

Title: Supporting Family Systems Struggling with Adolescent Self-Injury and Suicide

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Moderator: Hello and welcome to today's webinar, Supporting Family Systems Struggling with Adolescent Self-Injury and Suicide. This webinar is paid for by McLean Hospital, a top-ranked freestanding psychiatric hospital, a leader in psychiatric care, research, and education, and the largest psychiatric teaching hospital of Harvard Medical School. Some important points before we get started. Dr. Gillian Galen and Jim Holsomback, the presenters for today's webinar, work at McLean Hospital. As such, they have both a financial and intellectual interest in the content.

The purpose of this presentation is to provide a balanced view on strategies to support families of youths struggling with self-injury and suicide. APA does not endorse any products or services. The content was created by McLean Hospital and does not reflect the views of APA or its editorial staff. Email advertising at apa.org to learn more. Next, this program does not offer CE. However, we will email everyone watching live today a Certificate of Attendance. Certificates will only be issued to those who watch for a minimum of 45 minutes.

A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides. During our time together, you will be on mute. You can communicate with us using the Q&A box located on your webinar screen. Have a question for our presenters? Type them in using the Q&A box located on your webinar screen. A link to the presentation slides will be posted in the chat box of your webinar screen. If you miss them, don't worry. We'll email them to you with the recording. Now, let me introduce our presenters.

First, Dr. Gillian C. Galen. Dr. Galen's PsyD is a Senior Child and Adolescent Psychologist specializing in Dialectical Behavioral Therapy. She is the Director of Training for the 3East Continuum, an array of programs for teens that use DBT to target self-endangering behaviors and symptoms of Borderline Personality Disorder. She has extensive experience in diagnosing and treating adolescents and young adults who struggle with emotion dysregulation, anxiety, depression, trauma, and self-endangering behaviors, such as self-injury and suicidal behaviors.

Dr. Galen has a particular interest in the use of mindfulness in the treatment of Borderline Personality Disorder and psychiatric illnesses. She is a co-author of the books *Mindfulness for Borderline Personality Disorder: Relieve Your Suffering Using the Core Skill of Dialectical Behavior Therapy*, *Coping with BPD: DBT and CBT Skills to Soothe the Symptoms of Borderline Personality Disorder*, and *DBT for Dummies*.

Jim Holsomback. Jim serves as the Director of Marketing and Clinical Outreach for McLean Hospital. He previously served as a Director of Adolescent Clinical Education and has extensive experience working with adolescents and families, and with psychiatric programs and hospitals across the country. His leadership role in clinical outreach provides an opportunity to continue working for clinicians to provide awareness and access to services for families nationally and internationally.

Mr. Holsomback has a particular interest in working with adolescents and families that have experienced trauma and have exhibited trauma-related behaviors that preclude them from accessing their personal, academic, and professional strengths. He finds assisting family systems understand and access evidence-based treatment to help patients and families regain their interests, relationships, and lives is particularly rewarding. Welcome, Dr. Galen and Jim Holsomback.

Jim Holsomback: Thank you very much, and I feel very fortunate to be here in collaboration with APA and everyone who is attending the webinar today. Our first slide doesn't exactly, fit perfectly with this presentation, and it feels really important, particularly for the content of what we're going to discuss and folks' presumed interest in self-injury and suicide. Mortality rates, while it seems to be a cold and crass way to assess medical and environmental risk, is the manner that the CDC views improvement or decline in medical or environmental death and disease. This is a really nice picture on advances that we've made in this country over a pretty substantial amount of time, 40 years.

In aggregate, we can see the medical pieces, heart, cancer, flu, brain-related disorders, have decreased about 40% across age ranges 5 to 14 and 14 to 25. Environmental deaths, accidents, and homicides, 40 to 45%-ish, decreased in 40 years, which is pretty substantial. The one category that the CDC tracks in terms of death rates that has not made an improvement but really declined a pretty substantial amount is suicide. As you can see, there's almost a 400% increase in suicide rates for 5 to 14-year-olds in that 40-year time period. The large overwhelming majority of those suicides are 10 to 13-year-olds.

I think in the scope of thinking about what we're going to talk about, this is an area that we really have not made advances in. We're hoping, both in thinking about adding supports and services to families and thinking about this problem differently because clearly, we haven't made any substantial differences or improvements around decreasing suicide, particularly in children, adolescents, and young adults. We think a little bit about our building blocks and how to establish and build more resilient family systems quite a bit. We'll talk about some of these during the presentation.

I think first in our foundational building block that we think about is specifically around compassion. We think about the compassion building block in three different ways. One, we think about helping and building compassion for families for their kids, which probably feels pretty self-evident. As families are going through a number of difficulties when they have kids that are really struggling around behavioral health issues, especially with self-injury and suicide. Compassion fatigue happens to families in the same way it can happen to us as providers.

We really need to make sure that we're helping families build and establish and maintain their compassion for their kids. The second way we think about compassion is, for ourselves, compassion for providers to families and making sure that we're taking care of in a way that we can maintain our compassion for families and for the kids that we're treating. Thirdly, and maybe most importantly, is compassion for families toward themselves. Understandably, families look toward themselves when

things aren't going well. Friends, family, Facebook, Instagram, everything seems to be going well with everyone except them.

It can be really easy for families to lose compassion toward and for themselves. We really need to help maintain that to keep them in the game. Second building block assessment, in the same way that we think about assessment to inform a treatment course and clinical care for individuals, kids, adolescents, adults. We really need to look at families and family systems in the same way. What have families been through? What do they need? What are their treatment needs based on their history and think about assessing a family system in the way that we would assess a child, adolescent, or young adult?

Psychoeducation, we'll talk a lot about trauma, PTSD, and Gillian will talk a little bit about that in a moment. It's really important that we actually talk to that with parents in addition to teaching really core skills around validation, empathy, and then building or getting ourselves up to the setting contingencies. Building block where we're going to talk a lot about behaviorism and building contingencies, which really when we help families build effective contingencies, it's really helping them help their kids establish, really good autonomous capabilities, which is what we want parents to be able to do.

Disaster prevention, we really want to make sure that we're leaning into that. Families avoided at all costs. It's unfortunately something when it comes we want to make sure that those crisis plans are coming out of logic when we're not in the moment of a crisis, versus families trying to figure out what to do in moments of crisis. Finally, ongoing support. What do families need in the same way that we would think about for a child, adolescent, or adult? What does somebody actually need in terms of their care in an ongoing fashion? Gillian will start to talk a little bit about some of the trauma piece.

Dr. Gillian Galen: Jim and I have worked over the years with many families. What we have seen is that families of kids that self-injure, and kids that have engaged in any suicidal behavior essentially are functioning as frontline workers. You are the emergency workers. You are the first on the scene many of the times. You're up close and personal to risky behaviors that your children are experiencing. I love this slide because it really, really hits home, the impact. You look at trauma in the general population, and then you start to look at occupations that you would think would have trauma.

Social workers, people, oncologists, treating cancer, people working with people that use substances who often have very high levels of overdose. People working in violent sexual crimes, military, first responders, those people in the ER, certainly child protection, DCF, DSS workers. Then what the research shows is the top of the scale for people experiencing trauma are parents of children with these types of life-threatening behaviors, so self-injury and suicide. I think this surprises many parents initially, but when they take a step back and look at what they've experienced and they start to pay attention to these symptoms, it makes a whole lot of sense.

Quick little piece of here's the psychoeducation, building block one of these pieces of psychoeducation that we provide for parents is that when people experience trauma, seeing somebody do dangerous behaviors. Something self-injury, hurting

themselves, or making a suicide attempt, or the threat of suicide, we have normal stress reactions. That's what everybody does. What we know, and you can see, everybody's going to have some trauma. We often call that an acute stress response. The first month after somebody's experienced trauma, you see a lot of trauma, trauma symptoms. You see people might be more hypervigilant.

They might avoid certain areas related to the trauma, or certainly might not talk about certain things, see certain people, go to certain places. They may have nightmares. They may have what we call flashbacks or see images of the traumatic event. Typically with social support and with being able to talk and process this and get validation and understanding within your community, most people don't develop PTSD. They work through that acute stress response, and then they don't end up developing the symptoms for PTSD. The problem with this group of parents is that this isn't something that people often feel that they can about.

This isn't something that people often share with their closest friends in the way that they might share a chronic illness diagnosis of their child, cancer, diabetes, where we often will say-- we've heard from many of the parents that we work with, nobody brings over lasagna. Nobody comes and offers this support. We feel like there's a stigma. We can have many, many, many friends, but the experience is often one of isolation and lack of social support. That in and of itself interrupts the process of being able to get validation and talk about your trauma and how scary this is, which then lets that PTSD and secondary trauma symptoms sink in.

If family members have their own personal history of trauma this makes them much more vulnerable to being traumatized and developing PTSD from their child's dangerous behavior. We know that then what happens is that we see that little arrow on the bottom you get a brain, you get a PTSD brain, there is much hypervigilant, much more scared, and then often what families will find is that their lives get smaller and smaller and smaller. They avoid people, they avoid places, and they live in constant fear of the next dangerous behavior that their child could engage in. Here we go. All right. Oh, perfect.

This is a, I think, a very, very, very helpful and often very validating slide for parents to look at. This is called the secondary trauma checklist. What happens to the traumatized brain or the traumatized parent? We recognize that you still have to parent through all of these symptoms. Through all of this fear, you have to go to work and life has to move on. People often say, "What, why do I feel this way?" This is why you feel this way. Parents that are experiencing trauma will often have feelings of guilt, of anger, which can be very, very hard to talk about. Sadness, feelings of helplessness, feeling disconnected and isolated.

You can see more depression often in parents that are experiencing this struggle and journey with their child. Many people will say they have a hard time concentrating, it's harder to get things done. They might feel like they're up all night thinking and what we call ruminating, thinking over and over again what if, what if. Much less interest, we often call it general apathy, but less interest in being engaged, feeling wake myself up and get what I need to get done, done, and not feel a whole lot of joy or drive or motivation.

It tends to be more survival coping like I'm going to do what I do to get through the day. Behaviorally, you may see social withdrawal. Many people have interrupted sleep. Appetite shifts, so either we'll have some parents report that they're much more hungry and they've gained weight. Other people will say, "I just have no appetite," and they'll have a lot of weight loss. There's that hypervigilant, being on alert all of the time, so a very activated nervous system. You might feel a more cynicism or a negative outlook, like things aren't going to work, nothing is going to get better, more of a resignation.

Then there's the physical symptoms that parents will often see which is certainly you can have pain, people often get sick more when the body is under stress. The immune response isn't as efficient so you get more illness. Difficulty taking care of yourself. People often say, "I used to work out, I don't work out anymore. I used to cook a lot and I felt good eating home-cooked foods, and now I do Uber Eats and DoorDash and snack because I don't have the energy." Then that just general sense of chronic exhaustion and depletion.

Jim: In an effort to try and combat the trauma and trying to support parents, there's a number of different skills that we'll work on teaching parents after this psychoeducation piece. One of which is a concept that was born out of a fantastic study of over 900 families around tenets of mindful parenting. The tenets, there's nothing particularly earth-shattering that's going to blow anybody away, parent or us otherwise. Sometimes I think when stress goes up and certainly when all of that secondary trauma and hypervigilance escalates, they can certainly slip out of our awareness.

The six tenets, listening to our kiddos with full attention, having compassion, she talked about before for our loved one, nonjudgmental acceptance of our parenting mistakes, emotional non-reactivity toward our kids, emotional awareness of our child, and emotional awareness of ourself. The nice thing with these, I think, these six tenets are that we see kids and families that feel more attuned to one another. We have kids that feel like their parents are more effective in terms of their parenting, and parents that just intrapersonally feel a little bit more confident in their parenting and their connection with their kiddos.

One of these six tenets is actually dynamic and powerful enough that when parents practice this tenet on a consistent basis that actually can lower states of depression and states of anxiety in their kids which is pretty remarkable. Just we can certainly feel free to use the chat if you want to take a little game show guess as to whether it's tenet one, two, three, four, five, or six. The findings again were very substantial. Again, just the fact that something that a parent can do can have that much of a significant impact on mood states of their kids is pretty impressive.

For anyone that chose or wrote in Tenet 3, fantastic, nice work. This sounds like a little bit of, "Okay, I need to be able to own up and say, sorry." It's a quality that actually can be a little bit difficult for parents, especially parents in crisis, in terms of being able to take responsibility and make a repair for whatever the mistake was and try not to do it again. Really it can be a difficult thing, even though the act of actually apologizing doesn't seem all that complicated, but very substantial in terms of impact for not just parenting but also for anxiety and depression states in kids.

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Another piece, we'll roll our memories back to *Psych 101* and all of those great behavioral principles. These are, I think, components that parents get early on, especially with younger kids. It can be not a overly complicated behavioral system that they set up, but it's parents, I think, just intuitively find different ways or read different strategies in terms of using these. As kids and problems get older and more complex, sometimes these go a little bit out the window. Just in terms of, a quick review, again, we like to think about positive reinforcement working.

This is something that parents, again, when kids are young, their kids eat their vegetables, they get dessert, they pee in the potty, they get a sticker, you get enough stickers, you get a toy. As kids get older, sometimes there's chores or cleaning your room that can elicit an allowance. We all operate under the positive reinforcement in our daily lives, our jobs. It's the way that we often think about reinforcement and incentivizing a behavior that we want to see in ourselves or in others. Secondly, negative reinforcement works.

This is probably one of the most misused and sometimes confusing topics, I think, is because often negative reinforcement can be used interchangeably, almost in the same way that punishment is. We really want parents to think accurately. It is literally just removing something that's unpleasant from another person's awareness. The idea is that by removing that unpleasant thing behavior that we want continues or behavior that we want to change changes. We all have this in our lives. We jump in the car, we drive down the street. 65 yards down the street, we get that annoying ding, ding, ding that our seatbelt isn't on.

Then we click our seatbelt unless you're incredibly tolerant to that kind of a noise. That's negative reinforcement. When we actually change our behavior from not wearing our seatbelt to wearing our seatbelt, the dinging goes away. We can replace for parents, sometimes that dinging can be the annoying noise that masquerades as parent nagging or parent reminders and things like that. When parents see those, the changes or the behaviors that they want, we have to remind them that-- we have to make sure that we're not continually giving their kids that ding, ding, ding or the nagging to make sure that, again, that behavior change persists.

Punishment, this is something, and again, very understandably in a moment of crisis, parents can get a little punishment heavy. Especially when they feel a little bit helpless and hopeless around how things are going or are going to go. Punishment can work in a really specific time-limited way. It's rarely effective over long periods of time, and it's actually a poor teacher of behavior change. When it's used as a primary motivator, kids, particularly adolescents, young adults, over a long period of time will actually spend more time figuring out how not to get caught or not to get punished more so than actually making really viable behavior change.

We need to try and get parents out of that punishment loop sometimes that they find themselves in. Behavior change is hard, and that's why we see extinction bursts. When we're making changes or we're asking for behavior change, we really need to make sure that it's really behaviorally specific and that we're asking for what we want. The hard part is, a parent, has been responding or providing behavior A, and then they change their behavior in an effort to create the behavior change they want to see in their kiddo to behavior B. Their kiddo is going to do anything and everything

they can to bring back the parent that they knew and loved that was behavior A parent.

We see that there's a lot of the behaviors that we're actually trying to get rid of can actually escalate while we're making those behavior changes. We really need to be able to support parents to be able to hold steady, be really consistent, know that those annoying behaviors are going to peak, and then start to level out as long as parents can be consistent in terms of their parent B behavior. One thing that happens a lot with parents is they intermittently reinforce the very behavior that they don't want to see. There's really not a more powerful behavior change schedule that we can provide.

Then what we're really teaching kids is if I really go for broke, if I really try and do the very behavior that my parents aren't willing to see, then they'll change their behavior instead of me changing mine. Really important concept for parents to understand. As well as finally that parents need to reinforce getting closer to the goal or approximations closer to the goal. Really, this is, again, can be a really difficult concept for parents because if you have a kiddo that never does their homework and they get five nights of homework a week. Then we set up contingencies where we see the kiddo is getting two nights of homework completed instead of zero, a parent has a choice.

They can either be really celebratory and happy about the two nights, or they can say, "Well, what about the other three nights that you haven't done?" Which one's going to be elicit or continue that behavior change? We really need to help parents really pay attention to when they see that behavior change to roll out the confetti cannon. Make sure that they're reinforcing that instead of harping on the behavior change that hasn't happened. Because two out of five nights is moving in the right direction and be much more likely to continue that change if we actually pay attention more to that than the behavior that hasn't quite changed yet.

We bring that up specifically because if parents don't understand principles of behaviorism, contingency management is going to be really, really difficult to do. Contingency management is, it's a skill really, and it's something that isn't necessarily taught or found in some sort of a parenting pamphlet. We really teach this because we really want parents to understand that if they can set and establish and carry through effective contingency, that that's what's really going to make help behavior change and build the capabilities that parents typically are going to want to see out of their adolescent or young adult.

Especially when some of those adolescent behaviors that we like to see with autonomy and responsibility aren't exactly where we might want to see them developmentally. This doesn't necessarily tell parents what contingencies to set or which ones are the right ones. Obviously, we wouldn't know that without stepping foot in the family's home, but it almost serves as a proof. We want to say, if your contingency meets these six principles, it's probably going to be fairly effective. At its bedrock and its foundation, consistency, probably the most important thing, I think, at the foundation of contingency management.

We really want to make sure that parents can set contingencies where they can reinforce that contingency in the most consistent way, not vary back and forth and really hold to it. Ensure that their behavior doesn't necessarily change based on their kids' behavior, based on emotional decisions in their behaviors. If parents can be consistent generally in that contingency, it's going to be pretty effective. Livable this is, I think, one of the hardest pieces in advance to think about for parents and really, really important. I have a 17-year-old daughter and she drives, and if I want to make sure that she can drive her younger sister to softball practice.

There's a contingency that she loses the car if she doesn't return it with the same amount of gas as she took the car and then she comes back the car's on empty. She didn't do her job, and I say, "Oh, no more car for you, no more driving." Suddenly my contingency isn't very livable for me. I'm going to be resentful, obviously, that she didn't-- that I've got to go put gas in the car, but also because now she's not able to drive her younger sister, which might mean my life has become a little bit less livable. I might have to leave work early to drive her younger sister to softball or whatever.

We want to make sure that all of our contingencies are livable by the very people that are really asked to establish and reinforce those contingencies. Intuitive, this is where we want to make sure that the crime and the reward fit the punishment and the good behavior. We want to make sure that it generally flows in something that makes sense. Often parents find really powerful reinforcers, freedom, cell phones, boyfriends, girlfriends, things like that, and link every single contingency to one of those three or four powerful things.

The hard piece is if I have 50 contingencies that all line up to my kiddo being able to use their cell phone, once they lose their cell phone because they weren't able to do whatever it was that the contingency called for. I now have 49 useless contingencies.

As we all know, there's nothing more scary than an adolescent with nothing to lose. We want to make sure that our contingencies follow there's some natural link to what we're asking for and what the reward or the consequence might be. We want to make sure that it fits both in terms of not just the what that reward might be, but also that the impact of it that it's not too great or too small.

We kind of keep kids understanding why they're doing the contingency and the reward lines up with that. Collaborative, we really want to make sure everybody that's involved with this contingency is on board and knows about it. This is all parents and caregivers. This is the kiddo themselves. We want to make sure that all of our contingencies are, again, really specific and everybody is on board. Sometimes we'll see, mom feels really strongly about something, dad doesn't feel so strongly. That adolescent makes a beeline for dad, the path of least resistance in terms of not wanting to change that behavior to whatever the contingency is calling for.

We want to make sure everybody's really on board. Holistic allows a lot of collateral treaters, schools, other people to be involved. We want to make sure that they're just aware that we're trying for behavior change, particularly therapists and other clinical providers. It gives them a chance to check in, not that they're necessarily in charge

of providing the reinforcements or feedback, but it gives another voice to checking in around that contingency management. Then closing out on the other side of consistent being one of the foundational tools, having an established plan is really, really integral as well.

This is how all rules work in our society. You drive 95 miles an hour down the highway. It's not like you get pulled over and nobody knows what to do. We know exactly what to expect. The nice piece, I think, with parenting and contingencies and having an established plan is that all of the work is done ahead of things working or not working. It's done very much rooted in logic versus emotion. There's an 11 o'clock curfew and somebody strolls into the house at 11:30. We don't need to come up with a plan or come up with a punishment.

Everybody knows, parents know, caregivers know, and most importantly, the adolescent knows themselves because the plan's already established. It's not something we necessarily have to set it and forget it. If we figure out we need to as we should every few weeks, check in and see what's working, what's not effective. Change the plan, and then again, keep that plan as established so everybody knows the expectations for the contingencies.

Dr. Galen: All right. To keep bringing all these things together. In ways that in supporting families that have kids that self-injure and are suicidal, we want to help them identify if they're traumatized. We want to teach them behaviorism so they understand why behaviors happen and what makes them persist and how they can help their adolescent change those behaviors. We teach them how to set contingencies, and we use this wonderful model from DBT around what we call common parenting dialectical dilemmas. This is part of the middle path skills in the adolescent DBT manual.

What these are common dilemmas that parents who have kids that self-injure, engage in suicidal behavior, have big emotion dysregulation. Parents find themselves polarized. Our task is to give them a tool to understand these extreme positions that they may be taking, have compassion for themselves. If they're co-parenting, have compassion for one another in trying to find a synthesis as they parent through these types of dilemmas. The way that we use this is we want people to think about where am I on one of these dialectics. How do I get driven to the poles?

I'll give you a clue. It's often fear. This is the emotion that pushes us. What makes sense about the position that I'm in? Where's some validation, which we're going to talk to you about? How do I respect if I'm co-parenting the other person's position? Because often marriages suffer when children struggle in these ways because emotions run high and parenting is so hard. Where am I most and least effective? How do I get myself into a more synthesized position? I'm going to briefly go through these. The first one we have is normalizing pathological behavior, and pathologizing normative behavior.

This is a challenge in general, but are there ways in which we're normalizing behaviors that are really problematic? This is where the new normal is. We reset a norm when actually the behavior is very problematic, but we get accustomed to it.

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The place where we're walking on eggshells because we're afraid to intervene. We convince ourselves that it's normal. It's okay that I don't set any limits with my child anymore. It's okay that I won't talk to them about these kinds of things because if I do they'll explode. We have people pay attention like are we normalizing things that aren't normal? We've just become accustomed to it.

All the way on the other side is, are we pathologizing things that are actually normative, often unpleasant, or challenging adolescent behaviors? Now, where this dialectic becomes the most important to think about is often for these kids, very normal adolescent behavior, tough days at school, not doing well on an exam that they had hoped to do well on, getting broken up by a boyfriend or girlfriend. These are all very normative things that make adolescents upset. Now, when adolescents pair that upsetness with suicidal behavior or self-injury, those two things become merged and parents need a lot of support.

Every time the child gets upset, we don't need to pathologize that. Adolescents come home and they slam their door and we don't see them for a couple hours and they listen to music in their room. If in the past, while doing that, they have hurt themselves, or done something dangerous, or not come out of their room for three days. Parents need support in not pathologizing that, but being able to see that that's actually a normative behavior. That we're now that they've learned skills, we're going to give them an opportunity to learn. Parents need a lot of support around this dialectic.

It's also, again, it's hard for-- many of us had adolescents that didn't include social media and cell phones and a lot of this technology. What we think is a normative experience may not be for them anymore. The next dialectic that we will tackle, Jim's going to put it up there, will be fostering dependency and forcing autonomy. This is another place where parents get very polarized. In every parenting dyad, there tends to be one parent that's going to be more comfortable pushing a kid towards independence and one that may be more anxious about it.

When you have kids that have deficits, parents can often inadvertently foster dependence. Meaning that because the child has some deficits we fill in the blank. In doing that, we reduce distress. It's anxiety-provoking to organize your backpack and you get very stressed out and I get very stressed out. So I organize your backpack for you and you feel better and I feel better as the parent. Again, this is working on negative reinforcement providing relief. What happens is the normative path is that we do things for kids when they're very young, then we do it with them so that they learn the skill and then they push us away and they do it on their own.

When we get caught fostering dependence, that cycle doesn't move forward. Parents end up, when you're 18, still organizing the backpack. Again, we need to help parents shift. Now what they can do, they can fly over to the other side and that's forcing autonomy. Which is pushing kids to do things independently before they have the skill set to do that. This is often pushed by peers, it can also be pushed when-- be challenging when some child's chronological age and their developmental age or skill set doesn't match. This can be one that parents can ping back and forth and get very, very stuck and also get very burned out and resentful of their child.

We need to help parents identify this and then work to navigate each of these different areas where they may have inadvertently fostered dependence, or force too much autonomy and have a slower more synthesized approach to help the kids learn the skills. Then the last dialectical dilemma is this authoritarian control or excessive leniency. This is highly, highly driven by fear. On one end of the authoritarian control is when we clamp down and we try to control the uncontrollable. We need to make them stop self-injuring. We need to make them go to school. We do all those things that don't work. We take everything away.

Again, an adolescent with nothing to lose is a dangerous adolescent to have. The idea is all the way at the poles, we end up trying to control the uncontrollable. When that doesn't work, we often swing to the other side, throw up our hands, and say, "I give up." DBT would call that willfulness, and we become much more lenient. That doesn't work and then people swing back and forth, and you get this swinging back and forth and we need to slow down. This is where we teach behaviorism and this is where cliché and contingency management begins.

Again, there will be times in which parents need to make the decision to be more lenient, and other times in situations where they need to be more authoritarian. When caught and driven by fear, that ability to discern disappears. We need to support parents in helping them regain that skill set. All right. We go into this one, Jim? Yes. Okay. We're going to validation. If you get the slide deck, there's a nice set of slides about sympathy and empathy, which is great. Validation is one of the most important skills that we teach. There's lots of webinars out there on validation. Validation lives in DBT and our relationship effectiveness skill.

This is the skill that helps improve communication, connection, and feelings of understanding between everybody. We particularly teach it for parents and their kids. What validation is, is it's simply recognizing that the other person's emotional experience makes sense given who they are. Validation has nothing to do with agreement or endorsement of behavior. We often may disagree. It has to do with letting that other person know that we're curious about their experience, that it makes sense given who they are, that we want to know more.

Validation actually functions as a way to help people regulate when we self-validate, which we also teach the kids to do. It helps emotions come down, thinking go back online. Often after validation, collaborative problem-solving becomes much, much more effective. We have a little three-minute video, which we love, which is a little bit of a parody, but it is an extreme illustration of what we are hoping people do with validation.

Female: It's just there's all this pressure, and sometimes it feels like it's right up on me and I can just feel it like literally feel it in my head and it's relentless. I don't know if it's going to stop. That's the thing that scares me the most is that I don't know if it's ever going to stop.

Male: Well, you do have a nail in your head.

Female: It is not about the nail.

Male: Are you sure, because I'll bet if we got that out of there-

Female: Stop trying to fix it.

Male: No, I'm not trying to fix it. I'm just pointing out that maybe the nail is causing-

Female: You always do this. You always try to fix things when I really need is for you to just listen.

Male: See, I don't-- think that is what you need. I think what you need is to get the nail out.

Female: See, you're not even listening now.

Male: Okay, fine. I will listen. Fine.

Female: It's just sometimes it's like there's this achy-- I don't know what it is, and I'm not sleeping very well at all, and all my sweaters are snagged, all of them.

Male: That sounds really hard.

Female: It is. Thank you. Ow.

Male: Oh, come on, if you would just-

Female: Don't.

[music]

Try to see things my way

Do I have to keep on talking till I can't go on?

We can work it out

We can work it out

Dr. Galen: All right. Validation is probably one of those most important skills that we teach parents when we put things all together. Now, the key to remember is that kids that struggle with self-injury and suicidal behaviors are often exquisitely sensitive. The dose of validation that they need is higher than the average person. You may have one child that doesn't need that much validation. You say, "Take the nail out." You have other more exquisitely sensitive kids that before you offer the problem-solving, you have to offer the validation.

These are just some quick points around validation. We could spend an hour on validation. When we validate, we deeply listen to the person. We don't lead them. We want to understand what their experience is. We want to work to see the wisdom in their position. In the same way we do with those dialectical dilemmas, we want to search for what makes sense about how they feel. When we want to do things like set limits or problem solve, we do use words like "at the same time" and "and." I recognize that this was a really painful breakup.

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At the same time, you need to get up and go to school. You need to help around the house. That both of these things are true. We are generating compassion and empathy for how someone feels even if we disagree, even if we think it's more intense than it ought to be. We recognize that the other person is an expert. If we lean in and get curious about somebody's experience and get it wrong, we let them tell us that we've got it wrong. We agree and we get more curious. When we invalidate, what we're trying to move away from is we're judgmental, or we assign intention to somebody's behaviors without being curious or we give advice.

Moving immediately to problem-solving for a sensitive person and giving advice is invalidating. It sends the message like, "Oh, this is an easy problem to solve," for them. Even though it may not be, they need more of that validation. Invalidating words like exactly what you saw in the video. "If you would just or you should just-- you should do this or just do this." Are often statements that are going to be followed by a way that's going to let the other person know that their experience wasn't valid. We try not to treat people as fragile.

We are compassionate and direct with them, or that we move into validating the invalid. It's not agreeing with something that's not true. It's looking for how to make sense of how they feel. We're looking at supporting parents and helping them understand their own experiences, and if they're traumatized what that means and give them some education. We're teaching them about behaviorism. We're helping them think more dialectically and helping them understand ways in which they may get polarized or extreme in their responses.

We're teaching behaviorism and contingency management, and we're helping them learn to validate both themselves and their exquisitely sensitive child. Fundamentally, parents who have children that have struggle with suicide and self-injury need support. When you support parents, when you educate parents, when you give them a community of other parents who are struggling like them they do better. Actually, their kids do better when you skill parents up and their marriages tend to do better.

Jim: I think that fourth bullet point is a great call out just for when parents receive support. The implicit relationship between parents and kids is better and kids are actually more adherent to treatment when parents are part of the treatment. We get out of that identified patient model and we see better outcomes in treatment when parents are involved and skilled up and supported.

There's virtually no downside. The fact that we can actually positively impact kids' treatment by supporting and skilling up parents is pretty integral. There's a couple pages of references that will come out with the slides as well. If you wanted to grab any of the references that helps build the slide deck out. Then a resource page for clinicians as well as families with some contact information at the bottom.

Moderator: Brilliant. Thank you so much. We have one question from the audience asking how can we foster resilience within family systems to support adolescents coping with self-injury?

Dr. Galen: You want me to take this one, Jim?

Jim: Sure. Go ahead, Gillian.

Dr. Galen: We teach them skills. Parents, kids will be more resilient. I think also if we can help support parents. Parenting is hard. Parenting in under the best circumstances now is hard. There are way more demands on kids. There's social media, which is a whole another dimension for those of us that are parenting now that didn't grow up with social media. If we can skill up and support parents and I-- we often go to schools and do general skills training for parents on things like validation, behaviorism. If your kid is doing this, what's reinforcing it?

How might you be inadvertently reinforcing it, and what can you do to help them develop new behaviors? Help parents understand, what are the warning signs? What should I look out for? Fundamentally, how do you get your teen or your middle school kid when life is getting hard to talk to you. What are the skills that you have as a parent to help kids feel like they can talk to you? How do we respond to them in a way that keeps them talking, even when what they're sharing with us might be very hard?

Jim: Great point, Gillian. I think the other piece is often when there's overlap when we think about a lot of skills that we use out of DBT, there's a lot of overlap in terms of skills that are being taught to parents and to kids. Again, I think, for parents to be able to recognize when kids are maybe not getting it perfect, but really leveraging some skill usage and maybe even more important or integral in terms of the relationship. When kids can recognize when their parents are actually practicing some good, effective skill usage, that really inherently is going to continue to build that communication.

That's the one piece I think is going back to the question around self-injury, as scary as it is for families to know that their kiddo has or is self-injuring, to not know that it's happening or not have communication, and that is probably tenfold scarier. We really want to make sure that open dialogue is there. Often teaching skills and having that shared skills that can help foster that.

Moderator: Wonderful. Thank you. We have another question that asks, how long can these symptoms of secondary trauma last for after a traumatic incident?

Jim: Do you want me to take it, Gillian?

Dr. Galen: Sure. I'll follow up if--

Jim: It's a great question. I think the longer somebody suffers by themselves, typically the longer those symptoms are going to last. There's not necessarily a timeframe, I think, where something starts, there's the middle, and then it ends. When we talked about that that arrow and the factors that potentially predispose folks to moving toward PTSD. I think the biggest thing is that first support where people aren't suffering by themselves. They have another voice or an audience. Often, we really, in addition to providing skills and support groups for parents, that obviously teach a lot of these skills.

I think one of the most important things is for parents to be able to feel like there are other parents and families that are going through similar scenarios with their kiddos. Because those aren't the things that show up on Facebook or that go into family letters or whatever. They're often suffering in silence and solitude, and to be able to know that there are families out there that they can say, "I know what you're going through. I was there three months ago." This is some of the stuff that I did that wasn't that effective, and here are the things that really helped me feel better and do better in terms of skill usage and with my kids.

Dr. Galen: I think one of the things to remember that I think we often, many people, and certainly many providers forget about these parents is that many of them are experiencing this over and over and over again with no end date. There's treatment and PTSD that happens when you have a single episode of trauma. There's another level of this trauma where it can go on for years, and they're just never quite knowing, are they going to self-injure again, and are they going to make another attempt. Because they never have that assurance. Again, many of these parents will have these symptoms for a long time and actually will do well with PTSD treatment.

Moderator: Brilliant, thank you. We have a different question that asks, how do you address social media when working with parents and adolescents?

Dr. Galen: This is such a hard question. I think how you respond with social media is also going to depend on the age of the adolescent. What a parent may do around social media at age 10 is very, very different than what they might do at age 16 or as they approach going to college. The younger the kids are, the more parameters I often work with parents to put on their social media because they can put those on their social media. The older the adolescent gets, certainly you can have those parameters, but the shift has to be around teaching the kids how to manage social media.

How to be mindful of, is checking your social media X number of times a day helpful for your mood. Is going to bed with your phone right next to you effective? How does being on or off social media impact your mood and your relationships? I always tell parents our goal with social media and managing screens and video games and phones and all of that stuff is we've got adolescents in high school to teach them the skills to manage. Because once they go off to college or they go live independently and get a job, we missed our opportunity.

They will be out there having to manage this on their own. I tend to take an approach of more restrictions when they're younger, and then lifting the restrictions and adding the skills to teach them to really pay attention to the way social media and screens impacts their moods and behaviors. How that is linked in an effective or ineffective way to their long-term goals and independence and all the things that they want in their life.

Moderator: Thank you. I think we have time for just one more question before we wrap up. One asks, how do you cater to denial and guilt that the parents might be experiencing?

Jim: That's a fantastic question. We see tons of parents that guilt and shame are really ever-present emotions for them. I think that compassion toward ourselves as parents, and teaching parents that they need to be able to be compassionate toward themselves. I think one of the hardest things for parents, particularly parents that have an emotionally sensitive kiddo. Then a second kiddo or a third kiddo that is not particularly emotionally sensitive is they can feel incredibly effective with one kiddo that didn't have the needs and the prerequisite validation that sometimes happens or needs to happen with emotionally sensitive kids.

They can feel really ineffective. They can feel like suddenly, I felt like I did a really good job with kiddo A and not so much with kiddo B or I feel really lost. That guilt and shame, I think, often being able to lean into it with parents to talk about it with parents. Again, a huge fan of those conversations that can happen with other parents that are struggling in similar ways, I think, often is able to reduce some of that guilt and shame around what they're parenting, what they feel like are enormous deficits that it's really, really hard.

Kids don't come out with sticky notes that say I'm emotionally sensitive and I have a different set of needs than maybe a different kiddo is. It makes sense and I think often that suffering in silence or suffering by themselves is probably the thing that really can ratchet up the guilt and shame in a way that we can really provide support and compassion and teach parents to be compassionate toward themselves.

Moderator: I think that wraps up our questions from the audience. Thank you so much.

Jim: Thank you so much.

Moderator: Thank you for joining us, Dr. Galen and Jim Holsenbeck. Thank you to all of our listeners for your participation. We'd also like to thank McLean Hospital for making this webinar possible. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides. As soon as the webinar has ended, a short survey will appear on your screen. Please take the survey and give us your feedback. We thank you for your attention and hope you have a great day.

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