Non Suicidal Self Injury in Youth:

An Overview of Treatment Interventions

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Overview

- Review different types of treatment modalities
  - Individual
  - Group
  - Family
  - Psychopharmacologic
- How our assessment guides treatment choices

Factors to consider when determining type of treatment for NSSI

- Age, cognitive and developmental stage
- Motivation for change
- Family involvement
- Acute and chronic stressors

- Access to a multi-disciplinary mental health team (i.e. psychologist, psychiatrist,, school counsellor, etc)

- Co-morbid mental health issues.
  - Ex: Axis I: Anxiety, Depression, Bipolar, ADHD, Eating Disorder etc
  - Addictions? Suicidality?

  - Treat these conditions with best practice treatments

Individual Treatment Options

- Psycho-education
- Problem Solving Therapy (PST)
- Cognitive Behavioural Therapy (CBT)
- Motivational Interviewing (MI)
- Dialectic Behavioural Therapy (DBT)

Psycho-education

- Forms the foundation of many therapies (CBT, DBT, family therapy, etc)
- Important initial step in treatment
- No evidence based psycho-education programs currently exist for NSSI
  - many develop their own materials and methods to disseminate information
- Use of internet sites such as www.insync-group.ca

Goals of Psycho-education

- Help client/family clearly identify which behaviours are NSSI as well as differentiate NSSI from suicide attempts.
- Dispel myths and misunderstandings about NSSI which will hinder treatment
- Facilitate understanding and communication
- Reduce shame, stress, and frustration
- Develop understanding around the course of NSSI – so they know what to expect
- Help youth and family identify triggers and functions – Help then better understand the common question of “Why” and “What can be done?”

Psycho-education in DBT

Problem Solving Therapy

- Posits that maladaptive coping and problem solving strategies are associated
- Therefore: teach better problem solving and coping skills and NSSI will be reduced.
  - teach youth how to break down problem components using behavioural analysis
  - set a goal (ex: will improve relationship with parents), brainstorm and determine possible solutions, implement solution(s), evaluate the outcome relative to the goal
- Townsend et al 2001: PST decreased depression, hopelessness, but not conclusive as to whether it reduced NSSI.

Cognitive Behavioral Therapy

CBT involves teaching youth how to identify the connection between thoughts, feelings and behaviours.

- Helping youth learn skills to identify and challenge irrational beliefs which contribute to maladaptive thinking patterns.
- Using behavioural therapy to change maladaptive behavioural patterns.

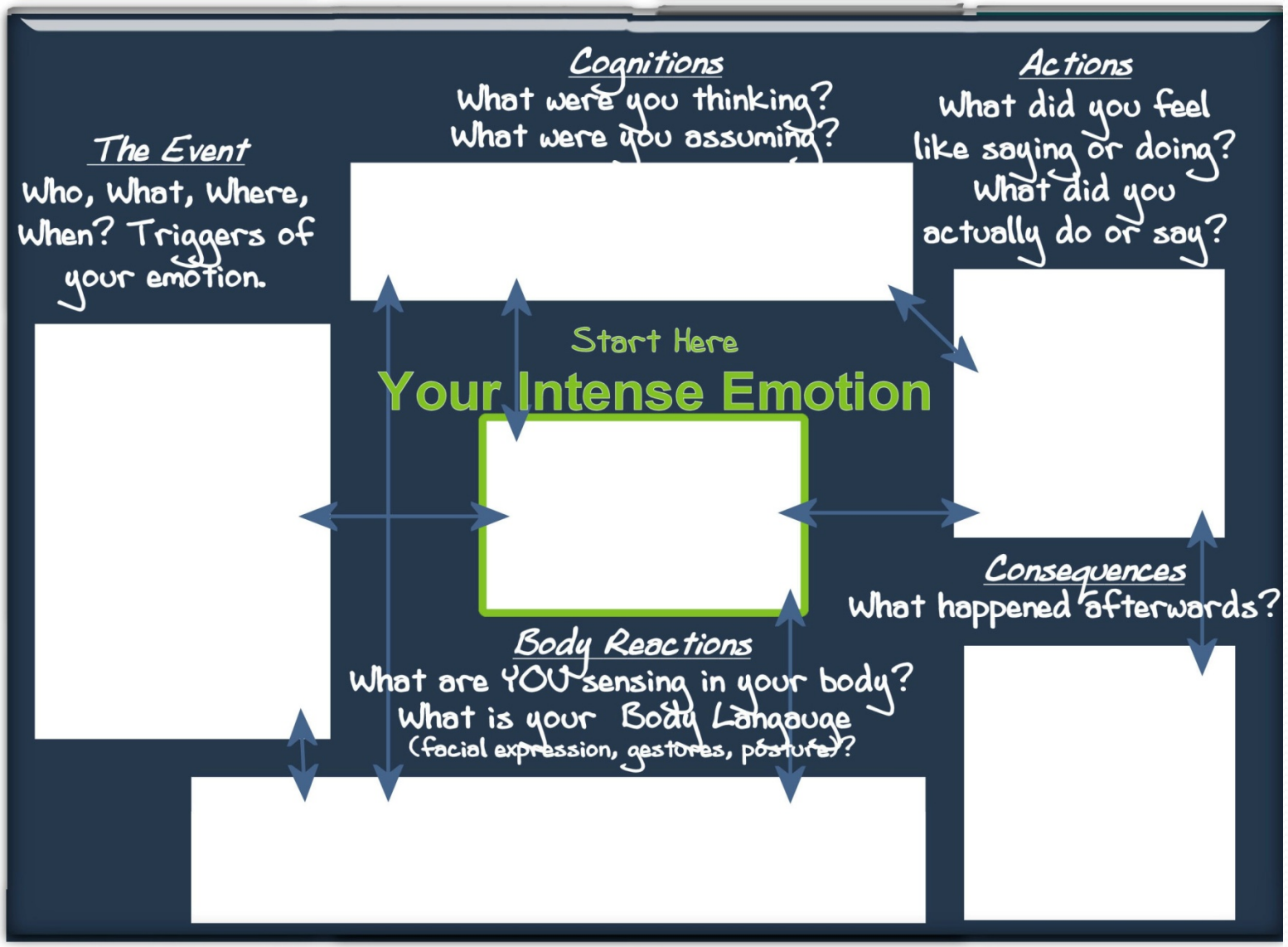
Short term treatment (6 sessions) (Tyre et al., 2003)

Combined PST plus CBT and interpersonal therapies to reduce repetitive NSSI via:

- -managing emotions
- -changing negative thinking

Breaking Down Emotions

Blackboard Exercise



Motivational Interviewing (Miller and Rollnick,1991)

- Combines Humanistic Therapy and Cognitive Therapy approaches
- Good efficacy with clients with drug and alcohol issues as well as those in pre-contemplative or contemplative stages of treatment.
- Consider MI for NSSI youth who an addictive component to their behaviour and/or are in the pre-contemplative stage of change.

Motivational Interviewing

- Main principals:
  - **Expressing empathy** using reflective listening to not only establish rapport, but accept and mirror the client's experiences as a means of increasing their awareness of the need for change.
  - **Developing discrepancy**, focuses on using specific types of questions, along with selective reflections, to focus the client on the discrepancy between their present behavior and broader personal values.
    - The aim is not to point out the positive and negative aspects of the behavior, but more so the discrepancy between what the youth is currently doing and would like to do in order to increase the motivation to change.
  - **Avoiding argumentation**
  - **Rolling with resistance**
  - **Supporting self efficacy**

Dialectical Behaviour Therapy

- Combines behavioral, PST, dialectical and validation strategies. (Rathus & Miller, 2002).
  - A balance of change based therapy techniques with Eastern philosophies of "acceptance" and "tolerance"
  - Traditional DBT: Individual and family skills training (24 session program conducted in 12 weeks):
- DBT skills training focuses on:
  - Mindfulness
  - Distress tolerance
  - Emotional regulation
  - Interpersonal/communication skills
  - Walking the Middle Path

Summary of DBT Skill Modules

Mindfulness Skills

- Learn to differentiate between emotional, reasonable and wise mind. Learn how to achieve wise mind (i.e., don't judge, observe, describe, be in the moment, participate, do what works)

Emotional Regulation Skills

- Learn to mindfully observe and describe emotions, increase experience of positive emotions and reduce vulnerability to intense negative emotions (i.e., improve physical health, sleep, diet, get exercise, avoid drugs, build mastery)

Interpersonal Effectiveness Skills

- Learn effective communication skills (i.e., be gentle, act interested, be fair, be truthful, stick to values, describe the issue, express, assert, reinforce, appear confident, negotiate, stay mindful, etc.)

Skill is useful for

- **Self-dysregulation**
  - (i.e., dissociation, identity confusion)
- **Emotion dysregulation**
  - (i.e., emotional lability, depression, anxiety, guilt, anger)
- **Interpersonal dysregulation**
  - (i.e., interpersonal conflicts, chronic family disturbance)

Summary of DBT Skill Modules

Distress Tolerance Skills

Crisis Survival Skills

- Distraction techniques; Self-Soothing techniques using the five senses; Improving the moment skills (i.e., imagery), and assessing the Pros and Cons of tolerating distress.

Acceptance Skills

- Radical Acceptance; Turning the mind to acceptance, and Willingness (to do what's needed)

Walking the Middle Path

- Learning to think/act dialectically, learning how to validate self and others, learning to use behavioral principals on self and others.

Skill is useful for

- **Behavioral dysregulation** (i.e., parasuicidal behaviors, and impulsive behaviors such as drug use or aggression)

- **Cognitive dysregulation** (i.e., poor problem solving/judgment, rigid black and white thinking)

Contracts, Emergency Card, Promises

- Self-Protection Contingency Management Contract (Walsh, 2006)
  - Get baseline of NSSI behaviour, collaboratively set realistic goals for reduction, teach skills to providing replacement coping strategies and rewards

- Promises
  - made to people they have close relationships with can often be motivating, but difficult to keep and dependent on the nature of the relationship.

- No Harm contracts – All or none, cold turkey approach - not effective and can worsen condition by making youth hide behaviour from you.

Developmental Group Psychotherapy Wood et al., 2001

Use of positive corrective therapeutic relationships as a means to help youth

- Goals: reduce self harm, reduce depression

- Combines Problem Solving, CBT, and Psychodynamic psychotherapy

  Open groups:

  - Acute phase: 6 themes including relationships, school problems, personal relationships, family problems, anger management depression and self harm, hopelessness and feeling re the future

  - Long term group: emphasis on group process

Group Therapy for DSH: Failure of a Replication of a Randomized Trial

(Hazell et al., 2009)

- Primary outcome measure was repetition of self harm at 6 and 12 months
- Experimental group vs routine care, ages 12 to 16
- No significant difference between groups on outcome measure
  - Much of DSH at outcome was self cutting in this study
- Australian study (2009) had more youth at baseline with self cutting and more females while the UK study (2001) had more DSH by self poisoning

Groups for Self Harming Adolescents and their Parents

(Nixon et al., 2004)

- *Adolescent*, 12-14 sessions, weekly
  - *DBT portion* (*Miller et al, 2004):*
    - Provides validation, introduction of new coping skills and provides practice to reinforce use of new skills
  - *Therapeutic Support for Adolescents, (Fine et al 1991):*

    Process oriented, based on experiential, interpersonal and insight oriented approach.

    Creates an environment where adolescents use their peers to facilitate separation from parents supportive environment within which change can be facilitated
- Parent Group, 6-7 sessions, every 2 weeks
  - psychoeducation re NSSI, adolescent development, therapeutic support for parents, parental skill building, mindfulness training

Families

Why would you consider family therapy?

- Some evidence of family risk factors for NSSI
  - emotional neglect, physical/sexual abuse,
  - Impaired parent-child communication
  - Family stressors (lowered family cohesion, parental illness or mental health issues, family suicide, family conflict)

- Some evidence of protective family factors:
  - Good parent-child communication
  - Positive emotional involvement of family members
  - Positive time spent together, common interests and activities
  - Collaborative decision-making

Families and Treatment

- Woodberry et al. (2002) suggested that the treatment of families with depressed, suicidal, and/or self-injuring adolescents should include the following objectives:
  - decreasing family risk factors (e.g., abuse or psychopathology)
  - reducing skill deficits in parents (e.g., affect identification and management)
  - increasing affect identification and management
  - enhancing potential protective factors (e.g., warmth and adaptability)
  - improving interpersonal interactions (e.g., parents decrease reactivity)
- Most importantly, using validation to acknowledge each person's emotional experiences, ie non judgmental and not minimizing

Working with Families: Treatment Objectives

- Decrease risk factors
  - Abuse, parental psychopathology, family conflict/stressors
  - Improve parental skill deficits (i.e. parent ability to regulate emotions, not be overly reactive, identify emotions, communicate effectively)
- Increase protective factors
  - Increase warmth, support, validation, cohesion, and adaptability
  - Improve interpersonal boundaries (i.e. improved communication skills, collaborative problem solving, finding middle ground between highly lenient/lax parenting style and authoritarian emotionally reactive style)

Managing a Crisis: Suggestions for Families

- **Do's:**
  - Stay clam, i.e. keep emotions/reactions in check
  - Encourage the adolescent to talk with you or someone they feel comfortable
  - Demonstrate support
  - Intervene as necessary
  - Determine further steps jointly with the adolescent
  - Encourage adolescent to find alternative ways to express themselves (e.g. writing, drawing)
  - Consult your family physician, mental health clinician, school counselor, psychiatrist or other health professional as necessary
  - Focus on the facts, what you can see
  - Collaborate with others who may have an understanding of extenuating circumstances, stressors, other important observations etc. Be reasonable in whom you might ask and if at all possible seek permission from the youth themselves to speak with them
  - Engage the adolescent in the process of problem solving
  - Take a temporary self-imposed break or time-out from discussions when they become side- tracked or out-of-control

Managing a Crisis: Suggestions for Families

- Don't:
  - Overreact, particularly if behavior is deemed non-life threatening
  - Under-react – ignore your teen when they are distressed, avoid communication with teen
  - Digress from getting the information you need to determine what to do next
  - Interpret behavior, be judgemental
  - Engage in power struggles, arguments or secondary issues during the crisis

Models for Working with Families

CBT and Psycho-education

(Walsh ,2006)

- Encouraged three key "skills practice ally" roles family members can play.
  - Noticing triggers and reminding the adolescent when cues have occurred
  - Encouraging the adolescent to practice coping skills and help to identify when they have been effective
  - Practicing skills with the adolescent.

Solution Oriented Brief Family Therapy with Self Harming Adolescents (Selekman, 2002)

"Changing the Family Dance":

- Solution-oriented therapeutic experiments and strategies

  - Connection building practices
    - Family storytelling
    - Adolescents mentoring parents
    - Compliment Box

DBT Multifamily Skill Development Group

(Miller et al, 2002)

- Miller suggested that family members attend group sessions to learn DBT components such as:
  - Mindfulness, affect identification and management, etc.
  - Family members are then encouraged to help the adolescent practice DBT skills within the family context.
  - Middle Path Skills -learning skills such as validation and reinforcement, parents are able to disengage from power struggles which could potentially decrease NSSI

Recurrent Topics with Families

- *Reviewing Basic Needs* (Rosenberg, 1999)
  - physical nurturance
  - autonomy
  - interdependence
  - integrity
  - celebration
  - play
  - spiritual communion
- When parents understand what needs may not be being met, they can focus on addressing those needs rather than engaging in conflict
- Reinforces and builds on family strengths

Recurrent Topics with Families

- *Promoting a predictable family environment*
  - Flexibility balanced with limit setting
  - Consistent, predictable approach to conflict
  - Appropriate expectations
- *Improving interaction and communication*
- *Increasing emotional connectedness*
- *Enabling adolescent developmental tasks*
- *Parental Functioning and Parental Factors*

Biweekly Parent Group Sessions (Nixon et al, 2004) (adjunct to weekly adolescent self injury group)

- **Session One: Introduction**
- 1. Introduction of members and therapists, including brief synopsis of personal goals re this group from parents
- 2. Overview of parent group sessions
- 3. Discussion and agreement of group goals and guidelines
- 4. Psychoeducation about self-injuring behavior in adolescence
- 6. Crisis intervention, management, and planning
- 7. Wrap up
- 8. Feedback and evaluation

- **Session Two: Basic Needs and Self-care**
- 1. Check in with each parent present
- 2. Review of group guidelines
- 3. Review/discussion of Basic needs
- 4. Review/discussion of Parental Self-care
- 5. Introduction to Mindfulness and Mindfulness exercise
- 6. Wrap up
- 7. Feedback and evaluation of session

Parent Group Sessions

- Session Three: Family Interactions
- 1. Check in
- 2. Review of Family Interactions
- 3. Review of Family Communication
- 4. Discussion: Creating a Safe Environment
- 5. Mindfulness exercise
- 6. Wrap up
- 7. Feedback and evaluation of session

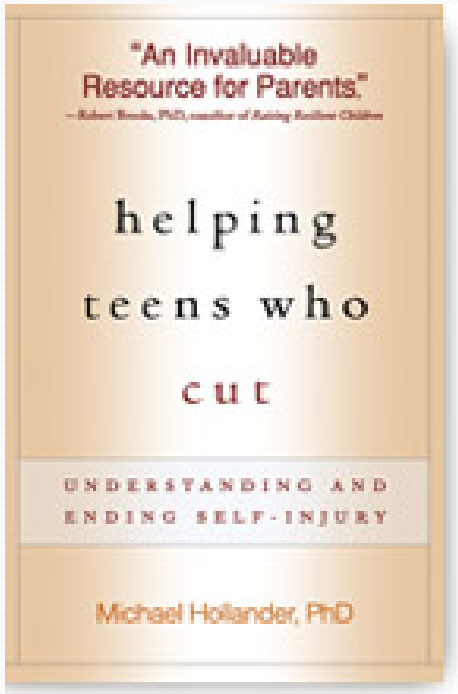
- Session Four: Effect of Family History
- 1. Check in
- 2. Review of self-understanding of parental influences
- 3. Discussion of family values and beliefs
- 4. Mindfulness exercise
- 5. Wrap up
- 6. Feedback and evaluation of session

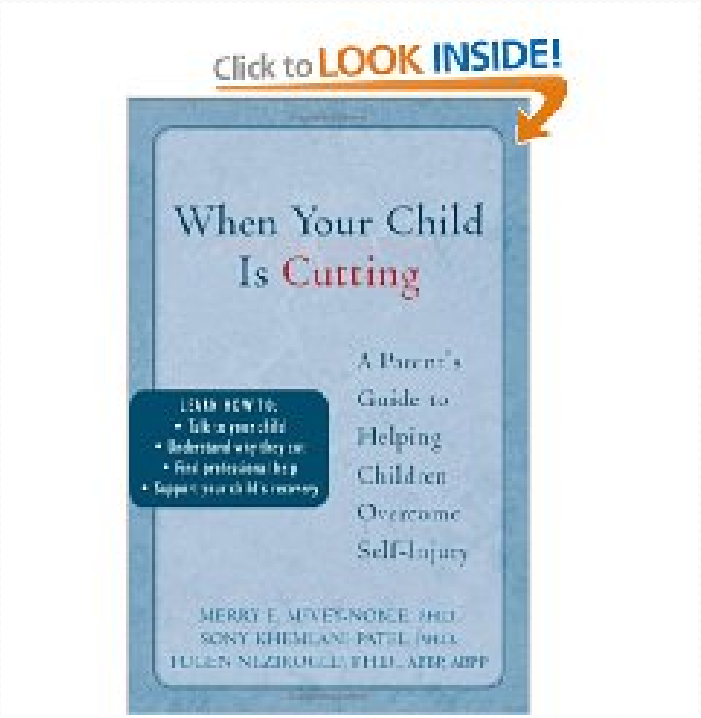
Parent Group Sessions

- Session Five: Parental Modeling
- 1. Check in
- 2. Parental modeling: affect regulation, interpersonal skills, distress tolerance
- 3. Family rules
- 4. Mindfulness exercise
- 5. Wrap up
- 6. Feedback and evaluation of session

- Session Six: Review/Where to go from here
- 1. Check in
- 2. Review and further discussion of previous material
- 3. Next steps
- 4. Mindfulness exercise
- 5. Wrap up
- 6. Feedback and evaluation of six sessions

Resources for Families





Resources for Families

- http://www.insync-group.ca/family_friends.php

Pharmacological Treatment Principles

- Medications can be utilized as part of a comprehensive treatment approach
- Patients and families should be informed that medications are considered 'off label' & warned of potential side effects
- Remember the principle: "Start low, go slow… and treat as short as possible but as long as necessary."

- Treat any underlying psychiatric disorder if it exists
- Target associated & clustered symptoms (eg. Affective instability, impulsivity) that may be responsive to medication
- Re-evaluate symptoms & diagnosis over time to ensure evolving psychiatric disorders (eg major mood disorder) are not missed

Disclaimer

- most psychopharmacological agents mentioned are being used OFF-LABEL

Medication options

- SSRIs
  - Target: depressive sx, anxiety sx (flashbacks, compulsions), and bulimic sx
  - Need to monitor closely in early phases of treatment for increased SI

- Mood stabilizers
  - Target: affective instability (with &without psychosocial triggers) and aggression

- Atypical Antipsychotics
  - Target: Co-occuring NSSI and affective instability, tension, impulsivity, anxiety or depressive states (with sleep disturbance or SI)
  - Choose agent with lower metabolic risk, warn pt & monitor for weight gain
- Typical Antipsychotics
  - Target: Acute & intense urges to self injure & sleep disorder difficulties
  - Use only on a prn basis due to side effect profile & use low potency AP

- Opiate antagonist (Naltrexone)
  - Target: Addictive features (eg. Cravings, increased tolerance) of NSSI
  - May be used as monotherapy or in combination with SSRI or SGA

- Alpha-2-adrenergic receptor agonist (Clonidine)
  - Limited evidence so far with no studies in youth.
  - Helpful in reducing urges to self injure, suicidal ideation and inner tension in a pilot study of women with BPD

- Benzodiazepines
  - No clear supporting evidence for use in NSSI
  - Beware of possible paradoxical reaction in youth and addictive potential of BZDs and use in short term only
  - Choose medium-duration half life BZDs –eg. Lorazepam

Plener, P., Libal, G. and M.K. Nixon. (2009). Use of Medication in the Treatment of Nonsuicidal Self-Injury in Youth.

Omega 3 Fatty Acids

- No clear supporting evidence for use in NSSI
- Some studies have shown benefit in decreasing depressive symptoms and aggression
- Side effect profile is low
- More research is needed