion is warranted/justified

- e.g. with anxiety – is your life, health, or well-being at risk?
- e.g. with anger – is an important goal being blocked? Are you or someone you care about being attacked, hurt, threatened, or treated unfairly? (it's not as important if it's justified because anger is often justified, but gets in our way)
- e.g. with shame – will you be rejected by a person or group you care about if characteristics of yourself or of your behaviour are made public.

- Stop feeding the emotion, do the opposite to your urge

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Opposite to Emotion Action

Emotion	Urge	Opposite
Anger	Attack	Gently avoid/be civil
Fear	Avoid	Approach
Sadness	Withdraw	Reach out
Guilt/Shame	Stop the behaviour	Continue the behaviour

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Emotion Regulation Skills

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Emotion Regulation Skills

Steps to Cope Ahead:

1. Describe the situation that is expected to be a problem (what's the catastrophe?)
2. Decide which skills you'll use to help you cope effectively
3. Practice! – imagine yourself in the catastrophe, using the skills and being effective – be specific!

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Interpersonal Effectiveness

Finding new relationships:

- Finding friends and getting people to like you (reducing interpersonal isolation and loneliness – Holt-Lunstad et al, 2015)
- It's important that people recognize the role of social anxiety, since we all have different needs for relationships; wise mind!
  - Reconnecting with old friends
  - Deepening relationships with current people
  - Finding new friends

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Interpersonal Effectiveness

Ending Relationships

- Safety First!
- Be sure to end relationships from Wise Mind, not from Emotion Mind
- If the relationship is important and NOT destructive, try problem-solving/repairing first (using DEAR MAN skills); practice Cope Ahead
- Practice Opposite Action for love when you love the wrong person

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The Solution Analysis

- Helps therapist and client see each point where an alternative response might have led away from the problem behaviour
  - Ways to reduce vulnerability factors?
  - Ways to prevent the prompting event?
  - Ways to work on changing the links in the chain? - i.e. where can you insert SKILLS?
  - How can you repair or correct the harm done by the problem behaviour?

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Thank You!

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Case Example: Andy

Andy is a 17 year-old straight, cis-gender female. Her parents brought her to treatment because of difficulties she was having managing her emotions – largely with anger explosions, but also with intense feelings of sadness that led to thoughts of suicide, and also anxiety at times.

Andy described a lot of relational difficulties – not getting along with her mother quite often, they would butt heads and Andy would lose her temper, yelling and getting verbally aggressive; some fights as well with her younger sister, and describing feeling hurt and left out by her younger and older sister; and a lot of drama (more than usual!) in her friendships. There were also some boys at school who were essentially bullying her.

As we progressed in therapy and looked at setting goals and working on skills to help change Andy's behavior, she shared with me that sometimes she would engage in self-harming behaviors: she had cut herself on occasion and would also do things like punch her dresser or the wall. Initially she struggled to identify why this happened at times, and we started doing behavioral analyses to help us understand the behavior better (the main cause of the self-harm, it turned out, was that the physical pain distracted her from the emotional pain). It was important for us to note that, although she had suicidal thoughts at times, Andy did not want to kill herself; and the times she had cut herself were not suicide attempts.

Understanding the behavior in and of itself was helpful for Andy; and once we had a better understanding of the self-harm, we were also in a better position to help her use skills to eliminate the behavior. Once Andy learned about the BioSocial Theory, and the causes for her emotion dysregulation difficulties, this helped her to be more accepting of herself and the problems she was facing. She was motivated to stop hurting herself (among other goals) and started using crisis survival skills right away with much success, re-regulating herself by changing her body chemistry; and using distracting skills. We also did a lot of work on mindfulness, which helped her become more aware of her emotions as they started to become activated. Andy realized that she often wasn't able to name her emotions accurately, and this became very helpful as she learned to better differentiate between her anxiety and anger emotions. Finally, we started working on interpersonal effectiveness skills, as Andy was able to recognize that the tumultuous relationships she had had most of her life weren't healthy, and would often contribute to more intense feelings that would get her into trouble (with self-harm, as well as aggressive behaviors toward others at times).

Chain Analysis of Problem Behavior (Example)

Date Filled Out: Monday, Jan. 4th, 2021 Date of Problem Behavior: Sunday, Jan. 3rd, 2021

What is the ***problem behavior*** that I am analyzing?

I cut myself on the arm with a razor blade in the bathroom

What things in myself and in my environment made me ***vulnerable*** to engaging in the problem behavior?

- I forgot to take my meds that morning
- I've been out of my usual routine because of the Christmas holidays
- I've been feeling anxious that we're not going back to school because of the pandemic

What prompting event ***in the environment*** started me on the chain to the problem behavior?

I had texted my boyfriend that morning and still hadn't heard back from him by the afternoon; I was worrying that he was going to break up with me.

What are the *LINKS* in the chain between the prompting event and the problem behavior? (make sure you're very specific and detailed about what happened between the prompting event and the problem behavior)

- I texted Matt asking him if he wanted to get together today
- after about half an hour I started to feel anxious, noticed thoughts about him maybe wanting to break up
- started thinking about other things that have been happening recently between us that may be more evidence that he doesn't want to be with me anymore
- started to feel more anxious, and sad
- my sister pissed me off because she borrowed something without asking, and we started fighting
- my mom started yelling at us which made me even madder and I started yelling at her
- I was so angry I could barely think straight
- ran upstairs to the bathroom, pulled the razor blade out of my shaver, and cut my arm three times

Keeping in mind that consequences can be immediate or delayed, answer the following questions about your behavior:

1. What were the ***negative consequences***?
- my mom got even angrier with me when she saw what I had done; she told my dad too and things were just awkward for a while
- I know it's hard for my parents to trust me again after I've done this
- I felt bad about myself for failing

2. What were the ***positive consequences***?
- felt an immediate sense of relief – the physical pain distracted me from my feelings of hurt, anxiety and anger

Solution Analysis of Problem Behavior

Ways to reduce my ***vulnerability*** in the future:

- I need to make sure I take my meds and stay in my routine; I'll put a daily reminder in my cell phone so that I'll remember to take them, even if I'm on holidays or out of my usual schedule
- I could do some extra self-care stuff right now to help with the increase in anxiety related to the pandemic: make sure I do yoga or relaxation daily, listen to music, and go for a walk in nature

Ways to prevent the ***prompting event*** from happening again (we don't always have control over this, but see what ideas you can come up with):

- I can't prevent the prompting event from happening – can't control others

Ways to work on changing the ***links*** in the chain from the ***prompting event*** to the ***problem behavior*** (how can you interrupt the links in the chain so that you'll be less likely to engage in the problem behavior next time)?

- I have to remember that people aren't always going to get back to me as fast as I would like, and work on not jumping to conclusions or making assumptions about why: use my distract skills, mindfulness, radical acceptance
- when I notice myself getting anxious: more mindfulness, bringing myself back to the present instead of catastrophizing about the future; and remind myself that thoughts are just thoughts, they're not facts (also maybe distracting)
- when I started getting angry with my sister I could have told her I was already struggling and now wasn't a good time to talk, to prevent us from fighting; maybe stick to myself a little bit more because I know I often get into fights with my family and that just makes things worse
- I need to keep working on noticing when I'm starting to get angry – the tension in my muscles, my heart beating faster, etc., so I can use more skills: I could have done a Forward Bend, paced breathing, or the TIP skill
- instead of just acting on the urge I need to keep practicing noticing the urge and doing things differently: distracting and self-soothing skills; maybe telling my mom that I'm having an urge so she can help me do something different. I also need to take the razors out of the bathroom so I don't have easy access.

Are there things that you need to do to correct or repair the harm caused by the problem behavior?

- I only hurt myself so I don't have to repair to others, but to repair to myself I can make sure I take good care of the cuts so they don't get infected. I'm also re-committing to not hurting myself and using skills instead.

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