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Family Therapy for NSSI

Imke Baetens, Lisa Van Hove, and Tinne Buelens

Abstract

Over the past few decades, an increasing number of researchers have studied the treatment of nonsuicidal self-injury (NSSI) in adolescent and adult samples in both clinical and nonclinical settings. Various scholars have emphasized the importance of a motivated family, satisfactory attachment relationships, and family support in obtaining a desirable NSSI treatment outcome. Also, several forms of family-based/systemic therapies, hereinafter identified as family therapy (FT), have shown relative efficacy for the treatment of NSSI (and broader self-injurious thoughts and behaviors). Therefore, the current chapter presents an overview of the available methods and evidence for using family-based approaches (e.g., attachment-based family therapy, emotionally focused family therapy) to treat NSSI. The chapter includes guidelines for FT based on both common elements for psychotherapy (e.g., countertransference) and FT elements (e.g., addressing attachment ruptures and supporting parents or caregivers suffering from secondary stress). Challenges and future directions for clinical practice and research on FT and NSSI are discussed in the concluding paragraph, stressing the need for more tailored interventions and critical view on outcome measurements.

Keywords

nonsuicidal self-injury, treatment, family therapy, psychotherapy, interventions, family

Introduction

Nonsuicidal self-injury (NSSI) is defined “as the deliberate, self-inflicted damage of body tissue without suicidal intent and for purposes not socially or culturally sanctioned” (International Society for the Study of Self-Injury, n.d.), and includes methods such as cutting, burning and hitting (Baetens et al., 2011). NSSI is prevalent among all populations and age groups, with lifetime prevalence rates of approximately 9% of children ages 9–10 (Deville et al., 2020), 17% of adolescents ages 10–17, 13.7% of young adults ages 18–24 years old, and 5% of adults (Swannell et al., 2014). Using the criteria according to the fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) (e.g., presence of repetitive NSSI behaviors on at least five days in the past year), prevalence rates of 1.5%–7.6% were found in child and adolescent community samples (Buelens et al., 2020; Zetterqvist, 2015; Zetterqvist et al., 2013). NSSI is commonly identified as a way to regulate intense emotions. In a meta-analysis of NSSI functions (see Taylor et al., this volume), researchers found intrapersonal functions, in which NSSI is a way to manage or change one’s own internal state (feelings, thoughts, or physical sensations), were prevalent among 66%–81% of the individuals engaging in NSSI. Interpersonal functions, in which NSSI is used as a way to regulate their social environment (e.g., increase social support) or to communicate distress (e.g., “to show others how I’m
feeling”), were endorsed by 32%–52% of the individuals engaging in NSSI (Taylor et al., 2018). Beyond the relational-related functions NSSI serves for individuals, there are several notable interpersonal risk factors, such as childhood trauma (see Serafini et al., this volume), family factors and dynamics (see James & Gibb, this volume) and peer relationship factors (see Pollak et al., this volume, and Jarvi Steele et al., this volume).

As described in James and Gibb (this volume), NSSI is also bidirectionally related to interpersonal factors, meaning that NSSI-linked social dynamics are reinforced through engagement in NSSI. This is especially the case for family environments where families often report heightened stress and intense emotions and conflicts within the family after the disclosure of NSSI (Whitlock et al., 2018), which can, in turn, heighten risk for NSSI. For example, Baetens et al. (2014) demonstrated changes in parenting after the disclosure of NSSI, where parents tend to withdraw support (i.e., showing less warmth) and increase controlling behaviors (i.e., more harsh punishment) after the disclosure of the engagement in NSSI by their child. Furthermore, Guo et al. (2022) showed that the association between parental controlling behaviors and NSSI is mediated by parental depressive symptoms and parent-related loneliness, suggesting that NSSI-linked family dynamics may be reinforced by the presence of NSSI.

The NSSI Family Cascade Theory (Waals et al., 2018) describes the reciprocal and reinforcing cycle of families in distress after NSSI disclosure. First, parents may experience overwhelmingly intense emotions, such as fear, anger and grief. Growing escalation can cause parents to attempt to gain control over the adolescent’s NSSI behavior (Baetens et al., 2015). Often, these attempts are experienced as intrusive by the adolescent, and may elevate the frequency and severity of NSSI. This, in turn, increases the pressure on the already tense family dynamic and hinders connection between family members (Waals et al., 2018). Also, this theory posits that the emotional intensity that parents may experience when trying to cope with their child’s NSSI engagement may lead to what “empathy burnout,” where the parent is increasingly unable to respond in an attuned manner to the adolescent’s needs (Thomas, 2013; Waals et al., 2018). Empathy burnout, which may be combined with confusion, misunderstanding, or fear (Kelada et al., 2016), can lead to a sense of hopelessness, which in turn can be experienced as unsupportive, harsh, or cold for the adolescent. These negative feelings, which can result in feeling “left alone or abandoned,” reinforce the likelihood of more severe and extreme forms of NSSI (and may elicit suicidal thoughts and behaviors). This reinforcing cycle prevents connection between family members and often contributes to already tense family dynamics.

Notwithstanding these negative reciprocal effects between adolescents and parents, several studies have also highlighted positive reciprocal effects and underscore the importance of supportive social networks as protective factors for NSSI continuation (e.g., Nixon & Heath, 2008; Tabaac et al. 2016). For example, Tatnell et al. (2014) described the importance of family support and connection for NSSI recovery. Also, Taliaferro et al. (2019) found that parent connectedness may buffer against adolescent NSSI engagement and youth moving from NSSI to suicide (Whitlock et al., 2013).
Treatment of NSSI

The past few decades, an increasing number of researchers have studied the treatment of NSSI in adolescent and adult samples, both in clinical and nonclinical settings. In a recent meta-analysis, based on 591 published articles with 1,125 unique RCTs over the past 50 years, Fox et al. (2020) concluded that the overall effects of intervention is significant yet small with a RR of 0.91 across all SITB (i.e., self-injurious thoughts and behaviors) outcomes. When focusing only on NSSI as a discrete outcome (based on 46 studies), Fox et al. (2020) reported no overall decrease in frequency and/or intensity of NSSI, and no moderator effect of specific intervention types. Despite the increase in interventions studies and RCTS examining treatments for NSSI, intervention efficacy has not been improved and no treatment for NSSI currently meets criteria for well “established” (Fox et al., 2020; Nock et al., 2019).

Notwithstanding the small effect sizes, several meta-reviews (Flaherty, 2021; Ougrin et al., 2015; Turner et al., 2014) point toward the following interventions as most promising for treatment of NSSI in adolescent samples: cognitive behavioral therapy (CBT-A; see Chapman et al., this volume), dialectic behavioral therapy (DBT-A; see Chapman et al., this volume), and mentalization-based treatment for adolescents (MBT-A; see Motz et al., this volume). Treatment protocols with a strong family component appear to be particularly effective in addressing NSSI, especially in an adolescent population (e.g., Brent et al., 2013; Ougrin et al., 2015). For example, Glenn et al. (2019) performed a systematic review on psychosocial treatments for NSSI in youth and concluded that NSSI was most reduced in studies that applied treatment models with family involvement. Indeed, various scholars have emphasized the importance of a motivated family, satisfactory attachment relationships, and family support to obtain a desirable NSSI treatment outcome (e.g., Muehlenkamp et al., 2013; Turner et al., 2014). Several types of family-based/systemic therapies, hereinafter identified as family therapy (FT), have shown relative efficacy for the treatment of NSSI (and broader self-injurious thoughts and behaviors, or SITBs) (Nock et al., 2019) and are therefore the main focus of this chapter.

This chapter presents a current state of the evidence for FT and an overview of the available types for a family-based approach to treat NSSI (e.g., attachment-based family therapy and emotionally focused family therapy). Opposed to other psychotherapies (such as CBT, which is more protocolized), there is less agreement among family therapists on key elements for FT. Therefore, we present some common elements for treatments of NSSI and provide an oversight of important FT techniques and approaches (e.g., addressing attachment ruptures and supporting parents or caregivers suffering from secondary stress). Next, a case example is discussed. Finally, the challenges and future directions for clinical practice and research on FT and NSSI are discussed.

Current State of Evidence for Family Therapy

Taken together, Nock et al. (2019) described family-based interventions as probably efficacious treatments for SIBTs. Although only a few studies have systematically researched
the effectivity of FT approaches for SIBTs, and only a paucity focus on NSSI specifically, preliminary results are promising.

The largest randomized control trial (RCT) study to date is the SHIFT (Self-Harm Intervention: Family Therapy) study by Cottrell et al. (2018), who examined the effectiveness of FT (N = 415) on self-harm (i.e., both suicidal and nonsuicidal self-injury) compared to one-on-one treatment as usual (TAU; N = 417) in one of the 40 participating CAMHS (Child and Adolescent Mental Health Services) locations. FT was not significantly different from TAU with regard to reducing the number of emergency department visits due to self-harm (primary outcome). With regard to the secondary outcomes, FT was demonstrated to be superior to TAU with regard to improvements in prosocial behaviors and decreases in emotional problems, problems with peers, and internalizing problems at 12 and 18-months follow-up. Taking into account quality-adjusted life-years (QALY) of both adolescents and caregivers, FT was overall superior to TAU. Effects of FT are most beneficial for adolescents who reported less difficulties communicating about their emotions and/or those who reported family problems. Vice versa, the FT group was at a higher risk of engaging in self-harm in comparison to the TAU group if they reported more communicative difficulties about emotions or less family problems. These findings indicate both that FT is likely to be an efficacious dimension of NSSI treatment and that assessing and working with adolescent capacity for talking about emotions and family dynamics may augment treatment efficacy, regardless of approach.

Overall, these findings are in line with other literature in this area finding little effects of FT on SITB frequency but positive effects on an array of secondary outcomes. For example, Witt et al. (2021) recently performed a systematic review of RCTs and concluded that there is no significant effect of family interventions over (E-)TAU (i.e., enhanced treatment as usual) with regard to frequency of SITB, neither immediately after the intervention (Asarnow et al., 2017) nor at an 18-month follow-up (Cottrell et al., 2018; Witt et al., 2021). Witt et al. (2021) concluded that, overall, the currently available RCTs show little to no effect of home-based (Harrington et al., 1998) or clinic-based (Asarnow et al., 2017; Cottrell et al., 2018) family interventions for SITB. This conclusion, although tentative given the heterogeneity in the operationalization of (E-)TAU, is in line with the meta-analysis of Fox et al. (2020), that no medical or psychotherapeutic treatments to date can satisfactorily decrease NSSI/SITB. However, when it comes to secondary outcomes, FT did outperform TAU and enhanced usual care (EUC). These secondary outcomes included treatment adherence, depression, hopelessness, general functioning of all family members, social functioning, suicidal ideation, and suicide (Witt et al., 2021). Given these secondary benefits, FT is likely to be an efficacious dimension of NSSI treatment and assessing and working with the family may augment treatment efficacy. For example, one key obstacle in most NSSI treatment is low adherence rates to treatment protocols. Notably, several studies show that more adolescents completed the full course of treatment when their family was involved (Cottrell et al., 2018; Harrington et al., 1998). Also, FT outperforms TAU when taken into account outcomes of all family members. Several studies have shown the
detrimental effect of NSSI on the surrounding, especially family members. For example, Whitlock et al. (2018) showed that NSSI often puts a great objective and subjective strain on parents. Therefore, taking into account the outcomes of all family members, FT may be recommended for treatment of NSSI, especially when the psychological distress of family members is heightened and they find themselves trapped in negative reinforcing cycles.

In sum, we conclude that FT is a promising treatment for some adolescents engaging in NSSI, especially taking into account secondary favorable outcomes (e.g., treatment adherence) and benefits (low cost, fewer than 10 sessions, outcome for all family members). FT may be especially helpful for those adolescents who do not show any signs of alexithymia (and/or more general difficulties talking about emotions) and those families who seem to be caught in a negative distress cascade after disclosure of NSSI.

Overview of Family Therapy for the Treatment of NSSI

Family therapy is an umbrella term for several different types of systemic or FT interventions. In the following paragraph, we present a brief overview of the different FT types that might be feasible for NSSI treatment in adolescence.

In 2011, Kissil was the first to suggest attachment-based family therapy (ABFT) as a family-based approach to treat NSSI. ABFT was developed by Diamond et al. (2007) and is an empirically supported therapy treatment for adolescents who struggle with suicidality and depression. It assumes that ruptured attachment can withhold adolescents from developing adequate coping skills. In ABFT, the ruptured attachment is restored by rebuilding trust, rectifying impasses in the attachment relationship, and fostering parents’ or caregivers’ positive involvement in the parent-child relationship. Kissil (2011) used a case study to illustrate how ABFT improved an adolescent girl’s emotion regulation by restoring a sense of security and supportive interactions with her parents. Diamond et al. (2010) conducted an RCT with two conditions, either ABFT (n = 35) or the EUC condition (n = 31) (i.e., monitored referrals to external aid providers). During the 12 weeks of treatment, the ABFT group showed a significantly greater rate of improvement in self-reported suicidal ideation and clinician-rated suicidality compared to EUC, with a strong overall effect size (ES = 0.97). However, these differences were not significant at the 24-week posttreatment follow-up visit. In 2019, Diamond et al. performed a new RCT in which suicidal and depressed adolescents (12–18 years) were either assigned to ABFT or to the Family Enhanced Non-Directive Supportive Therapy (FE-NST) condition. In FE-NST, the relationship between an adolescent and therapist is centralized as a way to enhance the adolescent’s access to supportive relationships with other adults. Findings showed that the ABFT group reported a significant decrease of suicide ideation and depressive symptoms. Yet, this was also the case for FE-NST, which implies that these decreases cannot be solely attributed to ABFT. It is more likely that these decreases can be explained by elements that were used in both systems-based approaches. No studies thus far, except for the case study of Kissil (2011), has specifically examined the feasibility of ABFT to reduce NSSI, but ABFT has shown relative
efficacy for the treatments of SITB and may be a promising FT approach for treatment of NSSI behaviors in adolescence.

Aside from ABFT, researchers have also examined emotionally focused family therapy (EFFT; Schade, 2013) and structural family therapy (SFT; Miner et al., 2016) to treat NSSI. Like ABFT, EFFT and SFT are also aimed at restoring a secure relationship with the parents or caregivers, as this may lead to an expansion of emotion regulation alternatives (Johnson et al., 1998; Miner et al., 2016; Schade, 2013). In EFFT, the therapist acts as a process consultant to help the family unclog emotional blockage and alter negative behavioral patterns that interrupt a family’s ability to respond effectively to the needs of one another (Furrow & Palmer, 2019). In SFT, on the other hand, the therapist initially creates space between the adolescents and caregivers as this allows the therapist to assess the possible presence of disruptive family structures (e.g., coalition) and to outline clear boundaries for both the child and parents or caregivers (Minuchin, 1974). Unfortunately, the empirical evidence on both treatments is scarce. Regarding EFFT, Schade (2013) described a single case study in his article, in which the application of EFFT led to NSSI cessation. In the article in which SFT was first proposed (Miner et al., 2016), prior research was used to strengthen the suggestion to apply SFT for NSSI treatment. However, no studies to date have systematically researched the efficacy of these treatments.

Regarding psychiatric populations specifically, multifamily therapy (MFT; Asen, 2002) has been mentioned as a possible efficacious family-based treatment for SIBT (Ougrin et al., 2015) but to date has not been examined for NSSI specifically. For the treatment of anorexia nervosa, MFT has been widely studied and shows benefits over systemic single-family therapy with decreases in eating disorder (ED) symptomatology, increases in family functioning, lower dropout rates, and higher satisfaction of all family members (Terache et al., 2023). Especially, the sharing of experience with other group members, role playing in empathic responses, and diminished feelings of social isolations are key outcomes for parents (e.g., Salaminiu et al., 2017). For adolescents, several studies showed decreases in ED symptoms and elevated levels of family functioning (less conflict, more support, e.g., Depestele et al., 2017).

Another family-based intervention which yielded positive results is the Resourceful Adolescent Parent Program (RAP-P; Shochet et al., 2001), a brief interactive psychoeducation program for parents of adolescents implemented over four two-hour sessions in four weeks. Pineda and Dadds (2013) examined the feasibility for RAP-P in an outpatient adolescent population and found greater improvement in family functioning and greater reductions in adolescents’ suicidal behavior and psychiatric symptoms, with a strong overall effect size. Benefits were maintained at follow-up. Interestingly, results showed that decreases in adolescent’s suicidal thoughts and behaviors were largely mediated by changes in family functioning. Pineda and Dadds (2013) also point out that they managed an excellent overall participant retention rate and high satisfaction ratings from parents, despite the challenges inherent in the socioeconomically disadvantaged clientele pool.
Finally, a two-therapist model, with one therapist focusing on the youth and the other therapist on the family, showed evidence in reducing the risk for a broad range of self-harming behaviors and might therefore be a promising approach for the treatment of NSSI. For example, Esposito-Smythers et al. (2011) examined an integrated CBT (I-CBT) protocol for suicidality and co-occurring addictions. The I-CBT protocol is founded on the social cognitive learning theory, which states that adolescents must relearn adaptive ways to acquire and apply skills such as coping strategies (Bandura, 1986). To accomplish this, I-CBT is aimed at identifying the underlying behaviors and beliefs which foster substance abuse and suicidality in adolescents, and simultaneously invest in parenting skills such as monitoring and communication. The I-CBT protocol includes individual sessions with the adolescent (e.g., affect regulation), individual sessions with the parents (e.g., monitoring) and family sessions (e.g., communication) (Esposito-Smythers et al., 2011). They found a significant effect for I-CBT, with fewer suicide attempts after 18 months compared to those in the control condition. Also, Asarnow et al. (2015, 2017) developed a cognitive-behavioral family treatment (SAFETY), which aims to strengthen cognitive, behavioral, and regulatory processes in both youth and parents and to increase support and protection within the family and social environment via joint family sessions, next to individual sessions with the adolescent. Results showed a significant advantage for SAFETY in decreasing suicide attempts over the three-month treatment period and reducing the risk of a first incident suicide attempt in the follow-up period. Weaker (nonsignificant) group differences were also found for NSSI. While results of these studies are promising, caution in interpretation is needed due to relatively small trials.

In sum, these findings show that several types of FT may be efficacious for the treatment of NSSI in adolescence and that they all have similar goals which are addressed with different approaches. Next to diminishing NSSI symptomatology, several findings, as described above, highlight the extra beneficial outcomes of FT such as family satisfaction, minimizing dropout rates, and long-term effects of treatment.

FT Guidelines for Treatment of NSSI in Adolescence

As a guideline for clinicians, there is a NSSI-specific FT guideline—that can be applied in addition to individual therapy—which integrates both common factors for psychotherapy (and how to handle these as a FT) and more specific FT components.

Common Factors for Psychotherapy

Three major common factors (i.e., therapeutic alliance, dealing with countertransference, and the client factors (e.g., motivation for change) are the basis for any effective psychotherapeutic treatments of NSSI.

First, the most significant common element in treatment of NSSI is the quality of the therapeutic alliance and an open and unprejudiced stance of the therapist toward NSSI (Miller et al., 2009). Building a strong therapeutic alliance is a necessity for any intervention for NSSI. For example, fewer NSSI episodes were reported during a DBT treatment if the
client experienced the therapist as warm and protective (Bedics et al., 2012). In a FT approach, the family therapist will build and monitor the working alliance with both the adolescent and the parents. Simultaneously, the family therapist will work on establishing overarching goals within the family (Friedlander et al., 2011). The framework of multidirected partiality as described by Boszormenyi-Nagy (2013) may guide family therapists to attune with all family members. Often this is particularly difficult in the case of NSSI behaviors as they evoke intense emotions in parents, whereas adolescents are often not motivated to cease the behavior, let alone talk about their emotions and/or NSSI in front of their parents. A family therapist should balance this line and attune with the emotions, expectations, and perspectives of the parents as well as with those of the adolescent. Furthermore, NSSI can evoke tension within FT as the adolescent often feels distrust regarding the parents and/or the parents who initially tend to focus on NSSI cessation as their primary goal. In such cases, the family therapist should avoid split alliance at all costs (i.e., the strength of the therapist’s alliance differs substantially between family members) and foster both a safe environment for and a warm, empathic relationship with all family members (Friedlander et al., 2006).

A typical challenge for the family therapist in the face of working with NSSI patients is dealing with their own emotions during the session. In some cases, for example, adolescents will keep wounds “on display” in therapy and this may shock/alarm the therapist and other family members (Thompson et al., 2008). Metacommunication (i.e., communication on the mechanisms, what is happening in the room) could be helpful to handle the countertransference. The therapist may reflect on this pattern and explore which reactions this evokes from parents and themselves. This reaction in turn might challenge the therapeutic alliance or test the unconditional love of family members. On the other hand, and more often the case, adolescents refuse to talk about their NSSI behaviors, especially when parents are present. This might evoke a shift toward individual therapy (unconsciously taking over the position of safe haven of the parent) or feelings of frustration from the therapist (in line with the frustration of the parents). In sum, in case of either hiding or showing NSSI, recognizing and handling the evoked countertransference by self-reflection and metacommunication can be helpful in keeping the therapeutic alliance safe.

Next, client factors, such as, for example, client’s and system’s willingness to change (Kruzan & Whitlock, 2019) and a tailored treatment (Turner et al., 2014), have been identified as common factors in successful NSSI treatment. First, the focus is on a core mechanism, namely, willingness to change. This can take several forms, including understanding of what specific behaviors, attitudes, or dynamics individuals are willing and able to actually modify and how these align within families. For example, a young person may want to focus on reducing severity and urges, without full cessation as an immediate goal (see also Whitlock et al., this volume). Parents, however, may want to focus solely on NSSI cessation. Because of this, it will be important for parents and therapists to explore and establish shared goals. In most cases, dealing with NSSI urges and learning how to react/talk about NSSI are treatment goals most family members can agree upon. Furthermore, most effective
therapies take into account the complexity of the client system as a whole and are therefore in nature tailored, flexible, multifaceted, and adapted (Mustafa, 2018). This might also be why protocolized treatments are not more effective than TAU, as TAU is usually multicomponent, more adapted to the person’s needs, and more flexible. One should always consider that a one-fits-all protocol rarely works and the FT should invest in maximizing tailored treatments to the client system to benefit the effectivity of the treatment.

The elements described in this section (i.e., therapeutic alliance, countertransference, and client factors) are common elements relevant for all NSSI treatments. When treating NSSI from a FT approach, these will be colored by the different voices and perspectives of all family members and may sometimes feel challenging for therapists, but on the other side may bring multiple layers and dialogues when the FT embraces the complexity.

Core Components of a FT Approach

This section presents core FT elements for NSSI treatment, including the overarching FT goal, addressing family stressors, addressing the family distress cascade, talking about the “not yet said,” supporting emotion regulation of all family members, and building connection among family members (including (re)discovering positivity within the family dynamic).

First, the key goal of each family therapy is to restore connection in the family while fostering the adolescent’s autonomy and individuality. In line with Erikson’s developmental theory, the main developmental task in adolescence is to build autonomy and identity and shift from a strong familial focus to a strong connection with peers. This developmental task poses new challenges for all families in this life stage. Often connection and autonomy might feel as irreconcilable opposites, especially for adolescents. Nonetheless, FT will handle this conflict from a dialogical viewpoint (Rober, 2002) and considers connection and autonomy are intertwined: Where autonomy is only possible within a context of a safe family connection with the family (a safe haven to return to in times of distress), and vice versa, feeling a strong connection with family members is only possible when all family members have the feeling they can/may be autonomous individuals. Therefore, the family therapist will help parents to foster and support their child’s identity formation and slowly become more independent while keeping a strong, safe connection. Parents will be supported to trust the strengths and growth of their child while being present as a safe haven.

Second, the family therapist will address family stressors, if present. Several metareviews (e.g., Arbuthnott & Lewis, 2015) have been devoted to describing some family-related factors to increase the risk for onset and maintenance of NSSI (for more information, James & Gibb, this volume). Therefore, addressing adverse family circumstances and patterns (e.g., high levels of conflict and criticism or familial stressors (e.g., abuse) are core elements of nearly all family therapy approaches. As discussed by Cottrell et al. (2018), FT might be particularly effective in those families with more family problems. For example, in the case
of a high-conflict divorce in which negative family dynamics have a negative impact on the well-being of the child and in turn heighten the risk for NSSI (Arbuthnott & Lewis, 2015), FT often focuses on helping adolescents to handle loyalty conflicts. Overall, one key feature of FT is to explore patterns and roles of each family member and install new relational skills and dynamics. For example, emotion-focused child-rearing practices can be provided (e.g., Havighurst et al., 2020), as increasing connectedness with a caring adult is one of the mechanisms for recovery of NSSI.

That said, the FT therapist should always take into account the complexity of the relationship between symptoms and the family dynamics (Eisler et al., 2005). For some individuals, family-related risk factors may be a part of a multifaceted interaction between intra- and interpersonal risk factors (for more information, see Fox, this volume, and James & Gibb, this volume). For others, a different cause/mechanism (also see Bastiaens & Claes, this volume) may explain the onset and maintenance of the NSSI behavior. But for all, NSSI has an impact on the environment, both positive (e.g., positive changes; Whitlock et al., 2018) and negative, and this in turn is bidirectionally related to NSSI. When treating NSSI, mental health professionals should always be mindful to not (un)consciously blame the family or get trapped in a linear way of reasoning or thinking.

Indeed, in line with the distress cascade theory (Waals et al., 2018), a FT therapist always considers the reinforcing cycles in the family dynamics and may consider that disclosure of NSSI can lead to the parents experiencing overwhelmingly intense emotions, such as fear, anger, and grief. Parent escalation of emotion and/or empathy burnout may cause parents to increase efforts to gain control over the adolescent’s NSSI behavior (Baetens et al., 2015). Often, the adolescent experiences these attempts as intrusive, which may elevate the severity of NSSI, increase the pressure on the already tense family dynamic, and hinder connection between family members (Waals et al., 2018). First, it is imperative to provide parent psychoeducation and to broaden both indirect and direct help as support networks for the family in crisis. This is in line with a review by Arbuthnott and Lewis (2015), which showed that indirect and direct help for parents is protective. Second, therapists should assist parents in learning to support their own self-care as a means to avoid feelings of “empathy burnout” and parental secondary stress.

One of the most important things a family therapist can do is to create a safe environment to talk about the “not yet said,” such as, for example, parents’ fear that their child’s NSSI will lead to suicide. From a narrative perspective, the family therapist can accomplish this by examining the story behind the wounds, “If your wounds could speak, what would they say?” For example, families can be asked to reflect on emotional stresses (e.g., conflict, anger, and sadness), in such a way that family stress may manifest itself in the behavior of one of the family members. Then, the adolescent may signal to the outside world through NSSI that certain tensions in the family (e.g., absent father) are too difficult to bear. Being able to speak and listen to each other, where the different narratives are allowed to stand side by side, is thus an important cornerstone in FT.
Next enhancing emotion regulation strategies and coping capacity among all family members is another FT key element. In crisis phases, it can be helpful to introduce an emotion thermometer. The adolescent is asked to communicate about how they are feeling each day via an emotion thermometer (e.g., on a scale from 1 to 10, ranging from red 1—I cannot bear this feeling and I’m afraid of myself—vs. green 10—life is perfect). Via this technique, parents get some insight on what is going on with their child, without forcing the adolescent to talk to the parents if they do not want to. A crisis plan is made based on this thermometer, where, for example, in case of a score 1 and 2, it is a signal that the adolescent is suffering from suicidal thoughts, and they will immediately be sent to the emergency room. Gradually, parents and adolescents learn how to talk about feelings, how to cope with stressful events, and soothe oneself and others. Investing in emotional awareness and emotion labeling during sessions and at home is an important mechanism for change (for more information, see Swerdlow et al., this volume). Finally, it is worth noting that FT might work best for those adolescents who can talk about their feelings, at least with a little support and coaxing. Adolescents with alexithymia or severe deficits in emotion recognition and communication are better referred to individual treatments before engaging in FT approaches.

Furthermore, all systemic approaches have another main goal, which is restoring trust and connection between family members. As such, adolescents will regain trust and experience a corrective attachment experience. The family therapist should emphasize the importance of being together in the same space, being able to speak and listen to each other, and allowing the different narratives to stand side by side. The family therapist may also emphasize the importance of engaging in joint activities to strengthen the sense of connection. Preferably these joint activities do not entail any communication in the beginning of the therapy (such as movie night or going for a run together without talking). While the therapy process evolves, the family therapist might explore activities that are focused on connection (e.g., family rituals such as pizza night or game evenings). These joint activities aim to focus on the family’s strengths and help to (re)discover positivity within the family dynamic. Whitlock and Lloyd-Richardson (2019) also developed an exercise “List of family strengths” where parents and their adolescents could be invited to indicate which items apply most to their family. This varied list, containing among others “We have enjoyable memories with each other” and “We trust each other,” ensures that most families will be able to find one or more shared strengths (i.e., Whitlock & Lloyd-Richardson, 2019). The parents and their child can then be invited to come up with a written/visual/metaphorical/. . . reminder of this shared strength, which can be helpful for each family member to foster resilience during current or later times of crisis.

Case Example

This case example illustrates the FT approach and its common effective components in youth who engage in NSSI.
Mr. and Mrs. Doe have been married for 23 years and are parents to John, age 17, and Jane, age 14. The teenage years of both their children have been tumultuous. With John, they constantly clashed over his nonchalant attitude when it came to his grades and fulfilling his academic potential. At age 16, John nearly dropped out of high school after an incident where he was caught using and selling drugs on the school grounds. The incident left Mr. and Mrs. Doe feeling confused and ashamed as they could not grasp how this could have happened. Around the same time, Jane, who had been an exemplary and high-achieving pupil in primary school, had started her adolescence with a vengeance. Mr. and Mrs. Doe felt like they did not recognize their once soft-tempered daughter, as she suddenly rebelled against every boundary they tried to set. After two years of high school, Jane had become a stranger to her parents, both in the way she looked with her now brightly dyed hair and multiple ear piercings, as in their relationship, which had become strained and distant.

At a doctor’s visit for her daughter, Mrs. Doe panicked as she noticed recent cuts and burn wounds on her daughter’s forearms. Feeling overwhelmed by worry and anxiousness about Jane being suicidal, Mrs. Doe broke down crying in the car on the way home. What follows is a fierce conflict between her and her daughter, where a terribly upset Mrs. Doe fires endless questions about when, where, and how Jane has self-injured and Jane reacting first hostile and then careless and distant about the self-injury. Mrs. Doe is left with no answers to her questions and Jane feels attacked, misunderstood, and annoyed by the whole situation. For the next month, Mrs. Doe brings up the self-injury constantly and persists for so long that Jane agrees to go to therapy in an attempt to stop her mother’s nagging.

Despite her initial suspicion, Jane quickly opens up to her individual therapist about the confusion she experiences about who she is (identity crisis): She feels caught between wanting to belong to a group of popular but sometimes vicious girls at school and wanting to stand out as an individual. She often ends up feeling lonely, confused, and tearful. After discovering self-injury through a friend at school, she shares with her therapist how self-injury “tones down my mind when I feel like I’m in overdrive.” Jane comes across as a confused and emotionally volatile adolescent but also intelligent and able to reflect upon her inner world with some support from her therapist in identifying and labeling her emotions. With Jane’s permission, Mr. and Mrs. Doe are invited to a separate FT intake session with the goal of later seeing all three of them together for a series of family therapy sessions.

During Mr. and Mrs. Doe’s FT intake, it quickly becomes clear how their marriage is starting to show some cracks under the pressure of their teens’ difficulties. Mrs. Doe has started to work part time in an attempt to keep an eye on Jane as she states feeling like “Jane is slipping through my fingers.” Mr. Doe disagrees very strongly and openly with his wife’s decision. He feels like Jane is manipulating Mrs. Doe and “her cutting has our whole family in a stranglehold.” He additionally outs his frustration on Jane defying all the restrictions that were previously put in place, specifically her curfew, as he sees her group of friends as part of the problem. Wanting to avoid conflict with his wife on this subject, Mr. Doe feels powerless and excluded from his own family. Mrs. Doe interprets her husband stepping
aside as carelessness and feels isolated and helpless with her daughter. Their different approaches and loss of connection were adding fuel to the fire, but in therapy some ruptures are repaired by pointing out their shared anger, sadness, disappointment, and fear about Jane’s self-injury. Additionally, efforts are made to put additional support systems in place, with monthly couple consultations and encouragement to reach out to their mutual friends and some trusted family members.

FT sessions allow the Doe family neutral ground to speak about the self-injury for the first time without the conversation escalating into a conflict. The therapist supports each family member to share their perspective and listen carefully to others, accepting that someone else’s experience can be somewhat different from their own. With the therapist modeling respectful and empathic curiosity about each perspective, all three family members start to slowly open up to each other, leading to some early signs of reconnection and reestablished communication. For instance, when Mrs. Doe disclosed that she interpreted Jane’s initial secrecy about the self-injury as a lack of trust in their mother-daughter bond, Jane was able to verbalize how she hid her self-injury because she was ashamed and scared to upset or disappoint her mother. As another example, when Jane spoke about how she perceived her father’s lack of interest in her as a confirmation of her self-image as “worthless” and “a hopeless case,” she shared a vulnerable and tearful moment with her father, who expressed how his feeling of powerlessness and frustration had resulted in him taking a step back. Although by no means every session leads to these breakthrough moments, the foundation is laid for a more communicative and less overheated family dynamic.

Besides fostering this new communication, Mr. and Mrs. Doe are supported in setting age-appropriate boundaries for Jane. Psychoeducation on the nonsuicidal aspect of self-injury, normalizing some of the developmental issues Jane is facing, and reassuring the importance of providing limits even in the face of crisis provides sufficient groundwork for Mr. and Mrs. Doe to pick up some of the rules they had let go and stick with them, but also fostering the wish for autonomy of Jane and giving her more “freedom.” Additionally, John is invited to a family therapy session and some mutual shame and sadness about letting go of the image of a “picture-perfect family” even gets addressed. The presence of John makes Jane feel less singled out as the “problem child” and is the therapist’s cue to start moving from a focus on self-injury to a broader perspective on family functioning. The aim is to bring the moments of (re)connection as they happen in therapy to the family home, and the therapist introduces some tools such as a “weekly check-in” and a crisis plan. Although a long road might lie ahead of the Doe family, family therapy provided some gear for along the way and reintroduced tranquility in their family dynamic.

Discussion

Although most of NSSI treatments are mainly individual-focused and behaviorally based (Bean et al., 2021), systems-based approaches are gradually gaining more attention as a useful addition to individual behaviorally based NSSI treatment (Freeman et al., 2016). Researchers have confirmed the importance of including the family system in NSSI
treatment. For example, studies found a larger decrease in the number of NSSI episodes if the family system was involved in the treatment (Brent et al., 2013; Ougrin et al., 2015).

In family systems therapy, the focus lies on providing each person in the system the opportunity to understand their own role in the family process and to try newly learned relational skills to recover trust between family members (Diamond et al., 2016). For parents or caregivers, this entails being resilient and having enough mental space in the midst of an emotional and stressful context (Arbuthnott & Lewis, 2015), elicited by NSSI disclosure (Whitlock et al., 2018). FT may counter the negative distress cascade of families after discovery of NSSI by supporting families in connecting again through facilitating communication. Indeed, studies show that striving for connection may lead to successful NSSI treatment outcomes (Baetens et al., 2021).

Future Directions in Research

Preliminary research shows that FT (or at least a dual-therapist model) might be a promising approach for treatment of NSSI in adolescence, especially given the unique benefits of FT superior to other forms of treatments such as treatment adherence, QALY for all family members, less intensive treatments (opposed to, for example, IPT/DBT). Future research is urgently needed on different fronts: first, more robust RCT research is needed to examine the potential effects and outcome relevant for FT, such as treatment adherence, satisfaction (of all family members), long-term sustainability of effects, and general family functions. Also, longer follow-up measurements should be taken into account to examine the potential long-term effects of psychotherapy. Furthermore, treatment studies should also broaden our scope when examining effectivity of treatment, based on recovery research (e.g., see Whitlock et al., this volume), where cessation of NSSI is often not a target but feelings of personal growth, connectedness with others (especially family members), beliefs in one’s own strength, and resilience are important outcomes to take into account. Also, next to empirically robust RCT research, future research needs to use more naturalistic and ecologically valid intervention studies and noninferiority designs (Leichsenring et al., 2018). Finally, several metareviews (i.e., Ougrin et al., 2015) have shown TAU (especially enhanced TAU) is often as effective as the targeted psychological treatment protocol, which might be explained by the flexibility of the (enhanced) TAU to individually tailor the treatment. In line with several other scholars in this book (i.e., Westlund Schreiner et al., this volume, and Rockstroh & Kaess, this volume), our NSSI research field should first and foremost invest research on individually tailored interventions. Systematic process monitoring (Stinckens et al., 2012) is a promising approach to support tailored treatments. With regard to the potential negative effects of continuous tracking of NSSI behaviors (and therefore prompting the attention to NSSI acts and urges), the main focus should be on process monitoring (and not as much on behavioral outcome monitoring), as this will benefit the work alliance between therapists and clients, the attunement of the therapist, and work with potential (counter)transference, which are common elements for psychotherapies, especially when working with clients who engage in NSSI.
Conclusion

NSSI is relatively common in adolescence and has a demonstrated and pronounced impact on both the adolescent and those around them. Systematic research on the effectiveness of family therapy has been limited to date but shows some promising results. In this chapter we have described some key elements for FT treatment of NSSI such as strengthening family cohesion and communication and repairing attachment issues, among others. Future research is urgently needed to examine the effectivity of FT robustly, taking into account these key elements.

References


Notes

1 Specifically, E-TAU as implemented by Asarnow et al. (2017) did include an in-clinic parent session, psychoeducation for parents, and follow-up parent telephone calls aimed at improving treatment attendance. Cottrell et al. (2018), on the other hand, deemed it impossible to specify TAU in their study, given the large number of practitioners involved. They did anticipate the TAU to be diverse and possibly to include both individual and family-orientated work.