

# NONSUICIDAL SELF-INJURY AMONG ADOLESCENTS:

## Implications for Treatment, Prevention, and Research

by Carolyn Raitt, M.A.

Nonsuicidal self-injury (NSSI) refers to deliberate, socially unacceptable destruction of one's own body tissue performed without the intention to die. Research shows that about 1 in 25 adults has engaged in NSSI, but rates are significantly higher among adolescents: around 1 in 5 engage in NSSI, and among adolescents hospitalized for psychiatric issues, rates are considerably higher (40-80%) (Muehlenkamp, Claes, Havertape, & Plener, 2012; Klonsky & Muehlenkamp, 2007). Given the high prevalence of NSSI, especially among adolescents, it is essential for mental health providers to be familiar with NSSI, know its risk factors, understand its functions, and be able to provide effective treatments.

Self-injurers (i.e., those who engage in NSSI) employ a wide variety of methods, including skin cutting, banging, hitting, burning, picking or interfering with wound healing, punching oneself or objects,

and inserting objects under the skin (Klonsky & Muehlenkamp, 2007; Lloyd-Richardson, 2010). The most common form is skin-cutting, which is used by over 70% of those who self-injure (Klonsky & Muehlenkamp, 2007). However, most people who self-injure use multiple methods.

### RISK FACTORS FOR NSSI

There are a wide variety of intrapsychic, psychosocial, and interpersonal risk factors for NSSI. Adolescents who self-injure are higher in negative emotionality compared to adolescents who do not self-injure (Klonsky & Muehlenkamp, 2007). That is, they experience more frequent and more intense negative emotion and struggle with emotion dysregulation. In addition, they report greater frequency of psychiatric problems, including mood and anxiety disorders, borderline personality disorder, eating disorders, and



substance use disorders (Klonsky & Muehlenkamp, 2007; Lloyd-Richardson, 2010). NSSI correlates with deficits in emotion skills. Self-injuring adolescents experience a range of difficulties such as detachment, separation from reality, and difficulty identifying and describing their emotions. Self-injuring adolescents experience separation or detachment from reality and have trouble identifying and describing their emotions (Klonsky & Muehlenkamp, 2007; Lloyd-Richardson, 2010). An additional risk factor for NSSI is self-derogation; adolescents who self-injure tend to be more self-critical, experience more self-directed anger, and have lower self-esteem (Klonsky & Muehlenkamp, 2007).

Adolescent NSSI correlates with poorer-quality family environments. For example, self-injuring adolescents are more likely than their non-self-injuring peers to have experienced family violence, separation from parents, and poor relationships with parents (Lloyd-Richardson, 2010; Kaess et al., 2013). They are also likely to have experienced maternal antipathy or neglect, adverse childhood experiences, high levels of parental criticism, invalidating family environments, and sexual abuse. It should be noted, however, that the association between childhood sexual abuse and NSSI is only moderate, suggesting that childhood sexual abuse may be a proxy measure of other experiences that predispose an individual to self-injure (Lloyd-Richardson, 2010). Adolescents who engage in NSSI are also more likely than their non-self-injuring peers to report the following interpersonal problems: difficulty making or keeping friends, problems with their

### **SIGNS THAT YOUR TEEN MIGHT BE SELF-INJURING:**

- Unexplained or poorly explained injuries (particularly scratches and cuts), especially when they appear frequently.
- Small, linear cuts, often running parallel to each other. The wrists, forearms, and legs are common sites for self-injury.
- Consistently wearing long sleeved shirts and/or long pants (to hide cuts on wrists, forearms, and/or legs) even in warm weather or when the clothes aren't their usual style.
- Consistently wearing multiple bracelets and wristbands.
- Avoiding activities like swimming or gym class, where arms and legs can be seen.
- Mood changes like depression, anxiety, and/or increased irritability.
- Changes in sleeping or eating patterns.
- Loss of interest in activities they usually enjoy.
- Stopping seeing friends.
- Decline in school performance.
- Hiding objects that can be used to self-injure (e.g., razor blades, stencil knives, safety pins, lighters, and matches).

girlfriend/boyfriend, fights with parents, being bullied at school, and/or having a friend or family member who has attempted NSSI or suicide (Doyle, Treacy, & Sheridan, 2015). In addition, NSSI is more common among adolescents who report a non-heterosexual

orientation or who are experiencing discomfort or concerns about their sexual identity (Doyle, Treacy, & Sheridan, 2015; Klonsky, Victor, & Saffer, 2014; Peterson, Freedenthal, Sheldon, & Andersen, 2008).

## **NSSI AND SUICIDE**

NSSI is, by definition, not intended to cause death. However, NSSI co-occurs with suicidal behaviors in both community and psychiatric populations. Adolescents who engage in NSSI are more likely than non-self-injurers to report a history of suicide attempts or elevated current suicidal ideation (Klonsky, Victor, & Saffer, 2014; Lloyd-Richardson, 2010). At least half of self-injurers report having attempted suicide at least once (Klonsky & Muehlenkamp, 2007), and NSSI is a “strong predictor of future suicide attempts—even stronger than a history of past suicide attempts” (Klonsky, Victor, & Saffer, 2014, p. 566). Given this high correlation between NSSI and suicide, Klonsky et al. (2014) suggest that NSSI “may represent a unique risk factor for suicide, as it is strongly associated with emotional and interpersonal distress, which increases risk for suicidal ideation and (or) desire, and desensitizes people to the pain associated with self-injurious behaviors, which increases capability to act on suicidal desire” (p. 567).

## **CHARACTERISTICS OF EFFECTIVE TREATMENT FOR NSSI**

### **THERAPEUTIC ALLIANCE**

Forming a strong therapeutic alliance is an essential first step in the treatment of NSSI (Muehlenkamp,

2006). In working with adolescents who self-injure, the therapeutic alliance must be strong enough to withstand the challenges that are likely to occur. In time, a strong relationship between the therapist and adolescent may become a key part of the intervention strategy. For example, research has found that clients who perceived their therapist as warm and protecting experienced fewer episodes of NSSI during the course of dialectical behavior therapy (Turner et al., 2014).

### **NONJUDGMENTAL STANCE**

Researchers and clinicians, as well as adolescent clients who self-injure, point to the importance of the therapist’s nonjudgmental stance (Brown & Kimball, 2013; Klonsky & Muehlenkamp, 2007). To this end, it may be helpful for the clinician to acknowledge the client’s emotional pain and the functions that the NSSI serves, thereby communicating a willingness to join—without fear—the client where they find themselves (Muehlenkamp, 2006).

### **COLLABORATIVE RELATIONSHIP**

In working with adolescents who self-injure, it is valuable to establish a collaborative relationship in which the client and therapist work as a team rather than as expert and subject (Muehlenkamp, 2006). Additionally, research has found that interventions that include a focus on building collaborative therapeutic relationships are among the most effective in reducing NSSI (Turner et al., 2014).

### **FUNCTIONAL ASSESSMENT**

Researchers and clinicians agree that it is essential to

assess the purposes NSSI serves for a particular client (Klonsky & Muehlenkamp, 2007; Turner, et al., 2014). For example, if the client consistently self-injures after an argument with a sibling, the NSSI may be helping the client regulate her anger. Moreover, in a family where expression of anger is taboo, such NSSI may also serve as a self-inflicted punishment for displaying anger. Knowing the purpose of the behavior from the client's perspective can help to inform treatment. In this example, the therapist might focus on increasing healthy expression of anger in the family, decreasing hostile interactions between the client and her sibling, and developing alternative outlets for the client to express her anger.

### **ADDRESSING NSSI DIRECTLY**

Research also advises directly monitoring and targeting NSSI on an ongoing basis (Turner et al., 2014). This kind of direct approach is essential for preventing escalation of the behavior and is one of the most effective ways to reduce NSSI (Muehlenkamp, 2006; Turner et al., 2014).

### **COPING SKILLS**

It is imperative that the therapist help the self-injuring adolescent develop alternative coping skills, especially for emotion regulation (Turner et al., 2014). The therapist and adolescent must work together to identify other ways to meet the needs fulfilled by NSSI; doing this may enable the adolescent's recognition that he or she has a choice about whether to self-injure (Gonzales & Bergstrom, 2013; Peterson et al., 2008). In addition to employing behavioral interventions and cognitive

restructuring, it is prudent to work on problem-solving, since adolescents who engage in NSSI often have poor problem-solving abilities (Muehlenkamp, 2006; Peterson et al., 2008).

### **IMPLICATIONS FOR PREVENTION**

Given the high prevalence of NSSI among adolescents, it is essential for mental health providers who work with teens to be familiar with effective intervention strategies. However, researchers and clinicians must go a step further and work to prevent the development of NSSI among adolescents. Literature on prevention is extremely minimal (Prinstein, 2008).

Tertiary prevention efforts for adolescents who are already self-injuring should focus on teaching educators, physicians, and mental health providers about NSSI so that they can respond more appropriately and effectively to adolescents who are self-injuring. This adult education should focus on distinguishing NSSI from suicide, and explain that NSSI is a form of maladaptive problem-solving which serves a wide variety of important functions (Lloyd-Richardson, 2010). Another important target of tertiary prevention work is parents of adolescents who are self-injuring. They, along with educators, physicians, and mental health providers, should know that adolescents who self-injure are at increased risk for suicide. Therefore, it is important for them to learn precautionary measures to support and protect these youth (Klonsky et al., 2014).

Primary and secondary prevention efforts would do well to focus on teaching developmentally appropriate emotion regulation and healthy coping skills to

students in elementary and high schools. Especially during preadolescence and adolescence, it may be valuable to provide psychoeducation in the context of adolescent psychosocial development. Applying a developmental perspective to the challenges of the teen years may help form a more collaborative therapeutic dynamic and may mitigate the experience of feeling not understood that is reported by many self-injuring adolescents (Brown & Kimball, 2013).

Secondary prevention efforts are particularly important during preadolescence, as youth are at increased risk for NSSI over the next decade of their lives. This psychoeducation, which would be well-placed within health classes, may include informing youth about the health risks and dangers of NSSI (e.g., risk of cutting tendons, veins, or arteries; infection), as well as the mental health concerns that put adolescents at increased risk for NSSI. It should also identify community resources for adolescents struggling with NSSI.

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## HOW TO RESPOND TO YOUR TEEN'S SELF-INJURY ACROSS THREE PHASES: INITIAL DISCOVERY, TREATMENT, AND RECOVERY

### Phase 1: Initial Discovery of Self-Injury

- **First, manage your own feelings** of shock, anger, panic, guilt, confusion, sadness, and/or fear before confronting your teen. It is normal and valid to feel strong negative emotions if you think that your teen might be hurting themselves, but expressing these feelings may not be productive to your teen opening up or wanting to change the behavior.
- **Provide first-aid for your teen's injuries.** If needed, seek appropriate additional medical attention.
- **Talk to your teen calmly, directly, and without judgment.** Approach this conversation with compassion. Listen to what your teen has to say without interrupting.
- **Ask your teen if they are hurting themselves.** Be straightforward. Say something like, "I've noticed that you have a lot of scratches on your arms these days. Are you cutting yourself?" Use a warm, gentle tone. If you sound accusatory, your teen might get angry, defensive, or shut down.
- If your teen admits that they are self-injuring, **ask follow-up questions to understand them better**, such as, "What makes you want to hurt yourself?" "What does it do for you?" and "How do you feel after you hurt yourself?" This is also a good time to clarify whether your teen wants to die or whether this is non-suicidal self-injury. Ask gently, bearing in mind that people who self-harm might feel ashamed about their behavior.
- **Respect that your teen may not want to talk about their self-injury with you.** If they are having trouble talking, offer that they can write you a letter about what's going on. Alternatively, if there is another adult who they trust and would feel more comfortable talking to, consider setting up a time for your teen to talk with that person.
- **Empathize with your teen.** Make sure they feel understood and supported, not judged. Listen to them, try to understand their perspective, and reflect this back to them. Say something like, "I know you're really upset," or "I can see how much you're struggling these days."
- **Keep the focus on your teen.** While your teen's self-injury affects you significantly, it is critical that you do not make the situation about you. Focusing on yourself may cause feelings of guilt in your teen, and it will not help them to stop self-injuring. Avoid criticizing how you have raised your teen or accusing the teen of injuring themselves as a way or punishing you. Your teen's self-injury is not your fault. However, you can be part of the reason why they stop self-injuring by being supportive and helping them to obtain professional assistance.
- **Tell your teen that you want to help them.** Assure your teen that you love them and will support them no matter what happens. Make sure that your teen understands that they do not need to feel guilty or embarrassed about asking for help. Explain to your teen that you are there to help them if they ever need anything or just want to talk.

## Second Phase: Seek Professional Help

- **Take your teen to see a therapist.** Explain to your teen that talking with a therapist is a way to help people learn how to better cope with their emotions. Discuss therapy in a positive, casual tone. Reassure your teen that professional therapy is not a punishment and that they should not feel guilty for obtaining help. If you have ever been to therapy, then discuss your experience with your teen as this will help normalize the idea of seeing a therapist.
- **Recognize that treatment takes time.** Therapy is not going to cure your teen overnight. It often takes months or years to stop self-injuring. But recovery is possible if you are patient. Likewise, your teen might need to try a few times, or work with different therapists of different approaches to therapy before they can stop self-injuring. Different therapies are effective for different people. Support your teen in sticking with therapy, and if necessary, in trying different approaches until they find something that works for them.

## Third Phase: Helping Your Teen through Recovery

- **Understand that you cannot force your teen to stop self-injuring.** Though it is difficult for parents to accept, the decision about whether or not to self-injure is your teen's alone. A teen who is intent on self-injuring will find a way to do so. Focus on supporting your teen instead of trying to control them. You should be aware that you cannot remove every means of self-injury from your teen's environment, but you may still want to lock up razors and knives if your teen is cutting themselves.

- **Help your teen manage the problems that make them want to self-injure.** Talk with your teen and try to find the "triggers" that prompt them to self-injure. Work with your teen to brainstorm alternative ways for them deal with their negative emotions and/or avoid triggers. Try to offer practical and/or emotional support whenever and however you can. Examples include offering to go for a walk or other outing with your teen if they need to talk about a problem or decreasing their household chores if they are overwhelmed with schoolwork.
- **Get your own support.** Talking to your own therapist can help you manage your own reactions to your teen's self-injury. You may feel a sense of fear, shame or self-judgement. It is important that you have support to process your own thoughts and feelings about your teen's self-injury before you respond to your teen. The support you receive will help you be a more level-headed, empathic, and effective parent. In addition, if your teen sees you modeling healthy coping, they are more likely to be open to seeking help for themselves.

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