The Brown University
Child & Adolescent Behavior
LETTER
MONTHLY REPORTS ON THE PROBLEMS OF CHILDREN AND ADOLESCENTS GROWING UP

Bradley Hospital
A Lifespan Partner
Published in cooperation with Bradley Hospital

October 2024
Vol. 40, No. 10
Online ISSN 1556-7575

Editor: Anne S. Walters, Ph.D.

Highlights…

Our page 1 leads this week look at how to use DBT to handle unwanted emotions, and how to treat sleep problems with Prazosin in youth with PTSD.

Inside

OCD/Anxiety

Be curious, not judgmental: A DBT emotion regulation handout for changing unwanted emotions

Sarah A. McHugh, Ph.D. & Andrea L. Gold, Ph.D.

Dialectical behavior therapy (DBT) and its adaptation for adolescents (DBT-A) provide evidence-based tools for individuals with chronic emotion dysregulation and their families (Linehan, 2015; Miller et al., 2007). Teens with emotion dysregulation struggle to understand, label, and accept their emotions; they are frequently unable to modulate the intensity of their emotions to match the goals of the present context. No matter how much emotionally-dysregulated teens and their families may wish it were so, emotion regulation does not include getting rid of emotions. Why not? We need emotions for survival, as emotions serve essential functions: to motivate us for action and to communicate to ourselves and others. Rather than eliminating emotions, emotion regulation aims to help individuals understand their own emotions, decrease

OCD/Anxiety, *continued on page 3*

[*Correction added on October 1, 2024, after first online publication: The updated article reflects changes to the text that were published in error.]

Sleep

Prazosin Treatment of Sleep Problems in Youth with PTSD

Jose Flores, M.D., Ingrid, J. Lauer-Arnold, M.D., Kristen Benito, Ph.D

Post traumatic stress disorder (PTSD) is a condition characterized by reexperiencing symptoms, persistent avoidance, negative alterations in cognition and mood, and changes in arousal and reactivity in response to a traumatic event (American Psychiatric Association, 2013). The pathophysiology of PTSD is not fully understood but likely related to dysregulation of fear-processing. Currently, the gold standard of treatment is trauma-focused cognitive behavioral therapy (TF-CBT). SSRIs are the only FDA-approved pharmacologic treatments for PTSD in adults and there are no FDA approved medications to treat pediatric PTSD. Unlike studies in adults, double-blinded randomized control trials (RCTs) did not show any efficacy for SSRIs in pediatric patients diagnosed with PTSD (Hudson et al., 2021). While estimates of pediatric PTSD prevalence varies, the prevalence of PTSD at age 18 is 7.8% (Rolling et al., 2023). Sleep disturbances such as insomnia, night-time awakenings, and nightmares often persist despite treatment with TF-CBT or SSRIs. Left untreated, sleep disturbances are predictive of PTSD persistence and comorbid psychiatric complications (Rolling et al., 2023). There is evidence supporting the use

Sleep, *continued on page 5*

OCD/Anxiety

continued from page 1

emotional vulnerability and suffering, and change unwanted emotions. This article presents "Check the Facts," a DBT skill for helping individuals with emotion dysregulation effectively change unwanted emotions. We share a handout that we adapted from DBT with step-by-step tips based on our experience treating adolescents with chronic emotion dysregulation co-occurring with obsessive-compulsive disorder (OCD)/anxiety disorders.

Individuals with emotion dysregulation often judge emotions as problems—intolerable to experience, unacceptable to express, or "wrong" to have. This view of one's emotions stems from experiences of invalidation; for example, being told by others that certain emotional responses are "irrational," "dramatic," or "overreactions." It is further exacerbated by self-invalidation; for example, thinking that you are "wrong" or "bad" for having emotional responses that are different or bigger than those of people around you. Experiences of invalidation may involve adverse childhood experiences such as childhood maltreatment, but this is not always the case. Indeed, in many cases invalidation from one's environment involves well-intended, caring messages from caregivers. For example, caregivers of anxious youth often engage in "errors of kindness," offering responses such as reassurance that are well-meaning and, at the same time, invalidate the child's emotional experience. As a parent may try to calm their anxious child by explaining why it doesn't make sense to feel afraid of the dark, they may simultaneously communicate the message that the child "shouldn't" feel scared, that their behavior "doesn't make sense." Despite good intentions, such messages tend to increase distress, often adding shame to existing anxiety or sadness. This in turn prompts self-invalidating thoughts such as "I should just get over it. It's not a big deal." In the long term, these experiences tend to erode an individual's trust in their own internal experiences and communicate the message that emotions are problems that need to be solved.

At the same time, messages of invalidation contain a kernel of truth: emotions can provide inaccurate information. For example, a child's fear of the dark may communicate inaccurate information about the likelihood of danger coming from their closet at night. A teen's anxiety about peer judgment may communicate inaccurate information about whether others are actually negatively evaluating them, or even looking at them at all. Several evidence-based cognitive-behavioral therapies (CBTs) aim to change emotions by calling out this inaccurate information. As a basic cognitive therapy strategy, cognitive modification involves changing one's thoughts, including appraisals and assumptions, to fit the facts of a situation. Cognitive modification addresses cognitive errors that arise in the presence of (and give rise to) intense emotions. For individuals with emotion dysregulation who are exquisitely sensitive and have a history of invalidation, however, this approach is often ineffective and, at times, harmful.

What differentiates DBT from other CBTs is that it teaches teens with chronic emotion dysregulation how to regulate their emotions by balancing emotional acceptance with change. DBT clinicians provide high doses of validation and promote clients' self-validation in addition to change-based strategies, which include cognitive modification as well as skills training, exposure, and contingency management. DBT explicitly teaches skills to increase acceptance of emotional experiences as an antidote to emotional avoidance, while also teaching families to practice nonjudgmental curiosity in evaluating the accuracy of emotional information. This balance allows for self-validation of emotions while acknowledging that emotions may communicate inaccurate information. That is, families learn how to validate emotions while also observing and describing when and how emotions may motivate actions or communicate information that do not fit the facts of the situation. DBT then empowers teens to leverage this information to make decisions and take actions that are consistent with their goals and values.

At the DBT-X Track within Bradley Hospital's Pediatric Anxiety Research Center (PARC), we integrate DBT within an exposure-based intensive treatment program for multi-problem, high-risk adolescents with exposure targets for OCD/anxiety disorders that co-occur with DBT targets. DBT targets include chronic emotion and interpersonal dysregulation, suicidal and non-suicidal self-injurious (NSSI) behaviors and/or borderline personality disorder (BPD) traits. For this population, a major challenge involves teaching adolescents how to accept and validate their anxiety (and other painful emotions) after years of emotional avoidance and (self-)invalidation. At the same time, effective treatment requires adolescents to engage in exposure therapy to learn that their OCD/anxiety provides inaccurate appraisals of danger and to engage in behaviors that are inconsistent with the information that OCD/anxiety provides.

We adapted the DBT Check the Facts skill into a handout to encourage curiosity around emotions and nonjudgmental evaluation of the information that emotions provide, without invalidating teens' emotional experiences or arguing for the "rationality" of specific thoughts. Check the Facts is a useful skill for both decreasing the intensity of painful emotions and increasing goal-directed (rather than mood-dependent) behavior. By helping teens accurately define the problem (if there is a problem), Check the Facts can help teens identify effective responses to the problem and effective behaviors for further changing unwanted emotions, if needed.

Before engaging in the Check the Facts skill, teens are provided with psychoeducation to foster acceptance of emotions and challenge judgments of emotions as "useless" or "a problem." First, teens are oriented to the evolved functions of emotions to communicate information, both to ourselves and to others. For example, fear communicates that there is danger, while sadness communicates the loss of something/someone important. Emotions, when they fit the facts of the situation, communicate useful information about our needs, wants, and values. Teens are also oriented to the idea that the information that emotions communicate isn't always accurate. For example, fear on a hike might be telling you "You're in danger! That's a snake!" even if what you saw was really a curvy stick in your path. Teens are also taught that emotions motivate us for action, and that each emotion has one (or several) associated action urges. Feelings of love prompt behaviors like reaching out for connection, while feelings of guilt prompt behaviors like apologizing or making amends.

Following an orientation that teaches skills for identifying emotions and understanding the functions of emotions, teens begin the Check the Facts skill by first labeling the emotion(s) that they want to change. For many, slowing down and labeling the emotion

is an effective intervention to regulate emotions in and of itself. Many anxious teens with emotion dysregulation routinely attempt to distract or avoid thinking about their emotions for fear that they will feel overwhelmed or unable to tolerate them. For these teens, practicing mindful awareness of one's current experience to label emotions can function as an exposure to emotions themselves. Labeling emotions also serves a self-validation function. By putting a name to a painful experience, adolescents acknowledge that their experience is real, it makes sense, and is understandable. If teens struggle to label any emotions they are experiencing, it can be helpful to go to the next step (identifying urges) and then use these urges as clues to identify corresponding emotions.

In step 2, adolescents observe and label the action urges associated with the emotions they are experiencing. For example, anxiety prompts urges to avoid, control or make perfect (e.g., to over-plan or over-prepare), or seek reassurance; in the case of OCD, individuals experience urges to engage in compulsions or rituals to neutralize anxiety or distress prompted by their obsessions. Anger prompts urges to yell, criticize, or physically attack. Shame prompts urges to withdraw, hide, avoid eye contact, or engage in self-punishment. When identifying urges, adolescents are encouraged to list all urges that they are experiencing, without judging these urges (and their associated behaviors) as "good" or "bad." If adolescents are struggling to identify their urges, it can be helpful to review common urges associated with the emotions that they identified in the previous step using other handouts for observing and describing emotions.

In our handout, step 3 coaches adolescents to record the facts of a situation and distinguish these from their interpretations. We define "facts" as what can be observed with the five senses (e.g., what others said or did, visible environmental cues), while "interpretations" include assumptions (e.g., guesses about what others are thinking and feeling), judgments (e.g., "This is terrible"), and predictions (e.g., "I'm going to fail"). Importantly, this step does not involve arguing against any interpretations, but nonjudgmentally noting that interpretations are not the same as facts. Unlike the approach included in the DBT manual, we do not coach teens with OCD to rate the likelihood of any predictions. If there is any uncertainty about whether or not something is true about the event that prompted the emotions (e.g., the outcome, others' intentions, others' reactions), the uncertain statements are put in the interpretations column. Distinguishing facts from interpretations can require repeated practice and is one of the most challenging steps of this skill, particularly when one is dysregulated and experiencing intense emotions. Teens should also be prompted to include facts that may have been observed in the past (e.g., past instances of similar events occurring, facts about their history) when relevant to the current situation.

In step 4, adolescents are asked to evaluate whether the emotions identified in step 1 "fit the facts" identified in step 3. Emotions fit the facts when the information that they communicate is consistent with the observable facts of the situation. For example, fear communicates that there is danger and motivates behavior to keep us safe by prompting urges to avoid, run away, or hide from anything that threatens us. These action urges are effective (i.e., the emotion of fear fits the facts) when there is an observable, certain danger to one's safety or wellbeing. For example, fear fits the facts when one is being chased by a bear. If an emotion arises based on an interpretation alone, or if the information that would support it is uncertain or unknown (e.g., "I heard rustling outside, but I don't know if it's a bear"), that emotion is deemed to not fit the facts. In order for an emotion to fit the facts, the intensity of the emotion must also fit the facts. For example, mild guilt rated 3/10 may fit the facts if an individual acts against their values in a small way (e.g., wishing an acquaintance "happy birthday" a little late), but intense 10/10 guilt would not fit the facts in this situation. If an emotion fits the facts, but its intensity does not, adolescents are encouraged to use a skill, such as DBT's "Opposite Action" skill, to reduce the intensity of the emotion before moving on to step 5.

Adolescents move on to step 5 if they conclude that their emotion *and* its intensity fit the facts. If the emotion does fit the facts, adolescents then evaluate whether acting on the action urges identified in step 2 would be effective. "Effective" here means "doing what works," or behaviors consistent with one's short-term and long-term goals in the current situation and one's values. If the action urge is deemed to be effective, the adolescent is then encouraged to practice mindful awareness of the emotion while acting on the emotion's urge. For example, an adolescent might feel sad over the loss of a pet. After checking the facts, they conclude that feeling sadness fits the facts given their experience of loss. They decide it is effective to mindfully experience and "ride the wave" of their sadness while acting on their urge to spend time alone in their room, look at pictures of their pet, and cry for a while. Step 5 can also involve problem-solving, if the facts include an identifiable problem that can be solved.

When an emotion or its intensity does not fit the facts (step 4) or acting on an urge is deemed ineffective (step 5), adolescents proceed to step 6, where they are coached to not act on the emotion's urge and instead identify how to act effectively given the observable facts of the situation. In cases where there is no immediate problem to be solved (e.g., a painful emotion is caused by predictions about the future), an effective response may involve practicing acceptance of reality as it is, including accepting uncertainty and the distress that it prompts. If painful emotions remain high, acting effectively might involve acting opposite to emotion urges in order to downregulate emotions, or implementing another skill to change emotions.

Below we share an example illustrating our Check the Facts handout.

Nicki, an adolescent with OCD and chronic emotion dysregulation, was eating pizza with her mother and her mother's friend, Alex. Alex, who was unaware of Nicki's OCD, made a comment during dinner about the pizza's ingredients, a topic that triggers Nicki's OCD obsessions involving unjustified fears of contamination leading to illness/death. In response, Nicki's mother asked Alex to "please stop talking about the ingredients because it is going to upset Nicki."

In coaching Nicki, she first identified feeling shame (8/10) and anger (6/10) about her mother's comment, along with some mild anxiety (3/10) about Alex's comment and the OCD obsessions it prompted. In step 2, she shared that shame prompted an urge to run out of the room, which she acted on in the moment. She also reported urges to cry and lie about how she was feeling while contradicting mom (e.g., saying "That doesn't bother me, I don't know

what you're talking about"). She shared that feeling angry prompted urges to snap at mom, say something that would embarrass mom, and call her father to complain about mom.

In step 3, Nicki shared many interpretations, including judgments about mom's intentions. Nicki recorded thoughts: "Mom was trying to embarrass me," "Mom was being rude," "Mom doesn't care about my privacy," and "Mom is blaming me for being too sensitive." Nicki also reported interpretations of Alex's thoughts: "Alex is judging me and thinks I'm weak," while noting positive interpretations of mom's intentions, including "Mom was trying to protect me."

Nicki also recorded the observable facts: Alex made a comment about the content of the pizza and mom said, "Please stop talking about the ingredients because it is going to upset Nicki." Nicki observed that Alex stopped talking after mom's comment and that Nicki left the room shortly afterwards. When prompted to include

OCD/Anxiety, *continued on page 9*

Sleep

continued from page 1

of the medication prazosin in alleviating pediatric PTSD sleep disturbances including nightmares and insomnia. Anywhere from 20–80% of children with PTSD report nightmares compared to a prevalence of 10–20% in the general pediatric population (Kovachy et al., 2013). There is a growing need for pharmacologic therapy given the paucity of providers trained in TF-CBT and a need for symptomatic management. In this review, we will examine sleep disturbances in pediatric PTSD patients and discuss the feasibility of prazosin as an adjunct treatment option.

In 2010, the American Academy of Sleep Medicine recommended two treatment modalities with their highest-level A rating for the treatment of PTSD-nightmares in adults. The first was a cognitive behavioral technique known as image rehearsal therapy (IRT) (Morgenthaler et al., 2018). The second was prazosin—an alpha-adrenergic antagonist. A 2015 comparative metanalysis found that there was a statistically significant effect size of both treatments for nightmares, sleep quality, and posttraumatic stress symptoms in adults (Seda et al., 2015). However, accessibility of IRT and a dearth of clinicians trained in this modality present significant obstacles to care. Pharmacologic treatment can address this access issue. Prazosin is an alpha-1-adrenergic antagonist that may alleviate PTSD-related sleep symptoms by acting on the prefrontal cortex, hippocampus, and amygdala (Akinsanya et al., 2017). While nightmares fall under the category of reexperiencing symptoms, insomnia is often secondary to increased autonomic arousal. As an adrenergic antagonist, prazosin blocks the fight-or-flight response that mediates some of the reexperiencing and hypervigilant sleep symptoms prevalent in PTSD. While alternate adrenergic agents like clonidine, guanfacine, and propranolol have been trialed to relieve autonomic symptoms associated with PTSD in pediatric patients, none have been more widely studied than prazosin (Morgenthaler et al., 2018).

Understanding the relationship between PTSD and sleep is useful in elucidating potential treatment options. Sleep symptoms are often some of the earliest symptoms to emerge in PTSD (Rolling et al., 2023). Even after PTSD treatment, sleep disturbances can, and often do, persist for patients at clinically significant levels (Seda et al., 2015). The amygdala, insula, and hippocampus are key structures involved in the neural circuitry underlying sleep regulation. Disruption in these circuits is thought to be implicated in the sleep architecture changes that characterize PTSD. Some PTSD-associated sleep architecture changes include more fragmented and less restorative sleep (Ressler et al., 2022). Several pediatric PTSD studies incorporate the Child Post Traumatic Stress Reaction Index (CPTS-RI) into their methodology. There is sometimes discordance between subjective measures, like this questionnaire and sleep diaries, and more objective measures like polysomnography and actigraphy. Polysomnography and actigraphy results were significant for increased fragmentation of sleep in children with PTSD compared to age-matched controls (Rolling et al., 2023). Incorporating objective sleep measures as part of the research process is not always feasible due to cost, requiring a controlled environment, or population dynamics, however (Kovachy et al., 2013). Despite these limitations, studies consistently show an appreciable difference in sleep disturbances between patients with PTSD and those without PTSD.

Patients with PTSD experience an increased incidence of trauma-related nightmares and sleep disturbances. Untreated sleep disturbances may play a role in PTSD maintenance and may predispose patients to the development of comorbid psychiatric conditions like anxiety or depression (Kovachy et al., 2013). Sleep disturbances in adolescents are also associated with a decreased response rate to the current gold standard of treatment (TF-CBT) (Rolling et al., 2023). A 2023 prospective case-control study investigated whether sleep disturbances were correlated with PTSD severity and comorbidities (Rolling et al., 2023). This study enrolled 11 participants between the ages of 3 and 18 with PTSD-associated sleep disturbances and matched them with an age and sex-matched control group to evaluate PTSD and sleep. Children with PTSD had statistically significant increased number of sleep stage changes along with increased fragmented sleep (Rolling et al., 2023).

Several studies have found evidence supporting prazosin's use in alleviating sleep disturbance symptoms. A 2017 systematic review found six case reports showing improvement in PTSD-nightmares with the use of prazosin with doses ranging from 1 mg-4 mg daily (Akinsanya et al., 2017). Rebound in nightmare frequency occurred after stopping the medication in three of the six case reports. An important consideration is that in two case reports, patients continued receiving cognitive behavioral therapy in addition to prazosin. A 2017 chart review of 34 pediatric patients with PTSD found improvement in PTSD-associated nightmares with doses ranging from 1–15 mg daily at bedtime (Keeshin et al., 2017). Notably, patients from this chart review attended a trauma clinic and were predominantly female patients who experienced sexual abuse (82% female and 76% experienced sexual abuse as their primary trauma). Of the 34 patients in this review, 79% of patients received TF-CBT as a primary source of psychotherapy. Nightmares reoccurred in several patients who stopped their dose of prazosin.

A separate 2021 retrospective chart review of 42 pediatric patients found that 24 (57% of patients) had significant improvement in PTSD-associated nightmares with a mean dose of just 1.06 mg daily (Hudson et al., 2021). In this chart review, all identified patients

OCD/Anxiety

continued from page 5

relevant facts about her past history, Nicki added, "Mom told me that she feels anxious sometimes and tries to protect me from triggers," and "I have gotten upset when people made comments about food ingredients in the past."

In step 4, Nicki evaluated whether shame (8/10) and anger (6/10) fit the facts. Nicki determined that shame did not fit the facts, as there were no facts to indicate that mom or Alex rejected or judged her for her OCD. In step 5, Nicki also concluded that the shame action urges to leave the room and hide/lie about her feelings were not effective, as they increased and reinforced her shame. She mindfully chose to return to Alex and mom in step 6 as a way of acting opposite to these urges, after first practicing self-soothing skills.

In step 4, Nicki also identified that the intensity of her anger did not fit the facts, as the intensity of her anger was being increased by her judgments/assumptions about her mother's intentions. Nicki also identified that her anger action urges to verbally attack mom were not effective. Given this, she used step 6 to choose to act opposite to those urges, which she did by giving mom the benefit of the doubt and gently avoiding mom rather than attacking, while she took a few moments to practice self-soothing before returning.

After Nicki acted opposite to the action urges of her anger and shame, as identified in step 5, she repeated the Check the Facts skill and realized that she was actually feeling frustrated (3/10) and hurt (5/10) in response to mom's observable comments. In steps 4–5, she decided that it was effective to act on her urges that fit the facts of the situation by engaging in emotional problem-solving. After Alex left, Nicki problem-solved (step 5) by asking mom to talk, expressing how she felt during the interaction without blaming or criticizing mom. Given that Nicki first engaged in emotion regulation skills, she was able to communicate effectively and they collaboratively brain- stormed ways mom could support Nicki in future similar situations. Nicki benefited from the functions of her primary emotions of feel- ing hurt and frustrated that fit the facts of the situation.

In summary, this handout is intended as an emotion regulation tool for clinicians helping patients with emotion dysregulation change unwanted emotions by checking the facts with step-by-step guidance. This handout aims to help clinicians and families approach emotions with curiosity, recognize the difference between facts and interpretations, and utilize this information to choose goal-directed and values-consistent actions. We have benefited from this approach in helping individuals with emotion dysregulation be curious, not judgmental, and we hope you will too!

(For the handout, see page 10.) ■

References

Linehan, M.M. (2015). *DBT skills training manual* (2nd ed). New York: Guilford Press.

Miller, AL, Rathus, JH, Linehan, MM. (2007). *Dialectical behavior therapy with suicidal adolescents*. New York: Guilford Press.

Sarah McHugh, Ph.D. (she/her) is a clinical instructor in the Department of Psychiatry and Human Behavior, Warren Alpert Medical School of Brown University, and a staff psychologist at the Pediatric Anxiety Research Center (PARC) at Bradley Hospital. Dr. McHugh's clinical interests include the treatment of anxiety and obsessive-compulsive spectrum disorders with exposure and response prevention and the treatment of co-occurring emotion dysregulation from a dialectical behavior therapy approach. Dr. McHugh's research interests include examining menstrual cycle effects on psychopathology, including cyclical worsening in anxiety, mood symptoms, and suicidal ideation, and exploring dialectical behavior therapy as a potential treatment for those with menstrual cycle-linked symptom changes. She can be reached at sarah_mchugh@brown.edu. **Andrea Gold**, Ph.D. (she/her) is a clinical assistant professor in the Department of Psychiatry and Human Behavior, Warren Alpert Medical School of Brown University, and a staff psychologist at the Pediatric Anxiety Research Center (PARC) at Bradley Hospital. At PARC, Dr. Gold is the Team Leader for the DBT-X Track, where she is developing an adaptation of dialectical behavior therapy (DBT) targeting exposure for adolescents with OCD/anxiety disorders co-occurring with emotion dysregulation, suicidal and non-suicidal self-injurious (NSSI) behaviors, and borderline personality disorder (BPD) traits. Dr. Gold is also on the board of directors for the National Education Alliance for Borderline Personality Disorder (NEABPD) and executive editorial team of the DBT Bulletin. She can be reached at andrea_gold@brown.edu

Check the Facts Step by Step

Use this handout with your patients.

Check the Facts Step by Step

1. Identify emotion(s) that you want to change and rate their intensity.

2. Identify the urges associated with the emotion(s).

Emotion (Rate Intensity 0–10)	Urges

3. Identify the facts (what we can observe with our senses; what we know for sure) and our interpretations (assumptions, judgments, predictions).

Facts	Interpretations

Tips for sorting facts from interpretations:
Are you observing just this one moment? Or predicting the future? (Predictions are interpretations.)
Are you assuming a threat or catastrophe you can't observe? (If so, it's probably an interpretation.)
Are there other possible interpretations of events? (If so, it's probably an interpretation.)
What are you worried will happen? (If it hasn't actually happened yet, or you're not sure if it will happen, it's probably an interpretation.)

4. Does the emotion and its intensity fit the facts you identified in Step 3?

5. Is acting on the urges from Step 2 effective?

NO	YES (or unsure)	NO	YES
Do not act on the emotion urge. Go to step 6.	Go to step 5.	Do not act on the emotion urge. Go to step 6.	Be mindful of your emotion. Act on your emotion urge.
If the emotion fits the facts but the intensity does not: Use a skill to reduce the intensity, then go to step 5.			If the facts include a problem that you can solve, engage in problem-solving.

6. Choose an effective action (an action that is consistent with your short-term & long-term goals, and values) based on the facts you identified in step 3.

Tips for choosing an effective action:
Are painful emotions still high, even though they don't fit the facts? Consider acting opposite to your emotion urges or using another skill to change how you feel.
Is there uncertainty about how things will turn out, or are there circumstances outside of your control? Consider practicing acceptance skills.

Adapted by Sarah McHugh, PhD & Andrea Gold, PhD from Linehan, 2015, 2nd Ed. DBT Skills Training Manual.