Examining the Relational Link Between Non-Suicidal Self-Injury and Suicidal Behaviors: A Systemic Approach to Understanding and Working with NSSI and Suicidal Behavior

Tony Watkins, LMFT

This presentation does not contain graphic pictures and/or videos depicting self-injury

One slide with a montage of injury wounds shown briefly

In this Workshop...

- Increase their knowledge of the coexistence of NSSI and suicidal behavior
- Explore the nature of the link between these two types of behavior as well as the ways that NSSI is conceptualized
- Understand the behaviors that are considered non-suicidal self-injury vs suicidal behavior
- Learn how to utilize systemic interventions to create safety plans for NSSI and Suicidal Behavior
A challenge

- Described throughout his first anthropological accounts.
- Clinical 2002 first epidemiological study published.
- First clinical account 1913 "self-mutilation." (Emerson)
- Karl Menninger 1938 ("partial suicide")
- Recent increase: Scientific interest, research papers over the past 14 years has tripled.
- Medical and MHPs find this difficult and upsetting behavior; can involve a large amount of countertransference.

Conners, 2000; Dieter et al., 2000

What is self harm?
### Terminology

<table>
<thead>
<tr>
<th>Term</th>
<th>Similarity to NSSI</th>
<th>Difference to NSSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-mutilation</td>
<td>Often used identical to NSSI</td>
<td>Has punitive connotation and does not correctly fit with NSSI</td>
</tr>
<tr>
<td>Deliberate self-harm</td>
<td>Often used identical to NSSI</td>
<td>Often includes self-directed behavior such as overdose - UK</td>
</tr>
<tr>
<td>Parasuicide</td>
<td>Often used identical to NSSI</td>
<td>Often includes suicidal behavior</td>
</tr>
<tr>
<td>Wrist cutting (cutting)</td>
<td>Often used identical to NSSI</td>
<td>Sometimes used to describe self-directed behavior such as cutting wrists</td>
</tr>
<tr>
<td>Self-abuse</td>
<td>Often used identical to NSSI</td>
<td>Equates NSSI with “abuse” which may not be accurate or helpful</td>
</tr>
<tr>
<td>Self-inlicted violence</td>
<td>Often used identical to NSSI</td>
<td>Sometimes used to describe self-directed behavior or other forms of self-directed violence</td>
</tr>
</tbody>
</table>

Kibler (2011) Nonsuicidal Self-Injury

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**Terminology/Definition**

- **Nonsuicidal Self-Injury (NSSI)**

  NSSI is the repetitive, direct, deliberate, destruction of one’s own body tissue of a socially unacceptable nature, in the absence of suicidal intent.

Walsh, 2006; Nock & Fava, 2009

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**When is a line crossed?**

- **Idiosyncratic Meaning? Intent? Function?**

- **Body modification is a growing phenomenon; 16 percent of American adults have at least one tattoo.**
### Importance of Nomenclature

<table>
<thead>
<tr>
<th>Repetitive ?</th>
<th>Direct</th>
<th>Indirect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>High Lethality</td>
<td>High Lethality</td>
</tr>
<tr>
<td></td>
<td>Low Lethality</td>
<td>Low Lethality</td>
</tr>
<tr>
<td>No</td>
<td>Taking small dose of arsenic over time</td>
<td>Self injury: cutting, burning, poisoning, etc.</td>
</tr>
<tr>
<td></td>
<td>Type 1 diabetic not injecting insulin</td>
<td>Smoking, alcoholism</td>
</tr>
<tr>
<td>No</td>
<td>Gunshot wound to the head</td>
<td>Major self harm</td>
</tr>
<tr>
<td></td>
<td>Terminal patient refusing treatment</td>
<td>A walk home alone at 3 a.m.</td>
</tr>
</tbody>
</table>

The World Health Organization defines violence as:

- "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation."

- **Suicide**
  Death caused by self-directed injurious behavior with an intent to die as a result of the behavior.

- **Suicide attempt**
  A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior; might not result in injury.

- **Suicidal ideation**
  Thinking about, considering, or planning suicide.

Vignette

After being diagnosed with breast cancer, a client goes to meet with the oncology nurse regarding her chemotherapy regime. Seeing that she is tearful and seemingly depressed, the nurse inquires whether or not she has been feeling suicidal. The client indicates that she has had thoughts, but before she can fully respond to the question, she begins crying uncontrollably.
Which Term?

- A. Suicidal ideation
- B. Suicide attempt
- C. Suicide
- D. Non-suicidal self-directed violence
- E. Suicide attempt interrupted by self
- F. Suicide attempt interrupted by other
- G. Other suicidal behaviors
- H. Unintentional injury
- I. Not enough information/undetermined

Vignette

The patient stated that she experienced heartbreak over the “loss of a guy” a week before the interview. She stated that she took four clonazepam, called a girlfriend, and talked/cried it out while on the phone. She was dismissive of the seriousness of the attempt, but indicated that she wanted to die at the time she took the overdose.

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- I. Not enough information/undetermined
**Vignette**

The patient was feeling extremely guilty and felt he deserved to die. He held a gun to his head. Just before he pulled the trigger, his wife came in the room and pulled the gun from his hand.

**Which Term?**

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**Vignette**

After months of expressing the desire to end her own life, a client maneuvered around barriers and jumped to her death from a very tall building.
Which Term?

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Vignette

After a long argument with his wife, a client with previous suicidal behaviors left the house and went to a bar where he drank heavily. He then got in his car, drove erratically, and broke the speed limit. He called his wife on the way home, and they shouted at each other briefly before he hung up. Shortly thereafter, his car hit a pole. He was taken by ambulance to the hospital where he was unconscious and could not answer questions about what happened and why.

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Vignette

The patient wanted to escape from her mother’s home. She researched lethal doses of ibuprofen. She took six ibuprofen pills and said she felt certain from her research that this amount was not enough to kill her. She stated she did not want to die, only to escape from her mother’s home. She was taken to the emergency room where her stomach was pumped and she was admitted to a psychiatric ward.

Which Term?

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As a matter of conveyance, I will use Self-harming Behavior, Self-Injury and Non-Suicidal Self Injury synonymously.
A significant number report engaging in both attempted suicide and NSSI.

Distinguish between self-harm behavior and suicide behaviors are phenomenologically distinct

<table>
<thead>
<tr>
<th></th>
<th>NSSI</th>
<th>Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intent</td>
<td>Non-lethal</td>
<td>Lethal</td>
</tr>
<tr>
<td>Function</td>
<td>Coping with emotional pain</td>
<td>Elimination of pain through death</td>
</tr>
<tr>
<td>Frequency</td>
<td>Often fairly frequent</td>
<td>Relatively infrequent</td>
</tr>
<tr>
<td>Medical Damage</td>
<td>Usually less severe</td>
<td>Often severe—deadly</td>
</tr>
</tbody>
</table>

Suicide and Self-Harm Behavior

- Hx of both NSSI & a suicide attempt, compared to NSSI alone, show higher levels of depression, suicidal ideation, impulsivity, and family dysfunction
- NSSI predicts subsequent suicide attempts in depressed adolescents nearly as strongly as previous suicide attempts themselves. (Clinical pop)
- A significant difference on attitudes toward life between self-injurers & suicide attempters

Differences and Overlap

Suicidal Behavior

NSSI
Non Suicidal Self Injury

Co-occurrence

14-70% clinical samples
3.8-7% HS Non clinical samples

Self-Harm and Suicidality

DISTRESS Dysregulation
Common Diathesis

Practice Guideline

☐ Always explore suicidality as a possible co-occurring condition with self-harming behavior, but always differentiate between the two phenomenon
☐ Clarify with the client your understanding of the difference between suicidality and self-harm behavior
Who engages in NSSI?

Age of Onset

- Between 12 and 24 years of age, with a bimodal peak in onset among those 12 to 14 and 18 to 19 years of age

Baxter et al., 2009; Heath et al., 2009; Lewis & Santor, 2008; Lewis & Santor, 2009a; Lewis & Santor, 2009b; Lloyd-Richardson et al., 2007; Ross & Heath, 2002; Yates, 2004

Despite some valuable epidemiologic data on NSSI, there are several important gaps in the knowledge base...there is no research reporting rates of NSSI in children younger than middle school (ie, age 11 or younger).

7.6% of third-graders reported having engaged in NSSI, sample

Bates et al., 2012. 

College/Young Adults

- 3,069 students: 41% started between 17 to 22 yrs of age
- 17% lifetime
- After controlling for multiple factors, SIB compared with non-SIB students:
  - Almost 3x more likely to have considered suicide
  - 3x more likely to report high levels of recent distress
  - 2x more likely to report one or more characteristics of eating disorder

Whitlock et al., (2006)

Typical Trajectory

- The presentation of self-injurious behavior can occur over several developmental time spans.
- Self-injury often begins in early adolescence, increases in middle to late adolescence and into young adulthood, and then decreases in one’s late twenties to early thirties.
- Outside psychiatric population, self-harm behavior seems tied to adolescent developmental period—time when emotional regulation is particularly vulnerable

Alderman, 1997; Whitlock et al., 2006; Yip, 2005

Typical Trajectory

The natural history of self-harm from adolescence to young adulthood: a population-based cohort study

"Our findings suggest that most adolescent self-harming behavior resolves spontaneously."

Moran, Coffey, Remanski, Olsher, Biederman, Gotlib, and Patton (2011)
Gender
- Believed to be more prevalent among females
- Males and females do not vary in the number of times, length of history, amount of methods used, or the pain experienced, but...
  - gender difference in types of self-harm:
    - Females more prone to cut
    - Males more prone to self-hit/bruise, bum

Kessler et al., 2000; Whittington et al., 2004; Witte et al., 2000; Nock, Joiner, Gender, Lloyd-Richardson, and Farmer (2006)

Psychiatric Diagnosis
Conditions for Further Study DSM-5
- According to DSM-5, DSM-5 diagnostic criteria are as follows (American Psychiatric Association, 2013):
- Over the past year, the person has for at least 5 days engaged in self-injury, with the anticipation that the injury will result in some bodily harm. No suicidal intent.
- The act is not socially acceptable.
- The act or its consequence caused significant distress to the individual's daily life.
- The act is not rating about being psychotic, delusion, cognitive function, or severe condition that causes the individual to engage in other medical condition.
- The individual engaged in self-injury on purpose.
- The individual feels relief from negative emotion.
- The individual feels relief from a negative emotion.
- The individual feels relief from a negative emotion.
- The self-injury is associated with one of the following:
  - Right before self-injury, the individual was preoccupied with the planned act.
  - Right before self-injury, the individual experienced a negative emotion, or fear that self-injury would help.
  - Right before self-injury, the individual experienced a negative emotion, or fear that self-injury would help.

American Psychiatric Association, 2013

Note: This information is for educational purposes only and should not be used as a substitute for professional medical advice, diagnosis, or treatment. Always consult a qualified healthcare professional for any questions you may have regarding a medical condition.
Psychiatric Diagnosis: Summary

- Those who engage in NSSI may experience a wide range of diagnostic profiles which are associated with emotional distress, but the presence of NSSI itself does not imply any particular diagnosis.
- Do not presume BPD

Self-Harm and Substance Abuse

- Although people who engage in self-injury are more likely than non-injurers to have drug and alcohol use disorders.
- Those who engage in self-injury report using drugs or alcohol during less than 5% of time when experiencing self-injurious thoughts, suggesting that self-injurious and behavior typically occur during periods of sobriety.

However...Something Old and Something New

- Something old: long documented hx within the psychiatric community.
- Something new: virtual explosion within general population, non-psychiatric population.
- Challenges the idea this behavior arises necessarily out of psychopathology alone.

An emerging new population

- Late 1990’s a new population emerged (not within psychiatric population)
- Regarding adolescents and young adults
  - Often have numerous strengths
  - Doing well in school
  - Never identified needing special supports
  - Often not disciplinary problems
  - Few have had previous psychological tx.; many don’t meet any Axis I diagnosis
  - Substantial circle of friends (in many cases they too self-injure)
  - Often deny trauma background

Walsh, 2006

What do you make of this?

- Certainly not “just” an adolescent/young adult fad--dismissive
- Dynamic response to cultural forces?
  1. What are the cultural forces which may drive this behavior? (YOUTUBE)
  2. What is the underlying factor of this behavior and how does it relate to culture?
  3. Healthy dialogue with those who utilize this behavior--de-stigmatize
- Impacts how we address it
- More sociological informed understanding

Chandler et al. (2011)

How Common is NSSI?
Prevalence: How common is NSSI?

Early 1980s  400 per 100,000
Late 1980s    750 per 100,000
Late 1990s    1000 per 100,000

As many as 2.1 million
high school students may engage in NSSI
each year

Prevalence Study

- Lifetime prevalence for adolescents in community: 15%-20%
- 440 students from urban and suburban HS in Canada
  - 15.9% reported engaging in self-injury
  - Frequency:
    - episodically: 16.6%
    - couple x's per month: 16.6%
    - couple x's per week: 4.5%
    - once per day: 1.6%

Ross & Heath (2002)

Prevalence Stabilized

- Muehlenkamp et al. (2012) systematic
  Review (2005-2011) about the prevalence of NSSI in adolescent samples
  - Review indicates a mean prevalence rate of 18% for non-clinical adolescent population
  - Prevalence rates seem to have stabilized within the last five years

Self-harm behavior has exploded within non-psychiatric community. There is a high likelihood of encountering self-harm behavior within the psychiatric population. Explore self-harm behavior among male clients.

Practice Guidelines

Self-Harm Practice

Most commonly used method described across virtually all studies is cutting or carving oneself with a sharp implement such as a knife or razor, with most self-injury occurring on the arms, legs, and stomach. Most people report using multiple methods, other common methods include scratching or scraping the skin until it bleeds, burning the skin, and inserting objects under the skin (SEB).


SEB: Self-Embedding Behavior

Practice Guideline

A distinction should be made between SEB and other forms of nonsuicidal self-injury.

SEB is performed with the intent to seriously harm and, in most cases, with accompanying suicidal ideations. The distinction between these 2 forms of self-injury is paramount, with SEB posing a potentially greater risk to patients.

Psychological Characteristics

Self-injurers experience greater negative emotionality which is more intense and frequent in nature than non self-injurers.

Self-injurers exhibit deficits in being aware of their emotional experiences, communicating their emotions, and positively coping with these feelings.

Impulse control issues (comorbid S/A; high risk behavior; anger issues).

Nock & Mendes, (2008); Najmi et al., (2007)

Emotional Dysregulation
Emotional Vulnerability

- High sensitivity
- Immediate reactions
- Low threshold for emotional reaction
- High reactivity
- Lower emotional reactivity
- Long time to recover
- More sensitive to next emotional stimulus

Distress Tolerance

- Degree an individual evaluates the experience of negative emotions as unbearable, i.e. Low distress tolerance takes less to reach point of being overwhelmed

Distress Tolerance

- Increased physiological reactivity to a stressful task (First to demonstrate ACTUAL Hyperarousal)
- Greater increases in SC during frustrating task was associated with those who reported engaging in self-injury to reduce negative emotions
- Decreased ability to tolerate distress and persist at a designated task

Distress Tolerance & Impulsivity
Clarified

- Common clinical wisdom suggests that people who engage in self-injury are impulsive. However, virtually all prior work in this area has relied on individuals' self-report of impulsiveness.

- Glenn et al. (2010)


Negative Urgency related to Brain Pathways

- The emergence of the urgency traits are recognizable in a brain system relating the OFC to the amygdala.

Cyders & Smith (2008)

Neurobiology and Dysregulation
Proposed function and method of regulation assume an underlying altered stress response

Genetic predisposition to high emotional, cognitive reactivity [inconsistent results]

Different brain morphology and neural activity [limbic system structures]

Abnormalities in neurotransmitters: Serotonergic, and dopamine, opioid system as well as the HPA axis (cortisol) which increase stress vulnerability [reduced levels of cortisol and opioids]

Neurobiology of NSSI


A Handy Model of the Brain

Stress Response: Above the shoulders—the Brain

Sensory Thalamus

Amygdala
Stress Response: Above the shoulders---the Brain

Sensory Thalamus
Hippocampus
High Road
- Conscious
- Thoughts
- Evaluation
- Emotional Regulation
- Draws on Integrated Memory (Hippocampus)
- Linked with Language
- Later Development (Cortex, PFC)

Amygdala
Cortex (PFC)
An Amygdala Hijack!!

- Emotions overwhelm your thinking and actions
- You are thinking and acting against your own will!
- You are unable to accurately read others’ emotions
- You are unable to focus your thinking or actions
- Your “fight or flight” response kicks in... heart races, blood pressure increases, sweating profusely, uneasy feeling in the "gut," clenched jaw, twitching, tapping foot, cold extremities as the brain rushes blood to muscles needed for fighting or fleeing...

Self-regulatory collapse can occur because of:

Emotional Vulnerability

1. High sensitivity
   - extreme reactivity to emotional reactivity
2. High reactivity
   - extreme emotional reactions
3. Slow time to recovery
   - long-lasting emotional reactions
   - more sensitive to next emotional stimulus
Basic principle for Emotions...

- Carry energy
- Action tendency

**Principle**

Emotions: You can act them out or talk them out; but either way they will come out.

Value of verbal processing skills

- Basic principle for Emotions...
  - Carry energy
  - Action tendency

Value of verbal processing skills

- Basic principle for Emotions...
  - Carry energy
  - Action tendency

**Putting Feelings into Words**


- Associated with inhibitory processes. More active in SPA rather than non-SPA, and more active in processing negative compared to SPA.
Something is going on in the brain when people self-injure—psychological state is being driven by underlying biology, i.e., an over functioning limbic system. Treatment tasks center around engagement and integration of prefrontal cortex through skill enhancement which alters brain function. Languageing feelings/emotions enhances neural integration and strengthens top down integration (key practice in mindfulness).

Practice Guidelines

- Childhood Trauma
  - Sets up predisposition vulnerabilities via attachment injury (sets up mind-dysregulation)
- Negative family dynamics: chaotic, confusing, rigid, overall INVALIDATING
  - Self-injurer and self-injury becomes both a reflection and communication
  - Preliminary data suggests self-harm may be more associated with negative relations to parents than with negative relations to friends.

Damage to the “Self” System

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Family and Invalidating Environments

- 1,300 students (West and East Coast)
  - 1/3 NSSI in past year and 3/4 of these endorsed recurrent episodes
  - Non-statistical gender difference
- Perceived parental criticism statistically predicted NSSI in both the cross-sectional and the longitudinal samples.

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  - 1/3 NSSI in past year and 3/4 of these endorsed recurrent episodes
  - Non-statistical gender difference
- Perceived parental criticism statistically predicted NSSI in both the cross-sectional and the longitudinal samples.

Overall research—NSSI report lower quality of family environment when compared with non-self injurers.
High Parental Criticism and Self-Injury

- The relationship between parental criticism and self-injury is especially strong among adolescents with a self-critical cognitive style.
- Can be more likely to develop a self-critical cognitive style that may then increase the likelihood of engaging in self-injury as a possible form of self-punishment.
- Specific pathway through which the family may influence self-injury behavior.


Lunch Break - 1 hour

Why engage in NSSI?
Core Issue

Emotional dysregulation and a damaged sense of "self" result in the adoption of maladaptive coping such as self-harming behavior.

Universal challenges of adolescence:
- Identity formation
- Striving for autonomy and independence
- Intimacy and sexuality

What is Emotional Dysregulation?

- Lack of awareness, understanding and acceptance of emotions
- Lack of access to adaptive strategies for modulating the intensity and/or duration of emotional responses
- An unwillingness to experience emotional distress as part of pursuing desired goals (distress tolerance)
- The inability to engage in goal-directed behavior when experiencing distress (distress tolerance)

Why self-harm?

- Maladaptive Coping: (Survival response)
  - To manage overwhelming emotions, to reduce tension. Tension may be due from unmanageable anger, anxiety, often unnamed negative emotion
  - To bring yourself back to yourself - end a dissociative state (grounding effect); to feel something

Functional Framework

- Automatic/Intrapsychic
  - Creates desirable physiological state; feeling generation (APR)
  - Reduces tension or other negative emotions (ANR)
- Social/Interpersonal
  - Provides attention from others (SPR)
  - Offers escape from interpersonal demands (SNR)

- Contextually complex.

- Multiple functions.

- GLR = Emotional Reduction
- SP = Self Punishment
- IC = Interpersonal Communication

- More likely to have made a suicide attempt.
- High suicidality, automatic/intrapsychic/Alone
- A particularly robust indicator.

NSSI and Social Context

- 1993-2004 over 14 pop icons revealed via media self-harm behavior (Princess Diana, Johnny Depp, Angelina Jolie, etc.)
- Dramatic increase in the frequency of references to self-injury in various media
  - Increase in mainstream movies, music and news articles depicting NSSI scenes or themes
  - TV dramas: Grey's Anatomy, Seventh Heaven, Will and Grace
- Self-report data indicates most adolescents and young adults initially learned about it from their friends, siblings, and the media
- Internet (much more virtual generation)

Role of Internet

- Research indicates people who self-injure often go online to connect with others who self-injure and view others’ NSSI experiences and share their own through text and video platforms.
- Risks
  - Share NSSI strategies and reinforcement of behavior
  - Triggers urges
- Therefore, when working with youth who engage in NSSI, the scope and nature of their online activities must be addressed

Actions can speak louder than words

- Use of self-injury as a means of communicating or signaling distress because it is more effective at eliciting help from others than milder forms of communication or with a communication deficit
- Clinical descriptions have depicted the use of self-injury as a means of communication and help-seeking when words fail to adequately do so
- If wounds could speak...
It “Seemingly” Works

- It is a rapid, effective, and easily implemented method of regulating one’s affective/cognitive and social experiences. It’s quick and brings immediate relief.
- Powerfully seductive & experientially addictive (not just about physical properties); never underestimate the power of what works even in the face of obvious self-destruction.
- Attractiveness of immediacy (immediacy shaped culture; immediacy is reinforcing).

Summary: Integrated Model

What Helps: Approach and Strategies
Good and Bad News

- Good news: the majority of people who engage in this behavior and seek help find significant remission.
- Bad news: currently, there is no evidence-based interventions or prevention programs for self-injury.
- NSSI requires specific Tx target beyond the treatment of depression and/or suicidality. Little research has examined the efficacy of treatments designed specifically for NSSI.


What Works

Approaches that emphasize problem solving, emotion regulation, and functional assessment and analysis of the behavior, cognitive restructuring, and a strong therapeutic relationship.

- Cognitive Behavioral therapies
  - Cognitive strategies: cognitive restructuring, challenge cognitive distortions.
  - Behavioral strategies: behavior analyses, modification, problem solving, behavior substitution, and relaxation.

General Treatment Concerns

- Tend to the therapeutic alliance
- Conduct a focused self-harm assessment
- Safety monitoring of self-harm behavior
- Regulate substitution/alternative behaviors within the capacity of the client
- Provide coaching for coping skill enhancement
- Cognitive Restructuring
- Tend to diminished sense of self
- Address any comorbid Axis I/II issues
General Mental Health First-Aid Guidelines

Therapeutic Alliance Issues

- Countertransference
  - 117 psychologists, self-injury was rated most distressing and stressful client behavior and found to be most traumatizing to encounter professionally
  - Behavior is disturbing
  - Treatment can be time consuming
  - Some clinicians "lack tolerance" resulting in power control
  - Confront sense of clinical competence
- Vicarious traumatization

Therapeutic Response

- Low-key, dispassionate demeanor
  - Concerned but not panic
  - Responsible
  - Respectful
  - Nonjudgmental compassion
  - Humility
  - Refrain from premature conclusions, labeling, interpretation
  - I have seen this before and I want to help and I'm not going to add my anxiety to your problems
**Primacy of Therapeutic Alliance**

- Model validation
- Serve as an attachment figure
  - Relationship is primary environment facilitating change (interpersonal nature of emotional regulation)
  - Serves as a "corrective emotional experience" by fostering "connection" as opposed to disconnection
- Engage within the dialectal
  - Nurture
  - Challenge

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**Assessment**

Effective treatment of self-injury must begin with a thorough and accurate assessment.

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**Key Assessment Areas**

- Age at onset
- Type(s) of self-injury
- Frequency
- Wounds per episode
- Duration per episode
- Use of tool or implement
- Functions
- Antecedents and consequences
- Extent of physical damage
- Environmental circumstance

**Case Illustration**
Case Illustration

- Do not attempt to contest for safety telling clients that they need to stop self-injuring.
- Asking individuals to give up self-injury when it is their best emotion-regulation technique can be both unrealistic and invalidating.
- Use of self-care agreement outlines certain limits and expectations by setting boundaries, and asking clients to monitor activity through a monitoring log [review during session; collaborative tool: add, address behavior; respect of function while showing care for the client].
- Sets safety for the client as a chief concern and begins to build relationship [monitor not to control but because I care]. Establishes collaboration.

Safety Monitoring

- Chain analyses: Identify the controlling variables for the target behavior—such as the precipitants, vulnerability factors, cognitions, and emotions.
- Identify negative consequences for oneself and the environment.
- A main purpose is to challenge the common contention that the emotion or behavior was beyond their control or “just happened.”
- Freeze frame adaptation: events are recalled as if reviewing a video replay and then “freezing the frame” at critical points; less tedious and aversive.
Provide Coaching for Coping Skill Development

- Maladaptive coping flows from a skill deficit
- Amygdala hijack locked in reactivity
- Skill development engages and strengthens the prefrontal lobe yielding increased control
- Also enhances therapeutic relationship
- Be careful how you frame coaching so as not to send invalidating messages of “deficit” “deficiency”

Emotion Regulation Skills

- Emotional sensitivity
- Rapid, intense mood changes
- Unmodulated emotional states

Emotions: Psychoeducation

- Teach about the interactive nature of emotions: emotion, cognition and behavioral
- Enhance understanding about difference between primary and secondary emotions – valid aspect of experience vs. primary emotion and distorted aspect (secondary-function of internalized negative voice)
- Draw attention to the Shame-rage spiral
- Point out the three key aspects of dysregulation
  - High sensitivity – (Fast)
  - High reactivity – (Big)
  - Slow return to baseline – (Slow)

Get client to verbalize examples from own life.
Emotions: Psychoeducation

- Understand action tendencies
  - A negative emotion often leads to an irresistible urge to act in a self-destructive way.
  - Urge to act on an emotion, we are not "obligated" to act on it—range of choices (keeps from operating solely from the emotional mind—overactive limbic system).
  - Distinguish between "urge" to act and the "action" itself (response management by enlisting better PFC integration to down regulate limbic system: "reappraisal").
  - Expand range of actions options beyond the usual "action urge" that accompanies a distressing emotion; so action urge is one among several choices to be made.

Action Tendencies

<table>
<thead>
<tr>
<th>Emotion</th>
<th>Innate Urge</th>
<th>Human Behavior</th>
<th>Animal Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger</td>
<td>Attack</td>
<td>Yell/Hit</td>
<td>Snarl/Pounce</td>
</tr>
<tr>
<td>Sadness</td>
<td>Withdrew</td>
<td>Isolate</td>
<td>Hide</td>
</tr>
<tr>
<td>Fear</td>
<td>Fight/Flight</td>
<td>Run/Attack</td>
<td>Run/Cower</td>
</tr>
<tr>
<td>Surprise</td>
<td>Fight/Flight</td>
<td>Grasp/Jump</td>
<td>Flinch/Run</td>
</tr>
<tr>
<td>Disgust</td>
<td>Retreat</td>
<td>Facial expression</td>
<td>Turn head away</td>
</tr>
<tr>
<td>Shame</td>
<td>Hide</td>
<td>Head down</td>
<td>Tail down, hide</td>
</tr>
</tbody>
</table>

Emotional Management by Acting Opposite the Current Emotion

- Opposite Action
  - Emotions are strongly influenced by our bodily posture and facial expressions (power of congruence and incongruence).
  - By altering posture, behavior, and facial expressions, we can delay, interrupt or de-escalate the progression of a problematic emotion.
  - Effective for tolerating painful primary emotions.
  - Effective for altering self-destructive urges associated with negative emotions.
Steps to Practice Using Opposite Action

- What emotion am I experiencing?
- What is the action (what is the emotion trying to get me to do)?
- Do I really want to reduce this emotion?
- What is the opposite action?
- DO the opposite action.
- Practice, practice, practice!

Opposite Action for Anger

- Keep one’s palms open when inclined to punch.
- Whisper when inclined to scream.
- Breath deeply and slowly rather than angrily hyperventilating.
- Gently avoid the person you are angry with rather than attacking.
- Put yourself in the other person’s shoes and imagine sympathy or empathy for the person, rather than blame.
Opposite action for Sadness or Depression

- Get active
- Approach, don’t avoid
- Do things that make you feel effective and self-confident
- Use the “half-smile”

Self-Care (Wellness)

- Teach how self-care helps to decrease vulnerability to negative emotions
- Emphasize importance of maintaining regular sleep schedule
- Eating balanced diet, treating physical illness, getting regular exercise, avoiding substance abuse and planning at least one activity a day that makes you feel good and in control
- Exercise is KEY
- Combats negative sense of “bad” self

Distress Tolerance Skills

- Cultivating Acceptance through self-talk
- Self-soothing through positive replacement training
- Develop tolerance through mindfulness
Importance of Distress Tolerance Skills

- Those who engage in NSSI spend MORE time and effort trying to control and minimize negative emotions as compared with non-injurers.
- They also indicate the wish to end stressful experiences sooner than those with no hx of self-injury.


Distress Tolerance Skills

- Teaching to suspend judgment – an emotion simply “is”
- Teaching to “accept” painful feelings vs. trying to get rid of them quickly

Regulating Substitution Behaviors

- Understanding the function of the behavior and the underlying biological drive --> not a behavior you can simply “will” or “demand” to stop.
- PROCESS of substitution, transitioning and strengthening toward positive coping skills.
Replacement Training

- Negative Replacement
- Positive Self-soothing
- Distraction techniques

Positive Replacement:
Self-Soothing through the 5 Senses

- An accessible and easily taught self-soothing/distress tolerance skill is the use of the 5 senses:
  - Vision, hearing, smell, taste, touch
- Usually at least 2-3 of the five senses are engaged or capable of being engaged at any given moment as a distraction from distress.

Self-Soothing

- Vision:
  Focus on an aspect of nature, or any visual detail

- Hearing:
  Music, nature sounds, relaxation tape, fan noise

- Smell
  Lotion, candle, perfume, favorite food cooking

- Taste
  Hot chocolate or tea, ice cream...taste slowly

- Touch
  Pet your dog, cat, soothing bath, hug, blanket
Distress Tolerance Skills

- CBT component of Distress Tolerance
- Acceptance self-talk
  - Learning to talk to yourself nonjudgmentally: e.g., “I’m doing the best I can,” “I know if I can just get through this difficult time things will get better,” “I can’t do anything to change how I feel or to change the situation so it is better to accept this for now rather than do something to make things worse,” and “I’ve survived these types of feelings before, so I can do it again.”
  - Acceptance self-talk counters the negative, critical “shoulds” and “shouldn’ts” that often accompany painful emotions.

What is mindfulness?

- Paying attention in a particular way, on purpose, in the present moment, and non-judgmentally.

Jon Kabat-Zinn

Reset threshold through skill development

Reactivity VS. Responsiveness

Emotional Mind

Wise Mind

Emotional Volume Control
Mindfulness

- Using the breath we learn to ground ourselves in the present moment
- Accepting what is happening in us and around us, whatever it is, we learn to open to experience, without judgment
- Teaches us ways to connect with our emotional experience without becoming overwhelmed
- Learning to watch our thought patterns come and go, we see about how our mind works.

Clamping Nature of the Breath

1. Autonomic Nervous System—biological system that functions automatically.
   - Sympathetic Nervous System—Activated-fight, flight, freeze—Occurs during the "in breath"
   - Parasympathetic Nervous System—Calm system—down-time to relax—Occurring during the "out-breath"
   - Generally, during inhalation, the heart beats faster and during exhalation, the heart slows down. When the parasympathetic nervous system is more active, the inhale-exhale difference in heart rate and blood pressure increases, and breathing slows down. People who have a relatively larger inhale-exhale difference in heart rate are more adaptable, regulated, flexible, physically healthy, and have more ability to control their behavior.
   - Hence why deep breathing works.
Mindfulness and Affect Regulation

- Nonattachment to thoughts and feelings
  - Disturbing thoughts and feelings can come up and go (parade)
  - Reduced identification with emotional experience
- Engages the frontal cortex and right brain processing

Example of mounting empirical research support:

Researchers conducted MRI scans of 16 people 2 weeks before and 2 weeks after an 8-week MBSR course. Scans were compared against a control sample of 17 people on wait list for the course. MBSR participants showed significant increases in gray matter density in the left hippocampus, an area of the brain associated with arousal, responsiveness, and emotion regulation. Hölzel, B.K., Carmody, J., Vangel, M., Congleton, C., Yerramsetti, S.M., et al. (2011). Mindfulness Practice Leads to Increases in Regional Brain Gray Matter. Psychiatry Research: Neuroimaging, 191, 36-43. This study demonstrates that changes in brain structure may underlie some of the reported improvements and that people are not just feeling better because they are spending time relaxing.

Addressing the Damaged Sense of Self
**NSSI and damaged sense of self**

- Negative self-view is a common feature of NSSI
  - Report higher level of self-degradation such as self-criticism and low self-esteem than those who don’t self-injure
  - Significant number report engaging in NSSI in order to “punish myself”
    - Internalized from trauma—attachment injury or abuse environment
    - Internalized from invalidating environments

**Collaborative construction of Healthy “Self” Narrative**

- Cognitive restructuring
  - Identify (ANTS), Intermediate beliefs and core beliefs which support and sustain self-harm
  - Relate to and identify primary/secondary emotions
  - Replace negative cognitions with adaptive thoughts and beliefs

**Cognitive Restructuring**

- Core beliefs related to self
  - Incompetent
  - Unlovable
  - Negative body image—compromised relationship with body (trauma)
  - Automatic thoughts: specific cognitions relative to self-harm
    - Self-harm is ok
    - Deserving of punishment
    - Self-harm is necessary for relief
    - Only way to communicate pain

(Rehlin, 2006)
Collaborative construction of Healthy “Self” Narrative

- Narrative (we are the stories we tell & the stories we tell, we are)
  1. Attend to client’s own narrative (how is the narrative problem saturated?)
  2. Enter narrative as a co-constructionist
    - Through reflective dialog externalize & deconstruct
      ✓ Externalize—separate person from problem
      ✓ Deconstruct—take narrative apart pointing out possible refractions, reflect possibility of wider lens—in a supporting, curious manner so as not to reinforce a sense of invalidation of story

- Create alternative stories
  ✓ Attend to “unique” outcomes—what did or didn’t happen which seem outside usual storyline
  ✓ Tends to liberate the cognitive distortion process of all or nothing, black/white, etc.
  ✓ Process of observation and pointing out leaves open their choice of incorporation—no power struggle
  ✓ Search for and reflect strengths, abilities, uniqueness which validate SELF

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SELF-INJURY IN YOUTH

Understanding Non-suicidal Self-Injury: Origins, Assessment, and Treatment

Mary K. Nixon • Nancy L. Youth
Co-Ocurrence: A Complex Interaction

The co-occurrence of non-suicidal self-injury and attempted suicide among adolescents: distinguishing risk factors and psychosocial correlates

All bear the distinct disadvantage (from a clinical perspective) of having been developed primarily for research purposes.
History of behavior

Practice significance: In general, the longer the problem has existed, the greater the challenge to alleviate it. Research indicates the longer the course of self-injury, the greater the number of methods, and the absence of physical pain, is associated with making suicide attempts.

Tonya has consistently denied suicide. Her self-injury has also been persistent (7 years duration); she has used multiple methods (cutting, burning, excoriation); monitor for suicidality and the indicated substance abuse.

Key Assessment Areas

- Recent self-injury activity (last month or two)
- Functions
  - Intrapsychic: “reduce feelings of sadness and anger”
  - Interpersonal: first trigger = boyfriend breakup and then multiple stormy relationships
- Number of wounds per episode: “only cut 3 or 4 times to get relief, but sometimes it takes as many as 20.”
- Practice significance: In general, the greater the number of wounds per episode indicates a higher level of distress; explore what circumstances result in lower versus higher numbers of cuts.

Level of physical damage

Most incidents involve modest tissue damage that do not require medical intervention. If medical attention required an emergency mental health evaluation is indicated and protective interventions such as hospitalization may be necessary.

Ask permission to look at the wounds; can provide a great deal of objective information about frequency and level of physical damage. Client not always accurate reporters.
Explore body areas for self-harm

- Most harm the extremities or abdomen. Body areas that are rare but of particular alarm are face, eyes, breasts in women, and genitals in either sex. Generally, people who injure these body areas are experiencing either psychotic decompensation or some type of trauma-related behavior.
- At times words, symbols, or other patterns are cared. Common examples are words like "hate," "pain," a partner’s name, or an inverted crucifix. Useful to explore why the self-injurer has chosen the specific content on his or her body. Use a nonjudgmental, respectfully curious question such as, "Of all the words (or symbols) you could have carved (or burned) into your body, how did you decide on X?"

Key Assessment Areas

Environmental antecedents

- Physical location: Such information is useful in identifying situational antecedents. For example, if a client usually self-injures in a locked bedroom, he or she may want to try not locking the door. Altering established habits is conducive to behavior change.
- Social context: Does the self-injury occur alone or with others? Most people self-injure alone, but some cut or burn together. May be triggered after (or even while) participating in a self-injury chat room or message board. Identifying these social reinforcers is a critical part of assessment.

Psychological antecedents: cognitive, affective, and behavioral antecedents:

- Cognitive: automatic thoughts, intermediate, and core beliefs that may precede self-injury.
Cognitive

- Explore possible negative body image
  - Some self-injuring individuals may report intense negative thoughts and feelings about their bodies. This bodily hatred can serve to support and facilitate the assaults on the body that are self-injury. Profound body alienation can be associated with childhood experiences of physical and/or sexual abuse, or sustained childhood physical illness.
  - A thorough assessment of self-injury needs to evaluate whether such aversive experiences have been part of a client’s history.

Key Assessment Areas

- Psychological antecedents: Behavioral
  - These include habits, practices, and even rituals that precede self-harm. Such behavior patterns make it difficult to interrupt once sequence is started. A better strategy may be to identify the earliest links in the chain and redirect to skills practice immediately.
  - For example, Tonya uses the same razor over and over again that she stores in her dresser drawer, and only uses it behind a locked bedroom door. All of these details could be targeted for intervention. As she experiences a strong urge to retreat to her bedroom to self-injure, she could be encouraged to avoid her bedroom and instead, to practice such skills such as relaxing breathing or visualizations.

Key Assessment Areas

- Psychological antecedents: Affect
  - Assessment identifies (a) which emotions are managed by self-injury, (b) how the antecedents to these emotions might be reduced as to frequency and intensity, and (c) how these emotions might be managed more effectively using replacement skills.
  - For Tonya, the primary emotional antecedents to self-injury are said to be sadness and anger. Assessment should start with a careful behavioral analysis of these two emotions, but should also move on to other affective states, so that a thorough map of her distress is obtained.
Key Assessment Areas

- Consequences: The counterpart to antecedents (precipitants)—evaluating the consequences.
- The environmental piece involves assessing who becomes aware of the individual’s self-injury after the fact. Is the self-injury private or public? Does social reinforcement play a role or is it absent? If the self-injury is reinforced by others, is it intentional or inadvertent? If significant others are reinforcing the behavior are they amenable to changing their responses? For Tonya, the answers to these questions are not yet known.

Key Assessment Areas

- Consequences: Cognitive aspects.
- The state of mind of self-injurers following the act. Are they remorseful, neutral, or enthusiastic about the self-harm? Those who have little motivation to stop pose a very different clinical challenge than those who are dismayed and urgently want to put an end to the self-harm.
- Tonya appears motivated to move on from self-injury. She expresses concern that her level of functioning is not where she wants it to be and that she is relieved to finally be seeking professional help.

Treatment Targets Matching Case Conceptualization

<table>
<thead>
<tr>
<th>Dysregulation Deficit</th>
<th>Skill Enhancement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self dysregulation</td>
<td>Core mindfulness/supportive self-talk</td>
</tr>
<tr>
<td>Emotional dysregulation</td>
<td>Emotional regulation</td>
</tr>
<tr>
<td>Behavioral dysregulation</td>
<td>Distress tolerance</td>
</tr>
<tr>
<td>Cognitive dysregulation</td>
<td>Cognitive restructuring</td>
</tr>
<tr>
<td>Interpersonal dysregulation</td>
<td>Interpersonal effectiveness</td>
</tr>
</tbody>
</table>
Thank you!