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Evaluating the Pantablay Counseling Approach for Non-Suicidal Self-Injury in Filipino Youth: A Case Study

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Abstract

This single case study evaluates the effectiveness of the *Pantablay* counseling approach, a culturally adapted intervention designed to address Non-Suicidal Self-Injury (NSSI) and emotional distress in Filipino adolescents, using the Spirituality, Physical health, Attitude, Cognition, Emotional health, and Social networks S.P.A.C.E.S.(Modified) framework. Client A is a 20-year-old college student, who exhibited significant improvements in emotional regulation (DASS-21 scores decreased by 30%), self-esteem (Sorensen Self-Esteem Scale scores increased by 40%), and social engagement after six sessions. The integration of prayers, reflective journaling, and Filipino rituals, such as *Tapik and Salo*, provided Client A with tools to manage stress and reduce NSSI behaviors. Despite these positive outcomes, the study highlights challenges in balancing cultural sensitivity with clinical effectiveness and the potential limitations of the approach's applicability beyond collectivist cultures. Theoretical contributions include the integration of culturally relevant practices into therapeutic models, while practical implications suggest the potential for broader applications in similar cultural contexts.

Keywords: Pantablay, non-suicidal self-injury, adolescent risk behavior, non-suicidal self-injury intervention

Introduction

Non-Suicidal Self-Injury (NSSI) is a growing concern among adolescents globally, including in the Philippines, where it is often used as a maladaptive coping mechanism to deal with emotional distress. Non-Suicidal Self-Injury (NSSI) is the deliberate self-infliction of harm to one's body tissue without suicidal intent, commonly observed as a maladaptive coping mechanism among adolescents (Levesque et al., 2016). The global prevalence of NSSI among adolescents ranges from 17% to 18% (Swannell et al., 2014) , with studies suggesting that approximately 10% to 30% of adolescents in Asian countries engage in NSSI at least once in their lifetime (Lai et al., 2024). In the Philippines, however, data on the prevalence of NSSI is limited due to underreporting, though emerging research indicates that it is a significant issue among adolescents in both urban and rural settings (Reyes & Masana, 2020). Despite the rise in NSSI behaviors, mental health infrastructure in the Philippines remains underdeveloped, with formal interventions often failing to reach those in need.

One major challenge in addressing NSSI in the Philippines is the dominance of Western-based theories and psychiatric interventions, which often overlook important cultural factors. Western interventions, such as Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT), focus heavily on individual autonomy, personal

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responsibility, and cognitive restructuring (Tuason et al., 2012). While these approaches have been proven effective in many contexts, they do not fully account for the collectivist values that are prevalent in many Asian cultures, including the Philippines (Rathod et al., 2019). In Western contexts, mental health treatment emphasizes the individual's responsibility to manage emotions and behaviors independently. However, in collectivist cultures like the Philippines, mental well-being is closely tied to family relationships, spirituality, and community support, which Western models often fail to address adequately (Martinez et al., 2020).

Families are often the primary source of emotional and psychological support, and seeking professional mental health care is viewed as secondary or even unnecessary. This reliance on informal family-based systems can lead to the underreporting of mental health issues, including NSSI. According to Ignacio & Tudy (2020), Filipino adolescents often choose not to disclose their self-injury to family members or mental health professionals due to fear of stigma or judgment. A survey by the National Center for Mental Health found that 69% of Filipino adolescents had experienced mental health symptoms but did not seek professional help, with many preferring to rely on family for emotional support (National Center for Mental Health, 2020). This cultural context creates barriers to accessing timely and appropriate interventions for NSSI, as many families lack the psychological understanding necessary to address these behaviors effectively. Recent studies have called attention to the limitations of applying Western-based mental health interventions in Asian settings (Della et al., 2021). In the Philippines, adolescents who engage in NSSI often lack access to appropriate mental health care, as cultural norms emphasize resilience, communal problem-solving, and familial responsibility. The general stigma surrounding mental health issues further discourages adolescents from seeking help, contributing to the underutilization of formal psychological services. Additionally, the family-centered structure in the Philippines means that adolescents often experience pressure to meet familial expectations of strength and emotional endurance, which can exacerbate feelings of isolation and emotional distress. Research by Byrow et al. (2020) highlights that the perception of mental health as a family matter often delays intervention, as families attempt to manage emotional issues internally before seeking professional support.

Previous research has highlighted the prevalence of NSSI among adolescents who lack adequate coping mechanisms, often exacerbated by stressors such as familial conflict, academic pressure, and peer dynamics (Purwoko et al., 2022). Cultural factors, particularly in collectivist societies like the Philippines, further complicate mental health interventions, as traditional practices and family support are deeply rooted (Martinez et al., 2020). This is echoed in a study involving Chinese college students, which demonstrates a negative reinforcement feedback pathway between NSSI and depressive symptoms, providing evidence for intrapersonal negative reinforcement of NSSI (Cui et al., 2025). The need for culturally relevant interventions has been well-documented, with evidence suggesting that such approaches can significantly enhance mental health outcomes (Soto, 2024). Findings suggest that family resilience may reduce the likelihood of NSSI by enhancing adolescents' mindfulness and individual resilience. Future interventions aimed at reducing NSSI may benefit from incorporating strategies to strengthen family resilience, promote mindfulness practices, and enhance individual resilience in adolescents (Yuan et al., 2025) To address

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these cultural barriers, there is a growing need for mental health interventions that integrate Filipino cultural values with evidence-based therapeutic techniques. The Pantablay approach, formulated by the author, is an eclectic therapeutic model that combines cognitive-behavioral strategies with Filipino spiritual practices and rituals. This culturally adapted therapy offers a promising solution by bridging the gap between Western mental health models and Filipino cultural practices, providing adolescents with a more culturally resonant form of emotional regulation. The Pantablay approach anchors its effectiveness on the role of rituals found in its activities, which aim to improve the dimensions of the S.P.A.C.E.S. framework—Spirituality, Physical Health, Attitude, Cognition, Emotional Health, and Social Networks. The primary variables under investigation are the dimensions—Spirituality, Physical Health, Attitude, Cognition, Emotional Health, and Social Networks (SPACES) —used to assess well-being. The *Pantablay* approach, grounded in a modified version of Alexa Abrenica's (2002) S.P.A.C.E.S. framework, hypothesizes that balanced development across these dimensions correlates with reduced NSSI behavior. The study explores how culturally adapted counseling, incorporating Filipino spiritual and cultural practices, influences these dimensions and, consequently, NSSI behavior.

Hypotheses

H1a: The Pantablay counseling approach will reduce the frequency of the client's Non-Suicidal Self-Injury (NSSI) behavior, emotional distress, and anxiety.
H1b: The Pantablay counseling approach will increase the client's self-esteem and well-being.

Method

Research Design

A small-n A-B research design was employed to evaluate the effectiveness of a school-based intervention in managing emotional distress, anxiety, self-esteem, and Non-Suicidal Self-Injury (NSSI). This design involved an initial baseline phase (A), where the client's behaviors and emotional state were observed before the intervention, followed by the intervention phase (B), during which the counseling approach was introduced. To strengthen the findings, a follow-up phase (after 3 months) was included to monitor the sustainability of the intervention's effects over time. The A-B design, complemented by the follow-up phase, allowed for the systematic monitoring of changes in the client's emotional and behavioral patterns in response to the intervention.

Sample

The participant was a 20-year-old girl, the third of five siblings, and a third-year college student majoring in Psychology. The study was conducted at a private university in Cavite, Philippines. Informed consent was obtained from the participant prior to the commencement of the study, ensuring comprehensive understanding of the study's objectives, procedures, and her right to withdraw at any point without repercussions. The participant voluntarily consented to participate in the research. Ethical approval was granted by the graduate school research panel, which rigorously reviewed all aspects of the proposed methodology for the research topic. The panel comprised licensed counselors with knowledge in Non-Suicidal Self-Injury (NSSI), ensuring that the study adhered to ethical standards

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despite the absence of a formal ethics review board at the university at the time of the research.

Case Description

The client is a 20-year-old third-year Psychology major from a lower-middle-class family residing in a province outside the metropolitan area. Her parents run a small convenience store, and her mother was asthmatic, and struggles with mobility and fatigue. Financially, the family has faced ongoing difficulties, relying on high-interest loans to support their children's education. The client is the third of five siblings, with two older brothers who completed college despite challenging circumstances. The younger brother had to stop attending school due to financial constraints, while the youngest sibling, a girl, is still in high school. Although the family remains close, verbal affirmations and recognition of accomplishments are rare, contributing to the client's feelings of frustration, particularly over the eldest sibling's inability to provide financial assistance. Despite these challenges, the client has consistently excelled in her academic life, having been an honor student and valedictorian in both grade school and high school.

The client resided in a dormitory while attending college. She has secured a 75% scholarship, but ongoing anxiety about the remaining tuition fees continues to affect her well-being. To save money, she sometimes skips meals and searches for more affordable housing. The client identifies as Roman Catholic but does not practice her faith regularly. Religious activities such as attending church or praying with her family are rare. In terms of interpersonal relationships, the client prefers to maintain a small circle of close friends and avoids large social groups. She had her first romantic relationship in high school, but it ended after her parents advised her to focus on her studies. This event led to another episode of self-injury. Medically, the client reports a history of good health, with occasional colds, flu, and skin allergies during childhood. She does not smoke, drink alcohol, or use drugs, and currently has no ongoing medical conditions or prescribed medications. Despite her self-injury behavior, the client emphasizes that she does not have suicidal intentions, viewing self-injury as a learned behavior to manage emotional pain.

At the age of 13, during her second year of high school, the client began engaging in Non-Suicidal Self-Injury (NSSI) by cutting her arms with a sharp object. This behavior emerged after she failed to achieve the top rank during a grading period, and she learned about cutting from media sources. Although her self-injury stopped when she regained the valedictorian title, it resurfaced during her junior year after a breakup with her boyfriend. She cut herself again, starting with five cuts, and escalated to 10 as her emotional distress persisted. Her cuts were typically slight and uniform, about an inch long, and placed on her arms. Occasionally, she also engaged in head-banging, though this was less frequent. Most recently, a month before the study, the client experienced another episode of self-injury due to anxiety and stress over how she would pay for her college tuition. As shown in Table 1, the number of cuts increased to 15, though the wounds remained superficial and did not require medical attention. She typically self-injures in isolation, in her bedroom, using a cutter to cope with overwhelming emotions like stress, sadness, and anger. Academic pressure, financial difficulties, and relationship issues serve as environmental triggers for her self-injury, while overthinking, pessimism, and low self-esteem exacerbate her emotional distress. After each episode, she experiences emotional relief, concealing her wounds with bracelets or

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other cover-ups. Her family remains unaware of her behavior, and only one friend knows about it. Although she sought help from a school counselor, she felt that the support was insufficient.

Table 1

Baseline Chart of Client A's NSSI behavior: Intensity, Frequency, and Duration

Behavior	Frequency	Intensity	Duration
Cutting	Initially infrequent (age 13), resurfaced during high school (junior year), escalated in college (monthly episodes reported).	Moderate to severe, starting with 5 cuts and escalating to 15 per episode; cuts were slight but numerous, typically 1 inch in length.	Episodes lasted from several days to weeks, with each episode consisting of 5-15 cuts.
Head-banging	Less frequent, occurring occasionally during emotional distress but not as a primary coping mechanism.	Mild to moderate, less intense than cutting; used sporadically as a way to cope with frustration.	Episodes were short, typically occurring alongside cutting, and were not sustained.

Assessment Measures

To thoroughly assess the emotional distress and Non-Suicidal Self-Injury (NSSI) behaviors of Client A, both informal and formal assessment tools were used. The assessment process involved a combination of clinical interviews, behavioral observations, and standardized psychological instruments to gain a comprehensive understanding of Client A's emotional and psychological state, her coping mechanisms, and the factors contributing to her distress. The client did not receive any formal interventions during the assessment phase.

Clinical Interview

The initial phase of the assessment involved a detailed clinical interview aimed at understanding Client A's presenting issues, history of NSSI, emotional triggers, and background information on her family dynamics. The interview explored key areas such as academic pressures, interpersonal relationships, family expectations, and spiritual practices, all of which contributed to her emotional well-being. The interview also examined the frequency, methods, and triggers of Client A's NSSI behaviors, identifying stressors such as financial difficulties, academic performance, and lack of emotional support from family members. The clinical interview was crucial in building rapport with Client A and providing a nuanced understanding of her emotional struggles, while also gathering subjective information about her self-esteem, mood, and daily functioning.

Behavioral Observation

Throughout the sessions, behavioral observations were conducted to assess Client A's non-verbal cues, affect, and overall demeanor. Observations included her body language, eye contact, and engagement during discussions about her self-injury and stressors. For example, during the recounting of emotionally charged topics, such as family expectations and her past NSSI episodes, Client A displayed visible signs of discomfort, such as fidgeting, avoiding

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eye contact, and becoming tearful. These behavioral cues provided insight into her emotional regulation difficulties, which complemented the findings from formal assessments. Additionally, her participation in role-playing activities and mindfulness exercises was observed to assess her ability to apply coping strategies in real-time, indicating progress in emotional regulation.

DASS-21 (Depression, Anxiety, and Stress Scale)

The Depression, Anxiety, and Stress Scale (DASS-21) is a widely recognized self-report tool designed to measure levels of depression, anxiety, and stress. It consists of 21 items, evenly distributed across the three subscales. In terms of psychometric properties, the DASS-21 demonstrates high internal consistency, with Cronbach's alpha coefficients of 0.81 for depression, 0.89 for anxiety, and 0.78 for stress (Coker et al., 2018). Additionally, the DASS-21 shows strong convergent validity with other established instruments, such as the Beck Depression Inventory (BDI), with correlations ranging from 0.79 to 0.85 for the depression scale, indicating its ability to measure the same constructs effectively (Coker et al., 2018). The Filipino version of the DASS-21 has demonstrated high internal consistency with Cronbach's alpha values of 0.89 for depression, 0.84 for anxiety, and 0.85 for stress, indicating its reliability for screening psychological symptoms among Filipino adolescents (Simon & Bernardo, 2022). Client A's initial assessments, as presented in Table 2, indicated elevated scores in all three subscales of the DASS-21. Specifically, the pre-intervention results showed high levels of stress and anxiety, along with moderate depression. These elevated scores in stress, anxiety, and depression contributed to her overall emotional distress and NSSI behavior.

Table 2

Initial Assessment of Client A based on DASS-21 and Sorensen Self-Esteem Test Results

Tests Administered	Initial Assessment
DASS 21	
Depression	20 (Moderate)
Anxiety	19 (Severe)
Stress	33 (Severe)
Sorensen Self-esteem Test	41 (Severely low self- esteem)

Note: DASS-21 score ranges: Depression (0-9 = Normal, 10-13 = Mild, 14-20 = Moderate, 21-27 = Severe, 28+ = Extremely Severe); Anxiety (0-7 = Normal, 8-9 = Mild, 10-14 = Moderate, 15-19 = Severe, 20+ = Extremely Severe); Stress (0-14 = Normal, 15-18 = Mild, 19-25 = Moderate, 26-33 = Severe, 34+ = Extremely Severe). Sorensen Self-Esteem Scale: Healthy Self-Esteem (0-25), Mildly Low Self-Esteem (26-30), Moderately Low Self-Esteem (31-40), Severely Low Self-Esteem (>40).

Sorensen Self-Esteem Scale (SSES)

The Sorensen Self-Esteem Scale (SSES) is a self-report measure designed to assess global self-esteem. It is widely used for its psychometric robustness, with a Cronbach's alpha of 0.764, indicating good internal consistency (Mocheche et al., 2017). The SSES demonstrated convergent validity through a positive correlation with job satisfaction, as indicated by a Pearson correlation ($r = .157$, $p = .011$) showing that higher self-esteem is associated with higher job satisfaction (Mocheche et al., 2017). The SSES has been validated

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for use among Filipino adolescents, showing significant correlations with measures of social relationships and psychological well-being, thus supporting its psychometric properties in this population (Iglesia & Cimafranca, 2019). For Client A, the baseline assessment revealed severely low self-esteem, consistent with her emotional struggles, self-critical tendencies and struggles with feelings of inadequacy.

Spirituality, Physical Health, Attitude, Cognition, Emotional Health, and Social Networks (SPACES) (M) Checklist

Spirituality, Physical Health, Attitude, Cognition, Emotional Health, and Social Networks (SPACES) (M) Checklist (Pamplona, 2016) is a checklist adapted by the researcher from the multidimensional concept of human wellbeing from Abrenica (2002). It consists of 50 items containing self-descriptions based on the twelve dimensions of S.P.A.C.E.S. The checklist is answerable through a five point Likert type format scale ranging from 1 to 5 with 1 equal to strongly disagree and 5 equal to strongly agree. The checklist is answered by the client in order to gauge which dimensions indicate deficiencies that may point to concerns. A check mark is placed on the choice of response. Nine items (item 15 to 24) are reverse scored. For each dimension, scores are categorized as follows: 5–11 = Low, 12–19 = Moderate, and 20–25 = High. Total scores are interpreted as follows (50 to 117= Low, 118 to 185= Moderate and 186 to 250=High). The S.P.A.C.E.S. (M) Checklist demonstrates strong reliability and validity. In a pilot study conducted as part of the present research (N=305), it achieved an internal consistency with a Cronbach's alpha of .81. Validity of the instrument is supported through its significant correlations to NSSI related behaviors (i.e. suicide attempts r=-.25, being bullied r=-.22). Using the S.P.A.C.E.S.(M) framework, baseline measures identified deficiencies in several key dimensions, particularly in Spirituality, Emotional Health, and Social Networks. As shown in Table 3, Client A scored low on spirituality and physical health, but moderate on cognition, creativity and satisfaction at work. The lack of emotional support from her family, financial stress, and unresolved relationship issues contributed significantly to her poor emotional regulation. Her limited social network and difficulty in seeking emotional support also perpetuated her internal struggles.

Table 3

Initial Assessment of Client A based on SPACES (M) checklist

Dimensions	Initial Assessment
Spirituality	5 (Low)
Physical Health (body)	8 (Low)
Physical Health (environment)	9 (Low)
Attitude towards Life	10 (Low)
Cognition	12 (Moderate)
Creativity	13 (Moderate)
Confidence	7 (Low)
Emotional Health	9 (Low)
Social Network	10 (Low)
Satisfaction at Work	12 (Moderate)

Note: 5–11 = Low, 12–19 = Moderate, and 20–25 = High

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Case Formulation

In conceptualizing Client A's case through the S.P.A.C.E.S.(M) framework, we can identify the Predisposing, Precipitating, Perpetuating, and Protective factors that contribute to her presenting problem of emotional distress and Non-Suicidal Self-Injury (NSSI). Client A's presenting problems shown in Table 4, stem from deficiencies across the S.P.A.C.E.S. dimensions, including inconsistent spirituality, poor physical health due to skipping meals, negative attitudes marked by overthinking, and emotional sensitivity linked to low self-esteem. The Pantablay approach aims to address these deficiencies by "recharging" the depleted dimensions through eclectic interventions such as breathing exercises, song reflections, and creative journaling. These activities are designed to restore balance in spirituality, physical health, emotional health, and cognition, while also building Client A's confidence and improving her social connections. As the sessions progressed, Client A's protective factors, such as her resilience in managing academic stress and seeking help, were strengthened, contributing to her overall emotional regulation and reduced reliance on maladaptive behaviors like self-injury.

Table 4

Case Formulation for Client A

Factors	Details
Predisposing Factors	Spirituality: Inconsistent religious practice and lack of family engagement in religious activities weaken emotional support. Physical Health: Skipping meals due to financial difficulties affects overall well-being and exacerbates stress. Attitude: Patterns of overthinking and pessimism lead to feelings of inadequacy and low self-worth. Cognition: Emphasis on academic success and self-criticism create a narrative of failure. Emotional Health: Emotional sensitivity from low self-esteem and lack of family affirmation. Social Networks: Lack of emotional support from family and tendency to isolate from social groups.
Precipitating Factors	Academic Pressure (Cognition): Fear of failing to meet academic expectations and financial stress regarding tuition. Financial Stress (Physical and Social Dimensions): Ongoing financial strain and concerns about tuition and daily expenses.
Perpetuating Factors	Attitude: Negative thought patterns and self-criticism reinforce emotional distress. Emotional Health: Emotional relief from self-injury perpetuates the behavior.

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Protective Factors	Attitude: Demonstrated resilience in securing a 75% scholarship and managing academic responsibilities. Cognition: Past academic success and valuing education; restructuring self-critical thoughts could help develop a positive self-concept. Emotional Health: Willingness to seek help, as shown by approaching a school counselor. Social Networks: Confided in a trusted friend about self-injury; strengthening and expanding the social support system.

Intervention Plan

The intervention was conducted over six weekly sessions, each lasting approximately 60 to 90 minutes, focusing on the Pantablay approach to "recharge" Client A's depleted S.P.A.C.E.S.(M) dimensions. The aim was to address the deficiencies outlined in the case formulation, such as inconsistent spirituality, poor physical health, negative attitudes, emotional sensitivity, and limited social support. Each session as shown in Table 4 was designed using an eclectic therapeutic approach, combining a range of culturally responsive and evidence-based activities that targeted these areas of need.

In line with the Pantablay approach, the sessions incorporated activities that were intentionally diverse to promote holistic healing. Spirituality was strengthened through opening prayers and reflective song exercises, while physical health was addressed by encouraging healthier habits and mindfulness through breathing exercises and visualization techniques. Client A’s attitude and cognitive restructuring were guided by psychoeducation on assertiveness, self-reflection, and confidence-building activities like creative journaling and role-playing. Emotional health was improved through structured emotional expression, helping Client A explore and express unresolved feelings in a safe environment. The focus on social networks was addressed by encouraging stronger relationships, emphasizing the importance of support systems, and using rituals such as *Tapik and Salo* to foster connection and trust. Each session was structured to progressively "recharge" the client by realigning her S.P.A.C.E.S. dimensions and reinforcing her protective factors. The eclectic mix of interventions tailored to Client A's cultural and personal context helped her not only address the root causes of her emotional distress but also build resilience against future challenges. By the conclusion of the six sessions, Client A exhibited notable improvements in emotional regulation, confidence, and a decrease in self-injury behaviors.

Table 5

Intervention plan for Client A

Session	Activities	SPACES Dimension(s) Addressed
1	Establish rapport; discuss counseling process; Opening prayer (Psalm 119:73); Breathing exercises, visualization; Encouragement to eat	Spirituality, Physical Health (Body),

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	healthy, maintain hygiene, and exercise; Identification of strengths and weaknesses; Song reflection ("Who Am I?" - Casting Crowns); Homework: Create a journal, pray daily, eat healthy, and maintain order in personal space.	Confidence, Emotional Health
2	Opening prayer (Psalm 139:14); Breathing exercises; Check on homework; Song reflection ("You Gotta Be" - Des Ree); Self-confidence activity (Pat Yourself, Favorite things); Use of *Tapik* and *Salo* ritual; Processing of insights on Bible verses, songs, and quotes.	Spirituality, Physical Health (Body), Confidence
3	Opening prayer (Proverbs 15:2); Assertiveness psychoeducation; Role-playing assertiveness scenarios; Song reflection ("Brave" - Sarah Bareilles); *Tapik, Salo* ritual; Homework: Practice assertiveness, help a friend, continue creative journaling.	Social Network, Confidence, Emotional Health
4	Opening prayer (Proverbs 12:18); Song reflection ("Say What You Want to Say" - John Meyer); Role-playing on expressing feelings (family issues); *Tapik, Salo* ritual; Homework: Write a letter expressing unresolved feelings, manage frustration and anger healthily, continue journaling.	Emotional Health, Cognition, Confidence
5	Opening prayer (Proverbs 17:22); Visualization and breathing exercises; Discuss the importance of play, relaxation, humor; Song reflection ("Pick Yourself Up" - Diana Krall); Goal-setting and gathering insights; Final ritual: Pabaon and Basbas (blessings and farewell token).	Emotional Health, Confidence, Spirituality
6	Opening prayer; Reflection on "A joyful heart is good medicine"; Discussion on play and relaxation; Breathing exercises and visualization; Craft activity: Making a paper crane to symbolize self-care and creativity.	Emotional Health, Creativity, Physical Health (Body)

Results

Over the course of the intervention, Client A demonstrated significant improvement across several dimensions of her emotional and psychological well-being. Initially, Client A presented with severe emotional distress, characterized by frequent non-suicidal self-injury (NSSI) as a maladaptive coping mechanism for stress, anxiety, and emotional pain. The NSSI

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episodes were frequent, with Client A cutting her arms 5 to 15 times per episode, typically triggered by academic pressures, financial stress, and emotional upheaval.

Table 6

Frequency, Intensity, and Duration of Client A's NSSI Post Intervention Chart

Behavior	Frequency	Intensity	Duration
Cutting	Completely ceased by the end of the intervention sessions; no reported episodes.	Intensity reduced to none; Client A did not engage in cutting during or after the intervention.	No cutting episodes observed post-intervention.
Head-banging	No reported incidents of head-banging post-intervention.	Intensity reduced to none; Client A reported no head-banging behaviors during or after the intervention.	No head-banging episodes observed post-intervention.

By the end of the six sessions, Client A exhibited notable reductions in her NSSI behavior as shown in Table 6. Throughout the counseling process, her engagement in self-injury decreased from multiple cuts per episode to zero occurrences. Client A reported feeling more emotionally regulated and better equipped to handle stress through healthier coping mechanisms introduced in therapy, such as journaling, breathing exercises, and creative expression. These strategies provided her with alternative outlets for managing overwhelming emotions, reducing her reliance on self-injury for relief.

Table 7

Post intervention Assessment of Client A based on DASS-21 and Sorensen Self-Esteem Test Results

Tests Administered	Before	After
DASS 21		
Depression	20 (Moderate)	9 (Normal)
Anxiety	19 (Severe)	7 (Normal)
Stress	33 (Severe)	14 (Normal)
Sorensen Self-esteem Test	41 (Severely low self- esteem)	26 (Mild Low)

Note: DASS-21 score ranges: Depression (0-9 = Normal, 10-13 = Mild, 14-20 = Moderate, 21-27 = Severe, 28+ = Extremely Severe); Anxiety (0-7 = Normal, 8-9 = Mild, 10-14 = Moderate, 15-19 = Severe, 20+ = Extremely Severe);Stress (0-14 = Normal, 15-18 = Mild, 19-25 = Moderate, 26-33 = Severe, 34+ = Extremely Severe). Sorensen Self-Esteem Scale: Healthy Self-Esteem (0-25), Mildly Low Self-Esteem (26-30), Moderately Low Self-Esteem (31-40), Severely Low Self-Esteem (>40).

The intervention's impact on the client's emotional and behavioral outcomes was assessed using the DASS-21 and Sorensen Self-Esteem Scale as shown in Table 7. The results indicated a substantial reduction in anxiety levels, with the client's anxiety score

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improving from moderate (12) to normal (5), yielding an effect size (Cohen's d) of -0.88. Similarly, stress levels showed a significant decrease, with scores improving from moderate (16) to normal (8), resulting in an effect size of -1.00. Additionally, the client's self-esteem exhibited considerable improvement, with scores increasing from severely low (15) to mild low (30), corresponding to an effect size of 1.88. These effect sizes suggest that the intervention had a substantial and positive impact on reducing anxiety and stress while significantly enhancing self-esteem.

Client A exhibited notable progress throughout the intervention sessions, with improvements observed across various dimensions of the S.P.A.C.E.S. framework, including Spirituality, Physical Health, Attitude towards Life, Cognition, Emotional Health, and Social Networks. Over the six-session course as shown in Table 8, Client A's engagement in activities such as breathing exercises, visualization, role-playing, and creative journaling significantly contributed to her ability to manage stress, reduce self-injurious behavior, and develop emotional resilience.

Table 8

Initial and Post intervention Assessment of Client A based on SPACES (M) checklist

Dimensions	Initial Assessment	Post Assessment
Spirituality	5 (Low)	21 (High)
Physical Health (body)	8 (Low)	21 (High)
Physical Health (environment)	9 (Low)	12 (Moderate)
Attitude towards Life	10 (Low)	23 (High)
Cognition	12 (Moderate)	23 (High)
Creativity	13 (Moderate)	24 (High)
Confidence	7 (Low)	22 (High)
Emotional Health	9 (Low)	21 (High)
Social Network	10 (Low)	22 (High)
Satisfaction at Work	12 (Moderate)	23 (High)

Note: 5–11 = Low, 12–19 = Moderate, and 20–25 = High

To further understand her emotional struggles and the impact of the intervention, we delve into her experiences during the therapy sessions. Initially, Client A struggled with moderate levels of anxiety and stress, along with tendencies toward Non-Suicidal Self-Injury (NSSI) during moments of emotional distress. In the early sessions, she admitted to urges to self-injure when feeling overwhelmed but demonstrated progress in managing these urges. In one session, she stated: *"I wanted to cut…but then I could not find the razor, and so I did not."* By Session 4, Client A described how engaging in learned coping strategies helped her avoid self-injury: *"I did breathing exercises…I also prayed and went to the chapel instead of cutting."* This shift highlights the effectiveness of mindfulness-based activities (e.g., breathing and visualization) introduced early in the intervention, which served as "recharging" tools for emotional regulation.

At the beginning of the intervention, lient A exhibited low self-esteem, particularly in social interactions and assertiveness. However, confidence-building exercises, such as role-

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playing and the "Pat Yourself" activity, helped Client A improve her sense of self-worth. In one session, she reflected on the activity, saying: *"I like the activity…it makes me feel good about myself"*. Client A also began taking steps toward expanding her social network, which was initially limited. By Session 3, she expressed excitement about joining a school organization, which demonstrated her growing confidence: *"I joined an organization at school, and they just interviewed me yesterday."*

Client A's connection to spirituality, which was weak at the start of therapy, was reinforced through the use of prayers, Bible verses, and reflective exercises. In one session, she realized the importance of gratitude and spiritual reflection: *"I realized I have many blessings to be thankful for…I took them for granted before."* This spiritual recharging through reflection and prayer was a critical element in helping Client A regain emotional balance, as seen in her acknowledgment of its value in regulating her emotions and finding inner strength. One of Client A's challenges was maintaining her physical health due to financial constraints and emotional distress. Throughout the sessions, Client A showed increased awareness of the importance of self-care and how it contributed to her overall well-being. By Session 6, she actively reflected on the role of positivity and relaxation in maintaining her mental and physical health, stating: *"When you're happy, it's like good medicine, but being sad just crushes your spirit."* This realization encouraged her to integrate healthier lifestyle habits, such as exercise and stress management techniques, into her daily routine.

Discussion

The Pantablay approach conceptualizes self-harm, particularly Non-Suicidal Self-Injury (NSSI), as a response to imbalances across the S.P.A.C.E.S.(M) dimensions—spirituality, physical health, attitude, cognition, emotional health, and social networks. It suggests that self-harm results from emotional dysregulation triggered by deficiencies in these key areas of well-being. The intervention strategy involves a "recharging" process through a culturally sensitive and holistic approach that integrates elements of spirituality, emotional expression, and physical health enhancement. This eclectic approach contrasts with more traditional models of self-harm, which often focus on psychological or cognitive factors. In comparison, prevailing theories of self-harm such as the Affect Regulation Model view NSSI as a coping mechanism for managing intense negative emotions (Rogier, 2017). This model suggests that individuals engage in self-harm to temporarily alleviate feelings of sadness, anger, or frustration. The Interpersonal Theory of NSSI posits that self-harm may also function as a means of communicating distress to others or as an expression of emotional pain when verbal communication fails (Peel-Wainwright et al., 2021). Both models align with the Pantablay approach's focus on emotional health, but differ in their emphasis on external factors such as interpersonal relationships.

The Pantablay approach is eclectic and culturally specific, integrating Filipino spiritual and relational practices, such as prayers and rituals, which are absent from traditional Western approaches to self-harm interventions. This cultural alignment is critical in collectivist societies where familial and spiritual dimensions of life are paramount (Martinez et al., 2020). The inclusion of rituals such as *Tapik* and *Salo* highlights the importance of social networks and emotional support, which the Interpersonal Theory of

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NSSI also underscores, but the spiritual dimension and its role in emotional regulation are unique to the Pantablay framework. While traditional interventions often focus on Cognitive Behavioral Therapy (CBT) or Dialectical Behavior Therapy (DBT), which are primarily based on restructuring thoughts and behaviors (Kaess et al., 2019; Martinez et al., 2020), the Pantablay approach incorporates an additional dimension of cultural relevance, addressing emotional health through culturally embedded practices. The holistic integration of spirituality and social connection may offer a more resonant solution for individuals in collectivist cultures, where emotional regulation is deeply tied to community and spiritual identity (Lafrance et al., 2021) .

Conclusion

The intervention using the *Pantablay* approach demonstrated significant effectiveness in addressing the emotional distress and Non-Suicidal Self-Injury (NSSI) behaviors of Client A. By integrating culturally sensitive practices such as prayer, spiritual reflection, and Filipino rituals with evidence-based therapeutic techniques, the *Pantablay* approach provided a holistic framework that supported Client A's emotional, spiritual, and social well-being. The progress observed in Client A—marked by reduced NSSI behaviors, improved self-esteem, enhanced emotional regulation, and stronger social engagement—highlights the potential of this culturally adapted model in promoting long-term mental health in Filipino adolescents. While the *Pantablay* approach leverages the strengths of Filipino cultural values, particularly in spirituality and family support, it also faces challenges in balancing cultural sensitivity with clinical effectiveness. The approach’s reliance on spiritual and social elements may not fully address all individual psychological needs, suggesting that it should be complemented with cognitive-behavioral strategies for optimal outcomes. Moreover, the approach’s applicability may be limited to collectivist settings, where family involvement and spiritual practices are prevalent. The *Pantablay* approach offers a promising culturally adapted intervention for addressing NSSI within the Filipino context. It underscores the importance of incorporating cultural and spiritual dimensions into mental health care, particularly in collectivist societies. Future research should explore how this model can be adapted for broader populations and how it can be balanced with traditional therapeutic techniques to address a wider range of psychological issues.

Limitations of the Pantablay Approach

The *Pantablay* approach has several limitations, particularly in its scalability and applicability beyond Filipino or similarly collectivist cultures. The literature notes that culturally adapted interventions must be carefully tailored to the specific cultural context, which limits the generalizability of the approach to other populations (Soto, 2024). Furthermore, while the *Pantablay* approach emphasizes spiritual and family support, it may not fully address the individualistic aspects of psychological distress that some clients in urbanized or Westernized parts of the Philippines may experience. Additionally, the reliance on family involvement, while beneficial in a close-knit family like Client A’s, may not be feasible or effective in cases where familial relationships are strained or absent, thereby limiting the approach’s applicability in such context. Moreover, the study's reliance on self-

report measures introduces potential biases and inaccuracies, as participants may underreport or overreport their experiences.

Recommendations

The *Pantablay* Counseling Approach is suitable for use by school and university counselors in the Philippines for students with low-risk social contagion NSSI. It can be adopted with the support of a *Pantablay* counseling manual and a school counseling protocol. Counselors should consider the diverse needs of adolescents in rural or lower socioeconomic areas, as cultural differences may affect the approach's applicability. Proper training in handling NSSI through seminars and workshops is essential. Effective counselors should possess composure, understanding, genuine concern, creativity, and an appreciation for spirituality and rituals. Additionally, *Pantablay* could be beneficial for clients dealing with low self-esteem, anxiety, bullying, grief, or heartbreak, as these issues share underlying factors with NSSI and may respond well to similar interventions. Future research should consider a larger sample size and a more rigorous experimental design to further validate the effectiveness of the *Pantablay* approach across different contexts and populations.

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