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Services for Teens at Risk

Emotional Regulation, Interpersonal Effectiveness, and Distress Tolerance Skills for Adolescents

A Treatment Manual

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University of Pittsburgh Health Systems

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INTRODUCTION

This treatment manual is intended as a complement to and extension of STAR-Center's cognitive therapy manual for depressed and suicidal adolescents (Brent & Poling, 1997). Although our previous manual's treatment approach has been effective in helping many of the teens we have seen (Brent, Holder, Kolko, et. al., 1997), we have found it to be insufficient in meeting the needs of a sub-group whose depressions and suicidality are chronic and treatment resistant. These teens do not improve significantly in response to the 12-16-session course of traditional Cognitive Behavioral Therapy (CBT). They usually remain in treatment a year or more. Even multiple medication trials have been of limited benefit with this group.

We have found that many of these treatment resistant teens display borderline personality traits-- such as feelings of emptiness, fear of abandonment, high emotional reactivity, impulsivity, self-cutting, and chronic suicidality. In general, these are teens who often get caught up in episodes of emotion dysregulation. It has been our experience that mood disordered patients with difficulties in emotion regulation may make great strides in CBT, but under duress will have an emotion storm that interferes with their ability to utilize their new-found coping and cognitive restructuring skills. The net result is that the progress in treatment is only maintained in a controlled, low-stress environment like a treatment session, and thus there is limited generalization to the most worrisome and high risk situations experienced by these teens.

We have therefore felt called upon to develop a treatment approach that is better suited to the needs of our chronically depressed and emotionally dysregulated teens. For this purpose, Linehan's Dialectical Behavior Therapy (DBT) has been a primary source of guidance. DBT remains the only empirically validated treatment for reducing parasuicidal behavior and hospitalizations in adults with borderline personality disorders (Linehan, 1991, 1993c; Shearin & Linehan, 1994; Chambliss 1996; Linehan, Kanter, & Comtois 1999). Further, Miller and his colleagues (1997) have modified DBT for depressed and suicidal teens who have at least three borderline personality traits. Compared to a "treatment as usual" group, those teens receiving DBT–A had lower rates of treatment drop-out, suicidal ideation, parasuicidal behavior, and rehospitalization. Further, these DBT teens demonstrated reductions in general psychiatric symptoms, including depression, as well as endorsing significant reductions in symptoms of borderline personality disorder—particularly in the areas of confusion about self, impulsivity, emotional instability, and interpersonal problems. (Miller, A.L. et. al. 2000; Rathus & Miller, in press; Rathus & Miller, under review).

In drawing from a DBT framework, this manual spells out adolescent specific treatment techniques and skills training that were alluded to or only briefly described in Brent & Poling's (1997) CBT manual. These interventions include behavioral analysis of impulsive behavior, emotion regulation, assertiveness skills, and distress tolerance skills. Impulsivity, lack of assertiveness, and poor affect regulation skills have been recognized by Brent (1997) as common pathways to adolescent suicidal behavior. These skill deficits compound the cognitive distortions that characterize adolescent depression.

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While a focus on emotion regulation, distress tolerance, and interpersonal effectiveness skills has helped DBT reduce parasuicidal behavior, the approach has not been as efficacious in decreasing the chronicity and severity of depressive symptoms (Linehan, Kanter, & Comtois 1999). It is noteworthy, though, that Rathus and Miller's (under review) DBT-A pilot data did demonstrate a greater reduction in depressive symptoms compared to the treatment as usual group. To more aggressively target depression in our treatment resistant teens, we have retained traditional CBT interventions at the same time that we have bolstered them to be more affectively evocative, adolescent friendly, and ambitious in their goal of identifying and modifying core beliefs.

To make our approach more adolescent friendly, we have adapted portions of Wexler's (1991a, 1991b, 1993, 1998, in press) Program for Innovative Self-Management (PRISM) The PRISM model is at its core cognitive-behavioral and designed exclusively for adolescents. Further, there is a significant degree of compatibility between the DBT and PRISM approaches-- both in terms of treatment philosophy and in the specific skills taught to patients.

In addition to developing the affinity between DBT and PRISM, this manual will also introduce an innovative intervention for accessing self-critical cognitions, generating supportive self-talk and identifying core beliefs in teens. We have named this intervention the "You Turn," which has been adapted from the work of Firestone (1997a, 1997b), and promises to bring an evocative affective component that is often missing from the traditional practice of CBT. We have found that very harsh and persistent criticisms toward self are a dominant cognitive cluster in our chronically depressed teens. Therefore, it makes sense to proactively target self-criticisms. We also hope that the "You Turn" will help target the pervasive self-invalidation that Linehan (1993a) has found to a defining feature of borderline personality style.

The first section of the manual will review treatment philosophy, and subsequent sections will focus on treatment techniques and skills training. Consistent with the format in DBT, this treatment approach is designed to be implemented through concurrent individual therapy and a skill-training group. All of the material is relevant to both individual and group modalities, although the applications of specific techniques will vary in each context. To illustrate the implementation of the treatment approach for group, the manual will conclude with an outline of a 9-session CBT skills training group for adolescents and their caretakers. Throughout the manual, there will therapist scripts suggested for use with teens in individual sessions. These scripts will always appear in italicized print. Finally, the 10 handouts referenced in the manual are available in the appendix in a perforated, pull-out format.

A Treatment Philosophy Suitable for Adolescents: "You're Doing the Best You Can, But You Can Do Better"

Linehan's Dialectical Behavior Therapy: Validation as a Core Therapeutic Strategy

Dialectical Behavior Therapy was originally designed to treat adults with borderline personality disorder, particularly those with a chronic history of parasuicidal behavior, inpatient psychiatric hospitalizations, and failed outpatient treatment. The core dialectic

governing the implementation of DBT is that between Acceptance vs. Change. Patients are assumed to be doing the best they can given their limitations and histories. To foster acceptance, the therapist is encouraged to actively provide validation for the patient's perspective, responses, and emotions. Linehan (1993a, 1997) elucidates emotional, behavioral, and cognitive validation strategies for the DBT therapist. DBT assumes that "... there is some inherent validity in every response..." (Linehan, 1993a, p.224), which she metaphorically describes as akin to finding the gold nugget in a cup of sand.

Validation is a core concept not only for DBT therapist behaviors, but also for Linehan's biosocial theory of how borderline personality develops. Linehan (1993a) describes borderline personality as resulting from the transaction between a child's biologically based emotional vulnerability and an invalidating familial environment (see also Hoffman, et. al. 1999 & Links, 1990). Such a child has a low threshold for emotional reactions, with these reactions tending to be extreme and prolonged, so that there is a slow return to baseline and a high sensitivity to the next emotional stimulus (Linehan, 1993a). Invalidating responses from the child's environment exacerbates this tendency toward emotion dysregulation. Linehan (1993a) defines an "invalidating environment" as

"... one in which communication of private experiences is met by erratic, inappropriate, and extreme responses. In other words, the expression of private experiences is not validated; instead, it is often punished, and/or trivialized. The experience of painful emotions, as well as the factors that to the emotional person seem causally related to the emotional distress, are disregarded. The individual's interpretations of her own behavior, including the experience of the intents and motivations associated with the behavior, are dismissed" (p. 49)

As a result of an invalidating environment, the emotionally vulnerable child does not learn how to accurately label private experiences, does not learn to trust in their validity, and does not learn how to modulate emotions or tolerate distress. Further, such a child may come to favor extreme emotional displays in order to elicit a helpful response from the environment. These environmental responses are often given on an intermittent reinforcement schedule, so that the child learns to alternate between extreme emotional displays and emotional inhibition. Since such a child mistrusts and invalidates her own experiences, she becomes very dependent on her social environment for cues about how to feel, think, and behave (Linehan, 1993a).

This developmental transaction between the emotionally vulnerable child and an invalidating environment engenders a pervasive pattern of self-invalidation, wherein the person essentially reacts against her emotional experience in ways that repeat the invalidating responses of her formative environment. This pattern of self-invalidation is especially evoked by the experience of strong or painful emotion. The person responds to such emotions with shame, guilt, self-hatred, or other varieties of self-critical cognitions and self-directed hostility. These reactions of course only serve to intensify the pain of the original emotion and further support the self-critical backlash. This dynamic illustrates the distinction between primary and secondary emotions, a distinction which will be discussed

in detail a subsequent section of this manual (p. 22 -23).

To avoid repeating this pattern of invalidation, the DBT informed therapist must nonjudgmentally acknowledge the destructive consequences of borderline behavior and the necessity of developing more skillful ways to cope. This is the spirit of the DBT slogan "You're doing the best you can, but you can do better". In being nonjudgmental, the therapist refrains from criticizing the patient or even the patient's behavior itself, but instead focuses on the negative <u>consequences</u> of specific behaviors. It is in this way, among others, that DBT is a behavioral approach. As such, it draws upon all available empirically validated technologies of change, including but by no means limited to traditional cognitive-behavioral techniques.

Another dialectic in DBT is the balance between employing the technologies of change and practicing mindfulness skills that have their origin in Zen meditation. Linehan views mindfulness skills as enhancing the patient's capacity for acceptance, particularly when change is not immediately possible. Linehan deems mindfulness skills to be the core DBT skills, essential to the successful acquisition of the other three DBT skill sets-- these being Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance. Adolescent versions of these skills domains will be described throughout the manual. However, rather than explicitly promoting mindfulness as the core skill, we have deemed "supportive self-talk" to be the core skill to be taught to teens. We have developed and expanded the definition of self-talk, wherein learning <u>any</u> new skill includes practicing more supportive self-talk—even if this consists only of the teen reminding him or herself to practice a new skill as an alternative to more destructive options. When coupled with the increased self-awareness required to interrupt dysfunctional habits, the practice of supportive self-talk actually entails several of the mindfulness skills advocated by Linehan-- such as the non-judgmental observation and description of emotional states (see section on "Mindfulness of Emotion," p. 28-29).

Wexler's Program for Innovative Self-management: A DBT Friendly Approach for Teens

Wexler's PRISM model is similar in spirit to Linehan's DBT insofar as it seeks to articulate the core of validity and purposefulness at the heart of what otherwise may seem to be purely impulsive and destructive adolescent behavior. Drawing on the principles of self psychology (Kohut, 1971), Wexler affirms how much of this behavior is motivated by the need to restore inner cohesion and equilibrium in the face of feeling fragmented, affectively overwhelmed, or empty. That is, these destructive behaviors are assumed to be serving a valuable function, a perspective that often comes as a surprise to adolescents more accustomed to hearing their behavior judged as stupid, reckless, irresponsible, or selfish. Instead, the therapist can present the teens with such reframes as "Your behavior makes sense" and "You're trying to take care of yourself in the best way you know how."

Similar to Linehan, Wexler emphasizes that it is the consequences of impulsive behavior that work against the adolescent. The PRISM approach particularly makes use of the normative adolescent desire for increased autonomy and power, emphasizing how

impulsive behavior often results in a loss of power for the adolescent (e.g., being hospitalized, being grounded, alienating friends, losing self-respect). From this perspective, adolescents can then be convinced that by learning new skills they will in fact gain power-- such as having more control over their emotional reactions and having a better chance at getting what they want from others through using assertiveness skills. The desire for autonomy as a motivator for adolescents in therapy has also been developed in helpful ways by Church (1994) and Hanna & Hunt (1999). The reframing of what constitutes true power is a core principle of the Wexler's PRISM approach.

Finally, both DBT and PRISM advocate concurrent individual therapy and group skills training. The techniques and skills described in subsequent sections of this manual are suitable for both modalities, although they will lend themselves to different applications in each context. In contrast to the DBT model, the PRISM approach has not been empirically validated for work with teens. Nonetheless, we have found Wexler's work valuable insofar as it mirrors basic DBT principles, retains an essentially CBT orientation, and is designed exclusively for working with adolescents.

Chain Analysis: Developing a Road Map for Intervention, Solution Seeking and Skill Building

Defining problem behavior through identifying its antecedents and consequences

Both the DBT and PRISM approaches lend themselves to targeting any emotion or behavior that has been identified as having negative consequences. For the adolescents seen at STAR-Center, depression, suicidal ideation and behavior, self-cutting, social anxiety, and anger management have been the most commonly targeted areas. In other settings, targeted behaviors can include substance abuse, bingeing and purging, running away, shoplifting, etc. Even less dramatically problematic behaviors, such as missing therapy appointments, can be targeted using these approaches. The phrase "problem behavior" is also intended to include internal experiences such as thoughts and feelings. For example, in "being depressed" it is assumed that the teen is engaged in specific mental activities that support depressed mood (e.g., self-criticisms).

Both the DBT and PRISM models employ behavioral chain analysis as a core strategy to assess and target problematic behavior. What is the chain of events, both internal & external, that culminated in the problem behavior? Chain analyses help identify the controlling variables for the target behavior-- such as the precipitants, vulnerability factors, cognitions, and emotions. The negative consequences for oneself and the environment are also included in chain analyses of problem behavior. For adolescents, a main purpose of the chain analysis is to challenge their common contention that the problem emotion or behavior was beyond their control or "just happened."

Chain analyses leads naturally to "solution analyses" in which alternative coping strategies are proposed for specific key problematic links in the chain, and alternative outcomes are imagined. This is where the therapist can identify the adolescent's main skill deficits and focus on tailoring treatment to remedy these deficits. In essence, the chain analysis

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provides a road map for prioritizing which interventions to pursue and in what order. What is the weakest link in the chain? What are the stronger links? What is typically the first link in the chain of events that culminates in the problem behavior?

Chain analyses, as Linehan describes them, tend to be a rather tedious undertaking-- she in fact encourages the patient to articulate the chain links in "excruciating detail". Part of her intention is for the chain analysis to be a somewhat aversive activity for the patient, taking up much of the session when the patient might prefer to speak about other issues. Linehan believes that if done consistently, chain analyses can serve as a motivator for alternative behaviors that will be worthy of praise instead of the scrutiny necessitated by the chain analyses. The Freeze Frame technique, described in the next section, provides a less tedious and more inviting chain analysis strategy for teens.

The Freeze Frame Technique: An Adolescent Friendly Chain Analysis

To engage and connect with adolescents, chain analyses in their more adverse adult form can be modified to make them more "user friendly." Wexler's (1991) PRISM model has accomplished precisely this modification in developing the "Freeze Frame" technique, in which events are recalled as if reviewing a video replay and then "freezing the frame" at critical inflection points.

The same reasons why chain analysis is important for these adolescents—the importance of slowing down the sequence of events that are distressing and feeling beyond the individual's control — also contribute to the adolescent's difficulties in engaging in this task. Therefore, it is necessary to model this approach in the session, to assist recall by having the teen recount "irrelevant" or emotionally neutral details such as the weather, clothes he or she was wearing, etc. Whereas a complete chain analysis can be quite complex and cognitively demanding, the procedure of breaking up the events into discrete and manageable bits, using the freeze frame, makes this approach within reach for virtually all adolescents. The Freeze Frame consists of the following steps, to which we have added some DBT embellishments (available for teen as Handout # 1):

- Identify a situation in which you lost control of your emotions and/or you behaved in a way that was harmful to yourself and/or others.

- Recall as may details as possible about what happened before, during, and after the problem emotion or behavior.

- Describe the "who, what, where, and when" of the problem situation; if you have trouble doing this, first try recalling such "irrelevant" details such as the weather, what you were wearing, etc.

- Focus on the "vulnerability factors" that made you more susceptible to the problem emotions and behaviors (e.g. sleep deprivation, drug use, hunger, physical illness— see pages 26-27 and handout # 4 on the HEAR ME acronym).

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- As you recall the actual scene/situation where the problem emotion or behavior happened, picture it as if you were viewing a "slow motion instant replay."

- As the scene approaches the moment when the problem emotion intensified or the "uncontrollable behavior" happened, "slow time down" so that you can really focus on the details of your experience.

- When you reach the moment just prior to the problem emotion or behavior, FREEZE THE FRAME and describe your self-talk, thoughts, images, feelings, bodily sensations, and action urges at that moment.

- Next, ask yourself this question: What needs were you expressing through your emotion or attempting to meet through your behavior, even if the results were negative?

- What other ways might there have been to take care of these needs?

- What were the negative consequences for yourself and others, and how can you make amends for these consequences?

- If you could go back in time and relive this situation, what would you have done differently to help things go better than they did?

- Replay the situation in your mind so that it has a better outcome— picture yourself using your new knowledge and skills, and imagine how these would have made a difference in how you and others handled the situation

Once these needs have been identified, the therapist must help the adolescent develop self-respect for these needs as well as help formulate and rehearse alternative ways to take care of these needs. This focus on articulating "needs" is consistent with Wexler's integration of self-psychology with CBT principles.

A recurring question for teen post-freeze frame is "If I knew then what I know now, what might I have done?" One of Wexler's (1993) main messages to the teen following the Freeze Frame is **"ONCE YOU KNOW THE NEEDS, YOU ARE SMARTER. ONCE YOU HAVE NEW TOOLS FOR HANDLING THE NEEDS, YOU ARE MORE POWERFUL"** (my emphasis, p. 4). This type of message clearly embodies basic DBT principles, as it simultaneously validates and accepts adolescents while challenging them to change.

Wexler (1991) originally suggested the Freeze Frame be conducted in the context of a guided relaxation and visualization exercise. However, he has subsequently found the technique to be just as effective without the guided visualization. Wexler (1998) has in fact come to prefer the more straightforward version of the Freeze Frame, especially for use in group sessions— where group members can help generate a list of options for taking care of the identified needs. Role-plays may be incorporated as a way to help recreate the problem situation. Here

is an outline we have developed for the use of the Freeze Frame in our teen skills group (based on Wexler, 1993, p. 3-4):

- One group member chooses a situation, whether in the recent or distant past, where he or she acted in way that is regretted.

- In as much detail as possible, the group member describes the situation that culminated in the problem behavior-- scene-by-scene, frame-by-frame, like a movie.

- The volunteer is encouraged to specify what his or her Negative Observers were saying and how this affected feelings (the concept of "the Observers" will be described in the next section, pages 15-18).

- Instruct the volunteer to stop the story— i.e. freeze the frame— when she gets to the moment right before she does the problem behavior.

- While the volunteer is telling the story, one group leader might put a 4 column chart on the board and keep track of the 1)self-talk, 2)feelings, and 3)needs mentioned by the volunteer. The 4th column is reserved for "options".

- Recruit group members to play some of the roles and do some of the "voices" that the volunteer has described-- these roles should be both for external people who were part of the set-up situation (e.g. peers & parents) and the internal dialogue provided by the Negative Observers.

  o For example, one group member could voice the insulting statement of a peer and another could then speak the voice of the Self-critical Observer in response to the peer.

- Once the group gets back to the point right before the problem behavior, everyone should then help the volunteer identify everything that was going through her mind at that moment-- the feelings, thoughts, images, self-talk, and *especially the needs*.

- After the volunteer's needs have been identified, then have the whole group brainstorm other ways these needs could have been addressed and the problem behavior avoided.

  o The group leaders can add specific skill suggestions based on what has been recently taught in-group.

  o The results of the group brainstorm can be listed in the "options" column on the board.

- To conclude the Group Freeze Frame, the volunteer should pick and practice those suggestions that make the most sense to him or her.

- Group members can play roles in helping the volunteer practice the alternative outcome—e.g. some can play a Supportive Observer who says soothing things and suggests alternative behaviors.

Whether done in an individual or group session, the Freeze Frame is conducted in a non-judgmental fashion; taking a page from the DBT model, the therapist may at times employ an irreverent communication style to help build rapport with the adolescent, and inject a dose of levity to balance the seriousness of the enterprise. Even when an adolescent engages in positive alternative behaviors, the therapist should of course first praise and reinforce it, but then can also with humor imagine with the adolescent what negative consequences would have likely resulted if he or she had done "behavior as usual" (i.e., had engaged in the originally targeted problem behavior).

Wexler (1999, personal communication) has come to conceptualize the Freeze Frame as the cornerstone of his approach to adolescent treatment. As with the chain analysis in DBT, the Freeze Frame is a core intervention from which many other interventions flow. Often the teen will present with a flurry of details about all manner of situations, people, actions, and reactions. This discourse is primarily one in which the world and others are described as if they existed independent of the teen's unique perspective. Lost in this discourse are the multiple inner and private experiences that shape the teen's perceptions, feelings, and behavior.

On other occasions, especially with depression and anxiety, teens are very vague in describing just what is troubling them. In these cases, the Freeze Frame helps teens pinpoint when their mood may have worsened and what cognitions accompanied this shift. The Freeze Frame provides a focus and a starting point to help the therapist and teen access those problematic cognitions that otherwise would not be recalled.

The Freeze Frame in Action: An Example of Mapping Interventions

To illustrate the use of the Freeze Frame, let's look at a first person description of a rather typical sequence culminating in an adolescent suicide attempt. Although the following blurb is fictitious, it clearly contains elements that are extremely common and repeated daily by all too many teens.

I had an argument with my parents about getting a later curfew. They said "No" because I have been doing so poorly in school. I told them to "fuck off and go to hell". I was so angry that I went up to my room and smoked a joint to calm down, but it did not help very much. I then got a call from my girlfriend. She told me that she had been out with a group of friends, including this guy I worry she likes more than me. I started to feel very angry and jealous. I thought to myself "See, you are losing her already, you better let her know who's boss!" So, I got very rude with her on the phone, calling her some nasty names. We had an argument, she told me that she wasn't going to see me anymore, and hung up on me.

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I felt desperate that I had lost her for good. I kept on calling her, but she must have taken the phone off the hook. I snuck out of the house without my parents' permission. I went to my girlfriend's house and rang the doorbell, but nobody answered. I then started throwing stones at her window to get her attention, but it didn't work. I thought to myself that this was more proof that "No one really loves you" and "You will never have another girlfriend." I also thought "What a jerk you were for calling her all those names, you really don't deserve to have a girlfriend"

I went home and my father yelled at me for leaving without permission. He said I was grounded for the next weekend. I went upstairs to my room, and felt incredibly stupid, angry, and lonely. I hated myself and wanted to punish myself, so I grabbed my knife and cut my wrists. I passed out, and my parents found me and took me to the emergency room. After that I was admitted to the psycho unit at the hospital.

In this example, we can list multiple points of possible intervention and skill development. The relevant skills will be printed in bold along with their page reference in the manual.

Parent-teen conflict— We see how this teen escalates when he does not get what he wants and ends up behaving in ways that make things worse. The therapist would need to assess just how often this type of conflict occurs and how the teen contributes to it. Here **Interpersonal Effectiveness Skills** may ultimately be the most helpful (see p. 32- 36).

Substance Use--The teen smokes a joint to "calm down" after conflict with parents, but getting high then seems to make him more vulnerable to further emotion dysregulation during his phone call with his girlfriend. The clinician will of course at some point need to assess the extent of this teen's pot use. In the context of the above situation, pot use is a "vulnerability factor" that increases the likelihood of the next stressor being too much to bear. The **HEAR ME** material would help here in educating the teen about this factor (see p. 26- 27).

Angry & jealous self-talk-- The teen clearly expresses cognitions that support angry and jealous feelings. There are some "should" and "should nots" that may need to be identified here—such as "girlfriends should not socialize with other guys and should only be with me." This teen may also have an underlying belief that he needs to control his girlfriend in order to feel secure about their relationship.

The material on the **"Negative Observers"** may be helpful here— such as the "Resentful Observer" for anger. Also, perhaps a "Jealous Guy" observer could be named and separated out as the source of jealous self-talk (see p. 15-18). The **"You Turn" technique** could also be adapted here to help this teen more fully voice the feelings and thoughts that support his jealousy (see p. 19-22). A **"Supportive Observer"** or **"Wise Mind"** will need to be developed to be the voice of wisdom and compassion (see p. 15-19).

This teen will also ultimately need to learn and practice **Interpersonal Effectiveness Skills** to better negotiate conflict with future girlfriends, but it seems the priority here will be the modification of angry and jealous self-talk.

Desperation and Action Urges-- Following his girlfriend's hang-up and unavailability via phone, the teen feels desperate and cannot resist the urge to seek her out in person— which only produces more frustration and despair (see p. 27- 28 re: action urges). This is a point in the chain where the teen would have benefited from letting the action urge pass and practicing **Distress Tolerance Skills**—which include as their goal the acceptance of situations and feelings that cannot be changed at the moment .

Self-critical cognitions—Following his failed bid to reconnect with his girlfriend, the teen experiences a flurry of self-critical cognitions, which predictably contribute to an intensification of his emotional distress and set the stage for his self-cutting. The **"You Turn" technique** might again be employed here to help the teen more fully voice and combat his self-critical thoughts and feelings— i.e. to spell out his **Self-Critical Observer**. A **Supportive Observer** could also again be quite helpful at this juncture.

The suicide attempt-- Consistent with the Freeze Frame approach, the therapist will need to focus with this teen on the moments just prior to deciding to cut himself with his knife. It is at this juncture in the chain that the question should be raised about what emotional needs the teen was attempting to address through this behavior. The teen described feeling stupid, angry, lonely, and self-hatred. He experienced the urge to punish himself.

What would it have taken at this moment for the teen to decide against cutting himself as a means of self-punishment? He needed to not feel so lonely and self-loathing. He needed to be able to forgive himself for his poor choices that evening. If he could not get past the need to punish himself, perhaps he could at least allow that he has already suffered enough for the evening and this could be punishment enough. Any number of the skills in this manual might have helped him at this point if he could past the self-punishment urge. If a supportive friend were available by phone, this would certainly be a better option. If no one is available, the **Supportive Observer** or specific **Distress Tolerance Skills** could be called upon—such as **Self-Soothing with the Five Senses** .

Aftermath of suicide attempt -- The final phase of a full chain analysis is to review the internal and external consequences of the problem behavior. In this case, what were the teen's thoughts and feelings once in the hospital? What were the pros and cons of being in the hospital? What impact did his attempt have on his family and friends? What repairs may he need to perform in order to make amends to those he has hurt?

The Supportive Observer, Wise Mind, and the Self-Critical Voice

The Battle for Emotional Cohesion: The Negative Observers vs. The Supportive Observers

Borrowing from Kohut's (1971) self psychology, Wexler emphasizes the importance of helping adolescents develop their self-management and self-soothing skills. To help

themselves maintain a sense of emotional cohesion, troubled adolescents are often overly dependent upon others' physical presence and/or compliance with their demands. When these relationships are disrupted or the other does not comply with these demands, the sense of self-cohesion is lost and adolescents' inner experience becomes dominated by a variety of negative cognitions and affects. Wexler adopts Kohut's concept of the "selfobject" to describe any relationship that helps adolescents maintain a sense of cohesion and selfhood. Selfobject relationships not only exist with others but also can include any activity that provides and promotes a sense of cohesion-- including spirituality, pets, sports, academics, imagery, etc.

Wexler has developed the concept of the "Supportive Observer" or "Ally" to bring alive for adolescents the cohesion enhancing function of self-object relationships. The Ally is defined as an inner voice or presence that makes reassuring and soothing statements to the adolescent, instilling a sense of confidence and safety. This concept can be explained to teens as "someone who is on your side, working for you." The analogy of military allies might be used to further illustrate this point. For adolescent males in particular, military metaphors might be used to describe the use of the Ally to combat attacks from enemy self-talk.

In CBT terms, the Ally can provide the supportive self-talk required to counter the negative self-talk common to depression, anxiety, and anger. Wexler uses the concept of "Negative Observers" to describe for adolescents what has been termed "negative self-talk" in traditional cognitive-behavioral therapy. The Negative Observer is "... an imagined homunculus... " (Wexler, 1991, p.48) whom the adolescent can picture as the source of the negative self-talk that dominates their thinking and adversely influences their mood. The phrase "Negative Self-talker" might also be used to describe this adversary. Or, in an irreverent variation, the phrase "Self-stalker" has been suggested as a way to capture the hostile intent of negative self-talk.

The three typical negative observers noted by Wexler are the Resentful Observer, the Self-Critical Observer, and the Hopeless Observer. The Resentful Observer fosters frustration and anger, the Self-Critical Observer contributes to depression through decreasing self-esteem, and the Hopeless Observer contributes to depression by issuing pessimistic predictions about the future. We have added the "Worried Observer" to this list, since so many depressed teens also experience significant anxiety—with the "what if" cognition being most common in these instances.

It can also be helpful to have adolescents develop more specific and personalized names for their Negative Observers. Bertolino (1999) notes how this strategy can help distinguish the problem from the person and empower the adolescent in combating the problem (e.g., "Mr. I.B. Truant" is a name given to the problem of truancy). Bertolino (1999) also notes how "once the problem has been given a name, the therapist talks with the adolescent, family, or others as if the problem is another person with an identity, will, tactics, and intentions that oppress, undermine, or dominate the youth, family, or others" (p. 21).

In countering the claims made by the Negative Observers, the Supportive Observer enacts the traditional cognitive-behavioral task of developing alternative cognitions to replace cognitive distortions. The Supportive Observer can at times propose alternative cognitions or any other skillful behavior in a more lively and personal way than CBT thought sheets alone. This is an adolescent specific enhancement of traditional CBT techniques, and is especially useful in group sessions. Like many other aspects of the PRISM approach, the concept of the Supportive Observer incorporates the use of imagery and relaxation as a way to enrich the cognitive-behavioral methods that adolescents otherwise may experience as too abstract or sterile. Wexler (1998) has described his goal as that of "jazzing up" traditional CBT techniques for adolescent consumption.

The Supportive Observer can be fleshed out for adolescents by having them recall people in the recent or distant past who have served as ally figures and helped reassure them when scared, soothe them when angry, express pride upon an accomplishment etc. If adolescents are unable to recall an actual person, then they can be encouraged to create their own ally figure or to combine features of two or more such figures. For example, an 18-year-old depressed male combined his youthful soccer coach with the image of a 70 year-old grandfatherly, wise man. Wexler (1991) in fact describes an intervention in which the "wise man ally" is introduced as a way to familiarize the adolescent with the general concept of the ally.

Ally figures can be brought to life in the present by having the adolescent use visual imagery to recall a recent distressing experience and then imagine their ally figure appearing on the scene and saying or doing just what is needed to help soothe and guide them. Wexler (1991a) notes how "... the use of visual imagery to recreate ally figures from the past intensifies the experience and elicits a response from more than just the cognitive realm. The mental representation of this ally seems to leave a greater imprint.... than the concept of self-talk alone is able to do" (p. 51). Wexler (1991b) has designed a specific imagery exercise to introduce and develop the adolescent ally. Ally figures can also be elicited at the conclusion of other images—i.e., the therapist can have the teen imagine an ally figure join him or her to offer further support or reassurance.

Just as they do in regard to their Negative Observers, adolescents should be encouraged to designate more personalized names or identities for their Supportive Observer. Ideally, several varieties of Supportive Observers can be developed to counter the variety of Negative Observers and their troubling self-talk. Members of our CBT skills training group have listed such allies as the Humorous, the Proud, the Spiritual, and the Buddy Observer. For example, having learned about "black and white thinking" as a form of faulty self-talk, a teen in our program developed "Mr. Gray" -- the Supportive Observer who could be called upon to challenge the dichotomous claims made by the Negative Observers "Mr. Black" and "Mr. White".

In contrast to traditional CBT language, which favors such phrases as "rational vs.

irrational" when discussing self-talk, we prefer the phrases "negative vs. supportive" or even "unsupportive vs. supportive" These latter phrases better capture the affective tone specific to each variety of self-talk. To speak of "supportive" rather than "rational" also guards against the judgmental tone that CBT therapists on occasion convey in attempting to convince patients of their "errors in thinking" or "cognitive distortions". Finally, as will be elucidated in the section on the "You Turn" technique (pages 19-22), the content of negative self-talk may at times be accurate. What is ultimately more destructive is the self-directed <u>hostility</u> with which this cognitive content is processed. Even if the content is true, such one's height being 5' 5", this never justifies the person condemning and attacking him or herself.

Wise Mind: An integration of Emotion Mind & Reasonable Mind

Ally figures and supportive observers are intended to convey knowledge that is quite akin to Linehan's DBT concept of "Wise Mind." Linehan considers "Wise Mind" to be one of three primary states of mind-- the other two being Reasonable Mind and Emotion Mind. Reasonable Mind refers to what one thinks to be true, and depends upon a person's intellectual, rational, and logical capacities. Reasonable Mind is planful and attends to empirical facts. Emotion Mind is governed by affect and focuses upon what one feels to be true, with logical thinking having less of a place. Within Emotion Mind, "facts are amplified or distorted to be congruent with current affect... and the energy of behavior is likewise congruent with the current emotional state" (Linehan, 1993a, p. 214). Both Reasonable Mind and Emotion Mind can be valuable in their own right, but at other times may place limits on knowledge and effectiveness.

Wise Mind refers to an integration of Reasonable and Emotional Mind, and does not depend exclusively on either intellect or affect, instead depending upon "... a full cooperation of all ways of knowing: observation, logical analysis, kinetic and sensory experience, behavioral learning, and intuition." (Linehan, 1993a, p. 214-15). Wise Mind captures what one intuitively knows to be true, and requires a calm presence even in the midst of crisis. Linehan notes how Wise Mind can be accessed through focusing on deep breathing, locating Wise Mind at the bottom of one's inhalation, at one's physical center (akin to "the calm at the center of the storm"). We are all assumed to have Wise Mind, but to differ in our ability to access and make use of its wisdom.

In teaching adolescents how to draw upon their Supportive Observer or ally figure, it can be helpful to depict this figure as embodying Wise Mind-- who is to be trusted with knowing just what to say or do to help guide the adolescent through difficult feelings, situations, and relationships. The Supportive Observer's wisdom can include challenging problematic self-talk as well as offering other types of reassuring advice or suggesting self-soothing strategies. In addition to "the ally", other names can be offered to capture the Supportive Observer's wisdom—such as the "Wise Guy", "Wise Mind Guide", or any other more personalized, creative name suggested by the teen.

Adolescents are coached to call upon their Supportive Observer whenever they are inclined to act purely out of Emotion Mind, especially when the emotion is a troubling one

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and where there is a danger of destructive consequences. As we will see in the section on emotion regulation, education on emotion is essential to enhancing the adolescent's wisdom, expanding their range of behavioral options, and generating the type of alternative self-talk needed to make wise choices. For now, a separate discussion is in order as to the resistance we have encountered in teaching teens about supportive self-talk and the Supportive Observer.

The "You Turn" Technique: A Method for Eliciting the Self-critical Voice, Generating Supportive Self-talk, and Identifying Core Beliefs

We have been struck at STAR-Center by how reluctant our chronically depressed teens are to learning and practicing supportive self-talk. This is particularly true in regard to challenging self-critical cognitions, which are usually the most pervasive and impairing of the cognitive distortions common to depression. Self-criticisms also more clearly reflect the "core beliefs" or "schema" that have been recognized in CBT as the foundation for the range of the depressed person's automatic negative thoughts. The identification and modification of core beliefs is the ultimate goal of CBT, and essential to progress with the more chronically depressed patient. Core beliefs have been discussed by Caspi (1993) in terms of "internal working models", which are very resistant to change since contradictory information poses a challenge to psychological equilibrium. This is one of the reasons why the depressed person will dismiss even positive events and meanings. This dynamic is amplified by borderline pathology, where self-invalidation is a defining feature of affective and cognitive processes (Linehan, 1993a)

We have found that treatment resistant depressed teens seem to have so identified with their self-critical cognitions that it is very anxiety provoking to consider modifying them. In fact, the self-critical voice will protest the value of adopting a more supportive perspective. To understand this phenomenon, we have been aided by the work of Robert Firestone (1997a, 1997b) on the pervasiveness of self-destructive thought processes both in the general population and in clinical cases, particularly where depression and suicidality are involved.

One of Firestone's core concepts is that of "the voice," which he defines as "… a well-integrated system of thoughts and attitudes, antithetical toward self and cynical toward others that is at the core of the individual's maladaptive behavior…. " (1997a, p.145). From this perspective, the voice generates both hostile self-attacks and harsh assessments of others. In generating self-attacks, the voice undermines the person's ability to more fully enjoy life and derive satisfaction from everyday accomplishments. In attacking others, the voice impairs the person's ability develop and sustain intimacy in relationships. Indeed, the voice has been implicated in a range of phenomena in addition to suicidality (Firestone & Seiden, 1990; Firestone, 1997b)—such as child abuse (Firestone, 1990, 1997a), addictions and addictive relationships (Firestone 1993, 1997a), violence (Doucette-Gates, Firestone, R., & Firestone L., 1999), and marital dysfunction (Firestone & Catlett, 1999).

We have been impressed with the core therapeutic intervention that Firestone has

developed to elicit and combat the destructive dictates of the voice. This technique is deceptive in it's simplicity, as it has the power to produce detailed self-criticisms and powerful affect, both of which tap into complex issues that must be carefully attended to by clinicians. The technique basically involves asking patients to voice their self-criticisms using the second person pronoun "You," as if another person was addressing them. That is, instead of saying, "I'm so stupid, I'll never amount to anything", the teen says "You're so stupid, you'll never amount to anything." The teen is encouraged to go into as much detail as possible in stating and elaborating upon his or her self-criticisms. We have found that when teens speak their "voice" in the second person, it is often possible to elicit significantly more detail than that gained from such traditional CBT tools as filling out thought sheets and seeking in-session "hot cognitions."

In fact, Firestone's technique permits access to a range of affect that exceeds what is usually possible when more traditional CBT techniques are employed. In his work with adults, Firestone (1997a) found that the voice technique often elicited intensely hostile affect—that is, the person would voice their self-criticisms with an affective tone ranging from mildly sarcastic to dramatically condemning and attacking. At the extreme, this might include injunctions such as "You should just kill yourself!" (Firestone, 1994, 1997b). As adult patients hear the ferocity of their voice attacks, appropriate sad and hurt feelings often emerge in response.

In adapting the voice technique to teens, we have given it what we hope is a more user-friendly name-- the "You Turn." On the one hand, this phrase captures the voice technique's focus on articulating self-criticisms using the second person pronoun. On the other hand, in echoing the "U Turn" of the road world, this phrase also implies that this intervention can help teens to begin "turning things around" in their lives. They can do this by first becoming more fully aware of their destructive directions, and second by helping reverse this trajectory in favor of a more supportive path. At the very least, we hope to open alternative roads and detours to help the teens be more flexible in their approach to self and others.

We have attempted to adapt the You Turn technique for use with teens in both individual and group therapy. In general, teens seem more comfortable doing the You Turn in individual sessions, since in group sessions they feel more vulnerable and exposed. As group leaders we have demonstrated the technique, and have gotten the sense that group members were a bit intimidated by the potential potency of the exercise. This anxiety is more readily managed in an individual therapy relationship where a sufficient sense of trust and safety has been established.

We have also found that teens tend to initially do the You Turn with a more matter of fact affective delivery than the adults discussed by Firestone. This is an acceptable variation on the technique, as it at least elicits detailed content. Firestone (1997a) refers to this version of the technique as the analytic approach, whereas the more emotionally evocative version is referred to as the cathartic method. After the teen has articulated their self-criticisms, it can be useful to employ the more traditional CBT technique of

seeking evidence for these beliefs. Further, we have found it helpful to have the teens "talk back" to their self-critical voices in the first person, presenting counter evidence against the voice's accusations. Firestone (1997a) has developed this stage of the You Turn, and like the first phase of the technique it can either be enacted in an analytic or a cathartic manner. The analytic approach is closer to the traditional CBT technique of encouraging the person to develop a more realistic and objective self-appraisal. As previously noted, we prefer to describe this alternative viewpoint as "supportive" rather than "rational," since the latter is judgmental while the former is more sympathetic. The idea of developing "compassion for oneself" is another way to describe this goal in more affectively attuned terms.

Firestone also makes the important point that on occasion some of the voice's criticisms may be valid in reference to specific problematic behaviors or personality traits. To avoid invalidation of the teen, the therapist must recognize the validity of these criticisms and encourage the teen to develop more supportive means of addressing and changing these troublesome behaviors and traits. The therapist can point out that accurate criticisms are a way to "play fair" with one's self. This supportive approach is contrasted with the more malicious versions of the voice in which the teen is attacked and condemned for his or her shortcomings. In such instances, fair play is absent and harsh tactics prevail. Firestone is clear that although the facts of some self-criticisms may be valid, the hostile tone in which they are experienced is never justifiable.

In employing the You Turn, the therapist must be mindful of the anxiety and/or guilt that may be evoked as the teen first articulates and then challenges the voice. Firestone (1997a) has found that the voice often includes internalized versions of familial messages with which the person has identified and to which he or she feels bonded for various defensive purposes. Questioning the voice can therefore be akin to challenging familial authority and separating from the more troubled aspects of specific familial relationships. This process will at the very least elicit anxiety as one seeks to redefine oneself apart from familial characterizations. Guilt is common when there a sense of betraying family loyalties and/or when there are inner rules against expressing anger in general. Teens whose depressions include a consistent guilt component are especially likely to disavow legitimate angry feelings and to struggle with implementing the You Turn in even it's more analytic incarnation. It appears probable that the voice's self-criticisms are not limited to familial influences, but include aspects of the peer relationships that are of course so central to teens' emotional lives.

Clinicians should also be prepared for the possibility that voice attacks may temporarily intensify in response to the teen's efforts to articulate and implement a healthier vision of self. Firestone has identified an almost retaliatory quality to the voice attacks that follow efforts to change and grow. It is important to prepare teens for this prospect and to support them in riding it out while continuing to question the validity of their self-criticisms.

If a teen is reluctant to do any version of the You Turn, this may indicate that emotion regulation skills must first be developed in order to reduce and manage the distress

associated with evoking powerful affect. Also, it seems that teens are hesitant to do the You Turn when they have difficulty accessing a compassionate perspective from which to counter their self-criticisms. For these teens, more preparatory time will first need to be spent developing a Supportive Observer or other internal resources.

For now, we are encouraged by the potential of the You Turn as another avenue for expanding the scope and impact of traditional CBT conceptualizations and interventions. The You Turn has helped us recognize that it is not only "errors in logic" that keep teens stuck in depression. Teens will tell us that they clearly recognize the cognitive distortions evident in their self-criticisms, yet they still struggle with changing them. Through Firestone's perspective, we have come to appreciate how the emotional reasons for resistance can override the corrective logic of challenging cognitive distortions.

The lessons of the You Turn have also highlighted the importance for a more encompassing emotion model than the traditional CBT scheme of thoughts producing feelings. The next section details such a model and its use in teaching teens emotion regulation skills.

Emotion Education and Emotion Regulation Skills

An Integrative Model of Emotion: Contextualizing Cognition and Distinguishing Primary vs. Secondary Emotions

Teaching emotion regulation skills requires providing psychoeducation about the nature of emotion. This raises the question of what emotion model to teach adolescents. In recent years there has been a shift in CBT circles from viewing emotions as mainly the product of cognition to viewing "... emotion, cognition, and action... as interdependent aspects of a complex system that is involved in generating meaning" (Safran, 1998). Cognitions retain a significant role in this model, but are no longer assumed to have a primacy above and beyond the other components of emotion (see Hand-out # 2, which is further discussed on p. 27-28).

This shift in the preferred model of emotion is evident in Linehan's DBT approach. Although Linehan's book is entitled Cognitive-Behavioral Treatment of Borderline Personality Disorder, the more traditional CBT model does not exclusively inform the model of emotion she employs or the treatment techniques she espouses. In fact, her description of Emotion Mind in particular and emotion theory in general is somewhat at odds with the more traditional CBT contention that thoughts determine feelings and that distorted cognitions are responsible for distressing affect. Linehan (1993a) here states her position:

> Although DBT does not assume that borderline patients do not at times distort
> events, the first line of approach is always to discover the aspect of an event that is
> not being distorted. Distortion of events is often a consequence rather than a
> cause of emotional dysfunction (p. 225).

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Here Linehan first reiterates the importance of initially affirming what is valid in the patient's response before moving to challenging the more dysfunctional or distorted dimensions of the response. Otherwise, the patient may feel invalidated and not be able to benefit as much from the therapist's attempts to challenge distortions. Linehan's second point speaks to the primacy of emotion dysregulation in the borderline individual and how distorted cognitions can also be understood to be a product of dysregulated affect. As noted in the previous section, within Emotion Mind "facts are amplified or distorted to be congruent with current affect..." (Linehan, 1993a, p. 214).

The distinction between primary and secondary emotions is essential to understanding Linehan's position regarding the place of distortion in affective experience (Greenberg, 2002; Greenberg & Safran, 1987; Safran, 1998). Primary emotions are considered to be a person's most immediate reactions to an event and to contain adaptive motivational information about the event's meaning; primary emotions therefore are the bearers of what is valid or undistorted in the person's reaction. Secondary emotions are reactions to or against primary emotions, and are often engendered by the types of distorted cognitive appraisals traditionally addressed in CBT. Secondary emotions are often maladaptive in that they tend to inhibit or block the experience and expression of primary emotions. Such inhibition limits access to the valuable information provided by primary emotions. Secondary emotions also often motivate the types of behavior that have destructive consequences for the person, and can be conceptualized as a function of the voice as defined by Firestone (1997a; see previous discussion of the You Turn technique). As previously noted, for the borderline patient, a pervasive pattern of self-invalidation supports secondary emotions.

From this perspective, increasing awareness and expression of primary emotions helps decrease maladaptive secondary emotions, expands problem-solving capacities, and mobilizes the action required to bring about lasting change (Greenberg & Saran, 1987). Such mobilization is especially important in the treatment of depression, where immobilization is such a core characteristic. The depressed person is often blunted or restricted in his or her experience and expression of primary emotions, including sadness and anger. The You Turn technique, in its more cathartic version, can assist in the task of accessing primary emotions, helping free the teen from the tyranny of excessive self-criticisms and their associated secondary emotions (e.g., guilt).

All emotions may function as either primary or secondary emotions, or even as both at once-- such as fear of fear. Anger and shame are excellent examples of an emotion twosome that can function in either the primary or secondary roles in relation to one another. A person may be legitimately angry about some injustice but feel ashamed about experiencing and expressing these feelings, believing them to be unacceptable and/or fearing that to express them will be to risk embarrassment, hurting someone, or losing control. Here anger is the primary emotion and shame is the secondary emotion. Shame is also a common secondary emotion relative to such painful primary emotions as hurt, loneliness, and sadness. Especially common in adolescents, though, is the experience of anger as a secondary emotion when shame is the primary emotion-- a phenomenon so

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pervasive that it warrants a separate discussion.

The Shame-Rage Spiral in Adolescence

In many ways adolescence is a minefield for shame and its variants, which range from mild embarrassment to mortified humiliation. Indeed, Schave & Schave, (1989) have viewed shame as "... the main disruptive affect of early adolescence..." (p. 4). Vulnerability to shame is an inescapable consequence of adolescents' self-consciousness, exposure to peer scrutiny, disrupted relationships, and attempts to measure up to adult ideals. Thrane (1979) has noted how some degree of shame is intrinsic to the adolescent experience insofar as the autonomy ideal is always to some extent unrealizable. He notes how "as long as autonomy is not yet fully achieved, as long as identity is not fully defined, as long as ambition outstrips actual performance... a liability to shame is inevitable" (Thrane, 1979, p. 338).

As we all know from our own experiences of even mild embarrassment, one of the core inclinations accompanying shame is to hide-- to hide our exposed selves from the scrutiny of others, but also possibly to conceal even from ourselves the fact that we are feeling ashamed. When shame is especially painful, it is common for the person to bypass it without acknowledgement and to instead become caught up in angry attacks toward whomever is experienced as responsible for inflicting the shame. The intention of such angry, retaliatory attacks is to shame the other and to transform oneself from the weakened position of feeling shamed to the more powerful stance of embarrassing the other. The other usually responds to being shamed by also reverting to an angry counterattack in which further shame is evoked. It is easy to see how the two people in such an interaction are embroiled in a loop of shame and anger where the underlying shame may never be acknowledged. Additional shame may be experienced as each party at least implicitly recognizes that their angry, retaliatory behavior exposes them as deficient in their emotion regulation and interpersonal effectiveness skills (Lansky, 1992).

These dynamics have been identified and described as the "shame-rage spiral" (Lewis, 1987), which has been implicated as a significant factor in aggression (Scheff & Retzinger, 1991; de Zuleta, 1993), suicidality (Bonner, 1993; Lansky, 1992; Schreve & Kunkel, 1991), marital conflict (Retzinger, 1991), and a host of psychopathological conditions (Lewis, 1987; Kaufmann, 1996).

Varying degrees of the shame-rage spiral are pervasive in adolescent interpersonal interactions, where there is an exquisite sensitivity to being respected vs. "being 'dissed'", with the latter being occasion for all manner of aggressive retaliation-- ranging from verbal attacks to homicide. In CBT skills groups that we have run for adolescents, we have been struck by how normative and accepted this type of retaliation is. We have also been struck by how unaware adolescents are of the shame that motivates their angry retaliations. It is partly for this reason that we make the distinction between primary and secondary emotions an essential aspect of emotion education and emotion regulation skills training, both in individual and group therapy. The Freeze Frame technique can help the teen learn the distinction between primary and secondary emotions, and is

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especially useful in revealing the shame that precedes anger.

Formal and Informal Definitions of Emotion Dysregulation

Since the problem of emotion dysregulation is so central to these teens' troubles, this issue must also be made an explicit part of the information shared in teaching emotion regulation skills. For the clinician's reference, it is helpful to be familiar with Linehan's (1993) definition of the three components that constitute vulnerability to emotion dysregulation. These three components are:

> High sensitivity (to emotion stimuli)
> > Immediate reactions.
> > Low threshold for emotional reactions.
>
> High Reactivity.
> > Extreme reactions.
> > High arousal dysregulates cognitive processing
>
> Slow return to baseline
> > Long lasting reactions
> > Heightened sensitivity to next emotional stimulus.

The therapist should of course translate these three components into everyday language for the teen (at this point, the therapist can share Handout # 3 on "Three Aspects of Vulnerability to Emotion Dysregulation"). Here is a sample script for sharing this information with a teen:

Let's talk about what we mean by emotional dysregulation. It seems that there are three basic factors that make us more likely to get emotionally dysregulated. These three factors are:

- *"A very FAST emotional response; it does not take much to get the ball rolling, and the ball gets rolling very rapidly down the hill to the land of dysregulation."*

- *"A very BIG emotional response; emotions are felt and expressed with much intensity, making it difficult to think clearly; when the ball gets rolling down the hill, it quickly becomes a BIG ball—perhaps with jagged edges."*

- *"A very SLOW return to being calm or relaxed; it takes a long time to roll the ball back up the hill; there may have been damage done by the ball as it sped down the hill, so extra distress may have been added to whatever got the ball rolling in the first place."*

Until the ball is returned to the top of the hill and order is restored, you are even more sensitive and vulnerable than usual to responding with intense emotion to the next stressor that comes along.

Can you give me some examples of things that have happened recently that may fit with this description? How did each of these three factors contribute to the problem?

After identifying an example or two, the clinician can begin to educate the teen about other vulnerability factors may make emotion dysregulation more likely—namely, those factors summarized by the HEAR ME Handout (# 4).

Reducing Vulnerability to Negative Emotion (HEAR ME)

Drawing from Linehan, we advocate ways in which adolescents can reduce their vulnerability to negative emotions-- also referred to as "How to Stay Out of Emotion Mind" (Linehan, 1993b). Particularly important for the treatment of depression, we offer psychoeducation on the relationship between the sleep cycle and mood. We give out written sleep hygiene guidelines and, when needed, we teach relaxation techniques to help adolescents fall asleep. In addition to balanced sleep, we also advocate reducing vulnerability to negative emotion through eating a balanced diet, treating physical illness, getting regular exercise, avoiding substance abuse, and planning at least one activity a day that elicits a sense of competence and mastery.

In addition to the three aspects of emotion dysregulation we just reviewed, it is also important to be aware of other factors that can make us more vulnerable to becoming depressed and dysregulated. Perhaps most important of all is getting enough sleep. Research has shown that there is a very close connection between trouble with sleep and problems with mood – especially depression. We all have had the experience of not getting enough sleep and being more irritable the next day because we are too tired. Therefore, we have developed a set of suggestions for your teen to help him/her develop better sleep habits (share "Suggestions to Improve Sleep," which is page 2 of the HEAR ME hand-out).

In addition to balanced sleep, vulnerability to negative emotion can be decreased through eating a balanced diet, treating physical illness, getting regular exercise, avoiding substance abuse, and planning at least one activity a day that brings a sense of competence and mastery (consistent with the goal of activity scheduling).

Like many DBT skills, we have adopted an acronym to help adolescents remember how to stay out of Emotion Mind (see Hand-out # 4):

H ealth (treat Physical Illness)
E xercise regularly
A void mood altering drugs
R est (balanced sleep)

M astery (one rewarding activity daily)
E ating (balanced diet)

This acronym was developed by an adult DBT skills training group as an alternative to Linehan's original acronym for these skills-- which was PLEASE MASTER (Linehan, 1993b). Some group members objected to this acronym as too suggestive of begging and subservience, so they took it upon themselves to create a more acceptable acronym that still summarized the same skills. We also playfully encourage adolescents to devise their own acronyms to more personally capture the skills they need to remember.

Emotion & Choice: The Interaction of Emotions with Thoughts, Images, Bodily Reactions, Action Urges, and Behaviors

For adolescents especially, another essential dimension of emotion regulation training is cultivating their ability to discriminate, name, and accept a wide range of emotions and internal states (Wexler, 1991). The distinction between primary and secondary emotions will not mean much unless the adolescent is also able to move from just stating that they are "upset" to distinguishing among a variety of feeling states. In addition, the distinctions between thoughts and feelings as well between feelings and facts must be repeatedly reinforced for the teen. Learning the basic A-B-C model of CBT is an essential step in this direction (where **A** is an activating event, **B** is the self-talk, and **C** is the consequences of self-talk for mood and behavior). Although clinicians can ultimately work from the more integrative emotion model summarized in Hand-out # 2, in some cases the clinician should be sure the teen has at least understood the basic A-B-C model of emotion.

As illustrated by Handout # 2, we work out of an emotion model in which the precipitating event for problematic affect can be either external or internal. By internal, we include such "inner events" as troubling thoughts and memories, as well as emphasizing the role of primary emotions as precipitants for secondary emotions. As the figure further illustrates, this model emphasizes the reciprocal transactions among thoughts, images, feelings, and bodily sensations in initiating, maintaining, and perhaps intensifying an emotion. This model allows for numerous possible "points of entry" for emotion regulations skills-- with the modification of cognition being one among several intervention options.

Action urges and choices One of the most important aspects of this expanded emotion model is how the "action urge" is characterized as a distinct component and moment of emotion. Teens are reminded that just because they experience a strong urge to behave in some way, they are not obligated to follow through on this urge. Instead, the generation of several action choices is emphasized as an alternative to simply following whatever action urge is present. Particularly for impulsive adolescents, a negative emotion leads to an almost irresistible urge to engage in an often self-destructive and dysfunctional action.

What about when your feeling badly leads you to have strong urges to do something that may not be in your best interests? We call these "action urges." Can you think of a time when you had a strong feeling that led you to take some course of action that turned out not to be so good for you in the long run? It is important to remember that everyone has these urges; the trick is not to act on them, at least without thinking through the consequences and taking the time to first try some of the new emotion regulation skills you are learning.

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The clinician's goal is to expand the teen's range of actions options beyond the usual "action urge" that accompanies a distressing emotion, so that the action urge is one among several choices to be made. Action choices are generated through use of any of such new skills as: 1) consulting their Supportive Observer before deciding what action to take, 2) Reviewing the lessons learned from a past Freeze Frame exercise, or 3) Employing any of the other skills described in subsequent sections of this manual— including the mindfulness skills summarized in the next section.

Mindfulness of Emotion: Learning to Nonjudgmentally Observe and Describe Emotions

As we have seen in the previous discussion of primary vs. secondary emotions, a core aspect of DBT's approach to emotion regulation is teaching teens to nonjudgmentally observe and describe their emotion states and responses. That is, teens need to be taught self-validation. Emotion dysregulation is often complicated by harsh judgments teens make about having a strong emotional reaction in the first place. Further, these teens often judge specific emotions as wrong or invalid, and then feel more distressing emotions in turn—such as feeling ashamed about feeling hurt, or guilty about feeling angry. Hence, the goal of becoming nonjudgmental in appraising their emotions is to prevent further dysregulation. To accomplish this task, teens must become more skillful at accurately identifying and labeling multiple dimensions of their emotional responses— such as the physical sensations associated with the emotion, the interpretations of the precipitating event, the action urges and actual behaviors motivated by the emotion, and the consequences of these behaviors in the teen's environment.

To help teach teens to nonjudgementally observe and describe their emotions, we have adapted Linehan's (1993b) handout-out on "Mindfulness of Your Current Emotion" (Hand-out # 5). This handout offers the following emotion regulation reminders:

Observe your emotion:
NOTE its presence
Step BACK, Get UNSTUCK from the emotion

Experience your emotion....
As a WAVE, coming and going
Try not to BLOCK the emotion
Try not to SUPPRESS the emotion
Don't try to GET RID of the emotion
Don't PUSH it away
Don't try to KEEP the emotion around
Don't HOLD ON to it
Don't INTENSIFY it.

Remember: you are not your emotion

Do not necessarily ACT on your emotion
(that is, let destructive ACTION URGES pass)
Remember times when you have felt DIFFERENT

Practice accepting your emotion
Do not JUDGE your emotion as wrong, bad, too painful, unfair, embarrassing...
Do not CRITICIZE yourself for feeling the emotion
ACCEPT your emotion as it is in the moment

One interesting thing about strong emotions is that by just observing what's going one and noting what is happening to you, you can sometimes begin to actually get a handle on your feelings. We call this way of looking at things "being non-judgmental" or "practicing acceptance." One of the things that gets people into the kind of difficulties we have been talking about is having strong feelings like anger or sadness and then saying, "I shouldn't be feeling this way. I am a bad person for having these kind of feelings." Let's try a little experiment— imagine yourself being angry. Now try saying some of these kind of critical thoughts to yourself. What happens to how you are feeling? It is really interesting how we can sometimes take a bad problem, and make it even worse just by how we think about what we are feeling!

Let's take a look at Handout # 5 on "Mindfulness of your Current Emotion." Why don't we pick a particular feeling that has been troublesome to you lately and go through this sheet to start with. {Go through it}. Any thoughts or reactions? [Try to elicit any negative cognitions that may get in the way of the person practicing these techniques]. I will take notes while you think out loud, and then let's look through things that you said to yourself that may be particularly helpful both now and in the future.

A related set of "acceptance skills" will be reviewed in the section on distress tolerance (p. 37-42), summarized in Handout #9 on "Practicing Acceptance." If the teen is really struggling in this area, the clinician might elect to review this material in conjunction with the preceding information from Handout #5 on "Mindfulness of Your Current Emotion."

Emotion Regulation and Anger Management through "Opposite Action"
The DBT emotion model and emotion regulation training also includes a discussion of how emotion is strongly influenced by the bodily posture one assumes and the facial expressions one adopts. The clinician should very matter-of-factly describe for teens basic research on emotion, such as the fact that there seems to be a "hardwiring" between facial expressions and their corresponding emotions. To illustrate this, we will have teens intentionally make an angry face and then notice that they begin to feel angry. We will then have them change their posture to include additional angry elements, such as making clenched fists or stomping a foot; these postural shifts usually intensify the angry feeling that had originally been evoked by the change in facial expression. The clinician can even suggest that the teen make an angry statement in a loud tone of voice.

This can be an especially lively skills group exercise.

This information is then used to justify a key emotion regulation technique-- that of altering posture, behavior and facial expressions in order to delay, interrupt or de-escalate the progression of a problematic emotion. Linehan (1993a, 1993b) labels this technique "Acting Opposite to the Current Emotion", while Wexler (1991, 1993) refers to it as "Opposites Training"-- presenting such anger management examples as keeping one's palms open when inclined to punch and whispering when inclined to scream. As has been well established in the treatment of anxiety disorders, repeatedly approaching what one fears is the most effective opposite action for anxiety. For depression, of course, the behavioral component of Beck's (1979) CBT has always emphasized the importance of the depressed patient getting active in any way possible, especially in activities where mastery and enjoyment are experienced. Wexler (1991) notes how cognitions and imagery can also follow the principle of "opposites", such as saying the word "soothed" when feeling nervous and imagining oneself hugging a person toward whom one is feeling aggressive.

Because anger includes often dramatic and public physical displays, it is a particularly effective target for Opposite Action. Further, since anger is such a common problem emotion for these teens, they are usually quite interested in developing mastery over destructive expressions of this emotion.

Here is a script we have developed for this purpose, to be used in conjunction with Handout # 6:

> *I would like to teach you something called Opposite Action. This method is based on the fact that how we experience our emotions is strongly influenced by our bodily posture, facial expressions, and actions. It is sometimes even possible to change your experience of an emotion by altering the posture, behavior & facial expressions that go with the emotion. You may be able to at least slow it down or make it less intense so that you do not behave in a way that makes things worse.*
>
> *Anger, perhaps even more than any other emotion, is strongly affected by facial expression, rate of breathing, muscle tension, and the general urge to take action. Let's focus on anger as a way to learn more about opposite action*
>
> *So for example, try making an angry face, clench your fist, and say, loudly, "I am so angry!" What do you experience when you do this? Most people find that if they make an angry face, and also make their body language consistent with this, they actually find themselves experiencing anger. But we don't need to find ways to make you get angrier! Now try our anger experiment again—okay, now that you are good and mad, smile, take some deep breaths, and relax your fists and open your palms. What do you experience? What most people find is that it*

does take the edge off of the anger, and may make it less likely that you will give into the "action urges" that go with anger.

It is important to note that here is nothing wrong with feeling angry. In fact, anger is a clue that we are not getting our needs met or that people are not meeting our expectations. The part we are trying to avoid is the destructive behaviors that stem from the action urges of anger. Opposite action doesn't deny feelings. In fact, to use this technique you must become more rather than less aware of your feelings.

Finally, using Handout # 6 as a reference, review the following suggestions for opposite actions to manage anger:

- Keep your palms open and arms at your side when inclined to punch or attack; gently touch an object rather than throw it.

- Whisper when inclined to scream or verbally attack.

- Breathe deeply and slowly rather than hyperventilating.

- Do progressive muscle relaxation on tense muscle groups.

- Relax tense areas of facial expression, such as furrowed eyebrows and pursed lips—perhaps closing your eyes and allowing yourself to smile.

Of course, teens should be asked to think of other opposite actions that could help manage their anger.

For depressed teens, emotion regulation through "opposite action" can also be employed in individual therapy sessions where the teen presents with a bodily posture that is clearly reinforcing if not intensifying depressed mood and behavior. For example, I once worked with a 17 year-old female who early in treatment --from the session's start-- routinely curled up in her chair, hung her head face down, and covered her face with her hands. To remind her about the connection between bodily posture and emotion, I would make statements such as "By sitting in that way you are sending messages to your brain to feel even more depressed and remain withdrawn." I would then directly suggest that she shift her posture so that she was sitting up and facing me. She would then usually acknowledge at least a slight lift in mood; just as importantly, she would also become more available to work in therapy.

Over time, after continually being given the opposite action speech when she assumed a depressed posture, this patient more often then not started the session in an upright position. She still at times reverted to the withdrawn posture when discussing emotionally difficult issues, but at these times responded relatively rapidly to a reminder about opposite action. It is noteworthy that at these moments of withdrawal she seemed to be

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experiencing shame as a secondary emotion relative to thoughts and feelings she found embarrassing.

We can see here how opposite action served to dilute a secondary emotion that was masking a primary emotion. That is, altering emotionally expressive behavior through opposite action is most therapeutic when focussed on a secondary emotion. Opposite action should be selectively employed toward primary emotions since this could collude in the patient's avoidance. Instead, this is where exposure techniques may be more appropriate (Linehan, 1993a). Usually, a secondary emotion must first be modified through blocking or changing expressiveness so that the patient is exposed to the primary emotion.

There are certainly occasions when Opposite Action may be useful in containing potentially destructive action urges from a potent primary emotion, such as the inclination to be aggressive when angry, but the emotion itself needs to be experienced by the patient and validated by the clinician. Opposite Action can also help a teen tolerate a painful primary emotion and prevent the shift to a secondary emotion. Recalling our discussion of the shame-rage spiral, the use of humor has been found to be a highly effective way to acknowledge embarrassment and avoid the lapse into anger (Retzinger, S.M., 1991). In this case humor serves as an Opposite Action relative to shame. In shame one wants to hide; with humor we call attention to ourselves and perhaps share a laugh with others rather than feel ridiculed by their laughter. Indeed, Hanna & Hunt (1999) have noted just how essential humor is in psychotherapy with aggressive teens, who are exquisitely sensitive to shame.

Wexler (1991) emphasizes how in learning emotion regulation skills in general, the adolescent develops a sense of competence and self-efficacy. Even when employing emotion regulation skills that do not explicitly target problematic self-talk, new self-talk is nonetheless being learned as teens remind themselves about specific emotion regulation principles. For example, with regard to "opposite action," when the previously discussed teen reminds herself that sitting up in her chair will help decrease depressed mood, she is practicing a new, more supportive form of self-talk. This illustrates how an expanded definition of "supportive self-talk" allows it to assume the status of the "core skill" in this approach to CBT skills training.

INTERPERSONAL EFFECTIVENESS SKILLS

Knowledge is Power: How to Sell Interpersonal Skills to Teens

Interpersonal effectiveness, otherwise known as assertiveness training, is the skills domain that gets adolescents' attention the quickest and sustains their interest the longest. Adolescents spend much of their conscious energy preoccupied with all manner of peer relationships and conflicts. When they are not caught up in some peer driven interpersonal drama, adolescents are instead entangled in a conflict with a sibling, parental figure, or some other adult authority-- especially school teachers. Quite often,

teens are simultaneously in conflict with two or more of these groups-- the classic scenario being one in which specific peer relationships are deemed unacceptable by parental figures.

These interpersonal scenarios are the ones that teens most often bring to both individual and group therapy as the identified problem to be solved. Teens typically see addressing interpersonal problems as more important and relevant than doing chain analyses, learning emotion regulation skills, identifying cognitive distortions, or working in any of the more inner oriented ways favored by us mental health folk. We have learned this lesson especially in some of our skills training groups, where on one occasion our teen members let us know they were bored with our attempts to teach "inner skills" without sufficient reference to their everyday interpersonal conflicts. Indeed, a group mutiny was imminent unless we found a way to make the group feel more directly relevant to them. We responded by 1) giving priority to members' presentation of current interpersonal conflicts, 2) role playing the use of assertiveness skills to resolve these conflicts, and 3) using the results of these role plays to provide a more meaningful context for teaching the other, less obviously relevant skills-- such as emotion regulation and distress tolerance. It should be noted that this particular group included many aggressive teens whose relationships were more consistently antagonistic than those teens on the internalizing side of the diagnostic fence.

Consistent with Wexler's (1991) perspective, interpersonal effectiveness skills are best sold to adolescents as a way to increase their chances of having power and influence in their relationships. At the same time, we make it clear that even the most skillful behavior does not guarantee that they will get what they want, and that therefore they must also be prepared to accept "No" for an answer (at which point they may need to draw upon their emotion regulation and distress tolerance skills). Gentle challenges may need to be made with those adolescents who hold beliefs such as "I should always get what I want" and "I cannot stand not getting what I want."

Wexler (1991) also emphasizes that in teaching adolescents the differences among passive, assertive and aggressive behavior, we should not present assertiveness as the mode to employ at all times no matter what. Room is to be left for passive and aggressive modes to remain options for the teen. There may in fact be occasions when these modes are more appropriate.

More therapeutically relevant is the idea that you want to help adolescents learn a range of options for addressing interpersonal conflict so that they can then have the experience of actually making a well-informed choice about what behavioral mode to employ. We explain to adolescents that if they only know one method of responding to conflict and employ this method on every occasion, they are not acting out of choice but out of habit; they are not acting out of freedom and autonomy, but out of slavish devotion to using a hammer to fix every problem even when every problem is not a nail!

The tool metaphor can be expanded to describe the adolescents' new skills as "additional

tools" to add to their "tool boxes". Male teens might be more easily engaged by this metaphor-- e.g., you can discuss the many different types of tools and how some work well for one job but not all jobs; how even one type of tool has many variations, such as different types of screwdrivers. A more female friendly metaphor might be developed through discussing the necessity of having different types of clothing and shoes available for different social situations and weather conditions. Further, it can be noted how specific clothing types can be modified to better fit changes in situations or weather conditions. For example, some warm weather raincoats can become suitable for winter wear by adding a warm heavy lining. The clinician must convince the teen that just as it is essential to have a range of clothing options, it is vital to have a range of skills with which to navigate diverse situations. Other metaphors can be created to convince adolescents that without having knowledge of at least more than one coping strategy, true choice and personal power is impossible. This psychoeducational point can be hammered home by paraphrasing the famous slogan that "Knowledge is power!"

In introducing interpersonal effectiveness skills to adolescents, it is also helpful to have them think about when others have and have not been effective in making a request from them. You will usually hear stories about the other being ineffective when the teen has felt disrespected or criticized in some way. Conversely, when the teen's perspective has been affirmed and included in the other's request, the chances increase that this was a situation in which the teen was convinced to cooperate with the request. These basic facts can then be used to explain to teens that this is a fundamental rule of human behavior-- i.e., that when we feel controlled or criticized, we are less motivated to agree with the other's request. Once the teen agrees that this rule makes sense, you can then ask if the rule must also apply to how others are affected by their behavior. That is, if they criticize and disrespect the other, wouldn't their chances of eliciting cooperation also decrease? To believe otherwise is to believe that this "law of the land" should apply to everyone else but not for oneself, a belief likely to produce much misery and disappointment.

The previously discussed information on the shame-rage spiral and other emotion regulation skills can be especially helpful as a supplement to interpersonal effectiveness training. Adolescents are often most ineffective in negotiating interpersonal conflict when they are feeling belittled in some fashion and retaliate by being verbally or physically aggressive. Or, in the case of the more depression prone teen, a common response is to feel helpless, withdraw, and embody a passive rather than either an assertive or aggressive style of interpersonal problem solving.

The Adolescent Assertiveness AID (or, an alternative to angry altercations and anxious avoidance!)

Linehan (1993b) has developed three acronyms to help teach interpersonal effectiveness skills, but we prefer to start with one simple acronym before progressing to a modification of Linehan's more detailed information. The AID acronym is an elaboration of Wexler's (1991b) "The Magic Formula", which he limits to situations in which teens want something from an adult in authority. The AID acronym is applicable in any conflictual interpersonal

situation, and is presented in Hand-out #7. Here are the three AID domains:

A ppreciate
-Acknowledge other's perspective
-Affirm other's feelings
-Accept disagreement

I statements
-Identify feelings
-Identify beliefs
-Identify wants

D on't criticize
-Don't blame or judge
-Don't disconnect
-Detective questions

The "Appreciate" aspect of AID encourages adolescents to communicate that they have heard and understood at least some part of the other's statements. It is preferable to include this acknowledgment toward the beginning of their response, in this way decreasing the other's defensiveness and increasing the chances that the adolescent's request will be heard. Some adolescents get stuck on the idea that if they acknowledge the other's perspective they are agreeing with it, and therefore they have a hard time implementing the "Appreciate" step. We emphasize that accepting the other's perspective is not necessarily synonymous with agreement, and that it is possible to express an understanding of the other in one breath before expressing an alternative perspective in the next breath.

The "I statements" step in AID reiterates the classic communications strategy of keeping the focus on oneself rather than focussing excessively on the other. This is often a difficult shift for adolescents to make, as it requires them first to become more aware of their thoughts, feelings, beliefs and wants. We also emphasize how the ability to make "I statements" can help teens feel better even if the other does not understand them or change their position. That is, making "I" statements can be a form of emotion regulation or self-soothing that can be an end in itself, independent of how much the other is influenced by these statements. The adolescent can then walk away from the interaction with such supportive self-talk as "Even though I couldn't change the other's mind, I did not lose control and I was able to make it clear how I felt. I did what I could and I have done everything in my power to resolve the disagreement." The adolescent then experiences less helplessness and feels less like a victim.

The "Don't criticize" reminder in AID is perhaps the hardest for teens to master. Criticizing, judging, or blaming the other has often been the main communication strategy for teens in conflict. Especially when angry, it feels easiest to attack the other through such tactics as name calling, accusations of unfairness, dragging up past injustices, screaming and-- if

all else fails-- getting aggressive through throwing things or physically attacking the other. The second of Wexler's (1993) skills training workbooks includes a tongue-in-cheek section entitled "The Dirty Fighter's Instruction Manual". This section lists and describes the most common ploys in aggressive communication, and is written for both teens and their parents.

The "Don't disconnect" directive in AID reminds teens to persevere in an interaction even if it becomes clear that they are not being heard and may not get what they want on that occasion. Often teens will withdraw into a sulking silence when feeling rebuffed, and may passively feign agreement with the other while feeling helpless about having their perspective recognized. They then leave the interaction feeling frustrated, and are less likely to comply with the perspective of the person by whom they have felt misunderstood. Teens can be coached on verbal strategies for remaining connected, even when faced with a "No" from the other. The "broken record" is one such strategy (Wexler, 1991b), in which the teen is instructed to calmly repeat his or her basic point on several occasions in the interaction, ignoring any criticisms or attacks coming from the other.

Asking "Detective questions" is another useful strategy for keeping connected in a conflictual interaction (Wexler, 1991b). Teens are instructed to "play detective" and ask the other what would be required for him or her to agree with the request, whether for the present situation or for the future. If a present agreement is not forthcoming, Wexler (1991b) suggests a response he calls "the future credit". In the requesting a "future credit", adolescents accept disagreement for the moment but express the hope that when a similar situation again arises, the other will remember how skillfully they handled the current situation and consider an alternative decision.

Relationship Effectiveness through AID GIVEN

Linehan's interpersonal effectiveness module provides a useful supplement to the AID acronym for teens. She emphasizes the distinctions among three forms of effectiveness—objectives effectiveness, relationship effectiveness and self-respect effectiveness. In more adolescent friendly language, these three modes of interpersonal effectiveness refer to 1) How to get someone to do what you want, 2) How to keep a good relationship, and 3) How to keep your self-respect.

Objectiveness effectiveness is the most encompassing set of skills, and focuses on clarifying what one wants from an interaction as well as how to achieve this goal. Relationship effectiveness emphasizes how to interact with the other so that the relationship is preserved or perhaps even improved. Finally, self-respect effectiveness is concerned with maintaining one's values and beliefs so that following the interaction one can feel good about himself or herself. This is especially an issue for teens when peers ask them to do something that they know is wrong, and they must find a skillful way to say "No."

It can be very enlightening for teens to learn to articulate which mode of interpersonal effectiveness is most important and feasible in a given situation. These distinctions can

help prevent the teen from focussing too much on an area where success is unlikely. For example, in one of our skills groups, a female adolescent presented the dilemma of wanting to convince a girlfriend that the guy she was dating had a bad "track record" and that she should break up with him. Since this outcome was very unlikely, this teen was encouraged to see her main goal as preserving her friendship through focussing on her concern for her friend. That is, relationship effectiveness was prioritized over objectiveness effectiveness, allowing this teen to be much less frustrated by her friend's not agreeing to break up with the "bad boyfriend."

Linehan (1993b) has designed three acronyms to summarize the skills required for each form of interpersonal effectiveness. For our skills training, we have adopted Linehan's relationship effectiveness acronym GIVE and changed it to GIVEN by adding "Negotiation" (which for Linehan originally appears in the DEAR MAN acronym). For teenagers, we have found that keeping one's cool and being willing to compromise are among the most crucial yet challenging aspects of interpersonal effectiveness. The GIVEN acronym stands for:

> (be) **G**ENTLE
> act) **I**NTERESTED
> **V**ALIDATE
> (use a **E**ASY MANNER
> **N**EGOTIATE

More detailed descriptions of each element of GIVEN can be found in Hand-out # 8. Combined with AID, this second acronym allows us to tell teens to remember the phrase creates "AID GIVEN" when they are challenged to practice interpersonal effectiveness skills.

DISTRESS TOLERANCE SKILLS

The Philosophy of Acceptance
Even if adolescents become extremely skillful in emotion regulation and interpersonal effectiveness, this does not guarantee that they will always be able to modify every difficult emotion or resolve every interpersonal conflict. This is where distress tolerance skills are essential-- when neither the situation nor one's experience of it can be significantly changed, at least not at the moment. Settings such as work, school, or other formal settings are often not the most appropriate places to express and process distressing feelings or to resolve significant interpersonal disputes. At the very least, adolescents may have to wait until a class is over or a work shift is completed before using their other skills. What can they do to tolerate their distress and not make things worse?

Linehan (1993b) defines distress tolerance as "... learning how to bear pain skillfully" (p. 96) and as "... the ability to perceive one's environment without putting demands on it to be different, to experience your current emotional state without trying to change it, and to

observe your own thoughts and action patterns without attempting to stop or control them" (p. 96). This is the aspect of DBT that draws most explicitly upon the Zen philosophy of acceptance and the use of mindfulness skills-- including the nonjudgmental observation of one's present emotional state, however distressing it may be.

The philosophy of distress tolerance also includes the wisdom that when pain is not accepted then suffering is insured and intensified. Linehan (1993b) summarizes this point in noting how "avoiding all the cues associated with the pain insures that the pain will continue... experiencing, tolerating, and accepting emotional pain are the ways to reduce pain" (p. 96). This principle has been well established in the treatment of anxiety disorders, especially phobias. Recalling the previous section on emotion regulation, it may be evident that distress tolerance skills can help patients experience primary emotions without falling prey to the pull of secondary emotions and their problematic actions urges.

Adolescents often object to the distress tolerance philosophy due to equating acceptance with approval. This equation must be repeatedly challenged on the grounds that both approval and disapproval are judgments, whereas acceptance is nonjudgmental and simply acknowledges "what is".

The clinician should review the "Practicing Acceptance" handout with the teen (Handout # 9). The first part of the handout lists three distress tolerance formulas:

> Suffering = Not accepting pain
>
> Acceptance = 1. Letting go of fighting reality
>   2. Turning suffering you <u>can't</u> cope with into pain you <u>can</u> cope with
>
> Acceptance ≠ Approval or Agreement

Many adolescents assume that it is always best to try to get rid of bad feelings and find it odd to hear acceptance advocated as an option. In his program's modification of DBT skills training for adolescents, Miller (1997) lists three myths about acceptance that often first must be challenged before teaching distress tolerance skills. These are also printed on Handout # 9, and should be reviewed with the teen. The three myths are:

> If you refuse to accept something, it will magically change.
>
> If you accept your painful situation, you will become soft and just give up (or give in).
>
> If you accept your painful situation, you are accepting a life of pain.
>
> *What are your reactions to these three myths? Do you believe some of these? Recall a strong emotion and a painful situation you recently experienced. What*

were some of the other thoughts and emotions that happened after that? Let me suggest some other things you may want to try saying to yourself. Try these, and let's see what happens. Can you come up with some other accepting things you could say to yourself? Let's write them down so that you can try these at home. We might refer to this skill as "practicing acceptance self-talk".

The CBT component of distress tolerance skills can be described as the development of **"acceptance self-talk,"** which we see the clinician suggest in the preceding script. That is, teens practicing distress tolerance will remember to say to themselves such things as: "I'm doing the best that I can," "I can't do anything for now to change how I feel or to change the situation, so it is better to accept this for now rather than do something to make things worse," and "I've survived these types of feelings before, so I can do it again" (listed at bottom of Hand-out # 9). Acceptance self-talk is especially effective as a counter to the litany of "should" and "should nots" that often dominate the "nonacceptance self-talk" common to the secondary emotions unleashed in response to painful primary emotions.

Willingness vs. Willfulness: Using metaphors and images to teach distress tolerance and Wise Mind

Another way to help adolescents understand acceptance is to discuss the distinction between willingness and willfulness. Willingness is synonymous with acceptance and entails "... doing just what is needed in each situation..." (Linehan 1993b, p. 177). Within willingness, one is concerned with being effective and following Wise Mind. In contrast, willfulness involves the attempt "... to impose one's will on reality-- trying to fix everything, or refusing to do what is needed [to tolerate the moment]" (Linehan, 1993b, p. 103).

Numerous metaphors can be employed to illustrate the distinction between willingness and willfulness. These metaphors can be designed to fit the interests of the individual adolescent. Athletic and game metaphors can be especially useful in this regard-- such as the baseball player at the plate trying to get a hit. The baseball player must first accept that despite his best efforts, he may still not get a hit. The reality of the game is such that even a very well hit ball may be caught for an out, while a poorly hit ball might luckily land between fielders and count as a hit. Further, the hitter does not have control over or certain knowledge of the types and location of the pitches he will be thrown-- there's the fastball, the curve ball, the slider, the change-up, etc. These pitches can be thrown inside, outside, or over home plate; they can come in low, high, or belt height. The hitter's chances of success are best if he can patiently work with the pitches that are thrown. It would be willful for the hitter to swing at every pitch with the hope of hitting a home run. Such players are described as trying too hard or "pressing". The best hitters are those who can be selective about what pitches they swing at and go with the pitch as it is thrown (such as hitting an outside pitch to the opposite field). Patience is essential in waiting for the best pitch to hit, but the batter also cannot be passive and take too many pitches; occasionally this will be a skillful strategy if the pitcher has poor control, is not throwing strikes, and instead ends up walking the batter. However, more often than not a completely passive strategy at the plate will result in striking out.

Sports analogies are also excellent ways to illustrate Wise Mind. Athletes who have performed exceptionally will often describe "being in the zone", where there is a harmonious fit between them and the game. They skillfully work within the rules and strategies of the game, where Reasonable Mind is necessary. These players also draw on the drive and motivation provided by Emotion Mind, which is especially important when it comes to translating anger and frustration into skillful play. This is in contrast to the players who lose their temper and get ejected from the game, perhaps costing their team a chance for victory. Skillful players have developed sufficient self-soothing capacities to calm themselves when angry and not retaliate in ways that result is a loss of power-- much the same goals we have for adolescents.

Dolan (1991; cited in Straus, 1999) has designed a guided imagery exercise called The Wise Old Person. This exercise concisely captures the inner resources and knowledge that Linehan (1993a) defines as Wise Mind. The image goes as follows:

> *Imagine that you have grown to be a healthy, wise old woman [or man] and you are looking back on this period of your life. What do you think this wonderful, older, wiser you would suggest to you to help you get through this current phase of your life? What would she tell you to remember? What would she [or he] suggest that would be more helpful in healing you from the past? What would she [or he] say to comfort you? And does she [or he] have any advice about how therapy could be most useful and helpful? (p. 36)*

Teens have the option to share the results of this image or keep them private. They can be encouraged to consult with their "wise old self" when distressed in the future, in this way allowing the image to be a Supportive Observer assisting with both problem solving and self-soothing.

Self-soothing Skills: The use of imagery and the five senses

Increasing the capacity for self-soothing is an essential aspect of Wexler's PRISM approach. The "Ally" and other imagery exercises described by Wexler include self-soothing among their purposes. Some of these skills may serve more of an emotion regulation function, while others will be more in the service of distress tolerance. Regardless, alternative modes of self-talk are what matter most, and such alternative self-talk can just as helpfully come in the form of images as it does in words.

In presenting the rationale for developing self-soothing skills, the clinician must be mindful of possible adolescent specific resistances. For one, adolescents' relation to the world is predominantly action and other oriented. Self-soothing skills involve neither action in the external behavioral sense nor an explicit relation with others. In fact, adolescents often feel strongly that it should be others who soothe them when distressed, and struggle with accepting that they must at times instead depend on themselves. Finally, some adolescents may feel that they do not deserve to self-soothe, but instead believe that they should be punished or made to suffer more; such adolescents may feel shame, guilt, or anger when they try to self-soothe (Linehan, 1993a). This phenomenon is a variation of

the self-critical voice described by Firestone (1997a) and previously reviewed in the section on the "You Turn" technique.

Many adolescents, though, take very naturally to the use of imagery as a self-soothing modality. In some cases, the benefits can be quite dramatic. For example, we have had success using a modified version of Wexler's (1991b) "Protective Shell" image to help a 14 year-old female counter intrusive, repetitive violent images. It was not clear to us whether these images were an aspect of Obsessive Compulsive Disorder or reflected psychotic process. Nonetheless, the patient described seeing "flashes" of herself getting either stabbed or hurt in other ways; she stated that she would see this flash for several seconds, have a brief break, and then the flash would happen again very soon, with this at times being constant. It was worse when she was by herself and worse at night; it did not happen as often when with someone, such as during a therapy session.

The "Protective Shell" image was introduced to this patient by having her close her eyes, doing a basic relaxation induction, and guiding her to imagine a protective shell, shield or bubble that surrounded her and protected her from any possible harm. She was able to imagine a "transparent solid metal bubble" that surrounded her and warded off the knife wielding man's effort to attack her; she also imagined the bubble as repelling the attacking figure and causing it to disintegrate. After the first week of using this image, the patient reported that the frequency of the violent image had decreased to 5-6x a day for only 1-2 seconds; after two weeks the frequency was down to 1-2x a day for 1-2 seconds, with there being some days where the patient reported not having any violent images at all. The patient also described herself as feeling safer knowing she had a way to combat and defeat the violent image.

One of the most accessible and easily taught distress tolerance skills is "Self-soothe With the Five Senses" (see Hand-out #10). The five senses are commonly considered to be vision, hearing, smell, taste, and touch. Usually at least 2-3 of the five senses are engaged or capable of being engaged at any given moment as a distraction from distress. Wherever the teen may be, at least the senses of sight, hearing, and touch can usually be stimulated in a way that is at least distracting if not soothing. With some creativity, outlets for all five senses can be developed.

> *There may be times when it is not possible or it is too difficult to use any of the other emotion regulation skills you have learned. You may not be in a situation where it is possible to use these others skills, or you may simply feel too overwhelmed. In these situations it can be helpful to simply focus on whatever is available to any of your five senses—sight, hearing, touch, taste, or smell. Usually at least the first three senses are available to distract if not to calm you when distressed.*

Music is a very common means of using the sense of hearing, so almost all teens will make a connection with this. The therapist should acknowledge that sometimes the teen might choose to listen to music that instead keeps him or her stuck in a bad mod, or

makes it worse. Therefore, the therapist might suggest that the teen be more selective in choosing what type of music to listen to when distressed.

The therapist should review Hand-out # 10 and ask the teen to think about what other types of self-soothing he or she already does using any of the five sense, as well as to generate additional ideas for other ways in which to use the fives sense for self-soothing.

Teen friendly example of self-soothing with the five senses: *Let's take the situation in which a distressed teen must wait 50 minutes until the end of class before she will be able to talk to a friend with whom she is angry. That is, she cannot yet resolve the conflict with her friend nor can she resolve her anger. So, she must find a way to tolerate her distress. Assuming she was unable to concentrate on the teacher's lesson, what senses could she engage to self-soothe? (Encourage the teen to generate self-soothing suggestions before offering any of the below examples) .*

Vision is the most obvious-- she could focus on a poster on the classroom wall, on a ceiling tile, or on a colorful piece of clothing worn by another student.

Using her hearing, she could focus on the hum of the air conditioning or the buzz of the florescent lights.

Using taste, she could suck on a piece of hard candy, being mindful of how the flavor changes depending on what part of the tongue the candy touches, noticing the size of the candy gradually shrink, and focusing on the different sensations created by the changing the size of the candy.

Using smell, the distressed student might focus on the odor of a pleasant perfume that either she or a peer is wearing.

Finally, employing touch, the student might focus on the softness and texture of a piece of clothing she is wearing, or on the varying tactile qualities of her book bag.

When teaching these skills in group, we have gotten lists from group members about their favorite self-soothing objects for each of the 5 senses. We have also led an experiential exercise in which all 5 senses can be engaged: unwrapping and eating a candy bar-- where you have the sight of the colorful candy wrapper, the sound of the wrapper being opened, the taste and smell of the candy itself, and the touch of both the wrapper and the candy.

DBT AND CBT SKILLS GROUPS FOR TEENS AND THEIR CARETAKERS

Two models of DBT skills groups for teens: DBT-A and DBT-FST
As previously noted, an essential component of the DBT treatment package is the

attendance of a weekly skills training group in addition to weekly individual psychotherapy. This component has been retained in most adaptations of DBT for teens. Two programs have been particularly influential in adapting DBT for teens-- Alec Miller's DBT for suicidal adolescents (Miller, Rathus, et. al., 1997) and Hoffman, Fruzetti, and Swenson's (1999) Dialectical Behavior Therapy- Family Skills Training program (DBT-FST).

Miller's DBT-A was originally a 12 week course of concurrent individual therapy and group skills training. This is in contrast with the one-year commitment standard for adult DBT. Miler's DBT-A skills group includes teen patients and at least one caregiver, so that both parties learn DBT skills together. These groups are essentially multi-familiy groups. In the original 12- week version of DBT-A, the modules were taught in Mindfulness, Distress Tolerance Skills, Emotion Regulation, and Distress Tolerance. Each group session is 2 hours in length.

More recently, Rathus & Miller (in press) have added a fifth DBT-A skills module called "Walking the Middle Path". This module more explicitly addresses the skills required to improve relationships between teens and their caregivers. The "middle path" module includes a review of behavioral principles, validation strategies, and the dialectical dilemmas that are unique to the struggles between teens and their families, as well as between teens and their therapists. Three teen specific dialectical dilemmas have been identified by Rathus & Miller (in press): excessive leniency vs. authoritarian control, normalizing pathological behaviors vs. pathologizing normative behaviors, and forcing autonomy vs. fostering dependence. The addition of this fifth module has extended DBT-A's initial treatment length to 16 weeks. In addition, at the conclusion of successful acute treatment, DBT-A includes an optional 12-week Patient Consultation Group. This group permits teens to continue supporting each other in learning and reinforcing DBT skills. These groups are 75 minute long and include family members every third week.

Hoffman et al's (1999) DBT-FST is a 24 week multi-family skills group for borderline patients and their family members, with the age range for both patients and family members being age 16 and older. This program differs from DBT-A in that the identified patients include adults with borderline personality disorder. Family members can include parents, spouses, same sex partners, children and siblings. A main rationale for DBT-FST is to provide psychoeducation on the biosocial model of borderline personality and the significant role played by invalidation in the genesis of this disorder. This information is presented in as nonjudgmental a manner as possible, and helps to motivate group members to reduce critical communication modes and replace them with validation strategies. For this reason, similar to Miller's DBT-A, DBT-FST has added a fifth module on Validation in addition to the standard DBT skills modules of Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness. The specifics of the Validation module will be presented in the forthcoming book Dialectical behavior therapy with couples and families (Fruzetti, et. al. in press). DST-FST group sessions are 1 ½ hours long. Although a randomized clinical trial assessing DBT-FST is not yet completed, data from a within-subjects design demonstrated decreases in individual treatment targets

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(Fruzetti, 1998). Customer satisfaction has also been very high for the DBT-FST groups (Hoffman, Fruzetti, & Swenson 1999).

Skills training groups at STAR-Center: The integration of CBT and DBT

Over the years, STAR-Center has piloted several skills group formats, some solely for teens and others for both teens and their caretakers. We have also struggled with whether our groups are more useful as 1) a second line intervention offered after acute individual treatment or 2) as an acute treatment intervention offered concurrently with individual therapy. Based on these experiences we have found that the teens who most need this skills group are those who are in individual treatment, whose depressions are chronic, and who even with medication are very slow to improve— i.e., treatment resistant teens.

STAR-Center has piloted a 9- session CBT skills group for teens. The group accepted new members at sessions 1-3. The 9-session cycle can be repeated, with current group members having the option to continue if this is clinically indicated. In the past we have run a 12-session group consisting of 2-hour meetings, but we found that this format tended to lose too many members, so we switched to a 9-session course of 1 1/2-hour groups.

This group reflects an integration of separate CBT and DBT skills groups run over the past several years at STAR-Center. Past CBT groups focused on the more traditional use of CBT for challenging cognitive distortions and generating alternative cognitions to combat depression and anxiety. The more recent group reflects this treatment manual's expanded definition of cognitive behavioral treatment and what constitutes alternative self-talk. In the group, we have defined CBT skills as the core skills to be taught. Specifically, we tell group members that we want to expand the range of options for *how they talk to themselves and how they talk to others.* We emphasize how self-talk affects mood and behavior, including interpersonal effectiveness-- i.e., How we talk to ourselves affects how we talk to others, which affects how others talk to us, which in turn influences how we talk to ourselves

All specific skills are taught as variations on learning more effective ways to talk to oneself and talk to others. This is a different emphasis from DBT skills training groups, where Mindfulness Skills are defined as the core skills. We have found that teenagers have not taken easily to learning Mindfulness skills and appreciating how they are core skills; this enterprise requires a level of abstraction not so readily available to the average teen. The concept of self-talk is more concrete and user friendly for teens, and we have found that many of the mindfulness skills can be taught through the categories of supportive vs. unsupportive self-talk (e.g., "what" skills include the reminder to "just notice" and "how" skills include mindfulness of the ways in which one is being judgmental).

We acknowledge that in other settings there are group leaders who have developed effective ways to teach mindfulness skills to teens (Miller, 1997; Hoffman et al., 1999). At STAR-Center, since CBT is such an essential aspect of our individual treatment protocol,

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running the skills group around CBT principles has allowed for more consistency between treatment modalities. However, we have found that some basic mindfulness training is helpful in preparing teens to most effectively do imagery exercises. Often teens are distracted by worries or self-critical cognitions when attempting these images, and mindfulness training can help them let these distractions pass.

One DBT group innovation that we have adapted is Miller's (1997) teen-caregiver format. This group format encourages adolescents to learn the skills together with a caregiver who is also often lacking in these areas. For example, both in the group and at home, the adolescent and the caregiver can learn and practice interpersonal skills. Further, since parents are often suffering from their own depression or emotional regulation problems, the other DBT skills are equally welcome. As many clinicians have learned at STAR, parental psychoeducation and treatment are essential to the success of treating teens (Brent, 1993). For example, STAR-Center offers a once monthly parental psychoeducational group on mood disorders. The combined version of the CBT skills group therefore provided additional psychoeducation to parents.

Caregivers have reported particularly valuing the skills training group. Even if the adolescent "learns less," they now have the benefit of a caregiver at home modeling these skills both with them and other family members. As we have seen throughout this manual, validation skills are particularly important in helping families cope more successfully with borderline pathology in teens. Caregivers can also be supportive of each other in the group. Further, caregivers can support or "adopt" teens other than their own. This has been especially effective with residents from group home settings whose parents are unavailable. As will be evident in the session-by-session outline presented below, the CBT group has incorporated many of the elements detailed in this manual, including: 1) the treatment philosophy combining Linehan's emphasis on effectiveness and Wexler's concern with power/autonomy, 2) Wexler's various "Observers" and the use of imagery to build skills, and 3) Reviews of Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance Skills. Many of the handouts we used to teach the group are among the 10 hand-outs accompanying this manual; those handouts not included can be found in Linehan's (1993b) skills manual. Most sessions conclude with an imagery exercise, all of which can be found in Wexler's (1991b) workbook.

It must be emphasized that the following session-by-session outline is more a menu than a recipe for the content and sequence of material covered in the group. Depending upon the dynamics, composition, and needs of the group, some material may be presented sooner, later, or not al all. For example, in groups with more aggressive teens, the interpersonal effectiveness skills have taken priority. In groups with teens who are more depressed and/or anxious, the material on supportive vs. unsupportive self-talk has been central. It is also likely that, based on recent developments in DBT-A (Rathus & Miller, in press) and DBT-FST (Hoffman, Fruzetti, & Swenson, 1999), we will likely consider adding a module focusing on validation strategies and presenting more detailed psychoeducation on borderline personality disorder. In this case, the group would probably expand back to at least a 12-week course.

Session-by-session outline of CBT skills group for teens and their caretakers

GROUP ONE: *Learning how this group can help you.*
- Getting acquainted/introductions/group rules.
- Group philosophy: gaining power and control over self; improving relationships with peers and adult caretakers.
- Introduction of alternative self-talk the core skills for the group: A-B-C model of mood and behavior.
- How we talk to ourselves and how we talk to others: Interpersonal Effectiveness and the AID guidelines.
- The Freeze Frame: The main means to assess the A-B-C's of mood and behavior.
- Use of imagery exercise to end each group (good for anxiety reduction, anger management, falling asleep, general self- soothing).
- Introduction to deep breathing.
- Handouts: Adolescent Assertiveness AID

GROUP TWO: Getting along more effectively in relationships
- Interpersonal effectiveness: Role Plays with AID
- Identifying different communication styles
- Understanding the power of body language
- Relaxation Exercise: The Falling Leaf (Wexler)
- Handouts: Interpersonal Effectiveness Handouts #2-5 from Linehan's Skills Training Manual (Goals of Interpersonal Effectiveness, Factors Reducing Interpersonal Effectiveness, Myths about Interpersonal Effectiveness, Cheerleading Statements for Interpersonal Effectiveness)

GROUP THREE: *How can I get what I want more skillfully?*
- Learning active listening, asking for change.
- Clarifying goals for the interaction-- meet objectives, improve relationship, or preserve self-respect?
- Strategies to Keep a Relationship: the GIVEN acronym & handout.
- Special strategies: broken record, time out, and playing detective.
- Relaxation Exercise: The Sandbag Technique/Hot Air Balloon (Wexler)

GROUP FOUR: *How do you talk to yourself?*
- Identifying "unsupportive" self-talk e.g. black and white thinking, minimizing, overgeneralization, mind reading, etc.
- Developing "new" self-talk that is supportive, helpful and encouraging.
- Relaxation exercise: "The Shelf Technique" (Wexler)

GROUP FIVE: *Doing CBT by talking back to your Negative Observers*
- Discussion of "negative observers": e.g., the resentful, hopeless, critical, and worried observers.
- Group Leaders model the "You Turn" exercise in connection with the Self-Critical Observer.

- Encourage group members to do the "You Turn" exercise.
- If group is not comfortable doing the "You Turn", set up role-plays in which group members play the role of specific negative observers interacting with group members who attempt to counter them through using interpersonal effectiveness skills/offering supportive alternatives.
- Relaxation Exercise: The Protective Shell (Wexler)

GROUP SIX: *Alternative Self-Talk through the Supportive Observer*
- Introduce The Supportive Observer, also known as the Ally or Wise Mind Guide
- Distinguish varieties of allies, with input from the group about specific types (e.g. the humorous, spiritual, proud, realistic, empathic, comforting, and buddy allies)
- "Three Ally" imagery exercise from Wexler's PRISM workbook
- Option: Group Freeze Frame exercise

GROUP SEVEN: *Emotion Regulation Skills: Another form of Supportive Self-Talk*
- Primary vs. secondary emotion (e.g., the shame-rage spiral).
- Changing secondary emotions through Opposite Action.
- Learning to tolerate painful primary emotions
- Relaxation Exercise: The Horizon Symbol (Wexler)
- Hand-outs: Letting go of Emotional Suffering: Mindfulness of Your Current Emotion; The Interaction of Emotions with Thoughts, Images, and Behavior; How to Reduce Vulnerability to Emotion Mind (HELP ME); Changing Emotion by Acting Opposite to the Current Emotion.

GROUP EIGHT: *Distress Tolerance Skills: What to think and do when you cannot change the situation or the emotion*
- The philosophy of Distress Tolerance: Pain is part of life and we must learn to accept it (through acceptance self-talk)
- Suffering is made worse when pain is not accepted.
- Acceptance does NOT equal approval; address other myths about acceptance.
- Self-soothing with the Five Senses: An always-available distress tolerance skill.
- Relaxation Exercise: Opening and eating a piece of candy mindfully, attending to all five senses.
- Handout-outs: Radical Acceptance & Three Myths About Acceptance; Willingness & Willfulness; Self-Soothe with the Five Senses; Distract with "ACCEPTS".

GROUP NINE: Conclusion of the group cycle: Review of what we've learned and what we still need to learn/ practice.

Relaxation Exercise: Recall via memory and imagination the most helpful moments in the group, and preserve these for future use as supportive self-talk for interpersonal effectiveness, emotion regulation, and distress tolerance. **OR**

Lead group through The Wise Old Person guided imagery (see p. 40 of manual).

Endnote

As noted in the introduction, this manual was intended as a complement to the cognitive-behavioral model. In many ways, the skills and interventions described in this manual not only complement but also broaden the breadth of the CBT perspective. Emotion regulation, interpersonal effectiveness, and distress tolerance skills all result in expanding the range of self-talk options available to the at-risk adolescent. Both individual and group modalities provide valuable opportunities to teach, model, and practice these skills.

Further, the use of imagery and concepts such as the Supportive Observer are adolescent friendly ways to bring CBT to life. Techniques such as the "You Turn", coupled with an integrative model of emotion, allow for a more affectively challenging therapy experience for both patient and clinician. Continued clinical experience, in addition to data collection and empirical research, will help us further verify the effectiveness of these skills and interventions in ameliorating adolescent depression and suicidality.

REFERENCES

Beck, A. (1979) Cognitive therapy of depression. New York: The Guilford Press.

Belsher, G. & Wilkes, T.C.R.(in press) Assessment of depressotypic cognition in adolescent psychiatric patients: The cognitive Style Test for Teens

Bertolino, B. (1999) Therapy with troubled teens: Rewriting young lives in progress. New York: John Wiley & Sons, Inc.

Birmaher, B. (1997) The Screen for Child Anxiety Related Emotional Disorders (SCARED): Scale Construction and Psychometric Characteristics. Journal of the Academy of Child Psychiatry, Vol. 36, No. 4, p.545-553.

Bonner, C. (1993). An existential-phenomenological investigation of identity confusion as exemplified by adolescent suicide attempts. Doctoral dissertation. Duquesne University, Ann Arbor MI: University Microfilms International.

Brent, D., Poling, K., McKain, B.W. & Baugher, M. (1993). A psychoeducational program for families of affectively ill children and adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 32(4), 770-774.

Brent, D. (1997) Practitioner review: The aftercare of adolescents with deliberate self-harm. Journal of Child Psychology and Psychiatry, 38(3), 277-286.

Brent D., Holder, D., Kolko,, D., Birmaher, B., Baugher, M., Roth, C., Iyengar, S., & Johnson, J. (1997). A clinical psychotherapy trial for adolescent depression comparing cognitive, family and supportive therapy. Archives of General Psychiatry, 54, 877-885.

Brent, D. & Poling, K. (1997). Cognitive therapy treatment manual for depressed and suicidal youth. University of Pittsburgh, Pittsburgh, PA: STAR-Center Publications.

Chambless, D.L. et al (1996). An update on empirically validated therapies. The Clinical Psychologist, 49, 5-18.

Caspi, A. (1993). Why maladaptive behaviors persist: Sources of continuity and change across the life course. In D.C. Funder, R.D. Parke, C. Tomlinson-Keasey, & K. Widaman (Eds.), Studying lives through time (p.343-376). Washington, D.C.: American Psychological Association.

Church, E. (1994) The role of autonomy in adolescent psychotherapy. Psychotherapy, 31, 101-108.

Dolan, Y. (1991) Resolving sexual abuse. New York: W.W. Norton & Company.

Doucette-Gates, Firestone, R., & Firestone L., (1999). Assessing violent thoughts: The relationship between thought processes and violent behavior. Psychologica Belgica, October.

Firestone, R. (1990). Compassionate child-rearing: An in-depth approach to optimal parenting. New York: Plenum Publishing/Insight Books.

Firestone, R. (1993). The psychodynamics of fantasy, addiction, and addictive attachments. The American Journal of Psychoanalysis, 53, 335-352.

Firestone, R (1997a). Combating destructive thought processes: Voice therapy and separation theory, Thousand Oaks, CA.: Sage Publications.

Firestone, R. (1997b). Suicide and the inner voice: Risk assessment, treatment, and case management. Thousand Oaks, CA.: Sage Publications.

Firestone, R. & Catlett, J. (1999). Fear of intimacy. Washington, D.C.: American Psychological Association.

Firestone, R. & Firestone, L. (1996). Firestone assessment of self-destructive thoughts. San Antonio, TX.: Psychological Corporation

Firestone, R. & Firestone, L. (1998) Voices in suicide: The relationship between self-destructive thought processes, maladaptive behavior, and self-destructive manifestations. Death Studies, 22, 411-443.

Firestone, R. & Seidan, R. (1990) Psychodynamics in adolescent suicide. Journal of College Student Psychotherapy, 4, 101-123.

First, M.B., Spitzer, R.L., Gibbon, M., Williams, J. & Benjamin, L. (1996). Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II), (Version 2.0). Biometrics Research Department, New York Psychiatric Institute.

Fruzetti, A.E. (1998). Couples and family dialectical behavior therapy: Brief intervention outcomes. Paper presented at the 3rd Annual Convention of the International Society for Dialectical behavior Therapy, Washington, D.C.

Fruzetti, A.E., Hoffman. P.D., & Linehan, M.M. (in press). Dialectical behavior therapy with couples and families. New York: Guilford Publications.

Greenberg, L.S. (2002) Emotion focused therapy: Coaching clients to work through their feelings. Washington, D.C.: American Psychological Association.

Greenberg, L.S. & Safran, J.D. (1987). Emotion in psychotherapy: Affect, cognition, and the process of change. New York: Guilford.

Hanna, F.J. & Hunt, W.P. (1999). Techniques for psychotherapy with defiant, aggressive adolescents. Psychotherapy, Volume 36, Number 1, p.56-68.

Hoffman, P.D., Fruzetti, A.E., & Swenson, C.R. (1999) Dialectical behavior therapy—Family skills training. Family process, 38(4), 399-414.

Kaufmann, G. (1996). The psychology of shame: Theory and treatment of shame-based syndromes (2nd edition). New York: Springer Publishing Company.

Kohut, H. (1971). The analysis of the self. New York: International Universities Press.
Lansky, M.R. (1992). Shame and the problem of suicide: A family systems perspective. In Fathers who fail: Shame and psychopathology in the family system. Hillsdale, N.J.: The Analytic Press.

Lewis, H.B. (1987). The role of shame in symptom formation. Hillsdale, N.J.: Lawrence Erlbaum Associates

Linehan, M.M., Armstrong, H.E., Suarez, A., Allmon, D. et.al (1991) Cognitive behavioral treatment of chronically parasuicidal borderline patients. Archives of General Psychiatry, 48, 1060-1064.

Linehan, M.M. (1993a). Cognitive-behavioral treatment of borderline personality disorder. New York: The Guilford Press.

Linehan, M.M. (1993b). Skills training manual for treating borderline personality disorder. New York: The Guilford Press.

Linehan, M.M. (1997). Validation and psychotherapy. In A. Bohart & L Greenberg (Eds.). Empathy reconsidered: New directions in psychotherapy. Washington, D.C.: American Psychological Association.

Linehan, M.M., Kanter, J.W., & Comtois, K.A. (1999). Dialectical behavior therapy for borderline personality disorder: Efficacy, specificity, and cost-effectiveness. In D.S. Janowsky (Eds.), Psychotherapy: Indications and outcomes. Washington, D.C.: American Psychiatric Press.

Linehan, M.M., Tutek, D.A., Heard, H.L. & Armstrong, H.E. (1993c). Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. Archives of General Psychiatry, 151, 1771-1776.

Links, P.S. (1990). Family environment and borderline personality disorder. Washington, D.C.: American Psychiatric Press.

Miller, A.L., Rathus, J.H., Linehan, M.M., Wetzler, S. & Leigh, E. (1997). Dialectical behavior therapy adapted for suicidal adolescents. Journal Prac. Psychiatric and Behavoral Health, March.

Miller, A.L. & Glinski, J. (2000). Youth suicidal behavior: Assessment and intervention. Journal of Clinical Psychology, 56 (9), 1131-1152.

Miller, A.L.; Wyman, S.E.; Huppert, J.D.; Glassman, S.L.; Rathus, J.H (2000). Analysis of behavioral skills utilized by suicidal adolescents receiving dialectical behavior therapy. Cognitive and Behavioral Practice, 7(2), 183- 187.

Pilkonis, P.A., Kim, Y., Proetti, J.M., & Barkham, M. (1996). Scales for personality disorders developed from the Inventory of Interpersonal Problems. Journal of Personality Disorders, 10, 355-369.

Rathus, J.H. & Miller, A.L. (in press). DBT for adolescents: Dialectical dilemmas and secondary treatment targets. Cognitive and Behavioral Practice.

Rathus, J.H. & Miller, A.L. (Under review). Dialectical behavior therapy adapted for suicidal adolescents: A pilot study. Journal of the American Academy of Child and Adolescent Psychiatry.

Retzinger, S.M. (1991). Violent emotions: Shame and rage in marital quarrels. Newbury Park, Ca.: Sage Publications.

Safran, J.D. (1998). Widening the scope of cognitive therapy: The therapeutic relationship, emotion, and the process of change. Northdale, New Jersey: Jason Aronson, Inc.

Schave, D. & Schave, B. (1989). Early adolescence and the search for self: A developmental perspective. New York: Praeger Publishers.

Scheff, T.J. & Retzinger, S.M. (1991). Emotions and violence: Shame and rage in destructive conflicts. Lexington, MA: Lexington Books.

Schreve, B.W. & Kunkel, M.A. (1991). Self-psychology, shame, and adolescent suicide. Journal of Counseling and Development, 69, 305-311.

Shearnin, E.N. & Linehan, M.M (1994). Dialectical behavior therapy for borderline personality disorder: Theoretical and empirical foundations.. Acta Psychiatrica Scandinavica, 89, 61-68.

Strauss, M.B. (1999). No-Talk therapy for children and adolescents. New York: W.W. Norton & Company.

Thrane, G. (1979). Shame and the construction of the self. <u>The Annual of Psychoanalysis</u>, <u>8</u>, 321-341.

Wexler, D. (1991a). <u>The adolescent self: Strategies for self-management, self-soothing, and self-esteem in adolescents</u>. New York: W.W. Norton & Company.

Wexler, D. (1991b). <u>The PRISM workbook: A program for innovative self-management.</u> New York: W.W. Norton & Company.

Wexler, D. <u>The advanced PRISM workbook</u> (1993). New York: W.W. Norton & Company.

Wexler, D. (1998). <u>Cognitive Behavior Therapy with Adolescents: Strategies for Self-esteem, Self-management, and Self-soothing</u>. Symposium at New England Educational Institute,15th Annual Cape Cod Summer Symposia, August 17-21.

Wexler, D. (in press). Cognitive-Behavioral Therapy for Adolescents. <u>Textbook of Adolescent Psychiatry</u>. American Psychiatric Press.

Yookyung, K. & Pilkonis, P. (1999). Selecting the most informative items in the IIP scales for personality disorders: An application of item response theory. <u>Journal of Personality Disorders</u>, <u>Summer</u>, <u>13(2)</u>, 157-174.

APPENDICES

EMOTION REGULATION, INTERPERSONAL EFFECTIVENESS, AND DISTRESS TOLERANCE SKILLS FOR ADOLESCENTS: A TREATMENT MANUAL

<u>SKILLS HAND-OUTS #1-10</u>

University of Pittsburgh Health Systems

Services for Teens At Risk

Charles Bonner, Ph.D.

THE FREEZE FRAME: LEARNING TO CONTROL "UNCONTROLLABLE" EMOTIONS AND BEHAVIOR (#1)

1. Identify a situation in which you lost control of your emotions and/or you behaved in a way that was harmful to yourself and/or others

2. Recall as may details as possible about what happened before, during, and after the problem emotion or behavior.

3. Describe the "who, what, where, and when" of the problem situation; if you have trouble doing this, first try recalling such "irrelevant" details such as the weather; what you were wearing, etc.

4. Focus on the "vulnerability factors" that made you more susceptible to the problem emotions and behaviors (e.g. sleep deprivation, drug use, hunger, physical illness—see the H.E.A.R. M.E. hand-out)

5. As you recall the actual scene/situation where the problem emotion or behavior happened, picture it as if you were viewing a "slow motion instant replay".

6. As the scene approaches the moment when the problem emotion intensified or the "uncontrollable behavior" happened, "slow time down" so that you can really focus on the details of your experience.

7. When you reach the moment <u>just prior</u> to the problem emotion or behavior, FREEZE THE FRAME and describe your self-talk, thoughts, images, feelings, bodily sensations, and action urges at that moment.

8. Next, ask yourself this question: What <u>needs</u> were you expressing through your emotion or attempting to meet through your behavior, even if the results were negative?

9. What other ways might there have been to take care of these needs?

10. What were the negative consequences for yourself and others, and how can you make amends for these consequences?

11. If you could go back in time and relive this situation, what would you have done differently to help things go better than they did?

12. Replay the situation in your mind so that it has a better outcome— picture yourself using your new knowledge and skills, and imagine how these would have made a difference in how you and others handled the situation.

REMEMBER: "ONCE YOU KNOW YOUR NEEDS, YOU ARE SMARTER. ONCE YOU LEARN NEW TOOLS AND SKILLS FOR HANDLING YOUR NEEDS, YOU ARE MORE POWERFUL"
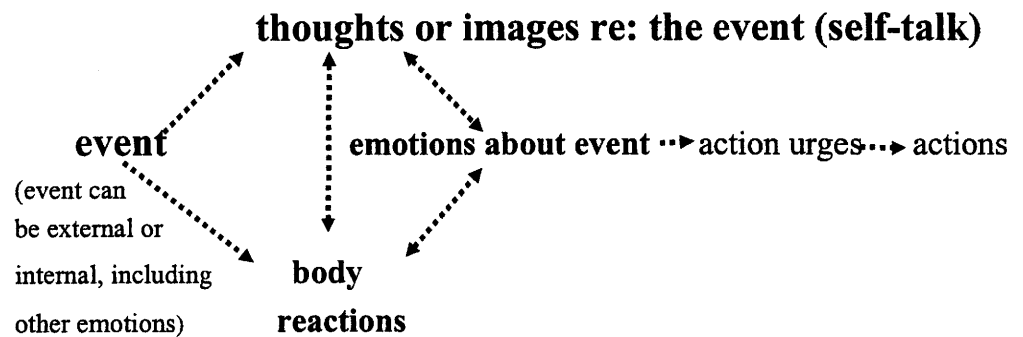
MODEL OF EMOTION

- •
- •
- •

████████████████████████████████████

- The interaction of emotions with thoughts, images, body reactions, & action urges

thoughts or images re: the event (self-talk)

event

(event can
be external or
internal, including
other emotions)

emotions about event ⋯▶ action urges⋯▶ actions

**body
reactions**

████████████   •   •   •   •   •   •   •   •

EMOTION REGULATION (#3)

THREE ASPECTS OF VULNERABILITY TO EMOTION DYSREGULATION

1. A very **FAST** emotional response; it does not take much to get the ball rolling, and the ball gets rolling very rapidly down the hill to the land of dysregulation.

2. A very **BIG** emotional response; emotions are felt and expressed with much intensity, making it difficult to think clearly; when the ball gets rolling down the hill, it quickly becomes a BIG ball—perhaps with jagged edges.

3. A very **SLOW** return to being calm or relaxed; it takes a long time to roll the ball back up the hill; there may have been damage done by the ball as it sped down the hill, so extra distress may have been added to whatever got the ball rolling in the first place.

   Until the ball is returned to the top of the hill and order is restored, you are even more sensitive and vulnerable than usual to responding with intense emotion to the next stressor that comes along.

EMOTION REGULATION (#4)

HOW TO REDUCE VULNERABILITY TO
NEGATIVE EMOTION: H.E.A.R. M.E.

H ealth   Take care of your body. See a doctor when necessary. Take prescribed medication.

E xercise   Do some form of exercise every day; try to build up to 20 minutes of sustained exercise.

A void   Stay off non-prescribed drugs like alcohol, pot, and other illegal drugs.

R est   Try to get the amount of sleep that helps you feel good. Try to keep a regular sleep schedule. (see page 2 of this hand-out for sleep suggestions)

M astery   Try to do one thing a day to help yourself feel effective, competent, and in control.

E ating   Do not eat too much or too little. Stay away from foods that make you feel overly emotional. Learn about nutrition and what foods are healthiest for you.

SUGGESTIONS TO IMPROVE SLEEP

1. Establish a regular time for going to bed and getting up in the morning and stick to it even on weekends and during vacations.

2. Use the bed for sleep only, not for reading, watching television or homework; too much time in bed can fragment sleep.

3. Avoid naps during the day.

4. Avoid caffeine, nicotine, and alcohol for four to six hours before bedtime. The first two are stimulants that can make it difficult to sleep. And while alcohol can have a sedating effect at first, it tends to disturb sleep after several hours.

5. Don't exercise within four to six hours before bedtime. However, working out earlier in the day can actually improve sleep.

6. Avoid fluids just before bedtime so that sleep is not disturbed by the need to use the bathroom.

7. Avoid eating a large meal before bedtime, but a light snack might help sleep. Foods containing tryptophan can also promote sleep (turkey, chicken, yogurt, bananas, warm milk); chamomile non-caffeinated tea can also be soothing.

8. Take a hot bath about an hour and a half before bedtime. The body temperature then begins dropping rapidly, which may help sleep after that time. (Taking a bath shortly before bed actually increases alertness.)

9. Do something relaxing in the half hour before bedtime (for example, reading or listening to relaxing music; doing a relaxation exercise or guided imagery, even once you are in bed).

10. Make sure your bed is comfortable and the bedroom is conducive to restful sleep – quiet, at a comfortable temperature, and well ventilated.

11. Do not look at the clock. Obsessing about the time will just make it more difficult to sleep.

12. If you can't fall asleep within 15-20 minutes, get out of bed, go into another room, read or do a quiet activity using dim lighting until you are sleepy again. (Don't watch TV, which emits too bright a light.)

EMOTION REGULATION (#5)

MINDFULNESS OF YOUR CURRENT EMOTION

OBSERVE YOUR EMOTION

- NOTE its presence

- Step BACK

- Get UNSTUCK from the emotion

EXPERIENCE YOUR EMOTION

- As a WAVE, coming and going

- Try not to BLOCK the emotion

- Try not to SUPPRESS the emotion

- Don't try to GET RID of the emotion

- Don't PUSH it away

- Don't try to KEEP the emotion around

- Don't HOLD ON to it.

- Don't INTENSIFY it.

REMEMBER: YOU ARE NOT YOUR EMOTION

- Do not necessarily ACT on your emotion
  (that is, let destructive ACTION URGES pass)

- Remember times when you have felt DIFFERENT

PRACTICE ACCEPTING YOUR EMOTION

- Do not JUDGE your emotion as wrong, bad, too painful,
  unfair, embarrassing, etc.

- Do not CRITICIZE yourself for feeling the emotion

- ACCEPT your emotion as it is in the moment

EMOTION REGULATION (#6)

ANGER MANAGEMENT THROUGH
OPPOSITE ACTION

- Emotion is strongly influenced by your facial expressions, bodily posture, and actions.

- It is possible to change your experience of an emotion by altering the posture, behavior & facial expressions that go with the emotion. You may be able to slow it down or make it less intense so that you do not behave in a way that makes things worse.

- ANGER, perhaps even more than any other emotion, is strongly affected by facial expression, rate of breathing, muscle tension, and the general urge to take action.

- These physical features are in addition to whatever angry thoughts are fueling the feeling (usually involving "shoulds" and "should nots", things that do not seem fair, or reactions to feeling embarrassed, put down, or disrespected)

Suggestions for Opposite Actions to Manage Anger:

1. Keep your palms open and arms at your side when inclined to punch or attack; gently touch an object rather than throw it.
2. Whisper when inclined to scream or verbally attack.
3. Breathe deeply and slowly rather than hyperventilating.
4. Do progressive muscle relaxation on tense muscle groups.
5. Relax tense areas of facial expression, such as furrowed eye brows and pursed lips—perhaps closing your eyes and allowing yourself to smile.
6. Let go of thoughts that revolve around "shoulds" and "should nots"; remembering that acceptance is not the same as approval or agreement (see hand-outs on Distress Tolerance).

**The Adolescent Assertiveness A.I.D. : An Alternative
to Angry Altercations and Anxious Avoidance**

A ppreciate

Acknowledge other's perspective
Affirm other's feelings
Accept disagreement

I statements

Identify feelings
Identify beliefs
Identify wants

D on't criticize

Don't blame or judge others
Don't disconnect
Detective questions

INTERPERSONAL EFFECTIVENESS (#8)
G. I. V. E. N: Strategies to keep a relationship

<div align="center">

(be) **G**ENTLE

(act) **I**NTERESTED

VALIDATE

(use an) **E**ASY MANNER

NEGOTIATE

</div>

(be) Gentle Be <u>courteous</u> and temperate in your in your approach

No attacks No verbal or physical attacks. No hitting, clenching fists. Express anger directly.

No threats No "manipulative" statements, no hidden threats. No "I'll kill myself if you.." tolerate a no to requests. Stay in the discussion even if it gets painful. Exit gracefully.

No judging No moralizing. No "If you were a good person, you would.." No "you should.." "You shouldn't.."

(act) Interested LISTEN and be interested in the other person.

Listen to the other person's point of view, opinion, reasons for saying no, or reasons for making a request of you. Don't interrupt, talk over, etc. Be sensitive to the person's desire to have the discussion at a later time. Be patient.

Validate Validate or ACKNOWLEDGE the other person's feelings, wants, difficulties, and opinions about the situation. Be nonjudgmental out loud: "I can understand how you feel, but.."; "I realize this is hard for you, but..", "I see that you are busy, and.."

(use an)

Easy Manner Use a little humor. SMILE. Ease the person along. Be light-hearted. Use a "soft sell" over a "hard sell." Be political.

Negotiate Be willing to GIVE TO GET. Offer and ask for alternative solutions to the problem

DISTRESS TOLERANCE (#9)

PRACTICING ACCEPTANCE

SUFFERING = NOT ACCEPTING PAIN

ACCEPTANCE= 1. LETTING GO OF FIGHTING REALITY
2. TURNING SUFFERING YOU <u>CAN'T</u> COPE
WITH INTO PAIN YOU <u>CAN</u> COPE WITH

ACCEPTANCE ≠ APPROVAL OR AGREEMENT

THREE MYTHS ABOUT ACCEPTANCE:

1. IF YOU REFUSE TO ACCEPT SOMETHING IT WIL MAGICALLY CHANGE

2. IF YOU ACCEPT YOUR PAINFUL EMOTION AND/OR SITUATION, YOU WILL BECOME SOFT OR WEAK AND JUST GIVE UP (OR GIVE IN)

3. IF YOU ACCEPT YOUR PAINFUL SITUATION AND/OR EMOTION, YOU ARE ACCEPTING A LIFE OF PAIN

EXAMPLES OF "ACCEPTANCE SELF-TALK":

1. "I'm doing the best that I can"
2. "I can't do anything for now to change how I feel or to change the situation, so it is better to accept this instead of doing something that could make things worse".
3. "I've survived these types of feelings before, so I can do it again"

DISTRESS TOLERANCE (#10)

SELF-SOOTHING WITH THE FIVE SENSES

VISION Watch a sunset; look at a picture or a poster that you like; make one space in a room look special or pretty; look at some pleasant aspect of nature around you; focus on any visual detail of wherever you are, even if the detail is emotionally neutral or bland (e.g. the spots on the wall)

HEARING Listen to beautiful or soothing music; sing your favorite soothing song; pay attention to the sounds of nature (e.g. rain, birds, wind); listen to a relaxation tape; focus on an auditory detail of wherever you are, even if the detail is emotionally neutral or bland (e.g. the hum of an air conditioner, the buzz of a fluorescent light bulb).

SMELL Put on your favorite perfume, lotion, or cologne; light a scented candle or incense; spray your room with a fragrant air freshener; choose some favorite scented oils; cook or bake food with a soothing smell.

TASTE Have a good meal; have a favorite soothing non-alcoholic drink, such as tea or hot chocolate; eat your favorite ice cream or piece of candy; really take the time to taste the things you drink and eat; do so slowly and in moderation.

TOUCH Pet your dog or cat; take a soothing bath; brush or braid your hair; hug a friend or family member; notice touch that is soothing-- such as a favorite fabric, stuffed animal or blanket.

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