



# Treatment of Child & Adolescent Non-Suicidal Self-Injury: An Adlerian Integrative Approach

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# Thinking About Self Injury



What questions do you have?

What concerns would you have if you were asked to work with a client who engages in self injurious behaviors?

Review *15 Misconceptions* – did you have any of these? What are your reactions?

# What is Self-Harm?

- ▶ Self Harm is an umbrella term
  - Includes Self Injury and Self Mutilation
  - Self Injury: A kind of self harm that leads to visible and direct bodily injury including cutting and burning (*McAllister, 2003*)
  - Research shows there is no association between suicidal intent and the act of self injury
    - Attempt at self soothing/coping
    - Harm done in the belief they will survive

Cornell Research Program on Self-Injury and Recovery

# Understanding the Difference



**Suicide**—deliberate and fatal self-harm with the presence of some intent to die as a result of the behavior (USDHHS, 2009a)

**Suicide Attempts**—self-injurious behavior with the intent to die (Claes et al., 2010)

**Self-Injury**—non-suicidal, volitionally self-inflicted harm to the body that is not socially sanctioned (Klonsky, Muehlenkamp, Lewis, & Walsh, 2011)

**Self-Harm**— parasuicidal behavior, including suicide attempts (Claes & Vandereycken, 2007)

Whisenhunt & Chang (2013)

# NSSI v. Suicide

(Whisenhunt & Chang, 2013)

<b>Non-Suicidal Self-Injury</b>	<b>Suicide Attempts</b>
Risk factors: Substance misuse, low self-esteem, suicidal ideation, disordered eating, non-heterosexual identity, trauma, early sexual experience	Risk factors: Substance misuse, low self-esteem, suicidal ideation, disordered eating, non-heterosexual identity, trauma, early onset of puberty and family history of mental illness
Non-lethal intent	Lethal Intent
Typically less severe physical damage	Typically more severe physical damage
Typically frequent	Typically infrequent
Triggered by anxiety/panic	Triggered by depression
Life preserving functions	Goal to end life
Anger precedes, but diminished following SI; Relief is a common emotional consequence	Anger precedes and increases following unsuccessful attempt; Guilt is a common emotional consequence
Can often identify reasons for living	May be unable to identify reasons for living
SI thoughts may be more intense & briefer	Less intense but pervasive

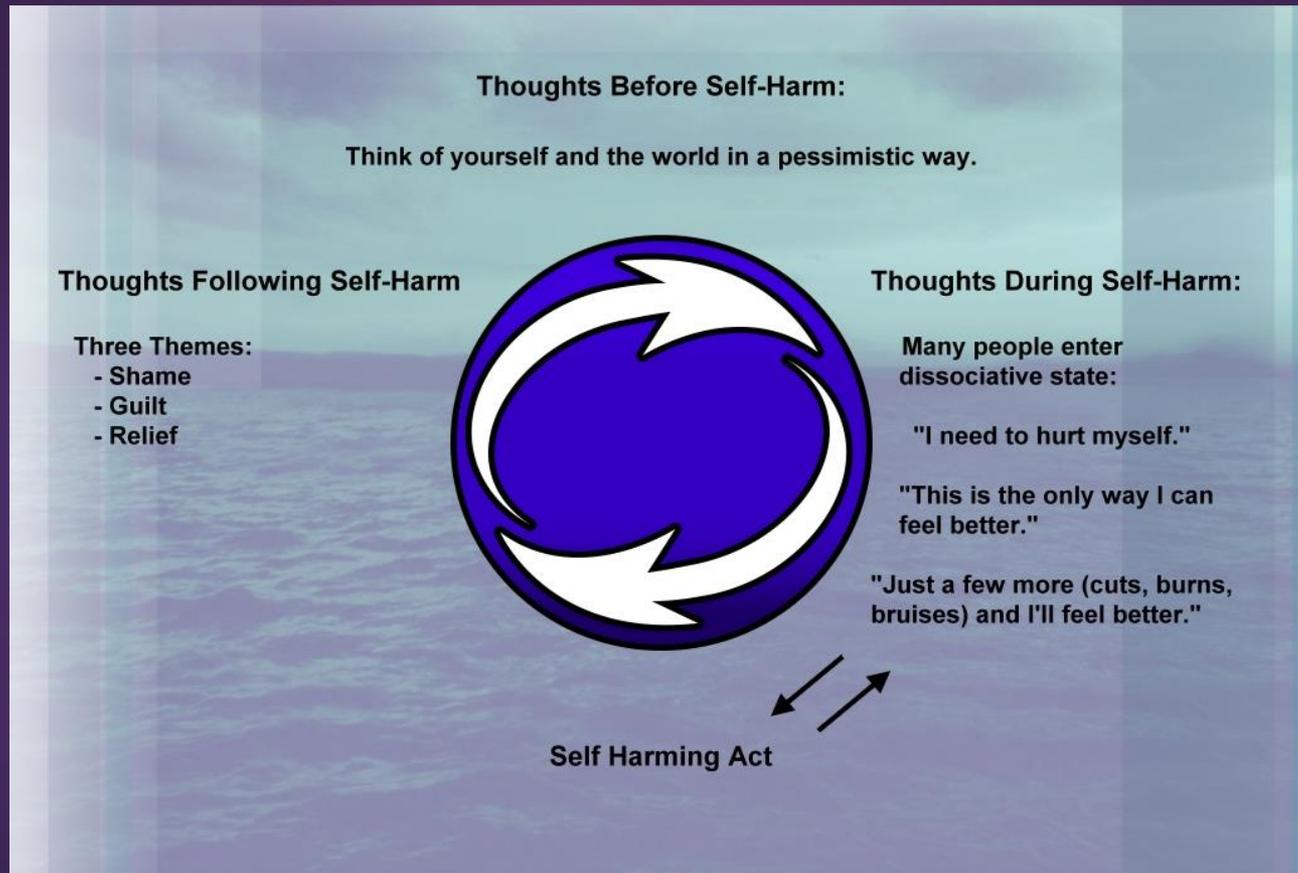
# Shame and Self Injury

- Shame appears to be a critically important emotion in self injury
- Individuals who chronically self injure often view themselves as evil/bad and deserving of punishment.
- Self Injury used to deal with memories of abuse
- Communication function of Self Injurious Behaviors (*symbolically cry, etc.*)

# Rituals of Self Injury

- ▶ **Generally**, most forms of Self Harm (including self injury) can follow some sort of ritualistic procedure when used over a longer period of time
- ▶ Environment
  - ▶ *Many people choose to engage in self-harm activities only in a specific location, mostly at home since it offers the desired seclusion and privacy.*
- ▶ Instruments
  - ▶ *Many people use one particular type of object or even one specific instrument when they injure themselves.*

# Cycle



# Population

## Recent Estimates:

- 7% of pre-adolescents
- 12-40% of adolescents
- 17 to 35% of undergraduate students
- Higher rates in clinical and incarcerated populations

30% of adolescents have suicidal thoughts

4% attempt suicide

18% have engaged in NSSI

- ▶ LGBT 2 - 4 times more likely to self-injure
- ▶ women, ethnic minorities, and youth subcultures also at heightened risk

# Risk Factors for Adolescent NSSI

“Mainstream youth” are using NSSI to manage emotional pain, gain attention, avoid or escape unwanted emotions (Mikolajczak et al., 2009)

Additional factors identified for adolescents in jeopardy of NSSI are  
(Askew & Byrne, 2009):

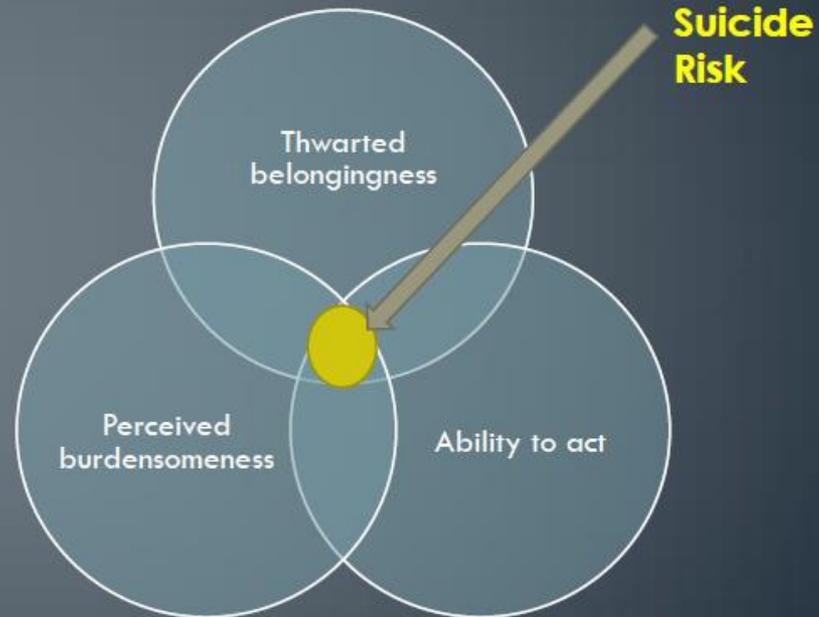
- *Past history of sexual abuse or violence in the home environment*
  - *Living in a home environment with family members who experience alcoholism or mental illness*
  - *Parental divorce*
  - *Personal long-term illness*
  - *Attentional issue*
  - *Low-self esteem*
  - *Anxiety and/or guilt*
- ▶ Research suggests that some adolescents become addicted to the emotional relief-seeking due to the high they experienced with the associated endorphin release (Derouin & Bravender, 2004)

# Adolescents and NSSI

- ▶ Adolescents become very creative and proficient at hiding signs of self-injury
  - ▶ *Dressing in long-sleeve shirts*
  - ▶ *Wearing concealing outfits*
  - ▶ *Avoiding activities such as sports, swimming, or other where skin exposure may occur*
- ▶ Adolescents who engage in self-injure also find a sense of community with others who self-injure.
  - ▶ Peer-pressure, want to emulate celebrities or fictional role-models = seeking sense of belonging  
(Purington & Whitlock, 2010)
  - ▶ **Social-Contagion Factors**
    - ▶ *While increased access to information (internet and all that that entails) has raised awareness of NSSI, also increased sense belonging for people who self-injure*  
(Whitlock et al, 2006)

# Need to Belong

## Joiner's Interpersonal-Psychological Theory of Suicidal Behavior



(Ribeiro & Joiner, 2011)

# Purpose of Behavior



- ▶ Intrapersonal negative reinforcement
  - ▶ reduction of emotions like anxiety or anger
- ▶ Interpersonal positive reinforcement
  - ▶ relieve numbness or feeling empty
- ▶ Interpersonal negative reinforcement
  - ▶ reduction in victimization
- ▶ Interpersonal positive reinforcement
  - ▶ gaining attention/emotional support from peers

# Signs of Adolescent NSSI

- ▶ Realization that NSSI is happening often occurs after pattern of self-injury has begun
  - ▶ Adolescents who display NSSI are more likely to seek help from friends and peers rather than adults or professionals
  - According to feedback from school counselors, most common method of discovering NSSI among adolescents is when a peer discloses the information (Roberts-Dobie & Donatelle, 2007)
    - *Classroom teachers and coaches hearing from peers were next*
    - *Adolescent self-discloser was third*
    - *School Counselors identifying the phenomenon was fourth*
  - Conditions that may enhance help-seeking action are a climate of caring and concern and having safe and trusting relationships (Rissanen et al, 2009)
- NSSI is the strongest predictor of eventual death by suicide in adolescence
  - ✓ Suicide risk increases up to 10-fold for adolescents displaying NSSI (Hawton & Harriss, 2007)

# Support

- ▶ Low family support, high family dysfunction, and low family cohesion are associated with NSSI and Suicide Attempts
- ▶ Peer support has been shown to exert a strong influence on suicidal ideation and NSSI
- ▶ 73% of females and 57% of males who self injure also have a friend who does
- ▶ NSSI Social Contagion Theory:
  1. Assortive Relations (predisposition leads to attraction)
  2. Direct Imitation
  3. Indirect Imitation/Media Influence

# FICTIONAL FINALISM



*An individual's expectations for the future motivate how a person lives and serves to orient her and him to the world and can influence a sense of belongingness.*

"... even minimal identification with a 'fictional' social group leads to increased in-group influence and adoption of stereotypical in-group behaviors, particularly among newer members..."

(Heilbron & Prinstein, 2008)

# Meaning

- ▶ Adolescents with a non-conformist nature are predisposed to greater acceptance and understanding of atypical behaviors
- ▶ Meaning of NSSI is socially constructed and how individuals make the choice to engage and communicate to others about self-injury is influenced by social context and psychological factors
  - ▶ Development of private logic to support NSSI behaviors
  - ▶ NSSI becomes common sense

# Gender

- Traditional Gender Guiding Lines
    - 1) Influences client behaviors/presentation of coping
    - 2) Influences counselor perceptions involved in diagnosis and treatment decisions
  - Diagnostic prevalence norms overlap with stereotypes of Western society:
    - ✓ Men = acting out (ODD, antisocial, ADD)
    - ✓ Women = acting in (Depression)
- (Ex.) Personality Disorders

# Influence of Gender on Diagnostics

- ✓ Lack of clinician awareness of how gender expectations play a role in clinical conceptualization
  - ✓ Assess yourself (Gender Roles Assessment for Women)
  - ✓ Bem Sex-Role Inventory
- ✓ Intersections of client gendered behavior with clinician gendered expectations
- ✓ House: Baggage - Season Six (22:20)

## Females are *supposed* to...

- ✓ Relational
- ✓ Supportive
- ✓ Emotionally Expressive
- ✓ Pretty
- ✓ Emotionally Reactive
- ✓ Followers

## Males are *supposed* to...

- ✓ Independent
- ✓ Aggressive
- ✓ Stoic
- ✓ Goal-oriented
- ✓ Logical
- ✓ Leaders

## Gender Guiding Lines Traditional Opposite Model

Violations = devaluation, exclusion, disappointment  
(Gilbert & Scher, 1999)

## Males Reported

- ✓ More burning
- ✓ More pain experience
- ✓ Less wound care
- ✓ Less concealing of wounds
- ✓ Social-function (attention-getting) (Claes et al ,2007)
- ✓ Self-hitting (Andover et al, 2010 non-clinical sample)
- ✓ Less concern about body disfigurement  
(Hawton, 2000)

## Females Reported

- ✓ More cutting
- ✓ More sexual abuse experiences
- ✓ Scored higher on agoraphobic and interpersonal problems measures
- ✓ More scratching  
(Andover et al, 2010)
- ✓ Earlier onset (NSSI & Depression, Andover et al, 2010)

# Researched Differences in Presentation

# Diagnosis & Conceptualization

## Risk Factors

- ▶ Environmental Risk Factors: Childhood sexual and physical abuse, emotional neglect, “invalidating environments”
- ▶ Individual Risk Factors:
  - ❖ Emotional Dysregulation
  - ❖ Affect Intensity/Reactivity
  - ❖ Alexithymia: Inability to express feelings verbally

## Motivations

- Automatic Reinforcement: Releasing internal emotions  
(e.g., to stop a feeling, to feel something [pain/relax])
- Social Reinforcement: Regulating external environment  
(e.g., to get attention, to escape/avoid being with people or doing activities, to get access)

# Keep in mind...

▶ Adler (1964): A counselor...

“...may very easily fall into the error of imagining that a type is something ordained and independent, and that it has as its basis anything more than a structure that is to a large extent homogeneous. If he [or she] stops at this point and believes that when he [or she] hears the word “criminal,” or “anxiety neurosis,” or “schizophrenia,” some understanding is gained of the individual case, one not only deprives himself [herself] of the possibility of individual research, but will never be free from misunderstandings that will arise between him [or her] and the person whom he [or she] is treating.” (p. 127)

# Conceptualization

- ▶ Gathering background information in order to better understand the perspective of the client
  - Contributing Factors
- ▶ Focus on how NSSI is serving a purpose in the client's life
  - Coping Mechanism
  - Connection to Trauma and/or need for control
  - Impulsivity, ritual behaviors, episodic
- ▶ Focusing on empathy, resiliency, encouragement, understanding, and connection rather than conflict
  - Focusing on problem-solving and contribution

# TX FOCUS ...

- ▶ Relationship Building (therapeutic alliance)
- ▶ Communication skill building (expression of needs)
- ▶ Affective Expression (identify feelings & appropriate expression of feelings)
- ▶ Behavioral Intervention (coping with difficult emotions – appropriate self-soothing)
- ▶ Cognitive Intervention (problem solving & addressing self-defeating thoughts)
- ▶ Safety Plans (specify health strategies for coping with intrusive thoughts and overwhelming emotions – activities, suggestions for communication, and contact list)

# Emotional Regulation

## Teach adolescents:

(a) awareness, understanding, and acceptance of emotions

(b) ability to engage in goal-directed behaviors and inhibit impulsive behaviors when experiencing negative emotions

(c) flexible use of situationally appropriate strategies to modulate the intensity and/or duration of emotional responses rather than to eliminate emotions

(d) willingness to experience negative emotions as part of pursuing meaningful activities in life

# Case of Juliana

- Juliana is a 17 year old female who has been self-injuring for two years.
- She has been hospitalized once in the last six months for NSSI and suicidal ideation, but did not have a plan to end her life
- She was recently asked to live with her maternal grandmother for a while
- Views self injury as the only viable option for dealing with intense feelings of anxiety, depression and at times, suicidal thoughts.
- Her parents are currently separated due to marital infidelity
- She has experienced teachers and counselors as authority figures who have insisted she stop her behaviors; she did not feel that she was understood or respected.

# Discussion



- What are your main concerns for working with Juliana?
- Why do you think she is self-injuring?
- How would you work with Juliana in as an Adlerian counselor?
- How would you approach her emotional needs?

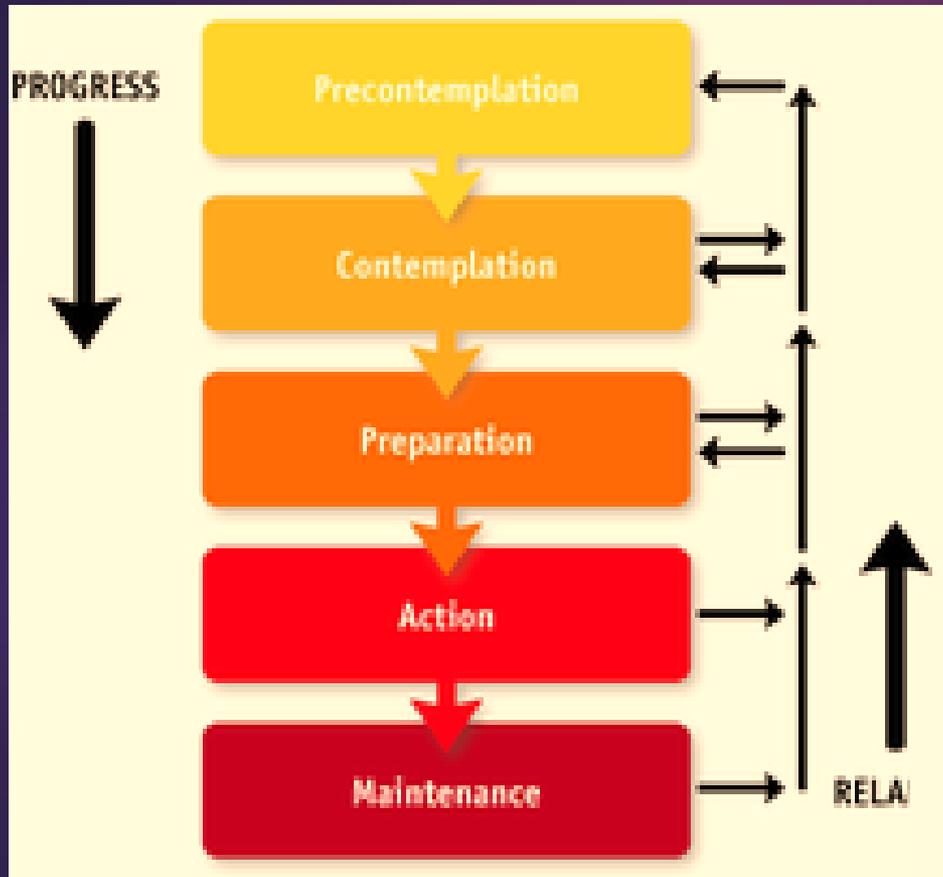
# Private Logic & Teology

- ▶ Assessing private logic using a style of living assessment in order to better understand her family constellation and view of self, others, and the world
- ▶ What is the role of shame in Juliana's understanding of self and her use of self injury?
- ▶ What does the NSSI give her? (assess the goal/purpose)
- ▶ What role does Juliana have in her family and amongst her friends?

# Breaking it Down: Beginning Work

- First focus on developing a collaborative therapeutic relationship
- Helping a client feel safe and understood:
  - *Addressing the inherent power differentials in your relationship with the client*
  - *Discuss how the client has experienced education/counseling in the past*
- Juliana should be allowed to have input on any behavioral plan or counseling process
  - *This would allow her a sense of control, something that may be inherent to her use of self injury as a coping mechanism.*

# Stages of Change and Readiness



On a scale from 1-10 where 1 is “not at all” and 10 is “I definitely want this”, how much do you want to stop self-injuring?



# Stages of Change

- ▶ Refer to Cornell Handout
- Awareness-oriented approaches
  - ✓ Stages 1-3
- Action-oriented approaches
  - ✓ Stages 3-5

For real change to happen, one needs to possess:

- hope** for a future that does not include self-injury,
- confidence** that change is possible,
- intention** to put time and effort into making changes,
- ability to identify and practice the skills** needed to stop the behavior, and
- resoluteness** – the ability to be disciplined in applying the skills needed to stop the behavior and use other methods instead.

# Clinical Considerations

- ▶ Use multiple means of assessing suicidal risk  
(Janis & Nock, 2008)
- ▶ People who self-injure and have a history of suicide attempts may underestimate the lethality of their suicide attempts (Toprak et al. , 2011)
- ▶ Use past self-injurious thoughts and behavior to help gauge risk (Janis & Nock, 2008)
- ▶ Pay attention to frequency of SI, because repeated SI is more closely related to suicidal ideation  
(Kakhnovets et al., 2010)
- ▶ Monitor for substance use/abuse because these clients may be at higher risk for suicide  
(Toprak, Cetin, Guven, Can, & Demircan, 2011)

# Basic Interventions

- ▶ Make statements that demonstrate your understanding of the client's feelings.
  - *Reflection/Summarization/Clarification*
- ▶ Make a list of people she/he can use as a support
- ▶ Attempt to understand why the client is utilizing these behaviors (be aware of the family system/history).

# Basic Interventions

- Help the client to find words to express her/his pain:
  - ✓ *"If your wounds could speak, what would they say about you?"*
- At each meeting, briefly ask the client whether or not there are any new injuries.
- With each new cut, ask her/him to verbalize her/his feelings before, during, and after the act.
- **DO NOT** treat as suicide attempt.

# General Process

- ▶ Externalize the self-injury
  - ▶ If your wounds could speak, what would they tell you?
  - ▶ If your self injury were alive (a person or another type of living being) what would it look like? What name would you give it?
  - ▶ When does *the self injury* come into your life? When do you notice it is not around?
- ▶ Develop an understanding of the cycle of NSSI
  - ▶ Discuss what happens before NSSI, when it shows up, what happens when it “enters the room” and what happens after the self injury leaves.
  - ▶ Develop interventions that focus on different places in the cycle

# Process:

# Building a Relationship

## Application

- *Important to understand that most behaviors are purposeful—even ineffective ones*
- *That we cannot understand individuals or their problems outside of the social contexts in which people live*
- *Friendliness and interest in the client is key*
- *Willingness to explore the client's perspective on the identified problem*

**Establish clear informed consent**

# Building Relationships with Adolescents

Adolescents often feel shame about NSSI and/or protective of their ritual

- Resorted to NSSI because other methods of coping have failed
- Important not to push them to discuss something before they're ready

## ➤ Keep in mind developmental level of the adolescent:

- Adolescence covers a broad range of developmental levels with different levels of cognitive ability and emotional intelligence
- Important to develop the relationship based upon understanding of the adolescent and how they communicate, understand themselves, and understand the world around them.
  - ***Common for adolescents to struggle verbally express NSSI or emotions associated with it; MEET THEM WHERE THEY ARE!***

# Example Wheel



Anxious, Attacker, Insecure

Supportive, Kind, Open

Mom

BF

Juliana

Dad

Listener, Avoids Conflict, Debater

Smart, Plain, Sad

Unsupportive, Judgmental, Holds a Grudge

Brother



# Process: Disclosure & Insight

- **Externalization:** Counselors formulate questions that would encourage the client to begin to see their self-injury as external to themselves
- Focus on function, role, and the feelings associated with self-injury, the client may begin to see the behavior exists independent of her. For clients, the process of verbalizing this aloud can be an empowering exercise.
  - *What function does self-injury have in your life?*
  - *How does the self-injury take over you, what is your role in letting it take over?*
  - *What feelings are often associated with self-injury?*

# Process: Disclosure & Insight

- Externalizing questions are to be followed by questions that search for unique outcomes (Gondim, 2006).
- Searching for unique outcomes allows the client to imagine what their future may look like, once they no longer need or want to harm themselves.
  - Was there ever a time when you wanted to harm yourself and didn't?
    - *How did this feel? What did you do to prevent yourself from cutting?*
  - If you could imagine resisting the temptation to cutting, what would it look like?

# Process: Disclosure & Insight

- **Acknowledgment of present experience**
  - ✓ *Noting the perspectives of the client and the experiences and contexts for experience in which these perspectives were developed*
  - ✓ *Exploring alternative interpretations, convictions, ideas, stories, and beliefs as new possibilities*
- Important to normalize any instances of self injury that have occurred during treatment to prevent discouragement
- Evaluation of early memories to create insight

# Example Early Memories

I saw my parents fighting. Mom was throwing pans and dishes at dad and they both were yelling really loud. They were hitting each other. I ran into the bedroom and hide behind the bed, peaking out to see what was happening. I was crying.

- ▶ Hiding behind the bed >> *scared, alone*

I was outside riding my bike and I fell. My brother was there and started laughing. He didn't help me, just made fun of me. I got up, walked my bike home and sat in the kitchen crying. No one was there. I washed my cuts.

- ▶ My brother was laughing at me when I was hurt >> *angry, pain, alone*

# Process: Re-Orientation

- Encourage the client to “create an audience” or to imagine how someone in their lives would view the accomplishments they have had thus far
  - *Reframe negative beliefs about self as strengths*
  - *Encourage other coping methods*
- This approach allows the counselor to assess support systems, but also serves to validate and empower the client

# Practice

ASSESSMENT & EXTERNALIZATION: GAUGE READINESS,  
SEVERITY, & SUPPORT TO BUILD A PATH TO CHANGE



# Simplified Procedure

- ▶ Hear the client's story of NSSI
- ▶ Discuss their readiness to change
- ▶ Assess severity and support (ERs & Wheel of Influence)
- ▶ Externalize the NSSI behavior
- ▶ Discuss the behavior as a separate entity
- ▶ Determine the NSSI process/purpose
- ▶ Suggest appropriate techniques for prevention, intervention, and reframing/normalization of needs
  - ▶ **Possible techniques:** DBT, Assertiveness Training, Cost/Benefit analysis
  - ▶ Create treatment plan

# Ethical Considerations

- ▶ School policy regarding referral and management of NSSI youth in the school must be in compliance with state law and other school policy
- ▶ NSSI management policy needs to be shared with all school staff members who may identify and refer youth – wise to train *all* school staff
- ▶ Role of confidentiality must be considered – personnel need to assess the risk level in the context of the student's developmental level before determining if parents or medical personnel should be contacted.
  - ▶ Significant self-injury warrants a breach of confidentiality as school personnel must take whatever steps necessary to keep the child safe.
  - ▶ When in doubt, err on the side of caution.

# Ethical Considerations



- ▶ School counselor must recognize the limits of services that can be provided in the context of school environment. Youth who engage in serious self-injury probably cannot be treated within the confines of the school – know procedures for community referral
- ▶ Document all contacts, phone calls, assessments, consultations, referrals, and reporting (authorities and parents) regarding NSSI behaviors.

(Juhnke, Granello, & Granello, 2011, p. 107)

# Keep in Mind...

- ▶ NSSI is complex and has biological, psychological, and environmental causes
- ▶ NSSI has not been demonstrated to lead to suicide but there are correlations between NSSI and suicide attempts so suicide risk must be assessed
- ▶ Prevention and management policies are necessary within the school system
- ▶ Teachers and school staff benefit from training via the school counselor and school nurse
- ▶ Youth who express NSSI need to be responded to with calm and empathy

Juhnke, Granello, & Granello, 2011, p. 108

# Questions?



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