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Walden University

College of Nursing

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Amarachi Chigbu

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the review committee have been made.

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Walden University
2021

Abstract

Use of Cognitive Behavioral Therapy to Reduce Patient Self-Harm Incidents in

Psychiatric In-Patient Settings

by

Amarachi Chigbu

MS, Walden University, 2019

BS, Morgan State University, 2012

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

August 2021

Abstract

This doctoral project aimed to assess how the provision of a mental health providers' education program regarding the use of cognitive-behavioral therapy for self-harm would assist in preventing and reducing self-harm incidents in an adolescents' psychiatric unit. The project entailed a literature search that used various databases. The doctoral project relied on evidence deduced from systematic reviews, meta-analyses, randomized controlled trials, and well-designed controlled trials without randomization. The evidence obtained from the studies formulated an education program for the providers. The education program was based on John Hopkins nursing evidence-based practice model, lewin's change theory, and the adult learning theory. The impact of the education program was assessed using pre- and postintervention surveys. Thirty-two participants, comprised of psychiatric mental health nurse practitioners, were administered questionnaires before and after the education session to determine whether the program resulted in any significant improvement concerning their knowledge of CBT as a treatment for self-harm. The pre- and postintervention survey results indicated that the education session was impactful in enhancing the providers' knowledge of CBT in reducing and preventing self-harm among adolescents. In the preintervention questionnaire, the participants had a mean score of 48% compared to 92% in the postintervention survey. These results suggest that the doctoral project will promote social change by significantly improving the competence of nurses in attending to adolescents with self-harm behavior at the study site. This enhanced competence may result in enhanced safety and clinical outcomes of affected patients at the practice site.

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Dedication

I dedicate this doctoral project to God almighty. He has been a source of my strength throughout this program. I also dedicate this project to my husband Aloysius Nlemadim, my father Sir Sunday Chigbu, my late mum Lady Victoria Chigbu, my siblings Mr. Chidi Chigbu, Mrs. Chinwe Ezeji, Mrs. Chinenye Ossai, Mrs. Onyinyechi Ire (twin sister), and my cousin Ms. Olachi Irechukwu. Thank you all for your endless love, sacrifices, prayers, supports and advice.

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I would like to express my special thanks of gratitude to my clinical preceptor Dr. David Horn, my Chair's Dr. Barbara Gross and Dr. Tatkon-Coker for their guidance and support in completing my doctoral project.

Table of Contents

Section 1: Nature of the Project....1

Introduction....1

Problem Statement....4

Purpose Statement....7

Nature of the Doctoral Project....8

Significance to Stakeholders....10

Impact on Social Change....12

Summary....13

Section 2: Background and Context....15

Introduction....15

Lewin's Change Theory....15

Application of Lewin's Change Theory to the DNP Project....17

Adult Learning Theory....20

Application of the Adult Learning Theory....21

Johns Hopkins Nursing Evidence-based Practice (JHNEBP) Model....22

Relevance to Nursing Practice....24

Local Background and Context....25

Role of the DNP Student....27

Role of the Project Team....28

Summary....28

Section 3: Collection and Analysis of Evidence....30

Introduction 30
Practice-Focused Question(s) 30
Search Strategy 31
Evidence Summary 31
Definition of Self-Harm 31
Prevalence Rates 32
Forms of Self-Harm 32
Risk Factors 33
Interventions and Treatments 34
Evidence Generated for DNP Project 36
Participants 36
Procedures 37
Education Intervention Content 38
Protection 39
Analysis and Synthesis 40
Summary 40
Section 4: Findings and Recommendations 41
Introduction 41
Findings and Implications 43
Analysis of Evidence from Experimental Studies 43
Results of the Pre- and Postintervention Surveys 44
Overview 44

Discussion 46
Limitations 47
Implications of the Findings 47
Individuals 47
Communities 49
The Mental Health Organization 49
Implications to Positive Social Change 50
Recommendations 51
The Recommended Guidelines 51
Organizational Policies Recommendations 54
Strength and Limitations of the Project 55
Section 5: Dissemination Plan 58
Dissemination to the Mental Health Facility 58
Dissemination to the Broader Nursing Profession 59
Analysis of Self 60
As a Practitioner 60
As a Scholar 60
As a Project Manager 61
Summary 61
References 63
Appendix A: Work Plan 75
Appendix B: Preintervention Survey 76

Appendix C: Postintervention Survey 78

Appendix D: Staff Education Presentation 80

List of Figures

Figure 1. Lewin's Change Theory 17

Figure 2. Adult Learning Theory 21

Figure 3. The Johns Hopkins Nursing Evidence-Based Practice Model 24

Figure 4. A Graphical Comparison of the Mean Scores 46

Section 1: Nature of the Project

Introduction

Self-harm and self-injury make up a broad cohort of actions that describe behaviors to cause direct and intentional injury and harm to oneself (Edmonson et al., 2016; Plener et al., 2018). There are different terms used to describe this concept of self-harm. There has been a noted distinction between suicidal and nonsuicidal thoughts and behaviors (Edmonson et al., 2016). Suicidal thoughts or actions are associated with the intent to die, whereas nonsuicidal phenomenon is not with the intent to end life (Plener et al., 2018). While these two phenomena are distinct and separate, evidence shows that self-injury and self-harm can be risk factors for suicidal behavior creating a complex relationship between both issues (Edmonson et al., 2016).

Kaes et al. (2019) define self-harm as "harming's one's body without the intention of suicide" (p.883). Rates of self-harm are low in childhood but skyrocket as the individual comes into adolescence. Studies report a lifetime prevalence of self-harm of 18% in the adolescent population (Kaess et al., 2019; Swanell et al., 2014). There has been growing interest in this public health concern because of the disproportionate prevalence among individuals 12 to 18 years old (Kaess et al., 2019). It is considered as a maladaptive strategy to cope with or regulate negative emotions and experiences of life such as anger, depression, anxiety, stress, guilt, and pain (Brunner et al., 2014). Some common ways the youth engage in self-harm include cutting, hitting oneself, burning, risky sexual behaviors, self-poisoning, and drug use that can lead to overdose (Cipriano et al., 2017; Hornor, 2016).

The detrimental effects of self-harm to adolescents include significant immediate risk to safety and potential risks to physical and mental wellbeing in the future (Cipriano et al., 2017; Kaess et al., 2019). Additionally, self-harm increases the risk of mental health problems, poor educational outcomes, and premature death due to other risk-taking behavior (Curtis et al., 2018). The evidence indicates that self-harm tends to occur during adolescence and can persist throughout the lifetime if there is no treatment. This issue is associated with youths that have recurrent psychosocial problems, impaired emotional regulation, and deficits in problem-solving and social support systems compared to youths that do not engage in self-harm (Edmonson et al., 2016; Hornor, 2016). Some of the risk factors for self-harm are bullying, mental illness, and a history of abuse or neglect in childhood illnesses (Cipriano et al., 2017; Hornor, 2016; Kaess et al., 2019; Swanell et al., 2014).

The family of an individual who engages in self-harm is also affected by a self-harm incident. Family members may experience stress associated with impaired school performance and the social functioning of the youth (Curtis et al., 2018). Family members of youth that self-harm reported feelings of shock, anger, disbelief as initial feelings. Subsequent feelings included guilt, fear, anxiety, and even depression (Ferrey et al., 2016). Cultural beliefs in families may also play additional strain if there is a stigma in the cultural group about self-harm. Self-harm incidents can also create stress and strain on parents or guardians who are unsure of how to support the youth who have self-harmed (Curtis et al., 2018; Ferrey et al., 2016).

Mental health care institutions also feel the impact of self-harm. It places a significant challenge on mental health services in that these adolescents show up in emergency care settings, as well as inpatient mental health hospitals and outpatient services (Doyle et al., 2017; Goldman-Mellor, 2019). Total inpatient admission rates and costs were higher among patients with deliberate self-harm compared to the rest of the population (Goldman-Mellor, 2019). Adolescents who self-harm also negatively affect the community and larger society (Edmonson et al., 2016). Given the correlation between self-harm and future suicide attempts, this issue is significant because it reflects the risk of premature loss of life, which is impactful at the various levels discussed: family, healthcare institutions, and society.

Despite knowledge of self-harm incidents in this population and more research available, there has not been a corresponding reduction in self-harm behavior in the United States among adolescents (Quinlivan et al., 2019). Additionally, there is not a universally accepted or agreed on best practice to treat self-harm in youth. Practitioners also lack the training and resources in many practice settings to implement interventions to address this issue (Doyle et al., 2017). This project aimed to address this gap in practice and research, considering the lack of interventions and training. As a quality improvement (QI) project, I explored the validity of effective treatments to reduce self-harm in this age group and then implement an educational initiative for mental health clinicians. There is a need for more effective treatments for self-harm in youth, especially those in mental health settings.

Problem Statement

Self-harm, regardless of suicidal intent, remains a growing public health problem (Centers for Disease Control and Prevention [CDC], 2019). The global and national self-harm rates have increased over the past 2 decades and significantly impact psychiatric and mental healthcare settings (Curtis et al., 2018). This problem disproportionately affects children and adolescents, which may be the result of a confluence of factors. Adolescence represents a developmental period that is crucial where there are biological and neurological changes occurring (Kaess et al., 2019). Simultaneously, adolescents are exposed to life changes with work and school, engagement in romantic relationships, and more responsibility and independence. These biological, social, and cultural events create a time where youth are at risk for the onset of self-harm (Curtis et al., 2018; Kaess et al., 2019).

There are many estimates about the rate of self-harm. However, studies estimate that up to 10 to 25% of young people have engaged in self-harm behaviors (Cipriano et al., 2017; Hornor, 2016). Experts estimate that these rates may be higher than reported since many people who engage in self-harm do not seek help (CDC, 2019). Additionally, the wide range is also since measures of self-harm are not always included in large-scale mental health epidemiological studies making it even more difficult to correctly estimate the prevalence of this problem (Curtis et al., 2018). Irrespective of how it is defined or estimated, the reality is that self-harm in adolescents is a growing and serious problem for the healthcare community.

The negative impacts of self-harm on youth remain serious. Engaging in self-harm increases the length of hospitalization, causes physical injury, contributes to missed work and school days, and is one of the strongest predictors for completed suicide (Curtis et al., 2018; Lockwood et al., 2018). Around 20% of adolescents will repeat self-harm within a year among clinical samples evaluated. An estimated 40 to 60% of completed suicides among adolescents have a documented self-harm incident prior (Lockwood et al., 2018).

Incidents of self-harm contribute to a higher financial burden on the healthcare system (Junker et al., 2017). Self-harm is associated with higher health service utilization costs and increased morbidity and mortality, mainly suicide (Junker et al., 2017; Morgan et al., 2017). Self-harm is also associated with hospitalizations and delays in recovery and treatment outcomes. There is also an elevated risk for the development of other mental health comorbidities in addition to primary diagnosis before the self-harm incident. (Junker et al., 2017; Lockwood et al., 2018).

Research studies indicate that current measures taken to ensure patient safety in mental health care facilities have not been adequate to protect patients and their caregivers from various issues related to their security (Konstanzer, 2017). The rise in the number of self-harm incidents by psychiatric patients has contributed to poor outcomes in handling mental health illnesses in the United States and other parts of the world (Yule & Kelly, 2019). Self-harm in children and adolescents continue to rise and have been associated with prolonged poor psychological health in this cohort if not addressed in a timely fashion (Morgan et al., 2017).

At the facility where the project took place, organizational data shows that self-harm remains a major sentinel event in this facility. As a Doctor of Nursing Practice (DNP) student, I have observed that self-harm is a significant safety threat to pediatric and adolescent patients. This finding is echoed in the literature where children and adolescents with mental health and psychiatric conditions face a higher risk of self-harm than their peers (Lockwood et al., 2018). Specifically, diagnosis of anxiety and mood disorders, eating disorders, psychosis, and personality disorders elevate the risk of self-harm. Additionally, Rodrigues et al. (2020), in their study, discovered that patient self-harm is one of the prominent patient safety issues facing these facilities. One of the primary challenges with self-harm incidents in inpatient settings is due to the reality that monitoring patients consistently is not possible (Konstanzer, 2017).

Research has explored the use of both restrictive and nonrestrictive measures to improve patient safety and reduce self-harm (Cramer et al., 2019). Of the many interventions explored in the literature, cognitive behavioral therapy (CBT) is a nonrestrictive measure that is effective (Glenn et al., 2016). CBT helps the youth to address maladaptive behaviors and actions, including self-harm, and how they result from distorted patterns of thinking and deficiencies in relevant skills. CBT also helps the youth to strengthen the skills required to effectively cope, communicate, and address any problems they have (Glenn et al., 2016; Hawton et al., 2016).

Despite the adverse outcomes of self-harm in this practice setting, there has been a lag in translating the best evidence to prevent and reduce self-harm incidents. For example, in the practice setting where this study took place, CBT interventions were not

uniformly and consistently used in the child and adolescent psychiatric unit. There is evidence that preemptive CBT interventions to reduce self-harm can improve treatment outcomes and disease trajectory in mental health patients (Glenn et al., 2016; Hawton et al., 2016). Therefore, this project has scientific support for initiating a psychotherapy approach to improve self-harm and safety outcomes for youth.

Purpose Statement

The primary purpose of this DNP project was to develop and administer a clinical staff education program for mental health professionals to reduce patient risk of self-harm using evidence-based CBT strategies. With rising self-harm incidents in this facility, this intervention sought to enhance the knowledge of the mental health providers (Psychiatric Mental Health Nurse Practitioners [PMNHPs] and Psychiatrists), which can reduce the self-harm incidents and their impact on adolescents and families.

The project addressed the practice-focused question: Does implementing a staff education program developed with current evidence-based practices increase mental health providers' knowledge and skills in using CBT to reduce self-harm incidents in a psychiatric mental health setting for children in the mid-Atlantic region of the United States? The project occurred in two stages. The first was to conduct a comprehensive literature review to identify the best practices for reducing self-harm. The second was developing and implementing an education initiative for mental health providers on preventing self-harm using CBT approaches.

The project was conducted to meet the following objectives to improve patient outcomes:

1. Design an evidence-based educational program to improve the knowledge of mental health providers on adolescent self-harm prevention and reduction in an inpatient mental health setting.

2. Implement a staff education program on adolescent self-harm prevention and reduction using CBT strategies.

3. Develop and administer a pre and post-test evaluation of clinician knowledge about self-harm prevention and reduction using CBT strategies in an inpatient setting.

4. Evaluate the intent to self-harm and self-harm incidents in the facility before and after the education intervention by comparing electronic health records (EHR) data.

Nature of the Doctoral Project

The practice problem is a lack of proper strategies for reducing self-harm in psychiatric inpatient settings. There have been some measures to promote safety for mental health providers and patients in the practice location. However, these interventions have not significantly reduced self-harm incidents in the psychiatric inpatient environment. Therefore, a review of the literature has shown CBT approaches effectively reduce self-harm and address underlying issues that precipitate the self-harm. By providing education to PMHNPs and psychiatrists about these approaches, the project applied the best evidence and created an opportunity for uniformity in delivering care to the patients.

The nature of this doctoral project was a staff education intervention taking place at a clinical site where I conducted my research. The facility is a comprehensive mental health/psychiatric facility in the North-East United States that caters to pediatric and adolescent patients with mental health and psychiatric diagnosis. The facility offers both inpatient and outpatient services. Patients receiving inpatient services are hospitalized from a few weeks to months and even up to a year. The project's rationale was to address safety concerns among this vulnerable patient group by educating PMHNPs and psychiatrists to implement CBT approaches to reduce self-harm incidents. The educational intervention used existing best practice CBT approaches that have been validated through primary studies as effective in reducing self-harm in mental health patients. Thus, the project was feasible and I ascertained could be completed within the allotted timeline; further, it contributes to the existing practice knowledge on the topic of interest.

The target population identified in this project were PMHNPs and psychiatrists working in the mental health facility regardless of discipline. The decision to leverage these two categories of providers was because of the collaborative culture and environment in this facility. The effectiveness of this project and outcomes for the youth subsequently hinged on disseminating the same training to all clinicians caring for the youth who are at risk for self-harm. The PMHNPs and psychiatrists, and other key stakeholders were involved directly in the project by reviewing the proposed intervention and project materials. There was a comprehensive search and appraisal of the literature

leveraging the Walden University library for pertinent peer-review journal articles on CBT for self-harm.

The providers who participated received staff education on the use of CBT strategies for self-harm. A pre/post evaluation approach was used to test clinician knowledge of CBT strategies before and after the training. Additionally, I conducted an evaluation of self-harm incidents before and after implementing the CBT approaches. The evaluation helped determine if the implementation of a staff education contributed to knowledge improvement and a reduction in the rates of self-harm incidents, and patient self-reported intent to self-harm using validated tools and questionnaires.

Significance to Stakeholders

Many stakeholders will be beneficiaries of this project. They include the patients and their families, healthcare providers in the practice setting, facility administrators, leadership and management, the healthcare organization, and the nursing profession at large. External stakeholders, including policymakers in other healthcare organizations, may also leverage the results to initiate similar quality improvement initiatives in their practice setting. There may also be opportunities for applying the project recommendations to other patient populations other than children and adolescents.

Both internal and external stakeholders will benefit from the implementation of this DNP project. The first stakeholders are the adolescent patients, who are among population impacted directly by this QI initiative. Furthermore, this project will empower clinical providers with the knowledge and skill to provide the evidence-based intervention of CBT to reduce the risk of self-harm and its negative impact on youth. The

patient families are also stakeholders in this project that will benefit from the reduction in self-harm incidents in patients.

Psychiatrists and PMHNPs are also stakeholders, as well as other clinical and nonclinical staff in the mental health facility. Per the literature, self-harm leads to increased utilization of healthcare resources and can impact the workflow and allocation of human resources, especially in organizations with shortages or insufficient staffing (Geulayov et al., 2019). Repetition of self-harm is also common, with 15 to 25% of adolescents treated for self-harm returning in less than a year (Harris et al., 2019). Therefore, this project can directly impact workflow and how care is administered to diminish the chances of repeated cases. The outcome can also impact how clinicians are trained moving forward to integrate CBT interventions into the practice guideline of the facility.

Furthermore, nonclinical staff would benefit from an environment where self-harm is reduced and addressed effectively using the best evidence. When a patient has a self-harm incident while hospitalized, or self-harm is a reason for repeat hospitalization, this can also affect the nonclinical staff as they seek to implement measures to address the clinical problem. The evidence-based intervention and findings from the education program will boost the existing protocols and alleviate concerns about the ubiquity and severity of this issue.

The hospital will also benefit from the project and the results. The reduction of self-harm will have cost-savings ramifications and boost staff morale about the ability to curb this patient outcome and reality. The control of this issue will also lessen the

duration of hospitalization for adolescent patients, allowing more patients to be seen in the facility. It also contributes to improved patient outcomes and better quality of care. Effectively addressing self-harm can also reduce the risk of suicide and mortality in the patient population.

The external stakeholders include academic institutions where the adolescents go to school, patient interest groups, youth advocacy organizations, insurers, lawmakers at the local, state, and national level, and government agencies committed to better health outcomes for adolescents. Implementing evidence-based measures can reduce the negative impact of self-harm on society and can contribute to changes in policies beyond the facility. The outcomes can be disseminated to these external stakeholders who can encourage similar initiatives in other healthcare organizations.

Impact on Social Change

The project leverages some of the Institute of Medicine's (IOM) aims to provide safe, effective, and patient-centered care. Effective care speaks to using the best evidence in the scientific literature to inform care decisions in the practice setting I conducted a preliminary review of the evidence to determine the best recommended evidence-based strategies to reduce self-harm. The result was evidence to support the implementation of a staff education program using CBT strategies. In this practice, nurse practitioners will be expected to apply these strategies to reduce instances of self-harm and injury to other patients and care providers in the practice setting.

Additionally, the project prioritizes patient-centered care by selecting an intervention that requires patient participation and engagement. CBT strategies integrate

problem-solving and motivational interviewing to help patients cope with difficult situations and have better insight into their behaviors (Sinyor et al., 2020). Patients enrolled in this project will participate actively in psychotherapeutic approaches to address underlying reasons for self-harm, identify maladaptive behaviors, and apply new ways to manage and prevent these incidents effectively.

Furthermore, the project optimizes patient safety. Nurse practitioners and other stakeholders may use the project results and the recommendations to promote safety, quality of care, and overall health and well-being of patients. The output of this project will be recommendations to cushion patients from self-harm. The project will integrate evidence to enhance patient safety measures. Engaging patients will also promote patient dignity and self-efficacy to make decisions pertinent to their safety and health. The project will also help improve the other treatment measures for the patients since their insight into illness and safety will be better preserved.

Additionally, this project aligns with the mission of Walden University to create positive social change. The project creates a positive difference both at the patient level and can create larger-scale systemic change. The project takes place within an inner-city community where there are already significant mental health care access disparities. Therefore, a project that promotes a reduction in self-harm in youth can create a ripple effect in the community regarding how to address mental health challenges.

Summary

The first section was an introduction to the practice problem of self-harm among adolescents. It detailed the scope of the problem, including statistics of the prevalence of

self-harm among adolescents and its impact on youth, families, healthcare organizations, healthcare providers, and communities. It also provided the project purpose statement and objectives and the proposed intervention to provide education to mental health providers to use CBT strategies to reduce self-harm. The nature of the project, including the setting and the proposed project steps and reasoning for a literature review followed by education to staff were explained. The stakeholders engaged in this problem were identified including how they will be impacted, as well as a discussion of how this DNP project can result in positive social change.

Section 2: Background and Context

Introduction

Adolescents engaging in self-harm is a critical public health issue that significantly predicts subsequent self-harm and is associated with the highest rate of suicide (Glenn et al., 2015). Some interventions can be implemented in psychiatric inpatient settings to address self-harm and reduce the risk of repetition or escalation to suicidal ideation and attempts (Glenn et al., 2015; Kaess et al., 2019). The purpose of this DNP project was to initiate a project that consists of educating clinical staff to implement CBT interventions for youth to reduce self-harm. This section of the proposal provides the theoretical support and justification for this project. The two theories/models used to underscore this project are Lewin's change theory and the Johns Hopkins Nursing evidence-based practice (JHNEBP) model. Additionally, the local context and background for the project is discussed. The project's relevance to nursing practice is addressed as well as my role as DNP student.

Lewin’s Change Theory

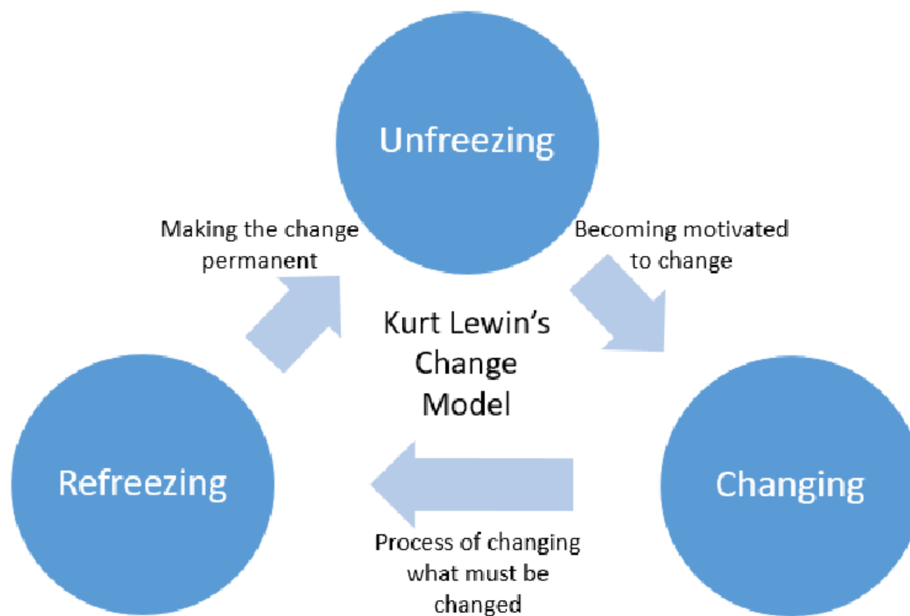
The change theory for this project is Lewin’s change theory. The theory posits three stages of change: unfreezing, change, and refreezing (Hussain et al., 2016). The unfreezing stage is where the stakeholders identify the problem, recognize the need for change, and agree to change. This stage is also where the extent of change and specifically the kind of change that will address the practice problem is identified. The second step is the change or the movement stage. This is where the change initiative is implemented. For change to be effective, there must be a plan and timeline for

implementation that is clear to all impacted parties. The final stage is refreezing, where the change is solidified and becomes a part of the facility or organizational practices (Hussain et al., 2016).

Kurt Lewin's theory of change was chosen as the framework to guide the project design because it helps the project leader to identify potential challenges that may affect the change implementation. This theory highlights the fact that there are driving forces or facilitators that enable change (Hussain et al., 2016). The model also considers that change does not happen in a vacuum, and thus the change agent must consider the organizational culture as part of successful and sustainable change. The organizational culture includes but is not limited to communication patterns, practices, values, priorities, goals, and vision (Hussain et al., 2016).

Figure 1

Lewin's Change Theory



Application of Lewin's Change Theory to the DNP Project

For this project, the unfreezing phase consisted of conducting a needs assessment to determine the extent of the problem. I spoke with stakeholders to identify the extent of the problem and reviewed organizational data to review the self-harm incidents in the organization to ascertain whether there were patterns within age groups, gender and ethnicity, and other sociodemographic factors. This stage also required evaluating the current practices to address self-harm in the organization.

At the time of this study, there was no universal approach to reducing and preventing self-harm among inpatient youth at the practice site. There are screening protocols for youth, but they are not used for all adolescent patients who present to the

facility. Additionally, when youth are screened, no intervention is applied to all patients to help address self-harm tendencies.

The unfreezing stage allowed the stakeholders and providers to let go of the current practice and replace it with the proposed evidence-based practice. The recommended intervention was to educate all providers to use CBT strategies to prevent self-harm in their patients. This protocol would also include screening all adolescent patients upon admission and during their stay for self-harm risk and intent using validated tools.

I attempted to create a feeling of urgency for changing the standard of practice for self-harm prevention and reduction by communicating with all stakeholders, including clinical providers, administrators, managers, and frontline nursing staff. Engaging the key stakeholders helped emphasize the benefit of the change on patients and the organization. It allowed for interprofessional team collaboration to enhance the odds of successful implementation.

Another strategy that I used was to have roundtable discussions with the stakeholders to identify driving forces or facilitators and potential barriers that may impact the project. From preliminary conversations, some of the driving forces include the facility's priority to reduce self-harm incidences and decrease the cost related to self-harm injuries, extended hospitalization, and repeat hospitalizations due to self-harm incidents upon discharge. The barriers or restraining forces included staff resistance to change, time for implementation, failure to see the benefits of the QI project, and

contradictions with existing facility policies. Thus, in this stage, I worked with the project team to address and reduce potential resistance.

The second phase of Lewin's change theory is the moving or change phase, and this is where the solution is implemented, and strategies to implement the changes are used. As project lead in this phase, I provided the evidence from the literature review to support the EBP intervention to prevent and reduce self-harm. The implementation phase requires cooperation and buy-in from the various staff members and would require the providers to take on a sense of ownership for the project success. I leveraged motivational communication techniques to encourage staff to embrace the change and complete the educational intervention and use the CBT techniques on their patients. The educational intervention was administered through interactive sessions that emphasized the benefits of this approach versus the current strategy in place. Finally, after the change is implemented, the practice change outcomes would be shared with pertinent stakeholders.

In the last stage, refreezing, the change will be evaluated to see if the pertinent stakeholder found the change noteworthy and acceptable. If the results are successful, then the goal of this stage is to make the change permanent by updating the existing protocols. The purpose of this phase is to ensure that there is a lasting change. This change will also require documenting the evaluation and any challenges encountered throughout the project to adjust for subsequent rounds of implementation. The objective is to ensure education intervention and CBT use are sustained. Also, ensuring there is oversight and compliance even after completing the DNP project is another objective.

Thus, educating staff semi-annually will promote and sustain the behavioral change that will lead to sustained practices to reduce and prevent self-harm among patients.

Adult Learning Theory

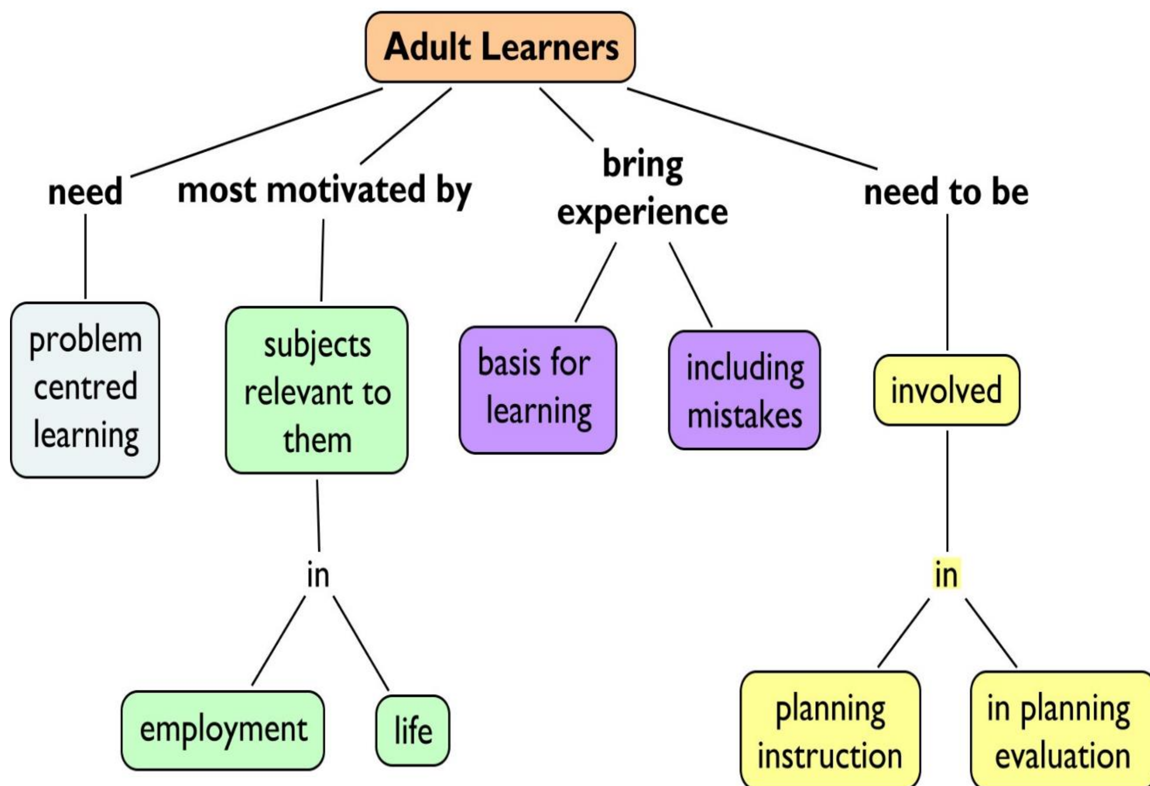
According to Malcolm Knowles' theory of adult learning, adults learn in ways different from how children learn. The characteristics of adult learners include an approach to learning that includes self-direction, readiness to learn, internal motivation, problem orientation and learning based on previous experience (Speed et al., 2016). Self-direction speaks to being deliberate about learning and following one's own pace.

In this theory, readiness to learn indicates that adult learners must be willing to learn if learning will succeed. Additionally, adult learners tend to be less content-centered but, instead, are problem-oriented (McEwen & Wills, 2014). Adults are more likely to learn if they view the information as relevant and vital (McEwen & Wills, 2014).

Another characteristic is that adult learners tend to relate learning to previous experiences (Speed et al., 2016). Adults also prefer to be actively involved in the learning experience when motivated to learn (Ho & Lim, 2020). Active involvement in learning can include self-pacing and assuming ownership for monitoring progress toward completing goals (Ho & Lim, 2020). Therefore, for the successful implementation of the staff education, the DNP student intends to use these concepts and principles.

Figure 2

Adult Learning Theory



Application of the Adult Learning Theory

The principles of adult learners can be applied to crafting the education intervention of this staff education. The first step is to leverage the self-direction by providing the course content through in-person and remote training opportunities. Participants will also be provided content to read ahead on their own, which will require self-direction. They must also plan out their time to attend the course and to review any materials after the course that were unclear or to ask questions of the DNP student conducting the education module.

Additionally, all participants must be ready to learn. Without a readiness to learn, there would have been a roadblock in enrolling participants for this intervention. Since adult learners are more problem-oriented than content-driven, the staff education will focus on reducing self-harm. While content is still essential, tying the content to resolving a clinical problem will garner more interest and engagement from the learners. The adult learners must see that the content are relevant to their clinical practice and patient safety. The presentation, as well as short exercises and discussions, will help tie the information and show its relevance to current and future practice.

Lastly, the learners will be actively involved in the session to prompt their motivation to learn, and the marketing materials will also appeal to the desire to learn something of significance to their practice. The content will build upon what the learners already know. The participants will be mental health providers already conversant with CBT. However, the staff education intends to expand their use of CBT to reduce self-harm incidents in adolescents specifically.

Johns Hopkins Nursing Evidence-based Practice (JHNEBP) Model

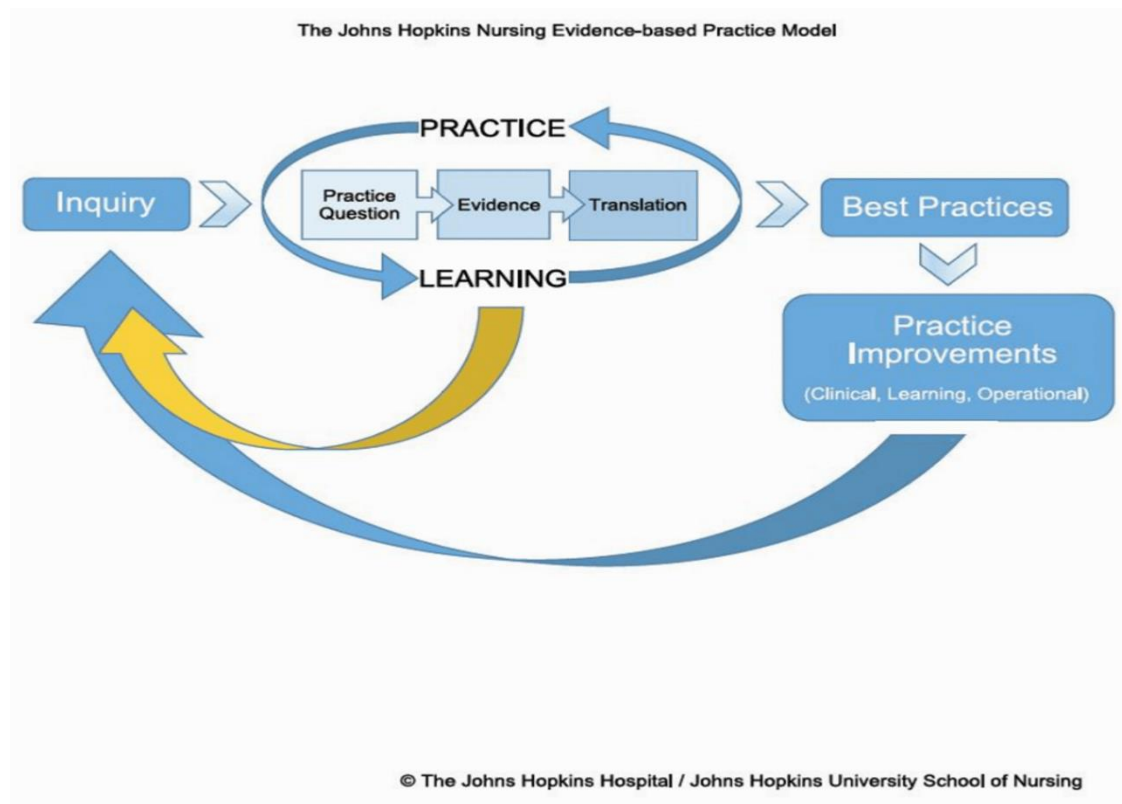
The model chosen for this project was the JHNEBP. This model is an advanced practice nursing model that uses a problem-solving approach to find lasting solutions to clinical problems (Ryan et al., 2017). The model can be used for individual patients as well as a guide for quality improvement projects. JHNEBP has three steps: practice question, evidence, and translation (Ryan et al., 2017). This model was chosen because of its focusing on nursing practice but because of its effectiveness while being simple to use.

For this project, the first step was creating a clinical practice question which is listed in Section 1. The question was derived from identifying the clinical problem, evaluating facility data on the problem and consulting with pertinent stakeholders. This process allowed for the question and focus to be streamlined to one that can be answered within the confines and timeframe of the DNP project.

The next step after the question was identified is to search and review the literature for best evidence related to preventing and reducing self-harm in youth. The findings from the literature are outlined in the next section. After reviewing the literature, the next step was to translate the evidence into clinical practice by implementing a practice change. This required identifying what interventions are feasible for this practice location and what the plan of implementation would look like. This model also aligns with Lewin's change model in that it requires the project leader to consider internal and external factors that can impact the project positively or negatively (Ryan et al., 2017).

Figure 3

The Johns Hopkins Nursing Evidence-Based Practice Model



Relevance to Nursing Practice

Traditional measures to address and reduce self-harm in this practice facility have not been effective. This project of reducing and preventing self-harm is significant to nursing practice. The nursing practice focuses on providing compassionate care to patients, including those who self-harm. Nurses at all levels of practice play an essential role in assessing and treating self-harm and self-injury in patients (Tofthagen et al., 2014). Nursing also leverages a person-centered model, which is essential when catering to self-harm patients or those who are at-risk for self-harm. Per Tofhagen et al. (2014), mental health nurses caring for inpatients who self-harm indicate that prompt evaluation

and initiation of interventions are essential. However, nurses seek to understand each patient and create a collaborative process that can help the patient to understand the harmful impact of their behaviors and choose other approaches to deal with any underlying issues resulting in self-harm.

The intervention is going to train and empower mental health clinicians to screen patients for self-harm risk and intent and implement CBT strategies that require personalization. This is congruent with nursing practice and models and can optimize patient outcomes. This project also helps to leverage existing evidence to implement an intervention that can both raise awareness among patients and providers but also reduce the stigma associated with self-harm. Self-harm can be a problematic issue for patients and providers to address. A comprehensive intervention, as is proposed in this project, helps mental health providers to understand how to effectively address self-harm and leverage the interdisciplinary team of providers to intervene when the patient is at risk.

Local Background and Context

The DNP project will take place in a comprehensive mental health facility in the Northeastern United States that provides mental health and psychiatric care to children and adolescents. The facility offers both inpatient and outpatient services to youth. Those receiving inpatient services may be kept anywhere from a few weeks (in crisis cases) to months and even up to a year. Although self-harm has been a problem in this facility, there has been no overall strategy to address this problem and the safety and quality of care ramifications of self-harm. Discussions with one facility administrator reveal an increase in self-harm incidents and self-harm ideation over the past two years by 10 and

15%, respectively (clinic administrator, personal communication, August 2020). The increase in reported self-harm ideation may be the result of implementing screening measures for all youth for self-harm. However, despite the screening protocols, no interventions are applied uniformly to patients who are deemed at risk. Thus, the facility intends to reduce self-harm significantly in adolescent patients and the recurrent admissions related to self-harm incidents.

The diagnoses of youth in the facility include major depression, post-traumatic stress disorder, bipolar disorder, various anxiety disorders, including generalized anxiety disorder and separation anxiety disorder. There are also patients with behavioral disorders such as conduct disorder, oppositional defiant disorder, personality disorders such as borderline personality disorder, autism spectrum, attention-deficit hyperactivity disorder, and disruptive mood dysregulation disorder. The facility administrator has noted that there are higher rates of self-harm for patients with depression, anxiety, bipolar disorders and alcohol or other substance use problems

The facility has an EBP team that has prioritized this issue as one that requires intervention. The DNP student will be working with this team to evaluate compliance with the existing self-harm screening protocols and to implement an education intervention for all the providers. This educational intervention aims to increase the capacity and knowledge of the providers to use CBT to reduce and prevent self-harm. Additionally, the evidence shows that youth may not be forthcoming about self-harm tendencies (Kaess et al., 2019). This project will address self-harm for all youth, even those who are not currently engaged in any self-harm.

Role of the DNP Student

The DNP student will be the project lead working with the EBP team of the facility to implement the project. The DNP student will leverage the DNP essentials to serve in this role successfully. The DNP student will conduct the literature search and appraisal and translate the content into an educational program that can be shared with the providers. Most of the providers are already familiar with and trained to use CBT. However, the education will focus on using CBT specifically to address self-harm.

The DNP student will also be responsible for securing approval from the pertinent ethics and institutional review boards (IRB) to conduct the project. Additionally, the DNP student will craft the project budget, timeline for implementation and work with the EBP team to determine the roles of participants and coordinate the change implementation process. The DNP student will also determine the mode for conducting the educational program and whether there are opportunities to leverage technology for online learning modalities.

Finally, the DNP student will coordinate meetings with stakeholders and be responsible for communicating project goals and objectives and plan with the stakeholders. The DNP student will continue to communicate project progress and eventually will present the outcomes of the project in a formal presentation to the stakeholders. The DNP student will also work with the organizational leadership to implement any systemic and lasting changes as needed once the project is complete and the outcomes are deemed favorable.

Role of the Project Team

The DNP student recruited the project team from the EBP team, which consists of clinical and nonclinical staff from different disciplines. The project team will serve as an additional resource to work with the DNP student to create the implementation project plan. This team will also aid in recruiting providers to participate in the education intervention and work with the DNP student to prepare and disseminate educational materials. This team will also be responsible for serving in an advisory and support role during the project implementation.

In addition to the EBP team members, the DNP student will be working with the facility administrators to collect data on self-harm before and after the educational intervention is completed. The team will also be monitoring the electronic health records for compliance with self-harm screening protocols to determine if there is more consistency in screening documentation before and after the educational intervention. Finally, the team will work with the DNP student to craft the evaluation materials to test provider knowledge on CBT strategies for self-harm prevention and reduction.

Summary

This section provided the theoretical support for the project using Lewin's change theory, adult learning theory and the Johns Hopkins Nursing Evidence-based Practice model. The three models/theories provide significant support for the project development and the implementation of the staff education intervention. The congruence between both the change theory and nursing model is evident and applies to the practice problem and the proposed project. The significance of this project to nursing practice was explored

and the role of the DNP student and the DNP project team. The project will allow the DNP student to serve as project lead and sharpen advanced practice nursing skills in implementing evidence-based interventions, leadership, management of resources, and creating systemic change.

Section 3: Collection and Analysis of Evidence

Introduction

I initiated this DNP project due to high self-harm incidents in an inpatient facility catering to adolescent patients with mental health and psychiatric conditions. While the facility had tried some measures to address self-harm, there had been a minimal long-lasting improvement. At the time of this study, there was no standardized intervention that was in place for clinicians to address self-harm in adolescent patients.

In discussions with several stakeholders, there was a consensus that there is a need to implement a standardized measure or intervention that can address self-harm in these patients. Thus, this DNP project aimed to change the current practice by implementing an education intervention to train providers to screen all patients for self-harm and implement CBT strategies for those at risk.

A comprehensive review of the literature was conducted to evaluate the evidence available on screening and on CBT to provide scientific evidence to support the project. The literature review was also conducted to explore the evidence, including the quality of the available research and any gaps in the literature, to determine if there was substantial evidence to warrant the intervention of using CBT. The practice-focused question guided this search, and the sources of evidence and the analysis and synthesis of the evidence is presented in this section, as well as the proposed methodology for the QI project.

Practice-Focused Question(s)

Does implementing a new staff education program developed with current evidence-based practices increase nurses' knowledge and skills in using CBT to reduce

self-harm incidents in a psychiatric mental health setting for children in the mid-Atlantic region of the United States?

Search Strategy

A literature search was conducted the following databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus with Full Text, Cochrane Database of Systematic Reviews, ProQuest Nursing, and Google Scholar. The search was limited to studies published between 2009 and the present. The rationale for expanding the search time frame was that there were fewer studies on self-harm focused on adolescents in the literature.

The search terms were *self-harm, self-injury, nonsuicidal self-injury, treatment, psychosocial intervention,* and *CBT*. Only articles published in peer-review journals in English were considered. Only primary studies or reviews were included. Studies had to align or contribute to answering the practice-focused question. Studies were excluded if the full text was unavailable, the article was not published in English, or the study did not contribute to answering the project question.

Evidence Summary

Definition of Self-Harm

The various studies had different definitions of self-harm. Some defined self-harm as harming one's body without intending to commit suicide. Others included intent of suicide in the definition of self-harm (Green et al., 2011; Hazell et al., 2010). Others considered self-harm to be any purposeful decision to harm oneself through behaviors such as cutting or burning to deal with other negative emotions (Chanen et al., 2009;

Meulenkamp et al., 2012; Nock et al., 2013; Plener et al., 2009). Other definitions did not address self-harm as a coping mechanism but rather symptomatic of other mental health, emotional disturbance or physical health challenges that require additional investigation. There was an overwhelming link in the literature of self-harm to mental health disorders (Chanen et al., 2009; Wilkinson et al., 2011)

Prevalence Rates

There was dissonance in the literature about the prevalence rates of self-harm among youth. The difference in the definition of self-harm and the parameters that constitute this phenomenon is responsible for the variation. Laye-Gindhu et al. (2009) and Meulenkamp et al. (2012) estimated the prevalence of self-harm to be between 10 and 18% in the community and up to 35% among youth with existing mental health and psychiatric disorders. Additionally, up to 30% of youth have self-harm ideations but have not acted on it (Barrocas et al., 2012; Fox et al., 2015; Ougrin et al., 2012). The consensus is that the incidence of self-harm is higher in the clinical communities and particularly for adolescents in psychiatric inpatient care. Even with the differences in prevalence rates, researchers agree that self-harm rates are rising among adolescents in the United States and globally (Ougrin et al., 2015; Glenn et al., 2015).

Forms of Self-Harm

The most common form of self-harm is cutting of the skin, usually the arm or leg. However, some youth may cut other parts of their body, including the back or abdomen. Items used to self-cut vary and may include razor blades, glass, and other sharp cutting objects (Fox et al., 2015). Other self-harm behaviors include biting oneself, punching or

hitting oneself, running into walls or other objects, or eating disordered behaviors to purposefully harm oneself (Brent et al., 2013; Fox et al., 2015). Self-harm may also manifest with reckless behaviors such as jumping off roofs of buildings, bone-breaking from falls, burning oneself, or severely scratching oneself to cause a wound (Fox et al., 2015; Swanell et al., 2014). Some youth also engage in ingesting harmful substances such as poison as well as illicit drug use or ingesting prescribed medications at higher doses to inflict harm. Promiscuous sexual behaviors can also be a form of self-harm when done to put oneself in danger and expose oneself to pain (Brent et al., 2013; Nock et al., 2013).

Risk Factors

Adolescents are at elevated risk for self-harm and suicide partly owing to the age and transition state of adolescence (Richmond-Raker et al., 2019). At this age, they are facing new independence, forming their identity, and dealing with significant physical, social, and hormonal/biological changes that can elevate the risk for anxiety and depression and potential self-harm (Richmond-Raker et al., 2019; Witt et al., 2019). The presence of mental and substance abuse disorders also increases the likelihood and severity of self-harm and suicidal ideation, intent, and attempts (Witt et al., 2019). Specifically, youth with borderline personality disorders and mood disorders were at high risk for self-harm (Witt et al., 2019). Other risk factors include past or current childhood trauma and abuse, being either the victim or perpetrator of bullying, experiencing stressful life events, toxic and ongoing stress, altered sleep habits, and being in the child welfare system (Mars et al., 2019; Witt et al., 2019)). Additionally, the family

environment can also influence self-harm if the youth lack a place where they feel support and love (Mars et al., 2019).

Interventions and Treatments

The most used interventions in the literature are psychotherapy and psychoeducation programs (Glenn et al., 2015; Glenn et al., 2019). Interventions or treatments were offered as individual interventions or in group settings. Some interventions focused on the patient, while others focused on the family unit. CBT-based treatments were the most common in the literature and were administered through one-on-one sessions or group sessions (Esposito-Symthers et al., 2011; Freeman et al., 2014; Green et al., 2011).

Some studies used these interventions in conjunction with medication, especially for youth already diagnosed with other mental health and psychiatric disorders (Arsanow et al., 2011; Wilkinson et al., 2011). The duration of these interventions varied, with some lasting weeks to months. Ougrin et al. (2012) note that brief interventions based on CBT and interpersonal therapy (IPT) were very effective in youth. Taylor et al. (2011) found that CBT reduced self-harm behaviors, depression, and anxiety in youth in an inpatient setting.

Green et al. (2011) and Hazell et al. (2009) found that six sessions of group therapy lasting an hour based on CBT principles effectively reduced self-harm ideations, intent, and incidence. Kaess et al. (2019) crafted a cutting down program (CDP) using CBT techniques and approaches. The program included parental involvement and found a

significant reduction in self-harm behaviors after six weeks of the intervention. The results persisted in the ten-month follow-up period (Kaess et al., 2019).

Dubicka et al. (2012) also found that CBT alone or in addition to medication reduced self-harm in patients diagnosed with depression and anxiety disorders. The medications were focused on resolving the underlying mental health challenge the patient was experiencing. Some medications mentioned by Dubicka et al. (2012) include sertraline, escitalopram, fluoxetine, olanzapine, and duloxetine. Pharmacotherapy helped to reduce symptoms of depression and anxiety in many of the adolescent patients, which augmented the CBT to reduce self-harm. Ougrin et al. (2015), in a systematic review and meta-analysis of randomized trials, found that CBT had a more extensive treatment effect on reducing self-harm compared to other psychotherapy modalities such as dialectical behavioral therapy, mentalization-based therapy, multisystemic therapy, and interpersonal therapy. CBT was also effective in addressing the underlying reasons for self-harm and other existing mental health challenges (Ougrin et al., 2015; Rossouw & Fonagy, 2012).

Two studies, Brent et al. (2009) and Stanley et al. (2009), combined individual CBT with family intervention. The evidence showed that CBT, when focused on problem-solving and activating healthy behaviors combined with family skills training, effectively reduced self-harm and suicide events (Brent et al., 2009; Wright et al., 2015). Additionally, the treatment outcomes sustained 6 months after follow-up in Brent et al. (2009). There was also a reduction in hospitalization rate for the CBT and family group compared to treatment as usual. However, the researchers note that it is difficult to

evaluate the effectiveness of CBT and family interventions versus CBT alone since most CBT with youth involves the family in some way (Brent et al., 2009; Stanley et al., 2009). With CBT sessions that were longer (over 3 months), attrition was a significant concern (Esposito et al., 2012).

DBT-based studies by James et al. (2011) and Fleischhaker et al., 2011) showed a reduction in deliberate self-harm. These studies used individualized sessions over 6 to 8 weeks, while one used intense 12-week outpatient DBT sessions. The concerns with the studies were small sample sizes and inadequate controls. More studies using this approach are needed to determine the generalizability of the findings to a larger patient group. One group DBT study showed an improvement in self-harm outcomes. The primary concern was that most participants were also receiving other therapies making it challenging to determine whether the improvement was solely due to DBT or other confounding variables (Pereletchikova et al., 2011).

Evidence Generated for DNP Project

Evidence and data for this DNP proposal is presented and discussed under the headings of participants, procedures, and protections.

Participants

The participants involved in this project are mental health providers (PMHNPs and psychiatrists) in the mental health facility who received the educational intervention. The facility had an estimated 40 providers who fall into this category at the time of this project, and the intention was to train as many providers as possible who expressed interest in participating in this voluntary staff education intervention.

Procedures

The implementation process is described below. The DNP student will craft an educational program based on the best evidence in the literature on CBT for preventing and reducing self-harm. The program will leverage the existing evidence and will be taught in two sessions for an hour. The rationale is that all the providers already have experience with CBT. Thus, the intervention is to train providers to conduct a self-harm reduction and prevention intervention in individual CBT session with adolescent patients. The DNP student will craft a PowerPoint Presentation which will form the basis of the educational intervention. After the approval of the education content, the DNP student will present the program to the project team for review and approval. Upon approval, the educational session content will be presented to the EBP team for approval.

The educational intervention will be presented as part of the quarterly seminar for mental health providers in the facility by the DNP student as the project lead. The decision was based on not adding another day of training to already busy professionals. The facility has agreed to use one of the existing training dates for this intervention. The DNP student will work with the project team to recruit participants and inform mental health providers of the in-service training. Marketing of the program will be done through flyers as well as emails and announced at staff meetings. The flyers will be disseminated to all potential participants and direct word of mouth invitations from the project team will also be used.

Participants will complete a pre-test and post-test evaluation of knowledge of how to execute a CBT intervention to reduce self-harm in youth. An abbreviated version of

the CBT Knowledge Questionnaire will be used for pre/post data collection and analysis. This tool has been used in various studies to evaluate the knowledge gained before and after a CBT training session (Simons et al., 2013). The tool was developed by Myles et al. (2003) and contained 26 multiple-choice questions. Out of the questions, 10 will be used for this evaluation purposes that focus on CBT knowledge and skills outside of background CBT theoretical knowledge.

Education Intervention Content

The staff education will discuss what CBT is and is not and focus on motivational interviewing techniques and principles to help youth initiate a plan to change their self-harm behavior. Providers will learn about goal setting with youth and strategies to facilitate discussion on the rationale and underlying reasons for the desire to self-harm. The provider will learn about techniques to help adolescents manage stress and anxiety and empower youth to spot triggers that may cause the desire the self-harm. Participants will learn how to help youth identify negative thinking and the impact it is having on their lives and learn new behaviors, cognitive restructuring and reframing, guided discovery, journaling and recording thoughts, activity scheduling and relaxation, and stress reduction approach. There will also be information presented on coping strategies that adolescents can use. These strategies include breathing exercises, mindfulness, and imagery.

Using the strengths-based CBT approach, providers will learn how youth can identify strengths and interests and engage in daily activities to boost mood and flourish. They will be equipped with strategies and exercises to help build self-esteem and help

you develop a plan of action if they feel the ideation to self-harm. Providers will also learn how to evaluate the patient environment for tools that can be used for self-harm and train parents to do the same for outpatients. The Suicide and Self-Harm Checklist by Frost et al. (2020) will facilitate the discussion on clinician and parent checklist protocols.

Protection

The staff education program is voluntary, and mental health providers will be encouraged but not mandated to attend. The project will be approved by the IRB of Walden University as well as the ethics committee of the facility where the project will take place. No identifying information will be collected from the providers to ensure confidentiality and anonymity. Participants will receive an ID that will be used for pre/post data collection.

All participants will receive a written and oral overview of the project disclosing all interventions, duration, and a reminder that the project poses minimal risks to human subjects. Participants received information that they could opt to discontinue their participation in the project at any time without explanation or consequence. Additionally, when evaluating self-harm rates pre- and post-intervention, there will be no identifying information collected. Consent forms, recruitment records, contact lists, and any other document that contains Protected Personally Identifiable Information (PPII) of the participants will be destroyed after the research is completed. However, documents containing the project content or the participants' responses will be stored for a minimum

of three years using password-protected folders. Only the doctoral student and the project team will access the content and the responses.

Analysis and Synthesis

The DNP student will perform the data analysis alone; the facility's QI team will be involved in the data collection but not the analysis. The data obtained will be analyzed using the Statistical Package for Social Sciences (SPSS) version 26 software program. Participant demographic data will be analyzed using descriptive statistics such as measures of central tendency including the mean and measures of dispersion, particularly standard deviation. The pre/postintervention data will be evaluated using a t-test to determine if there is a statistically significant improvement in knowledge due to the staff education. Self-harm incident rates before and after the intervention will be evaluated by comparing the means to determine if there was a reduction in average self-harm incidents the month before the intervention and the month after the intervention. The project will be considered effective if provider knowledge increased by at least 20%.

Summary

This section detailed out the evidence supporting the DNP project. Additionally, there was information about the search for the literature and the analysis of the evidence. CBT strategies are supported in the literature in a group or individual format and for adolescents in inpatient and outpatient settings. The protocol for the staff education intervention is presented as well as measures to maintain ethical standards of conducting a staff education project. The participants, data collection and data analysis protocols are also outlined.

Section 4: Findings and Recommendations

Introduction

Self-harm and self-injury can be described as a broad cohort of direct and intentional actions that are intended to injure and harm oneself. Of all age groups, self-harm incidents are more common among adolescents, considering a lifetime prevalence rate of 18% in this age group (Kaess et al., 2019). Adolescents engage in self-harm through actions such as drug use and overdose, self-poisoning, risky sexual behaviors, burning, hitting oneself, and cutting. Self-harm is a significant public health challenge since it affects both the physical and emotional wellness of individuals (Curtis et al., 2018). Furthermore, self-harm results in diminished academic performance, as well as increases the risk of premature death. Hence, self-harm presents significant challenges to the wellness of individuals; thus, the adoption of effective interventions that will reduce its incidence rate is necessary.

In the mental health facility in which this DNP project took place, there has been a 10% increase in self-harm incidents in the adolescents' psychiatric unit over the past 2 years. Despite the rising incident rate of self-harm, the facility had not formulated a standard strategy for minimizing the rate and safeguarding the overall safety of the affected patients. Worse, the incident rate was projected to remain high, especially considering that the unit attends adolescents diagnosed with depression and bipolar, anxiety, alcohol, and substance use disorders, which are all risk factors for self-harm and suicide (Curtis et al., 2018). Therefore, owing to the rising cases of self-harm among adolescents in the mental health facility, the doctoral project aimed at intervening on the

issue by initiating an education program for the care providers in order to improve their capacity and knowledge regarding the utilization of CBT as an intervention for reducing and preventing self-harm incidents among the targeted population. The project answered the following practice question: Does implementing a staff education program developed with current evidence-based practices increase mental health providers' knowledge and skills in using CBT to reduce self-harm incidents in a psychiatric mental health setting for children in the mid-Atlantic region of the United States?

The project relied on scientific evidence obtained from previous empirical studies that assessed various aspects of CBT as an intervention against self-harm. The review of the literature was guided by the practice-focused question. The literature search was undertaken in the following databases: Google Scholar, ProQuest Nursing, Cochrane Database of Systematic Reviews, and Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus with Full Text. The reviewed studies had to have been conducted within the past 5 years. The search terms were *self-injury, self-harm, non-suicidal self-injury, treatment, psychosocial intervention,* and *CBT*. Only articles published in peer-review journals in English were considered.

The evidence obtained from the review of the cited studies was used to formulate a care providers' education program that was aimed at informing them on how to screen for self-harm and apply CBT as an effective intervention among the identified patients. The education was provided in the form of a PowerPoint presentation (see Appendix D). The presentation was accompanied by collecting primary data in the form of a pretest and posttest evaluation of knowledge. The CBT Knowledge Questionnaire was utilized in

pre/post assessment of knowledge. The questionnaire comprised 26 questions, of which 10 were used in the case of this doctoral project. The accuracy of the participants' responses about The CBT Knowledge Questionnaire before and after the provision of the education program was analyzed using the SPSS software. The analysis assisted in determining whether the care providers' education program was effective in enhancing knowledge regarding screening for self-harm and initiating CBT among the identified patients.

Findings and Implications

Analysis of Evidence from Experimental Studies

Various studies indicated that CBT is the most effective intervention in preventing self-harm (Freeman et al., 2014). CBT treatment can either be administered in one-on-one sessions or group sessions (Freeman et al., 2014). Additionally, the cited literature also indicated that CBT for self-harm could also be effective if used alongside medications, especially among adolescents diagnosed with psychiatric disorders, because there is adequate evidence to indicate that CBT reduces the severity of anxiety and depression, as well as reduces self-harm behaviors among patients in a psychiatric unit (Wilkinson et al., 2011). According to Green et al. (2011), six sessions of CBT, which last an hour each in a group format, were effective in reducing self-harm ideations, intent, and incidence. Furthermore, Kaess et al. (2019) found a statistically significant reduction in self-harm behaviors among the at-risk adolescents, if the CBT intervention was initiated for 6 weeks; the reduction persisted for 10 months, which indicated CBT is effective in safeguarding complete remission from the maladaptive behavior. In addition,

according to Ougrin et al. (2015), CBT was found to be more effective in preventing and reducing self-harm compared to other psychotherapeutic interventions such as interpersonal therapy, multisystemic therapy, mentalization-based therapy, and dialectical behavioral therapy. CBT is regarded as more effective in preventing self-harm than other psychotherapeutic treatments because it intervenes in the underlying causes of self-harm and reduces the severity of the existing mental challenges (Rossouw & Fonagy, 2012). Based on a study conducted by Brent et al. (2009), a combination of CBT and family therapy was effective in problem-solving and activating healthy behaviors among adolescents detected with the risk of self-harm and suicide events. A follow-up assessment showed that the outcomes of the combined treatment had been sustained after 6 months, which indicated that CBT is highly effective in reducing the risk of self-harm in the long term (Brent et al., 2009). Therefore, the evidence deduced from various empirical studies indicated that CBT would effectively reduce and prevent self-harm incidents among adolescents. Based on this evidence and the high levels of self-harm at the practice site, I identified the need to educate care providers about the importance of adopting CBT to effectively intervene on the self-harm behaviors among the affected patients in the adolescents' psychiatric unit.

Results of the Pre- and Postintervention Surveys

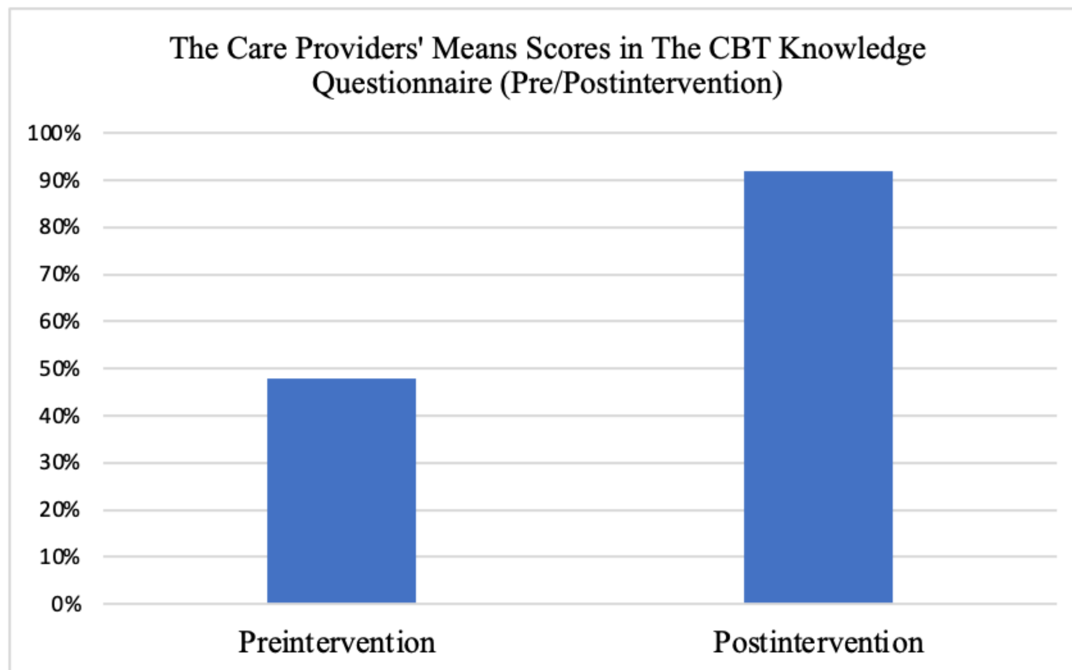
Overview

Apart from the evidence deduced from the existing studies, the doctoral project also relied on data obtained from surveys administered to the care providers who participated in the education program. It also relied on evaluating the self-harm rates in

the adolescents' psychiatric unit, one month after the provision of the education program. The surveys were in the form of the CBT Knowledge Questionnaire and the self-harm screening tool. The CBT Knowledge Questionnaire was utilized to assess the care providers' knowledge of effectively administering CBT as an intervention against self-harm. On the other hand, the self-harm screening tool was utilized to evaluate the participants' knowledge of effectively screening for self-harm among the at-risk patients. The two forms of the survey were administered before and after the provision of the education program. They assessed differences between the accuracy of the responses before and after the provision of the education. Improved accuracy would have indicated that the education program effectively improved the competence of the care providers regarding the effective screening of self-harm and the utilization of CBT as an intervention among the affected patients.

Figure 4

A Graphical Comparison of the Mean Scores



Discussion

An assessment of the participants’ mean scores about the CBT Knowledge Questionnaire indicates a significant increase in the care providers’ knowledge regarding the utilization of CBT as an intervention of reducing and preventing self-harm among adolescents, following the provision of the education program. An analysis of the results of the CBT Knowledge Questionnaire shows the participants had a mean score of 48% before the provision of the education program, compared to 92% after the education was provided. Hence, the education program effectively enhanced the participants' knowledge regarding the effective use of CBT as an intervention for self-harm among adolescents.

Limitations

Time was the main limitation that characterized the care providers' education program. The education was presented in PowerPoint. However, it lasted 30 minutes, owing to the tight schedules of the care providers. The time constraint meant that the presentation was not detailed, which could have affected the participants' level of enlightenment. The time constraint also meant that the participants were allocated inadequate time to fill the surveys. For instance, despite having 26 questions, only 10 questions were provided to participants, and they still took a significant amount of time to complete the CBT Knowledge Questionnaire. This means that they might have lacked adequate time to sufficiently explore the quality of their responses. The time constraint could easily explain why the participants had better scores in the first set of questions, compared to the last ones, because the trend indicates that they might have rushed through the final questions or lacked time to answer them at all. Therefore, there is a significant likelihood that the time limit could have prevented the participants from expressing their full knowledge and competence, in the surveys, regarding the screening for self-harm among the at-risk and initiating CBT as an effective intervention among the identified patients.

Implications of the Findings

Individuals

The absence of an effective and standardized intervention for preventing and reducing self-harm has significantly impacted the physical and mental wellness of individuals. Fortunately, the doctoral project was able to review various studies and

identify CBT as the most effective intervention for preventing self-harm among adolescents. The doctoral project was also effective in formulating a care providers' education program. The mental health staff was adequately educated on how to effectively screen for self-harm and administer CBT among the at-risk patients, as deduced from the results of the pre/postintervention surveys. Besides, an analysis of the adolescents' psychiatric unit self-harm rates indicates that the education program resulted in a significant decrease of self-harm incidents in the unit one month after the provision of the program. Hence, the cited outcomes of the doctoral project will improve the overall wellness of adolescents in several ways, particularly those with psychiatric disorders.

To start with, the effective management of self-harm will result in reduced rates of physical injuries such as cuts among the affected individuals. The outcomes will also diminish the risk of suicide among the targeted patients. Besides, since overdose is often regarded as one of the maladaptive behaviors of coping with self-harm, a reduction in self-harm rates will be accompanied by a significant decline in alcohol and substance use disorders among the affected teenagers (Curtis et al., 2018). Furthermore, the enhanced management of self-harm will result in improved interpersonal relationships and eliminate social isolation among the affected individuals, due to the reduction of poor self-esteem and self-image, as well as the elimination of the feelings of guilt, disgust, and shame following the effective utilization of the CBT intervention. Lastly, reducing self-harm incidents will result in improved academic performance and enhanced socioeconomic productivity among the targeted population. Therefore, one can deduce

that the outcomes of the doctoral project will be crucial in enhancing the overall wellness of the affected population.

Communities

Apart from individuals who are at risk of self-harm, the outcomes of the doctoral project will also be beneficial to the families of the affected adolescents and the broader community. A reduction in self-harm cases as indicated by the project outcomes means that the family members of the affected teenagers will not be characterized with social isolation due to the stigma associated with having a family member who engages in self-harm. Furthermore, the results translate that family members will no longer have to attend to costly medical bills related to self-harm, this is crucial especially considering that adolescents who engage in self-harm cope with 45% higher medical bills annually, compared to adolescents who do not engage in the maladaptive behavior (Tsiachristas et al., 2020). Besides, the findings will also facilitate the attainment of improved academic performance and socioeconomic productivity of the affected teenagers, reflecting on the overall wellness of their communities.

The Mental Health Organization

The doctoral project's findings will also positively affect the mental health institution in which the project was undertaken. According to Kinchin et al. (2017), inpatient self-harm incidents result in significant financial implications on healthcare organizations due to the increased length of hospitalization and the cost of attending to the self-harm injuries and complications. For instance, according to the authors, poisoning-related self-harm increases the hospital stay by 3 days and raises the cost of

treatment by $30,787, of which a significant portion of this cost is usually incurred by the respective healthcare organizations (Kinchin et al., 2017). Therefore, the care providers' education program regarding the effective screening for self-harm and the utilization of CBT as a comprehensive intervention of preventing and reducing self-harm incidents in the adolescents' psychiatric unit will have a favourable cost implication on the healthcare organization of interest. Furthermore, the reduced self-harm rates will raise the reputation of the mental health facility among the public since it will be perceived as having effective strategies of safeguarding the safety of the inpatients and optimizing their treatment outcomes. Hence, the demand for the facility's services will increase, enhancing its overall ranking and revenues.

Implications to Positive Social Change

1. The outcomes of the doctoral project will assist in minimizing the rates of self-harm among adolescents; thus, reducing the health burden posed by the maladaptive behavior, particularly in terms of injuries and the risk of premature death.
2. The project's findings will also enhance the overall productivity of the affected teenagers due to enhanced academic performance and improved social participation.
3. The doctoral project will reduce the stigmatization, shame, and depression associated with self-harm, especially among the family members of the affected adolescents.

4. The project will also diminish the treatment cost incurred by the caregivers of the affected teenagers, primarily due to a reduction of incidents such as burns, fractures, and traumas that are characterized by high treatment bills.
5. The project will also result in a decreased length of hospital stay among the affected patients, and this translates that the care providers will have more time to attend to other more complex psychiatric disorders.

Recommendations

The Recommended Guidelines

For the mental health facility to effectively adopt CBT as an intervention for preventing and reducing self-harm incidents among adolescent inpatients, the facility should adopt several practice guidelines and protocols to safeguard the attainment of the intended outcomes. First, it is crucial for the mental health providers to accurately detect the adolescents who are at risk of engaging in self-harm to be administered the proposed intervention and abstain from the maladaptive behavior. Therefore, for the at-risk patients to be diagnosed effectively, the facility is recommended to adopt the diagnostic criteria for nonsuicidal self-injury (NSSI) as per the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (Albon et al., 2016). Hence, based on the manual, for a patient to be positively diagnosed with self-harm, they must depict the following aspects:

1. In the last year, the adolescent has on 5 or more days has inflicted damage to his or her body intentionally and induced pain, bruising, and bleeding (Albon et al., 2016).

2. The self-injury was inflected in the following ways; excessive rubbing, hitting, stabbing, burning, and cutting, and the self-injury was not inflected for a socially accepted activity such as tattooing and body piercing (Albon et al., 2016).
3. Self-harm behavior is not typical such as in the case of nail-biting.
4. The intentional injury is associated with negative thoughts or feelings and interpersonal difficulties (Albon et al., 2016). For instance, due to self-criticism, generalized distress, anger, tension, anxiety, and depression.
5. The adolescent depicts an inability to resist the self-harm behavior, or in other words, he or she is preoccupied with it despite the pain or other negative consequences.
6. The adolescent engages in self-harm with the expectation that it will relieve a cognitive state, negative feelings, or interpersonal difficulties (Albon et al., 2016).
7. The self-harm behavior results in clinically significant consequences or interferes with the academic, economic, or interpersonal functionality of the affected individual.
8. The behavior does not manifest exclusively during states of intoxication, delirium, and psychosis (Albon et al., 2016). Furthermore, the behavior cannot be exclusively attributed to another medical or mental disorder such as; trichotillomania, a stereotyped movement disorder with self-injury, Lesch–Nyhan syndrome, mental retardation, pervasive developmental disorder, or psychotic disorder (Albon et al., 2016).

9. The behavior does not depict an intention for suicide (Albon et al., 2016). This can be ascertained based on the parent's or patient's feedback, or if there is evidence that the adolescent routinely engages in the behavior with the full awareness that it is not likely to result in death.

These nine diagnostic guidelines above will be crucial in identifying the adolescents who have already developed self-harm behavior.

The identified patients should then be administered CBT as a problem-solving therapy, based on the following guidelines. First, the care provider should focus on training the patient regarding skills and attitudes necessary in promoting problem-solving (Washburn et al., 2016). To be precise, the goal of administering CBT as an intervention against self-harm should focus on the following aspects:

1. Developing or enhancing a positive problem orientation and decreasing a negative orientation
2. Training in rational problem solving enables the affected patient to identify and define the underlying cause of the self-harm behavior and develop alternative solutions to the problematic behavior (Washburn et al., 2016).
3. Assisting the patient to overcome impulsive behavior and careless decision-making.
4. Furthermore, using CBT, the healthcare provider should also focus on cognitive restructuring and activating more constructive behaviors.
5. The patient should also be trained about emotional regulation and effective social skills.

6. Likewise, where possible, the mental health provider can also initiate parent-child sessions among the affected patients to encourage the parent to improve their support and avoid criticism (Washburn et al., 2016). Besides, such sessions would equip the teenager with crucial skills regarding family communication.

Other guidelines that should be adhered to when administering CBT include:

- The treatment should be provided within a minimum of 12 sessions.
- The 12 sessions should be spread out in 12 weeks, translating to a session per week (Washburn et al., 2016).
- The treated patient should be reassessed every month for 9 months to ascertain that he or she has not relapsed into the self-harm behavior (Washburn et al., 2016).
- Lastly, it is crucial to note that within the 12 weeks treatment period, CBT can be prescribed in combination with a Selective Serotonin Reuptake Inhibitor (SSRI) such as venlafaxine to reduce the depressive symptoms, particularly among the severely affected patients (Washburn et al., 2016).

Organizational Policies Recommendations

Several policies ought to be formulated by the mental health organization to ensure that the proposed intervention regarding the use of CBT in preventing and reducing self-harm among adolescents in the psychiatric unit is effectively adopted. One of such policies is the laying out of routine training schedules in the form of seminars, webinars, and workshops, in order to ensure that the mental health providers are routinely sensitized about the importance of utilizing CBT in managing self-harm and how to apply

the intervention appropriately. The continuous sensitization will ensure that the intervention becomes enshrined as part of the organization's culture or the standard treatment for managing self-harm in the adolescents' psychiatric unit. Furthermore, the facility's administration should allocate adequate finances towards ensuring that modern approaches to administering CBT such as Tele-CBT are adopted. Tele-CBT can ensure that the discharged patients can continue receiving the prescribed CBT sessions at their convenience areas without booking appointments at the healthcare facility (Dent et al., 2018). Tele-CBT is crucial among the discharged patients since it enhances their convenience, which reduces the possibility of lack of adherence to the prescribed schedules (Dent et al., 2018). Therefore, one can summarize that the organization's management will play a crucial role in facilitating the effective implementation of the proposed intervention by formulating the necessary policies.

Strength and Limitations of the Project

One of the main strengths of this doctoral project is the high number of participants. The facility has 40 healthcare providers, of which 32 of them volunteered to enroll in the education program. The high number of participants translates to the fact that the education intervention impacted most care providers. Besides, the high number also means that the results of the pre/postintervention surveys reflect the real-life scenario, or in other words, the feedback of large sample size is more likely to reflect the believes or attitudes of the larger mental health profession (Biau et al., 2019). Hence, the large sample size makes the findings to be more reliable or valid.

Another advantage is the level of collaboration among the various stakeholders. For instance, a majority of the mental health providers volunteered to take part in the education and responded to the two surveys comprehensively. In addition, the hospital's management was also a strategic partner in the doctoral project because it facilitated the undertaking by availing the conference hall in which the care providers' education session took place and provided a projector, which was used during the educational presentation. Furthermore, the management also allowed the doctoral student to use some of the organization's equipment, such as the printer and the photocopier, which were fundamental in initiating the education program, especially preparing the pre/postintervention surveys. Hence, were it not for the high level of collaboration among the main stakeholders, the doctoral student might have lacked the capacity to undertake some project segments.

However, despite having crucial strengths that enhanced the capability of the doctoral project to address the topic interest, the project was also characterized by one major limitation, in terms of time constraints. The education program was not allocated adequate time due to the care providers' tight schedules/shifts, which means that the facility's management could only allocate 30 minutes to the educational presentation without significant interference with their clinical duties. The 30 minutes allocated to the presentation impended the possibility of a detailed session, and this could have impacted the level of awareness, enlightenment, or sensitization created by the program. Furthermore, apart from having a limited timeframe for delivering the education presentation, the participants were also allocated inadequate time to fill both the surveys.

For example, they were only given 30 minutes to fill the CBT Knowledge Questionnaire, despite having 26 questions, and only ten were used. This limitation means that the participants might have lacked sufficient time to think through their responses, which might have diminished the reliability of the findings. Fortunately, in the future, a doctoral student can navigate this limitation by delivering the education presentation in shifts. In this case, the education program can be provided in groups, depending on the participants' level of availability on specific days within a given month. Hence, the program can be broken down into several days of the month, such as weekly, and reserve each day to the most available participants.

Furthermore, in the future, it will be appropriate to utilize emerging technology such as Zoom meetings to deliver the presentation at the participants' convenience. A virtual presentation will enhance the level of participation because it will safeguard the attendance of a majority of the care providers, even those on day-offs. Therefore, in future studies, a doctoral student will be able to resolve the various limitations that might impend the effective undertaking of the project if he or she becomes innovative.

Section 5: Dissemination Plan

Dissemination to the Mental Health Facility

According to Borrell et al. (2016), dissemination can be regarded as one of the fundamental parts of a research project since the process of dissemination ensures that research findings reach the relevant stakeholders in order for them to consider the proposed recommendations and initiate the necessary change. In this doctoral project, the dissemination of its findings was aimed at the healthcare facility in which the program was undertaken. The mental health facility will be the primary target of the dissemination because the doctoral project has comprehensively established that the facility is characterized by a significant gap in practice regarding the prevention and reduction of self-harm incidents among adolescent inpatients. Hence, dissemination will be fundamental in informing the various stakeholders about the research findings, which indicate that CBT can be an effective alternative in preventing and reducing self-harm incidents. Therefore, persuading the targeted parties to initiate a change in practice. The dissemination plan will comprise of the following components:

1. Objective: The main aim of the dissemination is to trigger or facilitate a change in practice, in which the mental health providers at the adolescents' psychiatric unit will be utilizing CBT as an intervention of preventing and reducing self-harm among the at-risk patients.
2. Audience: Both the facility's management and the mental health providers, particularly those who practice in the adolescents' unit, will be the targeted audience of the dissemination process. In this case, the dissemination will inform

the mental health providers on how the findings necessitate the adoption of CBT in preventing and reducing self-harm among adolescents. On the other hand, in the case of the facility's management, the dissemination will focus on persuading it on the need to lay down the proposed policies that will safeguard an effective change in practice.

3. Format: The results was posted on the facility's website and its noticeboard. Furthermore, the dissemination was done in the form of a PowerPoint presentation that were delivered to the managerial staff during the board meeting.
4. Timeline: The PowerPoint presentation was provided on Monday, 17th May, when the board meeting took place, while the posters were provided on the facility's website and noticeboard on 10th May.

Dissemination to the Broader Nursing Profession

Self-harm affects close to 18% of the U.S. teenage population (Dent et al., 2018). Hence, self-harm can be regarded as a significant public health challenge that affects a significant portion of this population. Since self-harm among adolescents is a national challenge, the doctoral project's findings must be disseminated to the larger nursing profession so that the recommendations can be considered, and hopefully, be adopted elsewhere. One way the findings will be disseminated to the larger nursing profession is through publication of a peer-reviewed article. The findings will be published in the American Journal of Nursing, which is characterized by a broad readership since it is an open-access journal. Furthermore, the journal is well recognized and highly ranked by various nursing scholars because all studies are thoroughly reviewed before publication.

Thus, the findings are more likely to trigger a change in practice since they will be published in a highly regarded journal.

Analysis of Self

As a Practitioner

The doctoral project has been beneficial to me in several ways. Of most importance, the project will be crucial in improving the quality of care I provide to individuals with self-harm behaviors since the project has empirically ascertained that CBT is an effective intervention against maladaptive behavior. Furthermore, as a practitioner, I have also appreciated the importance of collaboration with other nursing and multidisciplinary professionals in tackling healthcare delivery challenges. This is because the doctoral project would not have been comprehensive were it not for the input of other care providers, particularly those who volunteered to respond to the pre/postintervention surveys.

As a Scholar

The doctoral project has also enabled me to establish that a review of the existing evidence is fundamental in solving various healthcare delivery challenges and bridging various gaps in nursing practice. According to Tingen et al. (2019), nursing research ensures that emerging evidence or concepts are integrated into the nursing practice. Hence, ensuring that nursing services are responsive to the emerging healthcare delivery needs. This appreciation has encouraged me to embark on continued nursing education so that my knowledge and skills can remain aligned to the rapidly evolving healthcare delivery system and evolving patients' needs.

As a Project Manager

The doctoral project enabled me to utilize various leadership skills in resolving a healthcare issue. For example, I utilized practical communication skills in engaging the various stakeholders, such as the organization's management and my mental health colleagues. Effective communication with these parties ensured that the project was comprehensive. For instance, I utilized persuasive language for lobbying the facility's management to avail some of the resources needed when initiating the care providers' education program, such as a projector and the boardroom. Furthermore, persuasive language was also used in convincing the management to approve the undertaking of the project within the facility. Thus, as a project manager, I have become more appreciative of the importance of identifying strategic partners and utilizing practical communication skills when engaging them in order to collaborate with them towards resolving a specific healthcare delivery challenge.

Summary

As deduced from the doctoral project, nursing research is fundamental in solving various healthcare delivery challenges since it ensures that emerging evidence is adopted into nursing practice to optimize patients’ outcomes. The doctoral project has been able to empirically ascertain that CBT would effectively reduce the rising rates of self-harm incidents among adolescents in the US. Hence, tackling a public health challenge. Therefore, the doctoral project is in line with the EBP concept since the project entailed an analysis of literature to identify the best evidence that would assist in tackling the

topic of interest, followed by implementing the deduced evidence as recommended by the cited scholars.

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Appendix A: Work Plan

Activity	**WK1**	**WK2**	**WK3**	**WK4**	**WK5**	**WK6**	**WK7**	**WK8**
Introduction								
Background and Context								
Collection and Analysis of Evidence								
Findings and Recommendations								
Dissemination Plan								

Appendix B: Preintervention Survey

Unique Identifier: ________________________

1. How old are you?
2. What is your gender?
3. Have you ever attended to a patient with self-harm behavior?

   a. Yes

   b. No
4. If your response is yes to the question above, in a scale of 0 to 5, how can you rate your competence in treating the patient?
5. Which is your preferred treatment for self-harm?

   a. Antidepressants?

   b. Counselling

   c. Cognitive behavioral therapy

   d. Mindfulness-based therapy
6. Have you ever administered CBT to a patient with self-harm behavior?

   a. Yes

   b. No
7. Which is the ideal duration to prescribe CBT to a patient with self-harm behavior?

   a. 3 weeks

   b. 4 weeks

   c. 6 weeks

   d. 12 weeks

8. How many CBT sessions should the patient be prescribed per week?

   a. One session per week

   b. Two sessions per week

   c. One session every two weeks

   d. One session per month

9. In your opinion, does CBT assist a patient with self-harm behavior to identify negative unhealthy thoughts and behaviors, and replace them with positive adaptive ones?

   a. Yes

   b. No

10. In the future, are you willing to administer CBT to adolescents with self-harm behavior?

    a. Yes

    b. No

Appendix C: Postintervention Survey

Unique Identifier: ________________________

1. How old are you?
2. What is your gender?
3. Have you ever attended to a patient with self-harm behavior?

   a. Yes

   b. No
4. If your response is yes to the question above, in a scale of 0 to 5, how can you rate your competence in treating the patient?
5. Which is your preferred treatment for self-harm?

   a. Antidepressants?

   b. Counselling

   c. Cognitive behavioral therapy

   d. Mindfulness-based therapy
6. Have you ever administered CBT to a patient with self-harm behavior?

   a. Yes

   b. No
7. Which is the ideal duration to prescribe CBT to a patient with self-harm behavior?

   a. 3 weeks

   b. 4 weeks

   c. 6 weeks

   d. 12 weeks

8. How many CBT sessions should the patient be prescribed per week?

    a. One session per week

    b. Two sessions per week

    c. One session every two weeks

    d. One session per month

9. In your opinion, does CBT assist a patient with self-harm behavior to identify negative unhealthy thoughts and behaviors, and replace them with positive adaptive ones?

    a. Yes

    b. No

10. In the future, are you willing to administer CBT to adolescents with self-harm behavior?

    a. Yes

    b. No

Appendix D: Staff Education Presentation

THE USE OF CBT IN SELF-HARM PREVENTION AMONG ADOLESCENTS

STAFF EDUCATION PRESENTATION

INTRODUCTION

- The prevalence rate of self-harm is 18% in the country's teenage population (CDC, 2019).
- Self-harm affects adolescents' physical and mental health.
- It results in poor academic performance, reduced vocational capabilities, and social isolation.
- It also results in premature death due to suicide.
- Parents and guardians whose children engage in the self-harm are usually stigmatized.

EFFECTS OF SELF-HARM ON THE HEALTHCARE ORGANIZATION

- Self-harm incidents result in a higher financial burden.
- It results in health service utilization due to the manifestation of various comorbidities such as depression associated with self-harm.
- It results in prolonged hospital stay.
- Diminished treatment outcomes.

RISK FACTORS FOR SELF-HARM AMONG ADOLESCENTS

- Adolescents characterized with the following issues require more intense protection from self-harm;
  - Substance abuse disorders
  - Suicidal ideation
  - Borderline personality and mood disorders (Curtis et al., 2018).
  - Childhood trauma and abuse
  - Victims of bullying

COMMON SELF-HARM ACTIONS AMONG ADOLESCENTS

- Adolescents usually engage in self-harm in the following ways;
  - Drug abuse and overdose
  - Burning, hitting, and cutting
  - Risky sexual behaviors
  - Self-poisoning

BENEFITS OF CBT IN SELF-HARM PREVEVENTION

- Various experimental studies support the utilization of CBT in the prevention of self-harm.
- CBT can be administered in group sessions;
- Thus, enabling care providers to address several patients at a go (Kaess et al., 2019).
- CBT can compliment medications;
- Particularly among adolescents with self-harm comorbid with anxiety disorders or depression (Kaess et al., 2019).

BENEFITS OF CBT IN SELF-HARM PREVEVENTION

- 6 sessions of CBT can significantly reduce self-harm ideations, intent, and incidences.
- CBT increases the likelihood of full remission from self-harm behaviors.
- CBT is more effective in preventing self-harm compared to;
  - Dialectical behavioral therapy
  - Mentalization-based therapy (Freeman et al., 2014)
  - Interpersonal therapy
  - Multisystemic therapy

BENEFITS OF CBT IN SELF-HARM PREVEVENTION

- A combination of CBT and family therapy is effective in;
- Problem-solving and activating healthy behaviors;
- Among adolescents detected with the risk of self-harm and suicide events (Ougrin et al., 2015).

THE GOAL OF ADMINISTERING CBT IN SELF-HARM TREATMENT

- Enhancing a positive problem orientation and decreasing a negative orientation.
- Training in rational problem solving
- Assisting the patient to overcome impulsive behavior and careless decision-making (Washburn et al., 2016).
- Cognitive restructuring and activating more constructive behaviors.
- Emotional regulation and effective social skills.
- Equipping the teenager with crucial social skills regarding family communication.

HOW CBT FOR SELF-HARM SHOULD BE ADMINISTERED

- The treatment should be provided within a minimum of 12 sessions.
- The 12 sessions should be spread out in 12 weeks, which translates to a session per week (Washburn et al., 2016).
- The treated patient should be reassessed every month, for 9 months;
- To ascertain that he or she has not relapsed into the self-harm behavior.
- CBT can be prescribed in combination with a Selective Serotonin Reuptake Inhibitor (SSRI).

SUMMARY

- Self-harm is a significant public health challenge on the adolescents population.
- It affects their physical and mental health.
- It results in reduced quality of social interaction and poor academic performance.
- It results in a financial burden on the healthcare organization.
- CBT can assist the affected patients in rational problem-solving.
- It can also assist the patient to overcome impulsive behavior and careless decision-making.

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