“Self-injury involving cutting, burning, etc. can be seen as a symbolic way of expressing deep distress—a nonverbal form of communication in which the feelings are externalized, through the body, where they can be dealt with in a more visible way. Yet because of its very disability, self-injury is often treated with mistrust and fear”.

-Self-injury Survivor
(Levenkron, 1998)
Definition

Self-injury is self-inflicting bodily harm of a socially unacceptable nature performed to reduce psychological distress (Craigen, Healey, Walley, Byrd, & Schuster, 2008).
Why should we focus on the problem?

MAGNITUDE OF THE PROBLEM

- Mental health professionals are seeing an increased number of individuals who self-harm in their clinics, agencies, and schools ("The New Anorexia").
- A recent study showed that among third graders, 7.6 percent had intentionally hurt themselves, compared to 4 percent of sixth graders and 12.7 percent of ninth graders (Barrocas, 2012).
Self-Injury and the DSM-V

• Nonsuicidal self-injury (NSSI) was in DSM-IV only as a criteria for different disorders (e.g., borderline personality disorder (BPD) and stereotypic movement disorder).
• In DSM-V, (NSSI) is included under section 3, “conditions for future study.”
  • Section 3 disorders generally will not be reimbursed by insurance companies, since they are still undergoing research and revision to their criteria.
• In DSM-V, Personal History of Self-Harm is listed as a V code (V15.59).
  • V codes covers conditions and problems that may affect the diagnosis, course, prognosis, or treatment of a patient’s mental disorder.
  • V codes, though, are NOT mental disorders.
  • Note: Many payers to reimburse for services linked to V codes.
Self-Injury and the DSM-5

Proposed Criteria for NSSI requires:

A. In the last year, the individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body of a sort likely to induce bleeding, bruising, or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), with the expectation that the injury will only lead to minor or moderate physical harm (i.e., there is no suicidal intent).

B. The individual engages in the self-injurious behavior with one of more of the following expectations:

- To seek relief from a negative feeling or cognitive state,
- To resolve an interpersonal difficulty
- To induce a positive state.
Self-Injury and the DSM-V

C. The behavior must also be associated with 1 of the following criteria:

- Interpersonal difficulty or negative feelings and thoughts (e.g., depression, anxiety, generalized distress or self-criticism) immediately prior to the self-injurious act. premeditation, and ruminating on (non-suicidal) self-injury.
- Prior to engaging in the act, a period of reoccupation with the intended behavior that is difficult to control.
- Thinking about self-injury that occurs frequently, even when it is not acted upon.

D. The behavior is not socially sanctioned behaviors (e.g., body piercing, tattooing, part of a religious or cultural ritual) and is not restricted to scab picking or nail biting.

E. The behavior or its consequences cause clinically significant distress or interference in interpersonal, academic or other important areas of functioning.

F. The behavior does not occur exclusively during psychotic episodes, delirious, substance intoxication, or substance withdrawal. In individuals with neurodevelopmental disorder, the behavior is not part of a pattern or repetitive stereotypes. The behavior is not better explained by another mental disorder or medical condition (e.g., autism spectrum disorder, intellectual disability, etc.).
What Do We Know?

- Research remains unclear about the best approach to working with clients who self-injure.
- Majority of those who seek help for self-injury are dissatisfied with the treatment they receive.
- Many feel like their treatment providers failed to understand and judged them for their behaviors.
- Many are in fear that they will have “consequences” for revealing their self-injury.
How DO We Respond?

- The sight of these injuries can be alarming, disturbing, and gruesome.
- Many mental health providers may feel uncomfortable working with this population and are subsequently quick to pathologize these behaviors.
- Many mental health providers lack a clear understanding of this phenomenon (i.e., punish, suspend, expel, etc.).
- Attitudes and behaviors like these can have wide-ranging implications for individuals who self-injure.
- Thus, pre-service training and professional development on the topic of self-injury is paramount (but certainly lacking).

“Helper, Know Thyself”
Modes of Self-Injurious Behavior

**Cutting**
- Generally, self-injury involves cutting the skin with a sharp instrument (70-90%) of individuals.

- Scratching
- Self-Hitting
- Head banging
- Burning
- Interference with wound-healing
- Inserting objects under the skin

Extreme forms of self-injury:
- Bone breaking
- Limb amputation
- Eye enucleation

(Nock & Favazza, 2009).
Common Tools

- Knives
- Razors/Blades
- Scissors
- Safety Pins
- Broken Glass/Bottles
- Fingernails

“Scars have the strange power to remind us that the past is real.”

_ McCarthy, All the Pretty Horses_
Age: One’s first experience with self-injury is estimated to occur within early adolescence but studies are showing that children (ages 6-7) are engaging in the behavior at increasing rates.

Gender: 3 to 4 times more common in women than men. Newer research argues this statistic.

Race/Ethnicity: Research has neglected the examination of other racial and ethnic groups. Majority of research on white/middle class girls/women.
Characteristics:
Additional Identifying Factors

- Intelligent/high achieving
- High relationship with:
  - Depression
  - Anxiety disorders
  - Personality disorders (i.e., borderline personality disorder)
  - Eating disorders or disordered eating
  - Substance abuse
  - Kleptomania
  - Impulse Related disorders
  - Obsessive Compulsive Disorder
INFLUENCES
(Risk Factors)
Psychological

- Using physical pain to ward off emotional pain.
- Interpersonal vulnerability (deficits in emotion-related skills).
- Inability to express feelings verbally.
  - “The pain inside was so much and like I didn’t want to talk about it so it was just easier to cut and feel some sort of physical manifestation of the emotional pain.
  - “Some people cry, I cut myself.”
- Poor ability to tolerate negative states.
- Suppression of aversive thoughts/feelings.
Psychological

- Ineffective Coping Mechanism.
  - “I didn’t have any control in my life and that [self-injury] was the only way to exercise some kind of command over what was happening to me.”
  - Juliana talked extensively about cutting as a coping behavior. She often switched coping behaviors. For example, if she stopped cutting, she started smoking or drinking. She also shared when her eating disorder was at its’ peak, her cutting was at it’s lowest point and conversely, when she “recovered from the eating disorder, the cutting got worse.”
- Inability to express feelings of anger toward another person.
- Unconscious desire to inflict pain on a particular person.
- To punish oneself.
Psychological

- Poor problem solving abilities (Choate, 2012).
- A Release:
  - “Seeing my own blood was like, a rush for me. That sounds so gross...But, seeing blood like trickle down my leg or something, felt really good to me. It felt empowering, it felt dangerous, I guess and that gave me a rush and a feeling, almost like playing God...that is a little extreme. But, and so then, basically, you know, I would let it bleed and I would watch it, and I would be like, wow, this is intense.”
- To end period of depersonalization or to “ground” the individual.
- To provide a sense of control. (However, one study (Benum, 1983) found that 70% of those who self-injure feel no control over the act).
- For attention:
Biological

- Physiological antecedents and consequences which may instigate the behavior, making it difficult for individuals who self-injure to stop (Winchel & Stanley, 1991; Naomi, 2002).
NEUROTRANSMITTERS

- **SEROTONIN**: Lower levels in those who self-injure.
- **ENKAPHALINS**: Their role is to suppress pain and regulate emotion. Enkaphalins have a generally pleasurable effect, individuals who self-injure may harm themselves to induce the production of them (Favazza, 1998)

GENETICS:

- Genetic predisposition toward high emotional/cognitive reactivity (Nock, 2009).
Environmental-Familial/Friends

- Strong correlations between childhood physical/sexual abuse (up to 79% of those who self-injure report a history of child abuse, maltreatment, and/or neglect (Yates, 2009).
- Parental drug/alcohol abuse.
- Real or perceived lack of support.
- Distant parent-child relationships.
- Experienced loss or traumatic event (parental loss).
- Have friends who self-injure

"I had a lot of friends that did it too, a lot of girlfriends and so, I guess it seemed normal because a lot of my friends were very smart girls, so I thought it must be kind of normal for smart girls to cut themselves."
A Learned Behavior

“ I don’t think that I would have cut myself if I hadn’t heard about it...In class we read a book that talked about girls with problems and I was like “I am a girl with problems”, and it was like here is what people do when they have problems. I guess in a way, I wanted to do something to be like I think I am really depressed, rather than just talking about it.”

For another participant, she first learned about cutting from a movie, Secret Cutting, on the USA Network. Shortly after watching the movie, she shared, “I tried it and it was magic.”

Conformity-To fit in or bond with other friends/students.

To stand out.
Common Questions

1. Can self-injury be addictive?
2. Is Self-injury different than suicide?
3. Are piercings and tattoos typical of self-injury?
4. Is the individuals who flaunts his/her wounds a phony?
1. Addictive Qualities of Self-Injury

- Biological or psychosocial influences.
- Can serve as a form of self-medication.
- Many describe a “craving” for the behavior.
- Many describe a difficulty in controlling the urge.
- Describe a relief after the act is complete.
- Relapse is common.
- Individuals increasingly seek out more intense forms of self-injury, over time. (As if, they build up a tolerance).
- Role of neurotransmitters and endorphins.

This has direct implications for treatment.
2. The Relationship: Suicide and Self-Injury

Separate behaviors?
• Majority of research makes stark distinctions between the two (Walsh, 2006).
• Suicide and self-injury have differences in intent and outcome (symptom relief vs. a signal to end one’s life) (Whitlock, 2010).

Similarities?
• 50%-75% of individuals who self-injure have made at least one suicide attempt (Nock & Favazza, 2009).
• The individual who self-injures is 18 times more likely that the rest of the population to eventually commit suicide (Ryan, Clemmett, & Snelson, 1997).

A continuum of behaviors?
• Self-injury and suicide can be viewed as behaviors on the same continuum with suicidal behaviors being on the extreme end of the continuum.
3. Tattoos and Piercings = Self-Injury?

• Focus on intent.
• Artistic expression or symptom relief?
• Examine frequency.
• Is there an increased need to get tattoos/piercings?
• Consider modes of tattoos/piercings
4. Is the individual who flaunts self-injury a “phony”?

- Consider the behavior
- Can you “fake” self-injury?
- Should those who harm themselves for attention be ignored?
Working With Individuals Who Self-Injure: An Overview

1. Understanding your audience
2. Ethics
3. What To Avoid
4. General Approaches/Philosophy
1. Know your audience...

- Understand that the majority of those seeking treatment may be referred by others. Thus, expect resistance and possible manipulation, and/or hiding one’s scars/wounds).

*NOT ALWAYS THE CASE*

- “Jane”-initially started cutting in order to get the help she needed. “I remember thinking that I wished that I could get raped so that I could go to counseling…I think one of the main reasons I started cutting was because I felt I needed counseling.”
2. Ethical Considerations

- Duty to Warn?? (A gray area)
- Consider age of client.
  - Is it different working with minors?
- ALWAYS assessing suicidality.
- Weigh the risks and benefits.
  - A professional working with a client may be in legal jeopardy for non-disclosure if the client reveals that she is self-injuring and later seriously injures him/herself.
  - Familial Issues: Will breaking confidentiality further harm the client?
- Consider the context.
  - School vs. community setting (know your agency’s stance).
  - Does your school/agency have a self-injury protocol?
- Consider the extent of the wounds. Do they require medical attention?
- Always communicate where you stand with confidentiality, right from the start.
- Always seek supervision/consultation.
### 2. Ethical Considerations Cont...

#### What Does Danger to Self-Mean?

**Continuum of symptoms: Self-Injury**

<table>
<thead>
<tr>
<th>Less Severe</th>
<th>Moderately Severe</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Harm</strong></td>
<td><strong>Cutting</strong></td>
<td><strong>Burning</strong></td>
</tr>
<tr>
<td>Scratching</td>
<td>Rubbing</td>
<td>Cutting with Large Objects</td>
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<tr>
<td>Skin Picking</td>
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<td>Severing</td>
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<tr>
<td>Biting</td>
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<td>Eye Enucleation</td>
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<td>Pinching</td>
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<tr>
<td><strong>Psychological Harm</strong></td>
<td><strong>Depression</strong></td>
<td><strong>Desperation</strong></td>
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<tr>
<td>Low self-esteem</td>
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<tr>
<td>Anxiety</td>
<td>Crippling Anxiety</td>
<td>Revenge</td>
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<tr>
<td>Inability to Cope</td>
<td>Impulsivity</td>
<td>Wanting to Punish</td>
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<tr>
<td></td>
<td></td>
<td>Suicidal Inclination</td>
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</table>
3. What to Avoid

• Refrain from judgment.
• Do not scold the student for self-injuring.
• Do not let your own feelings about the client’s behavior get in the way.
• Avoid no-harm contracts/Don’t make the person stop their behaviors.
  • May lead to more extreme behaviors.
  • Many share that they may have stopped because they feel guilty, although symptoms still remain.
• Avoid categorizing your clients as “cutters”.
• Avoid an expert stance:
  Clients viewed their experiences as negative when their counselors set the direction of the session, conveyed the idea that they had all the answers, and often talked down to them.
3. What to Avoid

- **Be cautious of behavioral approaches**
  - Ice cubes, elastic bands, etc.
  - Realize that the above behaviors continue to associate physical pain with emotional pain.
  - It is important to recognize that they are only short-term solutions, or the “band-aid approach” to dealing with self-injury.
  - Remember: Alternatives focus on the outward, visible wounds, not the underlying symptoms.
4. General Philosophy:
Common Truths To Consider

• The majority of individuals who self-injure feel like they are “crazy”. Thus, it is important to normalize the behavior.
• Many feel a sense of shame/embarrassment. Thus, it is critical to create an atmosphere free of judgment.
• Working with this population takes time and requires patience. Avoid expectations for a quick recovery.
• Create a forum for voices to be heard.
Interventions....
Theoretically based interventions

• Cognitive behavioral
  • Influences of thoughts on behavior
  • Self-talk strategies
• Narrative approach
  • Helps the client to share and ultimately redefine her or his life story.
  • Narrative approaches focus on externalizing one’s problems in an effort to discuss them from an outsider perspective. Oftentimes, clients will present stories in which they and the problem is fused (i.e., cutters).
  • Thus, it is important to challenge this nomenclature and encourage the client to attempt the view the act of self-injury
• Melding of different theoretically based interventions (i.e., Adlerian, Narrative, Feminist, Cognitive Behavioral) aimed at
  (1) the Relationship
  (2) Investigation
  (3) Interpretation
  (4) Reorientation.
Establishing Rapport:

Importance of establishing rapport with individuals who self-injure is CRITICAL.

- “Back to Basics”---Rogerian concepts.
- Trust.
- A Collaborative Relationship--“It was kind of like a partnership. It was like a partnership of the two of us against the cutting.”
- Genuine, non-expert stance (As your knowledge grows, don’t assume you know everything).
- “A Listener”.
- A friendship: “A friendship that extends beyond the 1-hour counseling session.”
- Compassion.
- Learn who your client is beyond their self-injury.
Conducting A Thorough Assessment

- Age of Onset
- Course of behavior (has it increased or decreased in frequency?)
- Change in self-injurious behavior over time.
- Medical complications (i.e., stitches, infections, etc.).
- Types of tools used?
- Does the individuals engage in wound care?
- Does the individual share tools with others?
- Emotional states when self-injuring.
- Triggers leading to self-injury.
- Others knowledge of self-injury.
- Recent life experiences, past traumas, current stressors.
Treatment Interventions: History

Build a developmental history with your client.

- Gain an understanding of the interplay of biological, psychological, and environmental factors.
- Explore major events in client’s life that may have led to behavior.
- Gain knowledge about family of origin issues.
- Explore history of mental illness in client and/or family.
Treatment Interventions: Support Systems

- Assess systems of support.
  - Make a list of people he/she can use as a support.
  - Evaluate current influences of support in client’s life (positive vs. negative).
  - Ask questions that explore the client’s ability to ask for help/support.
Focus on the Underlying Issues

• View cutting as a symptom. The underlying issues drive the treatment approach and treatment focus.

• Focus, then, should be on underlying issues that drive the cutting.

  “I felt like it was all intertwined so you shouldn’t just have this one goal to stop the outward symptoms when the inward symptoms were just as important.”

• With this in mind:

  “When the cutting stops, the problem is NOT fixed.”

• Counselors should never rely on the absence of cutting as the only indicator of progress in therapy.
Treatment Interventions: Using the Scars as a Tool

◆ At each meeting, ask the client whether or not there are any new injuries.
  • Consider context here. In schools, this may not be possible and/or appropriate. Also, please note to only do this once a relationship has been established.

◆ Speak the language of the wounds.
  • “If your wounds could speak, what would they say about you.”
  • What were you feel before, during, and after you harmed yourself.
  • When you look at your scars what do you think/feel?
  • You must have really been hurting. Tell me about the feelings that led up to this episode.
Treatment Interventions: Building Emotional Intelligence

Expand feelings vocabulary.

- Assess your client’s ability to express a range of feelings verbally.
- Focus on the basics
- Develop relationship between thoughts and feelings
- Help your client identify what they are feeling.

Making a list....

- Make a list with your client.
- Go through the list with client. Ask, “Have you experienced this feeling lately? If yes, have you communicated it to someone?
- Process this exercise with client. Was it easy or hard? Which types of feelings were hardest to find words for?
Treatment Interventions: Warning Signs

• Identifying “Red Flags” or “Triggers” to their self-injury.
• Keep a log of it in a journal.
• Bring journal to session and process ways of paying attention to triggers and changing patterns.
Treatment Interventions: Coping Skills

Assess coping skills (building emotional regulation).
- Assess past and present coping skills.
- Discuss with your client how self-injury has served as a coping skill for them.
- Create a list of alternatives and additional coping behaviors the client can utilize in place of his/her self-harming behaviors.
- Practice coping skill in session (if possible) and assign for out-of-session homework.

Specific coping strategies:
- Drawing/painting
- Journaling/Writing Poetry
- Mantra
- Using music to express feelings
- Exercise
- Relaxation Exercises/Imagery
- Meditation
- Letter writing
Use Of A Personal Mantra

- Describe/Define Mantra.
- Talk about its’ utility.
- Have client come up with his/her own mantra (in session or as a homework assignment).
- Get creative: illustrate and decorate sheet with Mantra.
- Encourage client to post in a visible place.
Family Counseling Approaches

• Explore families’ reaction to the adolescent’s self-harming behaviors.
• Educate about self-harm and the seriousness of the behavior.
• Improve family communication and foster a sense of connectedness for the individual.
• Facilitate family awareness as how to best help the family member who is injuring herself/himself.
• Help to foster more meaningful and closer relationships between parents and teens.
• Create a safety plan with the family.
A Self-Harm Survivor

I have indulged myself in the worlds of dance, art, music, and literature.
I have succeeded in the worlds of history, mathematics, and science.
I have given up my childhood for a world of premature responsibility and suffered greatly from it. But from that I have gained a world of knowledge and respect.
I have rewarded myself with a world of love, full of friends and family.
I have earned and kept to myself the love of a man that I would die without.
I have made people mad, and made them hate me.
I have made people cry from laughter and earned the respect of even enemies.
I have made a world of mistakes and bad decisions.
But I have made up for them with a single good act of apology.
I have lied but never hidden from the truth.
I have endured countless deaths and survived my own near death experiences.
Yet I still await my 16th birthday.
Time may fly but not fast enough.
I cry at the thought of the worlds I have yet to come to, yet to conquer, yet to claim.
Looking up.
Face forward.
I await these worlds with a head held high.
....As if there was any other way to welcome these worlds.