Cornell Research Program on
Self-Injury and Recovery

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Bringing Up Self-Injury With Your Clients

Who is this for?

For therapists and other clinicians working with individuals who self-injure.

What is included?

Therapists, counselors, and medical professionals alike report difficulty broaching the subject of self-injury with their clients,[1,2,3] and often report burnout, vicarious traumatization, and a general lack of knowledge on how to effectively treat this growing mental health problem.[4,5,6] Parents, friends, and others report a similar hesitancy and lack of knowledge on what they can do to facilitate and support recovery from self-injury, but professionals have an ethical obligation to both assess for and be competent in treatment options for self-injury.[7] As a result of growing need, many therapists have added a few questions about self-injury practices in their initial assessment materials, or use structured evaluations when screening new clients. Access to useful assessment tools can be found on CRPSIR's website at: **http://www.selfinjury.bctr.cornell.edu/resources.html#tab**[7]

Evaluation tools and assessments can be a valuable way to get a baseline understanding of a client's experiences with self-injury. But, as self-injury is often a secretive and well-hidden pattern of behavior[8] that many clients are disinclined to disclose (at least initially), it is equally important to routinely assess for signs of self-injury throughout treatment.

Possible external signs of self-injury:

- Physical markings on the body
- Unexplained cuts or scars
- Frequent bandages
- Constant use of wrist bands and bracelets
- Inappropriate dress for the season
- Mention or discussion of friends who self-injure

Self-injury is often co-morbid or co-occurring with:

- Depression[9]
- Anxiety[10]
- Eating disorders (in particular, Bulimia, but also other forms)[11,12]
- Personality Disorders[9,13,14]
- Impulsivity[15,12,16]
- Alexithymia[17]
- PTSD and history of trauma or abuse (particularly emotional or sexual)[18,17,19]
- Issues with emotional and affect regulation (a tendency towards emotional suppression, dismissal and/or constriction)[20,21] and/or a fear that one's emotions are and will be overwhelming[22]
- A tendency towards internalization of problems and self-blame[2,3,24]
- Poor self-concept, self-esteem, or body-esteem[25]

If you notice any of the above external signs of self-injury, and/or the client has any of the above mental health symptoms/diagnoses, it is crucial to address the possibility that they may be self-injuring. Many people, therapists included, incorrectly assume that self-injury is simply a form of attention seeking and that the person will "outgrow" it or it will dissipate on its own. In addition to this, there are a number of other incorrect assumptions that clinicians and other professionals make about self-injury and these

incorrect assumptions can act as barriers to providing the support and treatment that a client needs.

Some common incorrect assumptions about self-injury:

"Only females self-injure."

This assumption, although common, is untrue. Some studies find that self-injury is about equally common in male and female populations[26,27] while others suggest that females are more likely to engage in NSSI.[28] Self-harm is on the increase in male populations though, with one study finding the largest rise (+194%) in males, ages 15-24.[29] Research indicates that gender plays a role in the form self-injury takes (i.e. females tend to cut/scratch more; males to punch/bang/burn themselves).[30] Operating under this assumption, one may not take self-injury seriously when it presents in male populations – or even fail to recognize some self-injury behaviors entirely.

"Only teenagers self-injure."

Rates of self-injury among both adolescent and young adult populations are on the rise and present a growing public health concern. A recent meta-analysis of prevalence found overall rates of NSSI (non-clinical samples) at 17.2% in adolescents, 13.4% in young adults, and 5.5% in adults, suggesting that this is a significant mental-health concern across age groups.[27] Many of these are "high-functioning", successful individuals who use self-injury as a coping skill to manage their stress. These individuals, in particular, may struggle with shame around their practices of self-injury, and strive to keep it secret.

"Clients who self-injure have Borderline Personality Disorder."

Although self-injury is one of the diagnostic criteria for a diagnosis of BPD, self-injury, in and of itself, does not qualify a person for this disorder. The DSM-V has listed NSSI (Non-Suicidal Self-Injury) in Section III as a disorder that requires more study, setting the stage for a separate disorder of NSSI.[31] Labeling and/or dismissing the behavior as part of a BPD "profile" can result in poor treatment outcomes.

"Clients who self-injure need to be hospitalized."

Although a history of self-injury increases risk for suicidal thoughts and behavior, self-injury is qualitatively different from suicidal behavior in that it is best understood as an attempt to feel better – or cope – rather than an attempt to end one's life. In distinguishing NSSI from suicidal behavior, it is critical to assess whether intent to die is present as this has been one of the strongest variables in differentiating between these two distinct but related phenomena.[32] Careful distinctions need to be made, and suicide risk should be assessed periodically as function and risk of suicide can change. Risk for suicide among those actively self-injuring is highest among individuals with a high number of lifetime incidents of NSSI, other co-morbid mental health conditions, a low sense of meaning in life, poor relationships with support systems (particularly parents), self-hatred, use of self-harm to avoid intolerable feelings, and/or a sense of hopelessness.

How to bring up the topic of self-injury:

All therapists know that the ideal therapy setting is a place where communication is genuine, honest, and purposeful. Therapy is a place where people can gain increased understanding of their internal cognitive and emotional structures, as well as practice skills that will serve them in their life. Expressing concerns about a suspected behavior to a client is part of this genuine and honest therapy relationship. Not expressing such concerns may send unintentional signals to the client that you do not wish to know, or are incapable of "handling" their secret. Despite fears and concerns to the contrary, bringing up the topic of self-injury is not going to cause a person who is not injuring to start engaging in the act. Self-injury can be a difficult subject to broach, especially with a teenager or young adult who is not coming to therapy out of their own desire to change, but is being "forced" to attend therapy.

If you suspect that your client is self-injuring:

- Make eye contact and speak in calm tones.
- Be specific about your concerns and why you have them.
- Remain neutral in your responses and don't characterize self-injury as "bad", "inappropriate", or through other negative terms. Clients who self-injure may be particularly vulnerable and susceptible to perceived criticism or heightened emotional response. When a client is discussing and disclosing self-injury, prepare yourself ahead of time to respond objectively and moderately.

If the client is mandated, or in a situation that requires them to attend therapy (i.e. parents are "making them"), it is most helpful to acknowledge this outright. Asking a client in this situation what they would want therapy to be like if they had chosen it—or what they would like to use their time for (and then honoring that request)—can be a way to increase the strength of the therapeutic relationship and the client's sense that you are to be trusted. Bringing up self-injury in this context is important and should be done in a way that acknowledges that the client was not ready to share the information and allows room for the client to grieve the loss of control and privacy they felt during this process. Acknowledging that the client did not want to be "found out," and did not choose to share the information, can allow for space to work through the often conflicting feelings that can result.

Normalize. Because self-injury is often so private, many clients have intense shame and guilt, as well as concerns about being "weird", "different", and "crazy". Helping them understand that many people use self-injury as a coping skill and that you, as their therapist, don't consider them "bad" or "crazy" will help them open up and get the help they need.

Frequently and actively assess your own reaction(s) to self-injury in supervision. If you suspect a client is actively self-injuring or has a history of the behavior and you find yourself hesitant to bring it up in session, it may be useful to explore this hesitancy in a clinical supervisory relationship. Ask yourself how you feel about self-injury and monitor your reactions. Self-injury is frequently cited as one of the most difficult client behaviors to treat, and it often results in burnout.[33,34] Perhaps it is "scary" to you as a therapist, or brings up thoughts, feelings, or sensations about a client that you would rather not experience, such as anger, shock, disgust, or inadequacy. Perhaps you view self-injury as just another attention-seeking behavior in a long list that your client engages in, or you wish to dismiss the behavior as dramatic and manipulative. Perhaps your own history or that of a family member makes the topic particularity anxiety-laden. When working with individuals who self-injure, transference and countertransference can be powerful tools and the willingness to examine your own reactions to the behavior is a crucial aspect of informed and effective treatment. While striving and working towards your own self-awareness throughout the therapy process, notice if the information that your client is self-injuring brings up any of the following reactions:

- Wanting to "fix" the NSSI
- Needing to see "progress" in each session
- Needing to show family member progress in the client
- Feeling responsible for "curing" the client
- Feeling "disappointed" in the client when they injure

These are understandable reactions but reflect an unhelpful level of anxiety in the therapist and are good topics to bring up and work through in supervision. Effectively working through your reactions, is vital to remaining present, curious, open, and empathetic with your client.

Find out about the "why" of self-injury. Why, in his/her experience, does it help? What is the function of the self-injury? What is happening internally (and externally) for the client directly before and after they injure? What is the client's perspective and lived experience as it relates to the meaning of self-injury in their life?[3] People often use self-injury as a means to regulate their internal emotional processes,[35] but this is not the only reason people injure, and helping your client get specific about *what the injury does for them* is the first step in helping them learn how to get those same needs met in different ways. For a comprehensive function charting/monitoring tool that is easily reproducible for use with clients, see Barry Walsh's *Clinical assessment of self-injury: A practical guide,* pp. 1063.[36]

Ask specific questions. Ask not only why, but how much, how often, and where (on the body, and also where in their physical environment?) (e.g. their bedroom, school, etc.). Ask how long the person has been self-injuring, when and why it initially started, and who knows. Find out more about:

- Form
- Function
- Wounds per episode
- Frequency of episode(s)
- Episode duration
- Body areas involved
- Extent of physical damage
- Other forms of self-harm
- Tools / implements used
- Wound patterns and meaning
- Physical & social context

Asking clients about the social context of their self-injury should include gathering information about a client's use of the Internet in general, in addition to finding out how their self-injury may be affected by online activities. Contemporary youth face many challenges related to Internet usage in general and on-line activities can strongly affect mental health. While the Internet can increase feelings of connection and acceptance, it can also exacerbate harmful behavior. Finding out more about what client's "do" on the Internet will let you know if what is happening on-line is likely to require additional attention. For example, it is common for individuals who feel isolated in non-virtual life to use on-line connections as an attempt to meet core acceptance and belonging needs. Assessing breadth, depth, and nature of use will help you assess whether clients need education and social skills training. The following questions are templates that may be beneficial when exploring a client's online activity (see Whitlock, Lader & Conterio[37] for a complete list of questions and in-depth article):

...it is common for individuals who feel isolated in non-virtual life to use on-line connections as an attempt to meet core acceptance and belonging needs.

- Have you ever made friends over the Internet?
- Have you ever visited a Web site to find out about or to talk about self-injury?
- Are there places you regularly go to find out about or to talk about self-injury?
- How often do you visit this/these site(s)?
- What do you like to do most while there?
- Do you like to post messages (or videos) or do you like to just see what is happening?
- What type of site(s) do you visit?
- How close do you consider your Internet friends to be?
- Have you ever met with friends you made online?

Discuss the process. What is it like for them to talk about this with you? What are their feelings while discussing self-injury in the session? What is happening physiologically as they bring up the self-injury? What are their feelings about sharing their self-injury habit, and how do they feel about you knowing? What are their fears?

Don't immediately ask the client to engage in a no-harm contract. Unless self-injury is a suicidal act for the person, engaging in contracts can cause them to wish they would not have shared the information with you in the first place and to believe you think what they are doing is wrong. It can also undue any attempts to normalize and understand the function of their self-injury.

Meet the client "where they're at". This can be difficult because the natural reaction, once a therapist knows self-injury is occurring, is to want to prevent self-injury from happening again. The key here is patience with measured concern, education, and support. Pushing a client to do something they're not ready for or to give up self-injury altogether can be more harmful then helpful, and cause the client to "go underground" again with their true use. Taking the stance that, as the therapist, one needs to argue against the self-injury, may have the unintended consequence of the client pushing back and injuring more.

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Motivational Interviewing (for more see Miller & Rollnick,[38]), along with education, can be helpful in gently moving clients in a direction of improved well-being. Utilizing techniques from common treatment approaches will be unfruitful if a client is not yet ready to give up self-injury. Helping clients understand the costs and benefits of their self-injury, and asking the client to identify what ways the self-injury is no longer working for them, can be more helpful for a client then hearing your opinion about why they should stop.

Give lots of positive feedback along the way. As clinicians well know, change often comes in small steps, or fits and starts. Giving clients positive feedback along the way, that highlights and summarizes the efforts you see them making towards a larger change, can be helpful in building self-esteem and confidence in their ability to continue making changes.

For example, is the client talking about and acknowledging that self-injury has consequences? Are they noticing their thoughts and feelings before and after they injure? Are they waiting, even 10 minutes, when the urge to injure comes up? Are they using other coping skills, even if these skills don't always work, and even if they don't work as fast or as well as self-injury? Are they willing to make a list of adaptive coping skills that they will try instead of or before injuring? There are numerous small opportunities to point out changes in a client's perceptions or beliefs about self-injury and its effects on their life. Positive feedback can come in the form of acknowledgment of these small accomplishments and the client's ability to choose other patterns of thinking and behavior. Feedback should be genuine and honest, not overblown and Pollyannaish, and should keep in mind the old saying, "A journey of a thousand miles, begins with a single step." If you have difficulty finding opportunities to provide positive feedback to clients, this may be a sign that the narrative in therapy has become bogged down in pathology, and "what the client is doing wrong," and should be addressed in supervision. Genuine positive feedback can be a learning opportunity for clients as they begin to conceive of more middle-of-the-road, strengths-based ways of thinking, and as they learn to internalize adaptive thinking patterns modeled in the session.

Utilize treatment approaches that emphasize emotional awareness, emotional acceptance, and emotional regulation, as well as use of healthy coping skills. Good choices are DBT (see Linehan,[39]), MB-CBT (see Crane,[40]) and ACT (see Luoma, Hayes, & Walser,[41]). Actively involve family members in treatment, and consider approaches that emphasize attachment and mentalization capacities, such as Mentalization-Based Therapy for Adolescents (see Rossouw & Fonagy,[42]). Utilize mindfulness and stress-reduction techniques, including evaluating and reworking the client's exercise, sleeping, and eating habits to increase restfulness, well-being, and regulation of the body's physiological responses. Teach social skills and interpersonal effectiveness. Have the client keep a log or journal about their experiences with self-injury and what thoughts, emotions, and situations are happening when they self-injure, as this information can help them realize when they need to practice newly obtained coping skills.

Conclusion:

Self-injury is a growing public health concern, and clinicians have an ethical responsibility to assess for and understand how to intervene in this issue. This factsheet is intended as a general introduction and overview on how to assess for and respond to self-injury, rather than a comprehensive tool. Self-injury is a complex mental health issue, and continued education, supervision, and clinical training in this area is strongly encouraged for anyone working with clients who self-injure.

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