USC University of Southern California

Adolescent Trauma Training Center

Using ITCT-A to Treat Self-injury in Traumatized Youth

John Briere, Ph.D.
Cheryl B. Lanktree, Ph.D.
Randye J. Semple, Ph.D.

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USC Adolescent Trauma Training Center (USC-ATTC)

attc.usc.edu

Department of Psychiatry and Behavioral Sciences

Keck School of Medicine

University of Southern California

Los Angeles, California

keck.usc.edu/psychiatry

National Child Traumatic Stress Network

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PART I. INTRODUCTION AND ASSESSMENT

This treatment guide was developed to assist clinicians in their treatment of traumatized adolescents involved in self-injurious behavior (SIB). Although all of the principles and interventions described here may be useful irrespective of the overall therapy modality used, this guide is specifically focused on treating SIB from the perspective of *Integrative Treatment of Complex Trauma for Adolescents* (ITCT-A; Briere & Lanktree, 2013).

The adaptations of ITCT-A found in this guide are especially assessment focused, employing interviews, measures, and worksheets that evaluate safety, trauma and attachment history, emotional dysregulation, and comorbidities such as depression, posttraumatic stress, and suicidality. Because SIB is a form of distress reduction behavior, considerable attention is paid to assessing the underlying reasons for self-injury, so that interventions can appropriately address its causes and functions.

Chapter 1: ITCT-A and Self-Injury

Integrative Treatment of Complex Trauma for Adolescents

ITCT-A is an evidence-based, multi-component, culturally sensitive therapy that integrates treatment principles from the complex trauma literature, attachment theory, and cognitive-behavioral and relational therapies. Originally based on *Integrative Treatment of Complex Trauma for Children* (ITCT-C; see Lanktree & Briere, 2008), ITCT-A involves semi-structured protocols and interventions that are customized to the specific issues and capacities of each client, since complex posttraumatic outcomes are notable for their variability across different individuals, cultures, and environments. See attc.usc.edu for information on ITCT-A, including webinars, intervention tools, treatment outcome research, and other treatment guides, including *Treating Substance Use Issues in Traumatized Adolescents and Young Adults* (Briere & Lanktree, 2014).

An important aspect of ITCT-A is its regular monitoring of treatment effects over one to several month periods, using the most recent version of the *Assessment-Treatment Flowchart for Adolescents*, the ATF-A-II (see Appendix B). The ATF-A-II allows the therapist to review therapy- or environmentally-related changes in symptomatology and psychosocial problems over time, based on interviews with the youth, information from other sources such as parents or teachers, and when appropriate, psychological tests. As treatment continues, some symptoms or problems will decrease, or occasionally increase over time (e.g., due to new stressors), and thus are prioritized differently at each assessment period.

Based on information from the ATF-A-II, the therapist customizes the client's specific treatment, applying one or more of 17 empirically supported components. As described later in this treatment guide, certain ITCT-A treatment components (e.g., *relationship building, relational processing, emotional regulation training, trigger management*, and *titrated exposure*) are especially relevant to SIB, and thus are emphasized here.

An Overview of Self-Injury

SIB can be defined as intentional, self-inflicted bodily harm that is not primarily suicidal in nature and is not related to normative social or cultural phenomena, such as tattoos or body piercing with decorative objects (Walsh, 2012; Walsh & Rosen, 1988). The research and clinical literature have described a range of SIBs (e.g., Briere & Gil, 1998; Walsh, 2012; Whitlock,

Eckenrode, & Silverman, 2006), including

- cutting, scratching, or piercing/stabbing;
- burning, by fire or caustic chemicals;
- biting or chewing;
- repetitive picking at wounds or scabs (also called *excoriation*);
- poking eyes;
- head banging;
- skin picking; and
- hitting oneself or external objects with enough force to produce pain.

In some cases, SIB may be especially severe, involving

- the ingestion or insertion of sharp objects that produce gastrointestinal pain or bleeding;
- eye enucleation;
- amputation;
- genital mutilation or castration; and
- "autosurgery," which is extensive and time-consuming cutting or "surgery," sometimes involving deliberate exposure of muscles, bones, or organs.

These are most likely when other serious mental health issues (e.g., psychosis, mania) and/or extreme intoxication are also present (Favazza, 2011).

SIB can be focused on any part of the body, but it most commonly involves injury to the inner arms or legs (Walsh, 2012). Although a few studies indicate that adolescent or young adult women are more likely to self-injure than their male counterparts (e.g., Zlotnick, Mattia, & Zimmerman, 1999), others have found no gender differences at the multivariate level (e.g., Briere & Eadie, 2016).

Typically beginning in the early teens, SIB is reported by approximately 16-18% of adolescents in the general population (Muehlenkamp, Claes, Havertape, & Plener, 2012). The highest rates of self-injury occur among those who have experienced childhood sexual abuse, but also physical and psychological abuse and neglect, and those with insecure parent-child attachment (Lang & Sharma-Patel, 2011; Wrath & Adams, 2018). SIB generally peaks in older adolescence and early adulthood, and tends to decline in prevalence over the lifespan, to the

point that it is relatively uncommon in older adults (American Psychological Association, 2015).

Childhood Maltreatment, Attachment Disturbance, and SIB

The strong connection between childhood maltreatment, attachment disturbance, and self-injury suggests that early life experiences specifically contribute to deliberate self-harm. Various researchers and clinicians suggest that maltreatment and attachment-related emotional distress can be triggered by reminiscent phenomena in the adolescent's current environment (e.g., interpersonal conflict, losses, perceived abandonment or rejection, or maltreatment), at which point the youth is flooded with unwanted emotions, thoughts, and memories, which motivate, among other avoidance behaviors, self-injury as a way to regulate negative internal states (Briere & Lanktree, 2013). Specifically, SIB may serve to

- distract from negative internal states (e.g., depression, posttraumatic stress, emptiness, and feelings of rejection or abandonment);
- block or terminate negative memories of childhood trauma, neglect, or attachment breaches;
- reduce guilt and shame, through self-punishment;
- externalize anger;
- reduce unwanted numbing, feelings of "deadness," or dissociation;
- communicate suffering;
- externalize internal distress; and
- increase a sense of control.

See Briere and Eadie (2016); Briere and Gil (1998); Brown, Comtois, and Linehan (2002); Conners (1996); Klonsky (2007); Klonsky and Glenn (2008) for specific studies.

Childhood maltreatment potentially contributes to SIB and other distress reduction behaviors in three ways.

1. It produces painful relational memories, both verbal/explicit and nonverbal/implicit, that, when triggered by reminiscent stimuli in the current environment (e.g., perceived rejection, abandonment, betrayal, or victimization), are "relived" in the here-and-now.
2. It disrupts early parent-child attachment systems, such that the child has distorted internal models of self, others, and the world.

3. Because dysregulated attachment typically interferes with the development of emotional regulation capacities, it results in a tendency to be overwhelmed by painful emotional states, including those triggered by relational stimuli.

These phenomena may lead to an *activation-regulation imbalance*. Not only does the adolescent suffer from easily triggered trauma- and attachment-related memories, she or he has fewer internal resources to regulate these experiences, thereby motivating distress reduction behaviors (DRB) such as self-injury, as well as avoidance behaviors like substance abuse, dissociation, bingeing and purging, "impulsive" suicidality or aggression, and indiscriminate sexual behavior (e.g., Briere, Hodges, & Godbout, 2010). From this perspective, childhood abuse, neglect, and attachment disturbance creates a "perfect storm." The previously maltreated or neglected youth is prone to easily triggered attachment and trauma memories that carry with them potentially great emotional pain—which, in the absence of sufficient emotional regulation skills, drives him or her to engage any avoidance behavior that reduces awareness of extreme distress. Unfortunately, although SIB may serve as a distress-reduction behavior, its effects

- are temporary, thus requiring repetition;
- can lead to disfigurement or even life threat; and
- are often a source of shame and feelings of unacceptability, potentially leading to additional self-injury.

Implications for Treatment

Because ITCT-A includes multiple components relevant to deliberate self-harm, including attachment processing, emotional regulation, trigger management, and titrated therapeutic exposure, it has special relevance to the treatment of self-injury and other DRBs. Beyond the usual components of ITCT-A, however, this manual introduces some new—SIB-specific—assessment and intervention tools, and adapts some ITCT-A components to be most helpful in work with SIB-involved youth. When the adolescent presents for treatment with a wide variety of problems, symptoms, and DRBs, these new components may be used to augment standard ITCT-A. When SIB is the primary, or only, DRB, the clinician may choose to use primarily the ITCT-A components highlighted in this manual, while still calling on the standard ITCT-A approach if necessary.

Chapter 2: Assessment

Because SIB often arises in the context of abuse, neglect, and reduced emotional regulation capacities, and can come with a variety of comorbidities (e.g., posttraumatic stress, depression, anxiety, substance abuse, and other DRBs), it is important to assess self-injuring clients before and during treatment, using the tools described later in this chapter, and in Chapter 2 of the ITCT-A Treatment Guide. There are six key targets for evaluation.

Safety. Is the client at risk of injury, disability, infection, or disfigurement that sometimes accompanies self-injury? Although SIB is usually not a suicidal behavior *per se*, both may occur in the same client (Grandclerc, De Labrouhe, Spodenkiewicz, Lachal, & Moro, 2016). For this reason, it is important to assess for suicidal ideations, plans, means, or previous attempts.

History of trauma and neglect. Does the youth or collateral information sources report early child maltreatment, loss, or parental disattunement or disengagement (e.g., chronic inattentiveness and non-responsiveness to the child)?

Evidence of a problematic attachment history. Did the child experience early insecure attachment? What is his or her current insecure attachment style?

Current emotional regulation difficulties. For example, does the youth exhibit labile mood, hyperreactivity, short periods of intense depression, or "impulsive" behaviors?

Comorbidities. Are there associated psychological difficulties that might potentially intensify SIB? As well, are there significant symptoms or problems, irrespective of SIB, that require intervention, such as significant depression, anxiety, substance abuse, psychosis, dissociation, cognitive impairments, or serious physical illness?

The antecedents of triggering. Does the adolescent report triggers that result in SIB, such as relational conflicts, perceived abandonment, or responses to therapy or the therapist? Once triggered, do these memories provoke unwanted emotions, thoughts, or sensations that result in SIB?

Suicidality

Although SIB often reflects a desire to survive painful internal states rather than terminate life, suicidality initially and continuously should be ruled out when treating SIB-involved youth. In some cases, what appears to be SIB may actually represent a sub-lethal suicide attempt. For example, superficial cutting can be a "dry run" to determine whether the pain

associated with a more lethal laceration is tolerable. In other cases, SIB and suicidality may occur concurrently, with SIB being used to manage lower-level distress, and suicidal behaviors invoked when SIB is insufficient, or when emotional pain is so overwhelming that ending one's life seems the only possible response.

The specific extent of suicide assessment necessary will depend on the client's current presentation and history. If the youth reports suicidal ideation or a history of suicide attempts, is suffering from significant depression, or is undergoing significant stress in her or his interpersonal environment, assessment of suicidal ideation, intent, and plans should be considered on a regular basis.

Assessment Tools

Beyond the intake interview, assessment of SIB-involved youth can be assisted by a number of psychological tests, ITCT-A tools, and SIB-specific measures.

Psychometric Tests and Interviews

Although formal psychological testing may not always be readily available to clinicians or agencies, it is recommended that those with significant SIB involvement be administered normed psychological tests or validated diagnostic interviews whenever possible, either by the clinician or through referral to a psychologist.

Presented below is a list of psychological tests and interviews that are directly relevant to the assessment of adolescents struggling with SIB. The clinician or consultant may find others that are even more useful. The two most relevant to this guide, the *ATF-A-II* and the *Self-injury Behaviors and Functions Review (SBFR*), are discussed in more detail.

Broadband Assessment of Symptomatology

- *Psychological Assessment Inventory – Adolescent* (PAI-A; Morey, 2007). Available at www.parinc.com.
- *Minnesota Multiphasic Personality Inventory – Adolescent* (MMPI-A; Butcher et al., 1992). Available at www.pearsonassessments.com.

Assessment of Posttraumatic Stress

- The NCTSN offers a searchable database of reviews of child, adolescent, and young adult screening and assessment tools. Available at www.nctsn.org/treatments-and-

practices/screening-and-assessments/measure-reviews.

Suicide Assessment

- *Beck Scale for Suicide Ideation* (BSSI; Steer, Kumar, & Beck, 1993). Available at www.pearsonassessments.com.
- *Suicidal Ideation Questionnaire* (SIQ; Reynolds, 1987). Available at www.parinc.com.

ITCT-A Tools (all downloadable at attc.usc.edu)

- *Initial Trauma Review, Adolescent version, 2nd edition* (ITR-A-II). See Appendix A.
- *Assessment–Treatment Flowchart, Adolescent/Young Adult version, 2nd edition II* (ITF-A-II). See Appendix B.
- *Possible Interview Question Topics, Adolescent version, 2nd edition* (PIQT-A-II).
- *Trigger Grid, Adolescent version, 2nd edition* (TG-A-II). See Appendix C and the ITCT-A Mindfulness Guide at *attc.usc.edu*.

SIB-specific Measures (Non-ITCT-A)

- *Deliberate Self-Harm Inventory* (DSHI; Gratz, 2001). Available at www.selfinjury.bctr.cornell.edu/perch/resources/deliberate-self-harm-inventory.pdf
- *Functional Assessment of Self-Mutilation* (FASM; Lloyd, Kelley, & Hope, 1997). Available at https://osf.io/8zpu7.

A New ITCT-A SIB-specific Measure Introduced in this Treatment Guide

- *Self-injury Behaviors and Functions Review* (SBFR; Briere, Lanktree, & Semple, 2019). See Appendix D.

The Assessment-Treatment Flowchart (ATF-A-II)[1]

Because the ATF-A-II is the primary assessment tool in ITCT-A, it is discussed here in detail as it relates to SIB, and is revisited later using a clinical example.

Items and ratings. There are 25 problems or symptoms listed in the ATF-A-II, plus two "other" items for any additional issues. Each symptom/problem is prioritized according to how immediately it must be addressed, on a 1 (*Not currently a problem, do not treat*) to 4 (*Most*

[1] The ATF-A was developed in 2012 for ITCT-A. It was revised and expanded in 2018, and is hereafter referred to as the ATF-A-II.

problematic, requires immediate attention) scale, with an additional option of "S" used when the clinician suspects that there may be a problem or symptom present, but neither client or collateral information is sufficient to support a specific rating. Typical ATF-A-II items are *environmental safety, caretaker support, depression, anger, dissociation, posttraumatic stress, attachment insecurity, suicidality,* and, apropos of this guide, *self-injury*[2].

As treatment progresses, ATF-A-II items may be differentially endorsed as a function of changes in immediate treatment priority. Successful treatment, for example, might reduce the child's posttraumatic stress during a given assessment period, yet his or her self-injurious behavior might be unaffected or even increase for some reason (e.g., new stressors, peer relationship changes, newly activated memories, or a new instance of abuse) at the next assessment period. This shift would typically require a change in therapeutic priority, in which posttraumatic stress was given slightly less attention, and self-injury received an increased focus.

The ATF-A-II at intake assessment. As per the ITCT-A Treatment Guide, completing the ATF-A-II at intake occurs in two steps. First, the clinician reviews all available assessment data, parent or caretaker information on the adolescent's symptoms and problems, collateral information such as school reports, other caregiver (e.g., health care professionals, other therapists), juvenile justice reports, etc. Then, in the intake interview, the clinician asks the youth about each of the items of the ATF-A-II, assisted, if necessary, by the Possible Interview Question Topics (PIQT-A-II), which asks questions about each of the 25 items of the ATF-A-II. In the "Intake" column, the therapist rates the treatment priority for each item from 1: *Not currently a problem, do not treat* to 4: *Most problematic, requires immediate attention*, based on the data collected at step 1. For example, for the ATF-A-II item *dissociation*, the PIQT refers to *Spacing out, Watching himself/herself from outside of his/her body,* and *feeling like things are unreal.* PIQT-A-II items are simply suggestions, however, and the clinician may choose other, equally relevant examples, especially in terms of crafting inquiries specific to the youth's circumstances, trauma history, age, culture, etc.

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[2] The item in the original ATF-A was *self-mutilation*, reflecting common language usage when ITCT-A was first developed. We recommend the more current ATF-A-II term, *self-injury*, which is less pathologizing and allows for description of a broader range of behaviors, some of which do not involve *mutilation*, per se.

Although the clinician completes the ATF-A-II, we recommend that, whenever possible, this process occur in collaboration with the youth. For example, if the clinician is determining how to rate ATF-A-II item 17 (self-injury), she or he might call upon test and interview data relevant to recent or current self-injurious urges and behavior, examine the client's responses to the SBFR and the five self-injury questions on the PIQT-A-II, but also solicit the youth's immediate opinion about how SIB should be prioritized on the ATF-A-II. In this regard, the clinician might say something like:

> *"Esperanza, the tests and questions, and what your mom said, make me think that we need to work on your cutting. As you've said, it's a serious problem that makes you feel bad after you do it. And it can leave scars or maybe get infected. Do you agree with that? Do you want to start working on your cutting now?"*

In response to the client's new input, along with the other sources of information, the clinician might rate self-injury with a 4 (*Most problematic, requires immediate attention*). Importantly, however, the clinician is the final arbiter of what the priority score on the ATF-A-II should be. There may be instances, for example, when the client seemingly under-reports or downplays the importance of a specific ATF-A-II item, such that the therapist's rating is not in agreement with the client's rating.

The ATF-A-II at later assessment periods. At each following assessment period (typically every one – three months, depending on the expected length of therapy), the clinician re-prioritizes symptoms and problems on the ATF-A-II, based on recent sessions, any new assessment or collateral information, and any changes in the client's psychosocial environment. In some cases, a new ATF-A-II assessment will occur prior to the planned next assessment point, generally when some new event intercedes (e.g., a crisis or a new instance of victimization) or a significant treatment event (e.g., a breakthrough or newly uncovered information) alters the trajectory of therapy. The ATF-A-II has rating columns for three assessment periods beyond the intake session. Additional ATF-A-II pages may be added, as needed, for therapy that exceeds the four assessment points.

The Self-injury Behaviors and Functions Review (SBFR)

Developed specifically for this guide, the SBFR is a structured review of different types of self-injurious behaviors (e.g., cutting, scratching, burning, head banging), the age at first and last SIB, number of times each type of SIB occurred in the last 6 months, in the last month, in the

last week, and in the last 24 hours. Also assessed is a range of potential reasons why the client engages in SIB (e.g., distraction, to increase a sense of control, to communicate distress, to reduce dissociation, and self-punishment). This tool, which is administered early in treatment, provides the clinician with important information on the severity of the client's SIBs, and the reasons for these behaviors. This information, in turn, helps the clinician determine safety activities and, importantly, the specific reasons for SIB for each adolescent that can be intervened in to reduce motivation for future SIBs. See Appendix D for a copy of the SBFR.

Timing and Foci of Assessment

Although somewhat flexible in terms of timing and content, assessment of the SIB-involved adolescent generally proceeds in the following order:

1. ***An initial interview-based assessment of immediate physical safety.*** Always conducted in the intake session, this involves informal questions about any sources of danger in the youth's environment, in case immediate intervention is necessary to establish physical safety. This typically includes
    - any current abuse, trauma, or neglect in the client's family or environment, including sexual exploitation and gang involvement;
    - whether the youth has a stable and safe place to stay at night;
    - any serious illness that requires immediate intervention; and
    - whether the adolescent is currently self-endangering—both in terms of the severity of his or her current self-injury, but also due to suicidality, major substance abuse, unsafe sexual practices, and/or the effects of other problematic, dangerous DRBs.
2. **A review of past traumas and/or abuse, both in childhood, and more currently in adolescence**; often assisted by responses from the Initial Trauma Review, Adolescent version, 2nd edition (ITR-A-II).
3. Psychometric tests and/or interviews for comorbidities, if indicated and possible.
4. **Administration of the ATF-A-II**, potentially assisted by the PIQT-A-II.
5. ***Completion of the TG-A-II and the SBFR***. Described in more detail later, the *Trigger Grid, Adolescent version, 2nd edition* (TG-A-II) is a generic assessment of the triggering process, *per se*, whereas the SBFR is specific to self-injury, and

reviews specific types of behavior and motives for self-injury. Although there is some slight overlap, both should be administered.

Assessing Amanda: A case example

Presented below is the case of Amanda, followed by her assessment results.

Amanda is a 16 year-old adolescent who has been referred to a therapist for self-injurious behaviors that began two years ago, and that have intensified over the last month. Currently, she cuts on her inner arms and legs with a razor blade on an almost daily basis, and occasionally scratches her arms and neck, picks at scabs or healing wounds, and punches walls when angry. In the prior week, several of her lacerations were of sufficient depth that she was evaluated for psychiatric hospitalization. However, the ER psychiatric resident determined that Amanda's behavior was not suicidal in nature, and declined to admit her subject to her agreeing to attend outpatient psychotherapy.

Amanda has a history of extended and complex trauma, including sexual abuse by at least two of her mother's boyfriends, as well as physical and psychological abuse by her mother throughout her childhood, although reportedly not currently. Her mother has struggled with polysubstance abuse (primarily heroin and alcohol) since before Amanda's birth, and temporarily lost custody of her at age three for physical and emotional neglect.

Amanda's therapist notes that, in addition to her self-injury, she is sexually active with several boyfriends, and possibly an older man, although Amanda refuses to give details. She also uses marijuana daily and binge-drinks alcohol several times a week. Although of above-average IQ, she has chronic truancy problems at school, and is in a special class for underachievers. Per her therapist, Amanda's self-injury is almost always triggered by a relational conflict or break-up, or arguments with her mother.

Safety Interview

At the beginning of her intake interview, Amanda denies any current danger or threats of danger in her current environment, although it is possible that her older boyfriend is an adult, in which case she is being sexually abused, and a report should be filed and child protection services involved. Perhaps aware of this, Amanda only vaguely refers to this man, and refuses to give any identifying information, including whether he is, in fact, an adult.

She currently lives with her mother in an apartment, and states that her caretaker is not

abusing or neglecting her, and is providing adequate food, shelter, and supervision. The clinician is not sure whether all of this is true, but, at this point, takes her client's word for her safety.

Amanda reports several currently self-endangering behaviors, including SIB of sufficient severity that she was evaluated in the ER; risky sexual behavior, involving multiple different sexual partners and a seeming willingness to engage in sex with relative strangers; and regular substance use, although reportedly limited to alcohol and marijuana, with no indication of addiction thus far. She reports no recent suicidal ideation, no suicide plans, and no history of previous attempts. Because this is only her intake interview, and Amanda is somewhat guarded in general, her therapist intends to query suicidality in future sessions as well.

Trauma, Maltreatment, and Attachment Screening

Amanda's therapist interviews her with the ITCT-A *Initial Trauma Review for Adolescents, 2nd edition (ITR-A-II)* during her intake interview, which indicates

- childhood physical and psychological abuse from age 3 to 11 from her mother;
- sexual abuse from age 4 to 13, by several of her mother's boyfriends;
- No history of peer sexual or physical assault, although she is somewhat evasive about the possibility of sexual assault, and her therapist makes a mental note to query this further in future sessions; and
- No motor vehicle accidents, torture, police-related trauma, or witness to the trauma of others.

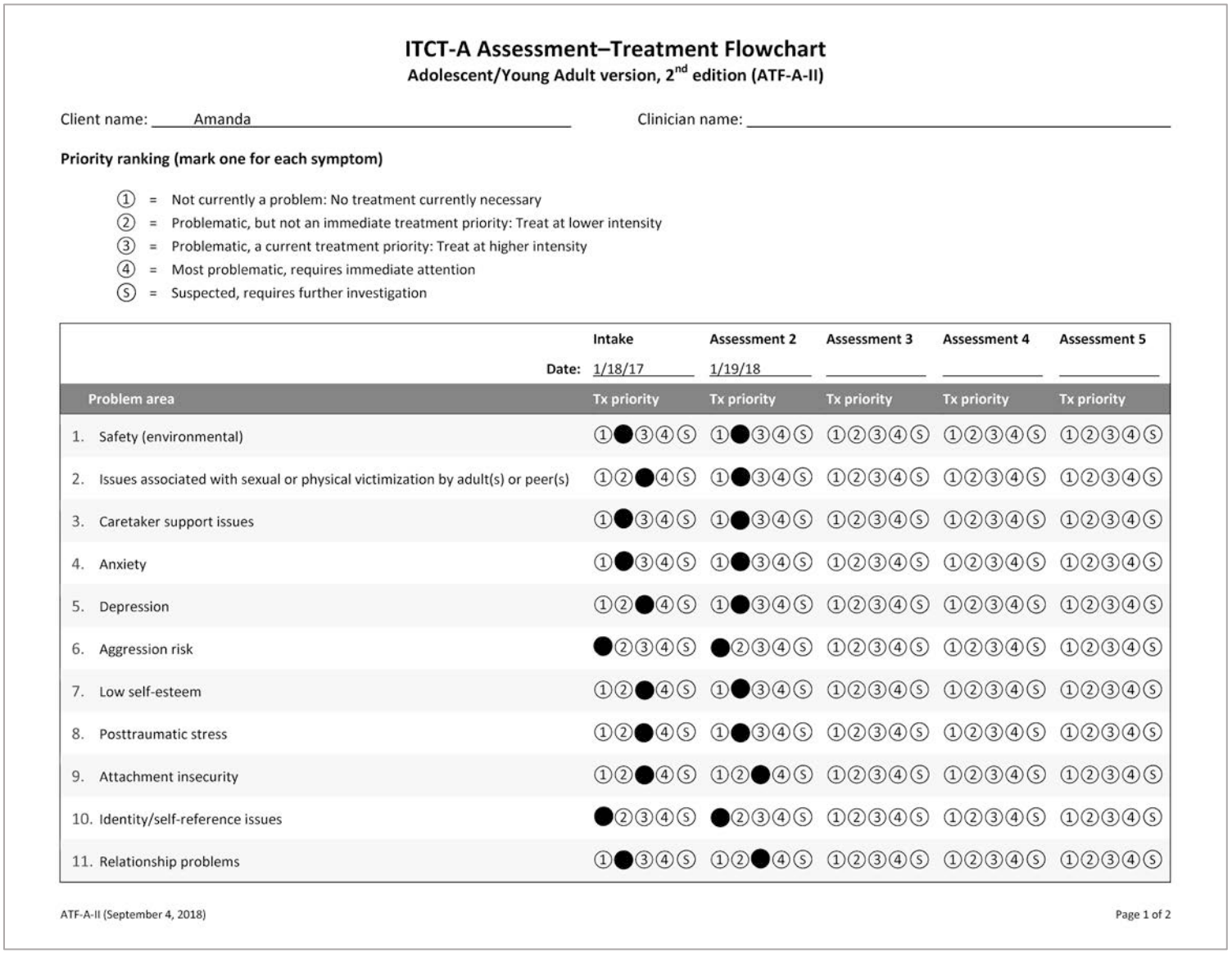
Comorbidities

Her therapist gives her several psychological tests, which she completes in the office prior to her second and third sessions. They indicate some degree of defensiveness (but not invalidity), and clinical elevations on scales measuring PTSD, depression, borderline features, sexual concerns, dissociation, and alcohol problems, but no clinically significant suicidality.

Assessment-Treatment Flowchart-A-II

Amanda's ATF-A-II, completed in session 2, indicated difficulties in a number of areas, some of which are improving and some of which are not. As shown in Figure 1, her ATF-A-II has been completed twice: at intake and two months later.

Figure 1. ***Amanda's ATF-A-II at intake and two months later.***



ITCT-A Assessment–Treatment Flowchart

Adolescent/Young Adult version, 2nd edition (ATF-A-II)

Client name: Amanda Clinician name: _____

Priority ranking (mark one for each symptom)

① = Not currently a problem: No treatment currently necessary
② = Problematic, but not an immediate treatment priority: Treat at lower intensity
③ = Problematic, a current treatment priority: Treat at higher intensity
④ = Most problematic, requires immediate attention
Ⓢ = Suspected, requires further investigation

	Intake	Assessment 2	Assessment 3	Assessment 4	Assessment 5
Date:	1/18/17	1/19/18			
Problem area	Tx priority	Tx priority	Tx priority	Tx priority	Tx priority
1. Safety (environmental)	①●③④Ⓢ	①●③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
2. Issues associated with sexual or physical victimization by adult(s) or peer(s)	①②●④Ⓢ	①●③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
3. Caretaker support issues	①●③④Ⓢ	①●③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
4. Anxiety	①●③④Ⓢ	①●③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
5. Depression	①②●④Ⓢ	①●③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
6. Aggression risk	●②③④Ⓢ	●②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
7. Low self-esteem	①②●④Ⓢ	①●③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
8. Posttraumatic stress	①②●④Ⓢ	①●③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
9. Attachment insecurity	①②●④Ⓢ	①②●④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
10. Identity/self-reference issues	●②③④Ⓢ	●②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
11. Relationship problems	①●③④Ⓢ	①②●④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ

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ITCT-A Assessment–Treatment Flowchart

Adolescent/Young Adult version, 2nd edition (ATF-A-II)

	Intake	Assessment 2	Assessment 3	Assessment 4	Assessment 5
Date:	1/18/17	1/19/18			
Problem area	Tx priority	Tx priority	Tx priority	Tx priority	Tx priority
12. Suicidality	●②③④Ⓢ	●②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
13. Dissociation	①②●④Ⓢ	①②●④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
14. Substance use and abuse	①②③●Ⓢ	①②③●Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
15. Grief	●②③④Ⓢ	●②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
16. Problematic sexual behaviors	①②●④Ⓢ	①②③●Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
17. Self-injury	①②③●Ⓢ	①②●④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
18. Bingeing or purging	●②③④Ⓢ	●②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
19. Other risky behaviors	①②③●Ⓢ	①②●④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
20. Legal/juvenile justice/immigration issues	①②③●Ⓢ	①②③●Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
21. Issues associated with bullying (victim)	●②③④Ⓢ	●②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
22. Issues associated with social response to race/gender/identity/orientation	●②③④Ⓢ	●②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
23. Easily triggered flashbacks, emotions, or behaviors	①●③④Ⓢ	①●③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
24. Emotion regulation/tolerance problems	①②③●Ⓢ	①②●④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
25. Issues associated with prostitution, sex for food/shelter/drugs sexual exploitation	●②③④Ⓢ	●②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
26. Other: Truancy	①②●④Ⓢ	①②●④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
27. Other:	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ

ATF-A-II (September 4, 2018)

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Based on her ATF-A-II, it appears that several issues (Anger/Aggression, Identity Issues, Suicidality, and Grief) were not problems for Amanda, and three others (Safety, Caretaker Support, and Anxiety) were problematic but not in need of immediate attention, either at intake or two months later. Dissociation, Attachment Insecurity, and Truancy were rated as *Problematic, a current treatment priority: Treat at higher intensity*, and did not change from intake to the second assessment period. Amanda's ratings were highest (*Most problematic, requires immediate attention*) for Safety – risky behaviors, Substance Abuse, and Self-injury.

Treatment may have had a positive effect for Depression, Low Self-esteem, and Posttraumatic Stress each of which moved from 3 (*Problematic, a current treatment priority: Treat at higher intensity*) to 2 (*Problematic, but not an immediate treatment priority: Treat at lower intensity*) at the second assessment period. Two other items, Risky Behavior and Self-Injury, improved as well, but are still of major concern (*Problematic, a current treatment priority: Treat at higher intensity*). Importantly, despite some treatment, Substance Abuse remains at a 4 (*Most problematic, requires immediate attention*).

Only two ATF-A-II items, Relationship Problems and Sexual Concerns and/or Dysfunctional Behavior, increased from intake to the second assessment period, likely because Amanda's improving psychosocial functioning has resulted in a healthier, more committed relationship with a peer, which appears to be activating painful memories of early, injurious relationships. Although this may be an example of when a higher ATF-A-II indicates a form of improvement, the fact that the sexual item is at the most extreme level (*Most problematic, requires immediate attention*) is a cause for continuing concern.

SBFR and TG-A-II

On the *Self-injury Behaviors and Functions Review* (SBFR), completed in sessions 3 and 4, Amanda reported high rates of cutting and scratching herself, and occasional instances of punching walls and picking at scabs and unhealed wounds. She indicated that SIB distracted her from feelings of sadness, anxiety, and emptiness, blocked memories and flashbacks, relieved guilt and shame through self-punishment, distracted her when she felt abandoned, and made her feel "alive" at times of unwanted numbness. See Amanda's completed SBFR in Figure 2.

Figure 2. *Amanda's Self-injury Behaviors and Functions Review (SBFR)*

Self-injury Behaviors and Functions Review (SBFR)

Client name: Amanda _____ Clinician name: _____

Please indicate below which of the following things you have done, when you did it, and how often. Do not include anything that you did to try to kill yourself.

Behavior	Your age		The number of times you did this			
	The first time you did this	The last time you did this	In the last 6 months (estimate)	In the last month (estimate)	In the last week	In the last 24 hours
1. Cutting or scratching yourself, with glass, a razor blade, or another object	14	16	20	14	5	2
2. Scratching yourself with your fingernails in order to bleed or feel pain	14	16	15	10	4	2
3. Burning yourself with a cigarette, candle, flame, or a very hot object						
4. Stabbing yourself or piercing part of your body in order to bleed or feel pain (not for decoration)						
5. Biting or chewing some part of your body, other than the inside of your mouth or lips						
6. Biting or chewing the inside of your mouth or lips, enough that there was blood or pain						
7. Picking at your skin, or at scabs	15	16	4	3	1	0
8. Banging your head against a wall or other object						
9. Punching or hitting yourself, with your fists or an object						
10. Punching a wall	15	16	4	2	1	0
11. Cutting a sexual part of your body						
12. Poking yourself in the eye hard enough that it hurt or bled						
13. Burning yourself with acid						
14. Scalding or burning yourself with very hot liquid or water						
15. Rubbing or scraping something against your skin until it burns, bleeds, or makes a mark						
16. Pulling your hair out						
17. Intentionally breaking bones in your arm, leg, hand, or foot						
18. Cutting off some piece or part of your body						

If you have done any of the things listed above, please mark with an X below how much each of the following were reasons why you hurt yourself.

Reason why you did one or more of these things	How often was this one of the reasons why you hurt yourself?				
	Never the reason	Occasionally one of the reasons	Often one of the reasons	Very often one of the reasons	One of the most important reasons
1. To distract yourself from your problems		X			
2. To feel in control of yourself or your body		X			
3. To stop feeling numb or shut down				X	

SBFR (June 28, 2019) Page 1 of 2

Self-injury Behaviors and Functions Review (SBFR)

Reason why you did one or more of these things	How often was this one of the reasons why you hurt yourself?				
	Never the reason	Occasionally one of the reasons	Often one of the reasons	Very often one of the reasons	One of the most important reasons
4. To let people know how you feel	X				
5. To block upsetting memories					X
6. To keep from thinking something		X			
7. To stop feeling upset	X				
8. To stop anxiety or worry			X		
9. To stop sadness or depression			X		
10. To stop a flashback				X	
11. To feel good	X				
12. To feel you were real or alive				X	
13. To feel sexual	X				
14. To keep from feeling sexual	X				
15. To control others	X				
16. To get someone to notice you or pay attention to you		X			
17. To get help	X				
18. To get your anger out				X	
19. To punish yourself				X	
20. To feel back in your body	X				
21. To show people how bad you were feeling	X				
22. To get even with someone	X				
23. To stop feeling empty				X	
24. To feel less bored	X				
25. To calm yourself down	X				
26. To scare yourself	X				
27. To stop from doing something that you shouldn't do	X				
28. To see blood	X				
29. To make yourself unattractive	X				
30. To relieve guilt or shame				X	
31. To stop feeling abandoned or rejected					X
32. To keep from killing yourself		X			
33. To keep from crying	X				
34. To mark yourself as a bad person	X				
35. To let people know that something is wrong	X				
36. To hurt yourself instead of hurting someone else	X				
37. To reduce stress or tension		X			

Amanda's responses to the TG-A-II in session 4 (see page 16), indicate multiple triggers, including perceived abandonment, relational conflict, rejection, sexual stimuli, and people yelling, that resulted in flashbacks and intrusive emotional distress. However, she reported very few ways of dealing with triggers and triggered states, other than trying to avoid them.

PART II. TREATMENT

Based on information from the client and collateral sources, summarized in the ATF-A-II, the next step in ITCT-A is to consult the Problems-to-Components Grid (PCG-A-II), which can be downloaded at *attc.usc.edu*. The PCG-A-II allows the therapist to determine what specific components of ITCT-A can be applied to the problems and symptoms identified by the ATF-A-II. In this way, assessment and treatment are directly linked. Treatment of a specific issue (a) only occurs if it is assessed to be a problem (i.e., has a higher ranking on the ATF-A-II), (b) involves interventions that have been shown to be specifically useful for the issues, and (c) only occurs as long as repeat ATF-A-II assessments indicate that it is still problematic.

The PCG-A-II suggests that self-injurious behavior be addressed primarily through *Trigger Identification and Intervention* (now referred to as *Trigger Management*) and *Distress Reduction/Affect Regulation*. In the current, more in-depth guide, additional treatment components are included as well. Together, the following components are suggested for intervening in SIB, and are outlined in subsequent chapters. The chapter in the ITCT-A Treatment Guide is noted for easy reference.

- *Relationship Building and Support* (Chapter 4)
- *Safety Interventions* (Chapter 5)
- *Psychoeducation* (Chapter 6)
- *Distress Reduction/Affect Regulation training* (Chapter 7)
- *Mindfulness Training* (Chapter 8)
- *Trigger Management* (Chapter 11)
- *Emotional Processing* (Chapters 10 and 13)
- *Relational Processing* (Chapter 13)

Chapter 3: Relationship Building and Support

In general, the psychotherapy outcome literature indicates that the quality of the therapeutic relationship is more predictive of treatment success than the specific techniques of whatever type of therapy is performed (e.g., Martin, Garske, & Davis, 2000; Norcross & Wampold, 2011). This may be especially true for traumatized or marginalized individuals (Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004; Cronin, Brand, & Mattanah, 2014). Relevant to this guide, clinical experience, as well as a small body of research (e.g., Bedics, Atkins, Harned, & Linehan, 2015), indicates that a positive therapeutic relationship is crucial in work with those who engage in self-injurious or life-threatening behaviors, including SIB.

Briefly, as described in Chapter 4 of the ITCT-A Treatment Guide, a good therapeutic relationship allows the client to experience a stable, caring environment within which he or she can address potentially upsetting material and learn new ways of coping, and process childhood maltreatment and attachment schema that are activated by the client—therapist relationship.

In fact, it is often only when the client is able to experience a "secure base" (Bowlby, 1988) and the stress-buffering effects of a positive therapeutic relationship that he or she can explore painful memories and feelings, and process early attachment-related assumptions about self and others. It is almost axiomatic that the youth must be able to trust the therapist—and therapy—enough to be vulnerable and "let down his or her defenses" and re-experience painful memories in the context of perceived safety and acceptance. If safety is not experienced, there will be insufficient disparity between triggered negative expectations and current reality, and memory/relational processing is less likely to occur.

Because many instances of SIB are rooted in child maltreatment and attachment disruption, which engenders fear, distrust, and anger in relational contexts, it is especially important that the therapeutic relationship reflect the opposing qualities of safety, caring, dependability, boundary awareness, and attunement. Per the ITCT-A Treatment Guide, the ideal therapeutic relationship for SIB clients is characterized by

- non-intrusiveness;
- visible positive regard;
- reliability and stability;
- psychological security;

- transparency;
- clarity about the limits of confidentiality;
- visible willingness to understand and accept;
- active relatedness; and
- patience.

Countertransference

Equally important, it is critical that the therapist monitor himself or herself for evidence of countertransference. Many youth involved in behaviors like self-injury view themselves as unacceptable, "bad," and shame-worthy. The child maltreatment and/or insecure attachment typically underpinning the adolescent's SIB often carry with them negative self-perceptions and harsh self-other schema. In this context, it is obviously important that the clinician convey conspicuous and ongoing nonjudgment. Yet, therapists, like others, are likely to experience the triggering of their own histories when treating survivors of trauma and/or attachment disturbance (Dalenberg, 2000). Although such countertransference is entirely understandable, it is antithetic to the needs of the self-injuring youth, whose difficulties may escalate in the face of perceived judgment or devaluation.

Especially relevant to SIB, the self-injuring adolescent may engender in the therapist fears of legal or professional liability, since the client is engaging in behaviors that are (sometimes dramatically) self-endangering. As well, work with SIB-involved youth sometimes can go slowly, with numerous ups and downs. This is often because SIB is a coping strategy, albeit a problematic one, and thus the client may resist giving up a behavior that he or she associates with psychological homeostasis, if not psychological survival. As noted by Linehan (1993), countertransference may be most likely when the client is in obvious psychological distress and yet does not appear to be improving with treatment. Finally, due to attachment problems, the youth may also distrust the therapist, challenge him or her on a regular basis, and do other things that activate the clinician's own issues associated with unfair judgment or criticism.

It is often helpful for the therapist to remind himself or herself that SIB and related behaviors are not freely chosen, but instead are triggered by relational stimuli in the context of inadequate emotional regulation. If the therapist can view the client's self-harming behavior as the logical result of suffering and inadequate internal resources, and see challenging behavior as not personally directed toward the clinician, countertransference is less likely to be a factor. It is

not always easy to maintain this perspective, however, when the youth's SIB is severe, or his or her presentation is especially challenging. For this reason, among others, we highly recommend that clinicians working with SIB-involved clients seek out regular consultation or, if relevant, receive supervision from senior clinicians who are conversant with SIB and countertransferential issues.

Relational Processing

Beyond communicating safety, attunement, and nonjudgment, a positive therapeutic relationship also supports the processing of early memories that motivate SIB. Because self-injury is often associated with child abuse, neglect, and parental disattunement, a positive therapeutic relationship is likely to trigger issues associated with early parent-child attachment and, yet, counter activated assumptions and learning regarding the inevitability of relational danger and deprivation.

Such corrective emotional experiences (Alexander & French, 1946) assist the adolescent in reworking and processing upsetting implicit memories and schema associated with early danger and attachment disruption. The repeated juxtaposition of (a) expectations of maltreatment and rejection with (b) their antithesis in treatment (e.g., safety, caring, and acceptance), can slowly weaken the connection between triggering phenomena and subsequent emotional distress. As described in Chapter 6 of the ITCT-A Treatment Guide, the specific mechanism whereby this occurs include counterconditioning and extinction. However accomplished, reductions in the youth's tendency to be triggered into extreme negative states may translate into a decreased need for avoidance responses such as SIB in the face of relational challenges. See Chapter 13 of the ITCT-A Treatment Guide for additional information on relational processing.

Chapter 4: Safety Interventions

SIB, by definition, involves the use of a self-harming avoidance strategy to deal with triggered, potentially overwhelming internal states. As a result, many self-injuring adolescents risk not only potential disfiguration, infection, or even inadvertent life threat, but also suffer from the conditions that motivate SIB in the first place. For these reasons, along with a positive therapeutic relationship, one of the most important early tasks in the treatment if SIB is to maximize the youth's physical safety, both from dangers in the environment and in terms of reducing self-endangerment associated with self-injury. See Chapter 5 of the ITCT-A Treatment Guide for more information.

Environmental Safety

Most of the environmental safety concerns for self-injuring adolescents do not come from the process of self-injury, *per se*, but from the phenomena that underlie it, such as emotional dysregulation, easily triggered distress, negative self-schema, abuse-related anger, and an elevated risk of victimization from others. The reader is referred to the ITCT-A Treatment Guide for detailed suggestions on increasing the environmental safety of those involved in DRBs such as self-injury. Several points, however, can be briefly made here.

A significant number of those who self-injure often meet, or will later meet, criteria for conduct disorder, borderline personality disorder, or an impulse control disorder, although those psychiatric labels may not be especially helpful (or even meaningful) in actual clinical work with traumatized youth. Apropos of such diagnoses, SIB-involved youth may present with interpersonal difficulties involving some combination of attachment insecurity, chaotic and/or unstable relationships, and easily triggered anger. When this occurs in the context of poor emotional regulation, other DRBs are also likely, ranging from domestic violence and risky sexual behaviors to triggered suicidality. Although somewhat beyond the purview of this guide, it is important to note that those involved in SIB are often prone to other unsafe activities and behaviors as well, and thus the clinician must monitor the client's full range of avoidance behaviors, whether other DRBs, substance abuse, or endangering levels of dissociation, and be prepared to respond to keep the client safe.

Safety in the Context of SIB

The primary dangers associated with SIB include

- infection associated with unclean implements, repeated excoriation, and/or inadequate wound care;
- disfigurement, when self-injury occurs on visible parts of the body, especially the face;
- diminished functioning, when SIB is severe, for example, involving cutting of tendons, eye injury, amputation, and sexual wounding;
- brain injury associated with repeated head banging; and
- inadvertent life threat, generally when self-cutting severs a major blood vessel.

Harm Reduction

Because it is often difficult for the client to give up a behavior that addresses activated, often overwhelming emotional states, it is frequently the case that SIB-involved youth experience ongoing physical risk prior to the eventual termination of this behavior. Short of hospitalization, which is described briefly below, this often means that the best option is *harm reduction* (see https://harmreduction.org). This intervention, often used in the substance abuse field, is predicated on the idea that some problematic behaviors, although dangerous, cannot be discontinued by some clients, or, at minimum, they require relatively extended treatment before they can be terminated. In such cases, failing cessation, the immediate treatment goal is to reduce the potential harmfulness of the behavior.

In the case of SIB, harm reduction generally involves attempting to forestall self-injury for as long as possible after a triggering stimulus or event, and then, if some sort of DRB is inevitable, doing something other than SIB that still reduces triggered distress.

Delaying. Although some clinicians recommend a non-SIB contract, or that the client promises to try to stop SIBs entirely, this is rarely possible for the client. In this regard, most of those involved in SIB would like to stop (Briere & Gil, 1998), but for one reason or another, cannot. As a result, the first goal of intervention is for the client to delay SIB (and other distress reduction behaviors) as long as possible on any given occasion, even if the behavior will ultimately ensue. Note that replacing "do not self-injure" with "try to keep from self-injuring for as long as possible" allows the client to, in almost all cases, succeed at some level. If the plan is for the client to completely stop SIB, he or she is almost doomed to failure—were the client able to "just" stop, treatment would not be necessary. And, when he or she is unable to stop, he or she only has two choices, both of which challenge the therapeutic relationship: he or she can lie and say SIB did not occur, or she or she can "confess" to SIB and potentially experience a sense of

failure and/or shame.

On the other hand, the goal of trying to not self-injure for as long as possible can be met merely by the client trying to not self-injure for however long is possible. If the youth was only able to delay SIB for 30 seconds, for example, he or she still succeeded—especially if his or her usual practice is to self-injure almost immediately after a relational trigger. In general, delaying SIB involves the client learning to (a) "urge surf" the desire to self-injure, and, if that is insufficient, to (b) distract or ground him or herself until the activated state has lost its power. To the extent that delaying is successful, activated distress may fade with time (habituate), such that SIB is no longer necessary, the client can discover that triggered emotional states often can be tolerated, at least temporarily, and affect tolerance can build.

"Urge surfing" is a term first used by Marlatt and colleagues (Bowen, Chawla, & Marlatt, 2011; Marlatt & Gordon, 1985) with reference to Mindfulness-Based Relapse Prevention (MBRP). In the current context, this process involves the client learning to view the urge to engage in SIB as similar to riding a wave—it builds slowly, peaks relatively quickly, and then, if not acted upon, slowly lessens. If the youth can learn to see the need to self-injure as a temporary phenomenon that will lose its intensity over even a short period of time, and "watch" his or her feelings—seeing them not as an imperative for action, but "just" a triggered feeling or thought, then he or she may be able to delay engaging in in SIB, or even eventually avoid it entirely. Urge surfing is described further in Chapter 5 of the ITCT-A Treatment Guide, and in the ITCT-A Mindfulness Treatment Guide, available on *attc.usc.edu*.

Because urge surfing takes time to learn, and often requires some degree of mindfulness training, many adolescents first use grounding or distraction techniques as ways to keep from immediately acting on the urge to self-injure. As outlined in more detail in that chapter, the triggered client may ground himself or herself immediately after being triggered by

- focusing on the immediate environment, including what he or she sees hears, smells, etc., as well as noting the current date and time;
- noticing his or her internal experience, and labeling it as a triggered state, not evidence of danger, rejection, or other abuse-related phenomena;
- reminding himself or herself that he or she is *here* (in the real world) and *now* (not in the past), using statements like
    - "This just a flashback/memory; it's not real."

    - "This is just the past;" or
    - "I'm just triggered."
- using a mindfulness, breathing, or relaxation technique, such as *mindfulness-based breathing* (see Chapter 5 of the ITCT-A Treatment Guide, Appendix E of this Guide, and the ITCT-A Mindfulness Guide at attc.usc.edu).

The clinician is referred to the (2002) text by Lisa Najavits, *Seeking Safety* for additional grounding techniques, and Semple and Willard's *Mindfulness Matters Program* (2019) for helpful mindfulness exercises.

The client may also engage in strategic distraction or self-soothing, which support delaying by pulling his or her attention away from triggered states. As described in Chapter 5, this may include

- leaving or terminating the triggering situation;
- going for a walk;
- calling or texting a safe/supportive other, or a crisis line;
- listening to music; and
- Taking a "time-out" in a place or environment that feels safer and is less triggering.

Replacing. When delaying is insufficient, and a SIB is imminent, it may be necessary for the client to replace the specific SIB with a less detrimental behavior, such as holding ice cubes, doing push-ups or other exercises until they are painful, or holding one's breath. Some self-help groups also recommend lower level SIBs, such as scratching or punching a wall, rather than cutting, although we do not advise suggesting any actual SIB.

Replacing, however, should be a "last ditch" response. Although such activities are often suggested on self-help (and occasionally therapist) websites, we do not recommend this approach unless all attempts at urge surfing, grounding, and distraction have failed and SIB is immanent. This is because such behaviors, although potentially harm-reducing, still involve the use of pain as a way to avoid triggered distress, and rarely teach emotional tolerance. As well, in some cases, replacement behaviors may occasionally trigger more intense urges to self-injure, and thereby increase, not decrease, SIB.

Chapter 5: Trigger Management

Because SIB is almost always a triggered phenomenon, treatment for this problem typically involves some form of *trigger management*[3]. This occurs when the client

- understands and accepts the reality of triggers, including their etiology and their role in his or her current difficulties;
- discovers his or her own specific triggers, for example, certain people, situations, places, or stimuli;
- is able to determine if triggering has occurred at any given moment, thereby allowing him or her to differentiate "real," here-and-now thoughts, feelings, and perceptions from triggered memories of the past; and
- learns how to mitigate or reduce the effects of triggering, so that activated trauma-related sensations, emotions, and thoughts have less impact and thus are less likely to motivate SIB.

The steps of trigger management for SIB are presented below.

Psychoeducation about Triggers and Triggering

It is not uncommon for traumatized adolescents to be unaware of triggers they encounter, or even of triggering, per se. As a result, he or she may experience the need to self-injure as arising out of nowhere, or attribute it solely to whatever is happening in the immediate environment. In the latter case, referred to in ITCT-A as *source attribution errors*, activated early memories are often relived as if they were current perceptions rather than recollections of the past. For example, the triggered youth might attribute the source of his or her sudden rage or intrusive self-hatred to whatever triggered it (for example, perceived rejection or abandonment by someone in the current moment) rather than to activated memories of childhood abuse or neglect. When source attribution confusion can be corrected, for example when the adolescent can say "I've been triggered" rather than "she hates me," the likelihood of SIB may diminish, since there is typically less to be upset about in the current environment than he or she initially believed.

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[3] Previously referred to as *Trigger Identification and Intervention* in Chapter 11 of the ITCT-A Treatment Guide.

Psychoeducation about triggers and SIB often occur in the context of multiple conversations over time, wherein the following points are made:

- People who have experienced child maltreatment often have memories of these events later on in life;
- If the abuse or disattunement occurred in the very early years (i.e., ages one to three or four), these memories can't be recalled autobiographically, but they can be triggered by reminiscent stimuli (trauma reminders) in the current environment);
- Other memories, which may have occurred after ages three or four, can be recalled, but may emerge unexpectedly upon being triggered;
- These triggered memories are generally experienced as if they are occurring in the present moment, and tend to include the painful feelings and thoughts the youth had when he or she was being hurt or neglected;
- When these memories emerge, the person tends to attribute the feeling or thoughts to whatever triggered them, rather than to the original event that produced them.

All of the above may be translated, for example, as "Sometimes when people get reminded of something bad from the past, they suddenly feel very upset, or sad or mad, just like they did when it happened. Has that ever happened to you?"

- If the triggered emotions or thoughts are overwhelming (i.e., exceeding the survivor's emotional regulation capacities), he or she may engage in activities that distract, numb, or produce distress-incompatible states, such as substance abuse, indiscriminate sexual activities, aggression, or, in the current context, self-injury.

For example, "When memories are too upsetting, sometimes people do things that take the feelings away, like cutting or hurting themselves."

- Unfortunately, almost all of these activities have significant downsides, ranging from potential addiction to risk of illness or even death, and tend to block processing of traumatic memories.

For example, "Sometimes cutting or hurting yourself makes you feel better for a little while, but it has bad effects, too, like making you feeling ashamed of yourself, scars that won't go away, or sometimes even risking your life."

Importantly, warning clients of the risks of avoidance behaviors like SIB must be done without resorting to scare tactics, and should occur in a nonjudgmental, nonpathologizing way. Often, this topic can be introduced by the therapist gently asking the youth whether his or her self-harming behaviors are in any way problematic for him or her, and whether he or she would consider stopping SIB were it possible to do so. In general, psychoeducation about the risks of self-injury may be most effective when it involves a two-way, nonconfrontational conversation between client and therapist about the "plusses and minuses" of problem behaviors, as opposed to the clinician lecturing the client or merely providing written materials.

When successful, such conversations tend to unfold over time, and are

- jargon-free;
- culturally relevant;
- respectful of the youth's need for survival strategies; and
- can be integrated into his or her life.

Trigger Identification

Following psychoeducation about triggering, SIB, and the associated risks, the next step in trigger management is to help the youth to identify specific triggers in his or her environment that activate unwanted sensory or emotional memories and label them as triggers, which can then help him or her predict or identify triggered responses.

Trigger identification is not always easy, especially if source attribution problems obscure the presence of a trigger and/or the associated triggered state. As well, it requires the youth to objectively evaluate the environment to see what trauma-reminiscent stimuli regularly precede SIB or other problematic behavior, for example, someone reminiscent of an emotionally abusive mother or a sexually abusive uncle. Other potential triggers, most of which tend to be interpersonal in nature, include, but are not limited to:

- interpersonal conflict;
- criticism;
- perceived rejection, disattunement, or abandonment;
- physical touch;
- angry faces;
- the smell of alcohol;

- sexual situations or stimuli;
- interactions with authority figures;
- boundary violations;
- betrayal; and
- someone crying or yelling.

Notably, trigger identification tends to occur throughout treatment—although the youth may only be able to identify one or two triggers initially, the goal is to uncover as many of them as possible over time. As he or she becomes more aware of the number and power of triggers, and their basis in the past, the client often becomes less reactive to them, seeing them as activated sensory-emotional memories rather than environmental events that are "real" and indicate danger or loss. Throughout this guide, the growing ability to know that some perceptions and experiences are not based on what is actually happening in the world, but rather are actually triggered sensory and/or emotional memories, will be referred to as *metacognitive awareness*.

Using the Trigger Grid and the Self-injury Behaviors and Functions Review

Trigger management, and increased metacognitive awareness of triggered states, can be aided by the *Trigger Grid, Adolescent version, 2nd edition* (TG-A-II) is shown in Appendix C and downloadable at attc.usc.edu. This worksheet, which is completed by the client and therapist together early in treatment, and on multiple occasions thereafter—is a way for clients and therapists to identify the adolescent's major triggers, explore triggered states and how to identify them, and to problem-solve strategies that can reduce the likelihood of distress reducing behaviors, including SIB. For example, the section on "What Happened After You Got Triggered?" provides an opportunity for the youth to explore the thoughts, feelings, and behaviors associated with each major trigger, so that triggering becomes more obvious to him or her, and his or her responses to the trigger are better understood as reactions to the past, not the present.

As noted earlier, the TG-A-II refers to any trigger, triggered state, and distress-reduction behavior, as opposed to the specific focus of the *Self-injury Behaviors and Functions Review* (SBFR). As such, we recommend that it be completed in a session prior to administration of the SBFR, since it sets the stage for the latter's more SIB-specific items. When SIB is the prominent problem, or the clinician wishes to specifically apply the TG-A-II to the youth's SIBs, it may be

administered a second time, with the instruction that the client just focus on SIBs. Importantly, the TG-A-II and/or SBFR should be re-administered on any occasion when new trigger or SIB information comes to light.

The SBFR is specifically focused on SIB, and aids trigger management by mapping out the frequency, recency, and functions of self-injury. Because it breaks SIB down into 18 specific behaviors (e.g., cutting, burning, head banging), each of which is rated according to time of onset, frequency, and acuity, it highlights for the client (and clinician) the extent of the problem, and points to SIBs that might not otherwise be considered as such (e.g., punching walls or poking eyes). It then queries, in detail, the client's motives for SIB, whether it be to distract from triggered distress, increase a sense of control, or self-punish. As the adolescent responds to these items, two processes tend to occur. First, identification of the underlying functions of SIB for a given client can inform the clinician about which components of ITCT-A might be most effective in lessening the need for self-injury. For example, endorsement of:

- dissociation/numbing items (e.g., *To feel you were real or alive, To stop feeling numb or shut down,* and *To feel back in your body*) suggests the potential value of post-trigger grounding activities and, potentially, mindfulness exercises;
- distress-reduction items (e.g., *To stop feeling upset, To calm yourself down*, and *To reduce stress or tension*) signals the specific need for emotional regulation training;
- items tapping communication of distress or isolation (e.g., *To let people know how you feel*, *To get someone to notice you or pay attention to you*, and *To let people know that something is wrong*) suggests the value of relationship building and processing, as well as interventions that increase communication between the client and significant others (e.g., family or couple's therapy); and
- intrusion items (e.g., *To block upsetting memories, To stop a flashback,* and *To stop feeling abandoned or rejected*) indicates the need for emotional processing of trauma and/or attachment memories.

Second, the process of linking behaviors to underlying motives increases the client's metacognitive awareness of triggers and their functions, which may depathologize SIB and increase his or her "buy in" for interventions that address distress reduction behaviors.

Trigger reduction. Trigger identification via the TG-A-II and/or the SBFR can also help the adolescent proactively avoid situations where he or she otherwise might be triggered, or at

least may keep him or her from being as triggered as otherwise might occur. For example, once more trigger-aware, the client might learn to avoid specific triggering stimuli (e.g., intoxicated people, certain sexual acts, violent movies, arguments, or interactions with controlling or abusive individuals) that otherwise would lead to SIB. Although some degree of trigger exposure is inevitable for many trauma survivors, trigger reduction nevertheless can help the youth to

- reduce the turmoil in his or her life;
- feel more "in charge" of his or her environment; and therefore
- increase his or her overall emotional stability.

State Identification

Although many triggers are obvious and easily recognized (for example, sexual stimuli triggering memories of previous sexual victimization, or sudden anger or fear when encountering someone reminiscent of a past perpetrator), this is not always the case. Triggers are less easily identified when

- source attribution errors are more prevalent (for example in conflictual relationships, during which anger or fear may appear to be based solely on current difficulties);
- the trigger has not been identified before, because it is rare (for example, being triggered by someone speaking a rarely-encountered foreign language that was prevalent at the time of the trauma);
- the original memory was preverbal, and thus the client cannot recall the circumstances of the trauma, or stimuli that were present at the time and serve as triggers; or
- the trigger activates dissociation, denial, or another avoidance strategy and blocks the client's awareness that a trigger is present.

For these and related reasons, trigger identification is sometimes *indirect*—the youth may initially be unaware that a specific trigger is having an effect, and can only infer that one is present based on his or her reactions. For example, although the adolescent has not identified a trigger in his or her environment, he or she may notice

- a thought, feeling, or sensation that doesn't fully "make sense" in terms of what is happening around him or her;
- a thought and/or feeling that is too intense, based on the current context;
- a "mini-flashback," for example, a brief intrusive image or sensation from the past;

- a thought or feeling that carries with it explicit memories of a past trauma;
- an unexpected alteration in awareness (e.g., sudden depersonalization or derealization); or
- somatic experiences, such as a racing heart, shortness of breath, or dizziness.

In this way, the client may be able to indirectly identify the likelihood that he or she has been triggered—not by locating the trigger in his or her environment, but instead based on the fact that his or her current state is similar to what he or she experiences when triggered. The youth may learn to make these connections between current experience and triggering as a function of ongoing discussion with the therapist. This also can be facilitated by his or her responses to the *What happened when you got triggered* section of the TG-A-II, particularly the questions about thoughts, feelings, and behaviors following previous instances of having been triggered.

Intervention in Triggered States

Once the client is able to determine (either directly or indirectly) that he or she has, in fact, been triggered, the next step is for him or her to address the triggered state so that it is less able to motivate subsequent self-injury. In general, the ITCT-A approach involves teaching the youth how to manage triggered responses within the session, so that he or she can apply learned strategies later, when triggered outside of treatment. By working out interventions beforehand, the triggered adolescent does not need to figure out what to do *after* being triggered, a time when he or she is likely overwhelmed, distracted, and highly distressed. Instead, he or she can call on what he or she learned in prior sessions, and thereby respond in a more effective and self-protective manner.

Increasing Metacognitive Awareness

Although much of this section of the guide is concerned with specific ways in which the client can problem-solve triggered states and thereby intervene in SIB, one aspect of intervention, metacognitive awareness, often arises during psychoeducation and trigger management. As the client becomes more adept at discriminating memories from current perceptions, he or she often gains some degree of objectivity, or at least increased emotional distance, when triggered. This, in turn, serves to reduce the power of the thoughts and feelings and lessens the likelihood that SIB and other problematic distress-reduction behaviors will occur.

As noted earlier, increased insight into the triggering process is a form of metacognitive awareness. For example, an adolescent who was exposed to psychological abuse and witnessed domestic violence as a youth, may learn during treatment that experiencing interpersonal conflict. triggers feelings of helplessness and anger, which then motivates self-injury. As a result, he or she may realize that he is not "really" mad about what is currently happening, but rather is being triggered by it. And if, in fact, there is little to be upset about in the current context (e.g., it is "just" an argument), immediate anger or helplessness may lessen, and the likelihood of self-injury may decrease.

Direct Actions to Alter or Terminate Triggered States

As described in the ITCT-A Treatment Guide and elsewhere, there are a number of ways the client can intervene in triggered states. Many of these strategies can be generated when the client, together with significant input from the therapist, completes the TG-A-II, as described on page 31. As noted earlier, when self-injury is an issue, the TG-A-II can be completed twice: once for all potential DRBs, and once for SIBs in particular. Both can provide the youth with opportunities to problem-solve triggered states. Specifically, the final section of the TG-A-II is "*What do you think you could do after you get triggered that would make it better and you wouldn't get so upset, scared, or mad,"* answered for each of the triggers that the youth has identified in treatment. Strategies relevant to this section, most of which are outlined in detail in Chapter 4 of the ITCT-A Treatment Guide, include the following, either immediately after the trigger, or, if triggered states persist, in the ensuing hours.

- ***grounding, relaxation, and breathing exercises*** (see Appendix E for a mindfulness-based breathing exercise);
- ***self-soothing***, such as eating (but not bingeing) on a favorite "comfort" food, hugging or holding oneself, or saying comforting or self-compassionate things to oneself;
- ***analyzing the triggering stimulus or situation***, until a greater understanding changes one's perception and thus terminates the trigger. For example,
    - examining the behavior of an individual who is triggering posttraumatic responses, and becoming more aware of the fact that this person is not actually acting in a threatening or problematic manner; and
    - coming to understand that a given individual's seemingly dismissive or

disengaged style does not indicate a desire to reject or ignore as much as it does interpersonal awkwardness or self-preoccupation.

- ***practicing acceptance and self-compassion***. Based on research indicating that intrusive thoughts, emotions, and memories actually intensify when avoided or denied (the *suppression effect*; Briere, 2013), acceptance refers to nonresistance—not fighting or attempting to block triggered internal states, but instead allowing them to occur. Because acceptance can be difficult, this response also includes *self-compassion*—appreciating how difficult it can be to allow these experiences to occur without pushing them away, and honoring the bravery involved. The *ReGAIN-A* procedure described below is one application of this strategy.
- ***strategic distraction,*** so that the client's attention is pulled away from triggered, sometimes escalating internal states, such as
    - exercise;
    - reading;
    - conversations with safe/supportive others, including by phone when immediacy is important, for example, calling or texting a friend or AA sponsor to debrief an upsetting situation;
    - listening to music;
    - expressive activities, such as art, writing or journaling, or playing an instrument
    - yoga or tai chi; or
    - taking a "time out. Examples include:
        - leaving a party when triggered by people who are intoxicated or seemingly out-of-control;
        - intentionally minimizing interactions or arguments with triggering authority figures;
        - learning how to discourage unwanted flirtatious behavior from others that is triggering; and
        - going for a walk after being triggered.
- ***positive self-talk and metacognitive statements*** might include:

- "I am safe."
- "I don't have to do anything I don't want to do."
- "I'm being triggered, this isn't real."
- "This is just my past talking; this isn't really what I think it is."

ReGAINing

Mindfulness teachers Michele McDonald (see https://learn.tricycle.org/courses/rain) and Tara Brach (2013) initially developed what has become a popular technique for decreasing reactivity, referred to by the acronym RAIN, which suggests four steps for responding to an upsetting event: *Recognize, Allow, Investigate, and Nonidentify.* This exercise has been adapted to specifically assist those triggered by trauma reminders in their environment, and is presented here for adolescent trauma survivors (*ReGAIN for Adolescents; ReGAIN-A*). Reflecting many of the interventions suggested in this guide, ReGAIN-A consists of the following steps, which may require simpler language for younger adolescents (see Appendix F for possible wording).

- ***R****ecognize* that you are triggered, and that you are probably in a triggered state.
- ***G****round yourself.* Not included in the traditional RAIN procedure, this step encourages the youth to engage in activities that allow greater stability and self-support when experiencing the immediate effects of triggering. Grounding in the ReGAIN-A context involves activities such as
    - mindful breathing;
    - a brief relaxation exercise;
    - engaging in metacognitive and self-compassionate self-talk;
    - strategic distraction; and
    - attending to the immediate environment rather than to one's internal experiences.
- ***A****llow* yourself, *as best you can*, to experience whatever is coming up, without resistance, and with self-compassion. As noted earlier, "allowing" can be challenging, since many youth involved in SIB have reduced emotional tolerance capacities. However, this step can be practiced over time, with early attempts involving "just" *feeling the feeling* without acting on it for a few seconds, or as long as possible, until the client gets better at allowing and tolerating internal awareness of painful states.

Self-compassion in this step means appreciating how hard it is to be in a situation where one is triggered and feels compelled to engage in SIB, let alone trying to sit with activated memories. Notably, it is entirely acceptable for the adolescent to return to the *Grounding* step when *Allowing* is especially challenging.

- ***I**nvestigate* how you are triggered, where the thoughts or feelings come from, and why they make you upset. Among the questions that can be investigated are those discussed in the trigger identification section of this guide, including:
    - "What is triggering me?"
    - "Why is it happening right now?"
    - "Where do these triggers come from?"

As Brach (2013) noted more generally, it is important that the youth know that *Investigation* does not involve evaluation of his or her supposed inadequacies or symptoms—rather it is intended as a self-compassionate examination of triggering and triggered states.

- The final step in ReGAINing is *Do **N**ot always believe your triggered thoughts or feelings*. Sometimes more difficult to explain to younger people, this means not to identify oneself with whatever one is thinking or feeling. A form of metacognitive awareness, the youth is encouraged to remind himself or herself that triggered experiences aren't "real"—they are just triggered thoughts, feelings, or memories. They aren't the client; they are just what the client is experiencing. Metacognitive self-statements that may facilitate nonidentification include:
    - "Just because I think/feel that doesn't mean it's true."
    - "These are just thoughts, not facts."
    - "I am not defined by my history or how people judge me."
    - "I feel something, but these are just feelings, they aren't who I am."
    - "I am not my thoughts, they are from the past."
    - "Although I feel unlovable right now, that doesn't mean that I am an unlovable person."
    - "Just because I was raped as a kid doesn't mean that I am a lifelong victim, or that I deserve for people to treat me badly."
    - Even though I sometimes blame myself, abuse was what was done to me—it

doesn't have anything to do with who I really am."

Although the ReGAIN-A exercise is a useful component of trigger management and intervention for older youth, it may be too abstract for some younger adolescents, or those with significant cognitive impairments. When appropriate, however, it may be helpful to photocopy Appendix F so that the youth can carry it around with him or her.

A more compact option, also found in Table F, is a Pocket Card version of the five steps of ReGAIN, which can be photocopied and carried by the adolescent so that he or she has a way to remind him or herself of the ReGAIN exercise. Note that ReGAIN-A is likely to be most helpful when it is repeatedly discussed—and perhaps practiced—in therapy sessions, so that its more abstract elements are understood by the adolescent.

Chapter 6: Emotional Processing

For some adolescents, especially those with significant emotional regulation difficulties and/or who are chronically unstable, treatments for SIB may be limited to the previous chapters of this guide. In this case, therapy will involve repeated, appropriately-timed interventions, ideally conducted within a caring, supportive, and safe therapeutic relationship. These may include

- harm reduction and other safety interventions;
- psychoeducation;
- emotional regulation skills development; and
- opportunities to learn trigger management skills.

For such youth, premature use of the last component of the ITCT-A approach to SIB—emotional processing—might potentially overwhelm underdeveloped affect regulation and tolerance capacities, leading to dropout, continued SIB, or other unwanted outcomes.

Nevertheless, a significant number of adolescents who engage in SIB are able to tolerate some degree of therapeutic exposure to, and processing of, attachment or trauma memories. When this is possible, the client may be able to more directly address the actual triggered distress that underlies self-injury. However, because SIB almost always signals at least some level of emotional regulation disturbance, emotional processing typically must be conducted more slowly and often with initially less intensity than may be true for those who do engage in SIB or other DRBs. As a result, this last chapter focusses on how therapeutic exposure to attachment and trauma memories can be done with those suffering from less than robust emotional regulation capacities. The reader is referred to the ITCT-A Treatment Guide for more detailed information on the ITCT-A approach to this issue.

Central Principles of Emotional Processing for those Involved in SIB

Before emotional processing can be considered for a specific SIB-involved client, the clinician should ensure that

- safety and harm reduction procedures are in place;
- proper assessment has occurred, including the client's overall level of posttraumatic distress and current emotional regulation and tolerance capacities;

- the youth has received sufficient focus on emotional stabilization, psychoeducation, grounding skills development, and trigger management; and
- there is sufficient time (i.e., number of remaining sessions) for emotional activation, processing, and consolidation to take place.

If these conditions are met, we recommend the following adaptations to traditional exposure therapy for those who engage in SIB. In each instance, the goal is for the client to process attachment- and trauma-related memories, while not becoming overwhelmed or adversely affected by excessive emotional activation. Importantly, the following recommendations do not, by themselves, constitute an entire trauma treatment protocol. Instead, they should be considered useful principles and techniques that can be emphasized or added to the ITCT-A approach to emotional processing.

Prebriefing

Although shown in various studies to be helpful for many traumatized children and adolescents (Cohen, Mannarino, & Deblinger, 2017), therapeutic exposure nevertheless can be distress-producing, since it asks the trauma survivor to consciously engage memories that he or she has spent considerable time avoiding. The increase in distress associated with discussing previous traumas can lead to dropout (Najavits, 2015), reluctance to engage in exposure exercises (Markowitz et al., 2015), and other understandable client behaviors that interfere with treatment. For this reason, an important aspect of trauma therapy is prebriefing, which is explaining the rationale for therapeutic exposure, and its general methodology, before beginning treatment. Without sufficient explanation, the process and immediate effects of exposure may seem so illogical and stressful that the adolescent client may automatically resist and avoid exposure activities. However, if exposure can be explained so that the youth understands the reasons for exposure activities, there may be client "buy-in" for the notion of re-experiencing past traumas in the sessions. As described in the ITCT-A Treatment Guide, prebriefing ideally will include the following points:

- Unresolved memories of the trauma often have to be talked about, or else they may not be fully processed and will be more likely to keep coming back as symptoms or unwanted feelings.
- Although it makes sense to not want to think about what happened, and to do things

to keep from doing so, such avoidance often interferes with recovery.

- If the client can talk about what happened enough, in the safety of treatment, the distress associated with the trauma is likely to decrease, although this cannot be promised.
- Some people who undergo therapeutic exposure experience a slight increase in flashbacks, nightmares, and/or distressing feelings between sessions. This is normal and usually not a bad sign—in fact, it may signal that the client is processing traumatic memories. However, the youth should inform the therapist when this occurs, so that he or she can monitor whether exposure has been too intense.
- The therapist will work to keep the discussion of these memories from overwhelming the client, and the client can choose to stop talking about any given memory if it becomes too upsetting. The adolescent need only talk about as much about the trauma(s) as he or she is comfortable with. However, the more he or she can remember, think, feel, and talk about non-overwhelming memories during therapy, typically the better.

Titrated Exposure within the Therapeutic Window

From the ITCT-A perspective, therapeutic exposure occurs when the youth is asked to recall non-overwhelming but moderately distressing traumatic experiences in the context of a safe therapeutic environment. A central principle of emotional processing with those who suffer from reduced affect regulation capacities—including many SIB-engaged youth—is that such exposure be *titrate*d. In this context, titration refers to adjusting the exposure process so that there is enough memory activation to ultimately reduce trauma symptoms, but not so much that it exceeds the client's emotional regulation resources and overwhelms him or her, potentially leading to additional stress and even more avoidance. In general, maintaining this balance is referred to as *working within the therapeutic window* (Briere & Lanktree, 2013), where the window is the hypothetical "place" where therapeutic interventions are neither so trivial or nonevocative that they provide inadequate memory exposure and processing (referred to as "undershooting"), nor so intense or prolonged that the client's balance between acceptable memory activation and overwhelming emotion is tipped toward the latter (referred to as "overshooting").

As noted in the ITCT-A Treatment Guide, overshooting the window is considerably

more risky than undershooting it—perhaps especially for those involved in distress reduction behaviors such as SIB. Overshooting generally occurs when the clinician either

- inadvertently provides too much therapeutic exposure and, therefore, too much emotional activation relative to the client's existing emotional regulation capacities; or
- is unable to prevent the client from flooding himself or herself with overwhelming traumatic distress.

Interventions that are paced too quickly may overshoot the window because they do not allow the adolescent to adequately accommodate and desensitize previously activated material before triggering new memories. When therapy consistently overshoots the window, ironically, the adolescent may have to engage in within-treatment avoidance in order to keep from being overwhelmed by the therapy process. He or she may also leave the session in an overactivated state, potentially leading to further SIB or other avoidance behaviors as the client seeks to regain internal homeostasis.

Multiple Targets

In classical prolonged exposure, the client is asked to pick a single trauma—often the most upsetting one—and then process that memory for extended periods of time over multiple sessions. In contrast, the ITCT-A approach with SIB-involved youth encourages the client's choice of exposure target at any given moment in time. For example, he or she might start with a recent assault experience, then later switch to an instance of childhood sexual abuse, and then, perhaps, to a memory of homophobic taunting as an early teen. Instead of constraining the adolescent to discussion of a single adverse event, ITCT-A supports his or her discussion of—and thereby his or her exposure to—whatever trauma seems important at a given time, or whatever memory is triggered by any other memory. As noted, many clients have been exposed to multiple traumas and attachment disruptions in their lives, the memories of which interact with one another and, cumulatively, better predict posttraumatic outcomes than single-event traumas (e.g., Briere, Agee, & Dietrich, 2016). In such contexts, multi-target processing may be more efficient, and potentially less overwhelming, than a series of separate, extended exposure interventions for each of a large number of distressing memories.

An important aspect of client-determined exposure targets is that the youth's autonomy is honored, since he or she is free to discuss whatever he or she thinks is most important in the

moment. As noted by Linehan (1993), such control over the treatment process "may itself be therapeutic and render future exposure less frightening" (p. 352). As well, clinical experience suggests that when the client has the freedom to decide what he or she will talk about, especially when prebriefing has occurred beforehand, he or she tends to return to the most significant memories on a regular basis. These repeatedly selected memories, in turn, are likely to be the ones the client most needs to process, and thus may be associated with the most benefit.

Limited Exposure Periods

Because prolonged exposure to trauma memories can be challenging for many complex trauma survivors, the ITCT-A approach suggests, in most cases, shorter exposure periods. This recommendation is based not only on the fact that SIB-involved youth typically have reduced emotional regulation capacities, and thus may be more likely to be overwhelmed by extended exposure periods, but also recent research on the relative unimportance of extending emotional activation over long periods of time (*habituation*) on therapeutic exposure outcome (e.g., Baker et al., 2010; Prenoveau, Craske, Liao, & Ornitz, 2013).

The probable irrelevance of habituation—the most cited basis for extending exposure—to clinical outcomes raises the question of whether long exposure periods are necessary, especially given that it can be aversive or intolerable for some (e.g., Morris, 2015), runs the risk of overwhelming those with limited emotional regulation capacities (Levitt & Cloitre, 2005), 2005), and may motivate premature dropout (Najavits, 2015). Probably apropos of the relative unimportance of habituation in emotional processing, recent studies indicate that exposure periods of 30 minutes or less are just as effective as the more prolonged exposure (often 45 to 90 minutes) previously suggested in reducing posttraumatic stress (e.g., Nacasch et al., 2015; Sloan, Marx, Lee, & Resick, 2018). For example, Foa and McLean (2016) conclude that "the fact that within-session fear reduction does not predict treatment outcome suggests that the length of PE [prolonged exposure] sessions can be shortened without compromising efficacy" (p. 11).

Given these issues and findings, we suggest that the average SIB-involved youth not be asked to process any given trauma memory for more than 15-20 minutes at a time, unless they have demonstrated that they can tolerate more prolonged exposure. In fact, to the extent that multiple targets are involved, long exposure periods may not be an issue. For example, a youth might discuss one trauma for ten minutes, and then choose to move onto another memory for a shorter or slightly longer period of time, then return to the first memory or go onto a new one,

perhaps for an additional 10-15 minutes. Although many ITCT-A clinicians already support shorter duration, titrated exposure to multiple memories within a session, the newer research cited above is more supportive of this approach than what had been suggested previously.

Interspersal

In addition to shortened exposure periods, emotional processing in ITCT-A is often aided by *interspersal*. This involves interspersing short exposure periods with nondistressing—if not calming or grounding—activities, such as those described in Chapter 6. For example, the adolescent client might undergo ten minutes of exposure to a trauma memory, followed by five minutes of a breathing exercise (see Appendix E), then perhaps another exposure period, followed by a grounding exercise. Typical interspersal activities include exercises involving:

- relaxation;
- breathing;
- grounding;
- mindfulness;
- therapist encouragement, praise, support, or reflections on the client's progress; and
- time-limited discussions of nontraumatic or pleasant topics.

Existing research suggests that relaxation or mindfulness exercises before or after exposure periods do not interfere with processing (e.g., Meulders, Van Daele, Volders, & Vlaeyen, 2016; Tryon, 2005), and, in fact, are likely to increase the tolerability of exposure, contribute to the client's sense of self-efficacy (Linehan, 1993; Meulders et al., 2016), have neuropsychological effects that facilitate recovery from posttraumatic stress (King et al., 2016; Treanor, 2011), and in the case of post-exposure interspersal, reduce unresolved exposure-based distress (e.g., Peck, Schumacher, Stasiewicz, & Coffey, 2018). Finally, interspersal may provide positive, relatively distress-incompatible states that promote counterconditioning of traumatic memories.

Emotional Processing Revisited

Although treatment for most SIB-involved adolescents initially begins with assessment, safety interventions, relationship building, and trigger management strategies, in many cases emotional processing may also be helpful, albeit typically later in therapy. This is because, as noted, most young clients who self-injure and engage in other distress reduction behaviors have

histories of early trauma exposure and attachment dysregulation—experiences that are encoded in memory and are easily triggered by later relational stimuli. Unfortunately, unlike some other clients, those who self-injure often suffer from emotional regulation difficulties, and thus can be more easily overwhelmed by therapeutic exposure approaches most often used to address trauma. This leads to a dilemma—the best treatment for traumatic memory is, to some extent, least available to trauma survivors most in need of it.

Fortunately, emotional processing via therapeutic exposure need not be ruled out for many SIB-involved youth. Instead, the issue is whether exposure can be delivered in a way that is not overwhelming, and that does not motivate dropout or lead to even more distress reduction behavior. This can be accomplished as outlined in this chapter, generally involving

- titrated exposure;
- attention to the therapeutic window;
- limited exposure periods; and
- interspersal of grounding or deescalating activities between exposure episodes.

In general, these adaptations to classic exposure therapy may be implemented in some version of the following, although specific interventions will vary from client to client:

- Assess the client's trauma history, history of SIB, emotional regulation capacity, and any comorbidities, in order to determine if trauma processing is appropriate, and the extent to which titrated exposure is specifically indicated.
    - If not, focus on psychoeducation, relationship building, and trigger management—including trigger identification and emotional regulation skills development—until he or she is able to tolerate some level of activated distress in therapy.
- When some form of therapeutic exposure is possible, and deemed potentially helpful
    - Prebrief the youth on the reasons why talking about painful things from the past might be helpful, noting that he or she is in charge of the exposure process, including what memories he or she wants to address, with what intensity, and for how long.
    - As the client describes previous adverse events, monitor his or her level of

emotional activation, so that he or she does not become overwhelmed by the material.

- If he or she appears close to exceeding the therapeutic window, work to bring him or her back down to tolerable levels of activation, by
    - focusing on less upsetting, perhaps more cognitive material;
    - allowing the client to terminate processing for the moment, or at least decrease its intensity;
    - shortening exposure periods, and/or by
    - interspersing exposure periods with grounding, relaxation periods, breath exercises, or a mindfulness activity (for examples, see Semple & Madni, 2015; Semple & Willard, 2019).
- On occasions when the youth is able to tolerate some level of exposure, facilitate processing by asking questions about
    - the trauma;
    - his or her reactions to it at the time;
    - the meaning he or she ascribed to it then, as well as how he or she views the experience now;
    - intersperse as needed, in order to
        - break up exposure periods, and
        - provide positive emotional experiences that can serve to countercondition memory-related distress.
- Provide ongoing support and validation around the client's courage and resilience, such that he or she is able to engage in therapeutic exposure.
    - Consider ending the exposure process at least 10-15 minutes prior to the end of the session, so that the youth can
        - deescalate any exposure-related distress,
        - discuss the session with the therapist so that
            - a coherent narrative can be formed;
            - any insights, meaning, or closure can be extracted and

formalized; and

- the client has time to prepare for the "real world," and thereby transition out of therapy in a gradual, integrated manner.

Notably, emotional processing is not the last stage of treatment for SIB-involved adolescents; it is, instead, just one of several components of ITCT-A which may alternate and recur throughout the treatment process. For example, the client or therapist may determine that, after some attention to therapeutic exposure, more stabilization, psychoeducation, or trigger management is indicated, perhaps then followed by more emotional processing. In some cases, often when the youth has developed sufficient emotional regulation capacities, family therapy, and/or group treatment with other trauma survivors also may be helpful, as per the ITCT-A Treatment Guide.

Chapter 7: Conclusion

This treatment guide outlines central principles relevant to the treatment of SIB in adolescents, using the evidence-based intervention, ITCT-A. Each of the treatment components of ITCT-A are relevant to SIB, but especially include

- assessment with a new SIB-specific measure, *the Self-injury Behaviors and Functions Review* (SBFR), repeated application of the *Assessment-Treatment Flowchart* (ATF-A-II), and additional use of the *Trigger Grid* (TG-A-II);
- safety interventions, including harm reduction; and
- emotional processing, using
    - prebriefing;
    - titrated exposure;
    - client control over exposure targets; and
    - limited exposure periods.

An updated version of *Trigger Identification and Intervention* module, *Trigger Management,* is introduced, which offers new strategies for

- identifying triggers and triggered states, in part through the development of metacognitive awareness; and
- deescalating triggered responses through
    - grounding;
    - relaxation;
    - breathing exercises (including the *Mindfulness-based Breathing* exercise);
    - self-soothing;
    - strategic distraction;
    - positive and metacognitive self-talk;
    - increasing mindfulness and metacognitive awareness;
    - "analyzing the situation;"
    - practicing acceptance and self-compassion; and
    - using an adolescent version of the ReGAIN procedure.

Although all of these tools and approaches may be useful, no technique or worksheet is

likely to be helpful with traumatized adolescents without continuous attention to the therapeutic relationship. As noted in Chapter 3, the therapeutic outcome literature, over all, indicates that a stable, caring, compassionate, and boundary delimited relationship is perhaps the largest contributor to positive treatment results. Clinicians who work with ITCT-A continuously report in workshops and consultations that these aspects of a positive therapeutic relationship must be present before psychoeducation, emotional regulation skills development, or—in particular—titrated exposure can be effective. This may especially be the case with SIB-involved youth, who often struggle with shame, anger, attachment difficulties, and social alienation.

For this reason, we recommend that the therapist devote considerable attention to communicating visible compassion, acceptance, and patience when treating self-injuring youth. It is also important that the clinician apply these same qualities to him or herself, and seek out consultation and collegial support whenever possible. Ultimately, such valuable—and challenging—work should not be done alone.

Appendix A. Initial Trauma Review, Adolescent version, 2nd edition (ITR-A-II)

This semi-structured interview allows the clinician to cover the primary forms of trauma potentially experienced by adolescents (i.e., those between the ages of 12 and 21). The clinician may wish to paraphrase these questions in order to make them "fit" better into the session. However, (1) try to use the behavioral descriptors (don't just ask about "abuse" or "rape") and (2) only ask as many questions at a given time period as is tolerated by the adolescent. Remaining questions can be asked at later points within the first few sessions.

The question "How old were you the first time" usually indicates whether or not the trauma was a form of child abuse. The questions "When this happened, did you ever feel very afraid, horrified, or helpless?" and "Did you ever think you might be injured or killed?" indicate whether the trauma met DSM-IV (American Psychiatric Association, 2000) Criterion A2 for PTSD or ASD. Although DSM-5 (American Psychiatric Association, 2013) Criterion A does not require these questions, they nevertheless indicate the degree of the youth's distress at the time of the trauma, which is generally correlated with more severe posttraumatic stress. Note that this 2nd edition of the ITR-A also asks about psychological abuse and neglect, although they are technically not considered traumas in DSM-IV or DSM-5.

Initial Trauma Review

Adolescent version, 2nd edition (ITR-A-II)

Client name: _____ Clinician name: _____

Question			Yes	No
1.	[Childhood physical abuse] "Has a parent or another adult who was in charge of you ever hurt or punish you in a way that left a bruise, cut, scratches, or made you bleed?"		☐	☐
	If yes: "How old were you the first time?"	First age _____		
	"How old were you the last time?"	Last age _____		
	"When this happened, did you ever feel very afraid, horrified, or helpless?"		☐	☐
	"Did you ever think you might be injured or killed?"		☐	☐
2.	[Sexual abuse] "Has anyone who was 5 or more years older than you ever do something sexual with you or to you?"		☐	☐
	If yes: "How old were you the first time?"	First age _____		
	"How old were you the last time?"	Last age _____		
	"When this happened, did you ever feel very afraid, horrified, or helpless?"		☐	☐
	"Did you ever think you might be injured or killed?"		☐	☐
3.	[Psychological abuse] "Has a parent, or another adult who was in charge of you, said really mean things to you, put you down, or make you feel ashamed of yourself or humiliated?"		☐	☐
	If yes: "How often has this happened in the last year?"			
	☐ Almost every day ☐ Almost every week ☐ Once a month ☐ Less than once a month			
	"How old were you when it was the worst?"	Worst age _____		
4.	[Neglect] "Has a parent, or another adult who was in charge of you, not taken care of you when they should have, not paid attention to you for long periods of time, neglected you, or acted like they didn't care about you?"		☐	☐
	If yes: "How often has this happened in the last year?"			
	☐ Almost every day ☐ Almost every week ☐ Once a month ☐ Less than once a month			
	"How old were you when it was the worst?"	Worst age _____		
5.	[Peer sexual assault] "Has anyone who was less than 5 years older than you ever do something sexual to you that you didn't want or that happened when you couldn't defend yourself (for example when you were intoxicated or asleep)?"		☐	☐
	If yes: "How old were you the first time?"	First age _____		
	"How old were you the last time?"	Last age _____		
	"When this happened, did you ever feel very afraid, horrified, or helpless?"		☐	☐
	"Did you ever think you might be injured or killed?"		☐	☐
6.	[Disaster] "Have you ever involved in a serious fire, earthquake, flood, or other disaster?"		☐	☐
	If yes: "How old were you the first time?"	First age _____		
	"How old were you the last time?"	Last age _____		
	"When this happened, did you ever feel very afraid, horrified, or helpless?"		☐	☐
	"Did you ever think you might be injured or killed?"		☐	☐

Initial Trauma Review

Adolescent version, 2nd edition (ITR-A-II)

Question			Yes	No
7. [Motor vehicle accident] "Have you ever been involved in a serious automobile accident?"			☐	☐
If yes:	"How old were you the first time?"	First age _____		
	"How old were you the last time?"	Last age _____		
	"When this happened, did you ever feel very afraid, horrified, or helpless?"		☐	☐
	"Did you ever think you might be injured or killed?"		☐	☐
8. [Partner abuse] "Have you ever been slapped, hit, or beaten, or hurt in some other way by someone you were dating or who you were in a sexual or romantic relationship with?"			☐	☐
If yes:	"How old were you the first time?"	First age _____		
	"How old were you the last time?"	Last age _____		
	"When this happened, did you ever feel very afraid, horrified, or helpless?"		☐	☐
	"Did you ever think you might be injured or killed?"		☐	☐
9. [Non-intimate peer assault] "Have you ever been physically attacked, assaulted, stabbed, or shot at by someone who wasn't a parent, date, or sexual partner?"			☐	☐
If yes:	"How old were you the first time?"	First age _____		
	"How old were you the last time?"	Last age _____		
	"When this happened, did you ever feel very afraid, horrified, or helpless?"		☐	☐
	"Did you ever think you might be injured or killed?"		☐	☐
10. [Torture—if the adolescent is an immigrant from another country] "In the country where you used to live, were you ever tortured by the government or by people against the government?"			☐	☐
If yes:	"How old were you the first time?"	First age _____		
	"How old were you the last time?"	Last age _____		
	"When this happened, did you ever feel very afraid, horrified, or helpless?"		☐	☐
	"Did you ever think you might be injured or killed?"		☐	☐
11. [Police trauma] "In this country, have you ever been hit, beaten, assaulted, or shot by the police or other law enforcement officials?"			☐	☐
If yes:	"How old were you the first time?"	First age _____		
	"How old were you the last time?"	Last age _____		
	"When this happened, did you ever feel very afraid, horrified, or helpless?"		☐	☐
	"Did you ever think you might be injured or killed?"		☐	☐
12. [Witnessing trauma] "Have you ever seen someone else get killed, badly hurt, or sexually assaulted?"			☐	☐
If yes:	"How old were you the first time?"	First age _____		
	"How old were you the last time?"	Last age _____		
	"When this happened, did you ever feel very afraid, horrified, or helpless?"		☐	☐
	"Did you ever think you might be injured or killed?"		☐	☐

Appendix B: ITCT-A Assessment–Treatment Flowchart, Adolescent/Young Adult version, 2nd edition (ATF-A-II)

ITCT-A Assessment–Treatment Flowchart

Adolescent/Young Adult version, 2nd edition (ATF-A-II)

Client name: _____ Clinician name: _____

Priority ranking (mark one for each symptom)

① = Not currently a problem: No treatment currently necessary
② = Problematic, but not an immediate treatment priority: Treat at lower intensity
③ = Problematic, a current treatment priority: Treat at higher intensity
④ = Most problematic, requires immediate attention
Ⓢ = Suspected, requires further investigation

	Intake	Assessment 2	Assessment 3	Assessment 4	Assessment 5
Date:	_____	_____	_____	_____	_____
Problem area	Tx priority	Tx priority	Tx priority	Tx priority	Tx priority
1. Safety (environmental)	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
2. Issues associated with sexual or physical victimization by adult(s) or peer(s)	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
3. Caretaker support issues	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
4. Anxiety	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
5. Depression	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
6. Aggression risk	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
7. Low self-esteem	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
8. Posttraumatic stress	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
9. Attachment insecurity	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
10. Identity/self-reference issues	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
11. Relationship problems	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ

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ITCT-A Assessment–Treatment Flowchart

Adolescent/Young Adult version, 2nd edition (ATF-A-II)

	Intake	Assessment 2	Assessment 3	Assessment 4	Assessment 5
Date:	_____	_____	_____	_____	_____
Problem area	Tx priority	Tx priority	Tx priority	Tx priority	Tx priority
12. Suicidality	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
13. Dissociation	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
14. Substance use and abuse	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
15. Grief	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
16. Problematic sexual behaviors	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
17. Self-injury	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
18. Bingeing or purging	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
19. Other risky behaviors	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
20. Legal/juvenile justice/immigration issues	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
21. Issues associated with bullying (victim)	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
22. Issues associated with social response to race/gender/identity/orientation	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
23. Easily triggered flashbacks, emotions, or behaviors	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
24. Emotion regulation/tolerance problems	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
25. Issues associated with prostitution, sex for food/shelter/drugs sexual exploitation	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
26. Other: _____	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ
27. Other: _____	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ	①②③④Ⓢ

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Appendix C: The Trigger Grid for Adolescents, 2nd edition (TG-A-II)

The Trigger Grid for Adolescents, 2nd edition (TG-A-II)

1. **What is a trigger?**

_____

_____

_____

_____

_____

2. **Times you have been triggered (pick up to 7 of the most upsetting times)**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

3. **For each of these times, what happened when you got triggered?**

Trigger #	What I thought	What I felt	What I did
1.			
2.			
3.			
4.			
5.			
6.			
7.			

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The Trigger Grid for Adolescents, 2nd edition (TG-A-II)

4. Looking back, what kinds of things have triggered you (What are your triggers?)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

5. Looking back, what happened after you were triggered that might tell you that you are being triggered in the future?

☐ You had a flashback	☐ You spaced out or went away in your mind	☐ It was hard to breath
☐ Your heart started going fast	☐ You suddenly got a headache	☐ You felt dizzy
☐ You felt like things weren't real	☐ You had thoughts that didn't make sense	☐ You felt sick
☐ Your body felt strange or weird	☐ You suddenly felt like you were in the past	☐ Your face got hot

☐ You were way more upset or angry or scared than made sense

Anything else?_____

_____

_____

The Trigger Grid for Adolescents, 2nd edition (TG-A-II)

6. **Looking back, was there anything you could have done so that you wouldn't have gotten triggered?**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

7. **What do you think you could do after you get triggered that would make it better and you wouldn't get so upset, scared, or mad:**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Appendix D: Self-injury Behaviors and Functions Review (SBFR)

Self-injury Behaviors and Functions Review (SBFR)

Client name: _____ Clinician name: _____

Please indicate below which of the following things you have done, when you did it, and how often. Do not include anything that you did to try to kill yourself.

Behavior	Your age		The number of times you did this			
	The first time you did this	The last time you did this	In the last 6 months (estimate)	In the last month (estimate)	In the last week	In the last 24 hours
1. Cutting or scratching yourself, with glass, a razor blade, or another object						
2. Scratching yourself with your fingernails in order to bleed or feel pain						
3. Burning yourself with a cigarette, candle, flame, or a very hot object						
4. Stabbing yourself or piercing part of your body in order to bleed or feel pain (not for decoration)						
5. Biting or chewing some part of your body, other than the inside of your mouth or lips						
6. Biting or chewing the inside of your mouth or lips, enough that there was blood or pain						
7. Picking at your skin, or at scabs						
8. Banging your head against a wall or other object						
9. Punching or hitting yourself, with your fists or an object						
10. Punching a wall						
11. Cutting a sexual part of your body						
12. Poking yourself in the eye hard enough that it hurt or bled						
13. Burning yourself with acid						
14. Scalding or burning yourself with very hot liquid or water						
15. Rubbing or scraping something against your skin until it burns, bleeds, or makes a mark						
16. Pulling your hair out						
17. Intentionally breaking bones in your arm, leg, hand, or foot						
18. Cutting off some piece or part of your body						

If you have done any of the things listed above, please mark with an X below how much each of the following were reasons why you hurt yourself.

Reason why you did one or more of these things	How often was this one of the reasons why you hurt yourself?				
	Never the reason	Occasionally one of the reasons	Often one of the reasons	Very often one of the reasons	One of the most important reasons
1. To distract yourself from your problems					
2. To feel in control of yourself or your body					
3. To stop feeling numb or shut down					

SBFR (June 28, 2019) Page 1 of 2

Self-injury Behaviors and Functions Review (SBFR)

Reason why you did one or more of these things	How often was this one of the reasons why you hurt yourself?				
	Never the reason	Occasionally one of the reasons	Often one of the reasons	Very often one of the reasons	One of the most important reasons
4. To let people know how you feel					
5. To block upsetting memories					
6. To keep from thinking something					
7. To stop feeling upset					
8. To stop anxiety or worry					
9. To stop sadness or depression					
10. To stop a flashback					
11. To feel good					
12. To feel you were real or alive					
13. To feel sexual					
14. To keep from feeling sexual					
15. To control others					
16. To get someone to notice you or pay attention to you					
17. To get help					
18. To get your anger out					
19. To punish yourself					
20. To feel back in your body					
21. To show people how bad you were feeling					
22. To get even with someone					
23. To stop feeling empty					
24. To feel less bored					
25. To calm yourself down					
26. To scare yourself					
27. To stop from doing something that you shouldn't do					
28. To see blood					
29. To make yourself unattractive					
30. To relieve guilt or shame					
31. To stop feeling abandoned or rejected					
32. To keep from killing yourself					
33. To keep from crying					
34. To mark yourself as a bad person					
35. To let people know that something is wrong					
36. To hurt yourself instead of hurting someone else					
37. To reduce stress or tension					

Appendix E. Mindfulness-based Breathing

(Briere & Lanktree, 2013)

When stressed, many individuals breathe more shallowly, hyperventilate, or in some cases, temporarily stop breathing altogether. Teaching the adolescent "how to breathe" while under stress can help restore more normal respiration, and thus adequate oxygenation of the brain. Equally important, as the client learns to breathe in ways that are more efficient and more aligned with normal, non-stressed inhalation and exhalation, there is usually a calming effect on the body and the autonomic nervous system.

Breath training generally involves guided exercises that teach the client to be more aware of his or her breathing—especially the ways in which it is inadvertently constrained by tension and adaptation to trauma—and to adjust his or her musculature, posture, and thinking so that more effective and calming respiration can occur. Below is one approach to breath training.

First, explain to the client that learning to pay attention to breathing and learning to breathe deeply can help both with relaxation and be useful for managing anxiety. Note that when we get anxious or have a panic attack, one thing that happens is that our breathing becomes shallow and rapid. When we slow down fearful breathing, fear itself may slowly decrease. Explain that some people initially become dizzy when they start to breathe more slowly and deeply—this is a normal reaction. For this reason, they should not try breathing exercises standing up until they have become experienced and comfortable with them. Note that the exercises may feel strange at first because the client will be asked to breathe into his or her belly.

Then, have the client sit in a comfortable position. Go through the sequence below with the client. The whole process should take about 10 to 15 minutes. After each step, "check in" as appropriate to see how the client is feeling, and ascertain if there are any problems or questions.

- If the adolescent is comfortable with closing his or her eyes, ask him or her to do so. Some trauma survivors will feel more anxious with their eyes closed, and will want to keep them open. This is entirely acceptable. If they prefer to keep their eyes open, the client can be invited to take a "soft gaze," unfocusing the eyes while looking slightly downward at the floor about three feet ahead. Ask the client to try to stay "in the moment" while doing breathing exercises. If his or her mind wanders (e.g., thinking about school, or about an argument with someone), he or she should gently try to

bring it back to the immediate experience of breathing.

- Ask the client to begin breathing through the nose, paying attention to the breath coming in and going out. Ask him or her to pay attention to how long each inhale and exhale lasts. Do this for 5 or 6 breaths. It is usually helpful for the clinician to breathe along with the adolescent at the beginning of the exercise. You can guide him or her for each inhalation and exhalation, saying "in" and "out" to help them along.
- Instruct the client to start breathing more into his or her abdomen. This means that the belly should visibly rise and fall with each breath. This sort of breathing should feel different from normal breathing, and the client should notice that each breath is deeper than normal. Do this for another 5 or 6 breaths. Ask the adolescent to imagine that each time he or she breathes in, air is flowing in to fill up the abdomen and lungs. It goes into the belly first, and then rises up to fill in the top of the chest cavity. In the same way, when breathing out, the breath first leaves the abdomen, and then the chest. Some people find it helpful to imagine the breath coming in and out like a wave. Do this for another 5 or 6 breaths.
- Explain that once the client is breathing more deeply and fully into the belly and chest, the next step is to slow the breath down. Ask the client to slowly count to three with each inhalation and exhalation—in for three counts, out for three counts. With practice, the client may begin to slow his or her breath even further. Tell him or her that there is no specific amount of time necessary for each inhalation and exhalation, only that he or she try to slow his or her breathing. Do this for 5 or 6 breaths.
- Ask the client to practice this sequence at home for 5 to 10 minutes a day. He or she should choose a specific time of day (e.g., in the morning, before work or school, or just before sleep), and make this exercise a regular part of his or her daily routine. The adolescent should sit or lie down at home in a comfortable position, with no distractions, for this practice.
- Eventually, the youth can extend this exercise to other times in the day as well, especially when relaxation would be a good idea, e.g., in stressful social situations or whenever he or she feels especially anxious. Remind the client to internally count during each inhalation and exhalation, since counting, itself, often serves to trigger the relaxation response.

Appendix F. ReGAIN for Adolescents (ReGAIN-A)

When you suddenly get really upset, mad, or scared, and these feelings don't make sense, or seem too strong:

Recognize that you are probably being triggered. Remind yourself that you are probably remembering something upsetting from the past.

Ground yourself. Look around yourself, try a relaxation or breathing exercise, or do something that feels good and isn't bad for you. Let yourself calm down a bit.

Allow yourself to feel whatever your feelings are, as best you can. See if you can say good things to yourself when you do this, like

- "I can handle this."
- "I am strong."
- "Let's see how long I can feel my feelings."
- "I can stop feeling when I want to, if I have to."
- "I'm ok. These are just feelings."

Investigate or figure out what the trigger is, if you can, and what it is reminding you of. For example, you might ask yourself

- "Where is the trigger here?"
- "What is triggering me?"
- "Why am I getting triggered?"
- "What is this reminding me of?"

Do ***Not*** always believe what your triggered thoughts or feelings are saying to you or making you think. Remember, these feelings or thoughts may not be real. Say things to yourself like:

- "This is not me, these are from triggers."
- "I don't have to do what my mind is telling me to do."
- "I am remembering the past. What I am feeling is not real."
- "These are just thoughts or feelings. They may not be true."
- "These feelings are from a long time ago."

- "These are thoughts, not facts."

Here is the ReGain-A pocket card, which you can photocopy and carry around with you to remind yourself of the five steps.

ReGAIN-A

Recognize that you are probably being triggered.
Ground yourself.
Allow yourself to feel whatever your feelings are.
Investigate or figure out what the trigger is.
Do **N**ot always believe your triggered thoughts or feelings.

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