

Non-Suicidal Self Injury: *A Treatment Overview*

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American Counseling Association
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Who Are You?

- Clinical counselor in Private Practice
- Clinical Counselor in Agency/Hospital/Education/Community Setting
- Counselor Educator
- Student
- School Counselor
- Rehabilitation Counselor
- Psychologist

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What is Self-Injury?

- Self injury is defined as “a volitional act to harm one’s own body without intention to cause death.” (Yaryura-Tobtas, Nezirogula, & Kaplan, 1995).
- Self injury is “an act that is done to oneself, performed by oneself, physically violent, not suicidal, and intentional and purposeful.” (Alderman, 1997).
- Acts of self-injury are discrete, intentional acts of harm.

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Classification of Self Injury

- Stereotypic Self Mutilation
- Major Self Mutilation
- Compulsive Self-Mutilation
- Impulsive Self Mutilation

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Stereotypic Self Mutilation

Behavior	Tissue Damage	Rate	Pattern	Disorder
Head Banging Self-Hitting Lip or Hand Chewing Skin Picking Self-Biting Hair Pulling	Mild to severe (possibly life threatening)	Highly Repetitive Fixed	Fixed Contentless	Mental Retardation Autism Lesch-Nyhan Cornelia de Lange Prader-Willi

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Major Self Mutilation

Behavior	Tissue Damage	Rate	Pattern	Disorder
Castration Eye Enucleation Limb Amputation	Severe to life - threatening	Isolated	Impulsive or planned Concrete symbolism	Psychosis Intoxication Severe Character disorder Trans-sexualism

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Compulsive Self Mutilation

Behavior	Tissue Damage	Rate	Pattern	Disorder
Hair Pulling Skin Picking Nail Biting	Mild to Moderate	Repetitive	Compulsive (with impulsive traits) Ritualized Sometime symbolic	Trichotillomania Stereotypic movement disorder w/ self-injurious behavior

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Impulsive Self Mutilation

Behavior	Tissue Damage	Rate	Pattern	Disorder
Skin Cutting Skin Burning Self-Hitting	Mild to Moderate	Isolated or habitual; Not highly repetitive	Impulsive (may have compulsive traits) Ritualized Often Symbolic	Borderline / anti-social other impulsive personality disorders Abuse / trauma / PTSD Eating Disorders

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TREATMENT PRINCIPLES

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Basic Principles of Treatment

- **Respond non-judgmentally, immediately and directly**
 - Avoid emotional displays – effusive support or shock
 - Show “respectful curiosity”
- **Assure that client receives rapid attention and assessment**
 - Assess lethality and rarity of form
 - Assess immediate safety needs

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Assessment of Self-Injurious Behavior

1. Conduct a detailed mental status exam.
2. Discuss frequency, duration, and typical means of self injurious behavior.
3. Inquire about past suicide attempts as well as current suicidal ideation
4. Determine if the individual meets the criteria for a DSM diagnosis.
5. Inquire about cultural or religious implications of behavior so as to rule out sociocultural variables.
6. Determine if individual needs any medical attention for wounds, or if the individual has received treatment in the past.

Adapted from White Kress (2003).

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Individual vs. Group Counseling

- Individual counseling is generally the preferred method of intervention.
- Group interventions can promote the *contagion effect* if not properly structured and maintained. Tips for effective groups include:
 - Reduce communications about SI among members of the group. Explaining to individual clients/students that talking, emailing or instant messaging about SI has a negative effect on peers by making SI much more likely.
 - Reduce the public exhibition of scars and wounds. Directly request they cover the scars with clothing or jewelry when around others.
 - Groups that focus on skills training may be helpful. Such groups should be governed by strict rules that prohibit discussion of the details of SI (i.e., no *war stories*)

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Pharmacological Interventions

- There is no agreed-on pharmacological treatment for NSSI (Sandman, 2009)
- Psychotropic medications used to treat NSSI can include anxiolytics, SSRIs, antipsychotics, and anticonvulsants.
- Some research has suggested that pain and pleasure is confused in individuals who self-injure and thus, opiate blockers (e.g., naltrexone) may show promise in treating NSSI. At this time, however, results are not conclusive in support of the efficacy of this approach.
- In nearly all cases, pharmacological approach should be combined with behavioral interventions.

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Empirically-Supported Treatments for NSSI

- Cognitive Behavioral Therapy: Basic Principles
 - Identify triggering emotions
 - Understand and manage destructive thoughts
 - Develop more appropriate coping strategies
 - Empowering, consistent, structured and supportive relationship appear to be the most helpful interventions
 - Clients benefit from the ability to identify and express feelings verbally
 - Self soothing techniques (e.g., journaling, relaxation techniques, meditation, visualization) are useful in the development of clients' coping skills.
- **Two CBT Approaches focus specifically on NSSI:**
 - *Problem Solving Therapy*
 - *Dialectical Behavior Therapy*

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Empirically-Supported Treatments

- **Problem-Solving Therapy (PST; D’Zurillia & Goldfried, 1971)**
 - Major assumption of PST = dysfunctional coping behaviors result from a cognitive or behavioral breakdown in the problem solving process.
 - Goal of Counseling = Help clients identify and resolve the problems they encounter in their lives through the following steps:
 - Problem identification
 - Goal Setting
 - Brainstorming
 - Implementing a Solution

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Empirically-Supported Treatments

- **Dialectical Behavior Therapy (DBT; Linehan, 1993)**
 - Major Assumption of DBT = individuals need to balance the dialectical of change and acceptance
 - Treatment Goals of DBT = reduce NSSI by helping clients develop new coping skills, address therapy-interfering behaviors, and promoting skill development.

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Empirically-Supported Treatments

- One of the most important factors in the development of NSSI is emotion dysregulation (Gratz, 2007) as NSSI is thought to serve an emotion-regulation function
- Treatments such as DBT are designed to work with emotion regulation and are based on the premise that reduction of emotion dysregulation will decrease the occurrence of NSSI.
- Dialectical Behavior Treatment (DBT)
 - Originally developed as an outpatient treatment modality for chronic suicidality.
 - Combines Behavioral, Cognitive, and Supportive interventions.
 - Features of DBT for NSSI:
 - Contingency management contracts
 - Skills training
 - Behavioral analysis
 - Structure response protocols for self harm

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Strength-Based Models of Treatment

- Aims to Empower Clients
- Self injury NOT the focus of treatment
- Strength Based approaches to treatment:
 - Narrative Therapy for Self Injury (Hoffman & Kress, 2008)
 - Motivational Interviewing for Self Injury (Kress & Hoffman, 2008)

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Narrative Therapy Approaches

- Externalizing Questions: Separate clients from negative descriptions and labels. They also create distance from problem that allows reflection examination of problem and emphasizes problem not inherent in person.
 - **Develop a title of the “story” (i.e. Cutting) then ask “What does the story of Cutting require for you?”** .
- Unique Outcome: Counters the problem story & creates space for a new story. Provides a new theme of hopefulness present, past, & future events.
 - **When was a time that you defeated Cutting?**
- Unique Accounts: How were unique outcomes produced? Helps make sense out of unique outcomes. This helps bring forth alterative story
 - **What led to you getting your talking about your feelings? (not Cutting?)**
- Re-description questions: Describes self/ relationship in different light through the examination of commitments, beliefs, values.
 - **What does this new story about not cutting say about your values?**
- Unique Possibility Questions: Discover new behaviors Helps clients step into new story.
 - **If you were to step further into this new story about not cutting, what would you be doing?** (Hoffman & Kress, 2008)

Motivational Interviewing for Self-Injury

- Some researchers have conceptualized self-injury from an addictions model, and they believe that there is an addictive quality to self-injury that sustains the behavior (Nixon, Cloutier, & Aggarwal, 2002).
- Self-injury might have addiction-like dynamics; therefore, treatments that have demonstrated effectiveness with addictions (i.e., Motivational Interviewing) might also show promise in addressing self-injury (Kress & Hoffman, 2008).

Transtheoretical Model and Motivational Interviewing

- The transtheoretical model (TTM; i.e., Stages of Change) can be used to match interventions with the client's current stage of change.
- Applying the TTM may help align the agendas of the counselor and client minimizing resistance and making the intervention more effective (Britt et al., 2004; Kress & Hoffman, 2008).
- An element of TTM and MI involves the counselor operating from a harm reduction model; the goal of treatment is for the client to decrease incidents of NSSI but not necessarily abstain from the behavior.

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Motivational Interviewing

- Directive, client-centered counseling style for eliciting behavior change by helping clients explore and resolve ambivalence
- Foundation includes:
 - Collaboration
 - Evocation
 - Autonomy
- Counselors elicit change by:
 - Expression of empathy
 - Develop discrepancies
 - Roll with clients' resistance
 - Support client's self-efficacy

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MI Foundation

- Collaboration: promotes a value of egalitarian working relationship between client and counselor, which honors experiences & perspectives of client
- Evocation: developing the client's inherent resources & intrinsic motivation for change
- Autonomy: value of the client's right & capacity for self-direction & informed consent within the treatment process

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4 Basic Principles Counselors use to Elicit Change

- Expressing empathy: building of a strong client and counselor relationship (foundation of MI), facilitated through empathy
- Developing discrepancy: encourages the counselor to uncover & amplify discrepancies between the client's current behavior & his/her values or goals
- Rolling with resistance: counselor reframe resistance to encourage momentum toward change
- Supporting self-efficacy: described MI as a collaborative process that considers a client's motivation & resources for change
 - In increasing a client's self-efficacy, the counselor increases the client's hope that they can make changes related to their behavior
 - Even if client's perceive that they need to make changes, they may not embrace change if they believe they cannot successfully complete the change process

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Readiness for Change

- The proper question is not, “Why isn’t this person motivated?” but rather, “For what *is* this person motivated?”
- Instead of focusing on what the person doesn’t want to change – it’s best to focus on what the person does want to change.

(Miller & Rollnick, 2002).

Applying MI & TTM in Counseling Clients who Engage in NSSI

- Counselors must identify particular stage a client is at when he/she enters counseling and adapt treatment to the client’s level of motivation, interest, & readiness to change
- MI is useful model for people in the early stages of change (*i.e., precontemplation, contemplation*)
- The ambivalence to cease behavior may be higher in populations who are mandated to counseling (e.g., criminal justice population, adolescents required by parents, adolescents in hospital)

Assessment and Stages of Change

- After assessment, using the TTM, counselor should identify client's current level of readiness to change
- Template for identifying the client's stage of change:
 - Precontemplation- no intention to change within next 6 months
 - Contemplation- considering change within 6 months
 - Preparation- intending to change in next month
 - Action- has made change but not sustained for 6 months
 - Maintenance- change has been made and has been sustained for 6 months

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Intervention

- Incorporating MI & TTM, the counselor would use the first session to ask client to reflect on how problem interferes with daily functioning
- Use MI ask open questions about the client's values and goals & identify ways in which these values might be discrepant with client's current behavior
- Utilize discussions as a way of responding to discrepant client behavior with reflections that convey a sense of understanding and can avoid arguments when encountering resistance, which may convey hope that change is possible (MI)
- Begin by questioning lifestyle of client, which might include looking for costs and benefits NSSI
 - For example, research has suggested that NSSI is a way of expressing emotional pain and anger. This emotional pain might produce positive effects for client, NSSI removed painful emotions BUT also identify costs of self-injury, social stigmatization or guilt of not being able to control behavior

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Intervention

- When applying MI, avoid confrontation and instead aim to support client to generate reasons, plans and motivation for change
- Resistance is not confronted head-on but is skillfully deflected to encourage continued open exploration
- Central to MI client-centered spirit & technique, consistent emphasis on client autonomy and self-determination
- Client resistance is a signal to change therapeutic strategy, argumentation by counselor is counterproductive
- From TTM perspective, it's important to match intervention to client's stage of change
 - Concept of readiness to change provides ability to tailor interventions to suit the client's degree of readiness for change
 - Application of TTM with NSSI clients should ensure greater parity between agendas of counselor and client, therefore minimizing resistance and improving efficacy of intervention

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Precontemplation: Strategies

- If client is reluctant, try asking
 - "What would have to happen for you to know that NSSI is a problem?"
- Use self motivational statements with questions such as:
 - "How does the NSSI concern you?"
 - "What do you think will happen to you if you do not make any changes?"
 - "What has your self-injury prevented you from doing?"
 - "What would you consider as warning signs that would let you know that NSSI is a problem?"
- Try not to assume client has a problem. Instead, start from the viewpoint 'there is a possibility that there is a problem for you'
- If client seems willing, offer feedback from test results, ask, 'what do these results say to you?'
- Try not to come from the 'counselor as expert' point of view.
- If client is willing, explain the concepts behind the stages of change model. Involve them in the process.
- Ask client what they would like the next step to be.

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Moving from Precontemplation to Contemplation

- Individual's in the precontemplation stage rarely present for treatment by choice. They may truly believe that they do not have a problem. One goal is therefore to create doubt within the client, such that they may question their risky behaviors.
- When you first meet with client:
 - Establish rapport and trust
 - Explore events that precipitated treatment entry
 - Commend client for attending session
- "Why do you think your mother believes that your NSSI is a problem?" This enables the client to express the problem from the perspective of the referring party. It also provides you with an opportunity to encourage the client to acknowledge any truth in the other party's account (Rollnick et al., 1992).

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SUMMARY OF BASIC TREATMENT PRINCIPLES

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General Treatment Recommendations

- The treatment recommendations for NSSI fall into four broad categories (Muehlenkamp, 2006):
 - **Therapeutic Relationship**
 - Forming a strong working alliance is considered an important first step in the treatment process.
 - **Behavioral Analysis**
 - The counselor and client should work together to determine the precipitating and maintain events associated with the NSSI.
 - **Behavioral Interventions**
 - Interventions that focus on eliminating the positive and negative reinforcement associated with NSSI will likely be the most effective
 - **Cognitive Restructuring**
 - Cognitive therapy techniques can be helpful to challenge and change automatic negative thoughts clients have about themselves

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Common Treatment Goals

- Help clients develop an ability to identify and express feelings
- Help clients learn to identify the triggers, and cues associated with self-injury
- Help clients learn to use behavioral alternatives to self-injury (e.g., relaxation training, deep breathing) – behaviors that are inconsistent with self-injuring
- Help clients learn how to get their needs met in safe ways- especially with regard to interpersonal relationships
- As the client becomes more aware of his/her NSSI, and begins to develop behavioral alternatives, s/he may need to address underlying unresolved dynamics (e.g., issues associated with loss, abuse)

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Competence-Related Treatment Considerations

- Become familiar with the treatment literature related to NSSI
- Two of the most important factors believed to contribute to cessation of NSSI
 - Developing the ability to verbally express feelings
 - Learning to use behavioral alternatives (Dallam, 1997)
- Structured techniques are often necessary
 - unstructured, unfocused counseling has the potential to be harmful (don't want to be too structured or "controlling" though!)
- Negative consequences may occur when techniques aggressively challenge habitual coping strategies & defenses, thus always be respectful of clients and their coping mechanisms

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Competence-Related Treatment Considerations

- Mental health professionals must have the necessary training to work with this population.
- Ethical issues are considered most important – ensuring that the client is safe, that his/her confidentiality is protected, that the professional is competent to help the person.
- Safety issues – not using rusty blades or sharing sharps, the client tends to wounds.
- Creating a safe, structured counseling environment characterized by consistency and respect is paramount.

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Potential Pitfalls of Treatment

- Disempowering
- Overly Simplistic
- Negativistic Counselor Reactions
- Exclusive Focus on NSSI
- Countertransference

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Treatment Recommendations

- Many people who present for counseling don't want to cease NSSI, and due to variety of factors including wavering readiness & motivations, most clients who take action to modify such behaviors don't successfully maintain gains on their first attempts
- Approaching clients with element of curiosity and recognition they may not be ready to or want to stop injuring may prove helpful in facilitating open conversation related to NSSI, may be more effective, and ethical
- To prematurely assume client is ready to stop self-injuring may result in client's hasty termination of counseling or resistance to proposed treatment plan as evidenced by not following through
- A lack of understanding regarding NSSI has hindered appropriate treatment of NSSI
- 75% of those who self-injure feel they are a burden to others, pointing to the value of an empowering approach.

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Questions?



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Confronting the Darkness Webinar Series

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Self Care for Counselors Working with NSSI and Completed Suicide –
(Dr. Shannon Karl)- December 11

Additional Questions? Please email RBurke@counseling.org