**Counseling Adolescents Who Engage in Nonsuicidal Self-Injury: A Dialectical Behavior Therapy Approach**

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**Abstract (summary)**

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Nonsuicidal self-injury (NSSI), the direct and intentional destruction of one's own body tissue in the absence of any intent to die, is becoming an alarmingly common behavior in adolescents of both sexes and across all racial and ethnic groups. The purpose of this article is to (a) provide a model for conceptualizing the onset and maintenance of this behavior, and (b) describe how a dialectical behavior therapy treatment approach can be applied to working with adolescents who engage in NSSI. [PUBLICATION ABSTRACT]

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**Headnote**

Nonsuicidal self-injury (NSSI), the direct and intentional destruction of one's own body tissue in the absence of any intent to die, is becoming an alarmingly common behavior in adolescents of both sexes and across all racial and ethnic groups. The purpose of this article is to (a) provide a model for conceptualizing the onset and maintenance of this behavior, and (b) describe how a dialectical behavior therapy treatment approach can be applied to working with adolescents who engage in NSSI.

Nonsuicidal self-injury (NSSI), the direct and intentional destruction of one's own body tissue in the absence of any intent to die (Nock & Favazza, 2009), is becoming an alarmingly common behavior in adolescents of both sexes and across all racial and ethnic groups, with estimated rates of 13-45% in community and 40-60% in clinical samples (Hilt, Nock, Lloyd-Richardson, & Prinstein, 2008; Latzman et al., 2010; Muehlenkamp, Williams, Gutierrez, & Claes, 2009; Nock & Favazza, 2009; Rodham & Hawton, 2009). These high prevalence rates are of concern because NSSI is associated with high potential for health risks and severe physical harm, as it generally involves cutting skin with a sharp instrument (occurring in 70-90% of individuals) and can also entail scratching, hitting, inserting objects under the skin, or burning the skin (Nock & Favazza, 2009). Because the average age of onset is between 12 and 14 (Nock, Teper, & Hollander, 2007), the transition to adolescence may be a period of vulnerability for development of NSSI (Guerry & Prinstein, 2010; Nock, 2010; Prinstein et al., 2010). Further, NSSI is associated with other serious disorders that emerge during puberty, such as eating disorders, substance abuse, and depression (Kerr & Muehlenkamp, 2010; Klonsky & Muehlenkamp, 2007; Muehlenkamp et al., 2009). In addition, although NSSI by definition does not constitute a suicide attempt, 50-75% of those with a history of NSSI have also made at least one suicide attempt (Nock & Favazza, 2009).

Because of its prevalence, severity, and onset during a high-risk period of development, it is important for mental health counselors to have a model for understanding the complex functions of this behavior and be familiar with effective approaches to treatment that address the unique needs of adolescents. Unfortunately, counselors report general uncertainty about conceptualization and treatment of NSSI (Healey, Trepal, & Emelianchik-Key, 2010). To help resolve this problem, this article describes research-based models for understanding the onset and maintenance of NSSI and how the dialectical behavior therapy (DBT) treatment approach can be applied in working with adolescents who engage in NSSI.

RISK AND MAINTENANCE MODELS FOR NSSI

According to Nock (2010), individuals who self-injure often possess genetic or environmental risk factors that contribute to the likelihood that they will engage in NSSI as adolescents. For example, there is evidence that adolescents who engage in NSSI have a genetic predisposition toward high emotional/cognitive reactivity (Nock, 2010). Compared to adolescents who do not self-injure, those who do display higher physiological reactivity during distressing tasks, demonstrate less ability to tolerate this distress, and show deficits in social problem-solving (Nock & Mendes, 2008). Adolescents who engage in NSSI are also more likely to report traumatic experiences in childhood (such as chronic illness, major surgeries, or parental loss) and are more likely to report receiving harsh or critical parenting during their childhood (Yates, Tracy, & Luthar, 2008). Further, they are likely to have endured aversive childhood experiences, with up to 79% of self-injuring individuals reporting a history of child abuse, maltreatment, and neglect (Yates, 2009).

The presence of these types of risks in a child's life creates intrapersonal and interpersonal vulnerability to NSSI and other types of maladaptive coping behaviors, such as eating disorders or substance abuse. According to Nock and Mendes (2008), intrapersonal vulnerability includes deficits in emotion-related skills (e.g., problems with the experience, awareness, and expression of emotions; high levels of aversive emotions; suppression of aversive thoughts and feelings; poor distress tolerance; and poor ability to tolerate negative emotional states). Children with these types of difficulties are also likely to engage in selfderogation and self-directed anger. At the same time, these individuals may develop an interpersonal style that is deficient in verbal and communication skills and social problem-solving ability (Klonsky & Muehlenkamp, 2007).

In sum, certain risk factors (e.g., genetics, childhood maltreatment) create intrapersonal and interpersonal vulnerabilities that increase the likelihood of NSSI. These vulnerabilities also increase the likelihood that a person will develop other behaviors that serve the same affective/cognitive regulatory and relational function. It is therefore important for counselors to examine NSSIspecific risk factors in order to understand why certain individuals choose NSSI as a preferred though maladaptive coping strategy.

NSSI-Specific Vulnerability

According to Nock (2010), several processes may be operating in the selection of NSSI as a coping strategy. First, adolescents are highly affected by the media and readily absorb its messages. NSSI is regularly featured in popular media and is very familiar to today's adolescents. High-profile icons in popular culture have publicly discussed their personal use of NSSI (e.g., Johnny Depp, Angelina Jolie, Princess Diana), and NSSI is prominently featured in many current movies, television programs, books, music, and Internet sites (Whitlock, Purington, & Gershkovich, 2009). Scholars theorize that the prevalence of NSSI images in popular culture serves to normalize the behavior for adolescents and prime them to consider experimenting with NSSI behaviors they might not otherwise have considered (Whitlock et al., 2009).

Second, peers are another primary source of influence; most adolescents who engage in NSSI report that they learned about it from their friends, siblings, and the media (Nock, 2010). There is a complex association between NSSI and peer NSSI use that is particularly strong for young adolescent girls (Prinstein et al., 2010). As adolescents observe their peer group, they may learn about NSSI as a viable option for self-regulation, for fitting in with peers, or for gaining attention (Heilbron & Prinstein, 2008; Nock, Prinstein, & Sterba, 2009). The fact that the decision to engage in NSSI is associated with a desire to connect with or to shock peers has led to social contagion effects that have been observed in school, college, community, and treatment settings (Prinstein etal, 2010; Walsh, 2006).

In addition to media or peer influences, adolescents might choose to engage in NSSI when they believe it is an effective method for communicating the pain or distress they are experiencing. Often when they have tried to give voice to their pain through words, crying, or screaming, they have been invalidated by significant others. In contrast they learned that engaging in NSSI sends a signal to others that cannot be ignored and that their scars describe their pain in ways that words could never express (Nock & Cha, 2009). A Bright Red Scream (Strong, 1998), a collection of interviews with adolescents and adults who engage in self-injury, vividly describes the signaling and communication function of NSSI.

Finally, young adolescents in particular may choose NSSI for pragmatic reasons; it is readily available and easy to use. While 12-year-olds might have difficulty obtaining alcohol, drugs, or even binge foods, they have easy access to methods for NSSI. Even in a highly structured school environment, adolescents can escape to a bathroom stall to cut their thigh with a paper clip or lock themselves in the bathroom at home to burn an arm with a hair curling iron. Further, NSSI works quickly and is highly effective as a strategy for self-regulation. Many individuals who use NSSI report that it relieves distress much more rapidly and effectively than any other form of maladaptive behavior, including alcohol and other drugs or food binges and purges (Strong, 1998).

Maintenance of NSSI Behaviors

Once an adolescent begins to engage in NSSI, it can serve a variety of complex functions that reinforce the behavior over time. Nock (2010), Nock and Cha (2009), and Klonsky and Muehlenkamp (2007) have identified several of the most common functions:

Affect regulation: NSSI is mainly used to regulate affect. Before an NSSI episode, adolescents report that they typically experience intense feelings of anger, anxiety, and frustration and believe that the NSSI will release urgent emotional pressure, block negative feelings, or manage stress. They also may believe that the NSSI gives them a sense of control that they cannot achieve through any other means. Adolescents also report that they use NSSI to resist suicidal urges and release the pain and tension they are experiencing.

Antidissociation. Adolescents who engage in NSSI often report feeling "nothing," "empty," "numb," or "unreal"; NSSI helps to interrupt these episodes of dissociation or depersonalization. Adolescents report that the behavior helps them to "feel something" even if it is pain, and to "feel real again" when their sense of self has been disrupted.

Self-punishment. Many adolescents report experiencing extreme selfhatred and self-directed anger and believe that there are aspects of themselves that deserve punishment. Through NSSI they believe they can punish themselves; they report feeling "cleansed" or "satisfied" after NSSI episodes.

Establishing interpersonal boundaries. Adolescents may use NSSI to affirm boundaries between self and others. By using the skin to visibly mark the boundary between the self and the external world, they may feel more independent and in control.

Interpersonal influence. As mentioned, self-injury serves a social function in that it can be an attempt to influence others by communicating the extent of one's suffering, gain attention, fit in with peers, or disrupt family conflict so that the attention is refocused on the self-injury.

Sensation-seeking. NSSI can generate feelings of excitement, resulting in a rush or high that comes from the release of endorphins. This function may be particularly salient when NSSI is performed around friends.

Not only do NSSI behaviors serve these functions in an adolescent's life, they are maintained through intrapersonal and interpersonal reinforcement processes that perpetuate NSSI over time. Nock (2010) suggested four processes that maintain NSSI behavior:

(a) Intrapersonal negative reinforcement: the NSSI behavior is followed by tension release or the cessation of negative thoughts and feelings.

(b) Intrapersonal positive reinforcement: the NSSI behavior is followed by an increase in desired thoughts or feelings (e.g., feeling satisfied that one has adequately punished oneself).

(c) Interpersonal positive reinforcement: the NSSI behavior is followed by an increase in a desired social outcome (e.g., attention, support, as when adolescents feel more connected with their peer group or receive attention from their parents).

(d) Interpersonal negative reinforcement: the NSSI behavior is followed by a decrease in an undesired social outcome (e.g., peers stop bullying, parents stop fighting). Because NSSI behaviors are effective and are reinforced, many adolescents do not view them as problematic. As a result, they are not interested in eliminating NSSI- a significant impediment to treatment (Hoffman & Kress, 2010).

The research findings indicate the importance of understanding the function that NSSI serves in adolescents' lives and how it is reinforced over time. They also suggest the need for treatment that addresses both intrapersonal and interpersonal vulnerabilities associated with NSSI (including affect dysregulation, inability to tolerate uncomfortable feelings, self-invalidation, and interpersonal deficits). These areas will be emphasized in what follows.

DIALECTICAL BEHAVIOR THERAPY

The treatment approach for NSSI that has the most empirical support is dialectical behavior therapy (DBT), an approach first used by Marsha Linehan for clients with borderline personality disorder (BPD; Linehan, 1993). DBT is considered the gold standard for reducing suicidal and self-destructive behaviors in clients with BPD; its effectiveness has been demonstrated in at least seven randomized controlled trials conducted by four independent research teams (Lynch & Cozza, 2009; Lynch, Trost, Salsman, & Linehan, 2007). Although developed for adults with BPD, Linehan 's DBT model has also been adapted for use with suicidal and self-injuring adolescents, with highly promising results (Miller, Rathaus, & Linehan, 2007). The treatment model described below is based on a research-based adaptation of outpatient DBT for adolescent clients at high risk for self-injury (Miller et al., 2007; for a complete description of the model, see the treatment manuals of Miller et al. and Linehan, 1993).

The comprehensive, multimodal 16-week treatment approach is comprised of sessions that (a) directly address skills for interpersonal effectiveness, self-regulation, and distress tolerance; (b) provide the structure necessary to motivate, reinforce, individualize, and generalize these new skills; and (c) identify and interrupt learned behavioral sequences that lead to NSSI. It incorporates individual therapy, multifamily training groups, family therapy, telephone consultations for both adolescents and family members, and a consultation team to provide support for counselors (Miller et al., 2007). The approach can be adapted to a variety of treatment settings, both inpatient and outpatient (Miller et al., 2007).

Individual Therapy with Adolescents

The DBT approach for adolescents involves a relationship with a primary counselor who conducts weekly individual counseling sessions. The counselorclient relationship is paramount in helping the client build motivation for change and learn new strategies for coping with stressful thoughts, feelings, and events. The counselor's role is to be active, supportive, and collaborative throughout. The counselor works to convey acceptance of clients by taking their responses seriously, validating their pain, and displaying understanding of their choices to cope with this distress by using NSSI as a highly effective, though self-destructive, strategy (Muehlenkamp, 2006). The counselor's role is also to instill hope, encourage the client, and focus on client strengths.

Because client acceptance must be balanced with a commitment to change, however, the counselor continuously challenges clients to eliminate NSSI and other behaviors that interfere with their quality of life (Linehan, 1993). The balance between acceptance and change, a key DBT strategy, is based on the assumption that client validation will facilitate change, while at the same time the change process will facilitate client self-acceptance (Miller et al., 2007). However, many adolescents will be reluctant to give up a behavior that is effective in so many ways and may be in treatment only at the insistence of their parents, so the counselor may need to spend several sessions building the relationship and working to enhance the client's commitment to change.

In establishing a therapeutic relationship, it is critical for counselors to discuss confidentiality. When working with clients who engage in NSSI, the counselor should establish a balance between the ethical principles of protecting client autonomy and nonmaleficence (the principle of doing no harm). The client has a right to choose NSSI as a preferred strategy, but the counselor also has the obligation to protect the client from harm (Hoffman & Kress, 2010). In working with adolescents, there is also an ethical dilemma in protecting client confidentiality versus the need to disclose information to parents. Adolescents will be reluctant to trust the counselor if they believe the counselor will call their parents every time they discuss an episode of self-injury. Miller and colleagues (2007) recommended that counselors assure clients that a parent will not be contacted each time they self-injure but will be notified if the counselor deems that the behaviors are escalating in frequency or in severity. To preserve client respect, adolescents can also be assured that they will be involved as much as possible in the process of parental disclosure (Hoffman & Kress, 2010). This type of open communication helps both to build trust and to meet ethical and legal obligations for protecting client dignity, respecting parental rights, and promoting client well-being.

Initial sessions should thoroughly assess problem behaviors and skill deficits. Walsh (2006) recommended that counselors take a low-key, inquisitive, but dispassionate stance during the assessment process so as not to suggest to a client that they are shocked or horrified by client disclosures but also to refrain from reinforcing the behaviors by reacting the way significant others in the client's life (peer groups, parents) do. When a counselor asks questions and responds with interest but without alarm, clients will become more comfortable in disclosing their history with NSSI.

The initial evaluation can be conducted informally in a clinical interview or formally through a structured interview or self-report instrument. Some common structured instruments used are the Suicide Attempt Self Injury Interview (SASII; Linehan et al., 2006) and the Comprehensive Self Injurious Thoughts and Behaviors Interview (SITBI; Nock, Holmberg, Photos, & Michel, 2007). Recommended self-report instruments include the Functional Assessment of Self-Mutilation (FASM; Lloyd, Kelley, & Hope, 1997); the Inventory of Statements about Self Injury (ISAS; Glenn & Klonsky, 2007); and the Deliberate Self Harm Inventory (Gratz, 2001). In a more informal assessment, the counselor should ask about such areas as the onset of NSSI; methods and instruments used; frequency; the most recent instance; medical severity; level of pain experienced; the context in which it occurs (e.g., events, thoughts, and emotions that precede, accompany, and follow NSSI episodes); factors that contribute to vulnerability (e.g., use of alcohol or drugs, sleep problems); and the positive and negative intrapersonal and interpersonal reinforcement functions of the behavior (Hoffman & Kress, 2010; Nock, 2010; Walsh, 2006). The assessment should also inquire about related behaviors that interfere with quality of life (e.g., substance abuse, impulsive sexual behaviors, staying in abusive relationships).

Using the DBT model (Linehan, 1993), the counselor can integrate the results of this assessment into four DBT treatment target areas: (a) decreasing life-threatening behaviors (e.g., NSSI, suicidal thoughts); (b) decreasing behaviors that interfere with therapy (dropout, noncompliance, cancelling sessions, leaving early); (c) decreasing behaviors that interfere with quality of life; and (d) increasing behavioral skills (addressed primarily through the multifamily skills groups, described next). These broad areas and specific behaviors can then be written into an initial treatment plan with goals and objectives.

As treatment commences, the primary objective of the individual sessions is to help clients to eliminate NSSI behaviors by teaching them to identify relevant events, thoughts, and feelings that precede NSSI and the consequences that follow it. Clients are asked to complete weekly diary cards to address these aspects (Miller et al., 2007; Linehan, 1993). The diary cards assess (a) the specific problem behaviors; (b) the specific precipitating event (What were you doing, thinking, or feeling at that moment? Why did the NSSI happen that day instead of some other time?); (c) vulnerability factors (e.g., alcohol or drugs, poor sleep or eating, stressful event); (d) the entire chain of events that led up to the NSSI; and (e) the consequences (What happened next? What effect did the NSSI have on you or your environment?).

Finally, the last part of the card asks the client to begin identifying ways to disrupt the chain of antecedent behaviors, reduce vulnerability factors, or extinguish reinforcers of the behavior. Clients can examine the specific chain of behaviors leading up to the NSSI and examine what they could have done differently at each step that might have avoided the problem. For example, one adolescent engaged in NSSI after he stayed up late at night to post on a social networking site. On his diary card, he recorded that he was vulnerable due to lack of sleep and poor nutrition that day. He pinpointed that just before the NSSI episode he was feeling desperate for personal contact with others after reading about others' social lives and believing that his life was lacking in comparison. After cutting himself with a razor, he felt more in control and less tense and was able to go to sleep. In reviewing the diary card with his counselor, he recognized that he could have disrupted die chain by not viewing that particular site when he was overly tired, not logging onto his computer after 10 p.m., or making efforts to have more personal contact with supportive others rather than spending so much time on-line. In sum, the diary card is an essential part of individual therapy because it assists with self-monitoring throughout the week, helps to structure sessions through review of problems, and encourages generation of potential solutions.

Multifamily Skills Training Groups

While individual counseling helps to address the chain of behaviors that precede and follow NSSI episodes to generate solutions for disrupting this process, adolescents also need specific skills to be able to implement these new solutions. These skills are generally taught in a group format but may be taught individually if group sessions are not feasible (Miller et al., 2007). If adolescents are to learn to employ adaptive coping strategies, they need to be able to become aware of their thoughts, feelings, and actions; tolerate the pain or stress that often occurs with life circumstances; regulate their emotional states more effectively; and become more effective in communicating their needs and wants in relationships. Therefore, the DBT approach recommends skills-training groups to help clients master four essential skills: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness (Linehan, 1993).

Miller and colleagues (2007) added a fifth skill, walking the middle path, to specifically address the extreme polarized thinking typical in adolescent/parent conflicts. They also recommended that the skills-training groups consist of both adolescents and at least one parent from each family, so that there are five to seven adolescents and five to seven parents in every group. The same family member should attend each session so that one parent can consistently learn the skills, practice, help the child implement the skills at home, and learn new skills that can help strengthen his or her parenting practices and provide more effective responses to meet the child's needs. The groups meet weekly for 16 weeks and are structured as follows: warm up practice consisting of mindfulness exercises, homework review, learning a new skill, and a wrap-up exercise. The first sessions should address issues of confidentiality and risks of contagion. Because discussions and displays of NSSI can be triggers for members, the leaders can inform them that the group is a place for learning how to apply new skills in daily life. Members are not to discuss the specifics of NSSI and are urged to reduce the public display of scars, wounds, or bandages by keeping them covered during group sessions (Walsh, 2006). Members who bring up NSSI incidents can be reminded that their individual sessions are the appropriate place for these types of discussions.

Skill Set One: Core Mindfulness Skills. Mindfulness consists of paying attention to one's emotions, thoughts, and physical experiences without necessarily trying to end them, numb them, or avoid them. It involves nonjudgmental observing, describing, and experiencing emotions in the moment and learning to be in control of one's attention. As clients become more mindful of the present, they learn to understand the ebb and flow of their emotions (McCabe, LaVia, & Marcus, 2004).

The DBT model teaches mindfulness by introducing three states of mind: (a) reasonable mind, a state in which behaviors are controlled primarily by rationality and logic; (b) emotion mind, a state in which behaviors are determined by emotions; and (c) wise mind, a state which synthesizes all ways of knowing to produce knowing through intuition, or what can be described as an inner experience of truth or deep inner wisdom (Linehan, 1993). These three mind states can be taught in group through charades, with leaders first enacting one of the three states of mind and asking members to guess which one is being portrayed. Members can also take turns acting out scenarios, having other members guess the appropriate mind state, and then asking them to describe how they arrived at their decision (Miller et al., 2007).

Members are then taught skills for observing their thoughts with awareness. Miller et al. (2007) provided several examples: First, in the Wordless Watching exercise, members are asked to practice mindfully watching thoughts and feelings go by as if they are on a conveyor belt. Next, they learn skills for labeling their thoughts and reactions in a nonjudgmental manner. For example, members might be asked to use a Wordful Watching exercise, describing their experiences without judging their observations. They are also taught to approach tasks one-mindfully, learning to control their attention by focusing on just one thing at a time. Instead of multitasking, they are asked to focus attention on only the task at hand. A mindfulness exercise that incorporates one-mindfulness is to ask members to mindfully unwrap a Hershey Kiss, keeping their attention on the foil, the unwrapping process, and the feel of the chocolate. This exercise can be replicated by holding an ice cube, mindfully observing how it feels as the ice melts. Such exercises are repeated in each session and members are also asked to practice mindfulness throughout the week. These skills are deemed essential for becoming aware of what one is experiencing in order to make mindful decisions that will disrupt fhe typical sequence of thoughts, feelings, and behaviors that lead to NSSI (Miller et al., 2007).

Skill Set Two: Emotion Regulation. Members learn how to identify, observe, and describe emotions; regulate intense or painful emotions; increase positive emotions; and reduce vulnerability to negative emotions. As they practice emotion regulation, clients recognize that they do have control over how they react to emotional experiences and that they can change their emotional responses.

Specific skills for emotion regulation recommended by Miller et al. (2007) include processes for observing and describing emotions. These can be taught experientially by asking members to examine all aspects of what goes on for them when an emotion is triggered. Group leaders can play music or movie clips designed to provoke emotional reactions and ask members to listen or watch nonjudgmentally, directing their attention to what they experience inwardly in response. They are then asked to describe the emotions that emerged and the thoughts, body changes, urges, and observations associated with those emotions. They are also asked to notice secondary emotions that might have been associated with the primary emotion elicited (Miller et al., 2007). For example, adolescents might label an emotional response as "stupid," feel guilty about having the emotion in the first place, or try to block the emotion. Instead, members are taught to respond to negative or uncomfortable feelings with understanding and self-compassion. Responding to emotions and their associated effects in this way will decrease emotional intensity and lead to an increased sense of mastery (Safer, Telch, & Chen, 2009).

Other emotion-regulating skills are reducing vulnerability (decreasing the likelihood of negative emotions by caring for oneself physically, eating a balanced diet, getting enough sleep and exercise, and avoiding mood-altering drugs); increasing positive emotions (increasing daily pleasant events); building mastery (completing daily activities that contribute to a sense of competence and mastery); and acting opposite to cunent emotions (learning to change emotional reactions by acting in a manner opposite to the emotion currently experienced, such as approaching a feared situation instead of avoiding it).

Skill Set Three: Interpersonal Effectiveness. This module emphasizes skills for maintaining one's personal values and beliefs while striving to improve relationships generally. For example, members learn the acronym DEAR MAN (Linehan, 1993) to help them remember the components of assertiveness: Describe (describe situation in factual manner); Express (express feelings using I statements); Assert (ask clearly for what you want or do not want); Reinforce (explain the benefits to the other person of complying with your request); stay Mindful (keep your focus on what you want); Appear confident (make eye contact, use a confident tone); and Negotiate (Ask for feedback, offer alternative solutions, and be mindful of when to agree to disagree). Miller et al. (2007) suggested that interpersonal skills can best be learned through group role plays: First, a facilitator can role-play a hypothetical conflict he or she is having with someone outside the group, and members can offer coaching on effective responses. Next, either two adolescents or an adolescent/parent pair role-play in front of the group, with members providing coaching based on interpersonal skills learned in the group.

Skill Set Four: Distress Tolerance. Distress tolerance is the ability to effectively accept emotional pain in situations that cannot be changed, at least right now. By accepting a situation and not struggling against it, a client can cope with it more effectively (Safer et al., 2009). Further, distress tolerance skills help a client to self-soothe and distract if necessary to prevent impulsive decisions or actions.

There are two types of distress tolerance skills: skills for accepting reality and skills for crisis survival. Accepting reality skills help clients accept life in the moment, just as it is, even when it is painful or uncomfortable. These skills include observing one's breath through deep breathing and half-smiling (triggering positive emotions associated with a smile). Skills for crisis survival involve engaging in activities that help a client to function without resorting to behaviors that make things worse (Linehan, 1993), such as doing something to improve the moment in a small way, e.g., through prayer, taking a break, or thinking positive thoughts. They might also include ways to nurture the self through self-soothing strategies. In DBT, such strategies are presented to members using the five senses, with examples: vision (art, nature); hearing (pleasant music); smell (scented candles); taste (herbal teas, chocolates); or touch (velvet pillows). In groups led by Miller and colleagues (2007), the leaders set up objects like these on a table and asked members to select one that appealed to them. As the leaders lowered the lighting and played soft music, group members engaged in self-soothing by mindfully engaging with the selected object. Following this exercise, leaders asked members to describe how they felt before, during, and after the experience and how they might incorporate selfsoothing into their daily routines.

Skill Set Five: Walking the Middle Path. This module helps both adolescents and family members to address their unbalanced, polarized thinking and behaviors so as to achieve a more balanced lifestyle (Miller et al., 2007). All are encouraged to move away from black/white, either/or thinking; consider others' perspectives; realize that there are multiple ways to view any situation; and practice examining all sides of a situation. These concepts are then applied to three common parent-teen dilemmas: (a) being too loose versus too strict; (b) making light of a particular problem behavior versus making too much of typical adolescent behavior; and (c) pushing away versus holding on too tightly. All group members are directed to identify the point where they currenüy are on a balance scale for each of these dilemmas, identify where their family member is, and describe a middle path mat might create a more successful outcome for both adolescent and parent.

The module also teaches how to achieve a balance between acceptanceand change-oriented skills. Acceptance skills are taught by encouraging group members to use validating responses. That involves active listening skills: the ability to communicate to another individual that you have considered the person's feelings seriously, that the feelings make sense and have been communicated clearly to you, and that you are trying to understand that perspective. Members practice by applying active listening skills to scenarios within the group and then practicing with their family members. In contrast, change-oriented skills are taught through basic behavioral principles (e.g., reinforcers, shaping, extinction, punishment) that operate to either increase or decrease particular behaviors. Group members practice exercises using principles for decreasing behaviors and emphasize differences between extinction (withholding reinforcement) and punishment (delivering a negative consequence). Family members also practice exercises to better understand how positive reinforcement serves to increase adaptive behaviors. For example, parents can learn the importance of providing positive feedback when an adolescent uses a positive coping strategy instead of turning to NSSI.

Additional DBT Components

The DBT approach also provides for telephone consultation for both adolescents and family members. By providing the option of telephone contact outside of scheduled sessions, the primary counselor can provide coaching for skill generalization, intervene if there is a crisis, and repair any ruptures in the therapeutic alliance that may have occurred in a previous session. Clients are also encouraged to call the counselor not just when they are in crisis but also to relate when things are going well (Miller et al., 2007).

Another component of DBT for adolescents is family counseling as needed. When meeting with the family, the counselor identifies any aspects of the family environment that either reinforce NSSI behaviors or attempt to punish the adolescent's practice of new alternative coping strategies at home. Family therapy can also address any family behaviors that regularly interfere with the adolescent's participation in treatment or that reduce family interactions that interfere with the family's quality of life generally. This is important because family conflict is often a source of distress that triggers NSSI, and counseling might help the family to interact in a more functional way that reduces the conflict.

A final component of DBT is support for the counselor in the form of weekly team consultation meetings. Because working with adolescents who self-injure is extremely stressful, team meetings give counselors a vital opportunity to have their needs met by discussing difficulties and frustrations with the treatment process. Team support and feedback may help a counselor stay nonjudgmental and supportive and generate alternative perspectives or solutions when the counselor feels stuck (Miller et al, 2007).

CONCLUSIONS AND FUTURE DIRECTIONS

Adolescents who use NSSI have difficulty in recognizing and regulating their emotions; tolerating distressful thoughts, feelings, or circumstances; and effectively influencing their relationships (Nock, 2010). It is therefore understandable that some adolescents turn to NSSI as an effective, though selfdestructive, coping strategy for managing intra- and interpersonal problems. The DBT approach described here addresses these emotional and relational skill deficits by first emphasizing the counselor-client relationship in which the function of the NSSI is accepted and validated. In collaboration, together client and counselor can then carefully examine the chain of behaviors that lead to specific NSSI episodes, identifying triggers and generating possible ways to disrupt the behavioral sequence. The DBT approach also provides a structured method for teaching core mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness skills in a multifamily group setting. Additional components such as family counseling, telephone contact, and counselor collaboration meetings enhance DBT effectiveness.

However, there are also clear limitations to this approach. While the full DBT package described here is likely to be most effective (Miller et al., 2007), it is not feasible in many treatment settings; the multifamily groups in particular would be difficult for some counselors to offer consistently. Several research trials have found, however, that skills training is essential to DBT effectiveness, whether it is delivered in a group or individual format, and should always be part of the treatment (Lynch et al., 2007). Miller et al. (2007) suggested that if the group modality is not possible, the counselor should schedule twice-weekly sessions with the client, one session devoted to behavior analysis and problemsolving and the other to skills acquisition.

Other important treatment components are also difficult for many practitioners to manage. Phone coaching is deemed critical for adolescent clients so they can seek support and generalize skills throughout the week. Counselor consultation meetings are also essential to DBT success so that counselors receive the support they need for working with challenging clients. Practice limitations probably limit the feasibility of these two components for many practitioners, although Miller and colleagues (2007) suggest that counselors should seek to team with other therapists who use the DBT model to share the responsibilities of group sessions, phone coaching, and consultation meetings. While no research has been conducted to indicate whether limited or shared services would be as effective as the full package of DBT, it is assumed that the more comprehensive the treatment, the more likely it is to be effective (Lynch et al., 2007; Miller et al., 2007).

Future applications of the DBT approach for adolescents who self-injure might take more account of the client's sociocultural context and examine differential treatment effects for gender, race/ethnicity, and other cultural variables. For example, gender is not specifically accounted for in the treatment model, yet in early adolescence the needs of girls and boys will likely differ because girls encounter more stressors and pressures (Hilt, Cha, & NolenHoeksema, 2008). Future research might also examine how effective DBT is when a client experiences NSSI in conjunction with other disorders, such as substance abuse and eating disorders. Because NSSI often co-occurs with problems that also serve as emotion regulators, DBT is likely to help reduce these behaviors as well and may be an effective match for clients with comorbid concerns centering on regulating emotion (Safer et al., 2009).

There is also need for research focused specifically on adolescent clients. DBT is currently the treatment approach with the most research support, but most studies of its effectiveness have been conducted with adults and clients with BPD (Lynch et al., 2007). Moreover, DBT is not effective in all cases and there is little research to help counselors match the treatment approach to specific client characteristics. Future research might also examine how other treatment models might be matched to specific client characteristics.

In conclusion, an alarmingly large number of today's adolescents turn to NSSI as a strategy for managing emotions, relationships, and life circumstances. Mental health counselors need to be prepared to help their clients understand the functions of this behavior, generate more effective solutions to resolve their tensions and stressors, and learn skills that will enhance their entire quality of life. The model presented here is intended to guide counselors as they work to meet these complex and challenging treatment goals.

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