

Webinar Title: Supporting Families Impacted by Self-Harm

Date & Time: Thursday, April 23, 2026, 1pm ET

Moderator: Hello, and welcome to today's webinar, Supporting Families Impacted by Self-Harm. This topical webinar is paid for by McLean Hospital, a top-ranked, free-standing 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 have working relationships with McLean Hospital. As such, they have both a financial and an intellectual interest in the webinar topic and content.

The purpose of this presentation is to provide a balanced view on how to provide treatment for the entire family system. APA does not endorse any products or services, and the content today was created by McLean Hospital. It 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, and the recording will include the presentation slides. During our time together, you'll be on mute, and you can communicate with us using the Q&A box located on your webinar screen. The Q&A is enabled for attendee interaction with submitted questions. Attendees can view all submitted questions and upvote those that they find important. This helps the presenters identify questions that many attendees want answered.

A link to the presentation slides have been posted in the chat box of your webinar screen. If you miss them, again, don't worry. We will email them with the recording. Now, let me introduce today's presenters. Dr. Gillian Galen is a senior child and adolescent psychologist specializing in dialectical behavior therapy. She's the director of training for the 3East continuum, an array of programs for teens and young adults that use DBT to target self-endangering behaviors and symptoms of borderline personality disorder.

She has extensive experience diagnosing and treating adolescents and young adults who struggle with emotion dysregulation, anxiety, depression, trauma, self-injury, and suicidal behaviors. Dr. Galen has particular interest in the use of mindfulness in the treatment of borderline personality disorder and psychiatric illnesses. She's the co-author of 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*.

She also serves as the clinical director for Triad Adolescent Services, a practice specializing in teaching and supporting parents of preteens, adolescents, and young adults who struggle with self-harm and suicide. Jim Holsomback serves as the director of clinical outreach for McLean Hospital. He previously served as the director of adolescent clinical education and has extensive experience working with adolescents and families with the psychiatric programs and hospitals across the country.

His leadership role in clinical outreach provides opportunity to continue working with clinicians to provide awareness and access to services for families nationally and internationally. Mr. Holsomback has a particular interest in working with families that have experienced trauma and have exhibited trauma-related behaviors that preclude them from accessing their parenting strengths and values. He finds when family systems understand and access evidence-based treatments, patients and families regain their interests, relationships, and cohesiveness as a family.

He serves as the program director for Triad Adolescent Services and co-leads parent skills and support groups while also teaching and presenting at national and international conferences about the importance of supporting parents who often struggle to identify support and resources. Welcome, Dr. Galen and Jim Holsomback.

Dr. Gillian Galen: Thank you for the introductions, and thank you everyone, for joining us. We are really excited to spend the next hour talking with you about how to support families, particularly with kids who use self-injury or other self-endangering behaviors. Jim and I have worked for many, many years to support these families. Through the years of supporting them, and also knowing their kids, what we have found is that parents are often somewhat of an underserved group.

When you have kids that struggle with things like self-injury and suicide, they tend to be very high-resource-needed kids. Understandably, most of the professional resources get put in place to support the kids. The families are often left maybe with a family therapy, with some support, but often are not given enough support or skills to help them with parenting. What we've found is actually when you invest a lot of time into the parents, and you provide them skills, you treat trauma if there's trauma, the majority of the parents that come to work with Jim and I will meet criteria for PTSD based on the fear that they have around their child's either suicidal behavior, self-endangering behavior, or impulsive behavior.

What we've found, which has been really incredible and rewarding for both of us, is that the more you skill up parents, certainly the better parents do, we've often been told the better marriages do because of the level of stress that parenting kids that struggle in this way actually puts on marriages. The kids do better in treatment when their parents are also engaged in learning skills. We're really excited to talk with you all about what we think are some of the highlights and important skills that you can also provide the parents and the caregivers of the patients that you might be working with. Let's see if I can advance this.

Jim Holsomback: Thanks, Gillian. Great introduction. The initial slide is the only one that we use literally in every presentation, as it's really important. We don't, I think, talk enough about pre-teen and adolescent suicide. As you can see in the six boxes to the right, we've made incredible progress in the United States with folks that previously had died from diseases of the body and the brain, as well as environmental deaths. In a 40-year period, we've seen improvements of 5 to 14-year-olds, in aggregate, about 40%.

For every 10 kiddos that would pass away in 1980, four of those kids would actually live in 2020 from diseases of the body and the brain, and environmental diseases. Those numbers actually go up for 14 to 25-year-olds in a good way, in that about 5

out of 10 kiddos that would have previously died from those diseases in 1980 would actually live in 2020. As we layer across the statistics around suicide in the next slide, the numbers are pretty shocking and really demoralizing.

Rates of suicide for 5 to 14-year-olds or kiddos that have died by suicide have gone up by almost 400%, meaning those same 10 kiddos we would typically see 40 kiddos that have died by suicide. The large majority of that in the 5 to 14-year range is 11 to 14-year-olds. Then, even though the numbers look slightly better in 14 to 25-year-olds, that's really a statistical anomaly, that there's actually, in aggregate, more adolescents and young adults that have died by suicide, and that number has increased by 14% in those same 40 years. On the next slide, just very briefly, this is not just the US problem.

You certainly don't have to memorize numbers on this slide. It's pretty dense. Quick key, purple is good, orange is bad, and white is neutral. Even though the numbers, again, look much better in the left-hand side, the 15 to 19 and 20 to 24-year-old population, when we look at the next slide and the statistics, it's almost exactly the same. These are numbers in the UK and Wales. When you look at, without going all around the world, most numbers in First World countries, this is the pattern that we see, is typically, large improvements in the age ranges of 25, typically through aging adults, and really scary increases in rates of death by suicide in pre-teens, adolescents, and young adults. The next slide, we're going to ask for a little bit of a poll, if you can use your camera and hit the QR code. If the QR code isn't working, certainly, feel free to go to [menti.com](https://www.menti.com). It'll ask you for your eight-digit code. Once you do that, your privacy will be a thing of the past. We're going to download all your internet. It should ask you a poll. It'll be asking you for three words. On the next slide, hopefully, we'll be integrating everyone's answers into a little bit of a word cloud.

Dr. Gillian Galen: Here we go.

Jim Holsomback: It'll continue to update as we go. As with most word clouds, our words that are larger and toward the center have been typically entered more times, and words in the periphery that are a bit smaller are words that have been entered in less time. Just looking at our guess or the way we would describe parents of adolescents and young adults who self-harm is that they would be overwhelmed, concerned, scared, anxious, and worried, confused, stressed, feeling helpless, desperate, and struggling, which I think is largely just in our experiences, the way that I think parents would often describe themselves.

I'll give people another 15 seconds and technology a chance to catch up. What we'll look at is we have done the same exercise with parents that are in skills and support groups, and in the opposite direction, or the corollary of how they or what they feel providers or how the providers typically look at them. We'll pivot back to this slide in a second. If we can go to the next slide, we'll do a little comparison. Obviously, not quite as many parents. These are the words that parents think the experience that providers believe about them, or how they feel their providers view them.

They feel marginalized, incompetent, blamed, always in crisis, inadequate, problematic, and judged, which we can imagine going to a provider and feeling this way wouldn't really encourage a lot of communication, probably feeling this way. If we can go up to the next slide, Gillian. Parents experiencing how they experience

parenting their child who self-harms. These words are a lot more aligned with the words that I think folks entered in the poll. Low and anxious, exhausted, fearful and avoidant, sad and angry.

Gillian, if you don't mind pivoting back two slides. When we look at these words that it completely makes sense that folks entered, how we can bridge the gap between how we would imagine and how parents themselves feel about their parenting and their parenting efficacy and try and find ways in integrating a lot of compassion and inviting knowing that parents often feel very judged, feel very marginalized and not always a part of the treatment and have the expectation that often parents are feeling really lost and really overwhelmed as we would expect to when their kiddo or the person they care about more than anyone is struggling in the way that kids struggle when they find our care collectively, hopefully, again, it would be helpful for parents to be able to bridge how they feel or how they perceive their providers versus how they actually experience their parenting.

Gillian will talk a little bit about some of the ways that we can generate compassion and also make sure that that becomes prevalent for providers as well as for families themselves.

Dr. Gillian Galen: When we think about compassion, and we're thinking about families, there's three directions. There's from us, from providers, towards the family. Then we often will problem-solve from the family to the loved one. Then we'll talk about the family, the parents, or the caregivers to themselves. For providers, we tend to be anchored in principles around DBT, so we go back to our assumptions, which we'll talk more about. We think that in any given moment, the parents are doing the best that they can.

As providers, if we keep that frame, that lens of looking at family members, it helps us be more compassionate, less judgmental, and more willing to think about ways to support and problem-solve. We have to remember that these parents are traumatized. Often, we forget as providers that parents are often, in many ways, their kids' first responders. They are the first ones on the scene when they find their child has overdosed, or they're the first one that's seeing self-injury, or worrying about their child and their child not coming home or coming home late.

We have to remember that these parents are doing the best that they can and that they have often traumatized brains. Then, as providers and DBT, we anchor ourselves in a consultation team so that when we lose compassion, compassion is often one of the components of burnout, which we track in DBT, that loss of compassion, is that we're open about it, we talk about it, and we ask for help so that we are really committed to saying compassionate.

Families to loved ones. It is very, very easy. Many, almost all of the parents that come in our direction have lost some level of compassion for their loved one, given the kinds of behaviors that they do. Often, they're very judged by people in the family's life, by teachers, by providers, by family friends, that we need to remember that we have to help that family. The more families that we hear from parents all the time, it doesn't feel good to lose compassion and to negatively judge your child.

We encourage things like support groups. Jim and I run groups. There's parent skills group, parent support groups. There's groups like the National Education Alliance for Borderline Personality Disorder at NAMI. There are actually Sashbear in Canada. There are ways in which family members can be with other family members that struggle, and the impact of that is profound. To be around other people that "are nice, are smart, love their kids," "look normal," and have been through something that they have gone through is very, very important and very, very powerful.

We focus a lot on self-care. We focus a lot in DBT on ABC PLEASE skills, which are those basic self-care skills around vulnerability, but we focus on that. It's the idea of the oxygen mask. We tell parents, "It's just like on a plane. You have to put your oxygen mask on you first, and then you can help your child." We talk about skills practice. We talk about really helping families practice the skills that they need and support their loved ones. Then we talk about the family members' compassion for themselves.

They are often the least compassionate. This is usually the weakest area of compassion. They are their toughest critics. We remind them they're doing the best that they can, that we can give them more skills, that they can do things differently. We focus a lot on self-compassion skills for parenting. We use a lot of Kristin Neff's material, self-care, self-compassion, and mindfulness. Because we are more on a DBT lens, we really focus a lot with parents on parenting assumptions. We ask the parents to hold on to these assumptions about them and their child.

We, as clinicians, hold on to these assumptions about the parents that we work with. We firmly believe that parents are doing the best that they can. In any given moment, given all of the circumstances that bring them to that moment, it was the best they could do, even if it wasn't that great. If it wasn't that great, then we're going to look at what happened, and we're going to provide skills and compassion so that next time they can do it differently. We're going to hold in our mind because once we start thinking that they're not doing enough or what they should be doing, our problem-solving, our compassion begins to fall apart.

We remember that parents want to improve, that fundamental to human nature is that we want things to be better and improve. When parents get willful and throw up their hands and say, "I can't do this anymore," we compassionately remind ourselves it's the best that they can do right now, but fundamentally, they want to improve, and that helps us stay engaged with them. We believe that parents must learn new behaviors for parenting, just like their child has to do in all areas of their life.

When we teach skills to parents, we give them homework. We tell them, "This has to be in every area of your life, that you're rewiring your brain to become more skillful in all areas of parenting. In all areas. You do it in your parenting, you do it at work, you do it everywhere that you can." We are very, very clear that parents cannot fail treatment. This is even as providers for the least skilled, most challenging parents, that you cannot fail treatment. Maybe the treatment fails the parent.

Interestingly, behavioral health treatments are the only ones that tell the patient that they fail. All sorts of medical treatments will stick with the medical treatment failing. We don't say, "You failed your chemotherapy." We say that chemotherapy failed. We believe the same is true. If people are engaged in treatment, it is not the parents that

fail. It may be the treatment that fails. That again helps with blame and helps with compassion. We believe that the parents may not have caused all of their problems, but they are theirs to solve anyways. This is often a challenging one.

It is acceptance of the problem, whether it is fair or a result of their behavior or not, and a focus less on blame and more on problem-solving, compassion, and engagement. Just like we believe that parents are doing the best that they can in a very dialectical way, we also assume that parents need to do better, try harder, and be more motivated to change. We hold both sides. This again is the core of DBT. We're going to accept where people are at is the best that they can do, and we're still going to push them to do better, try harder, and move towards change.

Finally, we are going to wholeheartedly keep in our mind that the lives of parents who bear witness to loved ones engaging in life-threatening behaviors are unbearable. The pain and suffering that comes from that is truly unbearable. That's going to help us stay compassionate when perhaps they're not quite as skillful. We are holding all of these at the same time. There are times where we get stuck. When you consult with people, or you're thinking about when you get stuck, then you go back to these assumptions, and you think about, "Okay, which ones do I really need to hold onto even more right now, and where am I falling short?"

Like I had talked about before, we spend a lot of time, we use Kristin Neff's material, it's great, around caring for ourselves and paying attention to how we think about ourselves and how we talk to ourselves, and focusing on doing that in a much more compassionate and a much less critical way, because, in some ways, little changes about how we talk about things, how we think about ourselves, and that critical nature can have a profound impact on mood and functioning.

Kristin Neff gives us a couple of different guide points or touch points around how we're going to do that. We teach this to parents. We help them acknowledge and accept the problem and the current reality. One of the things that is the most difficult is true, radical acceptance of the problem in front of you and actually feeling all of the feelings that come with it. Often, people will not acknowledge the real problem, will avoid the feelings, and then what we find is self-compassion goes down, they become more critical of themselves because they're problem-solving, because they haven't acknowledged actually the problem at hand.

The problem-solving isn't effective. They end up problem-solving the wrong things. "Let's change the therapist," which sometimes is helpful, but sometimes just becomes something that we're doing because we're having a hard time accepting that our child isn't where we would like them to be. We talk about the three steps for suffering and self-criticism, and we talk about really, really being mindful of those kinds of thoughts. We use noticing the thoughts, describing the thoughts non-judgmentally, and doing that over and over again instead of feeding this kind of self-criticism with invalidation and judgment.

We ask people to notice. We do a lot of working with the self-critical mind and do some checking of the facts. We use a CBT tool a lot of the time. "Is that how you would talk to one of your friends or somebody in your life? If they felt the same way, would you judge them that way?" We work with people to reframe those kinds of thoughts. We help parents, and this is where being in a group is so important, that

we recognize common humanity, that our shortcomings, our mistakes, our kid's struggle, this is common.

People suffer. Things are unfair. We help people just experience those types of emotions and do it in a non-judgmental way. We remind people that shortcomings don't define them. They're part of us. We ask them to challenge these kinds of things. We ask them to check the facts. "Is this all of you or a piece of you?" In DBT, we know that all things are caused, so we ask people to think about, "How did we get to where we are right now?" Then we really focus a lot on kindness and compassion as skills and as a choice. We try to increase and enhance commitment around compassion and kindness towards self. Jim's going to pick up from here.

Jim Holsomback: We've run five cohorts, although we've had a parent skills and support group through our work at 3East at McLean Hospital. Folks will come heavily, heavily, heavily recommended. Most parents really want to learn. They want to be in a group of people who, like an italicized type, really get it, like, "What's the experience like?" At any given time, we'll have usually 10 to 12 kiddos with us, and then 10 to 12 sets of parents. Parents can stay forever in the group. I think the average is somewhere in the mid-80s in terms of how many parents tune in, even after their kids have left. Certainly, they could and likely are there to learn and reinforce the skills and relearn.

Largely, folks typically say, "It's nice to be a part of a community that actually understands what we have gone through, what we are going through, and to be able to help other families." Out of that, we started a parent skills and support seminar that had a little bit more focus around PTSD. What we found is the majority of our families, particularly two-parent families, have at least one parent, if not both, that have active PTSD. The numbers were more than 50%. In a two-parent household, more likely than not, there's going to be a parent that will be parenting with PTSD.

The seminars were held multiple times, a total of 12 hours of groups that were largely skills-based, but also, in addition to psychoeducation, a chance to do some role plays, and working with other families, again, that are going through or have recently gone through similar difficulties with their kiddos struggling around self-harm or attempting suicide. Four things came out of it that were pretty substantial. One, parents reported a lessening of their PTSD symptoms, which is a pretty important thing. That's across groups.

We're talking about hundreds of parents that PTSD symptoms went down. Parents' capacity to emotionally regulate for themselves was significantly higher, which, again, when we think about trying to stay present and when kiddos are struggling, to be able to stay present and regulate yourself is a really difficult thing to do. After just 12 hours, to be able to feel more capacity to emotionally regulate was another significant change. Three, a decrease in stress levels, both in stress levels that they experience as well as their ability to tolerate stress when it comes. Fourth, a decrease in family dysfunction or an increase in positive functioning within a family.

When we think about four really important, not just changes for parents, changes for family systems, but the feeling of just better control and efficacy in people's parenting, and we're talking about this over 12 hours, that's a whisper in time for families that often are struggling for months and years. Just 12 hours of skills and

support can make that much of a huge difference for families, again, as Gillian alluded to in the front of the presentation, for families that often feel alone and feel like they're putting all of their resources understandably into their kids' care and often kicking their own self-care and the activities that they used to be involved with down the road, to be able to care for their kiddos.

It's so important that we're able to capture some period of time so we can actually help skill them up and bring them a group of folks that really understand what it's like for what they've been going through. On the next slide, we talk a lot about validation. Often, when parents are starting a group for the first time, we'll talk about if there's one skill that we want them to walk away with, it's validation. It's one of the tools, or maybe just the strongest interpersonal tool that we have.

When somebody is dysregulated, validation is the one thing that has a fighting chance of actually helping to bring down that dysregulation. Just that being able to understand and reflect back that "I get the emotional experience that you're going through, and it's unpleasant, and it sucks," and whatever the words are. In addition to teaching the skill of validation within the DBT skill give, there's a fantastic-- They're called levels, and this, I know, looks hierarchical, but they're not hierarchical.

The levels really were just meant for coding for research. We give folks six ways to validate their kiddos. Going through them, Level 01, and being present. This sounds really basic and is foundational, I think, for validation, being with the person, not multitasking, paying attention, asking questions, and just being present, which sounds like something that would come naturally, I think, for families, but again, we're asking families, and we're asking parents to be present with a kiddo that is often emotionally dysregulated, that when they're dysregulated, they've engaged in self-injury.

We can imagine how difficult it is to be a parent and then compassionately being present with a kiddo that is starting to talk about or exhibit emotions that have ended poorly before, have ended in self-injury, have ended in just complete dysregulation of the family system. It's a really difficult thing. I think, often when families are used to that level of dysregulation, it's a really important place because just being with somebody, asking questions, being really interested in their emotional experience, and reflecting it back to them is fantastic.

The other thing we like to talk about with Level 01 validation is when our validation misses. We say, "As a parent, it looks like you were really upset, really angry about being left out of whatever social event all of your friends are going to," and they actually feel sad. They're like, "No, I'm not angry about it." Falling back into a Level 01 validation, just getting really curious, like, "I thought I understood what you were saying and what was going on. Tell me again." Just falling back into a Level 01 validation is such a nice anchoring way versus feeling like, "Oh my God, I missed it, and the opportunity is gone."

Level 02 is demonstrating accurate reflection. Again, with validation, we always want to make sure that we're validating tentatively and make sure that we got it correct. Even when we can see likely there's behavioral cues that we have, an angry kiddo, they come home, launch their backpack 40 feet, stomp up the stairs, slam the door,

we're pretty sure that it's anger. If we say, "It seems like you're pretty angry, what's going on?" and they say they're not angry, we don't get what's going on.

We have to assume that the person that's being validated is an expert in their own experience. Again, being able to reflect it, check in, "It seems like you're feeling," fill in the blank, "Is that right? Is that accurate?" If not, being, again, able to drop back into a Level 01 and just getting really curious about their experience. Level 03, mind reading, is a high-risk, high-reward level of validation. High reward because it feels really good when someone else gets our emotional experience, and we don't actually have to say a whole lot about it. Again, staying in the example of being left out of a social event that all of our kiddo's friends are going to be at, we can imagine that that would feel really lonely.

We can imagine that they might be sad about that, even if they don't necessarily use those words or even necessarily articulate exactly what's going on. If we know the situation, being able to take a little bit of a guess. Obviously, there's a high risk if we miss, if we guess wrong, and again, just getting curious if we do back into a Level 01 validation. Level 04 is all about understanding our kiddos. For folks that have worked with kids for a lot of years, have kids, often start to see some patterns.

For the kiddo that's really school-avoidant, hasn't had a great academic experience, gets really nervous around social situations, come end of August, we see that anxiety going up, knowing that school is going to be starting up again, it makes sense to be able to validate. Their anxiety makes a whole lot of sense, knowing that in three days, we're going to start the school year around. Just getting curious about what would be helpful in terms of not just reducing the anxiety, but if there's a way that we can support our kiddos that are struggling, just based on what we know about them, using contextual understanding.

Level 05, Gillian likes to live in this level quite a bit, is normalizing emotional experience. Just imagining if somebody, I don't know, got called on twice in class, and it were the only two questions they couldn't answer, feeling a little bit embarrassed or a little bit of shame would make sense. If we lined up 100 people that all had that very similar experience of being called on in class, and the only time they got called on was the question they didn't know the answer to, they too would make sense that they would feel a little bit of shame, a little bit of embarrassed, especially since it's unfair. They knew the answer to all of the other questions.

Just being able to normalize it makes sense. I would imagine most people would feel that way in the same situation, can feel really, really validating. Then, finally, Level 06, radical genuineness. I think about this as a lot of being radically sincere that sometimes there's not even words that go along with this validation. I think about meeting a coworker whose father passed away. Met the person once, had no huge emotional connection or whatever, but hearing him talk about it, him tearing up, myself tearing up, even though I didn't necessarily know this person at all, but just understanding the emotion, handing him a tissue, putting your hand around their shoulder, tearing up.

Just really showing that humanity, that authenticity, and the humanity within another person can feel really, really validating without necessarily having to use words. Those are the six levels. Obviously, every level doesn't work in every situation.

There's certainly pitfalls for each of them, but being able to give different strategies within validation, I think, can be a really important tool for parents to learn and understand.

Dr. Gillian Galen: Jim gave you really a solid overview. We spend a long time with our parents around validation, and once we've taught them validation, we've found that this video is really, really helpful to help distinguish validation, empathy, and sympathy because many times they get confused. This is a great way because most people can identify with the experiences in this Brené Brown little short video. We're going to show this, and then we'll talk a little bit more specifically about empathy and sympathy.

Brené Brown: What is empathy, and why is it very different than sympathy? Empathy fuels connection. Sympathy drives disconnection. Empathy, it's very interesting. Teresa Wiseman is a nursing scholar who studied very diverse professions where empathy is relevant, and came up with four qualities of empathy. Perspective taking, the ability to take the perspective of another person or recognize their perspective as their truth. Staying out of judgment. Not easy when you enjoy it as much as most of us do. Recognizing emotion in other people and then communicating that.

Empathy is feeling with people. To me, I always think of empathy as this sacred space where someone's in a deep hole, and they shout out from the bottom, and they say, "I'm stuck, it's dark, I'm overwhelmed." Then we look, and we say, "Hey, I'm coming down. I know what it's like down here, and you're not alone." Sympathy is, "Ooh, it's bad. No, you want a sandwich?" Empathy is a choice, and it's a vulnerable choice, because in order to connect with you, I have to connect with something in myself that knows that feeling.

Rarely, if ever, does an empathic response begin with at least. Yes. We do it all the time, because you know what? Someone just shared something with us that's incredibly painful, and we're trying to silver lining it. I don't think that's a verb, but I'm using it as one. We're trying to put the silver lining around it. "I had a miscarriage." "At least you know you can get pregnant." "I think my marriage is falling apart." "At least you have a marriage." "John's getting kicked out of school." "At least Sarah is an A student."

One of the things we do sometimes in the face of very difficult conversations is we try to make things better. If I share something with you that's very difficult, I'd rather you say, "I don't even know what to say right now. I'm just so glad you told me." The truth is, rarely can a response make something better. What makes something better is connection.

Dr. Gillian Galen: Parents and caregivers find this video very helpful because they've often experienced sympathy at times. Sometimes they don't even get sympathy because it's so hard to talk about. The empathy really lines up a lot with validation. Often, it can help for people to understand also what they need and what they can ask people. Brené Brown talks about the vulnerability that comes with empathy versus pity. Most people, it doesn't feel good to be pitied. It's about validation. It's about honoring the experience.

It's about being able to take another person's perspective, holding their own experience, making space for their experience without making it somehow about ourselves or our difficulty tolerating their experience. Empathy isn't really about avoiding judgment. Sympathy, there can be avoiding a judgment, but often it's really focused on feeling relief because they're somehow different, whereas empathy, again, is about that connection. This is why having parents in groups with other parents is so incredibly powerful.

It's why parents will say, even in-- Jim discussed that trauma program that I do with a bunch of other people at McLean, and almost universally, it's that shared experience that somebody else understands it. Not that they feel bad for them because their child isn't on the same path that my child is on, but that somebody truly has that shared experience, or has enough of a shared experience to have a connection. Empathy is about a genuine interaction, and there's space.

When people are empathic, there's space for their experience and their emotions. With sympathy, we're often trying to make people feel better. The challenges that these parents face are not things that get better quickly. Sympathy can often lead into invalidation, often, which is like, "If you would just do more discipline, do more of this, do less of this," and parents will universally say that that's not helpful because those tend to be very easy solutions to a very, very challenging problem.

Just some take-home points. We have to support parents. We have to recognize that parents are traumatized. When we are teaching parents and supporting parents, we also have to understand that often we are working with traumatized brains, and that parents that do not have support are just inherently at greater risk. They're at greater risk for developing PTSD. They're also at greater risk for ineffective parenting. We need to recognize that traumatized parents and parents without those kinds of skills that they need often have a hard time distinguishing between what is normal behavior and what is dangerous behavior.

In DBT, we often call normalizing pathological behavior or pathologizing normative behavior. Because they have been these first responders, and they don't have the skills, and they don't have the support, we have to remember that essentially those danger meters, no differently than any other patients that have been traumatized, are also faulty. They may be hyper-vigilant, over-responsive, and do behaviors that actually get in the way of the treatment of the child out of fear, not because they want to.

They're doing the best that they can. We know that adolescents who have parents that have been supported and have skills and have some sort of parenting community with shared experiences, that the kids have better relationships with their parents, that those relationships actually change. We know that kids are more adherent to treatment, and we know that they do better in treatment. Treatment generally just moves along much faster. When we treat these parents, we're essentially treating more of the system.

It's different than just providing family therapy. This is support specifically for the parents to help them become more skillful and learn how to manage some of their trauma symptoms in a way to be effective with their child. Often, supporting parents

in this way actually makes for more effective family therapy, which is very supportive of then individual therapy with the children, the teens.

Jim Holsomback: There are some resources that are available for folks. Gillian mentioned a couple of the parent resources for groups and educational things. They're listed there, and you'll get those there in the chat room, and they'll be sent out in a couple of weeks by APA as well.

Moderator: Thank you, Jim and Dr. Galen. As we move into the Q&A, I have a few. I've been watching the Q&A, and there are some very interesting questions. One of the questions that-- this was actually submitted pre-webinar by the registrants. What support groups are there for families?

Jim Holsomback: There's a number of organizations. The National Education Alliance for Borderline Personality Disorder, NEABPD, has a number of trainings. They also have loved one groups called Family Connections that are in a lot of different areas and are available online. It's a fantastic organization. You don't necessarily have to have or care for anyone with borderline personality disorder to access the resources or the support groups. Gillian also mentioned Sashbear, which is a Canadian organization.

Sashbear, I think it's Sashbear.org, a fantastic organization also that has a number of trainings that are held each month. They have a newsletter, and they do some advocacy and walks as well each year to raise awareness.

Dr. Gillian Galen: They also have Family Connections as well. That's another way to access Family Connections.

Jim Holsomback: Yes. There's a couple of, certainly, organizations that administer family skills and support groups and practices. Usually, if there's a DBT practice for adolescents, if they don't actually provide family skills and support groups, they'll know somebody that does. It's a great way to be able to support parents. Again, it gets to the more comprehensive treatment for the entire family system. Gillian, do you have other resources for families?

Dr. Gillian Galen: I think those are the biggest parent and loved-one-focused resources. There's certainly a lot of seminars and webinars through both NEABPD and Sashbear for very specific skills. It doesn't give the group piece. Like Jim said, different practices provide parent support and skills groups, and you're most likely to find those through DBT practices. NAMI may have a couple, but that may be a little bit more general.

Jim Holsomback: Then finally, there's a good group, and actually, there's for both practitioners as well as for patients, families, and loved ones on the McLean site, mclean.org/continuing-education. There's some good webinars and trainings, again, both for clinicians as well as for patients, families, and loved ones.

Moderator: This is a question that came in today from our live listeners, our watchers. What is the best strategy or mitigating factor to implement for parents and practitioners when the act of self-harm is a school-wide behavior as being part of a group or the in-group?

Dr. Gillian Galen: One of the hardest things is when the peer group reinforces a problematic behavior, whether it's self-injury, it can be, unfortunately, suicidal behavior, it can be substance use, it can be school refusal. There's all sorts of different ones. I think this is where it becomes really an individual therapy piece of work, which is we know that the most effective way to change someone's behavior is to link the changed behavior to their own personal goals.

Now, it's tricky because adolescents are highly motivated to be accepted and to fit in, be part of a group. The work is really in the individual therapy around helping the teen, the client, understand how does that behavior function? What are the pros and cons? What's the downside of giving it up? Then how do you replace those downsides with skills and support? What will they lose? What will they gain by not doing it? How does the very behavior that they're doing get in the way of whatever they want in the future? Which doesn't even have to be a far future.

It could be if kids self-injure enough, they end up not able to attend the school that they're in, which means that it renders the peer group moot because they get pulled out of schools, they get put in hospitals or therapeutic programs. It's a delicate piece of work to help the kids understand how that behavior actually gets in the way of their life. I stay away from my feelings about it, or parents feelings, or teachers and more focus on how does it get in the way for them. It works for some things, but ultimately, does it get in the way of what they want?

Moderator: Another question that we received is, what is the best way to handle a situation where a teen is not telling their parents about their self-harm or about the amount of it?

Dr. Gillian Galen: Jim, do you want me to take this one, or you want to take it?

Jim Holsomback: Maybe until you talk a little bit about it from an individual therapist standpoint.

Dr. Gillian Galen: I think this is a tricky one. Typically, when I take kids into my practice, I actually discuss this right off the bat. It certainly depends on the age of the kid, how much communication I have with their parents. One of my requirements is that if self-injury is decreasing and maybe going along the way that I'm hoping it's going to ultimately decrease self-injury, I don't necessarily need to tell the parent every episode if it's an older teen.

If it's a younger teen, I don't really keep any of those secrets at all. I say, "We just have to talk to them," and I say, "Actually, we can do it together." I don't like to do it behind kids' backs. I always have the caveat that if the self-injury is escalating, if it's happening more frequently, if it's more severe, then that's not a thing that can be kept quiet. I talk about that right up front with kids so that they're aware of it. Then I have those conversations with the kids and the parents together.

I talk with them very openly about why I do that, why that is my theory, why I think that those kinds of secrets tend to get them in trouble. Parents ultimately end up finding out. It erodes trust, which erodes freedom and independence, which is often all of the things that teens want more of. I do try to really understand why teens won't

tell their parents. There's lots of different reasons why they won't. Some are certainly shame-based. Many of them are based on how the parents respond.

If it is based on how the parents respond, I will actually do a piece of work with the parents to try to teach them skills and effective ways to respond that actually will reinforce communication from the kiddo. Often, if kids don't talk to their parents, a lot of the reasons why they don't talk to their-- Kids don't like fundamentally to keep big secrets from their parents. If they're not talking to their parents, it usually has a lot to do with how their parents respond.

I'll spend a lot of time with the parents, talking with them about how they respond, and then teaching them skillful ways, and then talking to the kid about how their parents are going to do it differently. Are we going to try to figure out this problem? Ultimately, they need to know, and we would like to build communication and trust so that the kids get what they want, which is often independence and freedom.

Jim Holsomback: It's a great point you brought up, Gillian, around the parents, how they receive the information, and react to the information. As scary and as upsetting as it is for parents to get that information, it's 10-fold scary when they are not getting that information, or they're wondering, "Is the self-harm still happening?" and they find out it's actually been happening for a long period of time. As scary often as it is and upsetting to learn that information when there's not that open path of communication, often parents will say, "I feel that much less at ease just because I don't know what's going on."

Often, as upsetting as it may be, they would rather know that something's happening than have behaviors go underground, which is often, I think, the scariest place for families and specifically for parents to be.

Moderator: I think that is all the time we have for questions today. I want to thank you, Dr. Galen and Jim Holsomback, for presenting today. What a great topic. Thank you all to our listeners for your participation. We'd also like to thank McLean Hospital for making this webinar possible. I'd like to add that McLean Hospital has done many webinars with APA. If you're interested in seeing some of the others, you can go to apa.org.

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 ends today, there will be a short survey. We would like to ask you to take that, and please provide your feedback. Thank you, everyone, for today. Take care.

Dr. Gillian Galen: Thank you so much.

Jim Holsomback: Thank you very much.

[00:57:41] [END OF AUDIO]