



Emotional Dysregulation: The Treatment of Self Injurious Behaviors in the Residential and Community-Based Settings: Part 1

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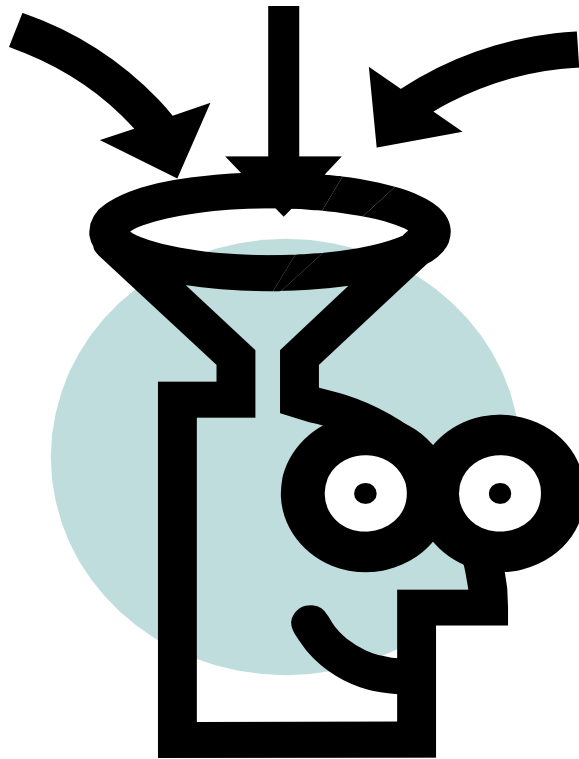
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Learning Objectives

- Recognize and understand the range of self injurious behaviors
- Identify the behaviors and characteristics of “emotional dysregulation”
- Recognize the connection between trauma and various “Disorders of Emotional Dysregulation”
- Use specific interventions in managing behaviors such as, self injury, emotionally reactive outbursts, violence, emotional disconnect
- Normalize stressors for children and reduce perceived trauma reactions




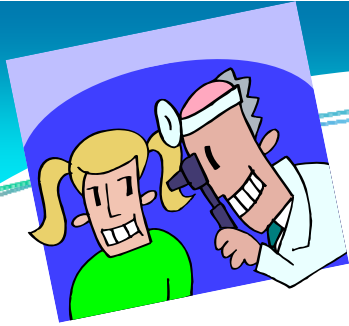
What Are Your Learning Objectives for Today?



Non Suicidal Self Injury(NSSI) or Self Injurious Behavior(SIB)

- NSSI is generally used to cope with distressing negative affective states, especially anger and depression, and mixed emotional states.
- Recent studies have found that one-third to one-half of adolescents in the US have engaged in some type of nonsuicidal self injury (NSSI)
- NSSI most commonly includes cutting or burning oneself without suicidal intent. Other types of NSSI include hitting, pinching, banging or punching walls and other objects to induce pain, breaking bones, ingesting toxic substances, and interfering with healing of wounds.
- NSSI typically begins in mid-adolescence. Adolescents who injure themselves are often impulsive, engaging in self harm with less than an hour of planning. They commonly report feeling minimal or no pain. Once started, self injury seems to acquire addictive characteristics and can be quite difficult for a person to discontinue. While some studies indicate that NSSI is more frequent in girls than boys, other studies indicate that there are no consistent gender differences.

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- Nonsuicidal and suicidal behaviors serve distinctly different purposes. Some adolescent inpatients report hurting themselves specifically to stop suicidal ideation or to stop themselves from actually attempting suicide.
 - Conceptually we can view self-injurious behaviors without suicidal intent as an unhealthy form of self help.
 - Among adult women, NSSI accompanies up to 35 percent of those diagnosed with anorexia nervosa, bulimia nervosa, and other eating disorders;
 - Repetitive NSSI is so common among people with BPD that BPD is the only clinical diagnosis in the DSM-IV-TR for which self injury, whether suicidal or nonsuicidal, is a symptom.
 - A sizeable percentage of adolescent and young adults who engage in NSSI—almost half—may not meet criteria for depression, anxiety, eating disorder, substance use disorder, or other major psychiatric disorders.
 - It seems more useful to understand NSSI as a “symptom” rather than as a distinct diagnosis.



Psychiatry

Clinical Picture/Presentation:

Attachment Disorder, Borderline Personality Traits, Mood Disorders, Post Traumatic Stress, Impulse Control Disorder, Substance Abuse/Dependence, and Sexual Reactivity

•What “they” look like.....

- Reactive
- Struggle to regulate emotions and responses
- Maladaptive coping strategies
- History of traumatic experiences
- Unhealthy view or engagement in relationships
- Skewed view of world and self
- Tend to stay in the “extremes”-struggle with the “gray areas” of life

What We See: Self Destruction



- Self Injury-Cutting, Insertion, Extracting Hair, Head Banging, Burning Self, Breaking Bones,
 - Binging/Purging/Restricting of Food
 - Avoidance-denial, sleeping, isolation, getting involved in others' problems
 - Substance Abuse/Dependence-Self medication
 - Promiscuous Sexual Behavior, unhealthy relationships-inappropriate attachments, internet relationships, sexting, running away
 - Vengeful Acts, Passive-aggressive acts
 - Parasuicidal Behaviors-tying things around their neck, swallowing objects, cutting/scratching
- Irrational Behaviors-On the extremes-Go from Shut Down to High Reactivity
0_____10
- Distorted focus, skewed view of the world, wearing “colored glasses”
 - Creation of self worth and “comfort” are based on interactions with others, based on others' response to the behaviors. Regulation is achieved through the validation by others, not through themselves. **This creates and continues the persistent cycle of dysregulation and self destruction**



As a whole we categorize these responses as “Disorders of Emotional Dysregulation”

Emotional dysregulation (ED) is a term used in the mental health community to refer to an emotional response that is poorly modulated, and does not fall within the conventionally accepted range of emotive response. ED may be referred to as labile mood or mood swings.

Possible manifestations of emotional dysregulation include angry outbursts or behavior outbursts such as destroying or throwing objects, aggression towards self or others, and threats to kill oneself. These variations usually occur in seconds to minutes or hours. Emotional dysregulation can lead to behavioral problems and can interfere with a person's social interactions and relationships at home, in school, or at place of employment.

Emotional dysregulation can be associated with an experience of early psychological trauma, brain injury, or chronic maltreatment (such as child abuse, child neglect or institutional neglect/abuse), and associated with a variety of disorders. ED is also found among those with autism spectrum disorders.

Dysregulation and the Connection to Trauma



- Trauma is viewed as the igniter of the dysregulation
- The trauma initiates survival skills within the patient and the response from providers is one of a “supportive stance.”
- However, if the “supportive stance” doesn’t move into more of an “empowerment stance” then we see the following pattern:
 - ❖ The Patient clings to the concept of “surviving” and begins to live the role of the “victim” consistently
 - ❖ Thought distortions begin to resonate within the patient:
 - “everything bad is happening...so I need comfort” (support)
 - “if only people can get me what I need....”
 - “no one wants me”
 - ❖ Begin to perceive normal stressors as “trauma”. Crisis becomes the normative response.
 - ❖ Self worth is connected to the traumatic event(s).

Dysregulation and Attachment

- Attachment tends to be over attachment and unhealthy-use attachment to gain unhealthy support
- Use of attachment to draw attention and validate their existence
- They are looking for validation and looking to gain support of their irrational thinking. So, they find a vulnerable person(s) to pull into their cycle of dysregulation and self destruction.
 - Often times this is can be a teacher or an advocate of some sort that has been trained to be of “supportive” nature rather than tends to empower and challenge them
 - A “friend” who “is just like me...” Further feeds the distortions and the role of the victim that they have learned to play so well
 - Attachment with parents(guardians): They tend to pull them in on a rope and just when the parent gets close, they let go.
 - Sexual Attachment: It is not about the sexual acts it is about the perceived connection, the validation of being “ok” or attractive or wanted.

Some personal descriptions of why people self injure

- Because sometimes it hurts so bad on the inside, it's nice to have something tangent to relate to. There is a weird sort of comfort in having an injury on the outside. It is also a whole lot easier to deal with than crud from the past and present. Before [I feel] out of control -- it's like a obsession I can't get rid of. During [I feel] a sense of satisfaction, control, victory. After [I feel] like dirt. *[female, age 37, 23 years SIB, graduate student]*
- Because it helps me to stop all the turmoil inside my head. I also think that I deserve to hurt because I'm such a horrible person. I don't know why I feel like this, but I do. *[female, age 34, 2.5 years SIB, teacher]*
- Because I feel so much internal pain that I need a way to release it all. So by cutting myself, it acts as an outlet for that internal pain, like it's all running out of me, like water out of a tap. *[female, age 17, 3 years SIB, HS senior]*
- 1. I feel like a pressure cooker that's going to explode. Cutting and bleeding sufficiently is like letting out the steam. If I do this to my satisfaction, I feel immediate relief, as if injected with valium or something. It helps stop the inner turmoil for a while. 2. To feel real when I feel numb. 3. It becomes an addiction. *[female, age 38, 13.5 years SIB]*



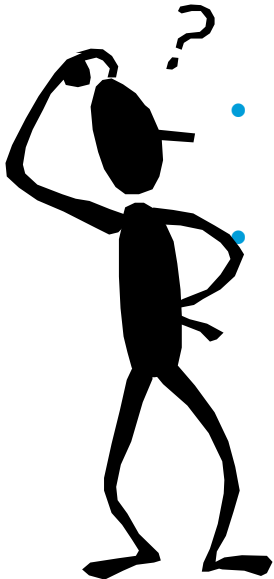
Silent

My cries at night are silent,
Ones that can't be heard,
They tear me up inside,
Because I refuse to let them out,
It's suffocating me so much,
It's like the slowest painful death,
One that cuts my soul each time
I take a breath,
It seems there is no way out
Of this trap,
That drives me to these silent tears,
So much agonizing and torturous pain,
That can't be put into words,
No one understands, no one can help,
To fix me is impossible,
So I thrive off shedding my own blood,
By simply taking the shard of glass
And sliding it across my skin,
To show the world, it has finally won,
That the people who have hurt me and took away my innocence,
Should feel their glory,
To the world I put a fake pretense,
Not daring to show them how I truly feel,
But yet at the same time, wanting them to see,
How it's like a knife stabbing me,
Each time I breathe,
Wanting them to see,
All my hurt, anger and agony,
But instead I stick to the nights,
Where I cry my silent tears.

17yo RTC Safe Haven Resident, 23 placements

How and Why Do We Treat This Population?

- We began to research methods of treating this highly reactive population because as treatment providers we were consistently seeing the following:
 - Consistent disruptions to the treatment milieu
 - Spending extraordinary amounts of time trying to “manage” (as we looked back at it, we were managing them, they weren't managing themselves) and attend to these patients
 - Revolving door to acute hospitalization-which in turn disrupted their path of treatment
 - Multiple failed placements-consistently being removed from RTC's, group homes, foster homes because they require “too much attention and are disruptive to the other patients/residents/children.”



Levels of Treatment Options

Acute	Residential	Intensive Outpatient
<ul style="list-style-type: none"> •Further exacerbates attachment issues. •Validates the role of the “victim” due to the safety protocols that are required •Typically they will “earn themselves into a 1:1, suicide gowns, etc. •Typical approach is safety and medication usage •Furthers the idea that they need someone else to protect them/keep them safe •Purposeful escape from treatment •Form “attachment” to the hospital setting-it is easier and safer because they are validated in the hospital 	<ul style="list-style-type: none"> •RTC should be utilized when IOP is not working and/or when the patient has bounced to multiple acute settings •RTC setting has to be specific to treatment of trauma, dysregulation and they should have a strong stance on NOT engaging in the sling shot approach to acute hospitalization •Should emphasize holistic approaches, reduction of medications that mask emotions •Exposure to “triggers” and Dialectical Behavior Therapy is recommended •Treatment should not be in a “sterile” bubble-experiential work is helpful 	<ul style="list-style-type: none"> •With the right provider(s) this is the best option, unless criteria for RTC is present •IOP will include 3 sessions a week •Family session •Parental support meetings-train the parents to respond to “crisis” •Group therapy-split between advanced and beginning patients



Emotional Dysregulation: The Treatment of Self Injurious Behaviors in the Residential and Community-Based Settings: Part 2

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Levels of Treatment Options

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How do you decide the level of care?

- Assess the nature of the self injury-determine the suicidality. This is best done by a provider(s) who are familiar with the patient. This is typically part of the outpatient plan.
- What is the patient “saying” to us through the behavior(s)? What message are they not conveying in a healthy/appropriate manner?
- What is the patient’s pattern? When was the last inpatient stay? What are they struggling with in their current setting that poses an imminent risk to self and/or others. Think of an acute inpatient stay in the terms of a medical emergency surgery. Without the “surgery” will the patient be at a high risk of further harm, death, etc. Can the “procedure “ be done in an office setting or achieved through a change in medications?

Treatment Methods and Intervention Strategies

- Consistency in Treatment and Approach
- Being clear, honest, and authentic
- Setting clear limits and boundaries
- Modeling-Teaching and emulating the Dialectics
- Encouragement to use healthy skills and acknowledgement of healthy skill use
- Reducing engagement when Resident is choosing to be unsafe or refusing to be an active member in treatment



Dialectical Behavioral Therapy

- Effective treatment found to work with Borderline Personality traits/disorder and those behaviors related to ED(Emotional Dysregulation)
- Evidenced based practice-It has been proven to be effective
- Everyone working on the team is a part of the treatment and working to enforce and reinforce the concepts being learned




Dialectics

- The struggles....Why we do the things we do..and why we keep doing these things when they cause us so many problems and pain and suffering....
- How do I get help without “forcing” help through my actions?
- How to do I start to operate my life differently when for all this time my destructive ways have “worked” for me?
- How to begin to feel comfortable with being challenged and supported-how do I do that for myself?

Concepts to Address in Treatment

- Compartmentalize the traumas-Step back and Observe-Don't address them all at once
- As providers we want to treat the underlying core rather than the presenting distraction
- We teach the patient to respond to the actual event-what is actual, what is layover, what is every day.
- Work through an empowerment approach and separate trauma/perceived trauma from normal stressors
- These patients tend to stay in treatment for so long that they don't really address the "WHY" and the "HOW"-because they are working so hard to find "support "in ways that mirror their trauma.
 - They tend to be stuck in their experiences. We assist them with separating them from their experiences and work in the present

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- We help them to determine a concept of self reliance and not base self worth on what others say, think or do
 - We work on the development of relationships-knowing who to trust and find balance and forcing change-Dialectical approach
 - We don't address or react to the specifics rather we teach as a whole. For example:
 - We focus as a whole on sexuality and healthy sexuality-rather than the specifics of their unhealthy sexual behaviors
 - We don't place them in a sterile environment.
 - **It is not the item itself that is the problem, it is the intent-it's the thoughts that they have that are associated with the item that is the problem

- We address their pattern of going in and out of control-address the Cycle of Dysregulation

Self defeating thought → negative emotions → tension-dissociation

Irrational Act → positive effects → negative effects

They use unhealthy soothing (injury, running, sex, drugs, aggression) to manage their feelings of “out of control”(feeling uncomfortable). When they engage in the unhealthy it shoots them in guilt/shame and that fast forwards the cycle. They can't stay in the “crazyville” portion of the cycle so they revert to a “ zero” and avoid. We think that they are “ok” because they are “staying out of negativity” but meanwhile the steam is building internally, the distortions/irrational thoughts are swirling around in their head, the “colored glasses” are on= eventual irrational behavior again(injury, running, drugs, aggression)

(avoid/robot) 0 _____ 5 _____ 10(crazyville)



How to Handle Irrational Behavior

Prior to the Behavior/Beginning Stages

“Someone needs to talk to me or I am going to cut” “You better give me what I want or I’m gonna go off.” “I am going to kill myself”

Response: “I can see that you are really struggling right now. This would be a good time to remember all of your options. Find a way to soothe appropriately and when you are ready to talk calmly I will be waiting.”

“I am calm!!!” “This all your fault”

Response: Focus on being clear and setting supportive limits: “I really hope that you are able to get back on track and use some skills we have been working on (supportive) “but if you choose to stay stuck your team will be forced to just manage your safety a this time , rather than you pushing yourself to get the support we both know you want”(challenge)

Disinterested Interest

During the Irrational Behavior

Limit verbal contact, stand and monitor, focus on safety. Avoid therapeutic process. Things you may hear, “You don’t care about me, I’m not gonna stop until you talk to me. Take me somewhere where people will listen to me....”

Response: “I am here right now to monitor your safety”, “Once you choose safe behaviors you will begin to earn what you want”, “At this time you force me to focus on managing your behavior rather than working with you to solve the problems that we have been focusing on,” “These behaviors are not helpful in building the relationships you are working so hard on.”

After the Irrational Behavior

24 hr rule, “The Bubble”

After the Irrational Behavior: (When apology and regret begins)

Things you may hear:

- *"I am a horrible person"
- *"I knew I would do that"
- *"I know you hate me"
- * "If only you would have talked to me I wouldn't have...."
- * "I am so stupid"

Response:


- >"Let's focus on how to get what you want...What do YOU need to do to get back on track?"
- >"Sounds like some of your choices have put you in a spot that you don't like. What can you do to help show YOURSELF and others that you are ready to move forward?"

Focus on the plan first rather than the behavior. You will be able to process this behavior more appropriately when they have to come to a more rational place. They will want to discuss the irrational behavior first . But, in an effort to reduce the validation that the irrational behavior gave them the "comfort" of attention, you have to delay the processing until a more WISE MIND has taken over.

Stay the course....no matter how long it takes. They have used manipulation and irrational behaviors for a long time and they know how to wear down people

The “24 Hour Rule and the Bubble”

- When working with patients that tend to engage in a form of emotional manipulation the “**24 hour rule**” is put in place. We call it the “bubble”-we can see them and monitor them but we can’t “touch them”
- A patient is “denied” therapeutic process of their issues and the thoughts and behaviors that led up to the incident are not processed until at least the following day by the clinician.
- The patient is told that because they chose this method of communication and problem solving that the “bubble” comes up around them and we now have to “protect them.”
- This plan could include several safety measures such as scrubs, taking away of items, therapeutic assignments. But it **will not** include a 1:1 process with staff or therapist until the “24 hour rule” is achieved and the patient is in a more rational support.
- In the outpatient setting, this concept is addressed as part of the treatment plan-an agreed upon approach between patient, family and clinician-if patient chooses self destructive behavior(s)

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- Assessment of lethality-assess from afar. Complete a suicide or other type of crisis assessment from a distance. Run through the risk factors, current behaviors, current environmental factors that can assist in keeping safe.

- This is when you will assess parasuicidal and suicidal behavior. Distinct difference. Tying, swallowing, cutting, are typical of parasuicidal and self preserving behaviors-while unhealthy they are meant to gain comfort through the actual act and through the response that it typically achieves.

- They recognize that they are feeling uncomfortable and want to “feel” better so they use unhealthy “coping” strategies

- Develop a safety plan-it is a balance of minimizing the injury with over reacting and validating the injury. Balancing your reduction of risk as a provider and damaging the therapeutic process-this can be tricky especially in a multidisciplinary team. Other professionals view irrational behaviors as requiring the most restrictive interventions to ensure that liability is covered

Other treatment suggestions:

- If possible, the patient should learn to manage mood and “distress” without the use of PRN medications.
- Focus of treatment should not be pharmaceutical, if possible. Use of minimal medications. Avoidance of antipsychotics-if at all possible due to the sensory areas of the brain that they impact. Avoid use of anti-anxiety meds such as Vistaril, Buspar, Xanax, etc. Use of a “basic” anti-depressant is most appropriate
- Use of animal-pet therapy if possible, taking care of others, teaching of empathy-get the focus off of them-as the patients tend to be closed off emotionally and focused primarily on their “misery.” We use EAGALA trained therapists to augment our treatment.
- Use of EMDR (Eye Movement Desensitization and Reprocessing) therapy is highly effective with patients with significant PTSD and other traumas




Intensive Outpatient

- Should include active engagement of the caregiver
- Caregiver support groups/parent training group-teaching them the “art” of non-reaction
- Family therapy with a review of skills and modeling of effective communication
- Reinforcing the concept of “coaching” the patient rather than doing for the patient
- If injury occurs an agreed upon plan is put in place that does not include disempowering, validating or punishing

Resource List

- Miller, Alec L (2007). *Dialectical behavioral therapy with suicidal adolescents*. Guilford Press: New York
- Shapiro, Francine & Forrest, Margot (2004) *EMDR: Breakthrough Eye Movement Therapy for Overcoming Anxiety, stress and Trauma*. Basic Books
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 - Miller, A.L., Rathus, J. H. & Linehan, M.M. (2006). *Dialectical Behavior Therapy with Suicidal Adolescents*. Guilford Press: New York.
 - Melanie Godon Sheets, PhD-*Out-of-Control: A Dialectical Behavior Therapy-Cognitive-Behavioral Therapy Workbook For Getting Control of Our Emotions and Emotion-Driven Behavior*.
 - Thomas Marra, PhD *Depressed & Anxious: The Dialectical Behavior Therapy workbook for Overcoming Depression & Anxiety*.
 - Callahan, Connie. Ph.D. *Dialectical Behavior Therapy: Children & Adolescents* PESI: Eau Claire.
 - Shapiro, Lawrence E. *Stopping the Pain: A workbook for Teens who Cut & Self-Injure*.
 - [Dialectical Behavior Therapy Skills Workbook: Practical DBT Exercises for Learning Mindfulness, Interpersonal Effectiveness, Emotion Regulation, & Distress Tolerance \(New Harbinger Self-Help Workbook\)](#) - Paperback (July 2007) by Matthew McKay, Jeffrey C. Wood, and Jeffrey Brantley
 - Websites:
 - www.truerecovery.org Go to Learning Center and there will be DBT info and worksheets.
 - www.dbtselfhelp.com Tons of resources on skill building, worksheets, sample diary cards



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