Second Edition

Cutting Down

An Evidence-based CBT Workbook for Treating Young People Who Self-harm

Lucy Taylor, Mima Simic and Ulrike Schmidt

Cutting Down

Cutting Down provides a practical and accessible treatment programme based on Cognitive Behaviour Therapy (CBT) principles for young people who self-harm.

This fully revised and updated second edition includes new techniques from 'third' wave CBT, Acceptance Commitment Therapy (ACT) and Dialectical Behaviour Therapy (DBT). This enriches the material and brings the concepts up to date. Another key addition to this new edition is the inclusion of strategies for young people who engage in suicidal behaviour. The manual is evidence based and focuses on a flexible and formulation driven model to direct treatment in around 15 sessions for young people and six sessions for parents and caregivers. It provides a clear structure for each session and an easy-to-follow outline on how the therapist should deliver each session. The content of each session is supported by handouts and worksheets which can be used within sessions or as homework between sessions.

Enhanced with online resources, the workbook will be useful for all professionals working with young people who self-harm across a wide range of settings from schools, primary care and voluntary sector, to community mental health services and inpatient units.

Dr Lucy Taylor is a Consultant Clinical Psychologist working in independent practice in Surrey. She has worked over 20 years in the NHS, including jointly heading up the National & Specialist Child and Adolescent Dialectical Behaviour Therapy (DBT) Service, Maudsley Hospital.

Dr Mima Simic is Consultant Child Adolescent Psychiatrist leading the Maudsley Centre for Child and Adolescent Eating Disorders. She was Consultant for the Community Adolescent Mental Health Team and National & Specialist Child and Adolescent Dialectical Behaviour Therapy (DBT) Service, Maudsley Hospital for nearly a decade. She has researched treatments for self-harm in which she teaches and trains mental health professionals.

Ulrike Schmidt is Professor of Eating Disorders at King's College London and a Consultant Psychiatrist at the Maudsley Hospital. One key focus of her research is on developing brief scalable psychological treatments of value to the NHS, for people with eating disorders and other common mental health problems, including self-harm.

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Cutting Down

- An Evidence-based CBT Workbook for Treating Young People Who Self-harm

Second Edition

Lucy Taylor, Mima Simic and Ulrike Schmidt

Routledge
Taylor & Francis Group
LONDON AND NEW YORK

Cover image: © Getty Images

Second edition published 2023
by Routledge
4 Park Square, Milton Park, Abingdon, Oxon OX14 4RN

and by Routledge
605 Third Avenue, New York, NY 10158

Routledge is an imprint of the Taylor & Francis Group, an informa business

First edition published by Routledge 2015

British Library Cataloguing-in-Publication Data
A catalogue record for this book is available from the British Library

Library of Congress Cataloging-in-Publication Data
A catalog record has been requested for this book

ISBN: 978-0-367-75580-5 (hbk)
ISBN: 978-0-367-75578-2 (pbk)
ISBN: 978-1-003-16304-6 (ebk)

DOI: 10.4324/9781003163046

Typeset in Stone Serif
by KnowledgeWorks Global Ltd.

Access the Support Material: www.routledge.com/9780367755805

Contents

Acknowledgements

We would like to thank all those staff and young people who contributed to the second edition of the manual. Our special gratitude to the group of 'wise minds' who inspired us to develop the parent sessions – Professor Dennis Ougrin, Dr Julian Baudinet, Dr Partha Banerjea and Dr Christy Wellings. They all shared their expertise and insights from their ongoing work with young people and families in their clinics. We offer our thanks to assistant psychologist Megan Tongs, for her invaluable help with editing the sessions, amending the worksheets and handouts and giving feedback with the manuscript.

We would also like to acknowledge the specialists in the field to whom we have referred throughout the book – in particular Marsha Linehan and Russ Harris.

We offer special thanks to the young people who have worked hard in both editions to illustrate the concepts and add their creativity and input to the book.

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Introduction

Lucy Taylor, Mima Simic and Ulrike Schmidt

There has been a dramatic rise in self-harm over the last decade. Even experienced therapists can find working with these young people difficult. Self-harm behaviours are widely defined as 'causing deliberate hurt to your own body', i.e. it is something that a person does to him/herself on purpose that injures or damages their body. (see NICE guidelines for information).[1] We are including suicidal behaviours under the umbrella term of self-harm, as the two often occur together and the border between them is fluid. There are specific exercises in the book that work to elicit the function and intention of the behaviour, which can guide the treatment plan. Based on Cognitive Behaviour Therapy (CBT),[2] a highly effective method for working with emotional problems, Cutting Down offers a practical and accessible programme for mental health therapists from different professional backgrounds working with young people who self-harm, or engage in suicidal behaviours. This manual is aimed for a variety of presentations of self-harm including strategies for young people with emerging borderline personality disorder, although Dialectical Behaviour Therapy (DBT) is currently the best evidence-based approach for this group of young people.[3,4] The manual offers ideas taken from the CBT, DBT, Acceptance and Commitment (ACT)[5,6] and Radically Open DBT (RO DBT)[7] literature to work with self-destructive solutions to intense emotions. Although the CBT elements of this book are rooted in Beck's Cognitive Model,[8] it also draws on Gillian Butler's work[9] in aiming to construct a 'plausible account' of the young person's experiences. Due to the nature of the young person's problems, the book also takes a trans-diagnostic approach within CBT: in other words, a form of CBT that targets cognitive and behavioural processes common to a range of underlying disorders and personality predispositions. It will allow you to 'move about' the manual to target strategies from more traditional CBT or draw on concepts from ACT, DBT and RO DBT, depending on the young person, their story and thinking style.

The programme has been adapted since the first edition to comprise five parts, with the addition of a module for parents/carers. *Note to*

DOI: 10.4324/9781003163046-1

therapist: parent sessions will be used as a term throughout the manual, but also includes carers. The parent module is designed to be offered alongside the young person's sessions and designed to be interwoven with the work the young person is covering at the time. The parent sessions start around young person's session 4 in the manual. However, occasionally therapists may need more time to encourage the young person or parents/carers to join in the programme, and this is acceptable. There are five parent/carer sessions, with an optional sixth but in line with the flexibility of the book, their content and timing can be adjusted according to the family you are working with.

Although, we know from research and experience that involving parents/carers in the treatment plan is beneficial, if there is a lot of resistance or animosity within the family, the therapist can use discretion and flexibility as to how and when to involve others.

YOUNG PERSON SESSION PARTS

Part 1: What's going on? Assessment, psychoeducation, risk assessment and safety planning
Part 2: Feelings, thoughts and behaviour
Part 3: Coping strategies
Part 4: On you go!

PART 5: PARENT SESSIONS

Understanding self-harm and behavioural reinforcements (coincides with the beginning of young person part 2)
How to validate your child and self-validation
Working together to reduce SH (coincides with ending young person's part 2)
Supporting your child with new skills (coincides with young person's part 3)
Ending and forward planning (coincides with young people's part 4)

As in the first edition, each of the four young person parts covers a specific stage of therapy, split into a total of 32 modules. Although designed to be delivered over a course of 15 sessions, the programme is presented in a way that allows the therapist to decide which combination of modules is chosen and how long is spent on each, based on the clinical needs of the person they are working with. Throughout the programme, virtual young persons are used to illustrate the various exercises and strategies, including their particular problems that led to self-harm (e.g., lack of assertiveness or self-critical thoughts). Look to ***Handout 1.2: Real life stories – virtual characters***, for a snapshot of their stories. Part 1, What's going on? introduces self-harm and CBT and aims to help young people develop insight into feelings, problems, goals and the concept of change. The second edition focuses a little more on motivation for change to speak to young people who feel very hopeless about life and are self-harming or

engaging in suicidal behaviours because they cannot begin to imagine that things could ever change for the better. Part 2, Feelings, thoughts and behaviour, looks at working on activities, managing depression or low mood and identifying and managing negative thoughts. The second edition has been adapted to include some strategies from different models that are described as 'third wave' CBT, e.g., ACT, DBT and Radically Open Dialectical Behaviour Therapy (RO DBT). ACT originated by Steve Hayes (see reference 5 for further reading) and, as Harris describes, aims to 'create a rich and meaningful life, while accepting the pain that life inevitably brings' (6). This therapy model teaches the young person additional ways to manage negative thoughts. The main components of ACT include learning psychological skills to handle painful thoughts and feelings effectively and to clarify what is important and meaningful to us, in other words – our values; then to use that knowledge to set goals and act in a direction that matters to us. DBT focuses interventions on teaching clients who tend to get easily emotionally dysregulated, how to increase skills in managing their distress, emotions and relationships while also practicing mindfulness. RO DBT was developed for clients who inhibit their emotional expression due to their persistent anxiety and harsh self-judgements leading to difficulties in connecting with other people. RO DBT promotes skills in changing client's physiology to promote social safety and more genuine emotional expression. All listed 'third wave' therapies address issues of the client's values as a part of their engagement and motivation for change in treatment. Part 3, Coping strategies, introduces modules on problem-solving, assertiveness, mindfulness and alternatives to self-harm. Here we have added further ways to reduce distress, such as basic emotional regulation strategies, and a section on hopelessness, drawing on the radical openness model. Part 4, On you go!, finishes the programme with a review of goals, identifying triggers and developing a keeping well bag of skills to reinforce the programme. Downloadable worksheets accompany the text.

This second edition includes a fifth part for parents and carers. The sessions include relationship skills, supporting parents to validate their young person, working together to help reduce self-harm and recognising how parents can contribute to recovery.

Who the programme is for and how to use it?

This book is designed for clinicians working with adolescents engaging in self-harm and suicidal behaviours and their parents/caregivers, this unique workbook is ideal for counsellors, counselling psychologists, clinical psychologists, CBT therapists and child and adolescent mental health workers and trainees, working in primary, secondary or tertiary care settings. The authors recommend the programme to be used by professionals who have some core CBT training. However, if this is not the case (and for general good practice), it is important that anyone delivering the manual has regular supervision with a CBT trained professional. It is beyond the scope of

the book to explain therapy style questions and the basics behind the CBT model. References are included for further reading.

The content was originally designed for one-to-one use, but the materials could translate to a group context as the skills are generic to common maintenance factors in self-harm. The addition of suicidal behaviours in edition 2 stemmed from the fact that some young people feel so depressed or hopeless that they do not feel life can get any better.

From epidemiology studies, we know that at least a quarter of all adolescents in the community engage in self-harm behaviour each year, with indications from the literature that this has increased over time. The need for effective treatments for young people who self-harm is evident.

The manual has already shown promising effectiveness. A pilot study of using this book with adolescents seen in a community Child and Adolescent Mental Health Service (CAMHS) setting, demonstrated significant reductions in self-harm behaviour, low mood and anxiety after eight to twelve sessions.[10] Although the number of sessions was deemed to be too low by the therapists, the positive results led to further development of the manual and publication of this book. More recently, in 2019, the manual was used in another pilot study[11] which compared the *Cutting Down* manual with solution focused therapy and mentalisation based therapy. The authors concluded that out of the treatments explored in this study the manual-based CBT was the most promising treatment for adolescents with self-harm referred to community mental health services. A randomised controlled trial has been carried out in Germany, which found that adolescents who were treated by clinicians using the *Cutting Down* manual reduced the rate of non-suicidal self-harm faster, compared to adolescents who had a significantly more intensive community treatment (more sessions of mostly CBT).[12] The authors suggested that the *Cutting Down* manual could provide a brief, practical first line treatment for adolescents in routine clinical care.

This book uses evidence-based strategies, in particular CBT, and is based on a flexible and formulation driven model. Edition 2 also contains a risk assessment and safety planning protocol and a parent package. It is particularly suited to younger adolescents and young people with symptoms of depression and/or anxiety who might find it difficult to express their feelings of vulnerability and suppress their emotions, referred to as 'overcontrolled' in RO DBT literature. The main aim of the book is to help the young person understand the factors that serve to maintain their problems and to teach them adaptive skills to address emotional difficulties. Whilst the most common methods of self-harm in young people are cutting and taking overdoses, this programme is designed to treat a broad range of self-harm behaviours. Feedback from therapists and young people who have used the manual has been positive and feedback from therapists has led to the changes/extensions included in this second edition. Therapists reported that they liked the 'session-by-session' structure and have found the book particularly useful, as it addresses the majority of problems traditionally associated with self-harm: for example, low mood, anxiety, anger, lack of assertiveness and difficulties with problem-solving.

In other words, it has a trans-diagnostic approach which lends itself well to individual formulations and tailored treatment. The young people themselves reported that they liked the virtual young persons. They were able to relate to some shared issues and found it useful to observe like-minded young people 'bringing' their own problems to the session and specific treatment strategies being illustrated. Sessions for parents/carers were developed recognising the importance for parents of understanding why a young person is self-harming, but also having in mind their crucial role in supporting the young person to reduce self-harm and manage suicidal urges. The aim of the new materials for parents/carers is also to help parents to improve relationship with their child when negative familial affect is maintaining the young person's difficulties.

Essential elements for the development of the Cutting Down programme have been identified through a comprehensive review of the evidence based on treatment of self-harm and associated psychological maintenance factors, such as depression, anxiety and hopelessness. Another addition to this second edition is the discussion of values (taken from the ACT model). This is to help the young person find meaning in their life and work within a CBT framework, to move towards a value led and meaningful life.

There are homework exercises for the young person to complete between sessions.

Initial modules focus on psychoeducation and a comprehensive cognitive behavioural assessment of the self-harm behaviour. Levels of motivation for giving up/reducing self-harm are assessed using simple 'motivational rulers' adapted from Rollnick and Miller[13] If motivation is assessed to be low, further motivation work is offered as an option.

General issues to consider during therapy

The terms 'feelings' and 'emotions' are used interchangeably through the book as meaning the same thing – technically, emotions. Young people have reported to us that they often prefer the term feelings. However, it is important to bear in mind that clinical experience has shown that people can easily mix up thoughts and feelings. As it is very important in CBT to become adept at recognising the difference between a thought and a feeling, consideration of terminology and each young person's understanding of thoughts and feelings throughout the book is recommended. A key aspect of the treatment throughout will be helping the young person distinguish thoughts from emotions on a daily basis.

The therapeutic alliance

From discussions with young people in therapy, we know that some aspects of building a therapeutic alliance are particularly difficult for them, in particular, developing trust and making connections.

Developing trust

Being able to trust a therapist can be extremely troublesome for young people. As a therapist, you cannot force someone to trust you. However, there are things you can do to help the trust-building process:

- Always be open with young persons about confidentiality and serious risk situations, when some information might be shared with others. Explain that in any of these instances sharing of information will be discussed first with the young person and they will know in advance what is shared, and with whom.
- Introduce the issue of trust into a session very early on. Have an open conversation with the young person about trust and show that you recognise that trust can be difficult and takes time to achieve. You could tie this in with talking about the collaborative nature of CBT. Explain that trust works in both directions and that during the course of therapy you will both need to try to build trust with one another. Make it clear that, whenever the young person feels trust is an issue throughout the course of therapy, they should be open about this.

Making connections

Young people can sometimes feel that they don't connect with their therapist. This can make them feel that the therapist doesn't really understand them and the way they feel. As a therapist, you will also find that you connect more easily with some young people than others. Trying to engage the young person by being as active as possible in therapy may help to establish a better connection. Also, make them feel heard by reflecting back to them regularly, listening carefully to what they are saying and getting feedback from them at the end of sessions. As much as possible, show that you have actively done something to respond to any feedback you receive.

General things to remember throughout therapy

Set an agenda at the start of each session. Although this book is fairly prescriptive, and there are specific issues to cover in each session, it is also important to ask the young person what they want to bring to the session. The young person will be less likely to attend to the information during the session if they are preoccupied with their own problems. Try to get into the habit of agreeing a joint agenda. This will include review of homework from the previous week; a bridge from the last session (to ensure that everything previously covered has been understood and remembered); your plan for the session; and some time for any agenda item the young person has brought. With young people that are suicidal, it will be important to factor in risk assessment and issues that have come up in the week that you may need to know. A new introduction to this second edition is the concept

of a safety plan. This will be completed early in therapy and adapted as new skills and strategies are covered. It is useful to bring the safety plan to each session (and have a copy for the young person and parent) to go through as necessary. Timing the agenda items is very important, to enable the bulk of time to be spent on the new topic for the week and is usually experienced as containing for the young person. Whilst setting the agenda, agree with the young person how much time you will spend on each issue. A guide to this timing might be: five-minute catch-up and agenda-setting; a risk check-in with suicidal young people, five-minute bridge from last session; 10 to 15 minutes for the young person's topic (unnecessary if the young person does not have anything specific he/she wants to discuss); 25 to 30 minutes for the specific session's topic; and 10 minutes for feedback and homework-setting. Some of the homework-setting will happen during the session topic but it is useful to recap with the young person what they are planning to work on at home at the end of the session.

This book is not intended to be rigid in its approach: timings are flexible, and it is important to remember that in all cases clinical judgement prevails, in particular when taking time out of the session structure to discuss and assess immediate risk issues. Similarly, if a young person brings a crisis to the session that they want to talk about, then it may be appropriate to devote some time to this away from the book plan. However, as much as possible, try to link it into the work you are doing, and draw on their crisis as an example to reinforce an idea or introduce a future coping or problem-solving technique.

Formulation

This therapy manual emphasises work on formulation from the start. Psychological formulation is viewed as a shared narrative, or a story that is constructed throughout the course of assessment and treatment and draws on the young person's personal meaning attributed to their life experiences. As well as this, it helps the therapist and young person understand what might have contributed/be contributing to the problem and why they are stuck in this position (what is maintaining this). The task of the therapist in constructing a formulation is to use their clinical skills to combine psychological theory/principles/evidence with personal thoughts, feelings and meanings. This is done through 'a process of ongoing collaborative sense-making'[14] in order to develop a shared account that indicates the most helpful way forward.

Start work on developing your formulation as soon as possible. As a therapist, it is a good idea to jot down information you have from the point of referral, continuing through the assessment and into the treatment sessions. Use ***Worksheet 2.2: Early formulation***, to jot ideas down by yourself, in the first instance, prior to the allocated collaborative formulation section later in the book. You will find a time when it feels clinically appropriate to start to share the formulation with the young person but use the workbook's timing as a useful guide.

End of session feedback

At the end of every session, get feedback from the young person on what they have found useful and less useful from the session. It helps you to guide the next sessions and remember what is useful to the young person, whilst appreciating their individual learning style. When you ask what has been difficult for the particular young person in the session, you might say, 'Is there anything that you found useful, difficult, 'rubbed you up the wrong way', did not find useful today?', how does it match with your expectations, what have we learnt about what we've covered today, or 'Was it easy/hard to talk to me about your difficulties? Is there anything I could have done to make it easier?' Suggestions for asking what they found useful might include: 'What was useful about today's session? What will you take away from today?'

Ending therapy

Planning for the end needs to start from the beginning of treatment (see Part 4 for specific suggestions and tips). Some young people build fast and trusting relationships with their therapist and may have struggled with attachments in the past. As well as this, self-harm and other behaviours may have served a strong communication function for the young person and when a relationship ends they might feel especially distressed. Some young people might have become accustomed to using self-harm as a default mechanism to manage such situations. It is important that you fully understand the functions of self-harm for the young person, so that you are aware of the behaviours and responses from others that might reinforce these behaviours. A good formulation and functional analysis of self-harm/suicidal behaviours are crucial. Be mindful of your reaction to specific behaviours and the attention paid. Be clear from the outset about the boundaries of therapy, where your confidentiality boundary ends and issues that will need to be shared with parents or carers (ideally with the young person's consent or jointly with them). It is important to maintain a balance between continuing with the scheduled session structure and spending appropriate time and attention on risk assessment and crisis management. This can be more of an issue at the end of treatment (see notes on 'goodbyes').

Measuring progress and outcomes

It is good CBT practice to measure change objectively and regularly. There are several possible options, the therapists might use to measure change: the children's Improved Access to Psychological Therapies (IAPT) has published a set of measures and provided evidence that session-by-session outcomes can be extremely helpful for young persons. You will be able to access measures and other resources for free at www.corc.uk.net/

Table 1.1 Self-harm log

Date	*Self-harm*	*Urge*	*Action/how many incidents?*	*What did you do?*
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Rating scale for emotions and urges: 0 = Not at all; 1 = A bit; 2 = Somewhat; 3 = Rather strong; 4 = Very strong; 5 = Extremely strong

outcome-experience-measures/. This enables young people to see that change really is happening as well as informing the therapist if change isn't that evident. Examples of measures used in IAPT are the Revised Children's Anxiety and Depression Scale (RCADS)[15] the Strengths and Difficulties Questionnaire[16] and the Outcome Rating Scale (ORS).[17] You can also use session-by-session measures, for example goal tracking, where the therapist and young person use the review of goals to check progress against the agreed focus, general wellbeing tracking, which uses the ORS to track general wellbeing, and symptom tracking. Three other widely used measures that can be downloaded free of charge from the internet are: the Mood and Feelings Questionnaire;[18] the Rosenberg Self-esteem Scale;[19] and the Screen for Child Anxiety Related Emotional Disorders (SCARED-R).[20]

Whichever measures are used, we suggest they should be administered at the beginning of therapy, mid-way (end of Part 2) and at the last session. It is also useful to measure the frequency and severity of self-harm as reduction/cessation is the aim of the book. One suggestion would be the use of a diary or log of self-harm. Table 1.1 is adapted from the DBT Diary Card[13] and enables the young person and therapist to look at the extent of self-harm behaviours every week, through both urges and specific self-harm actions.

During Session 2, Module 6 identifies the young person's problems and goals. They are asked to rate their problems in terms of Subjective Units of Distress (SUDS). This rating (out of 10) is revisited at the end of Part 2 and also at the end of the treatment programme.

Supervision

All good CBT involves regular supervision. This book is designed for therapists who have a good knowledge of CBT and who have access to supportive CBT supervision.

References

1. National Center for Clinical Excellence. (2011). *Self-harm in over 8s: Long-term management. (Clinical Guideline CGI 33).* Available online at https:// www.nice.org.uk/guidance/cg133
2. Dobson, K. (2010). *Handbook of cognitive behaviour therapies*, 3rd ed. Guilford Press.
3. Linehan, M. (1993). *Cognitive behaviour treatment of borderline personality disorder.* Guilford Press.
4. Miller, A. L., Rathus J. H., & Linehan, M. L. (2006). *Dialectical behavior therapy for suicidal adolescents*. Guilford Press.
5. Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behaviour change*. Guildford Press.
6. Harris, R. (2009). *ACT made simple: A quick-start guide to ACT basics and beyond.* New Harbinger Publications.
7. Lynch, R. T. (2018). *Radically open dialectical behavior therapy: Theory and practice for treating disorders of overcontrol*. Context Press, New Harbinger Publications.
8. Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects*. Harper & Row; Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. Guilford Press.
9. Butler, G., Fennell, M., & Hackmann, A. (2008). *Cognitive-behavioral therapy for anxiety disorders: Mastering clinical challenges*. Guilford Press.
10. Taylor, L. M. W., Oldershaw, A., Richards, C., Davidson, K., Schmidt, U., & Simic, M. (2011). Development and pilot evaluation of a manualized cognitive-behavioural treatment package for adolescent self-harm. *Behavioural and Cognitive Psychotherapy, 39*(5), 619–625.
11. English, O., Wellings, C., Banerjea, P., & Ougrin, D. (2019). Specialized therapeutic assessment-based recovery-focused treatment for young people with self-harm: Pilot study. *Frontiers in Psychiatry*, December 6; doi: 10.3389/fpsyt.2019.00895.
12. Kaess, M., Edinger, A., Fischer-Waldschmidt, G., Parzer, P., Brunner, R., & Resch, F. (2019). Effectiveness of a brief psychotherapeutic intervention compared with treatment as usual for adolescent nonsuicidal self-injury: A single-centre, randomised controlled trial. *European Child and Adolescent Psychiatry, 29*(6), 881–891.
13. Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy, 23*, 325–334.
14. Harper, D., & Moss, D. (2003) A different kind of chemistry? Reformulating 'formulation'. *Clinical Psychology, 25*, 6–10.
15. Chorpita, B. F., Yim, L. M., Moffitt, C. E., Umemoto L. A., & Francis, S. E. (2000). Assessment of symptoms of DSM-IV anxiety and depression in children: A revised Child Anxiety and Depression Scale. *Behaviour, Research and Therapy, 38*, 835–855.
16. Goodman, R. (1997). The strengths and difficulties questionnaire: A research note. *Journal of Child Psychology and Psychiatry, 38*, 581–586.

17. Miller, S. D., Duncan, B. L., Brown, J., Sparks, J. A., & Claud, D. A. (2003). The Outcome Rating Scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy, 2*(2), 139–143.
18. Costello, E. J., & Angold, A. (1988). Scales to assess child and adolescent depression: Checklists, screens, and nets. *Journal of the American Academy of Child and Adolescent Psychiatry, 27*, 726–737.
19. Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton University Press.
20. Muris, P., Merckelbach, H., Gadet, B., Moulaert, W., & Tierney, S. (1999). Sensitivity for treatment effects of the screen for child anxiety related emotional disorders. *Journal of Psychopathology and Behavioral Assessment, 21*(4), 323–335.

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

What's going on?

Assessment, psychoeducation, risk assessment and safety planning

Assessment and psychoeducation

There are ten modules in the first stage of treatment which can usually be delivered in three sessions.

Aims of Part One

Session 1

- To provide the young person with an overview of therapy.
- To educate the young person about self-harm – psychoeducation (Module 1).
- To gain a joint understanding of the function of self-harm, a timeline of self-harm and suicidal behaviours, and to introduce the virtual characters (Module 2).
- To start the risk assessment and start of safety planning (Module 3).

Session 2

- Revisit risk assessment and safety planning.
- To identify the young person's strengths.
- Formulation: the start.
- To identify specific problems and goals for therapy (Module 6) and introduce the concept of values.
- To introduce alternatives to self-harm.

DOI: 10.4324/9781003163046-2

Session 3

- To enable the young person to be motivated to change (Module 9).
- Thinking about relationships in the young person's life (Module 10).

Overall plan for therapy

The CBT model is referred to throughout the programme. Essentially this approach highlights the relationship between thoughts, emotions, behaviours and environmental factors and how to recognise triggers and maintenance factors in self-harm behaviours. Strategies will be learnt to monitor and manage thoughts that lead to self-harm and to learn alternative behaviours to cope with and regulate intense emotions that have historically led to self-harm. At or around Session 3, when the individual sessions are starting to address key relationships in the young person's life, the therapist will start meeting separately with the parents. The young person will be invited to join the third parent session to discuss the shared formulation.

Understanding self-harm

This session is a mixture of psychoeducation and assessment. It is divided into three modules: Module 1, what is self-harm and CBT for self-harm? Module 2, understanding the function of self-harm, timeline and the virtual characters; and Module 3, risk assessment and safety planning.

Session 1: Crib sheet for the therapist

- What is self-harm and how does CBT fit?
- The function of self-harm.
- Reasons why people self-harm.
- Introduce the virtual characters.
- Timeline of self-harm.
- Risk assessment and safety plan.

Module 1: What is self-harm and CBT for self-harm?

Aims

This module focuses on psychoeducation about self-harm, discussing with the young person that self-harm is common and that it is a topic that has been fairly well researched. During this session, therapists will share with the young person a summary of pertinent data from important research studies. Psychoeducation is aimed to help young people feel less isolated and different, and to understand the mechanisms and function of behaviours. Explain that, in this therapy programme, over the forthcoming sessions, they will learn different ways to manage difficult emotions that show up and identify the thoughts that contribute to these emotions, as well as learning skills to improve their relationships.

Note to therapist: You will explain the concept of CBT later, but try and highlight the difference between thoughts, feelings and behaviours, as you discuss examples and how they influence each other.

DOI: 10.4324/9781003163046-3

Agenda

As this is the first session, the young person will probably not know what to expect. Explain that you will be setting an agenda for each session, in order to make sure everything we want to cover is covered. This will always include:

1. Bridge from last session.
2. Homework review.
3. Any issues raised by the young person (see earlier notes on this).

Main session topic: today you will be discussing self-harm in general. Discuss the following issues and think with the young person how specific issues relate to their experience of self-harm:

Note to therapist: It is important not to lecture, try and check in regularly with the young person, if it makes sense to them, resonates with their experience, allowing for difference of opinions etc.

- Self-harm has been defined as 'causing deliberate hurt to your own body'. It is something that a person does to himself/herself on purpose that injures or damages their body. Reasons for why people do this vary.
- Suicidal behaviours are self-harming actions that could cause a person to die, such as taking a drug overdose, cutting deeply or tying a ligature.
- From the research, we understand that some people who self-harm do not want to die, some do want to die and some do not care if they live or die.
- Self-harm is often an expression of distress, or a way of coping. It may or may not be because the person wants to die.
- Self-harm can take many forms, but the most common methods are self-cutting and self-poisoning by taking an overdose of medicines. Other methods of self-harm include: burning, scratching, hitting, pulling out hair (needs to be assessed as to the function of the pulling hair, as this may not always be self-harm) and not letting old wounds heal.
- Anyone can self-harm, and it is more common than people think, particularly among young people in the United Kingdom.
- People have different feelings related to self-harm, but something that many people who hurt themselves have in common is a feeling of depression, loneliness and isolation and a sense that nobody understands. Another common theme is feeling desperate or overwhelmed by problems in relationships with important people in their life and thinking that there is no way out. Others feel angry and upset.
- Some people report that during the act of self-harm, they can feel numb, relief, distracted with the physical sensations, or just a sense of being 'alive'. After self-harming, people may experience a mixture of thoughts and emotions. Some may feel extremely shaken up, or tired; others may feel nothing or in part feel pleased or relieved. Some describe feeling happy for a short time; others feel ashamed or guilty; and others just don't want to think or talk about it at all.

In talking about these issues, make sure to elicit the young person's responses to this information and how this might apply to them.

Module 2: The function of self-harm, introducing the virtual characters and my timeline of self-harm

Aims

This module continues with psychoeducation about self-harm and starts to elicit the particular functions of self-harm for the young person.

Start by saying that people tend to do things for a reason, to meet a need. Some of the documented reasons young people have given for using self-harm will be discussed shortly. You will be asking the young person which they relate to and what other reasons of their own they might add to the list. ***Download Handout 1.1: Reasons why people might self-harm***. If it comes up, when you go through the list, highlight the links between thinking, feeling and urge to self-harm. For example, feeling hopeless might come with a thought 'what's the point', which increases the feeling of hopelessness and sadness and then triggers the urge to self-harm (the behaviour).

Some young people may be able to volunteer their own main reasons for engaging in self-harm, whereas others endorse options provided to them by the therapist. In any case, following this discussion, you should have some clues as to the reasons why the young person engages in self-harm. The next step is to get an understanding when the self-harm started, the triggers and frequency of occurrence. This information is gathered before carrying out a detailed functional analysis of a specific incident of self-harm. Functional analysis is important to understand what is going on for the young person.

Download Handout 1.2: Real-life stories – virtual characters. Show the young person the vignettes and give them time to read these through. Ask them whether they relate to anyone. Who do they think they are most similar to? This will enable the start of the conversation and further assessment of the issues, in a natural way.

After the discussion, you will be introducing the timeline and using Jessica's story as an example. Say to the young person that you will be looking at Jessica's timeline of self-harm for this exercise and ask for any thoughts the young person has on Jessica's timeline before introducing their own timeline.

Exercise: Timeline of self-harm

Download Worksheet 1.1: Timeline of self-harm and explain that the aim of this exercise is to think about how self-harm has fitted into the young person's life and for how long. You will focus on the history, type, severity and frequency of self-harm. Discuss Jessica's example (Figure 1.1) prior to carrying out the exercise.

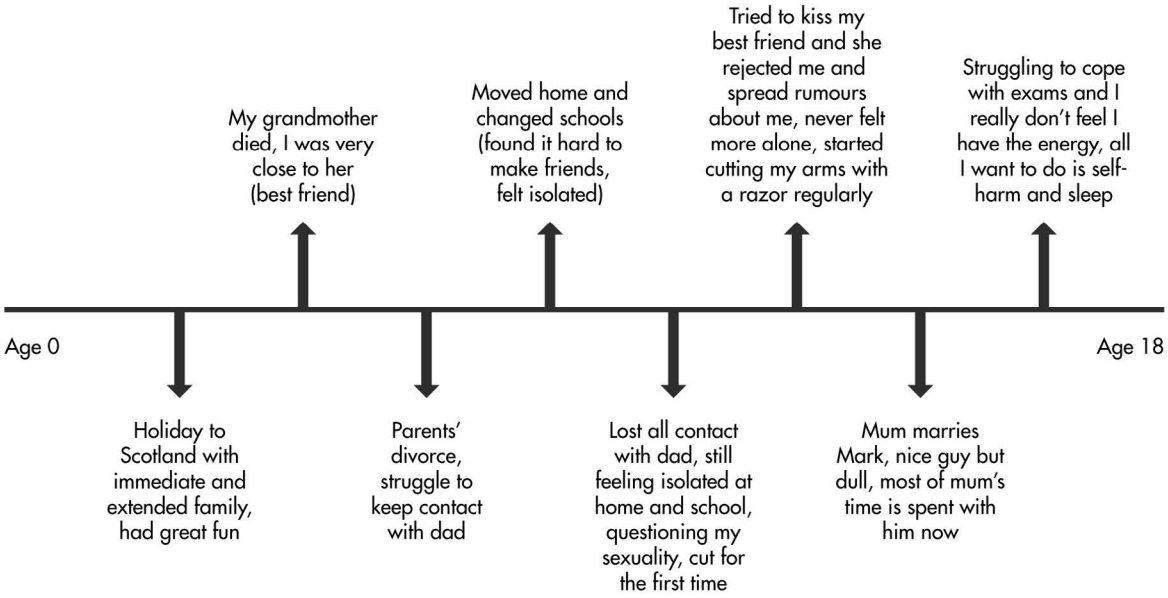

Figure 1.1 Timeline of self-harm: Jessica

1. First, the young person will need to identify several 'anchor points' to help remember where and why self-harm occurred. For example, key events like birthdays, special occasions and school changes. These are then positioned on the timeline using arrows.
2. Next, other incidents can be added around the timeline, generated by a series of questions. For example, 'What's your earliest memory?' 'Describe any big event that pops into your head' 'What is your happiest/saddest/most exciting memory?', etc.
3. Then, maybe in a different colour, incidents of self-harm can be added, again generated by a series of questions. For example, 'Do you remember when it started?' 'When was the worst time/the most worrying time for others/the most worrying time for you?', etc.
4. Then the discussion should be opened out and a chronology of incidents identified. For example, 'Has the self-harm changed over time?' 'Have you developed routines?' 'Do you do different things now?', etc.
5. As the timeline is being completed, start to explore with the young person which particular events were happening around the various incidents/times when they self-harmed. These data will be used for the formulation and will reveal clues to predisposing, precipitating and maintaining factors.

Exercise: Functional analysis: The self-harm chain

The next exercise involves the functional analysis of a specific incident of self-harm. It might be an example from the timeline or another example that is fresh in the young person's mind. Explain that functional analysis of self-harm involves identifying the specific factors (events, emotions and thoughts) that come before, during and after an incident

of self-harm. It is identifying and putting together the links in the self-harm chain to fully understand the sequence.

- ***Download Handout 1.3: Cassie's self-harm chain***. Go through Cassie's example of how she felt before, during and after an episode of self-harm and looking at her links in the chain. Then go on to discuss one of the young person's own incidents of self-harm.
- Use prompts to get as much detailed information as possible. For example, 'Who was around?' 'Where were you?' 'Can you remember what you could see/smell?', etc. Use this information to complete the worksheet together. Explain to the young person that this information will be really useful to start to understand the role of thoughts, emotions and behaviour in self-harm. It will also be useful in thinking about the therapy path and the young person's goals for recovery, which will be addressed in the next session.

Module 3: Risk assessment protocol and safety plan

Download Handout 1.4: Risk assessment handout

The aim of this module is to have a protocol for risk. This should be started at the beginning of therapy and referred back to regularly. Remember, if at any time in therapy, you are worried about a young person's safety, it is important to divert to assessing the current risk. This will be part of your regular clinical practice, but some guidance is offered here.

Try and make a start on this in Session 1, but it is fine to revisit at the beginning of Session 2 if you run out of time.

Note to therapist: If the young person has made a recent attempt, e.g., has taken an overdose, they need to go straight to A&E (Accident & Emergency). If they meet some of the high-risk pointers in the risk assessment, they need to be further assessed to see if they can keep themselves safe. If necessary, the parents/carers need to become involved, or the possibility of an assessment for an inpatient stay needs to be considered, if very high risk.

Safety Plan

It is useful to start a safety plan with young people who self-harm, particularly if the young person you are seeing has a history of suicidal thoughts or behaviours. Check safety early in each session and when you devise the plan make sure that the young person practices the skills they listed in the plan. This template is designed to be *revisited regularly*, to incorporate different skills and strategies that the young person has mastered or finds useful.

As above with the risk assessment, if you do not have time for this in Session 1, prioritise it in Session 2.