

[Företagets namn]

# **Possibilities of management of self harm and suicidal behaviors and other problem behaviors in Biosynthesis based therapy**

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## **Abstract**

Because of reports of increasing numbers of self-harm and suicidal clients entering Biosynthesis based therapy and various levels of general struggle with these clients, this paper is focusing on possibilities of implementing other methods and tools which can be helpful in handling such behaviors. There is good evidence about Dialectical behavioral therapy (DBT) for handling problem behaviors and therefore I tried to prove theoretical compatibility of two therapy schools and eventually translate some tools of DBT into the theory of Biosynthesis based therapy.

Conclusions are that these two therapy schools are by some means compatible and it should be possible to use DBT skills in the context of Biosynthesis based therapy. DBT skills can be used as they are in the original source or modified for body experience. Anyway further studies and good theoretical preparation recommends for such use, even controlled study is possibly needed to prove this in practical use.

**Special thanks** to DBT team at Personality disorder outpatient care in Borås, Sweden, especially Kristina, Kajsa and Monica, and also to consultant Ondrej Matejka.

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## **1. Introduction**

I decided to dedicate this work to problem behaviors, especially self-harm behavior, but also others mostly because I am experiencing the general struggle of my fellow therapists in the field of Biosynthesis based therapy with these types of behaviors. I was hearing a lot, at the lectures and even more in supervisions groups, about colleagues having hard times with clients, even colleagues' need for a lot of supervision and decreased capacity for the clients. Mainly it was discussed self-harm and suicidal behavior, struggle to attend to therapy sessions and commitment to therapeutic frame. Therapists and supervisors are also reporting increasing numbers of these clients. Biosynthesis based therapy as its predecessors Bioenergetics or Psychodynamic therapy does not possess specific tools to handle such behaviors, though can be handled in more unspecific ways and with help of supervision. I work with a group of patients which specifically show these types of behavior, I am having clinical experience as a psychiatrist and I have even learned to handle it in these unspecific ways. I have learned since I started medical practice and still doing it today. On the other hand there are manualized approaches which are specifically dedicated to clients with these types of behaviors. As I mentioned I am working with this group of clients, specifically clients with Personality disorders, mostly Borderline personality disorder. In this case different approaches can be used, but I would like to focus on Dialectic behavioral therapy even though it originates in Cognitive Behavioral therapy. I am familiar with this therapy form as there is a DBT team in the place where I work and often we cooperate tightly. As I know DBT already developed methods to work with problem behaviors. In that case I will try to explore the compatibility and possibilities to implement or use some of DBT tools in Biosynthesis

therapy. This could be helpful for therapists who can have a more structured and understandable way to handle problem behaviors.

## **2. Self harm and suicidal behaviours**

In gaining a comprehensive understanding of self-harm, it is imperative to reflect upon the cultural, historical and religious origins of the behavior, which throughout time has been used in many cultures to restore harmony and balance at perceived moments of chaos. In a similar way the person who self-harms becomes a microcosm of the world of mythology and religious symbolism, sacrificing. Favazza (1996) differentiates between culturally sanctioned practices such as tattoos and pathological acts of self-mutilation such as self-cutting. And also suggests that behaviors that cause harm to self have socio-historical gravitas and are embedded in our cultural psyche. For example in Christianity the path to martyrdom and sainthood was paved with self-sacrifice. Favazza (1996) frames understanding of self-harm in the context of cultural determinism, whereby behaviors will be interpreted differently within and between cultures. Culturally sanctioned rituals in one culture may be deemed pathological behavior in another.

There are various reasons to differentiate between self harm and suicidal behavior. Many self harm behavior have different goal than suicidal acts- intention is not to die but to handle intolerable emotions or to communicate how bad the person is feeling. There is also the possibility that the goal of self harm is to find fellowship in a specific community where others are practicing self harm. Common definition for non- suicidal self harm is that person is causing him/herself direct physical damage. Behavior that causes damage to the body indirectly doesn't count though, for example substance abuse, self-starving and other self destructive strategies. Neither tattoos or piercing counts. The proposal according to DSM-5

states its self-caused damage on the surface of the body of non-life threatening character. To pass the threshold for diagnosis, a person had to show self harm behavior at least 5 times in the last year and it led to clinically significant suffering, decreased function in interpersonal relations, school or other important parts of persons life. In addition it have to be connected at least with two of following criteria (1) it was immediately preceded of interpersonal problems or negative emotions or thoughts (2) it was preceded of period of preoccupation with thoughts about self harm and it was difficult to oppose them (3) self harm thoughts are common even if they are not leading to action (4) behavior executes in anticipation of decreasing of interpersonal difficulties, negative emotions or thoughts, or it leads till positive emotional state when self harm executed or shortly after.

According to Ribeiro and Joiner (2009) self harm behavior leads to increased pain tolerance and decreased fear of death. That can increase risk that person can make step from suicidal thoughts to suicidal actions.

## **2.1 Epidemiology**

Mild forms of self harm behavior is very common especially in groups of young people. On a more general question about self harm answer between 5 and 15% of subjects yes. If the question is more specific about self harm behavior in studies in Sweden and USA and other countries answers yes between 35 and 45%. Majority of these young people show no psychopathology and in many cases it's about testing strategy in isolated occasions without adopting these behaviors.

In a big Swedish study (Zetterqvist 2013) with a group of 3000 high schools students in Östergötland region, 35,6% (56,2% of girls) reported they self harmed themselves at least once. 6,7% (11,2% of girls) met diagnostic criteria.

In metaanalysis of 66 studies, Lim et al. (2019) estimated global lifetime and 12-month-prevalence of suicidal behavior, deliberate self harm (DSH; prevalent term in UK) and non-suicidal self-injury (NSSI; prevalent term in US) in a pooled sample size of 686,672 children and adolescents. Notably, aggregate prevalence rates of suicide attempts, DSH and NSSI were generally higher for full-time school attendees than partial and non-school attendees, perhaps due to an increased likelihood of exposure to risk factors such as academic stress and school bullying. Children in non-Western and/or developing countries, such as those in Africa, had the highest 12-month-prevalence of suicide attempts. Furthermore, mean age was identified as a moderator for both lifetime and 12-month-prevalence suicide attempts, such that older adolescents were exposed to more risk factors for suicide attempts than children and younger adolescents. This study reaffirms self-harm in children and adolescents as being a fairly common phenomenon, whilst demonstrating that certain factors are associated with an elevated risk of developing the behavior, such as older age. As such, further research into these risk factors is warranted.

There is also evidence to suggest that risk factors for self-harm can differ over time. For example, Hawton et al. (2015) found that between 1996 and 2010 in Oxford, England, person-based self-harm incidence rates declined for both males and females after peaking in 2003. However, between 2008 and 2012, Geulayov et al. (2016) found that there were increases in rates of self-harm for males in Manchester, which the researchers suggest may have been due to the economic recession during this period. This suggests that risk factors (e.g., financial problems) may pertain to a specific time period, and as such, synthesizing the most recent literature on risk factors may minimize reporting of factors that are unlikely to affect today's self-harm rates. The COVID-19 pandemic and its associated restrictions in 2020 has caused economic recessions in

several sectors, including hospitality, agriculture, petroleum and oil, the manufacturing, education, finance and aviation industries (Nicola et al., 2020), which suggests that this may be a current risk factor.

Systematic reviews investigating risk factors for self-harm in adolescents have been conducted, such as Webb's (2002) review of 11 studies. The observed risk factors centred around psychological (depression and hopelessness), psychosocial (family dysfunction) and social (sexuality and academic/career pressures) domains. Interestingly, those who repeatedly self-harmed had higher prevalence of depression, hopelessness and poorer problem-solving ability than those who harmed themselves for the first time.

Personality development is also known to play an important role in self-harm, such that the behavior is included as a diagnostic criterion for borderline personality disorder (BPD) in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) that has been independently validated by research (Krysinska, Heller, & De Leo, 2006) and as a measure in BPD screening instruments (Keng et al., 2019).

Until recently, self-harm, suicidal thoughts and behaviours have not received extensive attention in autism research (Cassidy 2020; Cassidy and Rodgers 2017). The extant research evidence indicates high rates of self-harm in autistic people, but this work has primarily focused on self-harm in the context of challenging and/or repetitive behaviour associated with intellectual disability (Minshawi et al. 2014). Although extremely important work, this research does not explore whether autistic people who self-harm also experience intent to end one's life, or whether self-harm increases risk of subsequent suicidal behaviours (as in the general population; Rebeiro et al. 2016). More recent research has explored self-harm and suicidality, as defined in the general population, in autistic



people. Early work showed that 66% of adults recently diagnosed with Asperger Syndrome had contemplated suicide in their lifetime, and 35% had planned or attempted suicide (Cassidy et al. 2014). Autistic adults are also significantly more likely to experience non-suicidal self-injury (NSSI) compared to the general population, and NSSI is associated with increased risk of suicidality in this group (Cassidy et al. 2018). Large-scale population studies have followed, showing that autistic people are significantly more likely to die by self-harm and suicide compared to those in the general population (Hirvikoski et al. 2016).

Borderline personality disorder (BPD) is a highly prevalent, chronic, debilitating, and deadly disorder characterized by chaotic, self-defeating interpersonal relationships, emotional lability, identity disturbance, poor impulse control, and angry outbursts (American Psychiatric Association [APA], 2013). Prevalence rates for BPD are approximately 1%–6% in the general population, 14%–25% among psychiatric outpatients, and 20%–40% among inpatients (Trull, Jahng, Tomko, Wood, & Sher, 2010;). BPD is also associated with self-injury, which occurs in 69%–75% of BPD patients (Kjellander, Bongard, & King, 1998), and a high risk of suicide (Pompili, Girardi, Ruberto, & Tatarelli, 2005), with suicide completion rates ranging from 3%–9.5%. Furthermore, BPD is commonly comorbid with other disorders that carry a suicide risk, such as major depression and substance use disorders (Zanarini et al., 1998), further increasing the risk of suicide (Kelly, Soloff, Lynch, Haas, & Mann, 2000), and the impulsive nature of self-injurious behavior presents a risk for accidental suicide (Yen et al., 2004). In fact, suicide completion rates among BPD patients with a history of self-injury are twice that of those without such a history (Stone, 1989).

A meta-analysis of 50 studies provides clear evidence on the association between suicide attempts/self-injury and Post-traumatic stress disorder

(Krysinska & Lester, 2010). Child sexual abuse has been found to be a risk factor for suicide and nonsuicidal self-injury (e.g., Maniglio, 2011). Survivors of Child sexual abuse, and especially women, are almost four times more likely to self-harm (Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003) In a meta-analysis of 43 studies investigating the association between Child sexual abuse and self-harm, a small association was established, which became negligible or disappeared when controlling for psychiatric risk factors, such as dissociation, alexithymia, and depression. Klonsky and Moyer (2008) suggest that there may not be a direct link from Child sexual abuse to self-harm, but rather a complex relationship between Child sexual abuse, psychiatric risk factors, and self-harm. There is clearly a need for further research in the area.

Estimates of the prevalence of self-harm in people with intellectual disability vary, partly due to the population and setting studied (Rojahn and Esbensen 2002) and the methodological diversity, but also due to the sometimes hidden nature of these behaviors (Nijman and à Campo 2002). Prevalence rates range between 4 and 23% in people with intellectual disability (Cooper et al. 2009; Kahng et al. 2002; Rojahn and Meier 2009).

### **3. Dialectical behavior therapy**

DBT was originally developed for treating people with features of Borderline Personality Disorder who engage in self-harm (Linehan, 1993). In its original form, DBT is a multi-component intervention involving: individual therapy, skills group training, group consultation for the therapeutic team and out-of-hours telephone coaching (Swales and Heard, 2016). Individual therapy involves analyzing (i.e., “chain analysis”) incidents of problematic behavior occurring during the preceding week, usually based on information provided in diary cards. A key feature of DBT

is the clear hierarchy of classes of target behaviour. Imminently life-threatening behaviour such as self-harm and suicidal attempts are prioritised, followed by behaviour interfering with the therapeutic process, followed by serious quality-of-life interfering behaviour. Other issues such as post-traumatic features are targeted once the higher target behaviors are under sufficient control. Skills group training consists of four modules: emotion regulation, interpersonal skills, distress tolerance and core mindfulness. DBT draws upon three philosophies: radical behaviorism, Zen Buddhism (e.g. in relation to radical acceptance and mindfulness processes) and dialectics. Dialectics refers to the process of finding a middle ground (synthesis) between two opposing positions (thesis and antithesis) (Swales and Heard, 2016). For example, the primary dialectic in DBT is the balance between acceptance and change (Linehan, 1993). Dialectics are not taught as part of a singular module, but are modeled by the therapist throughout the intervention, and clients are supported and shaped to think, talk and respond in dialectical ways, especially with respect to social problem solving, such as considering the validity of others' perspectives.

#### **4. Possibility of integration of DBT skills into Biosynthesis based therapy**

In this section I decided to comment on some key and basic aspects and general principles of DBT and those I could see similarity with Biosynthesis and Biosynthesis based therapy.

In the **skill training assumptions** below can be found what is possible to see from Biosynthesis point of view as references to essence and essential qualities, especially in point 1., 2 and 3. There are direct references to our power of life and drive to survive originating in essence,

also will to have a good life and pulsation and balance in individual lives (Life Fields, Unit Founding; CIB, 2017).

In points 4. and 6. below reference to attachment theory and developmental psychology can be observed and can be understood as a connection between individuals' history and its influence on the situation today. Some aspects of “good enough” parenting in point 6.

Point 7. can be seen as reference to the general humanistic approach of Biosynthesis and reference to develop personal resources rather than focus on psychopathology (Unit Founding; CIB, 2017).

Assumption in point 5. is influenced by cognitive methods and mostly suggests to be seen as Shaping and Forming with Biosynthesis point of view.

#### Skills Training Assumptions:

An assumption is a belief that cannot be proved, but that all participants in skills training (clients and leaders alike) agree to abide by anyway.

##### 1. People Are Doing the Best They Can

That is, given the multiplicity of causes in the universe (genetics, biological events, environmental events, consequences of previous behavior), each person at this one moment in time is what he or she is. Given who we each are and the fact that all behavior is caused, we are doing the best we can at this one moment, given the causes that have affected us.

##### 2. People Want to Improve

This is similar to the Dalai Lama's statement that the common characteristic of all people is that they want to be happy.

##### 3. \*People Need to Be Better, Try Harder, and Be More Motivated to Change

The fact that people are doing the best they can, and want to do even better, does not mean that their efforts and motivation are sufficient to the

task. The asterisk at the start of this assumption indicates that this is not always true. In particular, when progress is steady and at a realistic rate of improvement with no let-up or episodic drop in effort, doing better, trying harder and being more motivated is not needed.

#### 4. \*People May Not Have Caused All of Their Own Problems, but They Have to Solve Them Anyway

This assumption is true for adults, because the responsibility for their own lives rests with them. The asterisk before this assumption indicates that this is not always true. With children and adolescents, as well as some disabled persons, parents and other caregivers must assist them with this task. For example, young children or disabled individuals cannot get themselves to treatment if parents or caregivers refuse to take them.

#### 5. New Behaviors Must Be Learned in All Relevant Contexts

Behaviors learned in one context often do not generalize to different contexts, thus it is important to practice new behaviors in all the environments where they will be needed. (This is one of the main reasons it is important for participants to practice new skills in their daily environments.)

#### 6. All Behaviors (Actions, Thoughts, Emotions) Are Caused

There is always a cause or set of causes for our actions, thoughts, and emotions, even if we don't know what these causes are.

#### 7. Figuring Out and Changing the Causes of Behavior Works Better Than Judging and Blaming

This assumption is very much related to the previous one. When we agree that all behavior is caused, this leads to the understanding that blaming and being judgmental ("This should not be") are not effective in changing that situation or behavior (Linehan, 2014).

**Mindfulness skills** help us focus attention on the present moment, noticing both what is going on within ourselves and what is going on outside of ourselves and become and stay centered. Mindfulness as a practice has now become widespread, with courses taught in corporations, medical schools, and many other settings (Linehan, 2014). Mindfulness has its roots in Zen meditation which is common ground with Biosynthesis. There is no doubt about Biosynthesis' roots in eastern philosophy Buddhism included. As mentioned Mindfulness is a form of Centering technique, even can be understood as grounding technique. In general Mindfulness helps to decrease distress and increase contact with moment, emotions, thoughts and eventually body; even supports natural pulsation by balancing these parts.

**Dialectical strategies** refers mostly to group and interpersonal dynamics (Linehan, 2014). This aspect is compatible with Biosynthesis, though there are aspects which can be understood as lesser importance of transference and countertransference processes. Anyway due to lower mentalizing capability of the client group which can be relevant for DBT can it also be understood in that context. In the Core Strategies (Validation and Problem Solving) is the main focus on Having and Doing bonding styles (Unit Bonding; CIB, 2017). According to Linehan, 1993 primary dialectics can be even understood as a support of balance and through that support of natural pulsation.

**Therapeutic frame** refers to the fixed elements of the therapeutic relationship that provide the context for the therapeutic work. It includes both environmental and relational conditions, and the 'boundaries' of the therapeutic process. This encompasses the date and time of meetings, the duration of sessions and of the therapy itself, contact and

confidentiality. A good therapeutic frame should provide a safe and consistent professional structure for the therapeutic work to take place (Knox, Cooper, 2015). In DBT respects therapeutic frame as mentioned and in next chapters it's going to be referred to and worked with aspects as behaviors which destroys therapy and skills training.

Until now I referred to the compatibility of DBT with Biosynthesis but to understand and be able to implement aspects of DBT is necessary to understand also **shortcomings** of such implementation.

Usually Biosynthesis based therapy as taught and trained by Czech institute of Biosynthesis is individual psychotherapy. On the other hand DBT is a combination of individual contact and skills training in a group. There are even DBT forms which don't include individual contact and are skills training in group only, but there are forms where there can be skills training individual only, fitted to clients' needs. Group is described as important mostly because of validation of other members and other more general benefits of the group are also important.

Another aspect which needs to be considered is that DBT skills require some level of knowledge of methods on the therapist and skill trainer side. Even knowledge of the whole context and other techniques of DBT can be helpful. For example DBT extensively uses Mindfulness as one of the skills. On the client side, extensive training of the skill is needed to master it and understand it fully. When focusing on the therapeutic relationships with clients, it can be important to have in consideration that when skills are trained, the therapist is less of a therapist and more of a coach (Linehan, 2014).

As DBT is a cognitive therapy and has its roots in Cognitive Behavioral approach. This involves more focus on ectoderm, some specific bonding styles as doing and in some grade neglecting aspects as for example

Founding and Bonding. Anyway there is also some level of focus on integration of the primary germ layers (ectoderm, mesoderm, endoderm). From Cognitive Behavioral approach comes also extensive use of daily charts, screenings and tools to identify and categorize various experiences of clients which Biosynthesis based therapy are not so familiar with as standard.

In conclusion some of these shortcomings can be overcome by having them in consideration for example relationship client-therapist, some of them can be overcome by training and increasing knowledge and therapist skills in DBT method, some of them can be inspiration to implement even more DBT tools (diary charts), and some skills can be replaced, for example some of mindfulness skills in some grade by other meditation techniques which Biosynthesis is familiar with.

### **5. Implementing DBT skills into Biosynthesis based therapy**

This section was intensely consulted with the DBT team on the outpatient unit where I work, on the Psychiatric clinic of Southern Älvsborg hospital in Borås, Sweden, and I am going to refer to their clinical practice and practical implementation of DBT skills. The DBT team is one of the first in Sweden and introduced DBT at least in region if not in the whole country. Members of the team have clinical experience with DBT since the early 2000's.

The DBT team suggested that best and easiest and most accessible for non DBT therapists can be a skill called Chain analysis and Missing link analysis. There are though other factors which need to be considered and other skills should be used and learned before Chain and Missing link analysis. There is a need to master Mindfulness first for the client to help him be in better contact with emotions and body, to be able to exist more in the moment and increase perception in the moment. As I suggested



earlier this can be in Biosynthesis based therapy replaced by various meditation techniques and other exercises, or other psychotherapeutic work which leads to better contact with emotions and body. Some DBT therapists and skill trainers initiate sessions with Mindfulness exercise. Another helpful skill can be Check the facts which is practically part of the Chain analysis skill. Check the facts skill is about connection between EVENT, EMOTIONS and THOUGHTS. Even here I am also suggesting a connection to BODY experience. Problem Solving and Validation are also of big importance at least having some knowledge about but these skills probably master Biosynthesis therapist well, helpful may be knowledge of DBT structure of these skills.

I am going to mostly focus on **Chain analysis** as self-harm and other behaviors that usually disturbs therapists can be handled by it.

Any behavior can be understood as a series of linked components. These links are “chained” together, because they follow in succession one after the other; one link in the chain leads to another. For behaviors that are well rehearsed (practiced a lot), it may appear that the episode cannot be broken down into steps—that it “all happens at once.” A “chain analysis” provides a series of questions (e.g., what happened before that, what happened next) for unlocking these links that sometimes feel stuck together. The purpose of a chain analysis is to figure out what the problem is (e.g., being late for work, impulsively quitting a job); what prompts it; what its function is; what is interfering with the resolution of the problem; and what aids are available to help solve the problem (Linehan, 2014).

A chain analysis is an invaluable tool for assessing a behavior to be changed. Although performing a chain analysis requires time and effort, it provides essential information for understanding the events that lead up to a particular problem behavior (i.e., behaviors participants want to change). Many attempts to solve a problem fail because the problem at

hand is not fully understood and assessed. By conducting repeated chain analyses, a person can identify the pattern linking different components of a behavior together. Figuring out what the links are is the first step in finding solutions to stopping the problem behavior. When any of the links of the chain can be broken, the problem behavior can be stopped (Linehan, 2014).

According to DBT team consultations Chain analysis should be done or considered in the beginning of every session. Diary chart is controlled with client and client is asked about some types of problem behavior, such a behavior or event is observed or occurred and addressed by a therapist. Problem behavior is described as (1) behavior which destroys therapy (and therapeutic frame), (2) dangerous behavior (for example self-harm or self-destructive behavior) and (3) behavior that decreases quality of life. Before any other thing is done or discussed, for example themes which clients want to discuss or talk about, Chain analysis of problem behavior must be done. Generally the therapist is focused on problem behavior, asking with interest about the situation and about secondary gains of problem behavior which makes these factors of great importance. It's possible that in the beginning it is not possible to do all Chain analysis fully, it can take all length of the session. Also probably the client needs to learn some skills to handle acute crises in the beginning. Also we are allowed to state and say we understand when all links of a chain are connected in a meaningful way.

We can see this structure with the scope of Biosynthesis as the grounding process, because the structure is the same every session. In Biosynthesis based therapy we can also make an assessment to use Chain analysis if mentioned types of behaviors are present and adjust and implement Chain analysis to the therapeutic frame. Clinical experience is that clients after a while come to session and start with Chain analysis themselves.

Another aspect of using such a structure is the bonding and bounding perspective, through therapeutic relation and boundaries, also decreasing behavior that challenges the therapeutic frame. Grounding, Centering, Bounding and Bonding are among others of great importance for clients with this type of behavior. Support of pulsation between focused and rotational motoric fields could be also expected. Chain analysis apparently leads to better integration of structure of germ layers and especially anchoring emotional and body experiences in ectoderm. This process helps even more ground and center the client. In conclusion this process can go through all stages from grounding to shaping and forming.

I slightly modified General handout 7a (Linehan, 2015) of DBT skills worksheets to best demonstrate the process and how Chain analysis is done, see Appendix 1. Working with clients, use of the schematics on Fig.1 or similar schematics is recommended.

Biosynthesis description of steps of chain analysis:

1. This step is focused on ectoderm primarily, especially with detailed description of PROBLEM BEHAVIOR. It also gives us information about where the client problems are situated in terms of basic concepts- Motoric fields and Life fields. This can be applied to Motoric fields where it is possible to observe some kind of imbalance in almost all dimensions in various clients when talking about problem behaviors.
2. This step anchors the whole EVENT even more into ectoderm by detailed description of the event.
3. In this step we try to examine the level of Grounding and Centering clients had before the EVENT. This step can open up space for clients to be more compassionate with themselves by understanding their own basic needs and that BEHAVIOR is caused and can be prevented. Further examination of body sensations, use of Life Fields and motoric fields diagrams can be used for Biosynthesis use.

Steps 4. and 5. works with even more ectodermal anchoring.

Steps 5. and 6. have some similarities with crisis intervention and some aspects of it can be used as CRISIS PLANS and exploring COPING strategies that work. Such plans and strategies can have even more Grounding and Centering potential.

In step 7. are more shaping and forming in focus, even acceptance and prevention of experiencing shame and guilt, eventually other emotions or behaviors.

The **missing-links analysis** is a series of questions to help a person figure out what got in the way of behaving effectively. Its purpose is to show where in the chain of events something happened (or failed to happen) that interfered with effective behavior when it was needed or expected. Two types of effective behaviors can be missing.

#### 1. Expected Behaviors

Expected behaviors are ones you have agreed to do (e.g., get to work on time), have been instructed to do (e.g., skills training homework), have planned to do (e.g., clean your room), or have desperately hoped to do (e.g., exercise in the mornings).

#### 2. Needed Behaviors

Needed behaviors are skillful behaviors that constitute effective responses in a specific situation (e.g., skillful interpersonal behavior to calm down a stressful interaction) or to address specific problems (e.g., getting up on time when your alarm clock is broken).

Missing-links analysis and problem solving are likely to be sufficient when the problem is not knowing what was expected or needed, unwillingness to do what was expected or needed, or never having the thought enter your mind to do what was needed or expected. Missing-links analyses together with chain analyses may be useful in figuring out the problem

when you know what the effective behavior is but still do not do it. See below for an example.

A missing-links analysis can be an invaluable tool for assessing situations when effective behaviors are repeatedly missing. As noted in discussing chain analysis, attempts to solve a problem often fail because the problem at hand is not fully understood and assessed. An advantage of the missing-links analysis is that the questions can usually be asked and answered very rapidly.

In practice is missing-link analysis done by asking the client: “Answer the questions on General Handout 8 (Appendix 2) until further questions would not be helpful or don’t make sense. As soon as you get to that point, start problem solving.” For example, if a person did not know that an effective behavior was needed or expected, it is pointless to ask whether he or she was willing to do what was needed or expected. If a person is willful right from the start and decides not to engage in effective behavior, solving that problem is more important than asking whether the person thought about engaging in the behavior at a later point. If the thought of doing something effective never came to mind, asking what got in the way of effective behavior (other than never thinking of it) would not be very useful. General Handout 8 (Appendix 2) is structured to understand and solve missing link behavior (Linehan, 2014).

Again with scope of Biosynthesis Missing-link analysis is intensely focused on ectoderm but modification for Biosynthesis is possible. Suggestion is about Expected or Needed behaviors that can be directed through questions about body experiences, or eventually integration of body experience. For this part see simultaneously Appendix 2.

For example, in **step 1**. What did your body want to do in that situation/What were the impulses of your body? How did you feel? (to

integrate with endoderm). If the answer is No suggests problem solving as in the original source.

**Step 2.** could be possible focused on impulse. Were you willing to follow your body impulse? What hindered it? (Did you freeze? Were you afraid?) If the answer is No suggestion is the same as in step 1.

**Step 3.** suggestion can be integration with ectoderm, where the question could be: Did you think about following body impulses? If the answer is No suggestion is to work with images as in source material.

**Step 4.** What got in the way of following impulses?.

If the answer is no work with images, eventually try to design exercise first just in images then even try to execute in real.

## **6. Suggestions of using DBT skills in Biosynthesis based therapy**

Based on described and analyzed aspects of DBT skills suggested use in Biosynthesis therapy is following:

1. Firstly implementing this type of approach should be as a part of the therapeutic frame and should be discussed with clients in the beginning of therapeutic work. If clients fit this approach should be assessed by the therapist and if needed with help of supervision
2. Structure should be followed every session if needed.
3. In the beginning of every session meditative exercise should be done (circulation or similar).
4. Then the therapist should ask about problem behaviors.
5. If present, do Chain and Missing-link analysis as it is in source material. Alternatively modified chain and missing-link analysis with a more holistic approach with focus on body experience or integration of emotional, body and cognitive experience.
6. After executing step 5. continuing with the session in the usual way.

Note: Possibility of changing the therapeutic frame when structure is no longer needed, if there are no problem behaviors with possibility to return if needed in the future.

Note: Suggested mostly for Borderline personality disorder or Borderline personality features; try NOT to do with Autism Spectrum disorders or Intellectual disabilities- needed special DBT skills- Julie Brown manual.

## **7. Conclusion**

In this work I provided firstly information about self-harm behavior and its function and occurrence in various contexts of psychopathology. This is essential to understand behavior and could work with such a behavior in an empathic way. As described above even though DBT is Cognitive therapy, it seems to be compatible with Biosynthesis based therapy. Its mostly because of the general humanistic approach of both and some common roots in eastern philosophies, willingness of developing resources and essence instead of judging and pathologizing. DBT is mostly cognitive but even though it can be understood by the scope of Biosynthesis mostly for Biosynthesis' openness. It also seems to be possible to implement some of DBT skills to Biosynthesis based therapy to enrich it with a structured approach of handling problem behaviors as these behaviors can be some level of distress for therapists and mostly for clients. DBT skills can be used in its original form or even in form which is modified. Some DBT skills can be replaced because Biosynthesis based therapy possesses these tools. Modified tools are on the other hand unproven and suggestion is trial with clients on these modified DBT tools to assess if they can be used practically with Biosynthesis based therapy and even refining and further modification probably could be done. I am also suggesting further reading for those who decide to try to use these skills practically, mostly DBT skills manual second edition by

Marsha Linehan, 2014 to fully understand the context of these skills, even further education in the form of specific training recommends. There are trainings in Chain analysis only, though all of them are outside Czech republic as far as my knowledge goes.



## **8. Appendices (Linehan, 2015)**

### **Appendix 1**

#### GENERAL HANDOUT 7a

#### Chain analysis

Step 1: Describe the PROBLEM BEHAVIOR.

Step 2: Describe the PROMPTING EVENT that started the chain of events leading to the problem behavior.

Step 3: Describe the factors happening before the event that made you VULNERABLE to starting down the chain of events toward the problem behavior.

Step 4: Describe in excruciating detail the CHAIN OF EVENTS that led to the problem behavior.

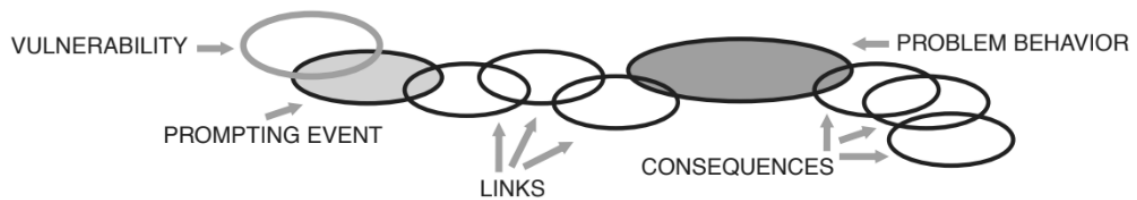
Step 5: Describe the CONSEQUENCES of the problem behavior.

To change behavior:

Step 6: Describe SKILLFUL behaviors to replace problem links in the chain of events.

Step 7: Develop PREVENTION PLANS to reduce vulnerability to stressful events.

Step 8: REPAIR important or significant consequences of the problem behavior.



1. Describe the specific PROBLEM BEHAVIOR (overeating or overdrinking, yelling at your kids, throwing a chair, having an overwhelming emotional outburst, dissociating, not coming or coming late to skills training, putting off or refusing to do skills practice, etc.).

A. Be very specific and detailed. No vague terms.

B. Identify exactly what you did, said, thought, or felt (if feelings are the targeted problem behavior). Identify what you did not do.

C. Describe the intensity of the behavior and other characteristics of the behavior that are important.

D. Describe the problem behavior in enough detail that an actor in a play or movie could recreate the behavior exactly.

E. If the behavior is something you did not do, ask yourself whether (a) you did not know you needed to do it (it did not get into short-term memory); (b) you forgot it and later it never came into your mind to do it (it did not get into long-term memory); (c) you put it off when you did think of it; (d) you refused to do it when you thought of it; or (e) you were willful and rejected doing it, or some other behavior, thoughts, or emotions interfered with doing it. If (a) or (b) is the case, skip from here to Step 6 below (working on solutions). Otherwise, keep going from here.

2. Describe the specific PROMPTING EVENT that started the whole chain of behavior. Begin with the environmental event that started the chain. Always begin with some event in your environment, even if it doesn't seem to you that the environmental event "caused" the problem behavior.

Otherwise, we could ask about any behavior, thought, feeling, or experience, “What prompted that?” Possible questions to help you get at this are:

- A. What exact event precipitated the start of the chain reaction?
- B. When did the sequence of events that led to the problem behavior begin? When did the problem start?
- C. What was going on right before the thought of or impulse for the problem behavior occurred?
- D. What were you doing/thinking/feeling/imagining at that time?
- E. Why did the problem behavior happen on that day instead of the day before?

3. Describe specific VULNERABILITY FACTORS happening before the prompting event.

What factors or events made you more vulnerable to reacting to the prompting event with a problematic chain? Areas to examine are:

- A. Physical illness; unbalanced eating or sleeping; injury.
- B. Use of drugs or alcohol; misuse of prescription drugs.
- C. Stressful events in the environment (either positive or negative).
- D. Intense emotions, such as sadness, anger, fear, loneliness.
- E. Previous behaviors of your own that you found stressful coming into your mind.

4. Describe in excruciating detail the CHAIN OF EVENTS that led to the problem behavior. Imagine that your problem behavior is chained to the precipitating event in the environment.

How long is the chain? Where does it go? What are the links? Write out all links in the chain of events, no matter how small. Be very specific, as if you are writing a script for a play. Links in the chain can be:

- A. Actions or things you do.
- B. Body sensations or feelings.

C. Cognitions (i.e., beliefs, expectations, or thoughts).

D. Events in the environment or things others do.

E. Feelings and emotions that you experience.

What exact thought (or belief), feeling, or action followed the prompting event? What thought, feeling, or action followed that? What next? What next? And so forth.

- Look at each link in the chain after you write it. Was there another thought, feeling, or action that could have occurred? Could someone else have thought, felt, or acted differently at that point? If so, explain how that specific thought, feeling, or action came to be.

- For each link in the chain, ask whether there is a smaller link you could describe.

5. Describe the CONSEQUENCES of this behavior. Be specific. (How did other people react immediately and later? How did you feel immediately following the behavior? Later? What effect did the behavior have on you and your environment?)

6. Describe in detail at each point where you could have used a skillful behavior to head off the problem behavior. What key links were most important in leading to the problem behavior? (In other words, if you had eliminated these behaviors, the problem behavior probably would not have happened.)

A. Go back to the chain of behaviors following the prompting event. Circle each link where, if you had done something different, you would have avoided the problem behavior.

B. What could you have done differently at each link in the chain of events to avoid the problem behavior? What coping behaviors or skillful behaviors could you have used?

7. Describe in detail a PREVENTION STRATEGY for how you could have kept the chain from starting by reducing your vulnerability to the chain.

8. Describe what you are going to do to REPAIR important or significant consequences of the problem behavior.

A. Analyze: What did you really harm? What was the negative consequence you can repair?

B. Look at the harm or distress you actually caused others, and the harm or distress you caused yourself. Repair what you damaged. (Don't bring flowers to repair a window you broke: fix the window! Repair a betrayal of trust by being very trustworthy long enough to fit the betrayal, rather than trying to fix it with love letters and constant apologies. Repair failure by succeeding, not by berating yourself.)

## **Appendix 2**

### GENERAL HANDOUT 8

#### Missing-Links Analysis

Ask the following questions to understand how and why effective behavior that is needed or expected did not occur.

1. Did you know what effective behavior was needed or expected (what skills homework was given, what skills to use, etc.)?

IF NO to Question 1, ask what got in the way of knowing what was needed or expected.

Ideas might include not paying attention, unclear instructions, never getting the instructions in the first place, becoming too overwhelmed and couldn't process the information, and so on.

PROBLEM-SOLVE what got in the way. For example, you might work on paying attention, ask for clarification when you don't understand instructions, call others, look up information, and so on.

2. IF YES to Question 1, ask were you willing to do the needed or expected effective behavior?

IF NO to Question 2, ask what got in the way of willingness to do effective behaviors.

Ideas might include willfulness, feeling inadequate, or feeling demoralized.

PROBLEM-SOLVE what got in the way of willingness. For example, you might practice radical acceptance, do pros and cons, practice opposite action, and so on.

3. IF YES to Question 2, ask did the thought of doing the needed or expected effective behavior ever enter your mind?

IF NO to Question 3, PROBLEM-SOLVE how to get the thought of doing effective behaviors into your mind.

For example, you might put it on your calendar, set your alarm to go off, put your skills notebook next to your bed, practice coping ahead with difficult situations (see Emotion Regulation Handout 19), and so on.

4. IF YES to Question 3, ask what got in the way of doing the needed or expected effective behavior right away? Ideas might include putting it off, continuing to procrastinate, not being in the mood, forgetting how to do what was needed, thinking that no one would care anyway (or no one would find out), and so on.

PROBLEM-SOLVE what got in the way. For example, you might set a reward for doing what is expected, practice opposite action, do pros and cons, and so on.

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