chapter eight

Self-Destructive Behavior, ACT and Functional Analysis

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This chapter introduces an ACT approach in the treatment of self-destructive behavior. Using case examples, metaphors and theoretical discussions the key elements in an ACT treatment for self-destructive behavior are highlighted. Case examples will be given from sessions with adolescent clients. The chapter outlines ways of working with clients using functional analysis of behavior strategies, specific ACT processes and instruments such as the Bulls-Eye diary and the presence report. Furthermore, a value-based therapeutic relationship based on a functional analysis is the foundation on which the ACT therapy is built. Creating a therapeutic environment, where creativity is fostered and where the clients dare to challenge vicious cycles and take new valued steps in life, is a necessary element of therapy. The chapter starts by focusing on self-destructive behavior and how it is described in the literature. It continues by discussing how self-destructive behavior can be analyzed with functional analytic thinking and the therapeutic relationship.

Self-Destructive Behavior

Self-destructive behaviors seem to have increased in frequency during the last decades (Hawton, Fagg, Simkin, Bale, & Bond, 2000; Gratz, 2001; Lundh, Karim, & Quilisch, 2007). A study conduced by Gratz (2001) showed that 35% of 150 students (mean age of 23) had self-harmed at least once during their lifetime. Furthermore, in a Swedish study, about 65% of the participating high school students reported that they had harmed themselves deliberately (Lundh et al., 2007). A study examining

the general and clinical population suggests that 4% of the general population and 21% of a clinical population had either deliberately burnt or cut themselves without attempting to commit suicide (Briere & Gil, 1998). Despite the recent increase in attention to the area of self-harm there is not a satisfying definition of self-harming behavior. When defined broadly, self-harming behavior can be stated as a deliberate and direct attempt to destroy or alter bodily tissues without trying to commit suicide (Favazza, 1998; Winchel & Stanley, 1991). However, the aim of this chapter is not to debate the definitions of self-harming behavior or to speak about self-harm as a category. Instead, the chapter discusses self-destructive behaviour from a clinical ACT perspective that is clearly based on a functional analysis of behaviors in certain contexts. From this perspective both the analysis and intervention view behaviors as less categorical and more dimensional.

There are a number of studies that describe similarities, background variables and maintenance factors of self-destructive behaviors (Gratz, 2001). The topography (e.g., traits, diagnosis) of self-harming behavior differs between populations. The most common self-harming behavior reported is overdose. Thirty per cent or more of those who commit suicide have a medically documented history of self-harming behavior (Hawton & Fagg, 1992). The literature suggests a number of overrepresented background variables for those who self-harm including sexual abuse, troublesome home environment, neglect, loss of significant other, and early injury that needs medical attention, to name a few (Chapman, Gratz & Brown, 2006; Hawton, Fagg & Simkin, 1996). In describing integration of topographical and functional assessments, it has been suggested that '… behavior topography may serve as a useful starting point for the identification of relevant target behaviors and that topographical assessment should then give way to the identification of the more functional properties of clinically relevant behavior' (Farmer & Nelson-Gray, 2005, p. 133).

Functional Analysis of Self-Destructive Behavior

Chapman and colleagues (2006) state that there is a lack of a unifying, evidence-based, theoretical framework within which to understand the factors that control deliberate self-harm (DSH). They suggest a model for understanding how DSH is controlled called the Experiential Avoidance Model (EAM). Experiential avoidance has been conceptualized as a functional response class. That is, it represents 'a group of behaviors that, although possibly different in form, are alike to the extent that they produce the same or similar outcomes' (Farmer & Nelson-Gray, 2005, p. 104). Experiential avoidance occurs when humans not only avoid situational dangers but also thoughts, emotions and memories related to unpleasant events. The EAM has been based on an integration of research on emotions,

DSH and experiential avoidance. The model is built on research findings that indicate that DSH is primarily controlled by negative reinforcement and concludes that emotional regulation is a key element of DSH (Chapman et al., 2006). Even though negative reinforcement is the most common described maintenance factor for DSH, positive reinforcement is also a contributing process. Thus, DSH is developed and maintained by multiple processes, and although one of the key functions appears to be emotional regulation, the specific manifestation of these relationships in individual cases, requires analysis.

Dialectic Behavior Therapy and ACT are two models built on functional analysis that have been evaluated in the treatment of self-harm, both on its own and in combination with other problems. The models aim to decrease experiential avoidance and increase behaviors that will help the client in directions that they consider meaningful and important (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Gratz & Gundersson, 2006; Swedish Council on Technology Assessment in Health Care, 2005). Both DBT and ACT therapists continuously conduct functional analyses of behaviors as they relate within sessions and outside of sessions. The following chapter examines an acceptance, values and mindfulness intervention, developed through a functional analysis of self-destructive behaviors.

The base of any ACT therapy is the functional analysis of behavior in a certain context. Context refers to behaviors that can be observed by one or more persons, and the situation in which the behaviors occur. Using a functional approach on behavior implies that it is not the topography of behavior that we as therapist are interested in, but the function of the behavior. The functional stance toward behavior in an ACT model suggests that self-destructive behaviors are only self-destructive if the function of the behavior is not effective in building a more value-based, vital life. Consider the following example of a broad and general analysis of how self-destructive behavior for adolescents may develop. Note that an analysis of behavior can be done on different levels and that this is a broad and general analysis. The focus that follows is mainly on an individual and interpersonal level.

Case Analysis

Linda is a 14-year-old adolescent who has grown up in a home where alcohol and fighting has been very common. Linda tried different ways to get her parents' attention during her early years, but most of the time she was neglected. She tried to talk to them but was not listened to; she tried to help out at home but did not get any feedback except when she had not done the dishes or taken care of her sister and her brother. She tried to talk to her teachers at school but they saw her as a troublemaker and did

not know what to do. In the classroom she was rowdy and disturbed the class in different ways. Linda's teachers tried to control and discipline her by sending her out of the classroom, yelling at her, imposing strict rules, and placing her in a smaller class. Nothing seemed to work; her destructive behavior escalated and she dropped out of school. Finally, the Social Service department conducted an evaluation about the ability of Linda's parents to care for her needs. Consequently Linda was removed from her home and placed in a centre for self-destructive adolescents who self-harm. Figure 1 depicts the vicious cycle Linda was stuck in before she was removed from her family and placed at the treatment centre.

Linda's basic human need for attention and care was neglected at home and in school. Teachers and adults around Linda tried to discipline her using rules and punishment that led to more resistance, self-harm and a rigid behavior pattern, which led to more out-of-control behavior. On the surface, this might not seem like functional behavior from Linda's point of view. However, on second viewing, her attention needs were met, she was removed from a family where she was neglected, and people started to listen to her and care about her family situation. Important human functions were met for Linda in both the short term and long term.

Nock and Prinstein (2004) target four types of functions that maintain self-destructive behavior:

- *automatic negative reinforcement*, where self-destructive behavior is used to reduce negative affect
- *automatic positive reinforcement* where self-destructive behavior is used to create arousal, elation or a feeling of being relaxed

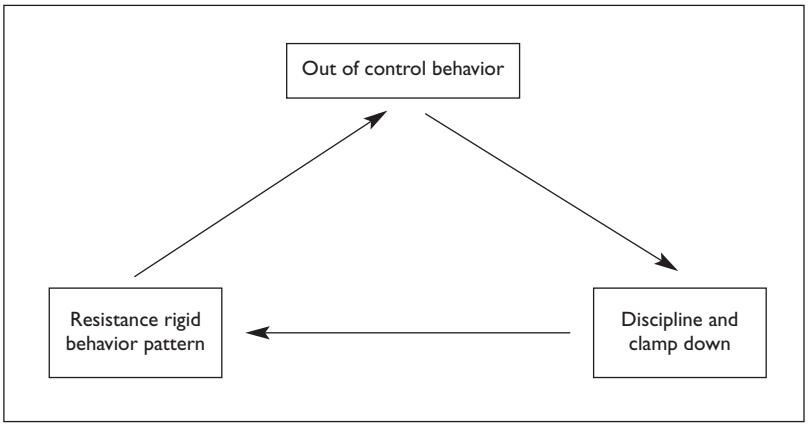


FIGURE 8.1
Linda's vicious cycle.

- *social negative reinforcement* with the function of escaping unpleasant situations
- *social positive reinforcement* which functions to create important attention from persons in his/her surrounding.

Obviously, the understanding of maintenance factors is of the utmost importance in treating a person with self-destructive behavior with an ACT approach.

Breaking the Cycle

The first step in therapy is to analyze the behavioral cycle and create a hypothesis about how to respond to Linda's behavior differently in order to stimulate new learning experiences. The analysis should include triggering factors, behaviors, maintenance factors, and the context in which the behavior occurs. The analysis will provide a guide during treatment. A treatment hypothesis is developed and evaluated, and the analysis and treatment hypothesis may need to be reviewed and revised to best help Linda. Linda's environment has not encouraged the development of commonly accepted behaviors. She has developed rowdy behavior and self-harm as a way of expressing herself and to help her gain both situational and emotional control (emotional control is discussed later in the chapter). Her behavior repertoire seems rigid. She is not behaving in a way that makes people around her want to care for her and spend time with her. Discipline and rules have not been helped Linda at school, but have led to more resistance and out-of-control behavior. In her context, being rowdy and self-harming have been functional, and it can be assumed she will continue to behave in that way if the response (discipline, rules and control) to her behaviors continues in the same way. This vicious cycle needs to be broken and help provided to Linda to build a broader behavior repertoire so that she can choose behaviors, rather than reacting to sensations and emotions. A key factor in behavior change is to create a space where an interaction between the client and the therapist can take place. In the following treatment sequence, the therapist responds to out-of-control behavior with acceptance and interest in order to break the destructive behavior cycle and make room for new learning experiences.

The aim of the treatment is to help Linda choose behaviors controlled by what she wants her life to be about, instead of being controlled by emotions, fears, memories, sensations and thoughts. Instead of reacting to out-of-control behavior and responding with increased discipline, rules and control, an alternative is to respond with values-based acceptance in order to make room for increased interaction, communication and new learning experiences. Discipline, rules and control are dysfunctional ther-

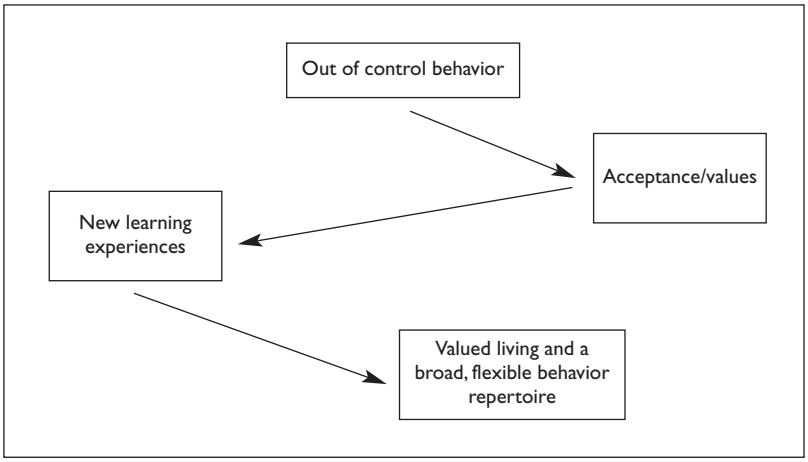


FIGURE 8.2
Example of treatment sequence.

apeutic behaviors in this context because the function of the responses is that Linda has continued to apply self-harming behaviors. It is not that discipline, control and rules are bad per se, it is simply recognizing that, according to our analysis, the function of the behaviors people around Linda have applied to her have functioned as reinforcers of self-harm. For Linda, although those behaviors may have had an important function, at this stage of her life they may no longer be necessary. The aim is to help Linda develop a broader behavior repertoire in her own valued direction. This will emerge from establishing of a relationship where Linda listens her therapist. The therapeutic space between Linda and the therapist is an important element in successful therapy. It is partly developed through an accepting and respectful stance between clients and therapists. Acceptance involves not only accepting Linda's and the therapist's feelings in session but also accepting feelings from both Linda and the therapist when they seek to understand what Linda cares deeply about. Metaphorically speaking, the role of the therapist is to be the 'advocate' of Linda's personally stated values. The therapist validates the suffering and gently acts as an advocate of values. In Linda's case this approach is likely to be radically different from anything she has previously experienced. Her behavior has either been met with frustration, neglect, punishment or full discipline, which have not helped her develop into a person living a valued, vital life.

Below is an example of a values- and acceptance-based introduction between Linda and her therapist in the initial phase of the treatment. Prior

to this conversation Linda had cut herself and she was obviously expecting the therapist to tell her that she has to stop doing that.

> T: Hi Linda, I am glad to see you.
>
> L: Hmm, sure you are … I have cut myself and I don't care what you say, it felt great!
>
> T: Ok … well Linda, I am here to get to know you and find out in what way I can be of help for you in your life and where we are right now. Even though it may sound strange to you, I am here because one important part of my life is being here for you and other girls, to find out a way to live life that is based on what you want, what gives you strength, fun and meaning in life. I am here for you and your life, not your cutting. I can't make you stop your cutting and I don't want to force you into anything. You will probably cut yourself as long as it works for you and until you have something that is more important and an alternative. If you ever want to try other things in life and other ways of relating to life I would like to do that with you. How does that sound?

In this initial phase of therapy the therapist wants to establish a values- and acceptance-based context. The aim of this relationship is to help the client to develop her behavior repertoire and contact new learning experiences. Ultimately, we want the client to get in touch with natural contingencies that help her choose valued behaviors, search for meaningfulness and not be a 'slave' to aversive stimuli. The therapist states his value of being a therapist and does not get into any discussions about right or wrong, good or bad. The functional approach is established and consistently flows through the whole treatment. Wherever possible, every response in the therapeutic relationship should be based on functional thinking.

Note that the therapist in this conversation stated that he was not especially interested in her cutting behavior; he was interested in what she wanted to be about, what she was afraid of and how he could be of help to her in life. The aim of that response is to help the client and the therapist not to get stuck in discussions about the pros and cons related to cutting, but to be about 'life' and 'something else', even if that 'life' and 'something else' is not defined yet in their relationship. What the therapist wants is to get in contact with other possible behaviors that would reinforce and develop another way of communicating. Furthermore, telling Linda (and many other self-cutting girls) to stop cutting herself is something others have tried to do and that has not worked, in the sense that she is still cutting herself and she is not developing and making her behavior repertoire more flexible. This approach states that Linda will cut herself as long as cutting works for her. This statement is informed by several concepts. First, the therapist does not want to get stuck in arguments with Linda about what she should or should not do. Arguments may make Linda distance herself from the therapist or engage in pliant behavior and that is not the aim of therapy. Second, the

therapist wants Linda to develop a behavior repertoire based 'in' her life, in contact with her natural contingencies. Third, the therapist wants to introduce a functional base in their communication for when they discuss behaviors. Fourth, the therapist wants to weaken the verbal and emotional links between this therapy and Linda's prior experiences of therapy and therapist. Adolescents like Linda may have often had negative prior experiences with therapists and 'helpers'. This therapy is meant to be about a fresh start based in the here and now, with the aim of increasing Linda's flexibility and valued behavior.

Therapist as a Stimulus, Responder and Reinforcer

As a therapist you are the stimulus, responder and possible reinforcer for behavior. Reflecting on your behavior as a therapist from a base of learning principles can affect the therapy session and the treatment of self-harming behavior. Applying learning principles in-session can broaden your behavior repertoire as a therapist and give you an opportunity to reinforce and stimulate behaviors that lead to a more valued life for the client, contingent on behavior. Functional analytic psychotherapy (FAP; Kohlenberg & Tsai, 1991) applies learning theory inside the therapeutic relationship and states that effective interpersonal behaviors can be trained in session. With a 'FAP stance' in ACT, problematic behaviors are evoked and blocked, and effective behavior is stimulated and reinforced. Ideas from FAP may be helpful in the treatment of self-destructive behavior, especially when interpersonal problematic behaviors are evident (which they often are). Interpersonal problems often co-occur with self-harming behaviors and this is found particularly in those diagnosed with borderline personality disorder.

The literature evaluating the etiology of self-cutting suggests that sexual abuse and other physical harm that require hospital care are positively correlated with self-harm (Weierich & Nock, 2008). Furthermore, lack of emotional closeness and neglect from caregivers during the child's upbringing is a common factor for those who self-harm (Briere & Gil, 1998; Favazza, 1989). Neglect occurs in an interpersonal relationship and influences the child's future behavior in relationships. The neglected child may not acquire the commonly accepted interpersonal skills, but instead develops behaviors to survive in a specific environment. The behaviors can be different, but share the same function of providing attention, feelings of security and so forth. The learning history in interpersonal relations affects the adolescent's future interpersonal skills and will be given special attention in this section of the chapter. A functional approach is used to reflect upon how neglect can affect behavior and how the developed behavior may be dealt with in the therapy room.

The interpersonal behavior repertoire for a person who has been neglected and for whom the needs of attention and care have not been met may be affected in numerous ways. Consider this example: a child seeks reassurance and comfort from her caregiver because she is sad. She has been hurt when she played with friends on the street and runs inside for comfort. When she gets inside and seeks comfort her caregiver ignores her most of the time, which in this case has the function of a punisher or blocker. A punished or blocked behavior will decrease in frequency when the punisher (the caregiver) is present. Running inside to seek comfort is something that the child will do less frequently. If the behavior class of seeking comfort is punished in different situations it is likely that the child will develop a rule saying that 'seeking comfort is bad and not something I should do'. The child may also develop a rule saying, 'I should not tell people what I feel or show them I am sad'. A clinical reflection is that the child will probably, through relational framing, mix two responses that could be called closeness and pain. Closeness refers to the warm, secure, safe and comforting experience a child/person has when he/she is taken care of when hurt. Pain refers to the experience a child/person might feel when he/she has been punished, hurt, traumatized or neglected. The caregiver who initially may have been associated with a safe haven, someone who has given comfort and someone to trust, has added punishment, hurt, ignorance and suffering functions to her/his appearance. This leads to uncertainty in relations and affects future relations in important ways. Intertwining pain and closeness has important implications for treatment planning.

Through transformation of stimulus functions it is likely that a therapist who wants to help evokes the same functions as the caregivers, earlier therapists, teachers and other persons in the health and social service agencies. The new therapist acquires both the 'good' and 'bad' functions. Seeking and receiving care and being vulnerable in relations are in a relation frame with pain and suffering. When the therapist applies a warm, caring therapeutic stance he or she may evoke both emotions and experience that trigger destructive behaviors. Consider the following therapeutic conversation between a therapist and a self-destructive adolescent with a history of being neglected and abused by her caregivers. The therapist uses a functional approach in session and is very sensitive to the client's body language, positioning and overall behavior in session. The conversation takes place during the start of therapy. The client has started to be a little engaged in session and they start to get a more relaxed contact.

T: Welcome back Linda, how glad I am to see you!

L: Sure you are … I am sure that you say that to everyone!

T: What is so hard about me saying that I am glad to see you?

L: Just because … (Linda looks away and starts to scratch her scars)

T: Linda, I don't want to hurt you, I notice that you are getting anxious. I am curious to understand why your body reacts and evokes so much feeling and you get so anxious when I say that I am glad to see you and that I care about you.

L: You are not the first and you will leave me just like everyone else! I hate you!

T: OK, Linda (with a soft voice), I see a lot of emotions and memories popping up … do I understand you correctly, that people you have been close have left you and that has been really painful for you?

L: Sort of …

T: So, when I say I am glad to see you and we are getting to know each other, painful memories of when people close to you, have abandoned you and emotions connected to those memories pop up, here and now, and makes our connection painful … am I correct?

L: Yes, that is what happens, I get very anxious and angry!

T: Would it be important for you to be able to develop relations where people can care about you without you pushing them away because your emotions and memories say that it is dangerous?

L: Yes, that would be nice but people leave me. That is how it is …

T: Is it OK if I suggest something?

L: Yes, I really don't want to get anxious around people I care about all the time, I want to be able to make friends, have fun and trust others.

T: In order to help you to be able to let people care about you, I suggest that we start in here with our relationship, you and me. When you react to me or to things I say you can just tell me that and we can stop and reflect on it together in order to learn more about you and what you need. No reaction or thought is wrong or bad, they are what they are. OK?

L: OK, a bit scary, but OK.

This conversation shows a range of different aspects of the analysis and treatment of self-destructive behavior. All of them are important, summarized and discussed below.

The beginning of the interaction between Linda and her therapist shows how Linda's memories are brought into the present and trigger an aggressive behavior. Linda is not reacting on natural contingencies but instead she reacts to the relation between stimuli in the outer and inner context, which is a verbally derived process. Her therapist states that he is happy to see her and that he cares about her. That triggers memories, emotions and sensations that remind her about being left behind and punished. This stimulates aggressive behavior and pushing people away. People around Linda have probably reinforced the aggressive behavior by letting her be alone or becoming angry with her when she has behaved aggressively. Being

on her own might be easier in the short run because Linda might think that at least she will not get hurt. The therapist presents this hypothesis to Linda and she supports it by stating that persons have left her and that she is afraid that the therapist will do the same. Nothing in the present moment suggests that he would do that, except Linda's memories and her related experiences.

The therapist acknowledges and validates Linda's feelings and says that he can see that Linda is strongly affected by her emotions. However, he does not let himself be drawn into a discussion about right versus wrong, pros and cons, nor does he get drawn into arguing about whether he is going to leave her or not. Instead he takes a functional approach toward the content she is presenting. He reflects on why the emotions are evoked in this context and how this can be brought into an analysis of Linda's behavior and treatment. He evaluates the possible contextual factors triggering her behavior and he reflects on the maintenance factors for Linda's behavior in their interaction. The therapist takes a functional stance toward Linda, both in their therapeutic relationship and toward the content she is presenting.

After acknowledging, validating and helping Linda to reflect functionally on her reactions the therapist takes the next step in the treatment by asking Linda about her values in this situation. The therapist introduces values early in the treatment to create a reference point. The reference point — metaphorically the 'lighthouse', the compass or the Bulls-Eye — will become a guide for the client, the therapist and their time together. The reference point will also function as the measure of whether Linda is on her preferred track. Values have important functions in a successful therapy. In addition to being a reference point and a guide for behavior, values work may broaden Linda's behavior repertoire and stimulate behaviors toward her valued directions. She would be able to build a relationship with the therapist based on what she wants and needs in therapy and not her negative emotions. Therapy can help Linda take steps to create the life she values, instead of getting rid of negative emotions. Furthermore, values work can highlight the discrepancy between how Linda is living and what she wants to be about. The experience of the discrepancy creates a psychological space that can stimulate value-driven actions.

The reference point is established and the therapist asks for a commitment to the chosen direction. What the therapist suggests is built on the analysis he has conducted in the first two or three interactions. He validates Linda by summarizing what she has said in the analysis and asks if he understands her correctly. Furthermore, he suggests that they start to act according to her valued direction inside their therapeutic relationship. He suggests that Linda practice being as she values being in their relationship and make room for all the emotions, memories and reactions in the service of learning more about her reactions. The aim of this intervention is to

help Linda be more able to choose actions, instead of reacting to emotions and memories. Linda agrees with the suggestion and commits to the work. A treatment hypothesis is created and built on a functional analysis. As in all behavior therapeutic the treatment hypothesis is tested, evaluated, and changed if the results dictate.

Avoiding Emotions, Thoughts and Sensations Instead of Natural Dangers

Aspects of how therapists can think about self-destructive behavior and self-harm from a functional analytic perspective have been discussed. An example was provided describing how functional analysis can be conducted relatively quickly and early in the session to create a treatment hypothesis and to develop direction in therapy. The following section of the chapter describes how to continue the treatment from the initial analysis. Limited space does not permit presentation of a full protocol but key processes and ways to work with these processes are presented. Initially, emotional avoidance is examined and related to self-destructive behavior. The discussion about emotional avoidance and how to relate to that leads to values clarification and how to use the Bulls-Eye diary in the treatment of self-harm.

Experiential avoidance has been shown to be a core process in psychopathology (Hayes et al., 2006). Experiential avoidance is the process where a person avoids thoughts, feelings and emotions related to a painful event and not the painful event per se. A review of information about Linda will help explain the concept of experiential avoidance.

Linda had one place were she could go when her parents fought in a way that she could not stand and that was to her grandparents. The grandparents did not live far from Linda's family. She could easily jump on her bike and go to them when she needed. At her grandparents Linda could rest and eat properly. She felt safe and in harmony with her grandparents. With them she could be a little girl who played with dolls and sat by the kitchen table drawing for hours. One day, just after Linda turned 12 her grandfather sexually abused her. The abuse did not stop until Linda was removed from her home by the Social Service. In therapy, Linda was a high experiential avoider, and much of her behavior was aimed at avoiding experiences that were likely to be related to that abuse. She tried to avoid almost all emotions, especially emotions related to possible important and vital relationships. She avoided thoughts about her grandparents and did not want to talk about her family. Her grandparents were related to pain as well as warmth, which probably made Linda try to avoid almost all emotions. Linda's emotional life was very chaotic due to her verbally derived network between her different experiences of warmth/security on the one hand and abuse on the other hand. 'Good' and 'bad' feelings were mixed and created emotional chaos.

When Linda felt emotions she automatically, almost reflexively, did something to diminish that emotion. She developed a behavioral repertoire that worked in the short run (symptom reduction) but with her valued life as a reference many of her behaviors were not effective. Her avoidance behaviors might have had important functions earlier in her life but not at the centre (new contexts often requires new behaviors) and probably not in her future life. Furthermore, her avoidance behavior made her less receptive to natural contingencies; instead she was under aversive control and acted on her thoughts and feelings about the world instead of what it is that actually happens in the situations she is in. Metaphorically speaking, it is not Linda who makes choices, rather it is her emotions, thoughts and feelings. Our aim is to help Linda be free and not a slave to her experiences; not free in the sense that she will be rid of her experiences, but in the sense that she can have emotions, sensations, and thoughts, and choose her behavior according to what she wants her life to be about. The aim is to help Linda get in touch with her 'potential' in any situation. For example, imagine that a valued area for Linda is friendship. Friendship for Linda includes being able to laugh and have fun as well as cry and be vulnerable in relationships. Therapy aims to help Linda be able to choose that direction. At the beginning of therapy Linda is fused and stuck with experiences that occur in situations here and now and control her behavior. This fusion and 'stuckness' with experiences creates a rigid behavior repertoire and a 'values illness'. Consider the following conversation, where the therapist tries to help Linda get present with natural contingencies and not be stuck in the past or the future. The aim of the session is to create a space for emotions in the service of making Linda more able to create relations outside the therapy room with all her emotions. The therapist will introduce a home assignment for Linda with the aim of being more in the present moment.

Linda: This is so hard, I cannot have a relationship with anyone I am hopeless (whispering, looking down).

Therapist: Hmm, you are sitting here struggling with a lot of thoughts and emotions.

L: Hmm

T: What does this lead to right now?

L: I don't know … nothing good I guess

T: Does it take us closer or further apart?

L: Further apart I guess.

T: OK, so when you are sitting there struggling with emotions and thoughts it doesn't help you to live the life you want, is that so?

L: Yes, that is right (looking up).

T: Hmm, and now you are more here with me, are you?

L: Yes, it loosens up in my chest a bit.

T: Let's sit with this for a moment … with your emotions at the same time as you are connecting with me, looking me in the eyes.

(After about 30 seconds of silence.)

L: Sometimes I am here and sometimes I wander off.

T: OK, so by looking up and getting in contact with the things around you, where you are and what you are set to do, loosens your chest a bit. Struggling doesn't seem to help you … Does this often happen to you? That you are getting stuck in experiences like emotions and thoughts instead of what is really happening in the actual situation?

L: Yes, it happens quite often, especially at school where there are a lot of people.

T: OK, I have an idea that you can try if you want to work with being here and now and do what you are set to do. I call it the Presence Report.

L: Sure, let's try it.

At the beginning of this conversation Linda is struggling with emotions and thoughts, instead of being in contact with the situation here and now. Linda is not in contact with what it is that happens between her and her therapist. Her focus is on her own emotions and thoughts. In this conversation the therapist is helping her to shift perspective and let the focus instead be on Linda's values (being present with others and her therapist). The therapist is asking about the function of her behavior in a values context. Furthermore, the therapist is reinforcing behaviors that seem to help her to be more in contact with natural contingencies, that is, her conversation and connection with her therapist. In the middle and the end of the conversation Linda is encouraged to be in the moment, in contact with her values and in contact with the moment. At the end of the conversation a home assignment is introduced and Linda shows a willingness to work on her ability to be more present in situations and relations.

The Presence Report (see Appendix A) was developed to function as a discrimination-training tool, an instrument to measure presence in life, a pedagogical tool and a way to measure outcome in therapy. It is also possible to ask the client to rate how she felt during different actions and to evaluate the correlation between being present and how they feel. In the example below, the client is given a diary to use with the Presence Report. On the second page the client is encouraged to write notes about how she felt and the differences between being present and not present. Furthermore, she is encouraged to develop her own thoughts about this exercise on the 'reflection page'. Doing this every evening aims to help the client to become more aware of thoughts, emotions and sensations that are controlling her behavior and

encouraging her to willingly embrace these experiences. Below is an example of Monday's reflection section from a self-destructive adolescent.

> Today was a pretty good day. I ate breakfast and usually I feel present when I do that, even calm. Maybe I should start eating breakfast more often, I think it gives me more energy during the days … At about 11 am I took the bus to the gym. There were some others on the bus but I didn't hide behind my hood as I usually do. I noticed them and that my pulse aroused a bit and continued to read my book. I went to school after the gym and it was OK. I was there to 3.00 pm. Got on the bus around 3:30 and went to the centre. When I arrived there were two girls fighting which made me scared and I almost dissociated. Fighting makes me so scared! It is even worse when I like the ones involved. Anna, who is a friend of mine, was one of the girls fighting. At 6.00 pm I had a meeting with the Social Service and I was just thinking about other things, I hate those meetings! I am not present at all! It didn't feel good because we talk about budget and that is important for me. Have to practice more on that! During the evening I sat by the computer watching movies, it was OK but I think I did that on autopilot.

Using the presence diary helps the client practice being present in everyday life. Furthermore, it encourages the client to reflect on her behavior and may help her to do her own analysis on triggers for fear and avoidance. In session, the Presence Report and reflection diary can be used to support functional analysis in difficult situations and when experiencing difficult bodily sensations and thoughts. The aim is to help the client to decrease experiential avoidance and increase psychological flexibility. Creating a psychological space for sensations and emotions also creates space for values and commitment work. Being present and in contact with natural contingencies is important, both in everyday life and in the therapy session. Without a functional contact between the therapist and the client therapy will not be of help to increase valued living.

Increase Valued Living, Avoid Values Pitfalls and How to Use the Bulls-Eye Living Instrument

Valued living is the goal of therapy for self-destructive clients, just as it is for all clients when using an ACT approach. The use of mindfulness training and the decrease of experiential avoidance increases the possibility of adding new learning experiences. Practicing mindfulness might, for many clients, be a new experience in itself. However, the aim of that training is to increase valued living and contact with natural contingencies. Choosing a new direction in life and broadening the behavior repertoire can be a tough task for self-destructive adolescents. Discussions about values need to be conducted in a way that helps the client become willing to embrace what they consider important in life.

Closely linked with values is pain. Values work has been incorporated in the chapter so far because it is closely intertwined with all the other processes. Contacting your feelings and being present with your friends can be an important value. Being present in therapy and in the therapeutic relationship can be a value. Being present with family members and your body can be a value. A key aspect of the therapeutic flow is the analysis. This will guide you about which processes to work with. Another way to work with values for self-destructive adolescents is the Bulls-Eye diary.

The Bulls-Eye diary is often presented to adolescents after work to decrease experiential avoidance to increase their willingness to explore what they want life to be about. Questions about what adolescents want their life to be about often need a base in psychological flexibility and a strong therapeutic relationship. Furthermore, work with values, psychological flexibility and the therapeutic relationship are intertwined and one does not necessarily come before the other. Again, what is done in therapy should be suggested by your functional analysis.

Working with values and what is important in life for adolescents needs careful attention. Values work contains dangerous pitfalls for the therapist. Possible pitfalls are described below, with a statement and an example from a conversation, followed by possible thoughts from the therapist's perspective.

Pitfall 1

Beware of your own values of what you consider to be an important and meaningful life.

Example from a therapeutic conversation:

T: What do you want your life to be about from now on, Linda?

L: I have given that quite a lot of thought. I want to move home to Mum and just be with her helping her with my brothers, clean and wash.

Possible therapist thoughts:

She's going to do what! She has the ability to do so much more! Move home, clean and take care of her brothers! Hmm, how can I make her choose school instead? I absolutely think that she is meant for something more than that!

It is quite possible that if you have worked with clients you recognize these types of thoughts. You want something different and something more, because of your own programming of what a good life is like. You care about your client and you might have had the thought that she is worth something else. Being a therapist does not mean that you are right about life; who are we to decide what a good life is? That is not our job as ACT therapists. An ACT therapist's job is to help our clients be able to live their chosen valued lives inside of the limits of the law. It is important that therapists working with self-destructive clients have access to supervision where they can discuss and reflect on their own reactions in therapy. Furthermore,

videotaping and letting colleagues in a supervision group comment on it might help the therapist get perspective on their therapeutic stance. It can also be a help to write a therapeutic diary reflecting on both the work and the reactions you might have as a therapists.

Pitfall 2

That action cannot be a value driven action because of the form of it!

> T: Hi Linda, I am very curious to hear about your values work during the week.
>
> L: I have taken steps! I contacted a guy over the Internet and met him. He wanted to have sex, he was ugly, but I had sex with him anyway. It was not very good but I really want to be able to have physical intimacy and closeness to others.
>
> Possible therapist thoughts:
>
> My God! She sold herself on the Internet! That was not a valued step, that was prostitution! You have to tell her to meet other guys!

As discussed earlier in the chapter, ACT work is built on a functional analysis. An ACT therapist is more interested in function than form and topography. All countries have laws that set limits on what we can and cannot do. It is important to make room for your own thoughts. However, in this case it is possible that it was a valued step. We can as therapists help adolescents to broaden their behavior repertoire and help them to reflect on the function of behavior in both the short and long term. An ACT therapist should avoid to get caught up in right or wrong or good or bad. An ACT therapist is only interested if it is workable or not with values as a reference.

The Bulls-Eye Living Diary

Using the Bulls-Eye in a diary form may encourage the client to work with values every day. The aim of the Bulls-Eye diary is to help clients get in contact with their valued directions and stimulate activity in those chosen directions. In this exercise we want the adolescents to ask themselves what they want their life to be about, every morning when they get up. We encourage them to choose a direction and choose a step that will coincide with that direction. When they get back to their diary in the evening they evaluate their steps using the Bulls-Eye dartboard. See Appendix B for an example of the Bulls-Eye diary for adolescents.

Clients are encouraged to write down what they are choosing to value during the day. If friendship is the area, we encourage them to describe the quality of friendship. Describing the quality and not only saying the word can strengthen the reinforcing qualities of the described value. Furthermore, after choosing the area to value they are asked to choose a step that they are willing to take to honor that value. Remember that it is not the form or the

topography of the step, but rather the function we are interested in. We encourage clients to challenge themselves, but at the same time not 'force' themselves into doing things. Forcing behavior can never be a valued action in ACT. If friendship is the value, sending an SMS to an old friend they lost contact with and asking them out for a cup of tea can be a valued action. They choose what they think is important. In the evening he/she marks an X on the dartboard describing how close he/she was to living in a valued direction during the day. An X in the Bulls-Eye of the dartboard represents that the action, sending an SMS to a friend and the area of friendship, were congruent with the valued direction and vital. An X far from the Bulls-Eye represents that the client was far from living in valued direction. The client and therapist evaluate the work in session.

The form and the layout of the Bulls-Eye diary may influence the effectiveness of the diary. The dartboard is attached on one page of the book. The other page is used as a space for reflection, as with the Presence Report exercise. Clients are asked to write down anything related to the exercise. Reflecting on the difference between living in the Bulls-Eye and not living in the Bulls-Eye is important for discrimination training purposes.

Summary

In this chapter important components in an ACT approach for self-destructive behavior have been discussed. The content is mainly clinical and built on clinical experiences with self-destructive adolescents. ACT applies a functional approach toward behavior. The chapter started with a general analysis of self-destructive behavior and continued with a discussion of treatment processes such as values, experiential avoidance and building a value-based therapeutic relationship. Using case examples, metaphors and transcribed sessions, protocols, experiential avoidance, values and being present were described. At the end of the chapter specific tools and possible home assignments were provided.

References

Briere, J., & Gil, E. (1998). Self mutilation in clinical samples: Prevalence, correlates, and functions. *American Journal of Orthopsychiatry, 68,* 609–620.

Chapman, L. C., Gratz, K. L., & Brown, M. Z. (2006) Solving the puzzle of deliberate self-harm: The experiential avoidance model. *Behaviour Research and Therapy.* 44 (2006) 371–394.

Farmer, R. F., & Nelson-Gray, R. O. (2005). *Personality guided behavior therapy*. Washington, D.C.: American Psychological Association.

Favazza, A. R. (1989). Why patients mutilate themselves. *Hospital and Community Psychiatry, 40,* 137–145.

Favazza, A. R. (1998). The coming of age of self-mutilation. *Journal of Nervous and Mental Diseases*, *186*, 259–268.

Gratz, K. L. (2001). Measurement of deliberate self-harm: Preliminary data on the Deliberate Self-Harm Inventory. *Journal of Psychopathology and Behavioral Assessment, 23,* 253–263.

Gratz, K. L., & Gundersson, J. G. (2006). Preliminary data on an acceptance-based emotion regulation group intervention for deliberate self-harm among women with borderline personality disorder. *Behavior Therapy, 37*(1), 25–35

Hawton, K., & Fagg, J. (1992). Deliberate self-poisoning and self-injury in adolescents: A study of characteristics and trends in Oxford, 1976–1989. *British Journal of Psychiatry*, *161*, 816–823.

Hawton, K., Fagg, J., Simkin, S,. Bale, E., & Bond, A. (2000). Deliberate self-harm in adolescents in Oxford, 1985–1995. *Journal of Adolescence, 23*, 47–55.

Hawton, K., Fagg, J., & Simkin, S. (1996). Deliberate self-poisoning and self-injury in children and adolescents under 16 years of age in Oxford, 1976–1993. *British Journal of Psychiatry*, *169*, 202–208.

Hayes, S. C., Luoma, J., Bond, F., Masuda, A., & Lillis, J. (2006). acceptance and commitment therapy: Model, processes, and outcomes. *Behaviour Research and Therapy*, *44*, 1–25.

Kohlenberg, R. J., & Tsai, M. (1991). *Functional analytic psychotherapy: Creating and curative therapeutic relationships.* New York: Plenum.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive–behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48,* 1060–1064.

Lundh, L. G., Karim, J., & Quilisch, E. (2007). Deliberate self-harm in 15-year-old adolescents. A pilot study with a modified version of the Deliberate Self-Harm Inventory. *Scandinavian Journal of Psychology, 48,* 33–41.

Nock, M. K., & Prinstein, M. J. (2004). A function approach to the assessment of self-mutilative behavior. *Journal of Consulting and Clinical Psychology, 72,* 885–890.

Swedish Council on Technology Assessment in Health Care. (2005). *Dialectic behavior therapy for borderline disorders*. SBU alert report NO; 2005–07, www.sbu.se/alert

Winchel, R. M., & Stanley, M. (1991). Self-injurious behavior: A review of the behavior and biology of self-mutilation. *American Journal of Psychiatry*, *148*, 306–316.

Weierich, M. R., & Nock, M. K. (2008). Posttraumatic stress syndrome mediates the relationship between childhood sexual abuse and nonsuicidal self-injury. *Journal of Consulting and Clinical Psychology, 76,* 39–44.

APPENDIX A
The Presence Report

Name_____Week_____

Time of day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8–9	~/X	Z	Z	€	Z	Z	Z
9–10	X	Z	€	€	Z	~	Z
10–11	~	Z	€	€	Z	€	Z
11–12	~	€	~	~	~	~	Z
12–13	X	€	X	~	~	€	Z
13–14	X	€	~	€	€	€	~
14–15	X	~	~	~	€	~	~
15–16	€	€	~	~	€	€	~
16–17	€	~	~	€	~	€	€
17–18	€	~	€	~	~	~	~
18–19	~	~	~	~	€	~	€
19–20	~	~	€	€	~	€	~
20–21	~	~	€	~	~	~	~
21–22	~	€	€	Z	~	~	€
22–23	~	~	€	Z	€	~	~
23–00	€	~	~	Z	€	~	~
00–01	Z	~	~	Z	~	€	€
01–02	Z	~	~	Z	€	€	~
02–03	Z	~0	€	Z	~	Z	€

Use the symbols below to describe your level of presence during the day. Use your dairy to reflect on your day. Here are some questions that may stimulate your thinking. What was the difference between being present and not being present? How did that feel? What type of situations was it easy or respectively difficult to be present? Is there a pattern in your presence diary, when you are present and when you are not?

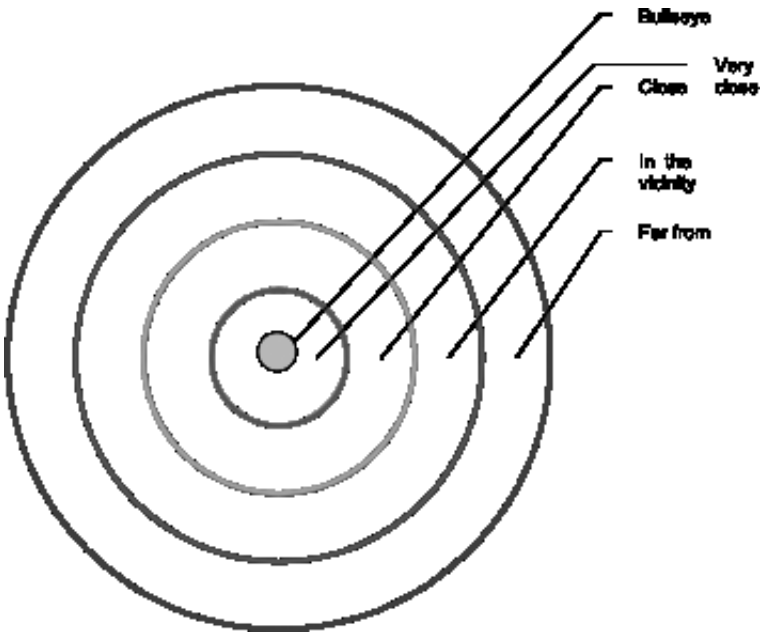
Note: € = Not present

~ = Present and not present

X = Present

Z = Sleeping

APPENDIX B
The Bulls-Eye Living Diary



Part A. What direction would you like to develop in today? Write the direction on the lines below.

Part B. What can be a step in that direction?