

# NON-SUICIDAL SELF-INJURY

## WHAT YOU NEED TO KNOW

BY BROOKE LEWIS, MA, RCC

It began with an urgent phone message and frantic email from Sandra, the mother of a 14-year-old daughter, Lizzy. Sandra had just found out Lizzy had been cutting and booked for my first available appointment.

Our first meeting was split, speaking with Sandra first and Lizzy afterwards. Sandra explained how she felt blindsided by the news. She teared up as she spoke about her loving, compassionate, funny daughter. Sandra shared about feeling lost, wanting desperately to help Lizzy but not knowing how. I walked Sandra back to the waiting room and tried to get Lizzy's attention.

Lizzy was sitting with both feet pulled onto her chair and her knees close to her chest. Her head was down and her hair blanketed her shoulders. She was absorbed in technology. Lizzy looked up, pulled out her earbuds, and handed Sandra her phone. I asked if she would like a beverage before we started. She gave me a half-smile, said no, and walked, somewhat stiffly, with me to the office. I made small talk along the way about the weather, and Lizzy played along. She plunked herself onto the couch across from me and let her eyes wander around the room for a second. Her gaze settled as we started our conversation.

This is the all-too-familiar start to many of my sessions with clients of Lizzy's age. While Sandra believed the most recent occurrence of cutting was the first, Lizzy said it was not. The first time had occurred two years previously. She spoke about "trying it out" once or twice before, but the most recent episode had been once or twice a week for about two months before her mother found out.

With authentic curiosity, I gently inquired about her experience and her life. She was six months into Grade 9 at high school. She had two or three close friends she had met that year. She had experienced bullying in middle school, which left her feeling excluded and hurt. Lizzy described her home life as "okay, I guess." She talked about her parents arguing all the time and how her siblings all had something special about them. Lizzy didn't believe there was anything special about her. She did, however, describe feeling pressure from others to do well in school and to be happy.

### RESEARCH FINDINGS

Non-suicidal self-injury (NSSI) is intentional self-inflicted injury to one's body without suicidal intent.\* The behaviour results in bleeding, bruising, or pain with the expectation that the behaviour will lead to mild or

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*\*For information on duties to report, please consult Duties to Report and Protection When Reporting:  
<http://bc-counsellors.org/app/uploads/2015/10/Practice-Summary-Duties-to-Report-Updated-June-2015.pdf>.*



"PARENTS OFTEN FEEL SURPRISED, SCARED, CONFUSED, AND HELPLESS AFTER FINDING OUT ABOUT THE SELF-HARM. SOME BELIEVE THE BEHAVIOUR IS FOR ATTENTION, WHILE OTHERS FEEL FAILURE AND TAKE OWNERSHIP FOR THE TEEN'S CHOICE."

moderate physical harm. Traditionally, NSSI has been left out of the DSM or paired as a symptom to Borderline Personality Disorder. As of the DSM-5, NSSI has been included under section III, conditions for further study.

To meet the criteria for NSSI, an individual must have engaged in NSSI behaviour five or more days within the past year. An expectation of relief from a negative feeling, acquiring a positive-feeling state, or resolution of an interpersonal difficulty accompanies the behaviour.

Additionally, the self-injury must be associated with one of the following: interpersonal difficulties or negative feelings or thoughts occurring in the period immediately prior to the self-injurious act, thinking about self-injury that occurs frequently, or a period of preoccupation with the behaviour that is difficult to control. The behaviour is not socially sanctioned, like tattooing or piercing, and causes significant distress in interpersonal, academic, or other areas of functioning.<sup>1</sup>

NSSI occurs in one to four per cent of the general population and in 14 to 39 per cent of the adolescent population.<sup>2</sup> Amongst female adolescents, there has been a 110 per cent increase in hospitalizations in relation to intentional self-harm and a 35 per cent increase for males over the past five years. While a variety of intentional self-harm behaviours were noted, NSSI rated as the second-highest presenting form.<sup>3</sup> Risk factors may include adverse life events such as victimization or trauma, stressful life events, depression, anxiety, substance use, and a family history of self-harm.<sup>4</sup>

I never sought out to work with NSSI. It found me. I have always been drawn to work with adolescents, especially in addictions, and that's where I focused. I worked in day and residential treatment for teens struggling with substance use, followed by work at a private high school and then in private practice.

I don't recall much training, or even mention, of self-injury in my

educational journey. Luckily, I didn't find the issue frightening — instead I found it intriguing. What creative individuals! I would have never thought of self-harm as a coping strategy — and yet there it was. My curiosity was piqued, and I began self-directed learning through reading any books I could find on the topic. At that time, there were few books available, and so, as it is for many other therapists, my clients taught me.

### EMERGING THEMES

I have noticed some themes over the years. Many of these young women and men have a sense of being disconnected and alone, they feel deeply and don't like it, and they are very worried about others' perceptions of them. There is a strong fear of expressing their feelings to others, especially their parents. Once a therapeutic alliance is built, these clients tend to open up and almost explode with sharing their stories. Additionally, clients tend to be ritualistic in their behaviours. They use

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the same cutting instrument, cut in the same room of the house, cut in a certain direction or a certain number of times, and have some sort of hygiene ritual afterwards.

In the case of Lizzy, much of her purpose behind cutting was “to feel better.” Lizzy described feeling deeply, which often felt overwhelming. The first time Lizzy cut was during the time she was being bullied. She wasn’t sure where she got the idea from; it just seemed like a natural thing to try. Entering into high school was especially stressful for her, because she was very concerned about fitting in and finding friends. What if the bullying happened again? What if people didn’t like her? Mixed with her concerns were hormonal changes. Lizzy experienced menarche during the summer prior to entering Grade 9. The final straw that increased Lizzy’s NSSI was a fight with her best friend. Lizzy didn’t feel she could talk to her parents about the fight because they were always fighting. Moreover, Lizzy and her parents didn’t have much time together, as her

parents both worked long hours and tended to retreat into their tablets once home. Lizzy didn’t want to bother them, so she tried to take matters into her own hands.

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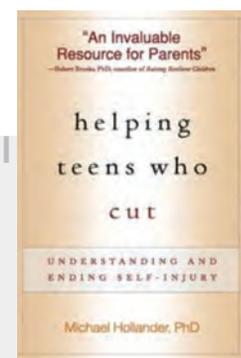
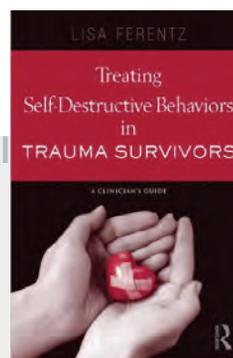
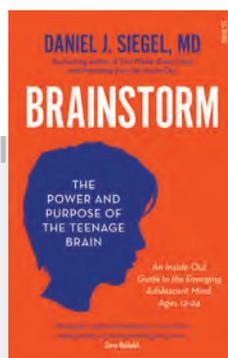
### SUGGESTED THERAPIES

Different perspectives have been applied to NSSI to try to make sense of it and provide treatment options. Klonsky<sup>5</sup> conducted a review of literature to explore the functions of NSSI. A total of seven functions was identified: affect regulation, anti-dissociation, anti-suicide, interpersonal boundaries, interpersonal influence, self-punishment, and sensation seeking. The most commonly cited function is affect regulation. Thus,

## NSSI RESOURCES

While research has been increasing in this area, there is still a lot to learn. An organization, International Study of Self-Injury (ISSI), has been formed to help bring researchers and clinicians together. More locally, Dr. E. David Klonsky is the director of the Personality, Emotion, and Behaviour Lab (PEBL) at UBC, and Dr. Alex Chapman is the director of the Personality and Emotion Research Lab (PERL) at SFU. Resources are available for counsellors and clients.

► To learn more about NSSI, I highly recommend visiting the website for Self-Injury Outreach and Support [www.sioutreach.org](http://www.sioutreach.org).



Dan Siegel’s *Brainstorm* is a great book for a basic understanding of the adolescent brain and what is happening developmentally and is appropriate for counsellors and clients alike. While it does not address self-harm, I believe it’s important to have a general understanding of the teenage brain when dealing with self-harm. Having an understanding can help guide the counsellor in adapting strategies or skills to be more age appropriate.

Lisa Ferentz’s book *Treating Self-Destructive Behaviors in Trauma Survivors* is a great resource to assist in perspective-building for counsellors.

Lastly, Michael Hollander’s book *Helping Teens Who Cut* is helpful for both parents and counsellors and looks at self-harm from a dialectical behaviour therapy perspective.

treatment of NSSI focuses on affect regulation.

Cognitive-behavioural therapies, including problem-solving therapy, dialectical-behaviour therapy, and standard cognitive-behaviour therapy, tend to focus on psychoeducation, skill-building, behavioural interventions, and cognitive restructuring. Psychodynamic therapies focus more on processing past life events, generating positive interpersonal relationships, and raising awareness of emotion.<sup>6</sup> Expressive therapies may also assist in treatment; the use of art, collage, music, sand tray, or movement has been used with benefit by some counsellors.<sup>7</sup>

As with most other presenting concerns in therapy, the use of an eclectic approach might be best suited for these clients. I have also found motivational interviewing to be helpful to build awareness and develop decision-making skills, especially with my adolescent population.

Mindfulness is another beneficial skill set when working with NSSI. The mindfulness movement has exploded over the past 10 years, resulting in much research and application within a broad spectrum of health and wellness fields. Using mindfulness with an adolescent population calls for some creativity on the counsellor's part. Traditional breathing or awareness-building exercises might result in your client shutting down out of disinterest. To build mindful awareness, the counsellor may want to start incorporating mindful questions such as "What are you noticing?" or engaging the client in focusing on the here and now by looking around the room to find items that match all of the colours of the rainbow, noticing through the senses, or using a textures-and-textiles box.

Something I use with my clients is Lisa Ferentz's CARESS.<sup>8</sup> I stumbled

across Ferentz's work while attending the Psychotherapy Networker Symposium, an annual conference held in Washington, D.C. Ferentz, who is the creator and director of the Institute of Advanced Psychotherapy Training and Education in Philadelphia, led a workshop focused on treating self-destructive behaviours in trauma survivors. Ferentz is able to conceptualize self-destructive behaviour by pulling from neuropsychology, trauma research, and attachment theory.

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## PERSPECTIVE ON PARENTS

Another aspect of working with teens who cut is parents. Parents often feel surprised, scared, confused, and helpless after finding out about the self-harm. Some believe the behaviour is for attention, while others feel failure and take ownership for the teen's choice. Working with the parents on NSSI education, adolescent brain development, and communicating with

teens has been very helpful in my practice.

Two of the most common questions parents raise are: "Is this for attention?" and "Does this mean my child is suicidal?" The answer to both is no, but these concerns are common myths about NSSI. It is often quite a while before NSSI behaviour is discovered. Teens go to great lengths to ensure their

self-injury is private, which is the exact opposite of attention seeking. Additionally, the self-injury is their chosen form of coping, and it does not necessarily mean the teen is a suicide risk. However, it is important for counsellors to ask about suicidal thoughts, ideations, and plans, as we would with any other client displaying self-destructive behaviour.

activity. CARESS is composed of three 10-minute stages. The first, Creative Alternative, encourages clients to find something artistic to do, such as painting, collaging, colouring, sculpting, or anything else to express emotion through art. The second stage, Release Endorphins, encourages the client to release endorphins naturally through physical activity, laughing, or hugging. Lastly, the client is encouraged to engage in Self Soothing: reading, hand massage, a bath, etc.

To help prevent dissociation, clients are asked to set a timer for 10 minutes per activity. When the timer buzzes, the client can repeat that step one more time or move on.

The role of the counsellor begins in proposing CARESS and helping the client brainstorm a few options for each of the three areas. The counsellor may also help the client create a CARESS kit, including all the things needed to complete CARESS. The client is asked to practice CARESS once per day to get used to the process prior to trying it when feeling the urge to self-harm.

### AN APPROACH FOR LIZZY

For Lizzy, an eclectic approach worked best. Together, we set goals for treatment, which included increasing self-esteem and managing emotions. By accomplishing these two goals, Lizzy and I both believed the NSSI would reduce on its own. Treatment included psychoeducation regarding the arousal system, the brain, and emotions. Behavioural techniques were used and encouraged to provide alternative means of emotional regulation. Expressive activities were used to help Lizzy learn to express herself. All of the treatment was intertwined with encouragement and a focus on strengths.

Sandra and her husband were very

open to connecting with me and eager to learn about NSSI. Together, we focused on communication skills such as active listening and encouragement. We practised via role-playing how to connect with Lizzy in an open-minded, non-judgmental manner. I also provided Sandra and her husband with education regarding NSSI and addressed any questions and misconceptions.



**AS WITH MOST OTHER PRESENTING CONCERNS IN THERAPY, THE USE OF AN ECLECTIC APPROACH MIGHT BE BEST SUITED FOR THESE CLIENTS.**

### MORE WORK AHEAD

NSSI rates have been increasing among the adolescent population. While research is being done, there is a lot more to do. Reviews of literature have been completed to help organize the research that is available on prevalence rates, functions, and treatment. Empirically based treatment has not been declared for this population.

When working with teens who cut, it's important for the counsellor to remain authentic, attuned, and present. Taking an eclectic stance on treatment using skill-building from a variety of treatment models can be helpful as it tailors treatment to the client's needs. ■

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