

Article 44

Non-Suicidal Self-Injury: Cutting Through the Pain

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Abstract

The number of youth presenting with self-injurious behaviors has increased over the past several years. For school counselors, this has brought a need for relevant information, training, and treatment strategies. This article offers pertinent information on self-injury such as a definition, the *DSM-5* diagnostic criteria, common misconceptions, prevalence, risk factors, cultural differences, the cycle of self-injury, ethical and legal considerations, and concludes with treatment options.

Keywords: non-suicidal self-injury, children, adolescents, dialectical behavior therapy, school counseling, butterfly project

Non-suicidal self-injury (NSSI), is growing at an alarming rate within the child and adolescent population. It is estimated that one in eight middle and high school students have participated in this risk-taking behavior (Bakken & Gunter, 2012). School

counselors are on the front lines of this phenomenon and may harbor misunderstandings that impede student outcomes. To assist with clarity and counter these misconceptions, a definition of NSSI, diagnostic information, prevalence, and warning signs follows.

Definition of Non-Suicidal Self-Injury

Claes et al., (2015) stated that non-suicidal self-injury is deliberate and direct harm done to one's own body tissue without suicidal intent. This harm can include a wide range of behaviors such as scratching, cutting, hitting, scabbing, embedding, bruising, bone breaking, and burning, among others (Claes et al., 2015). This vast array of behaviors may make diagnosis more difficult. Following is information to assist counselors as they try to identify students at risk of the behavior, including distinguishing between NSSI and other mental health issues.

Identification and Diagnosis

***DSM-5* Diagnosis**

Non-suicidal self-injury has historically been thought of as a symptom of borderline personality disorder (Vaughn, Salas-Wright, Underwood, & Gocherz-Kerr, 2015). For example, the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., *DSM-IV*; American Psychiatric Association [APA], 1994) discussed self-harm under the aforementioned diagnostic criteria. Despite this listing in the *DSM-IV*, practitioners had stated that the current diagnostic criteria were inaccurate for many self-injurious clients (Zetterqvist, Lundh, Dahlstrom, & Svedin, 2013). As a result, experts called for a definitive and more accurate diagnosis within the *DSM-5* (Groschwitz, Kaess, Fisher, Ameis, Schulze, Brunner, Koelch, & Plener, 2015). In response, the American Psychiatric Association placed NSSI in a new section of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., *DSM-5*; 2013) entitled, "Conditions for Further Study." The proposed criteria in this section require additional study and are not intended for clinical diagnosis.

Comorbidity and disagreements among criteria add to the confusion (Vaughn, Salas-Wright, Underwood, & Gocherz-Kerr, 2015). For example, eating disorders, depression, anxiety, and post-traumatic stress disorder are common co-occurring diagnoses (Vaughn, et al., 2015). NSSI may also mimic disorders such as trichotillomania or be a symptom of another disorder such as borderline personality disorder, eating disorders, or substance abuse (APA, 2013). To further complicate diagnosis, the *DSM-5* states there must be an absence of suicidal intent in order to meet the criteria for NSSI (APA, 2013). However, the lack of suicidal ideation is not agreed upon by all researchers. It seems clear more research and a better understanding of the relationship between NSSI and suicidal behavior is needed.

Differences Between NSSI and Suicidal Behaviors

NSSI and suicidal behaviors are not synonymous and may be confused with one another as part of the assessment and treatment processes (Butler & Malone, 2013). Because each behavior is treated differently, assessment is crucial and misdiagnosis must be avoided. Counselors might ask questions such as, "What is the reason you cut? Do you want to die?" A detailed history might also prove helpful in that it uncovers patterns

associated with intent. For those with NSSI, an over emphasis on suicidality may be counterproductive to treatment engagement and instill client anger (Walsh, 2012). As a result, it is important that counselors listen to clients and overcome their own fears about suicidality if proper diagnosis is to be given.

To further complicate differences between NSSI and suicidal behaviors, research infers an overlap between the two acts (Walsh, 2012). In fact, NSSI may be used as a self-healing mechanism that helps clients avoid suicidal behaviors. As such, NSSI is often seen as a mechanism used to self-heal in those exhibiting suicidal tendencies. The main distinction between the two facets involves simply whether one injures with the intent to die (suicidal behavior) or the intent to feel better (NSSI). Interestingly, NSSI and suicidal behavior can occur simultaneously in the same individual (Butler & Malone, 2013). It is also important to note that while the majority of self-injurers are not suicidal (Wilkinson & Goodyer, 2011), NSSI is the best predictor of a subsequent suicide attempt (Asarnow et al., 2011; Wilkinson, Kelvin, Roberts, Dubicka, & Goodyer, 2010). For this reason, it is important that counselors understand motives for injuring, and recognize and offer help to students demonstrating warning signs. Following are discussions on these issues.

Motives

Why do students injure themselves? This is a difficult question for many counselors to answer. The horrific and often bloody consequences of self-injury may incite counselor panic and misunderstanding. Knowledge about youth motives may help counselors overcome emotional reactions that impede treatment outcomes (Froeschle & Moyer, 2004). Several explanations are revealed in the literature.

The American Psychiatric Association (2013) stated that the self-injurer uses the behavior to relieve negative feelings, induce positive emotions, and resolve difficulty. Interestingly, self-injury is used to eliminate an overabundance of emotions as well as to manage dissociation (Walsh, 2012). Those wishing to eliminate emotions report feeling anger, shame, anxiety, sadness, frustration, and contempt at unmanageable levels. Youth experiencing few emotions state they feel “empty, zombie-like, dead, or like a robot” (Walsh, 2012, p. 8). The key motive for both types of injurers is to overcome devastating distress.

Higgins (2014) and Chapman and Gratz (2009) stated that brain chemicals play a role in self-injurious motivations. Youth experiencing chemical imbalances within the brain may injure to release endorphins or experience a “high.” Much like drug use, a person may develop cravings for these brain chemicals and even experience a form of addiction (Higgins, 2014).

Neurotransmitters such as serotonin have also been linked to self-injury (Chapman & Gratz, 2009). Serotonin levels are important regulators for issues such as depression, emotional distress, and aggression. Self-injurers, who typically have lower serotonin levels than individuals in the general population, increase serotonin levels upon injury. As a result, they instantly experience relief and a regulation of the aforementioned emotional issues (Chapman & Gratz, 2009). Moyer and Nelson (2007) described a cycle of self-injury that more thoroughly explains the experience and motives of the self-injurer.

Cycle of self-injury. The cycle of self-injury refers to the process in which adolescents cycle from one self-injurious episode to another. The cycle (Negative Thoughts, Tension Building, Urge to Act, Action, Relief, Shame) may be valuable in helping mental health professionals better understand self-injury and working with clients to find alternative coping strategies. Self-injury is commonly described as a coping skill or a way to regulate emotions (Nock, 2009). Therefore, the first three parts of the cycle of self-injury describe the buildup of emotions. The type of negative thoughts, the duration to the tension building stage, and the threshold between the urge to act and acting varies for each individual. However, much of the literature surrounding NSSI indicates that the tension and negative thoughts may be related to conflicts with family or peers, self-hatred, history of sexual or physical abuse, or other stress inducing situations (Kakhnovets, Young, Purnell, Huebner, & Bishop, 2010; Moyer & Nelson, 2007; Nock, 2009).

Step four of the cycle of self-injury is the act of harming oneself and, similar to most all other coping skills, relief of varying lengths and intensity follows the action. Contrary to other coping skills, self-injury produces shame in teens and adolescents. There is a stigma attached to NSSI (Berger, Hasking, & Martin, 2013). Teens participating in self-injury understand the stigma and after self-harming may begin to have negative thoughts about their ability to control their injuries and thus begin the cycle again.

The authors believe the most valuable part of the cycle of self-injury is understanding that all individuals (regardless of their coping mechanisms) may have occasional negative thoughts and that all individuals will have the urge to implement a coping skill. The key in working with individuals who self-injure is understanding the meaning behind the self-injurious behavior (Moyer & Nelson, 2007) and ultimately working with clients to implement a new coping skill that provides the same relief without the guilt or shame attached. If counselors are to thoroughly understand and utilize the cycle, specific knowledge of the inherent warning signs and risk factors is crucial. Following is a discussion on these issues.

Warning Signs and Risk Factors

Warning signs. It is essential for those working in the child and adolescent population to be cognizant of the warning signs associated with NSSI. There are several common warning signs that can help counselors become aware of their client's needs. For example, unexplained, frequent injury may be a sign (Mental Health Association of Illinois, 2014). Bruising, burns, or other injuries that are frequent can be a sign of abuse or they may be a sign of self-injury. Further, many teens who self-injure wear long sleeves or pants during the warm months of the year (Mental Health Association of Illinois, 2014). This may be a sign that they are hiding their injuries from others. Because the aforementioned injuries may be difficult to discern as self-inflicted or hidden, school counselors must develop rapport with students. Only through a great relationship will many students reveal the true nature of their injuries (Froeschle & Moyer, 2004).

Other warning signs school counselors should be alert to include: low self-esteem, difficulty managing emotions, relationship issues, poor social functioning, and long periods of wanting to be alone (Mental Health Association of Illinois, 2014).

Risk factors. According to Whitlock and Rodham (2013), “Adolescence is, in and of itself, a risk factor for NSSI” (p. 7). Adolescence is a vulnerable developmental stage because of all the stress and pressure teens are dealing with, and they often are not sure how to cope. Their bodies and hormones are changing, their emotions are up and down, and they are struggling with identity formation.

Diverse individuals participate in self-injury (Whitlock & Rodham, 2013). For example, self-injurers may be gifted or have learning disabilities, be outgoing or introverted, popular or unpopular, and may participate in diverse activities (Whitlock & Rodham, 2013). People who self-injure can be found in “the best neighborhoods and private schools, in colleges and in the workplace” and are “often bright, talented and creative achievers—perfectionists who push themselves beyond all human bounds, people-pleasers who cover their pain with a happy face” (Strong, 1998, p. 18). However, some adolescents who self-injure can be found “with certain subgroup cultures (e.g. emo, punk, or Goth)” (Whitlock & Rodham, 2013, p. 2).

Other risk factors for NSSI include depression, anxiety, and poor coping skills (Haines & Williams, 2003). Abuse and neglect histories are usually connected with NSSI (Miller, Rathus, & Linnehan, 2007). NSSI is common in patients who also struggle with psychiatric conditions such as substance abuse, obsessive-compulsive disorder, and depression (Lofthouse, Muehlenkamp, & Adler, 2009). Between 25.4% and 55.2% of eating disorder patients have reported that they engage in self-harm (Claes & Muehlenkamp, 2014; Svirko & Hawton, 2007). Another factor that contributes to self-injury is poor impulse control, especially in stressful situations (Peterson & Fischer, 2012). Because early detection positively influences treatment success, it is imperative that counselors comprehend the implications of the phenomenon based on the vast numbers of youth participating in, as well as the dire consequences, of the behavior. Since age at onset affects timing of interventions, this is also an important area of discussion. As a result, the next sections detail the prevalence and age at onset, warning signs, and consequences of the behavior.

Prevalence, Prognosis, and Consequences

Prevalence and Age at Onset

School counselors address NSSI on a daily basis, and adolescents see self-injury as commonplace. About one in six adolescents has attempted to self-harm at least once (Muehlenkamp, Claes, Havertape, & Plener, 2012). Up to 17% of teenagers and 4% of adults admitted to a history of NSSI (Muehlenkamp et al., 2012).

Typically, adolescents begin self-harming around the age of 13 to 15 and, without intervention, may continue through life (APA, 2013; Heath, Schaub, Holly, & Nixon, 2009). However, a quarter of adolescents started cutting before the age of 12 (Nixon, Cloutier, & Jansson, 2008), and about 25% of adolescents and adults who self-harm report NSSI as a one-time incident (Heath, Toste, Nedecheva, & Charlebois, 2008; Whitlock, Eckenrode, & Silverman, 2006).

Prognosis

Some adolescents are successful at overcoming NSSI; however, about 20% struggle throughout adulthood and have difficulty stopping the habit (Whitlock &

Rodham, 2013). For this reason, early treatment is crucial in improving prognosis (Conterio & Lader, n.d.). Those who start treatment as adolescents can learn better coping mechanisms for handling inherent adolescent identity issues (Breen, Lewis, & Sutherland, 2013), healthy methods for regulating emotions, and build lasting supportive networks (Conterio & Lader, n.d.).

Consequences of Self Injury

Physical consequences are of concern when teens self-injure. Permanent scarring is common among adolescents who participate in NSSI on a regular basis (APA, 2013; Walsh, 2012). Thick scarring is typically seen on the upper thigh regions, as this is becoming a common area to cut. Blood-borne infections and disease transmission are also a concern if youth cut with unsterilized or shared blades/instruments (APA, 2013; Nixon & Heath, 2008). When looking at these consequences, however, it is important to remember that self-injury transpires in more ways than just cutting. Forms of self-injury utilized may be too numerous to mention here. As a result, counselors must consider how the student is injuring to fully understand all consequences. A basic description of the most common types of self-injury follows.

Types of Non-Suicidal Self-Injury

Non-suicidal self-injury presents with many types. The most common type seen among patients is cutting. Cutting is mostly seen on the dorsal part of the arm or the upper thigh (Somer, Bildik, Basay, Gungor, Basay, & Farmer, 2015). Although, some teens cut within the groin area so that their parents will not see it. Skin picking until the skin bleeds and burning are also common forms of self-injury (Somer et al., 2015). Other types of self-injury include pinching, banging, biting, scratching, skin rubbing, needle sticking, carving, and wound picking (Somer et al., 2015). Adolescents will use a variety of objects to cause harm such as razor blades, knives, erasers, lighters, and needles. Cultural and gender differences may play a role in the type of injury inflicted. Consequently, a discussion on each of these issues follows.

Cultural and Gender Differences

Cultural Differences

Research indicates that Caucasians or multi-racial individuals have a much higher rate of NSSI than minorities (Borrill, Fox, & Roger, 2011). The same is true for the amount of reported self-injury. Caucasian students report five or more incidents of self-injury in their lifetime. Meanwhile, African Americans are least likely to report repeated self-injury. As a whole, African-Americans participate in self-injury less than other cultures (Borrill et al., 2011). While Hispanics have high rates of participation, they may underreport since the behavior is viewed as a weakness (Bakken & Gunter, 2012). Those Hispanics who do participate in NSSI are more likely to burn the skin, wound pick, or scrape the skin until it bleeds (Bakken & Gunter, 2012).

Adolescents who associate themselves with a religious group are less likely to self-harm (Whitlock & Rodham, 2013). Researchers have found that this trend is among those who identify as Christian, Muslim, and Hindu, among others (Whitlock & Rodham,

2013). On the contrary, those individuals who identify as atheist or agnostic have a much higher rate of NSSI (Whitlock & Rodham, 2013). Religious teens have a 6% rate of NSSI, while atheist and agnostic youth have a 33% rate of NSSI (Whitlock & Rodham, 2013).

Gender Differences

More research is needed to thoroughly understand gender differences among those who self-injure. While many researchers tout self-injury as a predominantly female behavior, others counter this notion. For example, Andover, Primack, Gibb, and Pepper's (2010) research found that males make up about half of all individuals who self-injure.

Specific behaviors are also influenced by gender. According to Bakken and Gunter (2012), males are more impulsive with their injury and participate in self-injury that produces more pain. For example, males participate in burning more than females (Bakken & Gunter, 2012). Males who report NSSI behavior are also more likely to identify as a sexual minority and are more likely to use hard substances such as cocaine or crack (Bakken & Gunter, 2012). Suicidal thoughts may be more common in males who self-injure than in females (Bakken & Gunter, 2012).

Females who present with NSSI often present with comorbid diagnoses. For example, they often have eating disorders, report being victims of sexual assault, and use substances such as alcohol and marijuana (Bakken & Gunter, 2012). Further, females have an earlier onset of self-injurious behavior than males and are more likely to participate in cutting.

Implications, Interventions, and Treatment

Implications for School Counselors

Because teens are more apt to confide self-injurious behavior to a friend than a parent or mental health worker, teens need training on how to help a friend who is suicidal or self-injurious (Hennig, Craig, & Crabtree, 1998). When feeling suicidal or in a crisis, adolescents are more likely to confide in a close friend (Evans, Smith, Hill, Albers, & Neufeld, 1996). As a result, schools should "support, prepare, and equip peers who may be the first person a friend turns to when he or she is thinking of or has already carried out an act of NSSI" (Whitlock & Rodham, 2013, p. 9).

Most adolescents engage in NSSI impulsively (Whitlock & Rodham, 2013). Half of the adolescents who self-harmed only contemplated it an hour before following through with it (Hawton, Rodham, Evans, & Weatherall, 2002). As a result, school counselors must be available to work with self-injurious students on a moment's notice. Further, counselors must be prepared to offer referral information to both students and parents. Finally, school counselors can train faculty, staff, and administrators on NSSI so they understand a student's impulsive needs, positive and negative ways to handle situations, as well as other accurate and current information (Whitlock & Rodham, 2013).

According to Maslow (1962), relationship and connection will occur whenever students feel safe in their current environment. Therefore, it is beneficial for teenagers to be given an opportunity to express their thoughts and feelings at school in a safe, therapeutic environment. Offering a weekly stress/anxiety group counseling session helps adolescents learn how to deal with stress, which will hopefully prevent them from

resorting to NSSI. These sessions serve as a support group so teenagers don't feel so alone. Adolescents who self-harm tend to feel isolated or rejected. However, a group enables them to relate with each other and learn how to cope with their issues together.

Ethical, Legal, and Safety Considerations

To avoid ethical and legal dilemmas, the following guidelines are recommended: check the school's policies in terms of cutting; ensure the safety and the welfare of the student; and obtain information regarding whether the student shares cutting instruments with others. This is especially important since the student could be exposed to life-threatening diseases such as HIV, hepatitis C, infection, etc. Document that safety risks were discussed with regard to the sharing of instruments. Assess whether the self-injury has escalated since the student began cutting. Additionally, Hoffman and Kress (2010) noted, "As in the cycle of drug and alcohol addiction, those who develop a tolerance to the pain may engage in more damaging SI in order to get the same effects as before the tolerance began" (p. 344).

The student and counselor should draft a plan for parental disclosure. The counselor should contact the parents or legal guardian regarding the self-injury (American School Counselor Association [ASCA], 2004, Standard A.7a). The literature encourages student/parent communication as a first effort in combating self-injury (White Kress, Drouhard, & Costin, 2006). If the student prefers, the counselor and the student could meet with the parents or guardian together. According to Froeschle and Moyer (2004), before unilaterally contacting parents, school counselors should create a parental contact plan with the child's consent. Because the courts have protected parental rights and usually give the parents ready access to information about their child, counselors must offer information to parents, who legally, serve as the client.

The counselor should assess for other risks. For example, assess for risks regarding whether the student is at risk for suicide, injury (physical), and co-occurring conditions. If the counselor determines the student is at high-risk, then the counselor should consider whether referral to an emergency mental health facility is warranted. If the assessment indicates the risk is low, then the counselor should assess the risk of suicide frequently. It is vital for the counselor to make sure and follow up (Juhnke, Granello, & Granello, 2011).

Remember the law does not address the duty to protect the self-injurious student to the same degree it addresses those who are suicidal. However, the counselor must address safety issues, such as self-injury, that could be related to suicidal ideation. For counselors, the ethical principle of *nonmaleficence*, do no harm, must be followed (American Counseling Association, 2014).

Confidentiality is an important ethical principle. When self-injury is life-threatening, however, confidentiality must be breached (White Kress et al., 2006). The intent here is to protect the student from harm and keep him or her safe.

Counselors should manage and monitor their own personal reactions to cutting (White Kress, Drouhard, & Costin, 2006). The student should not feel judged by a counselor's reaction. When dealing with students who self-injure, it is essential to consult with other professionals for ethical decision making (ASCA, 2004, Standard G.G3).

Treatments

Numerous treatments are available and too exhaustive to mention in this article. As a result, following is a small sample of the most common found in the literature. One common treatment for NSSI is dialectical behavior therapy (DBT). DBT is a combination of individual and group therapy that utilizes emotional regulation, interpersonal effectiveness, distress tolerance, mindfulness, and self-management (Peterson, Freedenthal, Sheldon, & Andersen, 2008). DBT teaches individuals to be aware of their emotional distress and the things that trigger it (Linehan, 2014). The idea is to teach patients to be aware of their triggers so that they may regulate their emotions and behavior by using techniques learned in therapy. For example, an individual who suffers from social anxiety may be triggered by trips to the mall. This individual is taught to be aware of the first signs of anxiety in order to control it prior to a panic attack. Each patient learns his or her own triggers and alternative behavior to manage stress. The individual who suffers from social anxiety may 1) feel panicked, 2) go home, and 3) participate in self-harm. As an alternative, the individual is taught to be aware that sweating is the first symptom of anxiety. At the first sign of anxiety, the individual will briefly remove himself or herself, go to the restroom, and conduct deep breathing exercises. It allows the individual to regulate his or her emotion before it reaches panic levels (The Linehan Institute, 2015).

Finding alternate behaviors has also shown promise in treating self-injurious individuals (The Linehan Institute, 2015). The goal is to find an alternative to NSSI in order to regulate distress. For example, deep breathing exercises may be utilized in lieu of cutting. Other alternate behaviors/techniques used for NSSI include progressive muscle relaxation, meditation, art/music, the ice cube method, and the butterfly project (National Self Harm Network, 2015).

The butterfly project instills a positive message so that NSSI can be avoided. This project has been a YouTube sensation over the past few years. The idea of the butterfly project is to bring awareness and an alternative strategy for those who self-harm. Clients who self-injure may avoid injurious behavior by drawing a butterfly that represents a loved one on their skin. The butterfly is not to be rubbed off, but rather, allowed to fade over time. If the butterfly is cut or rubbed off, then the butterfly, which represents the loved one, dies. If the butterfly fades on its own, it is set free. Setting the butterfly free means that the person has been successful and free of self-harm.

Conclusion

In conclusion, non-suicidal self-injury is a phenomenon that crosses all boundaries. Identification, early intervention, prevention, and treatment are essential if counselors are to help self-injuring youth. For many reasons, non-suicidal self-injury is a growing phenomenon among adolescents that cannot be ignored. Adolescents are in the most vulnerable stage of development and need support from parents, teachers, counselors, and doctors. This stage of development is already stressful without other factors such as bullying, dating violence, academic pressure, and family pressures. Counselors both in school and community settings must be aware of signs and treatments in order to aid in the recovery of these adolescents.

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