

Princeton House Behavioral Health

today



Empathy Without Enmeshment Protecting Yourself from Vicarious Traumatization

Also in this issue:

Non-Suicidal Self-Injury
page 3

Holistic Care from Princeton House
pages 4-5

Inclusive Treatment for LGBTQ Patients
page 6

Motivational Interviewing
page 7

Self-Esteem Building in Teens
page 8



For more information

about the Women's Program at Princeton House, visit princetonhouse.org/women or call 888.437.1610.



Empathy Without Enmeshment

Protecting Yourself from Vicarious Traumatization

When behavioral health professionals and those in other helping roles work regularly with patients who have experienced trauma, they repeatedly hear stories of horror and fear. The cumulative effect can impact not only the work they do, but also their experience with the world around them.

For some, coping strategies may help manage this impact. Others are able to enhance their vicarious resilience, in which personal growth is experienced as patients grow and overcome adversity. Yet for many, vicarious traumatization is a real risk.

"Vicarious traumatization happens when you begin to question your own beliefs about safety and trust, and your world view becomes distorted," says Judith Margolin, PsyD, Clinical Director of the Women's Program at Princeton House. "It impacts your overall sense of meaning and hope to the point where you may no longer find joy in life."

The impact is generally more severe than compassion fatigue or burnout, according to Dr. Margolin. In addition to a distorted world view and hopelessness, warning signs can include:

- Rumination or preoccupation with patient experiences
- Nightmares or sleep disturbances
- Withdrawal from your family or activities that you enjoy
- Symptoms consistent with hyperarousal or hypoarousal, ranging from constantly being on guard to feeling numb
- The inability to find relief through time off

"As caregivers, our roles are challenging," says Dr. Margolin. "We must have empathy—yet to protect ourselves, we also need boundaries. It can be like walking a tightrope. The goal is to show compassion and empathy but not become enmeshed in our patients' experiences."

Dr. Margolin suggests these tips for reducing the risk of vicarious traumatization:

- Recognize it as a real phenomenon and be in tune with your own mental wellbeing.
- Balance your work with positive experiences, including playful activities in which the world can be seen as a trusted place.
- Practice regular self-care, such as healthy eating, sleeping, and relaxation strategies.
- Share feelings and concerns with peers or your own therapist.
- Look out for peers who may be at risk.

At the Princeton House Women's Program, vicarious traumatization is integrated in the training curriculum and regularly incorporated into team discussions and presentations. To refocus attention on the positive and the present, daily meetings begin or end with a meditative or participatory mindfulness practice. Topics range from acceptance and gratitude to kindness and compassion.

“There’s an old Cherokee legend that whatever you feed will grow stronger. We help each other highlight the positive, focus on the present, and feel safe in discussing concerns. Negative thoughts will happen, but we don’t have to get stuck in them.” — Dr. Judith Margolin, Clinical Director, Women's Program



For more information

about child and adolescent programs at Princeton House, visit princetonhouse.org or call 888.437.1610.

When Inflicting Pain Provides Relief

The tween and early teen years are a time of change, growth, and discovery. Unfortunately, a dramatically increasing number of children in this age group are discovering a maladaptive coping mechanism: non-suicidal self-injury (NSSI). In this type of behavior, a person deliberately destroys his or her own body tissue without suicidal intent.

According to a recent *JAMA* study,¹ emergency room visits for nonfatal self-inflicted injury among boys ages 10-14 increased by 93 percent between 2001 and 2015. For girls, this rate increased by 261 percent. Substantial increases were also seen in teens ages 15-19, especially for girls.

The trends are truly alarming, according to Kristy Champignon, LPC, LMHC, ACS, Adolescent and Child Clinical Manager at Princeton House's Hamilton site.

"Some instances of NSSI are a call for help or a desire to generate a feeling when someone feels numb," she says. "In other cases, young people are replacing intense emotional pain—which is difficult to understand and manage—with a physical pain that they can control."

"Tweens and teens are more frequently seeing NSSI as a viable option via peers, social media, television, and music," she adds. "It can quickly become a vicious cycle if they experiment with NSSI and then begin to rely on it for relief."

A BIOLOGICAL COMPONENT

The brain registers both emotional and physical pain in the same two areas: the anterior insula and the anterior cingulate cortex, according to Champignon. The onset of physical pain brings discomfort, but the removal of the pain stimulus provides the more pleasant experience of relief.

Due to some degree of neural overlap, this relief is sensed for both physical and emotional pain. Through NSSI, a child may inflict pain to find relief from an array of confusing, self-questioning emotions or from comorbid conditions like depression or anxiety.

SUPPORTIVE STRATEGIES

Champignon recommends that behavioral health providers be vigilant given the increasing incidence of NSSI among young people. If a child or teen is self-harming, it's critical to involve parents in educational strategies. This includes tactics for creating a safe environment for communication, validating painful emotions, supporting the use of coping skills, and fostering self-compassion.

Dialectical behavior therapy (DBT) is an excellent treatment modality in this population, because it focuses on the main needs of a patient who is self-harming:

NEED	DBT STRATEGY
Invalidating thoughts or feelings that may lead to NSSI	MINDFULNESS
Intense emotion or emotional vulnerability	EMOTION REGULATION
Ineffective communication of needs	INTERPERSONAL EFFECTIVENESS
Low threshold for stress; lack of skills in the moment	DISTRESS TOLERANCE

"At Princeton House, we teach DBT skills ranging from cope-ahead plans and communication skills to building a toolbox of options that young people can use in moments of distress. We help them understand that no matter how difficult things may seem, there are safe, healthy ways to address emotional pain and find relief."
— Kristy Champignon, Adolescent and Child Clinical Manager

1. Mercado, M, Holland, K, and Leemis, R. Trends in emergency department visits for nonfatal self-inflicted injuries among youth aged 10 to 24 years in the United States, 2001- 2015. *JAMA* 2017; 318(19):1931-1933.

Princeton House Delivers the Highest Levels of Care FOR YOUR PATIENTS



When Gary Snyderman first considered his vocational options, he found himself drawn to the idea of working with individuals with mental illnesses. In order to understand their complex situations, he knew he also needed to understand their physical health.

Today, as Director of Nursing at Penn Medicine Princeton House Behavioral Health, Snyderman is an advanced practice nurse with a PhD in psychology who is responsible for the overall provision of nursing services for the organization, including 24/7 inpatient nursing services at our main campus as well as nursing care offered at our outpatient sites.

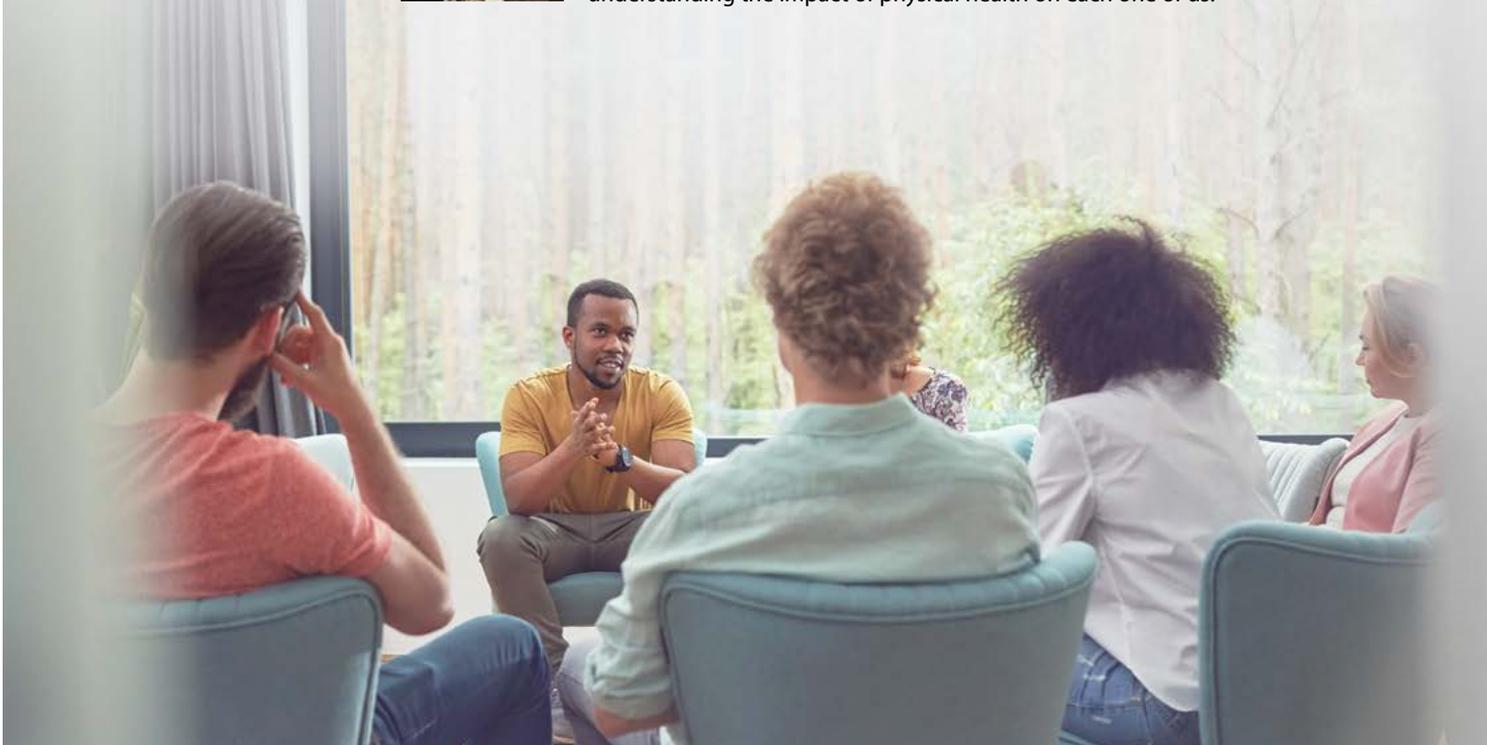
TREATING THE WHOLE PERSON, WITH THE WHOLE TEAM

“The holistic approach to care at Princeton House means that we work on behalf of our patients as a team: psychiatrists, nurses, social workers, psychologists, therapists, dietitians, and chaplains,” says Snyderman. “Each discipline has a unique perspective, which when added together, provides our patients with the best of us all.”

As the behavioral health division of Princeton Health, Princeton House patients benefit from seamless medical care while they are inpatients. Patients with a primary medical condition will, of course, be treated at Princeton Medical Center, where psychiatric consultations are provided. But when patients are medically stable and discharged, Princeton House stands ready to help them address their behavioral health issues. Conditions such as sleep apnea, stable asthma, diabetes, and COPD—as well as early pregnancy—are all safely managed during behavioral health treatment.



“We hold ourselves accountable for the highest quality of care,” says Richard Wohl, President of Princeton House Behavioral Health. “Our clinicians are often multiply certified and are engaged in our patients’ wellbeing—committed to healing the mind while also understanding the impact of physical health on each one of us.”



Expanding Roles for PRINCETON HOUSE CLINICIANS

Princeton House has one of the largest Departments of Psychiatry in New Jersey, with more than 50 employed psychiatrists and practitioners, many of whom are board certified in both psychiatry (or child and adolescent psychiatry) and addictions medicine.

As Princeton House expands to meet the needs of its growing patient population, the Department of Psychiatry has positioned its leadership team for the future through the following appointments and promotions.



Lorna Stanley, MD has been promoted to Senior Supervising Psychiatrist for the Department of Psychiatry at Princeton House. In this role, she will serve as departmental ombudsman, providing support and mentorship that includes assistance with work-related stress. Dr. Stanley joined Princeton House in 2003 and continues to serve as Medical Director of the Princeton outpatient site.



Arshad Siddiqui, MD has been appointed to the new position of Medical Director for Adult Outpatient Programs. Dr. Siddiqui joined Princeton House in 2013 and will continue in his current role as Associate Medical Director at the Hamilton outpatient site.

Dr. Siddiqui was recently recognized as a 2018 Top Doc by *New Jersey Monthly* magazine based on a survey of New Jersey physicians.



Madhurani Khare, MD has been appointed to the new position of Medical Director for Child and Adolescent Outpatient Programs to focus on program development. Dr. Khare became a member of the Department of Psychiatry in 2000 and will continue in her current position of Medical Director at the Hamilton outpatient site.



The two Medical Director positions complement the existing position of Medical Director for Women's Programs, held by **George Wilson, MD**. Dr. Wilson, who joined Princeton House in 1997, is the former Chair of the Department of Psychiatry, and has served in numerous positions during his tenure.



Jacqueline Zaremba, DPN, RN, APN-C has been promoted to the new position of Senior Supervising Advanced Practice Nurse for the Department. Dr. Zaremba will facilitate APN recruitment and provide support, supervision, and mentorship for the growing number of staff APNs. She joined Princeton Medical Center as a critical care nurse in 1980 and Princeton House as an APN in 2005, working with inpatient, outpatient, and eating disorders programs.

PRINCETON HOUSE IS ACTIVELY RECRUITING PSYCHIATRIC APNs.

To learn more, contact Ariana Sanjabi at 609-613-6131 or ariana.sanjabi@pennmedicine.upenn.edu.

▶ Having a comorbidity is not an uncommon occurrence. Studies have shown that adults with mental illness have higher rates of certain chronic physical conditions, including high blood pressure, asthma, diabetes, heart disease, and stroke.

For information

about sexual identity issues faced by children and teens, visit ustream.tv/princetonhealth to view “Coming out LGBTQ: A Sexual Identity Discussion for Families.”

Open Doors and Safe Spaces Ensuring Inclusive Care for LGBTQ Patients

It can take courage for any patient to seek behavioral health services and share extremely sensitive personal information. For LGBTQ patients, an additional layer of concern often factors in.

“Unfortunately, it’s likely that those who identify as LGBTQ have already faced stigmas at some point in their lives,” says Kyle Bonner, LCSW, LCADC, Coordinator of Diversity and Inclusion Programs for Princeton Health. “Identity-related negative experiences like bullying, trauma, and violence can precipitate the need for care. Seeking behavioral health care when you’re wondering if you’ll be treated differently can be especially intimidating.”

According to Bonner, behavioral health providers can help ease this anxiety by adopting simple strategies that ensure inclusivity as an overall approach to care for all patients. He offers these tips:

- Open the therapeutic relationship by asking how patients prefer to be addressed. They may use a chosen name rather than a birth name, and they may prefer specific pronouns that are not always evident based on appearance.
- Adjust the way questions are asked. For example, “Are you in a relationship with someone?” rather than “Do you have a girlfriend?” is more inclusive.
- Be mindful of your body language or any subtle reactions to a patient’s appearance.
- Post an inclusive sign on the door or in the reception area.

“Little adjustments in vocabulary and approach can make a big difference in building that comfort level with patients,” says Bonner. “These strategies can help LGBTQ patients know that they’re in a safe space and won’t be judged for who they are.”

As the therapeutic relationship evolves, a focus on self-compassion, acceptance, and empowerment can be invaluable for those who have faced criticism about their identity. Engaging parents or a loved one and educating them about specific challenges and how best to address them is also crucial. In addition, it can be reassuring to point out advances in LGBTQ rights in recent years.

Inclusivity at Princeton House

Princeton House’s work with patients identifying as LGBTQ focuses on dialectical behavior therapy (DBT) education and skills, empowerment, and inclusivity. Group therapy provides an inclusive environment for patients to express themselves in any way they choose while supporting their peers in doing the same. Staff receive education on gender identity and LGBTQ issues, and Grand Rounds are held on these topics at various departments across Princeton Health. A new hospital-wide committee on diversity and inclusion includes representatives from each department.

“We provide a safe space for all patients regardless of sexual identity or orientation, so that everyone can achieve their full potential,” Bonner adds.



“Little adjustments in vocabulary and approach can make a big difference in building that comfort level with patients. These strategies can help LGBTQ patients know that they’re in a safe space and won’t be judged for who they are.” — Kyle Bonner, Coordinator of Diversity and Inclusion Programs

Motivational Interviewing: **CREATING MOMENTUM FOR CHANGE**

When it seems like a behavioral health professional is working harder than a patient in a therapy session, it may be time to consider whether that patient may benefit from motivational interviewing (MI).

“Many treatment approaches assume that someone is ready for change, but actually people are often ambivalent about it,” says Jonathan Krejci, PhD, Senior Director of Clinical Development and Performance Improvement at Princeton House. “Motivational interviewing is a style of structuring conversation around change to help someone recognize and articulate their own reasons for change.”

Originally centered around substance abuse treatment, this style of therapy is now considered beneficial for a wide range of clinical problems, particularly when a therapist senses disengagement or resistance. By focusing on strengths rather than deficits, MI reduces defensiveness and instills confidence to provide momentum for change.

“Lasting change is more likely when a patient discovers their own motivations for it,” explains Krejci. “Behavioral health professionals can draw out these motivations with a person-centered, goal-directed approach.”

What is Motivation?

When considering what comprises motivation, Krejci refers to this MI formula for change:

$$M \text{ (Motivation)} = I \text{ (Importance)} + C \text{ (Confidence)}$$

Two elements are needed for motivation: Importance assumes that the patient understands the problem and expresses a desire, reason, or need to change. Confidence, which often can be overlooked, means the patient believes that change is not only desirable, but possible, and that he or she has the resources to effect change. When behavioral health providers identify and focus on the area that needs more work for a particular patient, motivation is more likely.

“When done well, motivational interviewing feels more like dancing and less like wrestling,” adds Krejci, who has provided comprehensive MI training for staff throughout Princeton House and across the state, in addition to once serving as an MI consultant for the United Nations. “It can be very empowering for patients, because it helps them recognize that they have the ability to create change rather than someone else solving a problem for them.”

Keeping PACE

Motivational interviewing (MI) is characterized by an attitude or approach to patients and to behavior change that can be summarized by the acronym PACE:

P

Partnership:

MI is best viewed as collaboration with another person, or a conversation between two people who have different but equally important areas of expertise.

A

Acceptance:

Acceptance is not the same as approval or agreement; rather, it facilitates change. When patients accept themselves as they are, change is possible.

C

Compassion:

Defined as the ability to actively promote another’s welfare and prioritize their needs, the use of compassion in MI ensures that change principles are applied in the interest of the patient.

E

Evocation:

The goal is to evoke motivation for change through a strength-based approach and techniques focusing on the patient’s own desires for change in their life.





A Boost of *Self-Esteem* for Teen Girls

In a recent psychoeducational group for teen girls at Princeton House, participants were asked to speak to themselves using language as if they were speaking to a friend—meaning to treat themselves less critically. This strategy is one of many designed to build confidence and empower teen girls as part of a new Building Self-Esteem Group.

Originally designed as a summer offering, the group is now a permanent fixture in the Teen Girls' curriculum in Princeton based on positive feedback from participants.

"Self-esteem goes far beyond appearance or the things you do well," explains Michelle Reuben, MEd, LPC, ACS, Clinical Manager of the Teen Girls' Program at Princeton House. "We focus on growth across all areas of life, empowering and motivating patients to be their best selves—whatever that might look like for each person."

With this continually expanding curriculum, the group begins with an exercise, video, or worksheet designed to provoke thought and inspire discussion. For example, patients may list five things that brought them peace that day, or three things they love about life. Throughout the group process, patients are encouraged to:

- Notice judgments
- Reframe negative thoughts
- Foster positive self-talk
- Validate feelings
- Understand that it's OK to make a mistake
- Identify and build on strengths



Patients in this age group are often going through similar transitions and challenges, according to Reuben, so peer-to-peer feedback is particularly important.

*"Self-esteem
can vary every day,*

but it needs to be practiced and continually refined to grow," adds Reuben. "We provide a safe space where peers can discuss sensitive topics, support each other, and build resiliency."

For more information

about the Teen Girls' Program at Princeton House, visit princetonhouse.org/teens or call 888.437.1610.