

**Behaviour Change Techniques in mobile apps targeting self-harm in young people: a systematic review**

## **Abstract**

**Background:** Despite the high prevalence of self-harm among young people, as well as their extensive use of mobile apps for seeking support with their mental healthcare, it is unclear whether the design of mobile apps aimed at targeting self-harm is underpinned by behaviour change techniques (BCTs).

**Purpose:** To systematically analyse and identify 1) what BCTs and 2) what theories are present in self-harm apps for young people in an attempt to understand their active components.

**Methods:** Systematic searches in Apple store, followed by thorough screening, were conducted to identify free mobile apps targeting self-harm in young people. Five apps met the inclusion criteria and were used by trained researchers, who coded identified features against the BCT Taxonomy V1.

**Results:** Despite the majority of apps being underpinned by principles of Dialectical Behaviour Therapy (DBT), no other information is available about specific theories underpinning these apps. Nineteen of the 93 BCTs were identified across the five apps. The most frequently used BCT was “Distraction” (54.2%), offering ideas for activities to distract users from self-harming. Other techniques that were used often were “Social Support (unspecified)” (27.0%) and “Behaviour Substitution” (10.6%).

**Conclusions:** This study provides the first analysis of BCTs present in mental health apps which are designed to target the reduction of self-harm in young people. Future research is needed to evaluate the effectiveness of the apps, as well as assess the effectiveness of the BCTs present.

**Keywords:** self-harm; behaviour change techniques; mobile apps; young people

## **Introduction**

Non-suicidal self-injury (NSSI) has been defined as the “intentional self-inflicted damage to the surface of one’s body likely to induce bleeding, bruising, or pain, with the expectation that the injury will lead to only minor or moderate physical harm (i.e., there is no suicidal intent).” [1]. The term self-harm is sometimes used in preference to the dichotomous separation of such behaviours into non-suicidal self-injury and attempted suicide, given that suicidal intent is a dimensional phenomenon, and patients’ and clinicians’ views on it may differ [2]. Therefore, in this review, the term ‘self-harm’ will be primarily used. However, when quoting previous research, the terms used in the respective studies will be mentioned.

Despite the fact that self-harm has become a major public health concern, our knowledge about it has been very limited for decades due to a lack of empirical research. Self-harm is especially prevalent among adolescents and young adults. A meta-analysis on non-clinical samples revealed that 17.2% of adolescents, 13.4% of young adults, and 5.5% of adults have engaged in such behaviours [3]. In clinical samples of adolescents, the rates are even higher, with 40% or more reporting that they have engaged in non-suicidal self-injury [4-5]. **Characteristics and functions of non-suicidal self-injury were examined in a study with a community sample of 633 adolescents, which found that 46% had self-harmed at least with one form of behaviour, including biting self, cutting/carving skin, hitting self on purpose and burning skin [6].** It is, therefore, evident that adolescents and young people are at greater risk for engaging in self-harming behaviours and, in order to prevent and/or intervene early, it is important to understand the particular risk factors that lead to self-harm.

A large body of literature has revealed that females self-harm more than males [7-10], however, other studies have demonstrated overall similar rates in between sexes [11-12]. One potential

explanation for why more females than males meet the criteria for self-harm may be that boys are typically less inclined to acknowledge the emotional and motivational aspects of the diagnosis [13-14]. Yet, such interpretations should be made with caution given the usual overrepresentation of females in samples [15]. Importantly, certain psychological characteristics are more likely to be displayed by individuals who self-harm. To begin with, a study highlighted that one of the main characteristics is negative emotionality [16]. Besides the elevated experience of negative emotions, individuals who self-harm also appear to have a deficit in emotional skills as they struggle with their awareness and expression of emotions [17] and also display higher levels of self-derogation [16,18]. Interestingly, various psychiatric diagnoses have been recurrent in individuals who self-harm. Symptoms of depression and anxiety disorders have indicated an elevated levels of self-harm [19], possibly because these disorders are primarily characterized by emotion dysregulation and negative emotionality [20]. Similarly, self-harm is more likely to occur with individuals who struggle due to eating disorders, which are also driven by negative emotions similar to what precedes self-injury [21]. Individuals who struggle with substance disorders are also considered more prone to self-harm, as both behaviours cause harm physiologically to the individual's body, possibly involving similar psychological processes [16].

With regards to treatment, problem solving therapy has been commonly used with adolescents who self-harm [22]. If depression is also present, cognitive-behavioural therapy may also be effective for adolescents, as well as fluoxetine (Prozac) [22], although it is highlighted that medical supplies should be limited as much as possible in order to reduce the risk of further self-harm by overdose [22]. In a recent review on interventions aimed at reducing self-harm [23], three Cochrane reviews were identified [24-26] and summarise relatively small numbers of studies which are of poor or moderate quality. For children and adolescents, only 11

interventions were identified, none of which were pharmacological. Neither group-based therapy nor dialectical-behavioural therapy (DBT) were found to be associated with a reduction in the percentage of participants engaging in self-harm, although a reduction in the frequency of self-harm was noted following DBT, as well as a reduction in depression, hopelessness and suicidal ideation [23].

Self-harm is conceptualised as a behaviour [27], therefore, focusing on behaviour change may be a useful way of helping camber individual change. Behaviour change interventions, defined as directed arrays of actions designed to change specific patterns of behaviour, are considered vital for the efficiency of clinical practice and public health [28]. Behaviour change interventions are often perceived as complex, comprising of various interacting active components and it is, therefore, challenging to accurately replicate research, synthesise it across various studies and translate it into practice. Interventions often describe several distinct techniques, such as “setting goals” or “self-monitoring the behaviour”, so a “common language” to identify and refer to such active components can simplify replication and adoption [29]. In light of this need for a “common language”, behaviour change techniques (BCT) have been defined as “an observable, replicable and complex component of an intervention designed to alter or redirect the underlying means that regulate behaviour”, which has been labelled as an “active ingredient” of an intervention [29]. In other words, the “active ingredient” is the “what” triggers the change rather than the “how”. In this taxonomy of BCTs [29], 93 techniques were identified and categorized into 16 groups, which addressed the various potential targets of capability, motivation and/or opportunity. BCTs have been identified in various interventions designed for health-related behavioural outcomes, such as promoting health protective behaviours (e.g. physical activity, healthy eating), as well as stopping or reducing harmful/risky behaviours (e.g. smoking, excessive drinking) [30,31]. However, a lack of

research on BCTs in mobile applications (apps) for mental health is noted, despite the current popularity of mobile technologies in the area of behaviour change, health promotion, and well-being, especially among young people.

The number of health apps available in the market has increased significantly. In a cross-sectional survey with 1,604 English-speaking adults in the United States, it was found that at least one health app had been downloaded by 934 participants, with the main themes that emerged being weight loss, calorie tracking, nutrition and physical activity [32]. Apart from health apps, mental healthcare is also currently expanding to smartphone apps for young people and apps for mental health become increasingly available, targeting depression, stress, anxiety, as well as self-harm. Young people, who tend to report fear of stigma associated with seeking professional help services for mental health issues, find self-management tools very helpful [33, 34]. It has been further stated that individuals are more inclined to use self-support materials that are delivered via known means, such as their own smartphone, rather than physically presenting themselves at a clinic [35]. Nevertheless, research which supports the efficacy of these apps is very limited [35]. A literature search was conducted to assess the credibility of the top-ranking, consumer-focused mental health apps [36]. Seventy-three mental health apps were coded and 64% claimed to be efficient in improving symptoms, mood or self-management or diagnosing a mental health condition [36]. However, the majority of the commercial apps have not been embedded in health behaviour theories and have not been evaluated using scientific means [37]. Despite an emphasis on the importance of theory when developing any intervention aimed at changing behaviour [38], theory is frequently neglected or incorrectly applied [39, 40]. Moreover, the use of theory when developing interventions tends to focus around four main theories: the Transtheoretical Model of Change, the Theory of Planned Behaviour, Social Cognitive Theory, and the Information-Motivation-Behavioural-

Skills Model, which may not be the most appropriate to address the change the intervention hopes to achieve [41]. This is important as theory not only allows for the identification of causal determinants of change and mediators [41], but also leads to more effective intervention outcomes [42, 43].

BCTs are the active components that trigger change in the addressed behaviour pattern. Hence, in order for an app to effectively target a specific behaviour, it is important to specify the BCTs used. The need to quantify and classify apps in terms of BCTs to understand their effect on behaviour change is increasingly recognised [44]. In one review, the effectiveness of mobile apps in achieving health-related behaviour changes was examined and it was found that out of 23 studies, 17 had statistically significant effects in the targeted behaviour change [45]. “Self-monitoring” was the most common BCT applied in 12 studies. Similarly, 12 BCTs were found to be present in 166 medication adherence apps, the most common being "action planning" and "prompts/cues" [46]. The presence of BCTs in physical activity and dietary mobile apps has also been reviewed and it was found that apps included an average of 8.1 (range 2-18) techniques [47]. In a more recent evaluation of BCTs in health and lifestyle mobile applications, 9 of the 93 BCTs were found to be common across apps and the most frequently used BCTs were “goal setting” and “feedback” [48].

While the evidence discussed above suggests that some health apps include certain BCTs, the number of techniques identified is quite low and entire categories from the taxonomy are absent. It is also still unclear whether the design of mental health apps is embedded in health behaviour theories and underpinned by BCTs. This is particularly important for mobile apps aimed at preventing self-harm among young people, given the high prevalence of self-harm in adolescents, as well as their extensive use of mobile apps for seeking support with mental

healthcare. To this end, the aim of this review is to systematically analyse and identify what theories and BCTs are present in self-harm apps for young people in an attempt to understand the active components of apps aimed at reducing self-harm.

## **Method**

A systematic approach was adopted for identifying self-harm prevention mobile applications (apps). Three independent reviewers were involved in the selection process and undertook the assessment of the presence of BCTs: two expert researchers in youth mental health and an MSc student of Developmental Psychology. All three reviewers were previously trained (<http://www.bct-taxonomy.com/>) in identifying BCTs based on the criteria provided in the taxonomy [29] and were certified prior to data collection.

## **Information Sources and Search Strategy**

The study sample was identified through systematic searches in the Apple Store search platform. The specific app store was selected due to easy access by all reviewers. The apps were searched, screened and downloaded between December 2018 and February 2019, using the search terms: *self-harm* and *self-harm prevention*. These were tested prior to being finalised and yielded the widest number of hits. The addition of more specific self-harm terms (e.g. overdose) did not.

In order for the apps to be included in the systematic review, they had to meet the following criteria (Table 1).

**Table 1:** *An outline of the eligibility criteria for inclusion in this review*

<b>The application had to</b>	<b>Rationale</b>
1. Be suitable for free download on a mobile phone	Systematic review focused on mobile apps only.



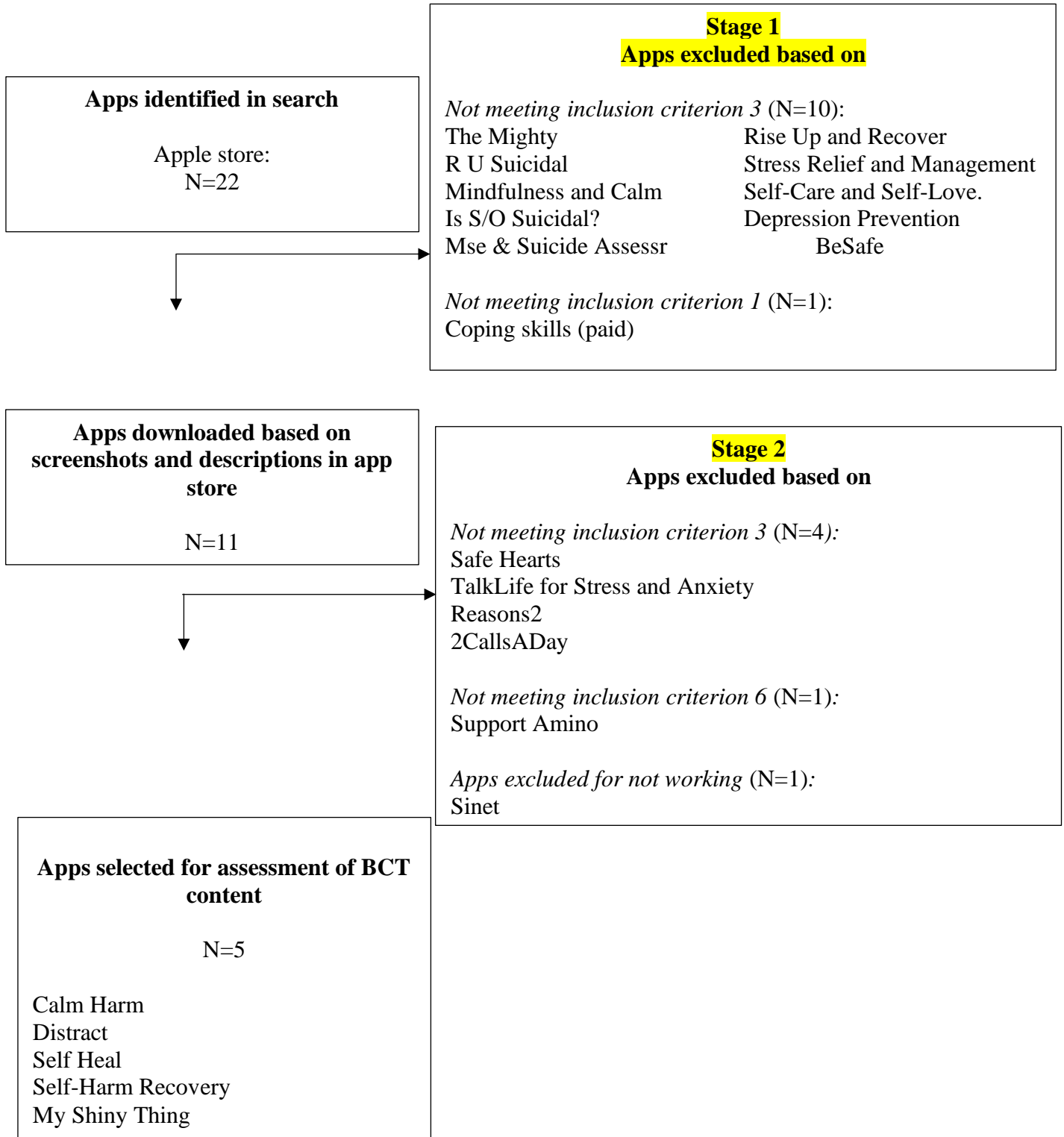
2. Be available in the Apple app store	App stores differ in their acceptance policy and therefore might offer different apps. The app sample for this review was identified through systematic searches in Apple store, which is the biggest iOS app store with over 2.2 million apps.
3. Only targets self-harm	Various apps targeting general mood, such as depression and/or anxiety, including self-harm as a sub-component. However, the focus of this review was merely on apps that are targeting specifically self-harm.
4. Be designed for children and young people below the age of 25 years	According to the World Health Organization (WHO), 'young people' are individuals in the 10-24 year group.
5. Be available in English	
6. Contain sufficient detail in order to extract BCTs	Some apps were solely support groups/chats and were, therefore, not containing sufficient detail to extract BCTs.

### Screening and Assessment

The selection of the apps was completed in two stages. In Stage 1, the search term(s) were entered in the Apple store and the apps were screened by Researcher 1, based on descriptions and images provided by the app store, with reference to the inclusion criteria. Any apps which were possibly deemed as suitable were downloaded on an iPhone 8. Only free apps were downloaded, and all apps that involved monetary costs for users were excluded. Once downloaded, in Stage 2, the apps were assessed more thoroughly with reference to the inclusion criteria. Researchers 1 and 2 explored the included apps in order to familiarise with the information provided, and this varied from a few hours for a basic app to a few weeks for a more detailed app. Some apps that were originally downloaded were excluded due to not targeting self-harm, not working properly or not containing enough information to extract

BCTs. The figure below (Figure 1) illustrates an overview of the selection and screening process of apps for the assessment of behaviour change techniques (BCTs)

**Figure 1:** Flowchart for screening process



## **Data Collection Process**

For the extraction of BCTs, the full version of the BCT taxonomy was used [29], consisting of 93 techniques, in order to have a high sensitivity of techniques. Prior to coding, Researchers 1 and 2 examined the coding manual and discussed each technique carefully, until a consensus was reached on definitions (see Appendix 1). Furthermore, it was decided to only code techniques that were specifically aimed at reducing the target behaviour (i.e. self-harm), rather than indirectly reducing it by improving mood, expression of feelings or increasing comfort. For each app, Researcher 1 extracted the BCTs on a file, which included the BCT, the excerpt coded, confidence levels, which were rated with +/++ and rationale/justification for the extraction of the specific BCT. The file was shared with Researcher 2 who double-checked all the BCTs extracted and any discrepancies were resolved by discussions among all three researchers. Furthermore, the developers of the apps were contacted to identify whether they have been evaluated. Only one app provider (i.e. distrACT) responded, confirming that the app had not been evaluated in a real-life clinical setting using formal qualitative or quantitative research.

## **Ethics**

This systematic review did not require any ethical approval as it involved assessing BCTs in apps that are publicly available.

## **Results**

Five apps met the inclusion criteria for this review. Table 2 outlines the apps included, the behaviour and age targeted, the number of reviews in Apple store and the rating (out of 5), the principles each app is based upon and whether the app is included in the NHS Apps Library or not.

**Table 2:** Characteristics of the apps selected.

Name	Behaviour	Age	No of ratings*	Rating out of 5*	NHS Apps Library	Based on:
Calm harm**	Self-harm	12+	178	4.3	Yes	Dialectical Behavioural Therapy (DBT)
distrACT**	Self-harm	17+	8	4.8	Yes	N/A
Self-heal**	Self-harm	12+	1	5	No	Dialectical Behavioural Therapy (DBT)
My Shiny Thing	Self-harm	17+	25	3.0	No	Dialectical Behavioural Therapy (DBT)
Self-harm recovery**	Self-harm	12+	1	5.0	No	N/A

\* Ratings in Apple store

\*\* App also available for Android

Overall, 19 BCTs out of the 93 BCTs (20.4%) were identified across the 5 apps. “Distraction” appeared in all 5 apps. This was followed by “Social support (practical)” which emerged in 4 of the 5 apps. “Behaviour substitution”, “Prompts and cues”, as well as “Social support (unspecified)” appeared in 3 apps. “Self-monitoring of behaviour”, “Self-talk” and “Problem solving” emerged in 2 apps, while the remaining BCTs appeared only in 1 app each.

The most frequently used BCT across all 5 apps was “Distraction” (54.2%), offering ideas for activities to distract users from self-harming. Other techniques that were used often were “Social Support (unspecified)” (27.0%) and “Behaviour Substitution” (10.6%). “Social Support (practical)” and “Prompts and cues” were used much less frequently (both 1.3%), and all other BCTs were used less than 1% across the 5 apps. For more details about BCTs, definitions used, examples of excerpts coded, frequency and % of usage across apps please refer to Appendix 2.

Three apps included a combination of techniques. Specifically, *Calm Harm* and *distrACT* included a combination of “Prompts and cues” and “Behaviour Substitution”, which was present twice in both of the apps. Similarly, a combination of “Prompts and cues” and “Social Support (practical)’ was identified once in both *Calm Harm* and *Self Heal*.

The table below illustrates the frequency (i.e. number of times identified) of BCTs across the five different apps.

**Table 3:** *Frequency of BCTs across five apps.*

	<b>Calm Harm</b>	<b>Distract</b>	<b>Self-Heal</b>	<b>My Shiny Thing</b>	<b>Self-Harm Recovery</b>
Distraction	165	7	1	1	31
Social support (unspecified)	-	22	78	-	2
Behaviour substitution	33	6	1	-	-
Prompts and cues	2	2	1	-	-
Feedback on behaviour	2	-	-	-	-
Monitoring of emotional consequences	1	-	-	-	-
Social support (practical)	1	2	1	-	1
Self-monitoring of behaviour	1	-	-	2	-
Problem solving	-	1	-	-	1
Information about health consequences	-	1	-	-	-
Framing/reframing	-	1	-	-	-
Restructuring of Physical Environment	-	-	2	-	-
Self-talk	-	-	1	-	1
Non-specific reward	-	-	-	1	-
Mental Rehearsal of Successful Performance	-	-	-	-	1
Commitment	-	-	-	-	1

Pros and Cons	-	-	-	-	1
Focus on Past Success	-	-	-	-	1
Comparative imagining of future outcomes	-	-	-	-	2

## **Discussion**

The aim of this review was to systematically analyse and identify the theory and BCTs present in self-harm apps for young people in order to understand the active components of apps aimed at reducing self-harm. Five apps met inclusion criteria for this review and three reported being based on the evidence-based therapy DBT; a specific type of cognitive-behavioural therapy, used mainly to treat problems associated with Borderline Personality Disorder (BPD), but also other mental health difficulties [49]. DBT is based on a biosocial theory according to which BPD is a dysfunction of the emotion regulation system [50]. DBT is one of the main models used to explain and treat self-harm and views self-harm as a strategy to manage overwhelming emotions, hence interventions aimed at enhancing affect regulation and problem solving are effective for its reduction [49]. No other theories were outlined as being present. However, the use of some theory (i.e. DBT model) is encouraging as it has been shown to increase effective intervention outcomes [42-43].

Within this review, 19 different BCTs were employed out a total selection of 93. This equates to 20% of the entire BCT taxonomy. The identified BCTs were spread out across different sub-categories in the taxonomy including: Social support, Repetition and Substitution, and Antecedents, which indicates that app developers believe that employing BCTs from these said categories are likely to facilitate positive change in relation to self-harm behaviour. On the other hand, certain categories of the taxonomy were completely missing due to a lack of BCTs within these domains. These included: Shaping knowledge, Scheduled consequences, and

Covert learning. This indicates that app developers view these BCTs as less important for this target behaviour. Whilst this may make sense for some BCTs such as “Punishment”, it is less clear why others (e.g. “Reward Alternative Behaviour”) are not included. Moreover, “Problem Solving”, which is one of the main interventions proposed by the DBT model for self-harm reduction [49], was only coded twice across the five apps, indicating a gap between the DBT model and the interventions proposed by the apps.

Within this review, the most common BCT identified was “Distraction”, followed by “Social Support (unspecified)” and “Behaviour Substitution”. When compared to other reviews utilising apps to change behaviour, different BCTs appear to be used. For example, a review on apps for medication adherence found "Action Planning" and "Prompt/Cues" to be the most common BCTs [46]. The use of different BCTs is likely to reflect the different underlying reasons why an individual would need help in changing behaviour. For example, "Action Planning" and "Prompt/Cues" highlight that an individual may need to remember to enact a certain desirable behaviour and put certain strategies in place in order to be able to do so. Conversely, the BCT “Distraction” implies that an individual needs support to stop enacting a certain undesirable behaviour. It, therefore, appears that given that the ultimate aim of these apps is to reduce a harmful behaviour, rather than promote a health protective one, the main interventions employed concentrate on either advising on an alternative focus of attention (i.e. distraction) or an alternative behaviour (i.e. behaviour substitution).

This is the first study to examine BCTs in self-harm apps aimed at children and young people, allowing for an understanding of how apps are currently trying to help young people cope and change their behaviour. Breaking apps down into their ‘active ingredients’ will allow for researchers and app developers to test and gain feedback from service users about what specific

aspects help young people manage self-harming behaviour. However, it should be noted that due to the paucity of research into the effectiveness of the apps identified in this review, the question of whether any BCTs are helpful remains unclear. A further strength of this study is the use of three researchers to extract the data from the apps and apply the BCT coding framework. This mitigates the risk of systematic bias, while also decreasing the total number of errors in data extraction [51]. With respect to the data extraction, online training was completed by all researchers to ensure consistency in identifying and recording behaviour change techniques.

Nevertheless, there are some limitations to this study. First, researchers limited the search to free apps. However, it is possible that paid apps for iOS and Android may utilise different theory, BCTs, or have had research conducted into their effectiveness. Second, the BCT taxonomy list has not been developed to be applied to apps, and therefore, the interpretations might have been different to what was initially intended as the researchers had to translate the BCTs to the app characteristics. For example, “Distraction” appeared to be a difficult BCT to interpret. It is defined as “advise or arrange to use an alternative focus for attention to avoid triggers for unwanted behaviour”, however, in this study, many apps included types of distractions, such as expressing yourself or comforting, which were not focused on the target behaviour – reduction of self-harm. After a consensus meeting between co-authors, it was decided not to code behaviour that was suggested in the app that was not targeting self-harm.

This study provides the first analysis of BCTs present in mental health apps which are designed to target the reduction of self-harming behaviours in young people. However, the usability and the effectiveness of these apps is not established. Given the lack of research conducted in relation to these apps, little can be said about whether they help young people manage self-



harming behaviour. Until rigorous research has been undertaken to test these, healthcare professionals should be cautious about recommending such apps, particularly as any negative outcomes are not known. With app developers being more focused on user experience, and researchers/mental health professionals focusing more on theory and effectiveness, there appears to be a natural chasm, which needs bridging for mental health apps for children and young people. It is recommended that these professions work closely together to develop more meaningful apps for children and young people's mental health.

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**Appendix 1: Decisions on definitions of BCTs:**

- “Social support (unspecified)”: when links were provided for psychological services, A&E, etc.

- “Behaviour Substitution”: when the apps provided suggestions for alternative behaviours to engage with when the urge to self-harm arose
- “Distraction”: when users were offered activity ideas in order to distract themselves from self-harming

**Appendix 2: BCTs, definitions, examples, frequency and % of usage across apps**

	<b>BCT</b>	<b>Definition</b>	<b>Example</b>	<b>Frequency (number of times)</b>	<b>Frequency (%)</b>
1.	Distraction	“Advise or arrange to use an alternative focus for attention to avoid triggers for unwanted behaviour”	“suggest writing a list of places you would travel to if money was no object to distract themselves from self-harm”	205	54.2%
2.	Social Support Unspecified	“Advise on, arrange or provide social support or noncontingent praise or reward for performance of the behaviour”	"advise on talking with a friend, relative, colleague etc about your situation and how you feel as it can help to reduce tension and make you feel better"	102	27.0%
3.	Behaviour Substitution	“Prompt substitution of the unwanted behaviour with a wanted or neutral behaviour”	“suggest the person to scream into a pillow to release tension until you feel better rather than self-harming“	40	10.6%
4.	Social Support Practical	“Advise on, arrange, or provide practical help for performance of the behaviour”	“advise on, arrange or provide practical help by someone trained in first-aid if the individual gets more severe cuts”	5	1.3%
5.	Prompts and Cues	“Introduce or define environmental or social stimulus with the purpose of prompting or cueing the behaviour. The prompt or cue would normally occur at the	"stick some sticker plaster to where you want to hurt yourself to remind yourself that you are letting yourself heal”	5	1.3%

		time or place of performance”			
6.	Self-Monitoring of behaviour	“Establish a method for the person to monitor and record their behaviour(s) as part of a behaviour change strategy”	“as the person to keep a diary of when you self-harm and triggers”	3	0.79%
7.	Problem Solving	“Analyse, or prompt the person to analyse, factors influencing the behaviour and generate or select strategies that include overcoming barriers and/or increasing facilitators”	“think about what makes you self-harm and what you could do the next time you feel overwhelmed by your feelings”	2	0.53%
8.	Self-Talk	“Prompt positive self-talk (aloud or silently) before and during the behaviour”	“can I practice self-talk when I have an urge? What could I tell myself”	2	0.53%
9.	Feedback on Behaviour	“Monitor and provide informative or evaluative feedback on performance of the behaviour”	“inform the person of the current urge strength and when he/she is most active during the day”	2	0.53%
10.	Comparative Imagining of Future Outcome	“Prompt or advise the imagining and comparing of future outcomes of changed versus unchanged behaviour”	“if I did self-harm today what can I do differently next time”	2	0.53%
11.	Restructuring of Physical Environment	“Change, or advise to change the physical environment in order to facilitate performance of the wanted behaviour or create barriers to the unwanted behaviour”	“advise to keep things you harm yourself in a locked cupboard or in a box with tape around it. It gives you time to think before you want to self-harm”	2	0.53%
12.	Mental Rehearsal of Successful Performance	“Advise to practise imagining performing the behaviour successfully in relevant contexts”	“advise to think how you will feel if you keep the promise to not self-harm”	1	0.26%
13.	Commitment	“Ask the person to affirm or reaffirm statements indicating commitment to change the behaviour”	“15minute promise videos asking the person to use an “I will” statement to affirm commitment”	1	0.26%
14.	Pros and Cons	“Advise the person to identify and compare reasons for wanting	“advise the person to list the benefits there	1	0.26%



		(pros) and not wanting to (cons) change the behaviour”	are from not self-harming”		
15.	Information about Health Consequences	“Provide information about health consequences of performing the behaviour”	what are the dangers of self-harming? -> "repeat episodes/poor health/ lasting damage"	1	0.26%
16.	Framing/Reframing	“Suggest the deliberate adoption of a perspective or new perspective on behaviour in order to change cognitions or emotions about performing the behaviour”	"advise to read real stories or write them down yourself as it can help to make you feel better by giving you new insights and providing different perspectives”	1	0.26%
17.	Monitoring of Emotional Consequences	“Prompt assessment of feelings after attempts at performing the behaviour”	Record on a scale of 1-10, how much do you want to hurt yourself right now? 1: not at all, 10: a lot	1	0.26%
18.	Non-Specific Reward	“Arrange delivery of a reward if and only if there has been effort and/or progress in performing the behaviour”	"leave yourself a good job message or emoji"	1	0.26%
19.	Focus on Past Success	“Advise to think about or list previous successes in performing the behaviour (or parts of it)”	“advise to describe or list occasions when you lost motivation to recover. Can you remind yourself of what motivated you before”	1	0.26%