

2016

# The cry among us: responding to adolescent female cutting in the evangelical Christian church

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SCHOOL OF THEOLOGY

Project

**THE CRY AMONG US: RESPONDING TO ADOLESCENT FEMALE CUTTING  
IN THE EVANGELICAL CHRISTIAN CHURCH**

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Submitted in partial fulfillment of the  
requirements of the degree of

Doctor of Ministry

2016

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2016

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## DEDICATION

To Harriett Jane Olson, Charles Langdon Olson, Jr., and Janet Pickering Olson, my sister, brother, and sister-in-law, with gratitude for all of your support and encouragement over the years. I'm so glad we're family.

The project you see would not have been birthed without the expertise of Dr. Chris R. Schlauch and Dr. Mary Elizabeth Moore. Thank you for your countless hours, and your careful reading of, and interaction with, my work.

I am also grateful to my “village,” including Elizabeth, Katherine, Caroline and David Olson; The Rev. Dr. Jim and Donna Williams; The Rev. Craig and Rikki Thompson; Natasha and Alan Neuroth; Dr. David Wayman; Jennifer Rafus, FNP; Amanda and Jim Darlack; Dana, Daryl, Hannah, Grace and Elizabeth Olson; Lee Snow and Jean Curcuru; Cynthia and Susan Kielinen; and the entire congregation at Gloucester Assembly of God who prayed me through

*Soli Deo Gloria*

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(Order No. )

**ANN ELIZABETH OLSON**

Doctor of Ministry

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**ABSTRACT**

The phenomenon of cutting is extremely complex, as is the care of those who engage in it. This work provides exhaustive knowledge of the kinds of clinical interpretations of cutting that exist and interventions offered to curb this maladaptive behavior. It empowers volunteer youth workers to feel more confident in responding to young women who are cutting. It also encourages those who work in evangelical Christian contexts to draw carefully, cautiously, and judiciously, from the resources of their faith tradition as their contribution to the care of young women who cut.

## PREFACE

It seems that everywhere I go, someone has a story. Since I began focusing my work on adolescent females and cutting, I have heard narratives of how cutting has affected individuals, families, friends, and even communities. Whenever someone introduces me and tells someone about my research, the gates open and the stories come rushing out. From the dentist's office to my local church, and from the faculty at my school to friends of friends, almost universally, when the topic is broached, I hear a cry of pain.

What prompted me to begin this study originally was the convergence of two of my worlds. In my life as a clinical counselor in a community health organization, I was beginning to see more and more teen girls coming to me who were involved in cutting. Several of these young women were involved in evangelical Christian churches. At the same time, in my role as a staff member in my church, I was approached by youth workers who were finding that cutting was common among their middle school girls. They felt out of their depth and wanted to know what they could do to help. I decided to look for an answer to that question.

As I moved forward with the project, a memory surfaced for me that I had not thought about for a long time. In one of my prior contexts, I worked with an adolescent we'll call Sarah. Sarah was an extremely intelligent and gifted young woman. She and her family held high expectations for what she would achieve both academically and socially. I knew that Sarah was deeply involved in the life of her evangelical Christian church.

One evening, I entered my office to find Sarah sitting hunched-over against the wall on the floor in a tight, little ball. When I asked her what was the matter, I got no answer. Clearly, she was not interested in communicating with me at the moment. I decided that I needed to give her time so she was able to talk, so I sat down beside her and waited. Before long, in tears, she began to tell me her story. She related how she had become so overwhelmed with the demands of her life that she felt paralyzed. She was sad all of the time and felt like bursting into tears at the oddest moments. All she wanted to do was sleep. But then the pain became so great that she began to think about ways to end that pain—forever. She had never opened up to someone about how she was feeling, but she recognized that when she began to think about suicide, she needed to tell someone.

As we talked further that night, I told Sarah that I could do a few things to help, but the first thing she needed to do was to tell her mother what was going on. I asked if she wanted to tell her mother by herself, or tell her mother in my presence, or have me talk to her mother for her. She chose the second option. She felt that if I were present, her mother would not react with as much anger as she might if Sarah told her on her own.

The next morning, I had both mother and daughter in my office, and silently prayed for Sarah as she revealed what she had been feeling to her mother. When Sarah was through with her story, her mother asked me to leave the room. This was a clear indication of how her mother would look on my involvement as Sarah worked through the process of healing from depression and suicidal ideation.

This was a child in whom I had invested countless hours over the course of several years. I had watched her grow from a sometimes giggly middle-schooler into a

serious, high-achieving high school student. Based on the fact that Sarah was able to talk with me about what felt like her life crashing down around her indicated that we had established some level of rapport, and Sarah felt safe revealing her inner struggles to me. But, in her mother's eyes, this counted for nothing. After that morning, Sarah was placed with a therapist, and had all of her external supports removed. Her mother kept her at home, away from her friends, her school routine, and her church activities. Even my phone calls were rebuffed.

I knew I was not a trained counselor, but I wanted so much to be there for Sarah. As much as I was personally processing the traumatic experience of seeing Sarah decompensate before my eyes, I also had to help the other youth, Sarah's friends, who were kept away from her during these critical weeks. With all methods of communication cut off, I had no idea what to do. Finally, one of Sarah's friends asked if they could make her a recording of all their favorite, encouraging songs and mail it to her. I watched a group that was often distant with each other deeply bond as they worked on their project for Sarah.

Eventually, Sarah returned to us. Through talk-therapy and medication, her depression was managed. Our group even experienced the positive value of working together in a critical situation. But I felt that there were resources we had to offer that could have been beneficial to Sarah during her process of diagnosis and beginning her healing journey. Even though I was not a certified therapist, I felt that there were ways in which I could have come alongside traditional therapies and helped Sarah, and even her family, through those trying days.

In retrospect, this is where much of the energy for this project originated. My hope was, that by equipping youth workers to understand their own, unique contributions, they could negotiate in a situation similar to what I faced, and be able to involve themselves and the wealth of their spiritual traditions and become a valuable adjunct to what traditional therapy and medication could accomplish.

This project is for all the Sarahs (and Samuels) that you, as a youth worker, may encounter. May you know the power of the relationship you have built, the value of the spiritual tradition of which you are a part, and the enormity of what you have to offer when you are permitted to come alongside the therapeutic and together create a path toward healing for your Sarah.

#### A Brief Word about Structure

This project is divided into four parts. Part I will be of interest to researchers and anyone who wants to learn more about the history of research into cutting or the broader category of Non-Suicidal Self Injury (of which cutting is one example). If you are a therapist and want to know more about risk factors, reasons for, and treatment of cutting, or about practices among young people in evangelical Christian traditions, you may want to begin with Part II. If you are a youth leader who is confronted with cutting among the youth in your church, you may want to skip directly to Part III. Part IV contains the conclusions reached, limitations of this project, and some ideas for further research in this area.

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## LIST OF ABBREVIATIONS

A & E	Accident and Emergency departments
AAU	assessment as usual
ACE	adverse childhood experience
ADHD	Attention Deficit Hyperactivity Disorder
BPD	Borderline Personality Disorder
CASE	Child and Adolescent Self-harm in Europe
CBT	Cognitive Behavior Therapy
CFT	Compassion-Focused therapy
DBT	Dialectical Behavior Therapy
DSH	deliberate self-harm
<i>DSM-5</i>	<i>Diagnostic and Statistical Manual, 5<sup>th</sup> edition</i>
EE	expressed emotion
EMA	Ecological Momentary Assessment
EOI	emotional over-involvement
ER	Emergency Room
ERT	Emotion Regulation Training for adolescents
FASM	Functional Assessment of Self-Mutilation
fMRI	functional magnetic resonance imaging
IAPS	International Affective Picture System
ISSS	International Society for the Study of Self-Harm
MBT-A	Mentalization-Based Treatment for Adolescents

MP3	from the file extension <i>.mp3</i> , short for <i>MPEG Audio Layer 3</i>
NA	negative affect
NAE	National Association of Evangelicals
NASB	New American Standard Bible
NICE	National Institute for Clinical Excellence (United Kingdom)
NIV	New International Version
NSSI	non-suicidal self-injury
PST	Problem Solving Therapy
PTSD	Post-Traumatic Stress Disorder
RCT	randomized-controlled trial
RPTC	Regional Poisoning Treatment Centre
SA	suicide attempt
SASB	Structural Analysis of Social Behavior
SES	socioeconomic status
SEYLE	Saving and Empowering Young Lives in Europe
SH	self-harm
SI	self-injury or suicidal ideation, more commonly suicidal ideation
SIB	self-injurious behavior
SII	self-inflicted injury
SITB	self-injurious thoughts and behaviors
SMB	self-mutilative behavior
SSI	suicidal self-injury

SSRI	serotonin re-uptake inhibitor
TA	therapeutic assessment
TAU	treatment as usual
WHO	World Health Organization

PART ONE  
RESEARCH ON CUTTING

In this section of the work, the focus will be on the extensive recent literature about cutting with relation to adolescent females. More specifically, we will look at the issue of Non-Suicidal Self-Injury (NSSI) and the stated population. Here, the reader will find the purpose of this project and its thesis, as well as definitions of the terms used in that thesis. Part I also speaks to the difficulty of definition and the role that ambiguous definitions have played in NSSI research, as well as offering an overall history of research into NSSI.

The anticipated audience of Part I is the research community. Others who are interested in the causes of, and therapeutic practices utilized with, NSSI may also benefit from reading this section. Those who are reading for more practical guidelines for the treatment of NSSI may prefer to begin their reading in Part II. Likewise, those who are working directly with youth in a church or other non-therapeutic setting may benefit from turning first to Part III.

## CHAPTER ONE

### THE PROBLEM AND ITS SETTING

Young women who cut and who are part of evangelical Christian churches can benefit from utilizing the spiritual practices of their religious communities as a supplement to the therapeutic assistance offered by mental health clinicians. The goal of this project is threefold. First, it provides knowledge for church workers that shows the complexity of suffering among adolescents who cut and explores the various clinical interpretations and responses currently available. Secondly, based on this knowledge, it empowers youth leaders to feel safer and more confident listening to and responding to girls who are cutting. Finally, it encourages those who work with youth to consider drawing creatively on specific Christian practices as their contribution to the care of these souls.

#### **Statement of the Problem and Thesis**

Adolescent females are cutting in growing numbers. Adolescent females who are part of an evangelical Christian church context are not unaffected by this trend. The problem for many church workers who are confronted by this situation is that they do not understand what cutting is, why young women participate in such behavior, and whether or not there is anything they can do to help. Many are initially horrified when they hear about their female teens engaging in this practice or when they see the scars that result.

Many church workers have no idea that there is extensive research and a range of practices relevant to a therapeutic context that can guide the treatment of teens

experiencing these issues. Even if youth workers are able to make appropriate referrals of these adolescents to counseling, they are often not aware of what they can do to assist in such a situation. There are specific practices that youth leaders can model to add a spiritual component to the healing process. Such spiritual practices are already taught in many evangelical Christian churches and they include daily quiet time, prayer, scripture memory, music, youth group, and mentoring.

Research says that the number and percentage of adolescent females who are involved in non-suicidal self-injury (NSSI), of which cutting is a subset, is increasing internationally (Walsh, 2012, p. 39). This is a phenomenon about which the general public has little understanding, but researchers have begun investigating. Due to the violent nature of the actions taken by some young women (cutting, burning or excoriating their skin in some other way), many people are scared and even horrified by what they see. Currently, researchers are working to delineate reasons why some adolescent females become involved in such behavior. When people understand something better, they are less apt to be frightened by it and more equipped to respond in helpful ways.

Many young women participating in NSSI are involved in evangelical Christian churches. Since this is a growing problem, it would seem that church leaders would want to become better equipped to assist in the healing process. By explaining this phenomenon (as far as the literature currently understands it) and enumerating ways in which church workers can accompany young women having this experience, this project will provide the research that can offer youth leaders a way to work productively toward

the health of their female youth and invite leaders to make a viable contribution to their healing.

### **Purpose**

The purpose of this investigation is to identify and interact with literature on two fronts, namely the phenomenon of cutting and evangelical Christian spiritual practices, in order to create a Doctor of Ministry project that can be shared with church leaders who may be confronted with cutting among their young people. This project is largely an academic study, but it paves the way for the later development of a curriculum resource for a wider audience of evangelical Christian youth workers. To this end, the project itself serves as a resource, but will also contribute in the future to a curriculum resource.

The initial goal of this investigation is to identify evidence that will enable church workers to be aware of ongoing research into cutting and its meanings. A review of current literature will be conducted and distilled thematically. The future communication of this information in written form for church workers can help combat unproductive responses such as being repulsed by young women who engage in this practice. Church leaders can also become acquainted with research and practices in the clinical mental/behavioral health field that support healing for teens engaged in cutting. This will assist youth workers in making appropriate referrals.

Once leaders understand that there is help and hope offered by the mental health field for young women who are cutting, they can emphasize specific practices that add a spiritual dimension to the healing process. Youth workers do not need to cede sole authority and responsibility for young women they may have known for years to mental

health care professionals. This project will outline contributions that church leaders may offer to the work of healing by utilizing spiritual practices such as daily quiet time, prayer, scripture memory, music, youth group, and mentoring in order to augment clinical intervention. A further review of current literature into these specific spiritual practices will demonstrate the benefits of teaching and modeling these historic practices. This information will be documented in written form and will show that these practices can provide an important adjunct to therapy and a path that youth leaders can follow in to accompany young women who are cutting through the healing process.

It should be noted that this project addresses three different audiences. Part I is directed toward those doing research into NSSI. Part II is written to clinicians currently working in the area of mental health who care for adolescent females with NSSI. Part III distills the previous information in a manner that will make it accessible to the youth worker in an evangelical Christian church who may have no background in the social sciences but has spiritual resources to offer in the healing process. For those reading straight through the project, some of the information will appear repetitive. I have used two sources of information (NSSI and spiritual practices) and presented the data in ways that emphasize what is most important to three different constituencies (researchers, clinicians, and youth workers).

### **Method of Investigation and Sources of Study**

The method of this study is to review and interpret existing literature and draw conclusions about the potential roles of evangelical Christian churches. First, the literature of clinical research about cutting is analyzed and interpreted in ways that can

reassure non-clinicians in the church that this issue is under investigation by the therapeutic community. This is a first step to help evangelical church leaders appreciate the wide variety of practices their adolescent females may encounter in a therapeutic context.

The study of NSSI is relatively new. Most of the research has been done over the last 50 years with the most active time being the last 20 years. The sources upon which this project rests are peer-reviewed journal articles and books published within the study areas of psychology, psychiatry, adolescence, and even suicide. These resources were accessed by using the key words “self-harm” and “self-injury” along with the more precise “non-suicidal self-injury.”

Secondly, the work identifies unique contributions that evangelical church leaders can make in the healing process, focusing on spiritual practices. These contributions include some of the basic building blocks of youth work in evangelical Christian churches, such as daily quiet time, prayer, scripture memory, music, youth group, and mentoring. I make a case that the creation of a spiritual climate can enhance the healing process for adolescent females who are cutting. I also investigate how these practices might assist youth workers in evangelical Christian churches to work alongside traditional therapy by providing spiritual supports for young women who deal with NSSI.

### **Significance of the Study**

The impetus for this investigation has come from personal experience. In my clinical experience over the past six years I have worked with several adolescent females who were cutting and who also attended evangelical Christian churches. At the same

time, I was asked by youth leaders in an evangelical Christian church context what to do when they found out that some of their middle school girls were cutting. These experiences pushed me to look at statistical evidence that showed a gap in the research pointing to the need for this work.

The numbers of adolescent females who engage in the self-harm practice of cutting is growing within the United States. Thus far, no research reveals that cutting trends in evangelical Christian church contexts differ from national statistics. Therefore evangelical Christian leaders need to take this issue seriously. Informed leaders in evangelical churches can offer assistance to adolescent females to augment professional care by teaching and modeling specific spiritual practices.

Currently, literature on NSSI is divorced from literature written for the consumption of church leaders. This study proposes that the varied literature on NSSI can be summarized in a way to be helpful for youth leaders who are working with adolescent females. This will mean reviewing the current literature and conveying its findings in terms understandable by those outside fields of mental health and psychology. With this information, church leaders can begin to understand what their adolescent females may encounter in a therapeutic context. Knowledge of the therapeutic context and processes is a precursor to leaders' ability to accompany young women on their journeys and augment the young women's clinical experience with spiritual care.

Further, this study will bring current and past practices of the evangelical church into focus and evaluate how these practices might be helpful in accompanying adolescent females struggling with NSSI. The practices to be explored include daily quiet time,

prayer, scripture memory, music, youth group, and mentoring. The study of how spiritual practices can augment clinical treatment with regard to cutting has yet to be done. I have found only two or three researchers who say that further research should be done on the influence of religion and religious practices on NSSI, and not one that I have found to date takes on this challenge.

I believe that a religious community, and for the sake of limiting the subject matter, the evangelical Christian religious community, has the capacity to come alongside and support therapy in a way no other institution can. Social workers are taught to look for natural supports when assessing a client's strengths, and the evangelical Christian church, given more information, can become an even better natural support for young women dealing with non-suicidal self-injury. Since this is a growing (or at least more public) problem, I believe this study is both timely and necessary. Once church leaders see that there is both research and protocol within the therapeutic community around the issue of cutting, they do not have to be horrified or afraid when confronted with this phenomenon. Once the adolescent is safely in therapy, there are powerful things that youth leaders can do to help. This can begin to counter the fear some leaders may feel in uncovering such behaviors because they do not know how to respond in helpful ways.

### **Definitions**

There are several terms which need to be clearly explained before moving forward. These include: Non-Suicidal Self-Injury (NSSI), adolescent, evangelical Christian, and spiritual practices.

## Non-Suicidal Self Injury (NSSI)

For the purposes of this project, cutting will be defined by the 2007 International Society for the Study of Self-Injury (ISSS) statement defining NSSI as “the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned” (International Society for the Study of Self-Injury, 2007). By using the term “cutting,” we are referring to the number one method used by adolescents to engage in NSSI.

Cutting, itself, is a physical behavior that is interpreted in a wide range of contexts, in conjunction with other phenomena, and different clinical researchers or interpreters focus on different conjunctions. This project focuses specifically on looking at the different ways that cutting is linked with other symptoms rather than the behavior of cutting itself. One of the most important hindrances to research in this area is a continued disagreement on terminology. The details of this debate will be covered in Chapter 2.

## Adolescent

For the purposes of this project, adolescent females are those from the age of puberty up to and including the teen years. Young women in their early 20s will be considered “young adults” and differentiated from those in their teens.

## Evangelical Christian

Another aspect of this project’s thesis requiring definition is what is implied by limiting the receiving group to “evangelical Christians.” Amidst the many possible ways

of circumscribing this conceptual group, this project will employ the definition used by the National Association of Evangelicals (NAE) on their website.

Evangelicals take the Bible seriously and believe in Jesus Christ as Savior and Lord. The term "evangelical" comes from the Greek word *euangelion*, meaning "the good news" or the "gospel." Thus, the evangelical faith focuses on the "good news" of salvation brought to sinners by Jesus Christ.

We are a vibrant and diverse group, including believers found in many churches, denominations and nations. Our community brings together Reformed, Holiness, Anabaptist, Pentecostal, Charismatic and other traditions. Our core theological convictions provide unity in the midst of our diversity. The NAE Statement of Faith offers a standard for these evangelical convictions. ("What is an Evangelical?" n.d.)

As this definition notes, there is much diversity within this community referred to as Evangelical Christian. Linked by theological convictions alone, these convictions serve to define the group. The NAE Statement of Faith referred to above is as follows:

- We believe the Bible to be the inspired, the only infallible, authoritative Word of God.
- We believe that there is one God, eternally existent in three persons: Father, Son and Holy Spirit.
- We believe in the deity of our Lord Jesus Christ, in His virgin birth, in His sinless life, in His miracles, in His vicarious and

atoning death through His shed blood, in His bodily resurrection, in His ascension to the right hand of the Father, and in His personal return in power and glory.

- We believe that for the salvation of lost and sinful people, regeneration by the Holy Spirit is absolutely essential.
- We believe in the present ministry of the Holy Spirit by whose indwelling the Christian is enabled to live a godly life.
- We believe in the resurrection of both the saved and the lost; they that are saved unto the resurrection of life and they that are lost unto the resurrection of damnation.
- We believe in the spiritual unity of believers in our Lord Jesus Christ. (“Statement of Faith.” n.d.)

### Spiritual Practices

Spiritual practices are those activities that put one in a place where one can be in touch with the Divine. Another word for “practices” is “disciplines.” In her book, *Spiritual Disciplines Handbook: Practices that Transform Us*, Adele Ahlberg Calhoun says this about spiritual disciplines: “From its beginning the church linked the desire for more of God to intentional practices, relationships and experiences that gave people space in their lives to ‘keep company’ with Jesus. These intentional practices, relationships and experiences we know as *spiritual disciplines*” (Calhoun, 2005, p. 17). As noted above, spiritual practices that characterize the evangelical Christian church

include daily quiet time, Bible reading and meditation, prayer, Bible memorization, music, youth group, and mentoring.

The Daily Quiet Time is encouraged by many evangelical Christian churches as a way for its members to meet with God each day. Members use this time for Bible reading and meditation on the biblical text, prayer, and reflection. In the context of an evangelical Christian church, prayer can be defined as a mode of communication between an individual or a group and God. One of the hallmarks of an evangelical Christian church is its emphasis on Bible memorization. Committing portions of the Bible to memory is thought to shape the mind in a God-ward direction. Music is also indicative of evangelical Christian church culture. The church draws on many different genres of contemporary music, and which are identified by lyrics that support the teachings of evangelical Christianity. Youth groups gather in evangelical Christian churches to strengthen ties between peers and further the teachings of the church in an age-appropriate manner while dealing with issues that are also germane to the teen years. Mentoring is the practice of pairing an adult church member with a youth from the congregation or community. The goal of this work is to give the youth an adult with whom to relate who is not a parental figure, but more like an aunt. The hope is that the mentor can be a confidante—a person with whom the teen can discuss serious issues as well as do fun things.

As we have seen, it is my belief that by providing a resource that will help evangelical Christian youth workers, such leaders can be better equipped to come alongside adolescent females who may be engaging in non-suicidal self-injury (NSSI).

This will allow youth workers to model and teach spiritual practices that can augment the approaches of clinical psychology to cutting in ways that lead to a powerful healing environment. Since NSSI is a growing problem, it is important that church leaders become aware of those who are struggling with this and have resources that can help. As we will see in Chapter 2, one thing that makes it very difficult to gather helpful information about this phenomena is that the academic community continues to use different terminology what speaking about this issue. Once the definitional challenge has been explained, we will look at the populations involved in NSSI.

## CHAPTER TWO

### THE DIFFICULTY OF DEFINING NSSI AND THE POPULATIONS INVOLVED

Psychological research on self-harming behavior is growing. However, cutting is not a new phenomenon. From biblical times to the advent of psychoanalysis and later psychoanalytic theory, a thread of information about self-harm can be traced. This chapter will place the issue in historical context and then explore the contemporary definitions and populations involved in NSSI.

Though some would date its advent from a much earlier time, Armando Favazza, a modern expert in the field, pointed to biblical evidence for the existence of self-injury from the first century A.D. He used the narrative of the Geresene demoniac to illustrate self-cutting from this period. Favazza identified, "...the first reported case of repetitive nonsuicidal self-injury in the fifth chapter of the Gospel of Mark, which describes a demon-possessed man chained in a cemetery, who, night and day, cried out and cut himself with small stones" (Favazza, 2011, p. x).

In the early 1900s, Sigmund Freud made passing reference to self-mutilation as "masochism" in his *Three Essays on the Theory of Sexuality* published in 1905. He stated that masochism may be "a relic of cannibalistic desires" (Freud, 1905, p. 158). For Freud, while primary masochism related to the death drive, secondary masochism "is 'merely' the enacted role of rejection and punishment..." (Gilman, 2013). Interestingly, the term "masochism" was used only when males were concerned. Similar behavior in females was known as "monomania." The difference between male and female behavior is

something that will continue to be under discussion even into the contemporary world of empirical research.

Karl Menninger made a distinction between socially acceptable and unacceptable self-mutilation in his article “Localized self-destruction: Self-mutilations.” In 1934, he wrote about “forms of attenuated and socially acceptable self-mutilation” such as “ear piercing, trimming the nails, hair cutting and shaving”, and distinguished them from cutting, which “is neither attenuated nor socially acceptable” (Menninger K. , 1934). Randi Tofthagen pointed to a late 1930s term that Menninger used: ‘wrist cutting syndrome’ (Tofthagen, 2010). In 1959, Menninger wrote, “[S]ome day we will be able to talk about chronic focal self-destructive attacks different from acute generalized self-destruction” (Menninger K. , 1959).

In 1952, Erwin Stengel referred to a similar phenomenon as ‘attempted suicide’ (McAllister, 2003). Stengel interpreted this behavior as “a cry for help” (Tofthagen, 2010). He “emphasized the difference between persons who kill themselves and those who harm themselves sub-lethally” (Stengel, 1959 in Kahan, 1984). Tofthagen went on to report that “In the late 1960s, the term ‘para-suicide’ was used to refer to self-harm associated with suicide” (Tofthagen, 2010).

## **Definitional Categories**

### The Problem of Definition

The basic definitions given in Chapter One are actually quite complex. Eight different terms have already been used to describe the behavior under discussion: self-mutilation, self-harming, self-injury, self-cutting, nonsuicidal self-injury (NSSI), wrist

cutting syndrome, attempted suicide, and parasuicide. One of the difficulties surrounding current research into this topic is that there is no agreement among scholars concerning terminology and definition.

### Self-Mutilation (SM)

Very little was published concerning this phenomenon prior to the 1980s. In 1987, Favazza published *Bodies under Siege: Self-mutilation in Culture and Psychiatry*. This work, updated and now in its third edition, remains foundational to the field. In the introduction to the first edition, Favazza wrote: “In the vast repertoire of human behaviors, self-mutilation ranks among the least understood and the most puzzling” (Favazza, 2011, p. ix). In his 1989 article “Why patients mutilate themselves” he defined self-mutilation as a “complex group of behaviours in which there is deliberate, direct destruction or alteration of body tissue without conscious suicidal intent” (Favazza, 1989).

Another early contribution to the field was by Barent W. Walsh and Paul M. Rosen in their treatise, *Self-mutilation: Theory, Research, and Treatment* from 1988. Here they used the term “self-mutilation” to indicate, “deliberate, non-life threatening, self-effected bodily harm or disfigurement of a socially unacceptable nature” (Walsh & Rosen, 1988, p. 10). Kim Hewitt followed this strand as she searched for meaning in her personal experience of cutting. In her book, *Mutilating the Body: Identity in Blood and Ink*, she explored social and religious factors that may have informed this practice (Hewitt, 1997). Hewitt discussed some aspects of cutting that were also present in eating disorders; anorexia specifically.

Looking for a way to distinguish between cutting and other forms of direct self-harm, Favazza adopted the term “self-mutilation,” as mentioned above (Favazza, 1987). In the third edition of his seminal work, notably revising its title, *Bodies Under Siege: Self-mutilation, Nonsuicidal Self-injury, and Body Modification in Culture and Psychiatry*, Favazza stated, “The term self-mutilation is still used in some psychiatric journals, but has been replaced by the more precise nonsuicidal self-injury (NSSI) in recent years” (Favazza, 2011 p. xi). He adds, “Although NSSI is an inclusive term, I have decided to retain ‘self-mutilation’ when referring to major acts of self-injury, such as eye enucleation and amputation of body parts” (Favazza, 2011 p. xi). Favazza delineates between such extreme acts of self-harm and those with less long term ramifications. “ I do use ‘NSSI’ when referring to moderate/ superficial acts, such as skin-cutting and burning, which are the most common form of self-injury as well as the major focus of current research and treatment” (Favazza, 2011 p. xi). Here we begin to see some of the evolution of terminology as “mutilation” or “self-mutilation” take on a more precise meaning.

#### Deliberate Self-Harm (DSH)

A different tack in naming was evidenced in a seminal article authored by Joel Kahan and E. Marsell Pattison published in 1984. In this work, the authors advocated for an addition to the *Diagnostic and Statistical Manual* (then in its third edition) called the Deliberate Self-Harm Syndrome (DSH) (Kahan & Pattison, 1984). The most helpful early delineation of those who cut came in 1984 from an article entitled, “Proposal for a distinctive diagnosis: The deliberate self-harm syndrome (DSH)” (Kahan, 1984). In this

piece, Kahan and Pattison argued that the essential features of this syndrome which should be added to the *Diagnostic and Statistical Manual III* were

1. Failure to resist an impulse, drive, or temptation to perform some act that is harmful to the individual or to others.
2. An increasing sense of tension before committing the act.
3. An experience of either pleasure, gratification, or release at the time of committing the act.

The authors went on to distinguish this from other acts in three distinct ways. DSH was a method of direct self-harm (as opposed to smoking or alcohol overuse) with low lethality and multiple episodes. They excluded overdoses since “intent and lethality level are difficult to determine” (Kahan, 1984). Instead of a failed attempt at suicide, these researchers saw DSH as a “chronic coping style” that may actually be “life-preservative” (Kahan, 1984).

The term deliberate self-harm (DSH) was earlier defined as “a non-fatal act, whether physical injury, drug overdosage or poisoning, carried out in the knowledge that it was potentially harmful and, in the case of drug overdosage, that the amount take was excessive” (Morgan, 1975). In the same year, Roberta Ferrence said, “As we use the term, self-injury includes all cases of self-inflicted overdosage, asphyxiation, and injury, whether or not there is evidence of suicidal attempt” (Ferrence, 1975). Twenty years later, DSH “is used to refer to any deliberate, non-habitual act that causes self-harm or may have potential to do so (non-habitual excludes overdose of drugs/alcohol by a habitual user)” (Goddard, 1996). A year later, in his article on deliberate self-harm, David A. Brent equated DSH with suicide attempters, but added the caveat, “One type of

behavior that must be differentiated from suicide attempts is that of self-cutting, usually with little suicide intent” (Brent, 1997).

In 1998, House stated, “The term DSH includes intentional self-poisoning or self injury (such as cutting), irrespective of the apparent purpose of the act” (House, 1998). His criteria here showed a departure from DSH as defined by Kahan and Pattison in 1984 for whom purpose was a defining benchmark.

Keith Hawton, an expert in the field from the United Kingdom, defined DSH as being comprised of both self-poisoning and self-injury (Hawton K. F., 2000). This set the stage for much future research in the UK. Hawton used the following rubric: “*Self-poisoning* is defined as the intentional self-administration of more than the prescribed dose of any drug whether or not there is evidence that the act was intended to cause self-harm” (Hawton, 2000). He further clarified that, “This category also includes overdoses of ‘drugs for kicks’ and poisoning by non-ingestible substances and gas, provided the hospital staff consider that these are cases of deliberate self-harm” (Hawton, 2000). His second category of DSH was self-injury, which he broadly delineated as, “any injury recognized by hospital staff as having been deliberately self-inflicted” (Hawton, 2000).

A year later, an American researcher, Kim L. Gratz, stated that, “Despite growing interest in this clinically important phenomenon...there remains a general lack of consensus among researchers as to how to define and measure deliberate self-harm” (Gratz K. L., 2001). Citing Favazza’s precedent, Gratz defined DSH as, “the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent, but resulting in injury severe enough for tissue damage to occur” (Gratz, 2001). Gratz created

the seventeen question “Deliberate Self-Harm Inventory (DSHI)” in an effort to create a, “standardized, empirically validated measure of deliberate self-harm” so that research could move forward (Gratz, 2001).

It is interesting that this terminology appears to have gone out of style among most researchers. This author wonders if calling it “deliberate” appeared in some way to blame the individual involved for her actions. Or, perhaps the question of whether or not the action is “deliberate” as in pre-planned and thought out or impulsive influenced the change. It is also noted that this terminology does not indicate the action’s relationship to suicide, as does NSSI.

#### Self-Injurious Behavior (SIB)

A third terminology was placed into context by Arabella C. L. Bowen in 2001. She adopted “self-injurious behaviour (SIB)” which she appeared to use interchangeably with self-harm (Bowen, 2001). In her section on “Clinical definitions of SIB” she referred to literature that used the terminology of self-mutilation, deliberate self-harm, and repetitive self-harm syndrome. In her opinion, “the term SIB is preferable because it accommodates the variety of self-destructive acts which knowingly invite physical injury, whether overt or covert, and which typically arouse feelings of shock and alarm in those who witness them” (Bowen, 2001). Here, two new aspects of the behavior in question were introduced. First, Bowen discussed “covert” acts of SIB. Although she did not define this further, other literature speaks of covert SIB as risk-taking behavior. Secondly, Bowen introduced the factor of how others respond to the individual participating in SIB.

American researcher Jennifer J. Muehlenkamp used the term SIB and equated it to self-injury (Muehlenkamp J. G., 2004). She defined SIB/self-injury as “the deliberate destruction or alteration of body tissue without suicidal intent...” (Muehlenkamp, 2004). She recognized another definitional problem. “Part of the difficulty in understanding SIB is due to the multiple terms used to describe the behavior and the confusion surrounding whether or not SIB represents a suicide attempt” (Muehlenkamp, 2004). She mentioned the theory of some (e.g., Marcia Linehan) that SIB and a suicide attempt rested “along a continuum of lethality” and differed in degree rather than type. Her research indicated preliminary support for the idea that “the distinction between self-injurious behaviors and suicide attempts can be assessed empirically” (Muehlenkamp, 2004). Muehlenkamp’s research brought to the fore another reason that not much empirical or anecdotal evidence for self-harm appeared in the literature prior to the 1980s. Self-injury was often seen as a failed suicide attempt. Some literature used the term “parasuicide.” Hawton referred to the World Health Organization/Europe’s Multicentre Study on Parasuicide (Hawton K. H., 2002).

Another nuance of the terminology debate was presented by Johnny Matson in his 2012 article entitled, “How do researchers define self-injurious behavior?” (Matson, 2012). He explained that in the field of developmental disabilities, self-injurious behavior indicated an action that caused physical harm (usually tissue damage), was typically repetitive and rhythmic, occurred over and over, was triggered by frustration and anxiety and the desire to escape an uncomfortable situation, was not predetermined, was seen in an individual who had an intellectual disability or autism, and became more likely based

on the severity of the disability (Matson, 2012). This was not what members of the “traditional mental health field” referred to when they talk about self-injury (Matson, 2012). Therefore he proposed that “it would be prudent to modify what those in our field label as self-injurious behavior to repetitive self-injurious behavior, or some other reasonably descriptive term” (Matson, 2012). Here we see the researcher grappling with the difficulty of definition across different areas of the discipline. His ideas reflect an attempt at refinement in thinking to more clearly target the behavior being discussed. He notes not only a departure in thinking from contemporary colleagues, but from what has become, over time, traditional nomenclature. This is an unintentional overlap of terminology between related fields. How would a single or short-term episode of cutting in a 15-year-old relieving stress be differentiated from the repetitive head banging or scab picking of someone with autism?

#### Self-Harm (SH)

Yet another term often used for similar behaviors was self-harm. Aviva Laye-Gindhu carefully sorted out what this term meant for her purposes. “Self-harm, [is] defined here as deliberate and voluntary physical self-injury that is not life-threatening and is without any conscious suicidal intent...” (Laye-Gindhu, 2005). She also bemoaned the lack of specificity in terminology. “Further, diverse terms, including self-harm, self-mutilation, self-cutting, and self-injury are used interchangeably. Without consensus among researchers of how to conceptualize and operationalize self-harm, not only is comparability across studies limited, the development of a solid empirical research base to guide future research is compromised” (Laye-Gindhu, 2005). Here the researcher

clearly states that the action is not meant as a suicide attempt, yet that is not clear from the simple terminology of “self-harm.” It also brings forward Kahan and Pattison’s 1984 terminology with the deletion of the word “deliberate.” Again, this author wonders if the word “deliberate” sounded blaming to the researcher’s ears.

### Self-Mutilative Behavior (SMB)

Another important voice in the discussion was that of Matthew K. Nock of Harvard University. He preferred the term “self-mutilative behavior (SMB)” which he defined as “the direct and deliberate destruction of one’s own body tissue without suicidal intent” (Nock M. P., 2005). Romuald Brunner picked up this term in 2009 as he explored gender differences in “self-mutilative acts” in Germany (Brunner R. P., 2009). Brunner equated “intentional self-mutilative acts like cutting and burning” with self-injurious behavior (Brunner, 2009).

Here is a reintroduction of the idea of self-mutilation, which, as previously stated, Favazza had reserved for only the most horrific of acts and had not used when referring to a small cut in the skin. Later, we will see Nock move toward the use of the term “nonsuicidal self-injury” as a replacement to “self-mutilative behavior.”

### Self-Injury (SI)

The terms “self-injurious behavior” or “self-injury” appear to be thought of as more generic by researchers over the years. As early as 1975, Ferrence used both “self-injury behavior” and “self-injury” to denote “all cases of self-inflicted overdose, asphyxiation, and injury, whether or not there is evidence of suicidal attempt” in Canada (Ferrence, 1975). As previously mentioned, Hawton, working in Oxford, used the term

self-injury as a subset of “deliberate self-harm” to indicate “any injury recognised by hospital staff as having been deliberately self-inflicted” (Hawton K. F., 1996).

In the United States, Zlotnick and her colleagues authored the Self-Injury Inventory in 1997 to explore “the relationship between affect dysregulation and self-destructive behaviors in adolescent suicide attempters” (Zlotnick C. D., 1997). Zlotnick’s method of analysis may have been missed by some working in the area of “self-injury” because it was specifically focused on suicide. The distinction between self-injury and suicide attempts will be discussed.

Another American expert, Muehlenkamp defined self-injury as “the deliberate destruction or alteration of body tissue without suicidal intent” (Muehlenkamp J. G., 2004). In her 2006 work on treatments for NSSI, Muehlenkamp said, “It is important to develop and strengthen the idea that self-injury is incompatible with self-respect and self-esteem...” (Muehlenkamp J. , 2006). Since this appeared near the end of the article and the author had referred to NSSI throughout, one might assume that this was simply a shorthand for the longer and more precise term.

Canadian researchers pointed out the gathering of a panel of experts in the International Network for the Study of Self-injury (ISSS) in 2006 (Heath N. T., 2008). Despite the use of the term “self-injury” in their name, this group preferred to use the term “nonsuicidal self-injury” (NSSI) to describe the behavior they gathered to study together. NSSI will be discussed later in this study.

In an article from 2008, Messer mentioned a website called [self-injury.net](http://self-injury.net) (Messer, 2008). The site’s author, “Gabrielle,” started a small website in 1999 that has

morphed into its current form. She stated that there was very little information available on the internet for self-injurers when she first put up her site. The site's author said that, in order to qualify as self-injury, five components must be present. It is a harmful act done to oneself and not someone else; it must be done by the individual him/herself; it must include some sort of physical violence; it is not done with the intent to kill oneself; and it is done intentionally rather than accidentally ("Gabrielle", 2014).

Canadian researcher Mary K. Nixon defined self-injury by giving the examples of “cutting, scratching, self-hitting” and she saw this behavior as a subset of non-suicidal self-harm (Nixon M. C., 2008). Janos Csorba, a Hungarian researcher took Ross and Heath's definition of “self-mutilating behaviour” (SMB), but agreed with them that there was no standardized definition. Csorba concluded with a nuance:

However, their description is valid not only for the terminological problems regarding self-mutilation, self-laceration, self-carvers, self-wounding, wrist/cutting syndrome, delicate self-cutting, etc., but more generally refers to interchangeable use of the terms DSH, self-destructive behaviour, self-injurious behavior (in cases of developmental delay, SIB), SI or even the outdated term ‘parasuicide’ (Csorba, 2009).

E. David Klonsky, an American researcher who continues to publish on this phenomenon, also preferred the term “self-injury.” He noted in his 2009 article that he adopted this as a shorthand for non-suicidal self-injury. Following Muehlenkamp and others, Klonsky stated that self-injury, or more precisely NSSI “can be defined as

intentional, direct damage to one's body tissue without suicidal intent" (Klonsky E. , 2009).

Betty Frances Gerstein wrote from her perspective as a Canadian family physician and gave the examples of "cutting, burning, or interfering with healing of wounds" to illustrate self-injury (Gerstein, 2010). She used the terms self-harm, NSSI, self-injury and self-mutilation synonymously. She sprinkled each of these terms throughout her article "Adolescent self-harm: Cutting away the pain."

Hawton, from whom we have heard previously, gives helpful insight into the geographic divide between researchers which will be discussed at length later in this work. "In the UK the term 'deliberate self-harm' (DSH) has been used to encompass all acts of intentional self-poisoning and self-injury, whereas in North America researchers often divide such behaviour into 'attempted suicide', where death is at least part of the intended outcome, and 'non-suicidal self-injury', where death is definitely not the intended outcome" (Hawton K. H., 2010). Italian researcher Irene Sarno followed Scandinavian scholars (Herpertz, 1995) by defining self-injury (SI) as "deliberate, direct physical self-harm without conscious suicidal intent that does not lead to evidently life-threatening wounds" (Sarno, 2010).

K. Jessica Van Vliet of Canada used the terms NSSI and self-injury interchangeably. She stated, "Some alternative terms for NSSI are deliberate self-harm, self-injury, self-mutilation, and nonsuicidal parasuicide" (Van Vliet, 2011). Interestingly, Scottish researcher Brody used the Scandinavian definition while quoting Italian

researcher Sarno instead of following Hawton's lead in research in the United Kingdom. He used deliberate self-harm or self-injury to refer to the same action (Brody, 2012).

While American researcher Joseph C. Franklin used the term nonsuicidal self-injury (NSSI) to indicate "self-inflicted tissue damage that is intentional, direct, socially unacceptable, and without suicidal intent (e.g., cutting or burning the skin)," he also used the term self-injury to denote the same actions (Franklin, 2012). In defining self-injury in this manner, he followed Matthew Nock (Nock M. , 2010).

Sarah A. St. Germain brought into the discussion the idea of direct and indirect self-injury. She appeared to reserve the term NSSI for engagement in direct self-harm while using "self-injury" to indicate indirect methods which might include "involvement in abusive relationships, substance abuse, risky or reckless behavior, or eating disordered behavior" (St. Germain, 2012). This researcher defined indirect self-injurious behavior as "behavior that is clearly damaging to the self but does not involve immediate and deliberate damage to body tissue" (St. Germain, 2012). She concluded that these two phenomena should be studied separately due to a significantly greater degree of harsh self-criticism and a higher potential for suicide existed within the NSSI population she studied (St. Germain, 2012).

In Australia, Emily Berger appeared to use the terms self-injury and NSSI interchangeably. She entitled her 2013 article "'Listen to them': Adolescents' views on helping young people who self-injure" but opens her work with Nock's 2009 definition of NSSI, "the deliberate destruction or alteration of one's own body tissue without suicidal intent" (Berger, 2013).

Here we have seen the term “self-injury” used as a shortened version of NSSI and as a less specific and clinical terminology. Also noted are the differences in nomenclature between geographic regions. This geographic divide will be covered more extensively following the history of the NSSI terminology.

#### Non-Suicidal Self-Injury (NSSI)

The earliest reference to the term NSSI seems to be from Goldston’s 2006 chapter “Suicidal and nonsuicidal self-harm behaviors” in Wolfe and Mash’s *Behavioral and Emotional Disorders in Adolescents* (Goldston, 2006). Although there was prior discussion about the possibility of the inclusion or exclusion of suicide attempts from the phenomenon under discussion, Goldston seems to have introduced the term which is now the accepted terminology. Goldston’s examples of NSSI cited Ross & Heath’s 2002 work and included cutting, hitting, pinching, scratching, or biting oneself (Goldston, 2006).

Also in 2006 Nock referred to NSSI as “direct, deliberate destruction of one’s own body tissue in the absence of intent to die” and described it as a subset of SIB (Nock M. J.-R., 2006). Muehlenkamp also used the acronym NSSI, although she spoke of non-suicidal self-injurious behaviors. In 2006 she defined this term for her work as “acts that damage body tissue (e.g., cutting, burning) and occur without suicidal intent” (Muehlenkamp, 2006).

Glassman created a hybrid of these in 2007 when she defined NSSI as “direct and deliberate harm of bodily tissue in the absence of suicidal intent” (Glassman, 2007). Although she referenced both Pattison & Kahan and Favazza, Elizabeth E. Lloyd-Richardson defined NSSI as “deliberate, direct destruction or alteration of body tissue

without conscious suicidal intent” (Lloyd-Richardson, 2007). Michelle M. Wedig used a slight difference in words by defining NSSI as “the direct deliberate destruction of body tissue in the absence of suicidal intent” (Wedig, 2007).

By 2007, a group of scholars who realized the difficulties of learning from one another’s contributions when they employed a varied terminology, met together and formed the International Society for the Study of Self-Injury (ISSS). Within the first year of their official launch, they drafted a statement defining NSSI as “the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned” (International Society for the Study of Self-Injury, 2007). Early members of this group included Nancy L. Heath, Ph.D. of McGill University; Janis Whitlock, Ph.D. of Cornell University; Matthew Nock, Ph.D. of Harvard University; David Klonsky, Ph.D. of Stony Brook University; Jennifer Muehlenkamp, Ph.D. of University of Wisconsin-Eau Claire; Paul L. Plener, M.D. of University of Ulm; and Stephen P. Lewis, Ph.D. of University of Guelph.

Nancy Heath wrote a very helpful piece in the *Journal of Mental Health Counseling* in 2008. Here she said, “Defining the exact parameters of NSSI behavior has not been straightforward and interpreting the research in the field can be challenging due to differences in the operationalization of the definition” (Heath N. T., 2008). She detailed the establishment of the ISSS in 2006 and their agreed upon definition of NSSI from June of 2007. Heath then explained that NSSI is part of a larger construct of self-harming behaviors.

Deliberate self-harm, as defined by the Child and Adolescent Self-harm (CASE) group in Europe, is an act with nonfatal outcome in which an individual deliberately does one or more of the following: initiated behavior (e.g., self-cutting, jumping from a height) intended to cause self-harm; ingested a substance in excess of the prescribed or generally recognized therapeutic dose; ingested a recreational or illicit drug that was an act that the person regarded as self-harm; or ingested a non-ingestible substance or object, irrespective of suicidal intent (Heath, 2008).

For her understanding of the CASE study, Heath referenced Keith Hawton and his team at Oxford. Heath went on to note that between 2003 and 2005 Hawton and others working with the CASE group had moved from using “deliberate self-harm” to simply “self-harm” (Heath, 2008).

Further, Heath noted that NSSI cannot be thought of as synonymous with other self-harming behaviors. She pointed out specifically that “while NSSI may be related to other suicidal behaviors, it is a distinct and separate behavior from either suicide attempts or the broader deliberate self-harm definition” (Heath, 2008). She encouraged careful differentiation in the clinical setting between self-harming with suicidal intent and NSSI (Heath, 2008).

Colleen M. Jacobson, despite working with Muehlenkamp (one of the original members of the ISSS), harkened back to an earlier era in her 2008 article when she referenced Favazza (1998) for her definition of NSSI as “purposefully hurting oneself without the conscious intent to die” (Jacobson C. M., 2008). She divided the larger

category of DSH three ways to include suicide, attempted suicide, and NSSI (Jacobson, 2008).

Nock, another founding member of the ISSS, defined NSSI in his 2008 paper “Physiological arousal, distress tolerance, and social problem-solving deficits among adolescent self-injurers” as “the direct and deliberate destruction of one’s own body tissue in the absence of intent to die and outside the context of socially or medically sanctioned procedures (e.g., ear piercing)” (Nock M. M., 2008). Here Nock used all the elements present in the ISSS 2007 definition but put them into his own words.

Hungarian researcher Csorba credited Lloyd-Richardson with coining the term NSSI. In his 2009 article he opted to use the term self-injury (SI) as the umbrella term which was then divided into suicidal and non-suicidal self-injury, SSI and NSSI respectively (Csorba, 2009). He felt that this new schema “seems to eradicate the previous terminological confusion” (Csorba, 2009).

American researcher Donald M. Dougherty defined NSSI as “a non-fatal act that results in bodily injury without the intent to die” in his 2009 article (Dougherty, 2009). By leaving “bodily injury” undefined, Dougherty could be including some behaviors that would not be included in the ISSS definition of 2007. For example, jumping from a high place, but not high enough to end in death could be an example of such a bodily injury.

Interestingly, Muehlenkamp and Walsh in their 2010 evaluation of The Signs of Self-Injury program designed for schools did not define NSSI, but give the examples of “cutting, burning, skin abrating [sic]” (Muehlenkamp J. W., 2010). Perhaps they felt that

by then the ISSS definition was well enough accepted that there was no need to specify this in each article.

In an internationally researched article by Laurence Claes, E. David Klonsky and Jennifer Muehlenkamp, et al., NSSI was defined as “any socially unaccepted behavior involving direct and deliberate destruction of one’s own body tissue without suicidal intent such as scratching, cutting, hitting, and burning oneself” (Claes L. K., 2010). Here both Claes’ (2007) and Muehlenkamp’s (2005) earlier works were referenced in the definition.

In Penelope A. Hasking’s quest to discover the link between personality and self-injury, she allowed her adolescent subjects to define what, in their own minds, constituted NSSI. Some options were given (deliberate cutting, burning, severe scratching, wound interference), but she also allowed the respondents to “self-nominate” other behaviors as NSSI (Hasking, 2010). She had students rate the severity of their actions and allowed for “life-threatening” as an option (Hasking, 2010). This would lead one to believe her results may have included some behavior that was actually suicidal rather than NSSI.

Another 2010 publication based the definition of NSSI on Gratz’s 2003 article. Vance V. MacLaren said that NSSI was “the deliberate inflicting of physical injury to one’s own body that is not due to accident or conscious attempt at suicide” (MacLaren, 2010). Again, as with Dougherty in 2009, “physical injury” might allow a broader inclusion of behaviors than did the ISSS’s 2007 definition (Dougherty, 2009).

Jason J. Washburn defined NSSI as “the deliberate damage of body tissue that is not sanctioned by society (e.g., piercing, tattoos) and is devoid of an active intent to die”

(Washburn, 2010). He credited Klonsky and Muehlenkamp's work from 2007 for his definition, and his level of precision matched the ISSS 2007 proposal. In 2011, Joan Rosenbaum Asarnow gave a shorter definition of NSSI but shored it up with examples. He said that NSSI is "deliberate self-harm without suicidal intent (e.g., cutting, burning)" (Asarnow, 2011). Despite the examples offered, this definition lacks the specificity of the ISSS 2007 definition.

Another international study involving both Claes and Muehlenkamp credited Nock and Prinstein (2004) with its definition. Author Imke Baetens wrote, "Non-suicidal self-injury (NSSI) is any socially unacceptable behavior involving deliberate and direct injury to one's own body surface without suicidal intent" (Baetens, 2011). This could also allow for more behaviors than what is slowly becoming the (at least North American) standard way of defining NSSI.

Catherine R. Glenn and E. David Klonsky's 2011 article is often cited by those who come later. Their definition of NSSI was "a class of behaviors defined by deliberate, direct, and self-inflicted tissue damage without suicidal intent and for purposes not socially sanctioned (e.g., skin cutting and burning)" (Glenn, 2011). These authors cite Favazza & Conterio, 1989; ISSS, n.d.; Nock & Prinstein, 2004; and Whitlock, Eckenrode, and Silverman, 2006 as sources that informed this definition. Benjamin L. Hankin followed Nock in his definition of NSSI as "the direct, deliberate destruction of body tissue without lethal intention" (Hankin, 2011). He did not include any mention of certain socially sanctioned practices that might be excluded from the category of NSSI.

Swedish researcher Goran Jutengren did not use the term NSSI, but instead used the less precise “self-harm” to describe “deliberate, direct destruction or alteration of body tissue without conscious suicidal intent but resulting in injury severe enough for tissue damage (e.g., scarring) to occur” (Jutengren, 2011). The author cited Gratz’ article on deliberate self-harm (DSH) from 2001 as source material for this definition. One might see this as a muddying of the definitional waters.

Dean McKay stated that “NSSI involves deliberate harm to the body without suicidal intent and includes such behaviors as cutting, scratching, skin picking, interfering with wound healing, burning, and carving words, designs, or symbols into the skin” (McKay, 2011). Although the author credited no one with having specifically influenced his definition, it mirrors the tripartite ISSS 2007 definition and gives examples for one of the ISSS definition’s tenets. Similarly, Van Vliet’s definition of NSSI was roughly equivalent to the ISSS’s 2007 proposal. However, she went on to say that “Some alternative terms for NSSI are deliberate self-harm, self-injury, self-mutilation, and nonsuicidal parasuicide” (Van Vliet, 2011). With that the author takes us back into the definitional forest and leaves us to find our own way out.

By 2012, a large majority of researchers who used the term NSSI did so with a definition that more or less conformed to the ISSS’s 2007 offering. However, German researcher Jennifer Svaldi reached back to Favazza’s 1998 work for her definition. She stated that NSSI “refers to the deliberate destruction of healthy body tissue without suicidal intent and typically includes repeated acts such as skin cutting and burning, hitting and banging body parts, scratching and interfering with wound healing” (Svaldi,

2012). Another researcher who slightly departs from the ISSS definition, even though she cited that as her source, was Sarah Elizabeth Victor. She stated that NSSI “is the intentional and direct injuring of one’s own body without suicidal intent” (Victor S. G., 2012). By not mentioning anything about injury to the skin, she left the door open for any sort of poisoning or overdose to be included as NSSI. Chinese researcher You made this same omission (You, 2012).

In 2013, Tori Andrews of Australia agreed with the ISSS 2007 definition and quoted Nock (2010) as her source. Another Australian researcher, Berger, similarly used the tripartite model of the ISSS 2007 definition but credited Nock’s 2009 work for her source (Berger, 2013). Konrad Bresin of the United States similarly included all the elements of the ISSS definition and cited Nock (2009) as his source (Bresin, 2013).

Arensman used information from the Irish National Registry of Deliberate Self-Harm and purposefully did not use the NSSI terminology. She stated, “If individuals diagnosed with non-suicidal self-injury are at similarly increased risk of repetition and suicide as those presenting with self-cutting generally, it could be that ‘non-suicidal’ is a misleading classification with potential risk for patients’ safety” (Arensman, 2013). The question of the relationship of NSSI to suicide is one that will be taken up later in this work.

American researcher Kathryn R. Cullen described NSSI as “the act of harming one’s own body tissue without the intent to die” (Cullen, 2013). Interestingly, she quoted a 1991 article by Winchel from the same journal in which she was publishing (*American Journal of Psychiatry*) as her source. This might lead one to wonder if the division in

terminology was between fields of study. However, the evidence appears to support a geographic rather than a discipline-based difference.

Canadian researcher Jamie M. Duggan used Favazza's 1998 work as the basis for his definition of NSSI calling it "intentional, self-inflicted damage to body tissue resulting in immediate damage, without suicidal intent and for purposes not culturally sanctioned" (Duggan, 2013). We see here the addition of "immediate damage" which was not included in the ISSS definition. Interestingly, Heath, a founding member of the ISSS was listed as a co-researcher on this study.

In an article concerned with the proposed inclusion of NSSI as a separate diagnostic category in the *DSM-5 (Diagnostic and Statistical Manual, 5<sup>th</sup> edition)*, Sander L. Gilman raised some sharp questions:

While the term self-harm in the DSM-5 is assumed by many to refer to what is widely known as non-suicidal self-injury (NSSI), the choice of the term is not incidental. As discussed below, the rhetoric of self-harm in DSM-5 mimics the definition of NSSI as defined by the International Society for the Study of Self-injury (2007), i.e. 'the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned.' In the public sphere, however, self-harm seems to be broader in scope and refer to NSSI as well as other acts that have a nonfatal outcome; this includes overdosing and suicide attempts (Gilman, 2013).

Gilman's perspective on creating a new diagnosis for NSSI was clear as he stated: "The idea that there is a standard, empirically observable category with its own autonomous history is a fantasy of the present. Indeed over the past half-century we have seen the shift in the actions labelled as self-harm as well as the meanings attached to them" (Gilman, 2013). Here Gilman cited Rodham and Hawton's 2009 article. This author would question if the evolution of terminology was not simply a joining together of disparate pockets of the research community reaching an agreement over terms so that they could learn from one another, rather than a shift in meanings.

Canadian researchers Chloe Andrea Hamza and Shannon L. Lewis both employed Nock and Favazza's 2009 articles as their source of definition, and used the three concepts covered in the ISSS 2007 definition (Hamza C. W., 2013) (Lewis, 2011). Michael Kaess of Germany covered the same three concepts but cited Lloyd-Richardson (2007) as his source. Norway's Melanie Straiton allowed participants in her study to choose the term with which they identified. She found that this nonclinical population often used the term "self-harm" to describe what Laye-Gindhu (2005) referred to as NSSI (Straiton, 2013). Taking a different approach, an international study headed by American researcher Landon F. Zaki defined NSSI by its causes rather than the behaviors themselves. He said that NSSI was "characterized by pervasive emotion regulation difficulties and behavioral impulsivity" (Zaki, 2013). Canadian researchers Victor and Klonsky used the ISSS 2007 definition of NSSI (Victor S. K., 2014).

For the purposes of this project, I will use the terminology "non-suicidal self-injury." I see this terminology as more clinically appropriate. It has the advantage of an

international study committee behind it, and clearly states that this type of self-injury did not originate in a wish to kill oneself. I agree with Favazza that the term “self-mutilation” should be reserved for the most extreme forms of self-harm. I would put “self-mutilative behavior” into this same category as “self-mutilation.” “Deliberate self-harm” speaks to the idea that it is self-inflicted, but does not differentiate between suicidal and non-suicidal motivations. Self-injurious behavior, self-harm, and self-injury seem more general in nature and, again, fail to give information about motivation. For these reasons, I use the term NSSI.

#### Geographic Differences in Nomenclature

Despite the careful efforts of the ISSS, researchers from different countries still disagree about the terminology for the behavior in question. Although many in North America, several European countries and Australia have begun to use the ISSS’s definition of NSSI, the United Kingdom has resisted this trend. In his 2012 article in *Lancet*, Keith Hawton spoke directly to this issue.

Self-harm refers to intentional self-poisoning or self-injury, irrespective of type of motive or the extent of suicidal intent. It is used here in preference to the dichotomous separation of such acts into non-suicidal self-injury (proposed as a new diagnosis for the Diagnostic and Statistical Manual of Mental Disorders, fifth edition) and attempted suicide—now popular in the USA—because suicidal intent is a dimensional phenomenon, the patient’s and the clinician’s view of suicidal intent might differ, and national clinical guidelines focus on self-harm (Hawton K. S., 2012)

The “guidelines” of which Hawton spoke came from the UK’s National Institute for Clinical Excellence (NICE) and their guidelines published under the title “Self-harm: Longer term management” (National Collaborating Centre for Mental Health, 2011). The relationship of NSSI and attempted suicide will be discussed in the next section of this chapter.

Most other countries are now following the new diagnostic criteria of NSSI, which has now been included in the *DSM-5*, listed under “Conditions for Further Study.” These criteria reveal close kinship to the ISSS’s definition. The *DSM-5* criteria are as follows:

- A. In the last year, the individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body of a sort likely to induce bleeding, bruising, or pain (e.g. cutting, burning, stabbing, hitting, excessive rubbing), with the expectation that the injury will lead to only minor or moderate physical harm (i.e., there is no suicidal intent).
- B. The individual engages in the self-injurious behavior with one or more of the following expectations:
  - 1. To obtain relief from a negative feeling or cognitive state.
  - 2. To resolve an interpersonal difficulty.
  - 3. To induce a positive feeling state (*Diagnostic and Statistical Manual 5*, 2013, p. 802).

The remaining sections of the *DSM-5* criteria for further study refer to the thoughts and feelings associated with NSSI (C) and the relation of NSSI to social sanctions, distress, and other mental disorders (D, E, and F).

- C. The intentional self-injury is associated with at least one of the following:
  - 1. Interpersonal difficulties or negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act.
  - 2. Prior to engaging in the act, a period of preoccupation with the intended behavior that is difficult to control.
  - 3. Thinking about self-injury that occurs frequently, even when it is not acted upon.
- D. The behavior is not socially sanctioned (e.g., body piercing, tattooing, part of a religious or cultural ritual) and is not restricted to picking a scab or nail biting.
- E. The behavior or its consequences cause clinically significant distress or interference in interpersonal, academic, or other important areas of functioning.
- F. The behavior does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal. In individuals with neurodevelopmental disorder, the behavior is not part of a pattern of repetitive stereotypes. The behavior is not better explained by another mental disorder or condition (e.g., psychotic disorder, autism spectrum

disorder, intellectual disability, Lesch-Nyhan syndrome, stereotypic movement disorder with self-injury, trichotillomania [hair-pulling disorder], excoriation [skin-picking] disorder) (*Diagnostic and Statistical Manual 5*, 2013, p. 802).

This is the language in the new *DSM-5*, and, despite a hot debate leading up to its semi-inclusion, this is now the basis of carefully constructed research in most of the world except for the United Kingdom.

#### NSSI and Attempted Suicide

As early as 1970, some researchers were wondering about a possible differentiation between self-harm and suicide attempts or “parasuicide.” In her article on parasuicide rates in Edinburgh, Buglass said:

Statistics compiled by the Scottish Home and Health Department show that in 1967 95% of all adult patients admitted to hospital from an Edinburgh address for treatment of poisoning were received by the RPTC [Regional Poisoning Treatment Centre]. Cases of self-injury are also received at the RPTC though they are less systematically referred than are the poisoning cases and thus likely to be less fully represented than the former (Buglass, 1970).

Here we see the author distinguishing between what she saw as parasuicide (what would today be referred to as suicide attempts) and “self-injury.”

This is one of the reasons that doing a literature search for material published prior to the 1980s will yield very few results. When self-harm was acute enough to

require medical attention, it was considered to be related to suicide as a failed attempt. The idea of “self-injury” as something separate from parasuicide as in the above article was part of the very first wave of research into something other than suicide and parasuicide. Even the modern study of suicide itself began only a few years prior to this. Norman Ferberow, credited as being one of the founding fathers of the study of suicide, began his work in Los Angeles in 1958 and published his seminal work on suicide entitled *The Cry for Help* in 1961.

In 1975, Canadian researcher Ferrence described self-destructive behavior as taking the forms of “suicide, alcoholism, or engaging in very high risk activities” (Ferrence, 1975). She went on to talk about “sub-suicidal” or “self-injury behavior,” which she defined as “all cases of self-inflicted overdosage, asphyxiation, and injury, whether or not there is evidence of suicidal intent” (Ferrence, 1975). In that same year in the UK, H. Gethin Morgan reported that “Patients who have deliberately harmed themselves...differ in certain characteristics from those who actually kill themselves” (Morgan, 1975). In fact, Morgan defined deliberate self-harm as “a non-fatal act, whether physical injury, drug overdosage or poisoning, carried out in the knowledge that it was potentially harmful...” (Morgan, 1975).

In 1984, Kahan and Pattison introduced another intriguing idea. They wrote their proposal for a new diagnosis of DSH from the perspective of “the person for whom self-destructive behavior appears to be a chronic coping style in life. Such behavior may not be suicidal in intent, but rather life-preservative” (Kahan, 1984). If the intent of the

behavior was to extend life rather than extinguish it, one would think a careful differentiation should be made.

Other researchers have also wondered about the ameliorating properties of DSH. When Favazza interpreted the early reference to self-harm in the biblical book of Matthew, he went on a bit further than was previously discussed. When Jesus exorcised the demons, Mark 5:13 says, "...the unclean spirits entered the swine [that were feeding on the mountainside v. 11]; and the herd rushed down the steep bank into the sea, about two thousand of them; and they were drowned in the sea" (NASB). Favazza asked the question, "...was it possible that the man had suicidal urges that were kept in check by his repeated skin cutting? (Favazza, 2011, p. x)." From its earliest descriptions, instead of an attempt to end life, is there some form of benefit to self-cutting?

While Kahan and Pattison were advocating for a separate classification of DSH in the United States, a very different trend was taking place in Europe. In 1988, the World Health Organization's European office was putting together a team of experts to study trends in the increasing numbers of suicides in member countries. The following year, the WHO/Europe Multicentre Study in Parasuicide came up with the following definition of parasuicide:

An act with nonfatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing

changes which the subject desired via the actual or expected physical consequences (Bille-Brahe, 1995).

It is clear from this definition that parasuicide included what would in contemporary parlance be referred to as suicide attempts as well as any other sort of self-harm regardless of the intent. So while American researchers were beginning to separate non-suicidal self-harm or DSH from suicide, a powerful group of European researchers was considering these part and parcel of the concept of suicide.

In 1996, Nick Goddard supposed a continuum of severity. He stated, “Suicidal behaviour covers a broad spectrum of behaviours, from an expression of despair to a wish to die” (Goddard, 1996). He then went on to define DSH as a subset of suicidal behavior that included “any deliberate, non-habitual act that causes self-harm or may have potential to do so (non-habitual excludes overdose of drugs/alcohol by a habitual user)” (Goddard, 1996). Goddard’s distinction that DSH included only “non-habitual” acts followed the WHO/Europe study.

In 1997, American researcher Brent introduced the terminology of non-suicidal self-harm. He claimed, “One type of behavior that must be differentiated from suicide attempts is that of self-cutting, usually with little suicide intent” (Brent, 1997). Here he referenced a 1975 article by Canadian researcher Simpson (Simpson M. , 1975). Brent went on to describe these incidences of “self-cutting” as superficial and repetitive, which, by description, shows that they were not meant to be life-threatening (Brent, 1997).

Keith Hawton, one of the experts involved in the WHO/Europe study, equated the term parasuicide with DSH and self-harm. He stated, “A collaborative study of self-harm

in 15 European centres (the WHO/EURO Multicentre Study on Parasuicide) has indicated that rates of DSH in 15—24-year-olds in the U.K. in 1989-1992 were among the highest in Europe...” (Hawton K. F., 2000). In the same article he divided DSH into the two categories of self-poisoning and self-injury (Hawton, 2000). Richard Harrington (Harrington R. , 2001), also of the UK, quoted this same statistic and cited a 1996 article also based on the WHO/EURO study (Schmidtke, 1996).

Lucy Webb cited the assertion that “while suicide and nonfatal self-harm appear to differ in epidemiology, compelling evidence points to a shared continuum of self-harm behaviour” (Webb, 2002) put forth in a 2000 book edited by Hawton and van Heeringen (van Heeringen, 2000). She continued to summarize their argument: “They propose a suicidal pathway of increasing helplessness, anger and suicidal ideation, and a decreasing escape potential, which results in a serious suicidal act for those unable to escape” (Webb, 2002). But Webb went on to say that the inclusion of those who poison themselves under the category of DSH may mask those who self-harm through other means. “Indeed, case evidence suggests that self-mutilation can be a coping strategy in anxiety and is a protective element against suicide” (Webb, 2002). She referred to the book *The Language of Injury* (Babiker, 1997). Here, she clearly stated the arguments of both those who included DSH as a lesser form of suicide and those who thought the phenomenon was something totally different.

In 2003, Hawton reasserted his position that DSH may have “variations in degree of suicidal intent” (Hawton K. H., 2003). He said that DSH included both self-poisoning and self-injury, and that self-injury was “any injury recognised by hospital staff as having

been deliberately self-inflicted” (Hawton, 2003). One motive for DSH he mentioned was “clear intention to die (i.e., ‘attempted suicide’)” (Hawton, 2003). Here he cited his own work on “Motivational aspects of deliberate self-poisoning in adolescents” (Hawton K. O., 1982).

Muehlenkamp discussed the question of whether self-injurious behavior should be considered categorically similar to but different in degree from suicide attempts. She defined self-injury as “the deliberate destruction or alteration of body tissue without suicidal intent” (Muehlenkamp J. G., 2004). At this point there was very little empirical evidence to support either claim. The author said, “The argument that appears to be offered most frequently in support of the distinction between suicide and SIB is that individuals who engage in SIB are doing so to manage distress and to feel better, whereas those who attempt suicide are trying to remove themselves from their current life” (Muehlenkamp, 2004). The researcher used a measure employed in suicide research to explore attraction to life and repulsion by death. In different studies done with adolescent inpatients and high school students (Cotton, 1996) and replicated with college students, it was “found that suicidality was positively associated with repulsion by life, attraction to death, and negatively related to attraction to life” (Muehlenkamp, 2004). She found that those who self-injured demonstrated significantly less repulsion by life than those who had attempted suicide. The researcher explained, “Repulsion by life represents a negative attitude toward life and assesses the amount of painful experiences a person has encountered” (Muehlenkamp, 2004). She was able to conclude that “the difference between SIB and suicide attempts is subtle and potentially based in the person’s attitude

toward life” (Muehlenkamp, 2004). Her work began a new era in the study of what we now call NSSI as empirical evidence was sought to understand the phenomena.

The following year, Laye-Gindhu of Canada defined self-harm as being “without any conscious suicidal intent” (Laye-Gindhu, 2005). She went on to point out some of the issues with research into the growing problem. “For example, deliberate self-harm and parasuicidal behavior, terms most often used to describe suicidal behavior, have also been applied to nonsuicidal behavior” (Laye-Gindhu, 2005). This is exactly the problem we are currently illustrating. “Without consensus among researchers of how to conceptualize and operationalize self-harm, not only is comparability across studies limited, the development of a solid empirical research base to guide future research is compromised” (Laye-Gindhu, 2005).

That same year, Keren Skegg of New Zealand stated, “Between 5-9% of Australian, US, and English adolescents reported having self-harmed in the previous year, with few episodes seeming to be true suicide attempts” (Skegg, 2005). For her statistics, Skegg credited Patton (1997), Grunbaum (2004), and Hawton (2002). Later in the same article she stated, “Self-harmers seem to have a different demographic profile to people who commit suicide,” lending more ammunition to research that treats self-harm and suicide as two distinct entities (Skegg, 2005).

In 2006, Nock used self-injurious behavior (SIB) as a term which included both NSSI and suicide attempts. He went on to say, “Some authors have noted the theoretical, methodological, and clinical importance of distinguishing among various forms of SIB (O’Carroll et al., 1996; Linehan, 1997); and these suggestions have been supported by

empirical studies demonstrating that self-injury-related constructs differ in their correlates (Nock and Kazdin, 2002; Nock and Kessler, 2006) and functions (Brown et al., 2002)” (Nock M. J.-R., 2006). The move to separate the categories of self-injury or self-harm from suicidal behavior was gaining momentum.

Andre Sourander of Finland moved against the rising tide as he stated, “The term suicidal behavior encompasses any form of intentional or deliberate self-injurious behavior (suicide, attempted suicide, deliberate self-harm). In the present article, deliberate self-harm is referring to self-injurious behavior with non-fatal outcome” (Sourander, 2006).

In 2007, Brunner considered an even more precise division of DSH. He suggested that there are both occasional and repetitive forms which are correlated to different variables. The researcher showed that “suicidal behavior (ie, [sic] suicidal ideation and suicidal attempts) was associated with both forms of DSH (though much more strongly with repetitive DSH)” (Brunner R. P., 2007).

In an article looking at DSH in those under age 15, Hawton said, “few of the acts of DSH appeared to involved [sic] high suicide intent, again unlike in older adolescents and adults” (Hawton K. H., 2008). Here we see Hawton and Harriss continuing to use the terminology DSH to cover both suicidal actions and NSSI.

Jacobson studied a clinical population and found that “Regardless of the frequency, duration, and recency [sic] of the DSH behaviors, those who had engaged in only NSSI reported lower levels of suicidal ideation than those in the combined group [suicide attempts and NSSI] and the SA-only group and similar levels of suicidal ideation

to the no self-harm group, supporting the notion that there is a subtype of self-injurious behaviors (i.e., NSSI) that are engaged in for reasons unrelated to suicide” (Jacobson C. M., 2008). The evidence for separate categories encompassing suicide and self-injury continued to mount.

Dougherty studied impulsivity among adolescents with no history of NSSI or suicide attempts [SA], NSSI only, SA only, and NSSI + SA. He followed O’Carroll (1996) in stating that “NSSI and SA are two forms of behavior that exist on a continuum of self-injury that ends with completed suicide” (Dougherty, 2009). However, his inquiry showed that relative to the NSSI only group, the NSSI + SA group was “(1) more severely depressed and hopeless; (2) had higher self-ratings of trait impulsivity and suicidal ideation; and (3) performed more impulsively on a laboratory measure of consequence sensitivity” (Dougherty, 2009). His conclusion was that these groups were clinically distinct and needed different treatment.

In Gerrit Scoliers’ work with the results of the CASE (Child and Adolescent Self-harm in Europe) study, he spoke to the motivations for self-harm. He reported that the two reasons for DSH reported most frequently were “wanted to get relief from a terrible state of mind” and “wanted to die” (Scoliers, 2009). This is an instance where we see that a more precise definition of terms would have been helpful. From reading this, one could think that any sort of self-injurious behavior is a suicide attempt. As has been show in other studies, this is not the case. Scoliers stated “Understanding the reason for why the deliberate self-harm occurred is important to provide the most appropriate treatment, and could prevent a future episode of deliberate self-harm” (Scoliers, 2009). I with that

statement, but disagree that the “most appropriate treatment” can be found while NSSI and suicide attempts, different in many ways, are treated in exactly the same manner.

Virpi Tuisku of Finland detailed the difficulties with the defining of terms around the subject and chose to follow Brunner (2007) in using DSH as the “intentionally [sic] injuring of one’s own body without apparent intent to die” (Tuisku, 2009). The researcher stated that “most previous researchers understand DSH and suicide attempts as distinct behavioral phenomena” (Tuisku, 2009). Tuisku went on to report that “In the present study, depressed adolescents with DSH and suicidal ideation or suicide attempts had more depressive and anxiety symptoms than adolescents with only DSH” (Tuisku, 2009).

In 2010, Claes and Muehlenkamp completed a study in which they compared NSSI and suicidal behavior in patients in a psychiatric crisis unit. They concluded “The importance of delineating NSSI from SA is corroborated by the current findings...” (Claes L. M., 2010). “Specifically, individuals who self-injure and are not suicidal tend to be more active, albeit avoidant, in their coping and they tend to have less severe symptoms of depression, hopelessness, and neuroticism compared to those who are suicidal” (Claes, 2010).

Gerstein stated “Self-injury is often performed in an attempt to alter a mood state....One who attempts suicide wants to end all feeling, whereas one who self-mutilates does so to feel better” (Gerstein, 2010). She went on to say that “Traditionally, such behaviour has been either minimized as attention seeking, regarded as a failed suicide attempt, or read as a telltale symptom of borderline personality disorder. Now we realize it to be a significant, pressing problem among young people” (Gerstein, 2010).

In a time when much of the research was showing differences between suicidal and non-suicidal self-injury, Hawton explained the geographic differences in definition. “In the UK the term ‘deliberate self-harm’ (DSH) has been used to encompass all acts of intentional self-poisoning and self-injury, whereas in North America researchers often divide such behaviour into ‘attempted suicide’, where death is at least part of the intended outcome, and ‘non-suicidal self-injury’, where death is definitely not the intended outcome” (Hawton K. H., 2010). For his UK sources he cited one of his own articles from 2003 and a 2005 study by O’Loughlin. For his North American source he looked to Silverman’s update on terminology in the journal *Suicide and Life Threatening Behaviors*. He gave three reasons to prefer the UK categorization. First, motivations were often a mixture of suicidal and non-suicidal. Second, “suicidal intent is a dimensional rather than a unitary phenomenon” (Hawton, 2010), and finally, motives were often unclear. It should be noted that Hawton’s categories included self-poisoning as self-harm whereas in North America many, if not most, researchers would say that any attempt at self-poisoning was a suicide attempt since the outcome would be so difficult for the individual involved to control. How would an adolescent determine exactly the right amount of a medication to take so that s/he would overdose and experience those deleterious effects, but not die? Here, my leaning toward the North American separation of suicide attempts (including any type of self-poisoning/overdose) and NSSI is evident.

In 2012, Hamza did a study *Examining the link between nonsuicidal self-injury and suicidal behavior: A review of the literature and an integrated model*. In this piece, Hamza did some important theoretical work looking at the connection between NSSI and

suicidal behavior. Although these are, by definition, two different phenomena, the presence of one increases the likelihood that the other might also be present. Hamza reviewed three theories concerning how NSSI and suicide attempts (SA) might be linked (Hamza, 2012). First she examined the Gateway theory. Some researchers see NSSI and SA as a continuum of behaviors. On one end of the continuum would be NSSI and on the other end would be completed suicide. In order to test this theory, more longitudinal research must be completed. From the few studies done so far, evidence against the Gateway theory is that an increasing severity of injury between NSSI and SA is not noted. However, in support of the theory, as previously discussed, Asarnow found that NSSI was a more frequent indicator of SA than previous SA. The second proposed scenario Hamza evaluated is the Third Variable theory. This posited that there is some as yet unknown factor that creates the overlap of NSSI and SA. For instance, Hamza pointed out that 90% of people who die by suicide have “a diagnosable psychiatric disorder” (Hamza, 2012). Nock found that 87% of inpatient youth who were cutting also had a psychiatric diagnosis. Perhaps having a psychiatric disorder is the third variable. Another possibility is that a perceived level of psychological distress is the third variable. Hamza found less support for this theory. The third proposal she took on is Joiner’s Theory of Acquired Capability for Suicide. The idea behind Joiner’s theory is that NSSI may habituate partakers to the fear and pain of a SA. In order to move toward a SA, an individual must also feel that s/he is a burden to others and experience social isolation. In support of this theory, more frequent NSSI predicts more lethal SAs, more methods of NSSI and longer engagement is predictive of the number of SAs, and those with a history

of NSSI and SA “reported less fear about engaging in suicidal behaviors than adolescents without a history of NSSI” (Hamza, 2012). In addition, those with NSSI appeared to “become desensitized to pain” (Hamza, 2012). On the other hand, evidence that might not support Joiner’s theory included the fact that SAs often employ different means than NSSI in the same individual. This makes one question the habituation model. Also, some research has found that there is a decreasing correlation between the number of incidents of NSSI and the number of SAs when one hits the 50 episode mark (Hamza, 2012). Hamza put these three theories together and came up with a tripartite connection between NSSI and SA: through the level of intrapersonal stress, through acquired capability, and through a third variable such as BPD.

In Rory C. O’Connor, Susan Rasmussen and Keith Hawton’s 2012 study attempting to describe the difference between adolescents who think about self-harm from those engage in it, it became difficult to distinguish the ideators from the enactors. O’Connor used the definition of self-harm more prevalent in the UK which included both self-poisoners and self-injurers. From a North American perspective, O’Connor, et al. were including both individuals with suicidal intent and those without any suicidal intent.

Plener weighed in on the debate about whether or not NSSI should be its own diagnostic category in the *DSM-5*. In his article, he mentioned “the high prevalence of adolescents that ‘use’ NSSI as [an] emotional regulation ‘skill’ and clearly distance themselves from suicidality” (Plener P. F., 2012). He also mentioned “the relationship between NSSI and attempted suicide. Despite their distinctiveness these behaviors are

intertwined sharing both similar and separate associated factors” (Plener, 2012).

Anderson also reported on the differences between suicide attempts and NSSI.

Suicide attempts are generally associated with thoughts of death and dying, while NSSI is generally associated with an intent to alleviate distress. Suicide attempts tend to occur with low frequency, a single method, and high lethality injuries, whereas NSSI tends to occur chronically, with high frequency, multiple methods, and low lethality injuries. With regards to response from the environment, suicide attempts often elicit reactions of care, compassion, and concern; in contrast, NSSI often elicits responses involving disgust, fear, and hostility. Unlike suicide attempts, NSSI results in calm and relief, even satisfaction, upon completion (Anderson, 2012).

The author leans heavily on research done by Muehlenkamp in an effort to have NSSI recognized as its own diagnostic category in 2005. Similarly, Lindsay A. Taliaferro pointed out that “adolescents who engage in NSSI report stronger future orientations and greater reasons for living than those who attempt suicide” (Taliaferro, 2012). For her information she also went back to an article by Muehlenkamp, this one published in 2007.

Duggan looked at body image and NSSI, and how emotion regulation might fit into the picture. He stated “Emotion dysregulation was found to significantly and fully mediate the relationship between negative affect and suicide-related thoughts related to the body and physical appearance, and engagement in NSSI among a community sample

of young adults” (Duggan, 2013). The question of emotion regulation will be an important one when we begin to talk about the functions of NSSI.

In this work, I will adopt the nomenclature more common in North America, and I argue that it is more precise in making necessary distinctions. Thus, from this point on, I will discuss NSSI defined as deliberate, direct harming of one’s own body tissue in way not culturally sanctioned that is without suicidal intent. The act of cutting will be seen as a subset of NSSI.

### **Populations Involved**

Once NSSI is clearly defined, other questions rise to the surface. How many people engage in this type of behavior? Is it true that NSSI is on the rise in today’s world? At what point in a young person’s life do we need to be looking for signs that NSSI may be present? Is there a gender difference in who participates in NSSI? These are the questions we will answer as we look at the populations involved in NSSI.

### **Prevalence**

A part of the research on NSSI that is greatly affected by how it is defined is the estimation of its prevalence. The percentage of population involved in NSSI varies widely from study to study. For example, in 1975, Ferrence reported “rates of self-injury varying from 80 per 100,000 to 300/100,000 population per annum” (Ferrence, 1975). For her data, Ferrence included studies from several different countries, some of which counted overdose and self-poisoning as self-injury. Morgan observed that same year that “DSH has become a major health problem, which has increases in size during the last decade at a rate of about 10 percent per annum” in the UK (Morgan, 1975).

Likewise, in 1996, Goddard said, “Quantification of the degree of the problem, however, has proven difficult. No country collects official statistics on DSH, and studies attempting to overcome this deficiency vary in their use of age groupings” (Goddard, 1996). He quoted a study by Diekstra that put the rate of adolescent DSH at anywhere from 2.2% to 10.5% (Diekstra, 1993). These figures also included overdose. In 1999, another UK researcher reported that “Prevalence rates for self-harm have risen since the mid-1980s to an estimated 400 per 100,000 population each year. This incidence is higher than most others recorded in Europe” (House, 1999). It is unclear how the inclusion of self-poisoning and overdose in UK statistics on self-harm affects this conclusion.

Bowen pointed out another area of difficulty in determining the level of NSSI among adolescents. “Even with a national cohort, statistical estimates are crude since most incidences of SIB never come to service attention. This is because acts are frequently carried out in secret, and wounds may be superficial and easily treated by the individual” (Bowen, 2001). She pointed to a 1985 article by Gardner and Chowdry as informing her thoughts on this issue.

As Gratz submitted her study on a new measure of DSH, she credited Favazza’s 1992 study in which 14% of college students said they had “engaged in self-harm at least once in their lives” (Gratz, 2001). This study was completed in the United States. Although most of the subjects in this study were past the age of adolescence, it is informative for our study since it was retrospective in nature. When she administered her own measure, Gratz found that 35% of college students “reported a history of self-harm

and 15% reported a history of more than 10 incidents of self-harm” (Gratz, 2001). As she attempted to account for the large discrepancy between findings, Gratz mentioned differences in measures, the passage of time between surveys, and the fact that in her study participants were told that it was about DSH which might have attracted a higher percentage of the population who had experience with these behaviors.

In 2002, Webb pointed to Kerkhof’s article on attempted suicide and said that DSH was continuing to increase among young females (Webb, 2002). This data was published in the United Kingdom. Also in the UK, Hawton pointed to his earlier work (1986) and stated that DSH “is particularly common in adolescents, especially females” (Hawton, 2003). Hawton’s claim that DSH was especially prevalent among adolescent females is one that will later be disputed.

In another US study, Klonsky stated, “Approximately 4% of the general population and 14% of college students have reported a history of DSH” (Klonsky, 2003). He credited Briere and Gil (1998) and Favazza (1989) for this information. Klonsky went on to report on Gratz’s 2001 study where 35% of college students “report having performed at least one self-harm behavior in their lifetime” (Klonsky, 2003). He also noted the “higher rates of self-harm in individuals from younger generations (Klonsky, 2003).

In 2004, Muehlenkamp stated that “Estimates of self-injurious behavior among adolescents range from 5.1% to over 40%” (Muehlenkamp, 2004). She credited Darche (1990), Patton et al. (1997) and Ross & Heath (2002) for her information. It is important to note that Muehlenkamp was looking only at studies dealing with adolescents and that

she was using a narrow definition of SIB. Therefore these percentages may be closer to the population studied in this project, although she was not limiting her work to only females.

Ron Best's work in the UK reminds us that Hawton (2002) "found that as few as 12.6% of self-harming 15-16 year-olds presented at the hospital" (Best, 2005). In this same study, Best stated that 13.2% of those answering the survey reported a "lifetime history of deliberate self-harm" (Best, 2005). The author went on to say that "Even if the figure of 'three in an average classroom' quoted at the launch of the National Inquiry is excessive, the prevalence of self-harm amongst adolescents is clearly something to which schools and those agencies who support them need to give thought" (Best, 2005).

Laye-Gindhu pointed out that "Prevalence estimates of self-harm are variable and lack of standardized nomenclature and methodological differences render cross-study comparison challenging" (Laye-Gindhu, 2005). She gleaned from previous research that the problem was increasing (Conterio, 1998; Klonsky, 2003) and that rates varied from 5.1% in Patton's 1997 work to 38% in Gratz et al. in 2002.

Nock reported that "Adolescence is a period of significantly increased risk for SMB [self-mutilative behavior], as evidenced by rates of 14%-39% in adolescent community samples and 40%-61% in adolescent psychiatric inpatient samples" (Nock, 2005). Nock's sources for these statistics came from Lloyd, 1997; Ross, 2002; Darce, 1990; and DiClemente, 1991. It is to be noted that Nock was using a precise definition of SMB as "the direct and deliberate destruction of one's own body tissue without suicidal intent" (Nock, 2005).

In 2006, Muehlenkamp adjusted her 2004 estimates slightly downward when she stated, “Prevalence rates of NSSI have ranged from 4.3 to 35%, and Favazza (1998) estimated that anywhere from 400 to 1,400 per 100,000 persons engage in NSSI behaviors per year” (Muehlenkamp, 2006). She cited Briere & Gil (1998) and Gratz (2001) as her sources for these statistics. One reason for the lower numbers in this study may have been that the researcher did not specify that she was looking only at adolescents. It is not clear from her article, but her 2006 estimates may be taken from adult populations.

Brunner quoted two studies of 15-year-olds, one done in the United Kingdom and the other in Australia, in his 2007 work. Here he noted that “Adolescent girls had significantly higher rates (3-7 times) of episodes of self-harm than adolescent boys” (Brunner, 2007). It would be important to note that only 15-year-olds were surveyed in the community samples of these studies. It is debatable whether or not looking at one subset cohort based on age can yield information that is relevant to all adolescents.

In her 2007 study, Glassman used Ross & Heath (2002), Whitlock, Eckenrode, & Silverman (2006), and Zoroglu et al. (2003) to show that 12-21% report “a lifetime history of NSSI” (Glassman, 2007). Interestingly, although Glassman was working in the United States, she quoted from Zoroglu’s work which was conducted with Turkish high school students.

Looking at only North American high school students, Lloyd-Richardson pointed to three studies in her 2007 work. Ross & Heath (2002) indicated a 14% report of lifetime NSSI. Muehlenkamp & Gutierrez (2004) found 15.9% of high school students engaged in

NSSI. Laye-Gindhu (2005) report that 15% of Canadian high school students exhibited NSSI behavior. The similarity of these findings is striking.

Heath presented a study on NSSI in college students in 2008. When she compared statistics on the prevalence of NSSI in the community, she put the range between 10% and 20% of college students. She commented that studies finding much higher percentages were all conducted using “checklists of all possible self-injurious behaviors” (Heath, 2008). Heath posited that by employing this methodology, researchers were shaping participants’ ideas of what constituted self-harm. Other studies with lower percentages allowed those surveyed to define what they describe as NSSI. Also, without a follow-up interview, it was impossible to determine whether the function of or reason for a given behavior was actually NSSI. She gave the example of “sticking pins into skin’ [which] may be a NSSI behavior or it may be related to drug use, self-tattooing, or other body modification” (Heath, 2008).

Using a very different population, Lori M. Hilt chose to look at young adolescents in her 2008 study and focused on American grades 6 through 8. Although she did not specify in this article, in another article she defined “young adolescents” as those between the ages of 10 and 14 (Hilt L. C.-H., 2008). She found an NSSI rate over the past year of 7.5% which she reported was lower than that of older adolescents, but much higher than adults (Hilt, 2008). Hilt wondered if her findings could be explained by the premise that NSSI often began in early adolescence, peaked during later adolescence, and tapered off toward adulthood (Hilt, 2008).

Jacobson pointed to an increase in the prevalence of NSSI. “For example, although Garrison et al. (1993) reported a prevalence rate of less than 3% among community dwelling adolescents in 1993, more recent estimates of the prevalence of NSSI fall around 15% (Muehlenkamp & Gutierrez, 2004; Ross & Heath, 2002)” (Jacobson C. M., 2008).

In discussing prevalence of NSSI, Messer helpfully reminded the reader that research does not allow precision. “Difficulties obtaining more accurate rates involve the private nature of the act itself, clinicians’ and doctors’ disagreement over definition of the act (labeling it as a suicide attempt versus self-mutilation), and contextual factors (higher rates in institutions and jails/prisons)” (Messer, 2008). She concluded her literature review with the information that “these rates vary from 15% in community populations to 60% in residential settings or within institutionalized populations” (Messer, 2008).

Other researchers have also taken account of multiple variables. For example, Nixon of Canada conducted a survey that found that 16.9% of adolescents had used NSSI at one time or another. Her survey included 20% of respondents who were not enrolled in school but all were between the ages of 14 and 21. Nixon’s work showed that “the mean age of onset was 15 years” (Nixon, 2008). The following year, Glenn & Klonsky claimed that “14-15% of adolescents (Laye-Gindhu & Schonert-Reichl, 2005; Ross & Heath, 2002), and 14-17% of college students (Favazza, DeRosear, & Conterio, 1989; Whitlock et al., 2006) reported having self-injured.” They said that among adolescent inpatients, 80% or more individuals had resorted to NSSI (Glenn, 2009). Donald E. Greydanus, also in 2009, reported on a study by Yates the previous year in which 26-37% of students in

grades 9-12 in the western part of the United States reported cutting (Greydanus, 2009). Another 2009 study looked at students of the same age. Muehlenkamp & Walsh used Lloyd-Richardson (2007) and Nixon (2008) to show that the rate of at least one act of NSSI among high school students was 23%. They also credited Heath (2009) with the information that “research consistently finds an age of onset for NSSI around 14 years” (Muehlenkamp, 2009).

Tuisku’s study in Finland stated “Between 5 and 9% of adolescents in Australia, USA and England report having self-harmed in the previous year, with few episodes seeming to be true suicide attempts” (Tuisku, 2009). This researcher credited Skegg’s work for these statistics (Skegg, 2005). A US study from the same year by Kathleen R. Tusaie reported “Although there has been a significant increase in the professional and lay literature on this topic over the past 15 years, it is difficult to determine the extent of the actual increase or prevalence of adolescent self-harm.” (Tusaie, 2009). She credited Nixon & Heath’s 2009 book *Self-injury in Youth* for this information. This researcher went on to say that “In the United States, a 194% increase in rates of self-harm among 15 to 24-year-old males has been reported between 1985 and 1995 and females have even higher rates of self-harm than males” (Tusaie, 2009). Here she looked to Ross & Heath (2002) for her information.

Some larger research bases included youth from different countries in a single study. Mette Ystgaard of Norway along with researchers from eight other countries reported on the CASE (Child and Adolescent Self-harm in Europe) study and found that “medically referred cases of deliberate self-harm represent the ‘tip of the iceberg’”

(Ystgaard, 2009). The author went on to say that “These findings indicate that there is a ‘hidden population’ of distressed adolescents, including some who may have serious mental health problems” (Ystgaard, 2009).

In 2010, Claes noted that “Adolescence is a period of increased risk for non-suicidal self-injury (NSSI) as shown by rates of 14%-39% in community samples” (Claes L. H., 2010). He pointed to research done by Lloyd-Richardson (2007) and Plener (2009) as his sources for these statistics. In another 2010 article, Hawton noted that “self-cutting is more common than self-poisoning amongst adolescents in the community... Also, self-cutting is likely to be repeated, often on many occasions” (Hawton, 2010). He cited his own 2006 book, an article by Nicola Madge (2008) containing information from the CASE study, and some of Favazza’s early work (1993) as the impetus for these conclusions. Coming from a slightly different perspective, a 2010 study on bullying and self-harm stated, “although the estimates vary widely, community-based self-report studies also reveal notably high levels of self-harm. Laye-Gindhu and Schonert-Reichl (2005) find the prevalence of self-harm to be ~ 15%” (Hay, 2010). The researcher went on to say that “In light of these patterns, deliberate self-harm is now recognized as a significant social problem facing adolescents” (Hay, 2010). Also in 2010, MacLaren said that “Although some forms of NSSI may be symptomatic of severe psychiatric disturbance, this behavior is practiced at varying levels of intensity and frequency by many adolescents and young adults, with lifetime prevalence estimates ranging from 13% to 35%” (MacLaren, 2010). This Canadian researcher cited Herbert Fliege’s 2009 study on DSH as his source. British researcher Steven Prymachuk agreed with Carter Hay

about the importance of NSSI. He used Hawton's 2002 statistics to state that at least 7% of young people, especially girls, have been involved in DSH (Prymachuk, 2010). He also introduced the 2006 National Inquiry into Self Harm among Young People in the UK to highlight that this was an issue of national importance.

In their 2010 study of the Self-Harm Inventory, the Sansones pointed out that "As for explicit empirical studies [of NSSI], most have explored non-United States adolescent populations" (Sansone R. S., 2010). After rehearsing the statistics from some representative studies, they concluded "collectively, these data among non-United States adolescent community populations indicate that between 2 and 17 percent have engaged in self-harm behavior at some point in their lifetimes" (Sansone, 2010).

In introducing a study done with Italian university students, Sarno put the range of adolescents and young adolescents who have self-injured between 14% and 66% (Sarno, 2010). For this statistic, the author looked at Bjarehed (2008), Hilt (2008), Lundh (2007), Ross (2002), Whitlock (2006), and Zoroglu (2003). Bridging the divide between research done in Europe and research done in the United States, Norway's Tofthagen stated "In the United Kingdom, self-harm is a common cause for admission into mental health care facilities and is also one of the five most common acute medical care diagnoses. A similar trend is also discernible in the United States" (Tofthagen, 2010). This researcher looked at Claassen (2006) for information about self-harm in the United States. Washburn wrote that "The lifetime prevalence rate of self-injury in studies of adolescents and young adults in the community is typically between 13% and 23%" (Washburn,

2010). He looked to Jacobson & Gould (2007) and Rodham & Hawton (2009) for his informational sources.

Asarnow took a different route in outlining the prevalence of NSSI by linking it to the prevalence of suicide attempts. She stated first that “Suicide is the third leading cause of death among youth 10 to 24 years of age, and national surveillance data indicate an annual suicide attempt (SA) rate of approximately 6.3% among high school students” (Asarnow, 2011). She went on to note that when mental health providers were surveyed, their feedback indicated “that NSSI is a more frequent problem than SAs among their patients” (Asarnow, 2011). Therefore, she put the figure at greater than 6.3% of high school students in the United States who engaged in NSSI over the course of a lifetime.

Baetens of Belgium noted that “Studies (e.g., Ross & Heath, 2002) suggest that 14%-39% of adolescents in community samples engage in NSSI and that male and female adolescents do not significantly differ with respect to NSSI rates in non-clinical samples” (Baetens, 2011). The information regarding the similarity between genders with relation to participating in NSSI came from Heath (2008). In another European study, Swedish researcher Franzen spoke of “western societies” when she used statistics of 17% of college students who reported at least one act of NSSI, in this particular case either cutting or burning themselves (Franzen, 2011). This result came from Whitlock (2006). However, Franzen stated that it could be as little as 4% if one looked at Klonsky (2003).

Hankin of the United States wrote that “NSSI rates among adolescents are alarmingly high (13-23% of community adolescents)” (Hankin, 2011). Here he cited Klonsky & Muehlenkamp (2007) and Nock (2009). A close companion to Hankin’s

statistics came from another North American source. Canadian researcher Lewis stated that “Among adolescent and young-adult populations, NSSI rates consistently range from ~14% to 21%” (Lewis, 2011). Here he looked at some of the more frequently quoted articles: Rodham & Hawton (2009), Whitlock et al. (2006), Ross & Heath (2002). McKay of the United States used higher statistics and said that “Between 12% and 38% of young adults report a history of NSSI” (McKay, 2011). Although he was using these numbers to represent only NSSI, his data was from Rodham & Hawton (2009) which was actually discussing a broader subset of DSH which included poisoning and overdose. Conversely, Van Vliet said that “In Canada and the United States, prevalence ranges from 12% to 41% in community samples of adolescents and young adults” (Van Vliet, 2011). She used Gratz & Roemer (2008), Klonsky (2007), and Laye-Gindhu & Schonert-Reichl (2005) to find her data. A much lower percentage was found in research with young adults. Whitlock of the United States studied college students in 2011 and found that out of 11,529 cases, 15.3% had participated in NSSI at some time in their lives (Whitlock J. , 2011).

In 2012, Brody did a study with a community sample of Scottish adolescents and found that 20.6% reported having engaged in NSSI at least once during their lives (Brody, 2012). Although the author mentioned that this finding was slightly higher than Sarno’s study of Italian university students in 2010, it should be noted that in Brody’s work he used subjects between the ages of 16 and 19. It has been argued that the median age of onset for NSSI is in the 14- to 15-year-old range, so one might anticipate higher percentages in 16- to 19-year-olds. Sarno’s sample ranged in age from 19 to 45, so he

was surveying a different birth-year cohort (Sarno, 2010). Although these samples were from different countries and cultures, it may lend credence to the argument that NSSI was increasing as new birth cohorts reached the median age of onset.

Courtney Brooks Catledge reported that between one in three and one in two adolescents in the US reported at least one episode of NSSI (Catledge, 2012). This statistic of 33.3% to 50% came from Peterson's 2008 study published in *Psychiatry (Edgmont)*. She also used Whitlock's (2006) finding that lifetime prevalence among college students was 17%. Catledge helpfully added, "A wide range in prevalence data is attributed to the fact that many who self-injure do not seek medical assistance" (Catledge, 2012). In fact, the statistics on those who reported their NSSI would indicate that far less than 50% were ever known to the medical community. Conversely, Sheila E. Crowell of the United States said that "In community samples, between 8% and 56% of young people self-injure" (Crowell, 2012). She used Gratz (2006), Hilt (2008), Hooley (2008), Lloyd-Richardson (2007), Plener (2009), and Ross (2002) to gather this information. She also used Crosby (1999) to indicate that fewer than 30% of individuals involved in SII (self-inflicted injury) were seen by a medical professional (Crowell, 2012). The same year, some research returned lower percentages. For instance, Robert J. Gregory of the United States said that "Self-injury behaviour among adolescents, especially cutting, has become increasingly prevalent" (Gregory, 2012). He used Madge (2008) and Sarah Stanford (2009) to note that in different countries, lifetime prevalence of NSSI has been found to be as high as 21% (Gregory, 2012). Hovering around a similar median, Canadian author Hamza said that "as many as 13 to 29% of adolescents...engage in non-

suicidal self-injury (NSSI), such as self-cutting, burning, and biting without lethal intent” (Hamza C. S., 2012). She cited Baetens (2011), Brausch (2010), Heath (2007), and Ross (2002) for her sources.

Using the definition of self-harm preferred in the United Kingdom, Hawton stated, “Although international variation exists, findings from many community-based studies show that around 10% of adolescents report having self-harmed, of whom some will report some extent of suicidal intent underpinning their self-harm” (Hawton K. S., 2012). For his sources, Hawton credited De Leo (2004), Madge (2008), Hargus (2009), Paul Moran (2012) and his own 2002 study. It is interesting that a researcher using a broader definition of self-harm found a much lower percentage than many researchers who applied a more conservative definition of the behavior.

Kaess of Germany used Nock’s (2009) research from the United States to say that 13% to 45% of adolescents have used NSSI at one time or another. Judi Kidger of the United Kingdom used information gathered in England (Hawton, 2002) and Sweden (Landstedt, 2011) to show that anywhere between 13.2% and 17.1% of 15- to 17-year-olds had participated in self-harm (Kidger, 2012). The same year, British researcher Dennis Ougrin used Evans (2005) as evidence that “Self-harm in adolescence is a common problem with a lifetime prevalence of attempted suicide of 9.7%, whereas an additional 13.2% of adolescents engage in self-harm at some point during that period” (Ougrin D. Z., 2012).

Using a broad brush approach, Plener (2012) referred to his earlier article (2010) for information on prevalence of NSSI. He stated that “Among adolescents, lifetime

prevalence rates between 15 and 30% are reported in community samples from many nations” (Plener P. B., 2012). Also in 2012, Trudie Rossouw put this rate at 17% based on Blakemore’s 2010 research (Rossouw, 2012).

In the United States, St. Germain put prevalence between 14% and 21% in adolescents. Her information was based on Ross & Heath (2002), Klonsky et al. (2003), and Whitlock et al. (2006). She also found that these percentages were on the increase. Similarly, another US researcher, Taliaferro, said, “Lifetime prevalence estimates suggest that 15% to 20% of community-based youth have engaged in NSSI” (Taliaferro, 2012). She found these statistics in Heath’s 2009 summary of “Self-injury today.” Nicholas J. Westers, who also hailed from the United States, said that “Prevalence rates of NSSI among adolescents range from approximately 13.9% to 46.5%” (Westers, 2012). He produced these statistics based on Laye-Gindhu (2005), Lloyd-Richardson (2007), and Ross & Heath (2002).

Maria J. E. Andersson of Sweden stated that a history of DSH was reported by anywhere between 9% and 66% of adolescents “depending on the DSH criteria” (Andersson, 2013). For her sources, Andersson chose Gratz (2001), Laye-Gindhu (2005), Lundh (2007), Morey (2008), and Muehlenkamp (2007). Here we see that such a broad range may be based on definitional differences, but almost renders the statistic useless due to its lack of specificity.

Andrews of Australia stated that “NSSI typically begins in adolescence with large-scale epidemiological studies showing prevalence ranges from 9%--14% among community-based adolescents” (Andrews, 2013). She used Brunner (2007) and Martin

(2010) for her sources. Berger, also of Australia quoted Martin's (2010) statistic that 8.8% of Australian youth between the ages of 10 and 17 have reported NSSI (Berger, 2013). One might assume this statistic is somewhat on the low side since the onset of NSSI is not usually until puberty.

Brunner looked at the results of the European Research Consortium SEYLE (Saving and Empowering Young Lives in Europe) for information on prevalence. He found that the average of all countries involved lifetime NSSI rates came to 27.6% (Brunner R. K., 2013). However, there is a cautionary tale here about using a set of statistics from another country to speak about one's own. The "Lifetime prevalence ranged from 17.1% to 38.6% across countries" (Brunner, 2013). The difference here is not in study questions or subjects, so this degree of variance should be carefully noted. A different take on a multi-national percentage is offered by Cullen of the United States, who said "the average prevalence [of NSSI] in adolescents around the world is 18%" (Cullen, 2013). This statistic came from Muehlenkamp's 2012 work on international prevalence.

Duggan stated that in addition to clinical populations, "Researchers and clinicians have since discovered that NSSI is also prevalent among community populations, with lifetime rates of occurrence ranging from 13% to 25% among adolescents and young adults" (Duggan, 2013). He used Yates (2009), Heath (2009), Rodham (2009), Hankin (2011), Whitlock (2006), and Heath (2008) for his sources.

Elin Anita Fadum of Norway flatly reported "Prevalence estimates from Europe and the USA indicate that, on average, 10% of adolescents report lifetime suicide

attempts and 13% report non-suicidal SH [self-harm]” (Fadum, 2013). She pointed to Evans (2005), Kokkevi (2012), and Jacobson (2007) as her sources. At the other end of the spectrum is Kaess of Germany, who stated that “epidemiological research shows lifetime prevalence rates of 13%-45% in adolescents” (Kaess M. P., 2013). For this information he cited Ross (2002), Brunner (2007), Lloyd-Richardson (2007), Plener (2009), and Nock (2010).

It is clear from this look at the literature on prevalence of NSSI, no hard and fast numbers can be applied. The difficulty in defining what is being measured and the probability that most NSSI is never documented in health records combine to problematize the measures of prevalence. Perhaps the safest and most current work is that of Duggan (2013) where he discussed non-clinical populations specifically, and cited one study done in 2011, 3 in 2009, one in 2008 and one in 2006 for his information. Duggan stated the prevalence of NSSI within adolescent and young adult populations in the United States was somewhere between 13 and 25 percent. I adopt this as my working estimate of the percentage of adolescents in the general population who are involved with NSSI.

#### Increase

An increase in NSSI within the adolescent population is traceable by looking longitudinally at the research. In 1975, Morgan stated that DSH had become a major health problem “which has increased in size during the last decade at a rate of about 10 percent per annum.” In their book *Bodily Harm*, Conterio and Lader stated, “For reasons that are difficult to pinpoint, self-injury has become pervasive in the United States, and

all signs indicate it is growing” (Conterio, 1998, p. 20). Conterio and Lader also spoke to possible reasons that newer birth cohorts were increasing the prevalence of NSSI.

Due to better nutrition and a host of other factors, children are entering puberty earlier today than ever before, plunging into adolescence perhaps before their cognitive and emotional capacities have had a chance to adjust. Their rapidly changing bodies force many issues of identity, maturity, and responsibility to the surface. The onset of menstruation, which is happening earlier and earlier with girls these days, often corresponds with the beginning of self-injury (Conterio, 1998, p. 23).

As the average age of onset decreased, the percentage of adolescents involved in NSSI increased.

In 2003, Klonsky noted “There is evidence that deliberate self-harm has become more prevalent in recent years. Several studies have found higher rates of self-harm in individuals from younger generations” (Klonsky, 2003). Klonsky quoted Zlotnick (1999), Briere & Gil (1998) and then used two studies done on borderline personality disorder: Shearer (1997) and Soloff (1994).

Walsh talked about self-injury among clinical groups but went on to say, Surprisingly, this pattern changed in the late 1990s, when self-injury began to appear in ever-greater numbers in people who did not fit the profiles described above [those with serious mental illness or who were incarcerated]. This is not to say that self-injury declined in the usual populations thought to be associated with the behavior. Persons with

major psychiatric diagnoses continued to have high rates of self-injury.

But, at the same time, a new generation of self-injuring persons was emerging from the general population rather than from clinical settings

(Walsh B. W., 2012, p. 39).

Dr. Walsh went on to elucidate the increase in research concerning self-injury and finding it increasingly prevalent in both middle and high school settings. Walsh's findings in 2012 supported his earlier work with Rosen in 1988 that was already seeing an increase in adolescent self-injury (Walsh B. W., 1988).

Researchers agree that the phenomenon of NSSI is growing. Whether it is due to higher prevalence in newer birth cohorts, earlier onset of puberty, or an unexplained increase in the 1990s among non-clinical populations, NSSI among teens is on the rise. This is important to know for any who work with middle or high school aged young people.

#### Age of Onset

As we move from prevalence and increase to information on the age of onset and the gender breakdown of adolescents involved in NSSI, we will focus on studies that were done in the United States using non-clinical samples. Many articles survey the literature to answer questions about onset and gender. Instead of looking at these, I will focus on primary source material where empirical work is reported.

All current research points to a much higher percentage of adolescent involvement in NSSI than adult. Many also say that the onset of this behavior does not generally occur until after puberty. The median age of first experience with NSSI is

reported as either 14 or 15 years old. Ferrence, using very early epidemiological information stated: “Females begin to self-injure somewhat earlier than males, but the general pattern for both sexes is similar; rapid increase to a peak during young adulthood followed by a decline through later ages” (Ferrence, 1975). This would make sense based on the fact that girls often reach puberty earlier than boys. Carrying on with this pattern, in 1984, Kahan and Pattison stated, “The vast majority of DSH cases are reported in late adolescents, particularly among violent and anti-social youth, with rates as high as 40 percent. On the other hand, DSH is rarely reported after the age of 30...” (Kahan, 1984).

Goddard helps us to understand why there is such a discussion concerning age with regard to NSSI. “No country collects official statistics on DSH, and studies attempting to overcome this deficiency vary in their use of age grouping” (Goddard, 1996). However, information was collected in Oxford, England since the 1970s. Based on this data, Hawton stated that “DSH in youngsters becomes increasingly common from 12 years of age onwards. This probably relates to the development of puberty, although it is also possible that some episodes by younger individuals may be regarded as accidental” (Hawton, 1996). Conversely, House stated that “The mean age of the self harm population is in the early 30s for both sexes, the peak age for presentation being 15-24 years for women and 25-34 years for men” (House, 1999). It is debatable whether this information is really about DSH or suicide, since the documents House used for reference were two yearly editions of “Trends in suicide in England and Wales.” Within the same range as House, Klonsky (2003) gave the range of ages 14-24 as typical onset for NSSI. He based this on studies by Herpertz (1995) and the team of Favazza & Conterio (1989).

The following year, Muehlenkamp did some original research with high school students that showed “a majority reported that they began the SIB [self-injurious behavior] between the ages of 13 and 15” (Muehlenkamp, 2004). She concluded, “This finding is consistent with other studies that have found a common age of approximately 14 years (Favazza, 1996; Favazza & Conterio, 1989; Walsh & Rosen, 1988)” for onset of NSSI (Muehlenkamp, 2004).

In 2007, Kimberly J. Mitchell found the average age of onset in her study at 14.59 years. The following year Hilt, Nock, Lloyd-Richardson, and Prinstein commented on their own research. “There were no significant differences across grade levels” (Hilt, 2008). So eighth graders were not significantly more likely to behave with NSSI than sixth graders. They also pointed out that their 8.5% rate of students in grade 8 is consistent with the range of 9-12 graders polled in other studies (specifically, Safer, 1997). Hilt said,

This suggests that NSSI may increase throughout early adolescence and peak during later adolescence before tapering off in adulthood. In fact, NSSI has been reported in children as young as age 6, but average onset appears to be around age 13 (Nock & Prinstein, 2004). Alternately, there may be a cohort effect for engaging in NSSI. Future research should examine rates of NSSI among even younger samples to establish age of onset and determine the appropriate time for primary prevention (Hilt, 2008).

Other researchers had previously proposed a cohort effect, so hopefully adults involved with young adolescents in any way will be looking for signs of NSSI at younger ages.

Another study done in 2008 by Jacobson, Muehlenkamp et al., put the mean age of onset at 15. Similarly, Messer, in her 2008 literature review, put the average age of onset at 14. Nock's 2008 study put the most common age of first engagement with NSSI at 13.5 years. In 2009, Seth Brown's study with college students showed an average age of onset at 14 years old (Brown, S., 2009). Glenn & Klonsky also studied college students and published their findings in 2009 (Glenn, 2009). They put the average age of onset at 13 years old. Working with a sample of adolescents and young adults, Janis & Nock found an average age of first experience with NSSI at 13.52 years (Janis, 2009). Klonsky worked with young adults and found a mean age of first skin-cutting at 14.1 years.

In 2011, Michael F. Arney did a small study with college students who had engaged in NSSI and found that the "Age of first NSSI episode, averages across all forms of NSSI behavior, was consistent with existing literature ( $M = 14.87$ ,  $SD = 1.47$ )" (Arney, 2011). In another 2011 study with undergraduates, Glenn & Klonsky found "the average age of NSSI onset was 13 years old" (Glenn, 2011). Hankin worked with a different birth cohort: adolescents between the ages of 11 and 14. In his 2011 study, he found that the average age of onset was lower than that found in college students at 11.22 years (Hankin, 2011).

In 2012, a multi-national study by Matteo Giletta with adolescents between the ages of 14 and 19 showed no difference in prevalence among the age cohorts in Italy, the

Netherlands, and the United States, however age of onset was not measured. The same year, Muehlenkamp conducted a study finding that the age of onset of NSSI among inpatient adolescents was 12.46 years and the age of onset of NSSI among community adolescents was 13.26 years for an average age from the full sample of 12.88 years. Another 2012 study, this one by Westers, showed the age of onset to be 11.20 years. His study was done with 30 adolescents who had recently self-injured. The small number of participants may make this study less generalizable.

Most researchers agree that the onset of NSSI does not usually occur until after puberty. A similar trend is detected between the decreasing age of onset of NSSI and the occurrence of puberty. While earlier studies set the median age of onset at approximately 14 years, more recent studies have shown this could be as young as 11 to 12 years. From my own clinical experience, I would lean toward the earlier onset. Many of the adolescent females I have had the privilege to work with were in grades six, seven and eight when their NSSI began.

#### Gender

Historically, it was thought that more females than males self-injured. As more research has been completed, this thinking has been called into question. In 1975, Ferrence stated that “An excess of females over males on the order of 2:1 is most commonly found in self-injury cases from the noninstitutionalized population, although this ratio varies considerably with age” (Ferrence, 1975). She did, however, go on to note that the rate of males engaged in self-injury was climbing much more rapidly than for

females which she posited “may reflect the growing similarity in sex-role behavior among young persons” (Ferrence, 1975).

In 1984, Kahan and Pattison said, “It is difficult to draw any clear conclusions from the literature [about gender and DSH] because different classes of self-damaging behavior are reported together. For example, completed suicide is more common among males (3:1), whereas ‘attempted suicide’ and ‘self-poisoning’ are more common among females (3:1). Yet recent data suggest that DSH events may be more equally distributed” (Kahan, 1984). Interestingly, Kahan and Pattison credited Bille-Brahe (1982) and “Lawton (1982).” I believe they actually meant “Hawton” here as it is Keith Hawton who had used the Oxford data since as early as 1976. With regard to the gender division, Hawton said in 1996 that DSH was much more common in girls than in boys from the early age of 12 onward, whereas “in adults the sex ratio is less marked and has declined in recent years” (Hawton, 1996).

House reported in 1999 that “Once there were two or three times as many episodes in women as men, now there is near equality” (House, 1999). He referenced Hawton’s work in Oxford (1996 and 1997), and a Scottish study by McLoone (1996). Gratz (2001) agrees, and supports this by using her own empirical data.

Interestingly, contrary to literature suggesting that deliberate self-harm behavior is much more common among women than men ( Boudewyn & Liem, 1995; Suyemoto, 1998), frequency of self-harm was not significantly associated with gender of participant....In fact, the present study found that rates of self-harm among women and men (34% and 38

% respectively) did not differ significantly from one another... (Gratz, 2001).

Note that Gratz's subjects were students in the American university system. This may be important when thinking about the generalizability of a study in an American cultural context.

As Klonsky tackled the topic of gender and NSSI, he stated, "It is unclear whether self-harm is more common in women than in men, although some researchers appear to take for granted that self-harm is more common in women..." (Klonsky, 2003). As examples of this, he listed Ogundipe (1999) and Suyemoto (1998). Klonsky went on to note that although Zlotnick (1999) found in studying adults that women self-harmed more frequently than men, other researchers found no appreciable difference in the rates between men and women in clinical settings. He also mentioned that neither Briere & Gil (1998) nor Gratz (2001) found gender differences in community populations. In his own 2003 study, Klonsky found that "Prevalence rates of deliberate self-harm in the present study were roughly equivalent for men and women... Although these findings seem to run counter to clinical wisdom, prevalence rates of deliberate self-harm may indeed be similar for men and women" (Klonsky, 2003).

The following year, Muehlenkamp & Gutierrez reported a similar finding. "We found no significant gender differences in the SIB [self-injurious behavior] group, but there were slightly more males in the self-injury group than females" (Muehlenkamp, 2004). Realizing that this departed from other studies, they attempted some provisional explanations for the difference in results.

However, there is evidence that SIB is increasing among adolescents and it could be that the increase is within males, which would account for the lack of gender differences in our study. Our findings that more males than females reported SIB could also result from our broad inclusion criteria. All descriptions of self-injurious behaviors such as ‘punching a wall,’ which may be more common in males, were coded as intentional self-injury. Other studies have limited their inclusion criteria to a small range of SIB, focusing on cutting or burning, which may be more common among females (Muehlenkamp, 2004).

The authors recommended more research to solve this mystery.

Laye-Gindhu’s 2005 study with Canadian adolescents returned to the earlier premise that more females than males self-injured. In her study, for those behaviors leading “to immediate and visible injury” 16.9% of females reported engaging whereas only 8.5% of males did the same (Laye-Gindhu, 2005). She also mentioned that, “Compared to boys, girls also reported more frequent self-harm over the year prior to the study” (Laye-Gindhu, 2005).

Goldston brought up an interesting dichotomy. He said that clinical samples, like those in Nixon (2002), showed those who self-injured were overwhelmingly female. However, at least one community sample “has failed to document sex differences (Briere & Gil, 1998)” (Goldston, 2006). Since much of the earlier research was done with clinical samples, and current research is focusing more on community samples, one wonders if the gender question is evolving simply due to the segment of the population

studied. A project that may prove this wrong is Mitchell's 2007 work. Mitchell found that 3% of respondents (who were between the ages of 10 and 17) reported having engaged in self-harm at some time in their lives. Of that 3%, 81% were female. This study was conducted with 1500 young people in the United States. Conversely, in 2008, Hilt and Nock conducted a study with young adolescents (aged 10-14) and found that among the 7.5% of the population that had engaged in NSSI in the last year, "rates were as high among boys compared to girls, which is consistent with other previous studies with adolescents (Gratz et al., 2002; Lloyd-Richardson et al., in press)" (Hilt, 2008).

Messer, in a 2008 literature review, did not find enough information one way or the other to take a position on the issue of gender and NSSI. Instead she stated, "Earliest studies found a higher frequency of self-mutilation for females than males (Darche, 1990; Ross & Heath, 2002; Simpson & Porter, 1981; Suyemoto & MacDonald, 1995). However, more recent studies have shown similar rates of self-mutilation in males and females (Gratz, 2001; Muehlenkamp & Gutierrez, 2004; Stanley et al., 2001)" (Messer, 2008). She was not the first to differentiate between earlier and later studies. Perhaps a case could be made for an increase in NSSI in male adolescents.

In 2009, Seth Brown did a study involving 238 college students. He found that DSH at some point over a lifetime was slightly more frequent for men (26.7%) than for women (23.6%). However, this difference was not statistically significant. Likewise, the following year, Kimberly Tyler did a study with homeless young adults and found that "there was no significant difference in the mean for self-mutilation between males and females" (Tyler, 2010). Similarly, a 2011 study by Allison S. Christian was conducted

with undergraduate students. In this, “No significant differences in DSH history were found across gender, ethnicity, age, or sexual orientation” (Christian, 2011). Also in 2011, Maria M. Wong studied two groups of US youth, the first aged 12-14 and the second aged 15-17. Wong reported that “no gender differences in self-harm/suicidal behaviors were found at either age period” (Wong, 2011).

In a multi-national study conducted by Giletta in 2012 “NSSI rates varied by gender, with females being more involved in NSSI compared to males...” (Giletta, 2012). The countries involved in this study were Italy, the Netherlands, and the United States. Another 2012 study conducted by Taliaferro noted a significant difference in gender among Michigan high school students reporting NSSI. According to her work, 5.3% of females in grades 9-12 reported engagement in NSSI while 2.7% of males did the same. The researcher stated that this difference was statistically significant. Here, one is led to wonder if the reporting was affected in any way by cultural standards. Perhaps there were different pressures on adolescent males than on adolescent females that caused the males to under-report or the females to over-report.

The research trends concerning gender and NSSI appear to come in waves. Earlier research indicated that NSSI was more prevalent among females than males. However, starting in the early 2000s, researchers were finding no statistical difference in rates between males and females. One possible explanation for this would be an increase in NSSI among males in their adolescent years. Despite this turn in research finding, two studies in 2012 found that more females than males were involved in NSSI. One of those studies found the difference to be almost 2:1. In summary, it would be ill-advised to

consider NSSI a “female problem” but the evidence on gender comparison is mixed within the NSSI population.

In this chapter, we have seen that different researchers use different terminology to refer to the same phenomena, making study in this field more complex. We have also discussed the populations involved and shown that the prevalence of NSSI is very difficult to determine, it appears to be increasing, the age of onset is around puberty, and it is an issue for both males and females. Next, we will look at the reasons for or the functions of NSSI and the sorts of treatments that are offered in a clinical setting.

## CHAPTER THREE

### REASONS, FUNCTIONS, AND TREATMENTS

One of the most important questions about the treatment of NSSI is an understanding of how it functions. What does NSSI accomplish in the experience of the adolescent cutter? To what is the individual responding? Is NSSI a statement or a response? With what is NSSI associated? In this chapter, we will look at why researchers think NSSI occurs, how NSSI functions, and what treatments for NSSI have been found to be effective.

The reasons and functions of NSSI can loosely be fit into fifteen distinct categories. Factors associated with NSSI include breaks or disruptions in the social environment (especially with parents), personality traits or internal vulnerabilities (including borderline personality traits and impulsivity issues), emotion dysregulation, lack of application of adaptive coping tools (particularly where school stress is concerned), lack of ability to communicate feelings to self or others, childhood trauma, self-punishment, contagion, sleeping issues, lower socio-economic status, substance use, eating disorders, biological factors, body image, and future orientation. These fifteen factors will be illustrated by the review of the literature that follows.

#### What NSSI is Not

Given the nature of research into NSSI, it is important at the outset to describe what it is not. In 2005, Laye-Gindhu published research which stated that her findings “do not support the common and longstanding believe that self-harm is manipulative,

attention-seeking behavior (Favazza and Conterio, 1989; Graf and Mallin, 1967; Hibbard, 1994)” (Laye-Gindhu, 2005). If this is not what motivates such behavior, then what does?

Jonathan Scourfield used discursive frames through which young people look at self-harm to evaluate its meaning for individuals. He found NSSI had a variety of social functions. Scourfield stated that “It would be wrong to replace one orthodoxy (self-harm is attention-seeking so should be ignored) with another one (self-harm is a private coping strategy) when in fact the picture is complicated and the same behaviour can mean different things to different people at different times” (Scourfield, 2011). This is a helpful reminder as the field attempts to draw conclusions about the etiology and functions of NSSI. That said, what are the reasons for NSSI and how does it function?

### Social Environment

Since the earliest days of modern research into NSSI, disruptions of the social environment, especially with parents, have been found to be positively correlated with an increase in NSSI. Relationships with peers and/or significant others return mixed results. Recent research on bully appears to show a direct causal link to NSSI. Another social factor observed by researchers was social isolation. Each of these factors of the social environment will be explored in turn. Because work in these areas is closely related, some overlap between sections will be in evidence.

#### *Parents and Peers*

In her 1975 article, Ferrence delineated four “characteristics” of the social environment that self-injuring patients may have in common. She named these hypotheses: the values, rejection, social status, and instability hypotheses. First, some

individuals and groups that adhere strictly to a system of values, be they ethnic or religious in origin, were more likely to self-harm. Secondly, some individuals may internalize rejection from parents which can lead to NSSI. Third, if society does not reward an individual with high social status, she may not develop a positive self-image which could be associated with self-harm. Finally, stressful life events such as divorce or becoming unemployed may be associated with individuals becoming self-harming.

In Morgan's work in Bristol, also in 1975, 64% of those hospitalized for self-harm and suicide attempts stated that there was a specific precipitating factor to their action. For 51%, this major precipitating factor was relational in nature (Morgan, 1975). Of patients admitted to the hospital, 90% had diagnosable mental illnesses. Of those who attempted overdose, psychotropic medications were the overwhelming drugs of choice. Morgan stated, "In view of these facts it seems that the time has come to review the clinical use of psychotropic drugs, especially for young adults with interpersonal or environmental difficulties" (Morgan, 1975).

In 1984, Kahan and Pattison stated that, "disruption or lack of social support relationships/systems..." was a common factor in those with NSSI (Kahan, 1984). Similarly, in his 1996 study of children and adolescents, Keith Hawton identified "problems preceding self-harm" (Hawton, 1996). Hawton said, "Relationship problems were by far the most common problems facing the youngsters, with difficulties with their parents being the most frequent..." (Hawton, 1996). He also noted that difficulties in friendship relationships and social isolation were common. In his 1997 research, Brent described the purpose of self-cutting: "to relieve tension precipitated by an interpersonal

crisis” (Brent, 1997). Also in 1997, Andrew L. Tulloch studied the effect of communication with parents on adolescent self-harm. He found that there was a strong correlation between the lack of a family confidant and adolescents with NSSI (Tulloch, 1997). He also demonstrated “a strong association between poorer parent-adolescent communication and adolescent self-harm...” (Tulloch, 1997).

Harrington of the UK separated NSSI from suicide and stated, “DSH in young people is usually precipitated by stressful life problems. The most common are arguments with parents, other family problems, rejection by a boy or girl friend, or school problems such as bullying” (Harrington, 2001). A year later, Lucy Webb provided a helpful meta-analysis of psychological and psychosocial factors involved in adolescent self-harm in 2002. She concluded:

He/she is likely to be experiencing personal worries with pressure from school or relationships. Most specifically, a vulnerable individual is likely to experience poor family communication channels with no parental confidant. Findings from this review suggest that key preventative intervention strategies lie in improving family communication....These finding also suggest that a response to a DSH act needs to include addressing the adolescent’s psychosocial needs, poor problem-solving and impulsivity, to prevent further acts of DSH (Webb, 2002).

She also suggested that “an identified ‘parental confidant’ within the family or the school/college system would go some way to addressing the adolescents’ immediate

needs (Webb, 2002). This should act as an encouragement to current-day mentoring programs which team adolescents with adults (as opposed to peer mentors).

In a Finnish study, Sourander found that “Living in a broken family at age 12 independently predicted future acts of deliberate self-harm...” (Sourander, 2006). In addition, “The mother’s mental distress, and health problems, and the mother’s and father’s unsatisfactory well-being when a child was 12 years old predicted acts of deliberate self-harm at age 15 in univariate analysis” (Sourander, 2006). The natural support provided by the family of origin is an important factor in many presentations of NSSI. Along with family of origin issues, John Townsend noted in his 2006 popularly written book, *Boundaries for Teens*, that one of the seven “common reasons” adolescents cut is because “they want to connect with peers” (Townsend, 2006). In addition to the natural support offered by family, friendship relationships may also play a role in NSSI.

Some researchers distinguish between occasional and more repetitive DSH. Brunner’s research published in 2007 indicated that occasional DSH could be related to school or family variables (Brunner, 2007). However, repetitive DSH appeared to be more related to psychological factors and body image. Here we see that the social environment may have direct impact on starting an adolescent on a course of NSSI.

In Lloyd-Richardson’s 2007 research, she found that “to try to get a reaction from someone” was one of the three most common reasons to engage in NSSI (Lloyd-Richardson, 2007). This appears to contradict Laye-Gindhu’s insistence, previously discussed, that NSSI is in no way an attention seeking behavior (Laye-Gindhu, 2005). Lloyd-Richardson’s work upholds Nock and Prinstein’s (2004) “four-factor theoretical

model of NSSI functions” (Lloyd-Richardson, 2007). She helpfully summarizes this theory.

First, NSSI is either intra-personal, automatically reinforcing (e.g. to obtain a reduction in tension or create a more desirable state) or socially reinforcing (e.g. to alter one’s environment). Second, NSSI is reinforced in either a positive (i.e. rewarded with a positive stimulus) or negative manner (i.e. rewarded by escaping a negative interpersonal demand) (Lloyd-Richardson, 2007).

Notice that there are both intra- and interpersonal aspects to the behavior. The intra-personal aspects will be discussed in the next section.

In her 2007 study on “*Parental Expressed Emotion and Adolescent Self-Injury*,” Wedig found that parental EE [expressed emotion—especially criticism] was significantly related to multiple forms of adolescent SITB [self-injurious thoughts and behaviors]...” (Wedig, 2007). She went on to find that “high parental criticism is associated with increases in these thoughts and behaviors, whereas high EOI [emotional over-involvement] is not” (Wedig, 2007). There is more to social support from the family than merely having family present and active in an adolescent’s life. The way parents interact with their children may also influence the use of NSSI. In another family-related study, Hilt found in her research that young adolescents (aged 10-14) experienced improvement in their relationships with their fathers after an episode of NSSI. This gave “initial empirical support for the social positive reinforcement function of NSSI” (Hilt,

2008). She suggested that this sort of support following an instance of NSSI may help to maintain self-harming behavior in a young adolescent.

In 2009, Glenn and Klonsky looked at social context during NSSI and found that those who would self-injure only when alone were more likely to have suicidal ideation and actual suicide attempts. The researchers suggested that this was an important find for treatment, since the determination of client safety is often difficult. When NSSI is done in total isolation, the clinician should err on the side of believing that suicidal ideation is present. Continuing with the theme of suicidality, Tuisku studied Finnish adolescents and found that among depressed adolescents, those who were both self-harming and suicidal had more pathology than did those who were neither self-harming nor suicidal. Specifically, those in the first group “perceived less support from their family” (Tuisku, 2009). But, somewhat surprisingly, “perceived support from friends and from significant others” was not significantly different (Tuisku, 2009). This finding is in conflict with other studies previously mentioned. In another study exploring both parental and peer relationships, Claes noted that his study participants reported less positive relationships with parents and same-sex peers. The cross-sectional design of the study means that there is no information here which goes across time in order to see if the decline in relationship predated or followed the incidence of NSSI (Claes, 2010a). Again, with regard to parental relationships, Hawton reported that both those with NSSI and those without were exposed to similar life problems, but those who cut more frequently witnessed parental arguments (Hawton, 2010).

In an extension of Wedig's 2007 work, Cinzia Novara found that different parenting styles could be related to different outcomes with regard to NSSI. Adolescents with NSSI had higher percentages of parental over-protection, punishment, pressure, rejection, and disapproval from the parental figure (Novara, 2010). Those with NSSI also had a lower percentage of parental support. The researcher stated, "Therefore, it seems that on the basis of self-injurious behaviours there is a perception of an educational style which is characterized by punishments, rejecting, and oppressive attitudes and by the lack of support" (Novara, 2010).

In addition to how a young person is treated by her parents, how her parents are functioning mentally can also have an impact. Hankin did a longitudinal study in which he looked at risk factors for NSSI. He found that "Negative cognitive style, onset of maternal depression, youths' recent depressive symptoms, and lack of support predicted prospective onset of NSSI" (Hankin, 2011). He noted the importance of including the family in the treatment of a client dealing with NSSI based on this study. The Novara study mentioned in the preceding paragraph did not take into account the effect of negative cognitive style in the young person. Later studies will point out the importance of both negative cognitive style on the part of the young person and punishing/rejecting on the part of the parent. In another 2011 study, Madge noted that experiencing the suicide or self-harm of others, physical or sexual abuse, and worries about sexual orientation were increased among the population that engaged in NSSI (Madge, 2011). This is the only mention of sexual orientation found to date in the literature.

One researcher, Taliaferro, attempted to see how youth who report NSSI differ from those reporting no NSSI. She found, “factors that consistently distinguished adolescents of both sexes who reported NSSI (ie [sic], NSSI only and NSSI + SA) from those who reported no self-harm included...less parent connectedness” (Taliaferro, 2012). In addition to this, for females she found “weaker connections to nonparental adults” was a factor more common to those with NSSI than those without (Taliaferro, 2012). In a longitudinal study also done in 2012, this one in China, family invalidation of emotional experience in year one was significantly associated with NSSI in year two (You, 2012). Again, the importance of parental support and engagement is emphasized. Iva Buresova worked with adolescents in the Czeck Republic and found that those with lower quality relationships with their parents had a higher occurrence of self-harm, but the quality of peer relationships did not appear to affect the rate of occurrence (Buresova, 2013). This replicated the study done by Tuisku in 2009 which was in conflict with earlier studies.

In 2013, Hamza found that students who engaged in NSSI were more likely to endorse interpersonal influence as one of the functions of NSSI. This could mean that they experience this need more frequently than those who do not engage in NSSI (Hamza, 2013). This parallels Lloyd-Richardson’s work completed in 2007 and contradicts Laye-Gindhu (2005). The major stream of modern research appears to say that the intent of NSSI is not manipulation. Perhaps this is an overreaction to a needed course correction. It might be truer to say that NSSI is not necessarily intended to be manipulative.

Graham Pluck worked with adolescents in the United Kingdom to find factors that were common to young people who self-harmed (including self-poisoning) and those who repeated this behavior. He found that a majority of those who self-harmed did not live with both biological parents (Pluck, 2013). A higher percentage of the repeat self-harm group lived in “residential care, at a private hostel, or were homeless” than those who only self-harmed once. Pluck posited that “these young people may feel more isolated and less supported with a lack of secure attachments possibly resulting in reduced ability to resolve problems as they are encountered” (Pluck, 2013). Additionally, the repeat self-harm group was more likely to cite conflict with parents as part of the reason for their self-harm. Both of these findings support previous research on family dysfunction and cohesion (Pluck, 2013). One item not investigated by previous research occurred in the Pluck study. This researcher was unique in finding that another factor identifying those adolescents in the repeat self-harm category was “Having an uncooperative caregiver at the time of assessment...” (Pluck, 2013). Pluck noted that “Parental attitude is also likely to influence engagement with treatment...” (Pluck, 2013). Pluck found that those with a family history of self-harm were more likely to fall into the repeat self-harm category (Pluck, 2013).

Straiton, in an article in the *Archives of Psychiatric Nursing* interviewed people from a community population and found two themes in the area of factors leading to self-harm. She categorized these as social influences and emotions (Straiton, 2013). Among the social influences were “specific underlying factors such as bullying, violence, separation, bereavement, and family problems” or a vague mention of “events in life”

(Straiton, 2013). Among factors mentioned less frequently was “a conflict or a period of social isolation” (Straiton, 2013).

The social environment of the adolescent may be directly correlated to use of NSSI. Lack of social support, especially within the context of the family, can be one of many reasons young people resort to NSSI, as can bullying. There are mixed results concerning the importance of peer relationships to NSSI.

### *Bullying*

Hay looked at bullying victimization and NSSI. This study found that being the victim of bullying significantly increased the possibility that one would be engaged in NSSI and/or suicidal ideation. Even cyber bullying had this effect. Additionally, social and personal factors could mediate the effect of bullying. These researchers looked at authoritative parenting and level of self-control and found that these could diminish the effects of bullying.

Also looking at both parenting and bullying, Jutengren measured the effect of interpersonal stress on self-harm and whether or not self-regulation would mediate that effect. This researcher found that “peer victimization has a predictive effect on deliberate self-harm in general populations of adolescents” (Jutengren, 2011). Also, “harsh parenting was a greater risk factor for girls than for boys” (Jutengren, 2011). Finally, levels of self-regulation had no moderating effect on either of these variables.

Rick Nelson Noble looked at the connection between NSSI and school-related issues. He found that students who scored low on indices of trust in school officials and peers and low on feelings of safety at school were more likely to participate in NSSI.

This bears out prior research into the effect of peer victimization as “Students from both middle and high school who engage in NSSI reported being bullied and threatened more often, and carrying a weapon to school more often than students who did not engage in NSSI” (Noble, 2011). In the school environment, both trust and perceived safety were shown to have a huge effect on NSSI behaviors.

In 2013, Suzet Tanya Lereya did a study on the possible connections between being bullied during childhood and NSSI in late adolescence. She found that being bullied was independently associated with NSSI without any mediating factors. She also found that being bullied could result in symptoms of depression which could lead to NSSI. Additionally, “there were significant indirect associations from domestic violence and maladaptive parenting to self-harm via being bullied” (Lereya, 2013). For girls, the more frequent path found was through depression symptoms (Lereya, 2013). Although there are not a plethora of studies done in this area yet, it seems that a connection between NSSI and bullying is clear.

### *Social Isolation*

Young people who cut are often experiencing loneliness and longing for relationships. Bowen reported that “Adolescent SIB [self-injurious behavior], more often than not, has identifiable precipitating events that have a direct and discernible impact on the adolescent’s identity, sense of autonomy, and independence (e.g. conflict with family or peer group, peer group status change, social isolation or rejection, Berman and Jobes, 1993)” (Bowen, 2001). Likewise, Laye-Gindhu found that “loneliness or alienation” were some of the reasons adolescents gave for acts of NSSI (Laye-Gindhu, 2005). Here we see

a disruption of social supports as associated with NSSI. In 2009, Csorba's study showed that loneliness was elevated in the NSSI population over the general adolescent population. In addition, social causes such as loss and failure were highly ranked (Csorba, 2009).

As we have seen, factors in the social environment can be highly correlated with NSSI. Difficult relationships with parents and peers, the presence of bullying, and feelings of social isolation appear much more often in the lives of those with NSSI than in those without. But there are also internal factors that appear to influence NSSI. In the next section we look at personality and the internal worlds of adolescent females.

#### Personality Traits and Internal Vulnerabilities

Another set of influences on NSSI are personality and vulnerabilities in the internal world of the adolescent. We will divide these into five rough categories: anxiety and depression, personality factors, negative self-concept or cognitive style, Borderline Personality Disorder, and impulsivity. Again, due to the close relationships among these factors, some overlap will be noted.

##### *Anxiety and Depression*

There is much discussion in the literature about the occurrence of anxiety and depression in those with NSSI. These are very common diagnoses for adolescents who seek mental health care. For example, Ferrence pointed out that in the early days of study, some medical characteristics were found to be fairly common among self-harmers. They included "previous psychiatric treatment, previous self-injury, [and] depression..." (Ferrence, 1975). Kahan and Pattison list 40 different psychodynamic explanations for

NSSI that had been offered to the date of their writing. Since these formulations were so varied and no consensus appeared to exist, the authors turned to “predisposing factors” instead (Kahan, 1984). They found “adult psychosis, and depressive/suicidal ideation” as some of the commonalities between people experiencing NSSI. (Kahan, 1984). Although their work was not conducted among an adolescent population, it is included here since there is so little written about NSSI prior to the 1990s.

A study by Harrington in 2001 noted that depressive symptoms were often present (Harrington, 2001). Webb seconded this in her 2002 study which stated that “A vulnerable adolescent appears to be depressed...” (Webb, 2002). Klonsky’s research with military recruits revealed that those with a history of NSSI “reported substantially more personality pathology, including more features of all of the DSM-IV personality disorders except obsessive-compulsive personality disorder” (Klonsky, 2003). This is important due to the fact that this work was done with a non-clinical rather than an inpatient population. Klonsky also interviewed those who knew the subjects and found that “a relatively coherent ‘self-harm personality profile’ emerged. According to their peers, self-harmers tended to have strange and intense emotions and a heightened sensitivity to interpersonal rejection” (Klonsky, 2003). Finding no inverse relationship between positive temperament and self-harm, Klonsky posited that those who engage in NSSI may be more anxious than depressed. He also investigated the function of NSSI and brought forward the findings that self-harmers feel relief after the behavior and experience reduced tension. “Taken together, the finding from past research and the present study suggest that self-harmers tend to be anxious and that self-harming is a

method of reducing anxiety,” Klonsky concluded (Klonsky, 2003). Heightened sensitivity to interpersonal rejection will be discussed in the following section under Borderline Personality traits.

Csorba did a study in Hungary in 2009 in which the most common psychiatric diagnoses were major depression (with both past and present episodes), dysthymia, and anxiety issues listed in order of rate of occurrence (Csorba, 2009). This conflicts with Jacobson’s 2008 finding that borderline personality disorder was the most prevalent diagnosis among adolescents with NSSI. With no mention of BPD in Csorba’s work, it is difficult to determine whether this diagnosis was considered. Since adolescents are not usually diagnosed with BPD, it may not have entered into this researcher’s work. He also found that “Suicidal self-poisoners practicing self-mutilation were significantly more likely to be diagnosed with oppositional defiant disorder, major depression and dysthymia, besides which they had higher scores on hopelessness, loneliness, anger, risk taking, recklessness and alcohol abuse than did non-mutilating suicidal peer patients” (Csorba, 2009). Many of these characteristics would point toward symptoms of BPD. Dougherty found that those with NSSI and SA compared to those without either had “elevated depression, hopelessness, and impulsivity” which led him to the conclusion, as it did Csorba, that NSSI and suicide attempters (and those with both NSSI and SA) are different populations which call for different treatments (Dougherty, 2009).

Tuisku studied Finnish adolescents and found that among depressed adolescents, those who were both self-harming and suicidal had more pathology than did those who were neither self-harming nor suicidal. Specifically, those in the first group “had more

severe depressive symptoms ... than non-suicidal depressed adolescents” (Tuisku, 2009). But, somewhat surprisingly, anxiety symptoms were not significantly different (Tuisku, 2009). The author also noted that those who both self-harmed and had suicidal ideation or attempts showed more symptoms of both anxiety and depression than those who only used NSSI. This conflicts with Klonsky’s earlier research which found that anxiety was more closely related to NSSI than depression. Hawton compared adolescents who cut to those who self-poison. He found that both populations were similar “in terms of depression, anxiety...[and] self-esteem...” (Hawton, 2010). The results of this study are important given Hawton’s continued lumping together of these behaviors under the DSH terminology.

O’Connor, Rasmussen and Hawton did a study looking at perfectionism and acute life stress in adolescents. They concluded that “perfectionistic beliefs associated with the prediction of depression and self-harm may differ from those associated with adolescent anxiety” (O’Connor, 2010). This indicates that clinicians should be aware of looking for social perfectionistic beliefs when treating adolescent depression. They also say that even a few stressors could push those with socially prescribed perfectionism into self-harm, so perfectionistic beliefs should be thoroughly explored with adolescent clients.

Asarnow looked at suicide attempts and NSSI in depressed adolescents. She found that throughout the 24 weeks of her study, NSSI was a better predictor of suicide attempts during this time than previous suicide attempts (Asarnow, 2011). This is surprising because it has been traditionally thought that previous suicide attempts would

better predict future suicide attempts. She also noted that the occurrence of NSSI was higher in adolescents whose recovery from depression took longer (Asarnow, 2011).

Madge worked with the data from the CASE study (Child and Adolescent Self-harm in Europe) and found that “increased severity of self-harm history was, in general, associated with higher levels of depression, anxiety and impulsivity and lower levels of self-esteem, as well as stressful life events in more areas of young people’s lives” (Madge, 2011). She concluded that “both psychological characteristics and stressful life events substantially increase risk” of NSSI (Madge, 2011).

Crowell, in a study which included Marsha Linehan as a researcher, looked at differences between self-harming and depressed adolescents. She found that differentiating factors included “self-reported anxiety/depression, delinquent behavior, conduct disorder, broad externalizing scores, PTSD symptoms, and both parent- and self-reports of adolescent substance use” (Crowell, 2012). Those who self-injured also scored higher on depression and manic symptoms, suicidal ideation, hopelessness, tobacco use, emotional dysregulation, and impulsivity (Crowell, 2012). Although many adolescents who exhibit depression and anxiety symptoms can also be diagnosed with PTSD, it is interesting that this is the earliest mention of this diagnosis in the research literature this author discovered.

One researcher, Taliaferro, attempted to see how youth who reported NSSI differed from those reporting no NSSI. She found, “factors that consistently distinguished adolescents of both sexes who reported NSSI (ie [sic], NSSI only and NSSI + SA) from those who reported no self-harm included a mental health problem, [and] depressive

symptoms...” (Taliaferro, 2012). The same year, in a study of Chinese adolescents, Jianing You found that depressive symptoms in year one were significantly associated with NSSI in year two of the study (You, 2012).

Cheryl Loh noted the strong risk factor of clinically diagnosed depression. “In the present study, DSH was strongly associated with depression, a condition that commonly manifests with loss of pleasure, lack of energy, poor concentration, and thoughts of dying and suicide” (Loh, 2013). Loh does not draw the same conclusion for anxiety. Pluck found that those with a diagnosis of “depression, [or] other mental illness,” were more likely to fall into the repeat self-harm category (Pluck, 2013). Hence it is important to look for NSSI with clients who are diagnosed with any mental illness, not only depression and anxiety.

### *Personality Factors*

Whereas anxiety and depression are diagnosable mental health issues, there are other aspects of personality that may be related to NSSI. Allan House attacked the issue by a different route looking at factors that predicted repetition of NSSI. He found ten in all and listed among them “a history of self harm prior to the current episode; psychiatric history, especially as an inpatient; ... antisocial personality; uncooperativeness with general hospital treatment; ... and high suicidal intent” (House, 1999). It should be noted that this information was gathered only from those, whether adults or teenagers, who went to an emergency room.

Skegg, in a 2005 literature review, discussed the psychological aspects of self-harm. She mentioned “rage toward others or self; feelings of abandonment, guilt, or

desperation; and ambivalence that may be reflected in an avowed wish to die that does not translate into a lethal act” as possible motivations for NSSI (Skegg, 2005). Here she credited Hendin (1991) and Harris (2000). She went on to discuss more measurable characteristics like “poor problem-solving,” “impaired decision-making,” “impulsivity, inflexible thinking, hopelessness, reluctance to self-disclose, lack of positive future-directed thinking, and difficulties with autobiographical memory manifested by a tendency to retrieve events from the past in an ‘over-general’ way rather than by recalling specific events,” as well as neuroticism, novelty-seeking, and dissociation (Skegg, 2005). She collected this information from Williams (2000), Jollant (2005), Horesh (2004), and MacLeod (2004). Again, several of the above traits will be handled under Borderline Personality below. Brunner also looked at repetitive NSSI and said that rather than school or family issues, repetitive DSH appeared to be more related to psychological factors (Brunner, 2007).

Seth Brown evaluated personality traits in those with NSSI. He found that those with experience with NSSI showed higher levels of neuroticism and lower levels of agreeableness, openness to experience, and conscientiousness. However, there was no statistical difference in the quality of extroversion. He stated, “The findings in this study support that individuals with a history of DSH have similar preferences and experiences for interpersonal interactions, activity level, and potential for enjoyment to those with no history of DSH” (S. Brown, 2009). In these important ways, teens with NSSI are just like any other teens. Cory F. Newman’s study found that when reporting reasons for self-harm, clients indicated they used it to “stop bad feelings” (Newman, 2009, p.202). He

cautioned therapists to question adolescent clients who present with other symptoms about the possibility of NSSI. If not brought up directly, it may not be discussed either because the client does not perceive it as a problem, or due to shame and secrecy (Newman, 2009, p. 215).

Stanford found three psychological subgroups of those who self-harm. She compared the pathological, the impulsive, and the “normal” subtypes. Interestingly, the largest group of those she worked with belonged to the “normal” cluster (Stanford, 2009). She found that 43% were in the psychologically “normal” cluster, 32% were in the impulsive cluster, and 25%, the smallest group, belonged to the pathological cluster. She helpfully noted in her discussion that “the pathological subtype of self-harmers appears to represent the ‘typical’ profile of a self-harmer as described in prior research” (Stanford, 2009). Yet three-fourths of those she worked with would not be described as pathological. The researcher suggested that it is important to understand the severity and nature of an adolescent’s NSSI in order to offer appropriate treatment.

In a 2010 article published with Muehlenkamp, Claes found a continuum of pathology among patients without NSSI and SA (suicide attempts), those with NSSI, those with SA, and those with both NSSI and SA exhibiting the most symptoms. In addition to less conscientiousness, patients with NSSI internalized anger more frequently than did patients without NSSI. Those with any SA were more depressed, showed more suicidal ideation and neuroticism and scored lower on scales for extroversion. This last item supports Seth Brown’s 2009 study discussed above.

Hasking's work looks at the relationship between "personality and NSSI, and the moderating roles of coping strategies and emotion regulation" (Hasking, 2010). She found that in opposition to current studies, "coping and emotion regulation were not related to NSSI after controlling for psychopathology" (Hasking, 2010). Instead, they interacted with personality traits. Conscientiousness acted as a protective factor, especially for those "utilising poor problem-solving skills and expressive suppression" (Hasking, 2010). Neuroticism appeared to be a risk factor for NSSI. The author suggested that looking at an individual child's levels of conscientiousness and neuroticism early on may be able to help predict those who may struggle with NSSI later in life.

Glenn and Klonsky did a study where they looked for predictors of future NSSI. They found that "lifetime NSSI methods and BPD [borderline personality disorder] features were the only variables to uniquely predict subsequent NSSI" (Glenn, 2011). The number of methods used for NSSI was more important than the prior frequency of the behavior or even how recently a subject had engaged in NSSI. Glenn also noted that based on the patterns of relapse discovered, "it is possible that 1 year of NSSI abstinence does not yet signal full recovery, whereas 2 years of abstinence is a better indicator of genuine NSSI remission," a very important thing for clinicians to note (Glenn, 2011). This somewhat conflicts with Haskings' (2010) finding that conscientiousness and neuroticism alone could predict future NSSI.

Nobuyuki Mitsui studied Japanese university students and looked for temperament and character qualities that might be predictive of self-harm. This researcher found that the character qualities of high self-directedness and high

cooperativeness were protective factors for self-harm. Self-directedness indicates “self-determination and the ability of an individual to control a situation in accordance with their individually chosen goals and values” (Mitsui, 2013). Cooperativeness is a measure of “social tolerance, empathy, helpfulness, and compassion” (Mitsui, 2013). These aspects of character are based on Cloninger’s psychobiological model of temperament and character (Cloninger, 1993). Despite some conflicting results, a vague personality portrait of someone who might be involved in NSSI begins to emerge.

#### *Negative Self-Concept or Cognitive Style*

How adolescents view themselves and how they think about their world also affects whether or not they are more likely to self-harm. In a study done specifically with adolescents, Laye-Gindhu found that in comparison to non-self-harming teens, those with NSSI were “more likely to be emotionally distressed, to have decreased self-esteem, to engage in more antisocial behavior, to report problems controlling their anger as well as increased discomfort with angry feelings” (Laye-Gindhu, 2005).

Rich Van Pelt and Jim Hancock, in their 2005 work directed at church youth leaders, stated that,

a person may engage in SIB [self-injurious behavior] to keep from killing herself. She inflicts physical pain to express interior pain, to contextualize and perhaps manage fear, rage, emptiness, isolation, and sorrow.

Victimized adolescents who lack the capacity to talk about their pain may express their pain and depleted self-esteem with self-injurious behaviors (Van Pelt, 2005).

These authors point to a variety of internal triggers for self-harm and mention the possibility that it is life-preservative. Carmel McAuliffe was able to expand on part of this work as she showed that higher self-esteem was a protective factor against repeated NSSI (McAuliffe, 2006).

Glassman suggested that a connection between NSSI and emotional abuse may be due, in part, to a “self-critical cognitive style. Emotional abuse during a child’s formative years could result in a tendency to internalize critical thinking toward the self. In the face of stressful events, adolescents who have developed such a cognitive style may be more likely to engage in NSSI for self-punishment” (Glassman, 2007). Here we see, again, the importance of a negative view of the self.

Wedig studied self-criticism in adolescents. She found “that such behavior [high expressed emotion—especially criticism] from parents has a significantly stronger relationship with SITB when the adolescent at whom the criticism is directed agrees that when others criticize him or her they must be right. Importantly, when adolescents were not critical of themselves, parental criticism did not have as large an impact” (Wedig, 2007). It is a result of the combination of a highly critical parent and an adolescent who has internalized that criticism that tips the balance. This is a key study with relation to negative cognitive style or internalized criticism. In a 2010 work related to self-concept and NSSI, Claes stated that the idea that negative self-concept was related to NSSI was supported. In fact, “Adolescents with NSSI described themselves as less intelligent, emotionally stable, and physically attractive than students without NSSI” (Claes, 2010a).

A 2011 study by Baetens, looked at the relationship between NSSI and temperament. This researcher found that “adolescents with NSSI reported higher Negative Affectivity (child report) and lower Effortful control (both child and parent report)” (Baetens, 2011). The study noted that negative affectivity is related to frustration, and effortful control is made up of attention control, activation control, and inhibitory control. These two temperament indicators, the lack of effortful control and the presence of negative affectivity, were the “strongest predictor of NSSI in community adolescents” (Baetens, 2011). Hankin did a longitudinal study in which he looked at risk factors for NSSI. He found that, “Negative cognitive style, onset of maternal depression, youths’ recent depressive symptoms, and lack of support predicted prospective onset of NSSI” (Hankin, 2011).

Madge worked with the data from the CASE study (Child and Adolescent Self-harm in Europe) and found that “increased severity of self-harm history was, in general, associated with...lower levels of self-esteem, as well as stressful life events in more areas of young people’s lives” (Madge, 2011). She concluded that “both psychological characteristics and stressful life events substantially increase risk” of NSSI (Madge, 2011).

In 2012, O’Connor did an interesting study comparing those who self-harmed to those who thought about self-harm. He found that both groups differed from controls in the pre-motivational and motivational phase variables of socially prescribed perfectionism, self-esteem, brooding rumination and optimism (O’Connor, 2012). This

brings up the interesting question of what it is that pushes a teen from thinking about NSSI to actually self-harming.

Westers looked at the role of forgiveness in NSSI. He found that there was no relationship between an adolescent's forgiveness of others and her use of NSSI. However, Westers did find a correlation between self-forgiveness and NSSI. He stated, "This suggests that self-injuring adolescents with lower levels of self-forgiveness may tend to engage in NSSI to get rid of unwanted feelings..." (Westers, 2012). This appears to be in line with previous findings concerning internalized self-criticism and negative cognitive style. In 2013, Andersson looked at the relationship between self-image and self-harm among Swedish adolescents. She found that "individuals who reported being relatively high in DSH behavior were also relatively high in the SASB [Structural Analysis of Social Behavior] clusters self-indicting and oppressing, self-rejecting and destroying, and daydreaming and neglecting oneself, and low in the cluster of self-accepting and exploring" (Andersson, 2013). Here we find further support for the idea that internalized self-criticism is one key to activating NSSI.

Bresin looked at impulsivity, negative affect (NA), and urge for NSSI. He found that college students with high levels of daily sadness had an "increased probability of urge to engage in NSSI, but more so for those high in negative urgency" (Bresin, 2013). Although this was true for daily sadness, a correlation was not found for negative affect and guilt (Bresin, 2013). Bresin's findings differ from those of previous researchers in the area of negative affect. Although somewhat mixed, it appears that a negative view of the self and a negative way of interpreting the world can be associated with NSSI. A 2015

study by Nock and Franklin made this point even more clearly. Those with NSSI could be separated by those who did not by observing, “How often they spontaneously described themselves as being ‘bad,’ ‘defective’ or ‘deserving of punishment” (DeAngelis, 2015). One researcher went on to say, “It was as if harming themselves or experiencing pain was somehow congruent with their highly negative self-image” (DeAngelis, 2015). Those who scored high in negative self-beliefs were either more able or more willing to endure pain, as if silently saying they deserved it. This increases the likelihood that clinicians would do well to work on self-esteem building with their adolescent clients across the board.

#### *Borderline Personality Disorder Traits*

Although it is not usually diagnosed until early adulthood, Borderline Personality Disorder (BPD) is important to include here, since so many of the characteristics are discussed with relationship to NSSI. According to the *DSM-5*, BPD is “A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning in early adulthood and present in a variety of contexts...” (*DSM-5*, 2013). Five or more of the following symptoms must be present in order to make this diagnosis:

1. Frantic efforts to avoid real or imagined abandonment
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.

4. Impulsivity in at least two areas that are potentially self-damaging
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger
9. Transient, stress-related paranoid ideation or severe dissociative symptoms  
(*DSM-5*, 2013).

As we see from the *DSM-5* diagnosis, many similar symptoms have already been discussed. It should also be noted that “self-mutilating behavior” itself is considered a symptom of BPD. The issues of unstable relationships, unstable self-image, impulsivity (below), suicidal gestures or threats, mood reactivity, chronic feelings of emptiness, anger, and even dissociation have been mentioned as characteristics of those involved in NSSI. Despite the fact that it is not usually diagnosed in teens, some researchers have taken it on.

John Townsend, in his popularly written book *Boundaries with Teens*, listed seven “common reasons” that adolescents cut (Townsend, 2006). Among these, Townsend said “they feel nothing, and pain makes them feel alive” (Townsend, 2006). The idea of feeling nothing is often brought out as a symptom of dissociation. Townsend’s audience for this book is the parents of teens presenting with a variety of difficult adolescent issues.

In 2008, Jacobson studied psychiatric diagnoses and NSSI. Her sampling showed that the only diagnosis that was more common among the NSSI group than the control group was BPD (borderline personality disorder). Jacobson stated that “Symptoms of BPD include difficulty regulating anger, chronic feelings of emptiness, impulsivity, unstable relationships, affective instability, and efforts to avoid abandonment (American Psychological Association, 1994)” (Jacobson, 2008). This study did not conclude which symptoms were more highly linked to NSSI than others, however those who engaged in NSSI were likely to exhibit four or more symptoms of BPD compared to the non-NSSI group. This suggests that clinicians should be aware of the possibility of BPD in adolescents although it is not normally diagnosed until adulthood.

Brent stated, “Often, these patients [those exhibiting NSSI] describe a feeling of emptiness or even depersonalization prior to engaging in self-cutting” (Brent, 1997). These symptoms are considered part of a BPD diagnosis.

Nock and Prinstein’s 2005 work indicated that “the experience of feelings of emptiness, detachment, anhedonia, and a restricted range of affect may increase the likelihood of engaging in SMB [self-mutilative behavior] for automatic positive reinforcement to generate certain sensations or feelings” (Nock, 2005). Their work also supported previous research, such as Laye-Gindhu’s, that pointed to automatic negative reinforcement.

Van Pelt and Hancock spoke of using NSSI to, “manage fear, rage, emptiness, isolation and sorrow. Victimized adolescents who lack the capacity to talk about their pain may express their pain and depleted self-esteem with self-injurious behaviors” (Van

Pelt, 2005). Again, it is easy to see how these symptoms mirror those of BPD. Along this same vein, Newman looked at symptoms and stated that they included, “to rid oneself of emotional emptiness and numbness” (Newman 2009 p. 204)

Crowell noted the overlap of symptoms between those with NSSI and those with BPD (borderline personality disorder). She suggested “Identifying whether BPD features are present may also improve care for self-injuring and depressed adolescents. In addition to targeting negative mood, interventions that address impulsive behaviors, interpersonal conflict, and other BPD traits are more likely to help these adolescents” (Crowell, 2012). She noted that the reverse is not true: treatment for depression does not tend to help with BPD behaviors.

Hamza puts these three theories together and comes up with a tripartite connection between NSSI and SA: through the level of intrapersonal stress, through acquired capability, and through a third variable such as BPD (Hamza, 2012). A year later, she published another study in which, students who engaged in NSSI were more likely to endorse the anti-dissociation and interpersonal influence. This could mean that they experience these needs more frequently than those who do not engage in NSSI (Hamza, 2013).

Research on protective factors against NSSI was the perspective from which Zaki approached this behavior. He found that individuals with Borderline Personality Disorder who were engaging in NSSI had more difficulty differentiating between emotional experiences (Zaki, 2013). Zaki pointed out that negative emotional states did not always lead to NSSI (Zaki, 2013). In fact, “Research supports the notion that specific types of

attention to emotion are differentially associated with maladaptive rumination and adaptive reflection” (Zaki, 2013). In his study, “participants who demonstrated greater differentiation among their various negative emotions reported fewer self-injurious acts and urges, even when prone to high levels of rumination” (Zaki, 2013). Zaki stated, “we posit that when individuals are immersed in an emotional cascade, the extent to which they label and distinguish the specific negative emotions experienced may decrease the likelihood that they will use NSSI to break this recursive ruminative cycle” (Zaki, 2013). He pointed to other research that has shown that the act of putting negative emotions into words decreased a subject’s reaction to it (Zaki, 2013). This researcher wrote, “the momentary ability to label and distinguish one’s emotional experience may reduce emotional intensity and help obviate the perceived need to engage maladaptive strategies such as NSSI to manage these intense emotions” (Zaki, 2013). Zaki pointed out the importance of helping individuals to differentiate more precisely between emotions in a clinical setting in order to build on protective factors (Zaki, 2013).

Although Borderline Personality Disorder is not normally diagnosed before one becomes an adult, it is clear that there is an overlap between the symptom cluster for NSSI and for BPD. I am not advocating for earlier diagnosis of BPD, but an awareness that BPD symptoms may be present in young people with NSSI. If so, these symptoms need to be dealt with along with the other underlying diagnoses such as PTSD, depression, or anxiety.

### *Impulsivity*

There is quite a debate in the literature about whether an event of NSSI is premeditated or impulsive. There appears to be evidence that weighs on both sides of this argument. Lucy Webb provided a helpful meta-analysis of psychological and psychosocial factors involved in adolescent self-harm in 2002. She concluded that:

A vulnerable adolescent appears to be depressed, with feelings of hopelessness and with a tendency toward self-blame and impulsivity. He/she is likely to be experiencing personal worries with pressure from school or relationships. Most specifically, a vulnerable individual is likely to experience poor family communication channels with no parental confidant. Findings from this review suggest that key preventative intervention strategies lie in improving family communication.... These findings also suggest that a response to a DSH act needs to include addressing the adolescent's psychosocial needs, poor problem-solving and impulsivity, to prevent further acts of DSH (Webb, 2002).

Note the researcher's claims concerning impulsivity.

Skegg discussed more measurable characteristics like "poor problem-solving," "impaired decision-making," "impulsivity, inflexible thinking, hopelessness, reluctance to self-disclose, lack of positive future-directed thinking, and difficulties with autobiographical memory manifested by a tendency to retrieve events from the past in an 'over-general' way rather than by recalling specific events," as well as neuroticism,

novelty-seeking, and dissociation (Skegg, 2005). This was from her review of the research literature to date.

In 2008, Jacobson studied psychiatric diagnoses and NSSI. Her sampling showed that the only diagnosis that was more common among the NSSI group than the control group was BPD (borderline personality disorder). Jacobson stated that “Symptoms of BPD include difficulty regulating anger, chronic feelings of emptiness, impulsivity, unstable relationships, affective instability, and efforts to avoid abandonment (American Psychological Association, 1994)” (Jacobson, 2008).

Nixon published a study in 2008 of Canadian young people from Victoria, British Columbia. She noted that young people between the ages of 14 and 21 who reported NSSI also reported “having depressive mood symptoms and problems with regulation of attention, impulsivity and activity” (Nixon, 2008). This suggests that adolescents reporting similar issues should be screened for NSSI.

Dougherty looked at the trait of impulsivity among adolescents with NSSI and compared them to those with NSSI and suicide attempts. He found that those with NSSI and SA had “elevated depression, hopelessness, and impulsivity” which led him to the conclusion, as it did Csorba, that NSSI and suicide attempters (and those with both NSSI and SA) are different populations which call for different treatments (Dougherty, 2009). This is the first empirical support for the idea that adolescents who have attempted suicide are likely to have higher impulsivity than those who have only NSSI.

Also in 2009, Janis and Nock did a study on impulsivity and NSSI. They found that there was a difference between what adolescents with NSSI report and what they

show in laboratory studies. Janis said, "...although self-injurers report greater global impulsiveness, they do not demonstrate greater impulsiveness than non-injurers on laboratory-based behavioral measures of impulsiveness" (Janis, 2009). Although they stated that their work is inconsistent with previous research, it may not conflict with Dougherty's 2009 findings. While Janis looked at all NSSI adolescents, Dougherty compared NSSI adolescents with and without suicidal ideation or attempts. Janis and Nock come up with several possible reasons for the discrepancy between how adolescents perceive themselves in relation to impulsivity and how they perform in a laboratory setting. First, the NSSI group tested had a variety of psychiatric diagnoses. Secondly, these adolescents may have been saying they were impulsive based on the fact that they self-injured. Third, it could be that adolescents with NSSI were only impulsive at certain times, such as "in response to extreme emotional distress" (Janis, 2009).

Stanford found three psychological subgroups of those who self-harm. She compared the pathological, the impulsive, and the "normal" subtypes. Interestingly, the largest group of those she worked with belonged to the "normal" cluster (Stanford, 2009). She found that 43% were in the psychologically "normal" cluster, 32% were in the impulsive cluster, and 25%, the smallest group, belonged to the pathological cluster. She helpfully noted in her discussion that "the pathological subtype of self-harmers appears to represent the 'typical' profile of a self-harmer as described in prior research" (Stanford, 2009). Yet three-fourths of those she worked with would not be described as pathological. The researcher suggested that it was important to understand the severity and nature of an adolescent's NSSI in order to offer appropriate treatment.

In 2010 Hawton looked at the similarities and differences between cutting and self-poisoning. He found that cutting was often more impulsive than poisoning, fewer cutters intended to die, and cutting seemed to relate to emotion regulation (especially of a distressed state) and self-punishment (Hawton, 2010). Both populations were similar “in terms of depression, anxiety, impulsivity, self-esteem and coping behaviours” (Hawton, 2010). These findings about the differences between those who cut and those who self-poison did not convince Hawton to divide them into different categories for research.

In 2011, Arney did a study using Ecological Momentary Assessment (EMA) where participants logged both their situations and their emotions in a computerized diary system. This allowed researchers to study emotion regulation as it occurred in someone’s life rather than in a laboratory experiment. He noted an important finding by Nock in 2009 who employed a similar method and found that “sad affect was negatively associated with NSSI behavior. In contrast, angry or hostile forms of emotion (i.e., self- and other-directed anger, self-hatred, and feeling rejected) were elevated in, and predictive of, an NSSI episode” (Arney, 2011). Arney attempted to enlarge upon this research finding by adding a longitudinal component. He asked questions about what emotions were present before, during, and after an NSSI event and how these increased or decreased over time. Arney found that “Across a variety of different forms of negative affect (e.g., negative affect, guilt, and anger) participants reported a significant increase in negative affect prior to self-reported NSSI and a decrease in negative affect following the NSSI event...” (Arney, 2011). This increase/decrease was also noted in “self-directed anger and shame” (Arney, 2011). Guilt and shame appeared to take longer to

taper off. Whether or not the lingering guilt or shame was a response to the NSSI was not determined by the study. Another important finding was that, although NSSI participants described themselves as impulsive, emotions associated with NSSI were evident an average of eight hours prior to the behavior. “These findings suggest a fundamental disconnect between the affective experiences – or awareness of affective experiences – reported by NSSI+ [positive] participants and their subjective perceptions of how an NSSI episode occurs” (Arney, 2011). This is a key study that differs with previous research and offers hope for intervention.

Madge worked with the data from the CASE study (Child and Adolescent Self-harm in Europe) and found that “increased severity of self-harm history was, in general, associated with higher levels of depression, anxiety and impulsivity and lower levels of self-esteem, as well as stressful life events in more areas of young people’s lives” (Madge, 2011). When she looked at what distinguished those who actually self-harmed from those who only thought about it, Madge found only four factors that independently determined this. Those four factors included impulsivity, experiencing the suicide or self-harm of others, physical or sexual abuse, and worries about sexual orientation (Madge, 2011). She concluded that “both psychological characteristics and stressful life events substantially increase risk” of NSSI (Madge, 2011). It should be noted here that other studies found a lack of impulsivity (though self-harmers perceived themselves as impulsive—see Arney, 2011), a minimal contagion effect, and only weak links to abuse.

Those who self-injured scored higher on depression and manic symptoms, suicidal ideation, hopelessness, tobacco use, emotional dysregulation, and impulsivity in

a study by Crowell (Crowell, 2012). Crowell noted the overlap of symptoms between those with NSSI and those with BPD.

With regard to “volitional phase variables” such as “self-harm by family, self-harm by friends, descriptive norms and impulsivity” along with “the experience of negative life stress that distinguished the ideators from the enactors (O’Connor, 2012). Among these volitional variables, “having family or friends who have self-harmed was statistically the most important,” which O’Connor noted pointed toward a contagion effect (O’Connor, 2012).

In a study of Chinese adolescents, You found that depressive symptoms in year one were significantly associated with NSSI in year two of the study (You, 2012). Family invalidation of emotional experience in year one was also significantly associated with NSSI in year two (You, 2012). Impulsive behavior was found to be significantly associated with both the occurrence of NSSI (as with depression and family invalidation), and additionally with the repetition of NSSI in the second year of the study. You states, “It appears that adolescents who display multiple impulsive behaviors earlier may be at particular risk for developing NSSI at a later time (You, 2012).

Bresin looked at impulsivity, negative affect (NA), and urge for NSSI. He found that college students with high levels of daily sadness had an “increased probability of urge to engage in NSSI, but more so for those high in negative urgency” (Bresin, 2013). Although this was true for daily sadness, a correlation was not found for negative affect and guilt (Bresin, 2013). Bresin stated that “negative urgency appears to be the impulsivity trait associated with NSSI” and that perhaps the varied results researchers

have found when looking at impulsivity are due to the moderating effects of negative affect (Bresin, 2013). In other words, “individuals with a history of NSSI might perform more impulsively on behavioral tasks while experiencing sadness, as opposed to other affective states” (Bresin, 2013). This could, perhaps, explain the differing findings on the issue of impulsivity.

In a study from Singapore, Loh made the interesting observation that some researchers have noted that alcohol use may lower inhibitions and increase impulsivity. “However, in cultures where alcohol is more widely available, alcohol use may be a means of emotional regulation, thus possibly replacing other more overt forms of self-harm” (Loh, 2013). She also posited that smoking in Singapore may be “associated with antisocial behaviour, thereby implying characteristics such as impulsivity, which may be seen as a factor for the increase of self-harm tendencies” (Loh, 2013). Finally, she noted the strong risk factor of clinically diagnosed depression. “In the present study, DSH was strongly associated with depression, a condition that commonly manifests with loss of pleasure, lack of energy, poor concentration, and thoughts of dying and suicide” (Loh, 2013).

Results of studies looking at the trait of impulsivity brought back conflicting findings. Perhaps Bresin (2013) is correct in seeing that not all the studies took into account negative affect, which could explain the diversity. In this section we have seen that the diagnoses of anxiety and depression are much more plentiful among those with NSSI than those without. Many who have been diagnosed with NSSI also have specific personality features like high neuroticism and low conscientiousness. The themes of a

negative self-image and a negative cognitive style have emerged from work with those who self-injure. Those with NSSI often have many of the symptoms of Borderline Personality Disorder. The jury is still out on whether or not NSSI is an impulsive act. There is credible evidence on both sides of that question. In the next section, we will begin to look more closely at how well emotions are regulated by those who engage in NSSI.

### Emotion Dysregulation

NSSI has been interpreted by many in the modern era as a method used to regulate one's emotions. Research has gone in two directions to show this. First, it has illustrated that those with NSSI have an inability to tolerate negative emotions. Secondly, research has been able to determine that negative emotions of high arousal, such as anger, are more likely to lead to NSSI than negative emotions of low arousal, like sadness.

#### *Inability to Tolerate Negative Emotions*

Those with NSSI are led to cut when their negative emotions become overwhelming. Laye-Gindhu found evidence corroborating previous research (Nixon, 2002; Osuch, 1999; Suyemoto, 1998) which determined that "self-harm functions as an effective strategy to regulate affect, chiefly negative or disturbing affect that becomes overwhelming or intolerable" (Laye-Gindhu, 2005). She reported that the major emotions leading up to an episode of self-harm were anger, depression, loneliness and frustration (Laye-Gindhu, 2005). After an incident, the self-conscious emotions of guilt, shame and disgust were increased as was the positive emotion of relief (Laye-Gindhu, 2005). The researcher went on to state that "The most frequently endorsed motivations for self-harm

in this study supported the affect regulation function of self-harm...” (Laye-Gindhu, 2005). The author concluded that “Results from this study suggest that self-harm is an emotion-focused coping strategy that often functions to regulate affect, particularly for girls” (Laye-Gindhu, 2005).

Quentin Spender reported that NSSI was “...a strategy for managing difficult feelings of the sort that are very common in adolescence” (Spender, 2005). Spender’s advice to a new cutter was to prepare him/her for a repetition of the behavior. “I try to frame this as positively as possible,” reported Spender, “saying that it does little harm if it remains superficial, is less dangerous than taking an overdose and may be a way of regulating feelings (like slamming doors or shouting)” (Spender, 2005). I would not endorse Spender’s approach.

Among Townsend’s list of reasons that adolescents engage in NSSI was that “...they want to replace bad feelings with good feelings...” (Townsend, 2006). Likewise, Lloyd-Richardson found that one of the most common reasons for NSSI was to stop bad feelings (Lloyd-Richardson, 2007). Heath found areas that were affected were “an individual’s ability to control the reactions to their emotions, as well as continue to function when experiencing strong emotions” (Heath, 2008). “The fact that emotion regulation difficulties were present in this sample, in the absence of these other risk factors, suggests that emotion dysregulation is a central difficulty for a college sample of self-injurers” (Heath, 2008). She suggested that the focus for practitioners should be on “helping the client to find more adaptive ways to tolerate intense emotions and regulate their emotions” (Heath, 2008).

Nixon published a study in 2008 of Canadian young people from Victoria, British Columbia. She noted that young people between the ages of 14 and 21 who reported NSSI also reported “having depressive mood symptoms and problems with regulation of attention, impulsivity and activity” (Nixon, 2008). This suggests that adolescents reporting similar issues should be screened for NSSI. Nock found that, compared to adolescents with no NSSI, those with NSSI “displayed (a) increased physiological reactivity to a stressful task, (b) a decreased ability to tolerate distress and persist at this task, and (c) deficits in several specific social problem-solving skills” (Nock, 2008). The author reported that this is the first physiological evidence supporting hyperarousal in the face of stress among those exhibiting NSSI. He also noted that this study is the first bit of empirical evidence that showed those with NSSI have “decreased distress tolerance” (Nock, 2008).

Leslie Sim looked at NSSI and how/if it was influential in emotion regulation and its relationship to family emotional climate. Sim found that “adolescent girls with difficulties identifying and expressing their negative emotions within an invalidating environment were less equipped to manage strong negative emotional experiences in adaptive ways” (Sim, 2009). The same was not true for boys. Sim’s research supported “the conceptualization of DSH as a maladaptive strategy to regulate emotion, evidenced by perceptions of significant reduction in negative affective states after engaging in self-harm” (Sim, 2009). Here the earlier work of Gratz in 2003 and Linehan in 1993 were mentioned. In 2010 Hawton looked at the similarities and differences between cutting and self-poisoning. He found that cutting seemed to relate to emotion regulation,

especially of a distressed state (Hawton, 2010). Both populations were similar “in terms of depression, anxiety, impulsivity, self-esteem and coping behaviours” (Hawton, 2010). The results of this study are important given Hawton’s continued lumping together of these behaviors under the DSH terminology.

In a 2012 study, Crowell pointed to emotion dysregulation as a cause of NSSI (Crowell, 2012). In another 2012 study, Franklin, working along with Prinstein, explored how emotional dysregulation may affect the perception of pain in those involved in NSSI. He found that “emotion dysregulation is generally associated with diminished pain perception, even in people without a history of NSSI” (Franklin, 2012). Franklin suggested that decreased pain perception may be a risk factor for NSSI, although due to the cross-sectional nature of his study he was able to add no empirical evidence for this possibility.

Victor asked the question, “Is NSSI an ‘addiction?’” (Victor, 2012). In conjunction with Glenn and Klonsky, Victor looked at the question of craving in NSSI compared with craving in substance use. She found that, “Substances are craved across a variety of contexts” whereas NSSI, “is primarily craved in the context of negative emotions” (Victor, 2012). This suggested that, “substance use is maintained by both positive and negative reinforcement” but, “NSSI is perpetuated primarily through negative reinforcement” (Victor, 2012). Thus she concluded that NSSI is better studied in the context of an emotion regulation model than in the context of an addiction-related model.

Andrews was interested to find out what factors could predict a continuation of NSSI during adolescence. She found that higher, “potential lethality, frequency, and number of methods” correlated to continued NSSI (Andrews, 2013). She also found support for the idea that poor emotion regulation was correlated to continued NSSI (Andrews, 2013). Andrews noted that within a one year period, half of those who were self-injuring at the outset had stopped the behavior, indicating that “NSSI is largely transient among community-based adolescents” (Andrews, 2013). This researcher noted a continuum effect where “prolonged engagement in NSSI is followed by more severe forms of this behavior” (Andrews, 2013). She stated that adolescents with increased severity of symptoms were at higher risk for suicide, hence the importance of identification and intervention in the earlier states of NSSI (Andrews, 2013).

Duggan did a study of how body image might influence NSSI. The results supported previous research indicating that emotion dysregulation is “a mechanism through which body image influences the decision to engage in NSSI for both female and male young adults” (Duggan, 2013). More specifically, emotion dysregulation mediates “the relationship between negative affect and suicide-related thoughts related to body and physical appearance, and engagement in NSSI...” (Duggan, 2013). Duggan was able to break down the dimensions of body image and show that the affective and cognitive aspects were the “potential risk factors for NSSI” (Duggan, 2013). Another finding that was particularly of note was that negative affect alone did not lead to NSSI. It was only when negative attitudes were combined with “an inability to regulate emotions” that NSSI resulted (Duggan, 2013).

### *Negative High Arousal Emotions*

Researchers have been able to show that it is negative high arousal emotions (like frustration) that lead to NSSI rather than negative low arousal emotions (like loneliness). Csorba noted that “any form of affective disorder is of eminent importance in self-injuring adolescents” (Csorba, 2009). Csorba also found that when asked to choose a reason for NSSI, the most popular choice was “to release anger” (Csorba, 2009).

Klonsky looked more closely at affect-regulation and cutters and found that both valence and arousal were affected. In his study, “High arousal negative affect-states decreased (e.g., overwhelmed), and low arousal positive affect-states increased (e.g., calm, relaxed, relieved)” (Klonsky, 2009). He suggested that states of high arousal being moderated would be more reinforcing than states of low valence being increased. This may “suggest that self-injury may be primarily motivated by a desire to alleviate high arousal negative affect-states, such as frustrated, overwhelmed, and anxious, as opposed to lower arousal negative affect-states, such as sad, lonely, and empty inside” (Klonsky, 2009). Klonsky concluded that “therapists should assess the functions of their patients’ self-injury and use the results to inform case conceptualization and treatment planning” (Klonsky 2009).

Newman introduced the idea of cognitive therapy for NSSI. When reporting reasons for self-harm, clients indicate they used it often to “stop bad feelings” (Newman, 2009, p.202). Newman also noted that reasons for NSSI can include control and coping, and quelling rage (Newman, 2009, p. 204). He cautioned therapists to question adolescent clients who present with other symptoms about the possibility of NSSI. The subject of

NSSI may not be discussed either because the client does not perceive it as a problem, or due to shame and secrecy (Newman, 2009, p. 215). Similarly, in 2010, Claes, Klonsky, and Muehlenkamp looked at how affect was regulated by NSSI in eating disordered patients. They found that the most common reason for many forms of NSSI was “to avoid or suppress negative feelings” (Claes, 2010). Their work concurred with previous studies with regard to affect valence and arousal. In all types of NSSI, “positive—low-arousal affect states (eg [sic], relieved) significantly increased, and negative—high-arousal affect states (eg [sic], anger and anxiety) significantly decreased” (Claes, 2010). They also found that one negative affect state, guilt, did not decrease after NSSI.

In 2011, Arney did a study using Ecological Momentary Assessment (EMA) where participants logged both their situations and their emotions in a computerized diary system. This allowed researchers to study emotion regulation as it occurred in someone’s life rather than in a laboratory experiment. He noted an important finding by Nock in 2009 who employed a similar method and found that “sad affect was negatively associated with NSSI behavior. In contrast, angry or hostile forms of emotion (i.e., self- and other-directed anger, self-hatred, and feeling rejected) were elevated in, and predictive of, an NSSI episode” (Arney, 2011). Arney attempted to enlarge upon this research by adding a longitudinal component. He asked questions about what emotions were present before, during, and after an NSSI event and how these increased or decreased over time. Arney found that, “Across a variety of different forms of negative affect (e.g., negative affect, guilt, and anger) participants reported a significant increase in negative affect prior to self-reported NSSI and a decrease in negative affect following

the NSSI event...” (Armeiy, 2011). This increase/decrease was also noted in “self-directed anger and shame” (Armeiy, 2011). Guilt and shame appeared to take longer to taper off. Whether or not the lingering guilt or shame was a response to the NSSI was not determined by the study.

With regard to emotions, Straiton’s 2013 findings were not unique. They included “distress and negative emotions such as anger, low mood, frustration and despair” (Straiton, 2013). Less frequently low self-esteem and homesickness were discussed by the subjects in her study. Straiton noted that it was overwhelmingly the women in her study who discussed emotions as leading to self-harm (Straiton, 2013). Most of those interviewed did not pathologize their NSSI behavior. Straiton commented, “It is plausible that participants do not see the diagnosis as a contributing factor but rather as another symptom of their experiences” (Straiton, 2013).

In this section of our study, we found almost universal agreement that one of the major factors in play with relation to NSSI is emotion regulation. Researchers were able to show that those with NSSI have difficulty tolerating negative emotions. They also found that it was negative high arousal emotional states (like overwhelmed) rather than negative low arousal states (like homesick) that led to NSSI. We find that emotion regulation is the most widely agreed upon function of NSSI.

#### Lack of Adaptive Coping Tools

While emotion regulation is largely agreed upon as one of the reasons for NSSI, so is viewing it as a maladaptive coping tool. NSSI has been shown to be a negative way of preserving life. There is also evidence that some deal with the stresses presented by

school through NSSI. Finally, much evidence exists to show that those with NSSI use more passive means of problem solving.

### *Life Preserving*

Bowen decided to search out the “positive effects” of this maladaptive behavior. She looked at a “recent alternative” to focusing on the “problems or weaknesses of adolescent self-harmers” and instead evaluated NSSI as a coping tool (Bowen, 2001). She noted that,

There is increasing evidence that superficial self-mutilation can be understood as a maladaptive attempt at self-help (Favazza, 1989; Favazza and Rosenthal, 1993), or morbid form of coping (Favazza, 1998). It provides rapid (although temporary) relief from overwhelming psychological distress. Release of tension, acquiring control, reconfirming the presence of one’s body, dulling feelings, and converting unbearable emotional pain into manageable physical pain, are commonly cited reasons for SIB (Bowen, 2001).

The author notes her indebtedness to Callahan (1996) for some of this information.

Van Pelt and Hancock, in their 2005 work directed at church youth leaders, stated that, “a person may engage in SIB [self-injurious behavior] to keep from killing herself” (Van Pelt, 2005). Here again we see the possibility of a life preservative function of NSSI.

### *School Stress*

Keith Hawton made the interesting discovery in 2003 that there was a seasonal pattern to DSH which did not conform to Preti's 2000 work on seasonal patterns of suicide. Hawton found a marked decrease in episodes from July through September and slight decreases in December and April. Hawton concluded "These three periods correspond to the school holidays. Given the high prevalence of school-related problems, this suggests that school stress may contribute to the higher prevalence during term times" (Hawton, 2003). He also found that more instances of self-harm were reported to hospitals on Mondays than on Saturdays during the time when school is in session, but that the Monday trend was not present during the summer holidays. In a study done in 1996, Hawton had already found that almost a third of those with NSSI were also having problems with school work (Hawton, 1996).

Buresova found that those who self-harmed five or more times had a significantly more negative attitude toward school (Buresova, 2013). Interestingly, "there was a significant positive relationship between the occurrence of self-harming behaviour and the discrepancy between one's academic aspirations and the actual school grades" (Buresova, 2013). Those who reported the most frequent NSSI were in the group most "likely to fail to meet their own academic standards" (Buresova, 2013). Hence a clinician would want to look more closely at goals and aspirations of specific youth and not simply find out if they like or dislike school. I once worked with a youth who was cutting who intimated that she had received a "bad" report card. Upon discussion with her guidance counselor, I discovered that she had received all As and Bs in her courses. Although this

would have been considered an excellent report card by some, it did not meet with her expectations, and moved her toward NSSI.

### *Passive Problem Solving*

In a 2005 study by Laye-Gindhu, NSSI was reported to be a, “distraction from problems” (Laye-Gindhu, 2005). In a study specifically focused on problem-solving and NSSI, McAuliffe found that those who self-harmed were more passive and avoidant when dealing with difficulties than those who did not. She reported that “this coping style is characterized by a preoccupation with problems, worrying about the past, feeling unable to do anything and taking a gloomy view of the situation” (McAuliffe, 2006). Also, “this response to problems involves a greater likelihood of giving in, so as to avoid difficult situations, the tendency to resign oneself to the situation, and to try to avoid problems” (McAuliffe, 2006). Here we see emphasized the possibility that NSSI can be used as a coping tool.

In 2007, Lloyd-Richardson used Nock and Prinstein’s “four factor theoretical model of NSSI functions” from 2004 to understand NSSI. Her findings agreed that one way NSSI was reinforced negatively was that individuals were “rewarded by escaping a negative interpersonal demand” (Lloyd-Richardson, 2007). Again, it can be used as a morbid form of coping.

Heath did a study with college students in 2008 in which she found that young people who self-injured only once and those who did so repetitively were no different with regard to difficulties with emotion regulation, but those with any level of NSSI were much different than the non-self-injuring controls. “This finding indicates that these

individuals [self-harmers] do not have a repertoire of strategies to employ when they are dealing with stress or difficulty” (Heath, 2008). Or, at least they do not choose to employ the more adaptive strategies.

Nock studied the relationship of NSSI to emotional reactivity and “deficits in social problem-solving skills (Nock & Prinstein, 2004)” (Nock, 2008). He found that compared to adolescents with no NSSI, those with NSSI “displayed...deficits in several specific social problem-solving skills” (Nock, 2008). Another finding was that those with NSSI were able to come up with as many solutions to a problem as non-harmers, but that they more frequently chose to employ a maladaptive response. This indicated that treatment may need to emphasize not the generation of more possible solutions, but the ability to slow down and choose the one that is most likely to be effective (Nock, 2008). This may be a helpful adjunct to Heath’s work done in the same year.

In 2009, Milton Z. Brown suggested further research was needed to see if there was a connection between the “hiding” inherent in shame and a lack of active problem solving methods (M. Brown, 2009). The following year, Claes and Muhlenkamp found that those employing NSSI were more avoidant and internalized anger more frequently than did patients without NSSI (Claes, 2010). Here again we see a more passive coping style.

Sarno’s study in Italy looked specifically at coping mechanisms. This researcher identified evidence linking NSSI and maladaptive coping mechanisms such as “projection, acting out, dissociation, undoing, repression, fantasy, conversion, and withdrawal” (Sarno, 2010). The study pointed out that those with NSSI had a propensity

for choosing avoidant strategies to deal with problems, even if they had more adaptive methods in their arsenal. Interestingly, the study also pointed out that “it is individuals with a more complex symptom presentation (rather than those with more severe symptoms) who are at greater risk for recurrent SI” (Sarno, 2010). So, the point was to look for variety of symptoms rather than severity when predicting those who may have difficulties with ongoing NSSI. These findings support Nock’s 2008 work.

Christian studied the relationship of depressive symptoms to maladaptive forms of coping and studied self-blame, distancing and self-isolation. She was surprised to find that, of these, only self-isolation was positively correlated to self-injury. The importance of this finding was, “For clinicians working with patients exhibiting depressive symptoms, discouraging self-isolating behavior (e.g. journaling alone), while encouraging more social behaviors (e.g., talking with a friend) [which] could help prevent or decrease DSH by increasing social support and decreasing depressive symptoms, rumination, feelings of loneliness, and low self-esteem” (Christian, 2011). Christian was drilling down into specific styles of coping tools and providing helpful information for clinicians.

Elena Cocorada worked with coping strategies among Romanian youth. She observed productive methods based on active problem solving such as “planning, reinterpreting, active coping, and seeking instrumental support” (Cocorada, 2012). Negative coping included using alcohol or pills, denial, behavioral disengagement, and mental disengagement. She also noted “turning to religion” which she characterized as neither positive nor negative. Despite the fact that Cocorada’s work did not look

specifically at NSSI, the author has included it here as a way to explain and develop the idea of adolescent coping mechanisms which are under discussion in this section of the paper.

Gregory did some interesting work in analyzing the narratives of adolescent cutters. He found that magical thinking was very common (Gregory, 2012). He stated that, “Mental and bodily processes in adolescent cutters appear to be confused and undifferentiated” (Gregory, 2012). As such, adolescents dealt with emotional pain like shame and anger “by magically substituting them for blood and physical pain” (Gregory, 2012). Gregory also noted that participants in his study fell into three distinct categories, so three subgroups of cutting. They consisted of:

1. A relatively high functioning subgroup with strong verbal skills who cut for pleasure and because others do so;
2. A lower functioning subgroup with magical thinking, who cut to cope with negative emotions; and
3. A lower functioning subgroup with histories of trauma and/or loss and suicidality, which cut to relieve dissociation (Gregory, 2012).

The author pointed out the importance of distinguishing between these subgroups for appropriate treatment.

Svaldi set up an experiment where she compared two groups of women diagnosed with Borderline Personality Disorder and who were involved in NSSI (Svaldi, 2012). They each watched a film clip designed to generate negative emotions. After this, one group was told to suppress their emotions while the other group was told to accept theirs.

The study showed that the group that was told to carefully observe their emotions was more prone to have an increased urge to self-harm and an increased urge to self-punish. On both measures, those who were asked to suppress their emotions were more apt to behave more adaptively (Svaldi, 2012). The researcher cautions against overgeneralization of this result since it flies in the face of so much literature noting the detrimental effects of emotion suppression.

In 2013, Hamza studied the functions of NSSI among college students. She studied six commonly discussed functions: three intrapersonal (affect regulation, anti-dissociation, and self-punishment) and three interpersonal (interpersonal boundaries, interpersonal influence, and peer bonding) (Hamza, 2013). This researcher found that a higher percentage of those engaged in NSSI as opposed to those not engaged in this behavior employed “maladaptive coping behaviors (i.e., marijuana, binge/under eating)” to accomplish the six functions studied (Hamza, 2013). From this, Hamza posits that those engaging in NSSI “may have greater difficulty regulating their affective and social experiences” than those who do not (Hamza, 2013).

What this research shows is a clear link between NSSI and lack of adaptive coping. Some are using NSSI as a method to preserve life. Others are responding to the stresses of school. Many are using passive methods of problem solving. Whether young people do not have the tools, or choose not to use the tools they have in the moment remains an open question. Whatever the cause, the practical implication is clear. Helping youth develop their coping capacities and then to employ adaptive coping in stressful situations appears to be an important factor in clinical work with this population. In

addition to adaptive coping tools, adolescent females need to be able to talk about their feelings.

#### Lack of Ability to Name Feelings and Communicate Them

Another major influence on NSSI was the ability for the individual involved to both name her feelings and communicate them with those around her. One interesting element that researchers found was that for many of the adolescents involved in NSSI, recognizing feelings and communicating them with others was extremely difficult. In 2001, Harrington noted that adolescents who self-harm often came from families that communicated poorly (Harrington, 2001). One would assume that feelings would come under the heading of things that were difficult to communicate.

Spender claimed that cutting could be viewed “as a communication, to oneself or to others” (Spender, 2005). So not only did it “speak” to others in one’s life, it also assisted the person involved to know how they felt in a given situation. Van Pelt found something similar when he said “Victimized adolescents who lack the capacity to talk about their pain may express their pain and depleted self-esteem with self-injurious behaviors” (Van Pelt, 2005). The following year, Townsend wrote that one of the reasons for NSSI in adolescents was that “they need a way to outwardly express inner pain” (Townsend, 2006).

Newman introduced the idea of cognitive therapy for NSSI. When reporting reasons for self-harm, clients indicated they used it, among other things, to “let others know how desperate you are” (Newman, 2009, p.202). Newman also noted that reasons for NSSI can include communicating how badly one feels (Newman, 2009, p. 204).

Scoliers used information from the CASE (Child and Adolescent Self-Harm in Europe) study and divided reasons for self-injury into two categories. The more externally motivated purposes he called “a cry for help” and the more inwardly directed functions he identified as “a cry of pain” (Scoliers, 2009). Less heartily endorsed were the cry for help motivations comprised of “I wanted to show how desperate I was feeling,” and “I wanted to get some attention” among other reasons (Scoliers, 2009). This study does not discriminate between NSSI and suicide attempts, which makes it somewhat less useful for our purposes.

Research on protective factors against NSSI was the perspective from which Zaki approached this behavior. He found that individuals with Borderline Personality Disorder who were engaging in NSSI had more difficulty differentiating between emotional experiences (Zaki, 2013). Zaki pointed out that negative emotional states did not always lead to NSSI (Zaki, 2013). In fact, “Research supports the notion that specific types of attention to emotion are differentially associated with maladaptive rumination and adaptive reflection” (Zaki, 2013). In his study, “participants who demonstrated greater differentiation among their various negative emotions reported fewer self-injurious acts and urges, even when prone to high levels of rumination” (Zaki, 2013). Zaki stated, “we posit that when individuals are immersed in an emotional cascade, the extent to which they label and distinguish the specific negative emotions experienced may decrease the likelihood that they will use NSSI to break this recursive ruminative cycle” (Zaki, 2013). He pointed to other research that has shown that the act of putting negative emotions into words decreases a subject’s reaction to them (Zaki, 2013). This researcher wrote, “the

momentary ability to label and distinguish one's emotional experience may reduce emotional intensity and help obviate the perceived need to engage maladaptive strategies such as NSSI to manage these intense emotions" (Zaki, 2013). Zaki pointed out the importance of helping individuals to differentiate more precisely between emotions in a clinical setting in order to build on protective factors (Zaki, 2013).

In order to remain in control over their emotions, youth need to be able to name them, both to themselves and to others. Simple labeling of emotions may go a long way to helping those with NSSI react more adaptively to the stresses of their lives.

#### Childhood Trauma

Before much empirical study was done in the area of NSSI, many assumed a direct correlation between early childhood trauma and NSSI in adolescence. For example, in 1991, Brent wrote, "[s]tudies in clinical samples of adults indicate that self-cutting is closely associated with a past history of physical and sexual abuse, emotional neglect, and often occurs in patients who are prone to dissociation (van der Kolk, Perry & Herman, 1991)" (Brent, 1997). Much of the research since that time shows that, although this is sometimes the case, often NSSI is not associated with childhood trauma. Researchers have warned clinicians against jumping to conclusions, and instead seeing each client as a product of her own, unique, history.

Michael W. Wiederman looked at a population of women between the ages of 18 and 50 who exhibited at least one of three self-harm behaviors: cutting, hitting oneself, or head banging. He noted that other forms of NSSI were not included such as burning, which is the second most popular means next to cutting. In this particular population,

Wiederman found that “having engaged in bodily self-harm in adulthood is more likely among women who have experienced a childhood history of sexual abuse, physical abuse, or witnessing violence...” (Wiederman, 1999). Although this study was conducted with adults it may have some relationship to our current focus on adolescents.

Bowen reported on Walsh and Rosen’s 1988 work which, ...examined the relationship between background experiences and risk factors. These included loss of a parent, childhood illness, physical and/or sexual abuse, marital violence and familial SIB. All variables significantly correlated, yet the strongest links were noted with a history of abuse and witnessing marital violence. Significant conditions ‘triggering’ self-injury during adolescence were recent loss, peer conflict, intimacy problems, body alienation and impulse disorder (Bowen, 2001).

Although this is an early study, we see here a diversity of correlations rather than a direct connection between childhood trauma and NSSI. Bowen’s work was specifically with adolescents. In the same year Bowen was studying NSSI, Harrington came out with a study saying many who employ NSSI have been abused.

Gemma L. Gladstone’s 2004 work demonstrated that “depressed women with a history of childhood sexual abuse have a strong propensity toward self-damaging behaviors” (Gladstone, 2004). She also made the point that DSH can be interpreted as a “‘short-circuiting’ strategy for diverting painful emotions” (Gladstone, 2004). She mentioned Bifulco’s work in this context. Interestingly, her research also showed that, “The association between childhood physical abuse and deliberate self-harm was less

direct and seemed to be mediated by the presence of childhood sexual abuse or by higher personality dysfunction scores” (Gladstone, 2004). Here we begin to see a direct connection between all forms of childhood trauma and NSSI called into question.

Townsend made a more sweeping generalization when he gave “they are reenacting some abuse or trauma and trying to resolve it;” as one of the reasons for NSSI (Townsend, 2006). Glassman published a study a year later and found that NSSI was related to sexual abuse, physical neglect, and childhood emotional abuse. However physical abuse and emotional neglect did not appear to be correlated, suggesting that “not all types of child maltreatment are associated with NSSI” (Glassman, 2007). This becomes a key finding as later studies attempt to deconstruct the relationship between childhood trauma and NSSI.

Heath’s findings were contrary to the earliest wisdom in the area of childhood trauma. She found that in the non-clinical sample she used there was no appreciable difference either in attachment measures or childhood trauma. She posited that perhaps a link was found in earlier studies because they were done with inpatient samples who had greater symptomatology. Heath concluded that:

It has been believed that dysfunctional or chaotic family histories have resulted in poor emotion regulation which the individual manages with maladaptive behaviors, such as NSSI. The fact that emotion regulation difficulties were present in this sample, in the absence of these other risk factors, suggests that emotion dysregulation is a central difficulty for a college sample of self-injurers (Heath, 2008).

In light of this study, practitioners must not assume that because a client presents with NSSI, she is a victim of childhood trauma or attachment difficulties. In fact, the focus should be on “helping the client to find more adaptive ways to tolerate intense emotions and regulate their emotions” (Heath, 2008). This was groundbreaking work on NSSI. Heath states that instead of looking for the existence of childhood trauma, treatment should focus more on emotional control. Two more studies appear to support the first part of Heath’s analysis. In 2011, Madge did a study in which she found only weak links between NSSI and abuse. The following year, Gregory’s work showed that there were three distinct communities of cutters, and only one, a lower functioning group, had “histories of trauma and/or loss and suicidality, which cut to relieve dissociation” (Gregory, 2012).

Kerry Hill used narrative analysis and found that the emerging theme was the importance of a place where adolescents could have conversations that put “difficult past events” in the context of their life stories (Hill, 2012). In fact, “Where reflection on past experiences is not possible, self-harm may be the only visible alternative for adolescents faced with unmanageable emotions and memories that are painful to confront” (Hill, 2012). Hill suggested that such conversations were key for identity development and would keep adolescents from feeling isolated (Hill, 2012). This work appears to indicate that if trauma can be explored in the context of an adolescent’s whole life story, NSSI may not appear to be the only option. It also takes us back to the idea that childhood trauma is directly correlated to NSSI. This contradicts Heath’s work.

Sarah Swannell looked at a population of adults in an attempt to find what mediated the relationship between childhood maltreatment and NSSI. In the females she worked with, she found that physical abuse or neglect independently increased the likelihood of NSSI, but sexual abuse did not (Swannell, 2012). The most important factor that mediated the relationship between childhood maltreatment and NSSI in females was self-blame (Swannell, 2012). Here we see the possibility that it is not the presence of abuse itself, but the person's response to it that correlates with NSSI. Dissociation and alexithymia also had some mediating effect. In the same year, Taliaferro told a different story. She found that factors that distinguished adolescents with NSSI from those with no NSSI were physical abuse and having run away from home. Also, for females, sexual abuse was much more common among those with NSSI as opposed to those with no NSSI (Taliaferro, 2012). The research continues to be murky concerning how childhood trauma might affect NSSI.

Kaess looked at the incidence of adverse childhood experiences (ACEs) in relation to NSSI. He found that there were significantly more ACEs among those engaging in NSSI than those who were not. "In particular, there was a significant association between NSSI and both maternal and paternal antipathy, maternal neglect, maternal physical abuse and any history of sexual abuse..." (Kaess, 2013). Specifically, antipathy and neglect from the mother was seven times more likely among those with NSSI than those without (Kaess, 2013). Kaess noted that this may give further support for Linehan's biosocial model "which describes an invalidating family environment as a core factor on the development of self-harm behaviour" (Kaess, 2013). For more information

on Linehan's biosocial model, see Linehan's 1993 article on Dialectical Behavior Therapy. The second largest ACE within the NSSI population was sexual abuse (Kaess, 2013). However, physical abuse did not show a correlation with NSSI (Kaess, 2013). Among the top three reasons given for NSSI in his study, Kaess found "to relieve feeling 'numb' or 'empty'" (Kaess, 2013). In addition to its anti-dissociative function, Kaess found support for the functions of affect regulation and self-punishment related to guilt, shame, and self-criticism (Kaess, 2013). Kaess also looked at frequency and severity of NSSI, but found that neither of these appeared to be associated with ACEs. Here Kaess introduces the idea that an "invalidating family environment" might be more directly linked to NSSI than sexual abuse (Kaess, 2013). Again, each client must be treated as her own story unfolds. It would be inappropriate to assume that every girl who cuts has childhood trauma she needs to work out, although this may be the case for some. Also in 2013, Pluck published research that determined that those with a history of abuse were more likely to use NSSI repeatedly rather than as a one-time event. The following year, Robert J. Tait noted a "strong association between self-harm and sexual abuse and trauma in women" which, he believed, had important clinical implications (Tait, 2014).

Despite the conflicting reports of research into childhood trauma and its relationship to NSSI in adolescence, we can discern two important factors. First, simply assuming that all childhood trauma will result in NSSI in adolescence would not be empirically supported. Secondly, not all adolescents who employ NSSI have a history of childhood trauma. The antecedents of NSSI cannot be narrowed to one simple factor.

Each adolescent exhibiting NSSI must be looked at as an individual with her own life narrative that must be explored.

### Self-Punishment

Another function researchers have found to be associated with NSSI is self-punishment. Ferrence found in 1975 that some individuals, having internalized rejection from parents, “may seek to negate themselves or punish themselves by self-injurious behavior” (Ferrence, 1975). Thirty years later, Laye-Gindhu wrote that self-hatred and anger, along with self-punishment, were some of the feelings preceding NSSI (Laye-Gindhu, 2005). Spender wrote that “female self-cutters were more likely than male self-cutters to say that they had wanted to punish themselves or had tried to get relief from a terrible state of mind” (Spender, 2005). One of Townsend’s reasons for NSSI in his book published in 2006 was that “they feel they deserve to be punished” (Townsend, 2006). “In the face of stressful events, adolescents who have developed such a cognitive style [critical toward the self] may be more likely to engage in NSSI for self-punishment” (Glassman, 2007). Based on that presumption, it seems odd that those involved in Nock’s study the following year “did not make more self-critical attributions than noninjurers” which was contrary to their hypothesis (Nock, 2008). In 2009, Milton Brown looked at shame as a predictor of NSSI. He found that “Although self-reported shame was associated with an increase [sic] risk of SII [self-inflicted injury], this association did not hold up after controlling for fear” (M. Brown, 2009). However, when researchers looked at facial expressions, they found that “greater levels of nonverbal shame expressions were

associated with an increase [sic] risk of SII after controlling for sadness and fear...” (M. Brown, 2009).

Scoliers reported that more students identified with the reasons comprising a cry of pain which included “I wanted to get relief from a terrible state of mind,” “I wanted to die,” and “I wanted to punish myself” (Scoliers, 2009) than a cry for help. Claes found that, while the number one reason in his study that adolescents use NSSI was “to avoid or suppress negative feelings,” the second most frequently stated was to “punish oneself” (Claes, 2010). That same year, in a study by Hawton where he distinguished between those who cut and those who self-poisoned, Hawton found that one reason cutters offered was self-punishment (Hawton, 2010).

Additionally, students who engaged in NSSI were more likely to endorse the anti-dissociation, interpersonal influence, and self-punishment functions. This could mean that they experience these needs more frequently than those who do not engage in NSSI (Hamza, 2013). Finally, “the highest percentage of individuals who endorsed self-injury did so specifically to regulate the need to self-punish, suggesting NSSI may serve the function of self-punishment better than some of the other coping behaviors” (Hamza, 2013).

The research is fairly clear in pointing out that self-punishment can be a function expressed by those who employ NSSI. Although it may serve a secondary purpose for many, the aspect of punishing the self is definitely present for much of this population.

## Contagion

One of the first questions many ask when first learning about NSSI is whether or not its presence could encourage other adolescents to do likewise. Harrington hinted at a contagion effect when he stated that adolescents who participated in NSSI “have often known someone who has harmed themselves” (Harrington, 2001). Brunner looked at contagion in terms of whether or not it could become a fad. He found that, “the opinion that DSH among adolescents may be because they view it as ‘fashionable’ could not be supported by this study” (Brunner R. P., 2007).

A research project on the internet and NSSI was published in 2011 by Lewis. He looked specifically at YouTube videos. Lewis stated that “In light of the present study’s documentation of NSSI videos on YouTube having frequent views, graphic content, questionable messages, and positive responses by youth (ie, [sic] receiving ‘favorite’ votes), it is essential that research investigate the impact of these videos on youth” (Lewis, 2011). His research showed that videos depicting “NSSI in the form of photographs or live enactments that typically show cutting on the arms or wrists that is moderate in severity” could be triggering for those struggling with NSSI (Lewis, 2011). This does not say that it will influence those who were not formerly involved, but that it could create a scenario where those who were already involved may be tempted to repeat their actions. That same year Madge’s study found “a minimal contagion effect” (Madge, 2011). Gregory found three distinct groups of enactors of NSSI. The first group he identified was “A relatively high functioning subgroup with strong verbal skills who cut for pleasure and because others do so” (Gregory, 2012). This would indicate that among

some who engage in NSSI, the act was indeed contagious. O'Connor looked at "volitional phase variables" such as "self-harm by family, self-harm by friends, descriptive norms and impulsivity" along with "the experience of negative life stress that distinguished the ideators from the enactors" (O'Connor, 2012). Among these volitional variables, "having family or friends who have self-harmed was statistically the most important," which O'Connor notes points to a contagion effect (O'Connor, 2012).

Is NSSI contagious? The answer appears to be "possibly." Although it does not seem likely that it will become a fad, having known people who have self-harmed is more common among those who engage in NSSI than among those who do not. Further, it is clear that those who have previously participated in NSSI can be triggered to do so again by seeing pictures of NSSI.

#### Lower Social or Economic Status

Several studies have looked at economic and social differences between those with NSSI and those without. Ferrence in 1975 introduced four possible models for NSSI. The third one she noted concerned the social status of the individual. If society does not reward an individual with high social status, she may not develop a positive self-image. Then self-rejection could lead to self-punishment and result in NSSI (Ferrence, 1975). This suggests that more important than high social status is the individual's vulnerability toward self-punishment.

Factors noted by House in 1999 that were associated with NSSI were current unemployment and/or lower social class (House, 1999). Taliaferro also looked at socioeconomic status (SES) as represented by those students receiving free and reduced-

price lunch at school. She found that NSSI was more prevalent among those with lower SES (Taliaferro, 2012). It is my opinion that this is an area requiring more study. Is it lower SES that correlates with NSSI, or is it a negative view of the self? This would take us back to the section on self-punishment discussed previously in this chapter.

### Substance Use

Another thing commonly associated with those who engage in NSSI is the use of controlled substances. Ferrence pointed out that in the early days of study, some medical characteristics were found to be fairly common among self-harmers. They included “the heavy use of alcoholic beverages” (Ferrence, 1975). Almost ten years later, Kahan and Pattison pointed to the common finding of drug and alcohol abuse (Kahan, 1984). In 1999, House attacked the issue by a different route looking at factors that predicted repetition of NSSI. He found ten in all and listed among them “alcohol or drug related problems [and] criminal record” (House, 1999). Gladstone may have come up with a reason for this. He made the point that DSH, along with drug and alcohol abuse, can be interpreted as “‘short-circuiting’ strategies for diverting painful emotions” (Gladstone, 2004). In 2009, Csorba found that the population involved in NSSI showed more “alcohol abuse than did non-mutilating suicidal peer patients” (Csorba, 2009). One wonders if this relates to Gladstone’s finding and means that both NSSI and substance use are methods of coping and suicide is a way of opting out of the system. So in a maladaptive way, perhaps both NSSI and substance use are engaged in for their life-preserving capacities. Tuisku studied Finnish adolescents and found that among depressed adolescents, those who were both self-harming and suicidal had ... used more

alcohol than non-suicidal depressed adolescents” (Tuisku, 2009). This does not necessarily contradict what has come before since the study author did not distinguish between those with NSSI and those with suicidal ideation.

MacLaren looked at “potentially addictive behaviors” and NSSI in 2010. He used a group of college students with “High NSSI” indicating a minimum of 10 incidents or 3 methods. Within this group, students were more likely to use alcohol (35% compared to 1% of the control group), more likely to use illegal drugs or abuse prescription drugs (25% versus 2.3%) (MacLaren, 2010).

In 2012, Brody published a study done with Scottish young people in which he found that “impaired emotional development (operationalized as greater use of immature defense mechanisms and lesser use of mature defense mechanisms), rather than substance use per se, is associated with greater risk of self-harm” (Brody, 2012). The researcher concluded that more attention should be paid to internal rather than external motivating factors. During that same year, Cocorada found those with NSSI utilizing “negative coping included using alcohol or pills” (Concorda, 2012). Crowell found “both parent- and self-reports of adolescent substance use” in addition to the use of tobacco (Crowell, 2012).

St. Germain looked at whether direct and indirect NSSI should be considered as a single phenomenon. She defined direct NSSI as a deliberate act such as cutting, whereas indirect NSSI may include “substance abuse, eating disordered behavior, continuous engagement in abusive relationships, and engagement in risky or reckless behaviors” (St. Germain, 2012). Based on her findings that those engaging in direct NSSI were more

self-critical, scored higher on scales of suicide proneness, and had more suicide attempts, St. Germain concluded that these behaviors are best looked at separately (St. Germain, 2012).

Taliaferro in 2012 found that cigarette smoking was more common in females with NSSI than females without NSSI (Taliaferro). Likewise, Andersson found a correlation between cigarette use and possibly alcohol use with NSSI. She noted that her community sample contained so few drug users that it was not possible to evaluate the use of illegal drugs in relationship with NSSI (Andersson, 2013). In a 2013 study, Hamza found that a higher percentage of those engaged in NSSI as opposed to those not engaged in this behavior employed “maladaptive coping behaviors” of which use of marijuana was one.

In a study from Singapore, Loh made the interesting observation that some researchers have noted that alcohol use may lower inhibitions and increase impulsivity. “However, in cultures where alcohol is more widely available, alcohol use may be a means of emotional regulation, thus possibly replacing other more overt forms of self-harm” (Loh, 2013). She also posited that smoking in Singapore may be “associated with antisocial behaviour, thereby implying characteristics such as impulsivity, which may be seen as a factor for the increase of self-harm tendencies” (Loh, 2013). In 2013, Pluck found that those with a family history of alcohol and/or drug misuse were more likely to self-harm repeatedly (Pluck, 2013). Also in 2013, Straiton saw intoxication as a factor influencing NSSI (Straiton, 2013).

Tait worked with a large sample of Australian adults in an attempt to find what mediated the connection between rumination, substance use, and self-harm. He found gender differences in mediating factors. For women, substance use as a coping mechanism was no longer statistically significant when tobacco use was included in the model (Tait, 2014). The relationship between alcohol use and self-harm in females was also non-significant (Tait, 2014). Tait stated that “The model that best explains the data suggests that rumination precedes subsequent depressed mood” (Tait, 2014). While in men the coping tool then employed to deal with depressed mood was frequently substance use, the same was not true for women. Tait suggested that a reason for this may be that females are socialized into using passive coping styles and substance use is a more active method (Tait, 2014).

The population that engages in NSSI has a higher likelihood of substance use. Longitudinal studies have not been conducted to see when SU occurs in the cycle of NSSI. Does the SU occur before an event of NSSI? Then we might test the idea that substances are used to increase inhibition. However, if NSSI and SU occur at different times, we could look at the possibility that both NSSI and SU are being used as maladaptive coping tools. Whatever statistic one looks at, SU is present in the NSSI population at a greater rate than in the general population. What this statistic indicates, however, remains unclear.

## Eating Disorders

Eating disorders such as *anorexia nervosa* or bulimia have been found to be associated with NSSI in some studies. Van Pelt and Hancock mentioned the frequently co-occurrence of eating disorders (Van Pelt, 2005).

In 2010, Claes, Klonsky, and Muehlenkamp looked at how affect is regulated by NSSI in eating disordered patients. They found that among the eating disordered patients they worked with, almost half (43.5%) had experienced at least one type of NSSI over the last year. Cutting, severe scratching, bruising and burning were the most common forms of self-injury. Also in 2010, MacLaren found that those with NSSI more likely to have an eating disorder than those within the general population (45% versus 10%) (MacLaren, 2010).

St. Germain wondered if there were both direct and indirect forms of NSSI and she included “eating disordered behavior” among the indirect forms (St. Germain, 2012). Based on her findings that those engaging in direct NSSI were more self-critical, scored higher on scales of suicide proneness, and had more suicide attempts, St. Germain concluded that direct and indirect NSSI were best looked at separately (St. Germain, 2012).

Taliaferro found that one of the factors that differentiated adolescents with NSSI and or suicide attempts was “maladaptive dieting behavior” (Taliaferro, 2012). Likewise, Hamza, in 2013, found that a higher percentage of those engaged in NSSI as opposed to those not engaged in this behavior employed “maladaptive coping behaviors (i.e....binge/under eating)” (Hamza, 2013).

Research again finds another maladaptive coping behavior, disordered eating, and shows that it often appears within the same populations as NSSI. This may also relate to body image, which will be discussed below.

### Biological Factors

How might biological factors play into NSSI? In 2006, David B. Goldston noted, “In contrast to the numerous theories that seek to explain suicidal behavior, relatively few theoretical notions have been proposed for understanding of nonsuicidal self-harm behavior” (Goldston, 2006). In addition to many of the items already discussed, he mentioned some biological possibilities:

Self-harm behavior may also be linked to brain chemistry changes that result from trauma. Sansone, Sansone, and Wiederman (1995) suggest that the relationship between trauma early in one’s life and self-destructive behaviors are complex and likely involve neurobiological changes that affect one’s ability to manage emotions and learn adaptive skills” (Goldston, 2006).

This is a somewhat different take on the relationship of childhood trauma to NSSI than that discussed earlier. This research suggests that the changes can actually be pinpointed in brain chemistry.

Sourander suggested that there may be genetic factors at work in those dealing with NSSI (Sourander, 2006). In the same year, Townsend listed reasons for NSSI and among them said of adolescents involved in NSSI, “they may have a biochemical issue” (Townsend, 2006). Kaess did a small study in which he found that the systems of those

engaging in NSSI secreted less cortisol in response to psychosocial stress. He posits that reduced cortisol could “play a role in promoting vulnerability to acute stress and maladaptive stress responses in adolescents with NSSI” (Kaess, 2012). This result mirrored the conclusions of earlier trials with monkeys.

In a study using functional magnetic resonance imaging (fMRI) and exposure to pictures from the International Affective Picture System (IAPS) and slides with reference to NSSI, Plener found that the brains of those engaging in NSSI reacted differently from those who did not participate in NSSI (Plener, 2012). The brains of those with NSSI became more highly activated when shown emotional pictures. Plener pointed to differences in the amygdala, hippocampus and bilateral anterior cingulate cortex (Plener, 2012). Plener posited that some of this brain activity may be an effort to compensate for hyperarousal in the limbic system (Plener, 2012).

In a different realm of biological factors, Wong worked on a possible connection between DSH and sleep issues. She found that “self-reported trouble sleeping between the ages of 12 and 14 was significantly associated with suicidal thoughts and self-harm/suicidal behaviours at ages 15-17...” (Wong, 2011). This was true even after controlling for depression. Further research could be done in the area of sleep, since Wong’s research did not differentiate between NSSI and suicide attempts.

Researchers are finding biological linkages to NSSI. Whether it is brain activity, the presence or absence of cortisol, trauma-induced failure to learn adaptive coping, or sleep issues, there appears to be some element of systemic biology associated with NSSI in at least a portion of those with NSSI.

## Body Image

Negative body image is another factor that may coexist with NSSI. Brunner's research published in 2007 indicates that occasional DSH can be related to school or family related variables (Brunner, 2007). However, repetitive DSH appears to be more related to psychological factors and body image issues. Newman states that one of the major reasons for NSSI can be "hating the body" (Newman, 2009, p. 202).

Muehlenkamp published an article in 2012 where she reported on research showing that body image mediated the relationship between negative affect and NSSI in adolescents. She stated, "the current data support the idea that adolescents who evaluate their body negatively and experience a disregard for their body may be more prone to engaging in NSSI when confronted with aversive, overwhelming emotional states" (Muehlenkamp, 2012). This may explain why some maladaptive coping comes out through NSSI and some does not. Efforts at promoting healthy body image may serve as preventative for NSSI for both adolescent males and females (Muehlenkamp, 2012).

High-occurrence self-harmers spent "significantly more [time] attending to their physical appearance" in a study by Buresova (Buresova, 2013). Although the work does not make a statement one way or the other about the acceptance or lack of acceptance of their bodies of those involved with NSSI, we can see that appearance plays a somewhat larger role in the life of high-occurrence self-harmers than the general population.

Duggan did a study specifically about how body image might influence NSSI. The results support previous research indicating that emotion dysregulation is "a mechanism through which body image influences the decision to engage in NSSI for both

female and male young adults” (Duggan, 2013). More specifically, emotion dysregulation mediates “the relationship between negative affect and suicide-related thoughts related to body and physical appearance, and engagement in NSSI... (Duggan, 2013). Duggan was able to break down the dimensions of body image and show that the affective and cognitive aspects were the “potential risk factors for NSSI” (Duggan, 2013). Another finding that was particularly of note was that negative affect alone did not lead to NSSI. It was only when negative attitudes were combined with “an inability to regulate emotions” that NSSI resulted (Duggan, 2013). So clinicians need to not jump to conclusions when they are working with adolescents with body image issues. These may or may not lead to NSSI depending on the level of emotion dysregulation.

Negative body image or even body dysmorphia could lead to an eating disorder, but this shows us that these could also lead to NSSI. Whether disregard for the body simply makes it easier to harm it, or if it is more from a self-hatred of the body perspective is unclear at present.

#### Future Orientation and Hopelessness

One of the markers that clinicians are told to look out for in suicide prevention is the level of hopelessness a client experiences. If a client can remain future-focused, the statistical risk of a suicide is drastically reduced. Researchers have found that both future orientation and hopelessness can also be associated with self-harm. House talked about the presence of “hopelessness; and high suicidal intent” among those he studied with relation to NSSI (House, 1999). In 2002, Lucy Webb reported that “A vulnerable adolescent appears...with feelings of hopelessness” (Webb, 2002). Again, in 2009,

Csorba discussed the element of hopelessness associated with those involved in self-harm.

In Claes' studies with people who had suicide attempts (SAs), those with any SAs were more depressed and hopeless, showed more suicidal ideation and neuroticism and lower extroversion. These features suggest "that attitudes towards life and future may be important clinical markers to identifying suicide risk within those who also self-injure" (Claes, 2010b). Crowell found in studying adolescents who were depressed as opposed those who self-harmed, those who exhibited NSSI scored higher on measures for hopelessness (Crowell, 2012).

Taliaferro expanded on research into hopelessness and future orientation and noted:

Overall, hopelessness was the only factor to consistently produce medium to large effects. This finding supports research indicating adolescents with stronger beliefs in their possibilities are less likely to engage in NSSI, and adolescents who engage in NSSI report stronger future orientations with greater reasons for living than those who attempt suicide (Taliaferro, 2012).

This appears to indicate a continuum of hopelessness. Those who feel most positive about their futures don't engage in NSSI. Those who feel most negative about their futures may attempt suicide. Those who fall in between may be involved in NSSI.

In this section, we have looked at reasons and functions of NSSI from the perspective of researchers. Factors associated with NSSI include breaks or disruptions in

the social environment (especially with parents), personality traits or internal vulnerabilities (including borderline personality traits and impulsivity issues), emotion dysregulation, lack of application of adaptive coping tools (particularly where school stress is concerned), lack of ability to communicate feelings to self or others, childhood trauma, self-punishment, contagion, lower socio-economic status, substance use, eating disorders, biological factors, body image, and future orientation. Next we will investigate what treatments have been attempted and found to be effective in working with adolescents with NSSI.

### **General Treatment Guidelines**

Given all the reasons and functions of NSSI detailed in the previous section, what treatments are useful in combatting this maladaptive behavior? As researchers evaluate treatments for NSSI, they ask if the treatment in question works more effectively than treatment as usual (TAU) or better than another specific treatment regimen. Treatment as usual (TAU) was not spelled out in detail in any of the research I explored, but examples of it abound. As this literature review works its way through the current research concerning treatment of NSSI, we will first look at good general treatment guidelines that may be part of TAU. Then we will turn to specialized therapies where we will be asking about the efficacy of specific treatments opposed to TAU.

In her 1975 article, Ferrence called treatment of NSSI, “tertiary prevention,” and said, “Some authors suggest that prolonged contact which allows the patient to develop satisfying relationships and more positive self-concepts reduces the risk of repeated self-injury” (Ferrence, 1975). She used Kessel (1965) and McCulloch (1972) as her sources

for this information. This could mean a relationship with a therapist or a therapeutic group within the community (Ferrence, 1975). Her sources also recommended services for crises that would be available at any time of the day or night. She noted that self-injurers who went to a hospital emergency room often received inadequate follow-up. Ferrence's suggestions involve TAU and better treatment after a hospital visit.

Michael D. Figueroa suggested in 1988 that dynamic therapists must be careful to root their interpretations firmly in the patient's experience. He said, "Insight into the dynamics of self-mutilation should always subserve the primary empathic therapeutic relationship." (Figueroa, 1988). And again, "Understanding must be assimilated into a theoretically solid, and clinically sensitive, application of the healing aspects of the interpersonal relationship between therapist and client" (Figueroa, 1988). Again, the researcher is citing good general practice techniques, or TAU.

Nock in 2006 gave further direction to clinicians. All clients engaging in NSSI should also be screened for suicidal ideation. The reverse was also true. All adolescents with suicidal ideation should also be screened for NSSI. "It is clear that these are distinct behaviors; however, it is equally clear that these behaviors often co-occur" (Nock, 2006). Nock speaks to what could and should become an aspect of TAU.

Heath pointed out the importance of differentiating between one act of NSSI and repeated self-harm. She noted that "an overreaction to a single or occasional occurrence of NSSI can result in unnecessary hospitalization" (Heath, 2008). She went on to refer to Muehlenkamp's 2006 article which pointed out the need to develop "strategies to manage difficulties with emotion regulation" (Heath, 2008). Heath concluded that clinicians

“need to focus on helping the client to find more adaptive ways to tolerate intense emotions and regulate their emotions” (Heath, 2008). While this does not point to a specific treatment modality, it does delineate what must be included in any effective treatment and become TAU.

Glenn was able to determine that the “tendency to self-injure exclusively while alone represents a theoretically meaningful and easily measurable indicator of suicide risk among those who engage in NSSI” (Glenn, 2009). This informs treatment in that clinicians can ask questions about social setting during NSSI and use this information in order to determine the presence or absence of suicidal ideation. This is another nuance that could be added to TAU for NSSI.

Ystgaard looked at the difference between those who received help following an episode of self-harm and those who did not. The researcher found that those who received help from the medical community “report more problems than those who do not receive any help. However, the remaining adolescents who do not receive any medical help also appear to be heavily burdened, although the lethality of their deliberate self-harm acts appears to be less severe” (Ystgaard, 2009). Ystgaard made the point that given this information, all adolescent DSH should be taken seriously. This is another item that could be added to our list of TAU for NSSI.

Gerstein had some very definite ideas about how patients with NSSI should be treated. She said, “The therapist should be authoritative but warm, supportive and trustworthy. Educate the patient on the potential lethality of self-harm and the possible side effects of their behaviours on others, to which they may be oblivious. It’s also good

practice to ask the patient for feedback on the session and to clarify their nonverbal expressions. The ultimate goal is to help the teen relinquish privacy and isolation for a healthy connection to another person” (Gerstein, 2010). This appears to be a common sense approach, not something specifically relevant to NSSI.

An Italian study, “confirms the need for interventions designed to build parenting skills and interventions that enhance the protective behaviour of peers’ group [sic]” (Novara, 2010). This researcher goes on to say that, “The process of identification, typical of adolescence, can be expressed in ‘extreme ways’ (such as self-injurious behaviours) if the parents’ educational style was characterized by over protection, punishment, pressuring, rejecting, disapproval and nearly [sic] lack of support” (Novara, 2010). Again, while this approach seems to be based on common sense it is lacking in empirical support at this time.

Christian explored coping behaviors mediating depression and self-harm. She suggested, “For clinicians working with patients exhibiting depressive symptoms, discouraging self-isolating behavior (e.g., journaling alone), while encouraging more social behaviors (e.g., talking to a friend) could help prevent or decrease DSH by increasing social support and decreasing depressive symptoms, rumination, feelings of loneliness, and low self-esteem” (Christian, 2011). She also admitted that “the evidence to support effective treatments of DSH is limited” (Christian, 2011). Her suggestions make logical sense, yet remain to be tested.

Greydanus made an interesting leap in his 2011 article. First he stated that “Traditional intensive interventions include identification of DSH behavior group

therapy; schoolbased [sic] programs; hospitalization; art therapy; and psychopharmacological treatment for underlying disorders, such as depression, anxiety, ADHD, and psychosis” (Greydanus, 2011). However, “there is no proven evidence that current management of DSH prevents eventual, or later, suicide” (Greydanus, 2011). But, “more research is needed to identify successful interventions for treating children and adolescents with DSH” (Greydanus, 2011). Against the foregoing statement Greydanus went on to offer the reader the lynchpin of treatment. “The key to successful intervention is the development of positive coping mechanisms, the reduction or relief of underlying stress, and improvement in communication skills. Positive or auspicious outcomes are enhanced by having therapy during times of crises, a trusting relationship between patient and clinician, appropriate treatment of comorbid psychiatric illnesses, and if possible, support from family members and friends” (Greydanus, 2011). He reached back to Skegg (2005) for some of his proposed interventions. So, having told the reader that successful interventions have not been identified, Greydanus goes on to state the “key” to such successful interventions.

Madge brought up an interesting finding in that she saw great similarities between adolescents who had thought about NSSI and those who had engaged in it at least once. She added to the discussion that clinicians needed to take “intentions as well as behaviour into account” (Madge, 2011). She also found that “There is no single pattern of self-harm among young people, but both psychological characteristics and stressful life events substantially increase risk” (Madge, 2011). Those working with adolescents needed to be aware that NSSI might be present even when “evident signs of depression or mental

illness” were absent (Madge, 2011). This seems important to keep in mind when working with all adolescents.

Wong’s 2011 study found a relationship between sleep problems, NSSI and suicidal ideation (SI) in adolescence. She suggested that when a client presented with trouble sleeping, the practitioner should ask questions about the presence of NSSI, SI, and suicide attempts. Although not a therapeutic intervention, as such, this may be an important factor to keep in mind for assessment purposes in TAU.

Alison Baker worked with a group of women on an inpatient unit. In 2012, the researcher had this insight to share: “Staff need to acknowledge that it may be difficult for a person to change a long held behaviour that ‘works’ in the absence of alternative means of coping, communicating and relating to others” (Baker, 2012). Baker also reminded the reader that “One size does not fit all” when it comes to treatment of NSSI, a statement we have heard before from the annals of NSSI research (Baker, 2012).

David Cottrell noted that treatment as usual in the UK is usually “of good quality” and that assessment and follow-up style influenced the level of engagement young people choose to have with therapy (Cottrell, 2013). Finally, he pointed out that, “In the absence of effective treatments it is not bad to know that assessment can be conducted in ways that are more likely to keep vulnerable young people in contact with services” (Cottrell, 2013). Cottrell is pointing out the advantages of TAU especially when it comes to client engagement.

Nav Kapur pointed out the importance of “good quality assessment” (Kapur, 2013). In fact, assessment was so central that “assessment by individual clinicians may

make a tangible difference to outcome” (Kapur, 2013). Kapur stated, “This is a cause for therapeutic optimism in a group of patients who are often perceived as difficult to help by clinical services” (Kapur, 2013). Here this researcher cited Saunders concerning attitudes of clinical staff. This author finds it telling that the article by Saunders was published in the *Journal of Affective Disorders* in 2012. This would lead one to conclude that the editors of this journal have accepted that NSSI is a problem of emotion regulation.

Ougrin used a controlled trial to test therapeutic assessment (TA) versus assessment as usual (AAU). The only outcome difference he could find was that the adolescents who received TA remained engaged in treatment longer than those who received AAU (Ougrin, 2013). This points to the fact that how those with NSSI are first assessed can affect their engagement in treatment long-term (in this case over a two-year period).

As we have seen, there are many guidelines for good therapeutic practice in the literature about NSSI. Researchers note the importance of the therapeutic relationship and healthy connections with others, the ability to tolerate and regulate emotions, that all NSSI should be taken seriously, the need for better parenting skills, increasing social interaction in those who show symptoms of depression, gaining support from family and friends, treating any comorbid psychiatric illnesses that may be present, asking about intention to self-harm in addition to the behavior itself, asking about trouble sleeping and suicide attempts, teaching alternative methods of coping and communicating, and making a good assessment. In addition to these general guidelines, there are also specific treatments that have been tested in working with those with NSSI.

## **Specific Treatment Guidelines**

In addition to good general guidelines for treatment, there is also research about specific therapies that have been used with NSSI. The question researchers are asking is whether or not a specific treatment can be found that will prove to be more effective than treatment as usual (TAU). Specific treatments that have been tested include Problem-Solving Therapy (PST), family counseling, group therapies, cognitive therapies (often CBT), Dialectical Behavior Therapy (DBT), mentoring, increasing emotional vocabulary, Compassion Focused Therapy (CFT), different approaches for different stages of therapy, narrative therapy, Mentalization-Based Treatment for Adolescents (MBT-A), Emotion Regulation Training for Adolescents (ERT), the use of medications, and trauma therapy.

### **Problem-Solving Therapy (PST)**

Problem-Solving Therapy is a method of increasing coping tools so that an individual can both prevent and deal with the stresses of life, and increase a positive outlook on the world. It is designed to move toward emotional healing through cognitive change. House did a review of recommended treatments in 1999 and concluded that no previous study contained interventions that were shown to be both effective and reproducible in the prevention of repetition of self-harm. He stated “Because of small sample sizes, no trial produced a statistically significant difference in repetition rates...” (House, 1999). However, there were some interventions that showed promise. A method of treatment that showed a trend toward success was problem solving therapy (PST) defined as “a brief treatment aimed at helping the patient to acquire basic problem solving skills by taking him through a series of steps” (House, 1999). House wrote that

this type of intervention usually included about six sessions. I note that this recommendation is the opposite of Ferrence's (1975) suggestion that relationship-building and improved self-image were what could prevent repetition.

Bowen (2001) quoted a general framework for treatment from Rudd and Joiner (1998). This conceptualization said that regardless of the therapeutic orientation, treatment must include "crisis intervention in the form of symptom relief and crisis resolution during the beginning phase of therapy; a short-term agenda of skill development during the middle phase of therapy; and a long-term agenda of working on self-image and interpersonal functioning during the end phase of therapy" (Bowen, 2001). She then discussed the two most promising treatments based on Hawton's 1998 research: DBT and PST. Both of these treatments were discussed in relation to House's 1999 article, which concluded they showed promise for being more effective than TAU.

Harrington suggested that PST and "family counseling aimed at improving communication" were commonly employed techniques (Harrington, 2001). However, "There is little research evidence about which intervention practitioners should offer" (Harrington, 2001). This researcher stated that PST in adults did not reduce the risk of repetition, information he gleaned from Hawton's 1998 review of treatments. He reached the conclusion that at this point there were not specific treatments that were statistically better than TAU.

In his 2003 article Hawton mentioned PST for adolescents which might help them "not only deal with urgent problems but also to develop improved problem-solving skills for the future" (Hawton, 2003). He noted that PST had been shown to be effective with

adults involved in DSH (Hawton, 2003). Hawton's information on PST is in direct contrast to Harrington's 2001 research. While Hawton said that PST had been shown as effective in adult populations with NSSI, Harrington stated that PST was not effective at preventing repetition of NSSI in adults.

Laye-Gindhu suggested that "intervention efforts should be directed toward teaching and encouraging more positive and constructive coping and problem-solving practices" (Laye-Gindhu, 2005). She relied on Southam-Gerow (2002) as she advocated for "an emotion-based approach in which emotions can be safely experienced" and adolescents find out that no emotion is permanent, that all are survivable and none are inherently harmful (Laye-Gindhu, 2005). This would suggest that short-term PST would deal with only one part of the suggested treatment. However, DBT (discussed below) would fit Laye-Gindhu's suggestions nicely.

McAuliffe's 2006 work echoes Ferrence's 1975 conclusions. The researcher noted that "The observed passivity and avoidance of problems associated with repetition of DSH in this study indicates the need for intensive therapeutic input and follow-up, as low self-esteem may hinder clients in coping with problems" (McAuliffe, 2006). McAuliffe stated that self-help had been shown not to be the best method of dealing with NSSI, instead "direct coaching by a therapist" and "an active and positive approach to problems through appropriate problem-solving skills training and modelling" were more effective. This researcher appears to support problem-solving therapy, but not the type of limited duration. Like Ferrence (1975), the help will come through a longer term relationship with a professional.

Muehlenkamp found that “Based upon the research reviewed, it is likely safe to tentatively conclude that PST and DBT are effective approaches to treating NSSI behaviors” (Muehlenkamp, 2006). This conclusion was provisional, however, due to the lack of empirical studies, especially those including randomized controlled trials (Muehlenkamp, 2006). Muehlenkamp stated that behavioral interventions were important to dismantle the positive and negative reinforcements surrounding NSSI. That might also require development of new skills in the areas of coping and distress tolerance, problem-solving, communication, and the “identification, labelling, and verbalization of emotions,” in addition to intimacy and conflict resolution (Muehlenkamp, 2006).

Lloyd-Richardson noted growing evidence of the effectiveness of PST in areas such as the “lack of reflection before engaging in NSSI and alternatives for managing intense affect” (Lloyd-Richardson, 2007). Nock looked more specifically at problem-solving deficits in an adolescent population participating in NSSI. He found that the issue was not that in the extreme of emotion a teen could not generate multiple solutions to a social problem, but that under these circumstances an individual had difficulty choosing an appropriate solution from among the options. Hence, “The current findings suggest that it may be most beneficial for clinicians to focus not on helping self-injurers learn how to generate more solutions but on helping them to select adaptive solutions for enactment” (Nock, 2008). He took his cue from the clinical treatment of children with conduct issues and suggested that treatment “may involve teaching self-injurers to slow down their problem-solving process to generate effective solutions and select the one most likely to be most effective, not merely the first one generated” (Nock, 2008). This

gives more credence to the use of specific parts of PST for working with adolescents with NSSI, and also relates to part of what DBT (discussed below) teaches.

Dougherty looked at impulse control in adolescents with NSSI with or without suicide attempts (SAs). The only clinical recommendation he put forth with regard to those in the NSSI only group was that if there was no “significant psychiatric comorbidity, brief treatments (e.g., skills training) may be considered...” (Dougherty, 2009). This conflicts with the conclusions of earlier researchers about the need for a strong and extended therapeutic alliance in the treatment of NSSI.

Researchers have investigated a variety of ways PST could be implemented. Most seem to agree that a six week manualized treatment will not be enough to change the ingrained behavior of a repetitive user of NSSI. However, increasing coping tools and practicing more effective methods of problem-solving could be a helpful enhancement in a broader overall treatment plan.

### Family Counseling

As is clear from its title, family counseling calls the entire family system to learn more effective methods of communication and how members can better support one another through the stresses of life. Harrington stated that including the family in the intervention was key (Harrington, 2001). He suggested that PST and “family counseling aimed at improving communication” were commonly employed techniques (Harrington, 2001). However, “There is little research evidence about which intervention practitioners should offer” (Harrington, 2001). He noted that family counselling had been shown

ineffective in preventing further episodes of NSSI. This leaves the reader with no method of treatment with any efficacy from Harrington's study.

Wedig pointed to the fact that helping parents to reduce the amount of criticism aimed at a child had been shown to help "in reducing patient relapse across a number of different disorders" (Wedig, 2007). She also noted that "Low self-criticism may serve as one protective factor for an adolescent in a highly critical family environment" (Wedig, 2007). How to help families to this end is not discussed in Wedig's findings. Tuisku's 2009 study pointed to the fact that depressed adolescents exhibiting DSH had less perceived support from the family which "suggests that family interventions may be needed in the treatment of these adolescents" (Tuisku, 2009). Again, this is a suggestion that has been put forth by previous researchers but has not to this point received empirical testing.

Gudrun Dieserud's work in Norway found that "many adolescents in our study are suffering because both their parents and the adolescents seem to be struggling with interpersonal conflicts related to the parents' current and/or ex-partners..." (Dieserud, 2010). From this, the researcher suggested that an intervention including the entire family system might be helpful. To date no empirical research has been done on the efficacy of family therapy.

In 2011, Hankin based his conclusions about treatment on a 2004 article about suicide when it is clear from his title that he is talking about NSSI, a clinical term that we have seen excludes suicide from its purview. Based on suicide literature, "The most promising treatments appear to involve a form of cognitive-behavioral therapy (CBT)

with family involvement” (Hankin, 2011). Here he credited a 2004 study by Macgowan on suicide. Hankin then proceeded to say why this agreed with his study. Due to the basis of his arguments, I reject the validity of Hankin’s claims.

Kaess studied adverse childhood experiences (ACEs) and their relationship to NSSI. Kaess posited that since the ACEs he studied took place within the family unit, intervention with the family as a whole might be a key to success (Kaess, 2013). What the foregoing says is that researchers feel that family therapy ought to be effective in treating NSSI. However, there is no empirical evidence proving this is the case, and at least one researcher claims a lack of efficacy in family therapies.

#### Group Therapies

There are many types of group therapies, but the basic idea is that a group of peers gathers with a leader and works on issues that are specific to the group. In this way, positive communication is modeled, and group members are enabled to feel less isolated in their particular issues. In his 2003 article Hawton brought up the idea of group therapy for repeated DSH in adolescents, but stated that there was not yet enough evidence to prove efficacy. Gladstone suggested that a specific type of group work might be helpful for women with depression, a history of childhood sexual abuse, and NSSI or suicide attempts. Groups needed to “facilitate the resolution of themes of guilt, isolation, and secrecy” (Gladstone, 2004). I note that this work was done with adults rather than adolescents, so its effectiveness with the population under discussion remains untested. Jane Burns conducted a search for “evidence-based approaches to reduce repetition” of DSH and found very little help in the current literature (Burns, 2005). In fact, she found

“only one specific treatment, group therapy, to offer any convincing advantage over standard aftercare in reducing repetition” in adolescents (Burns, 2005). This may be seen to extend some of the work that Gladstone (2004) was discussing to the adolescent population.

Like Burns, Philip L. Hazell looked at the use of group therapy for repeated DSH. Hazell found that his study was unable to replicate an earlier finding that this type of treatment yielded better results than “routine care” (Hazell, 2009). Hazell wrote, “In contrast to the first published evaluation of the [sic] group psychotherapy, we found a tendency for more participants in the experimental group than the routine care group to engage in self-harm during the follow-up period” (Hazell, 2009). Hazell shows that group therapy is not more effective than TAU with regard to NSSI.

Matthew D. Selekman offered an intervention that schools could make in order to assist those who engaged in NSSI. They could offer a support group. To this end, the researcher created what he called the, “Stress-Busters’ Leadership Group.” Since this is a type of manualized treatment, an empirical study of its effectiveness over against TAU might be fairly easily undertaken. This wisdom appears to support previous research, but again lacks empirical evidence regarding efficacy. As with PST, group therapies return mixed results as to whether or not they are effective in helping clients with NSSI.

### Cognitive Therapies

The goal of cognitive therapy is to help people see how their thoughts and behaviors influence their feelings. Clients learn how to replace distorted thinking so that they begin to feel better about their situations as they think more realistically about them.

In his 2003 article Hawton mentioned cognitive behavior therapy (CBT) for adolescents which might help them “deal with urgent problems” (Hawton, 2003). He noted that CBT was useful for depression in adolescents (Hawton, 2003). Researchers will later caution that depression treatments are not enough when it came to NSSI (see Crowell’s 2012 work below). Muehlenkamp noted the importance of cognitive restructuring. She used Walsh and Rosen’s (1988) four cognitive distortions common to those dealing with NSSI. These included: 1) self-injury was acceptable/necessary, 2) one’s body/self was disgusting and deserving of punishment, 3) action was needed to solve the immediate crisis, and 4) overt action was needed to communicate feelings to others (Muehlenkamp, 2006). Muehlenkamp also came to the conclusion that treatment for NSSI must deal with the causes rather than the act of NSSI itself.

In 2009, Milton Brown published on shame and NSSI in those with BPD. He suggested that treatments might be developed that “focus specifically on ways to help persons with BPD reduce or regulate aversive states of shame in the moment” (M. Brown, 2009). He suggested that cognitive therapies showed promise in this area.

In a 2009 article discussing cognitive therapy for NSSI, Newman pointed out the importance of assessment in order to offer appropriate treatment. By using formal measures such as the Functional Assessment of Self-Mutilation (FASM) credited to Lloyd (1997) and Nock (2004), “Clients’ responses can help therapists formulate hypotheses about clients’ faulty beliefs that support the NSSI” (Newman, 2009). Other important aspects of assessment included the scope and context of the NSSI, or what Nock (2004) referred to as “triggers and consequences” (Newman, 2009). Newman

talked about the importance of the therapist expressing “empathic understanding” and helping the client to build “direct, healthy communication skills...” both of which were thought to be important by earlier researchers (Newman, 2009). Although this article does an excellent job laying out cognitive therapy for NSSI, it does not offer any empirical evidence concerning its efficacy.

In 2011, Hankin based his conclusions about treatment on a 2004 article about suicide when it is clear from his title that he is talking about NSSI, a clinical term that we have seen excludes suicide from its purview. Based on suicide literature, “The most promising treatments appear to involve a form of cognitive-behavioral therapy (CBT) with family involvement” (Hankin, 2011). Here he credited a 2004 study by Macgowan on suicide. Hankin then proceeded to say why this agreed with his study. Due to the basis of his arguments, I reject the validity of the researcher’s claims.

O’Connor suggested that CBT could be useful in, “tackling perfectionistic beliefs or brooding rumination” that may occur while self-harm behavior is still being considered (O’Connor, 2012). Kaess studied adverse childhood experiences (ACEs) and their relationship to NSSI. Kaess stated that, “cognitive therapy implies potential success in order to challenge dysfunctional beliefs (e.g. one deserves to be punished)” (Kaess, 2013). Although there continues to be a lack of empirical testing using cognitive therapies, it appears that they hold promise for treating NSSI.

#### Dialectical Behavior Therapy (DBT)

DBT was developed specifically for treating people with Borderline Personality Disorder (BPD), of which NSSI can be a symptom. Based in cognitive therapy, DBT

seeks to improve person's ability to cope with stress, regulate emotions, and improve relationships with others. House reviewed recommended treatments in 1999 and discussed Dialectical Behaviour Therapy (DBT). House said that DBT was "intensive, involving in its full form a year of individual treatment, group sessions, social skills training, and access to crisis contact" (House, 1999). However, due to the level of its intensity, "better evidence of its applicability and cost effectiveness is required" (House, 1999). Bowen (2001) mentioned the two most promising treatments based on Hawton's 1998 research: DBT and PST. Both of these treatments were discussed in relation to House's 1999 article, which concluded they showed promise for being more effective than TAU.

In 2002, Alec L. Miller gave an overview of DBT with ideas about how families could be incorporated into this treatment. He pointed out that DBT had "been shown elsewhere to be a valuable treatment for multi-problem suicidal adolescents" summarizing his own 1997 article (Miller, 2002). I question the use of statistics regarding suicide and relating them to NSSI, however DBT continues to stand as a possible effective treatment for NSSI. Muehlenkamp found that "Based upon the research reviewed, it is likely safe to tentatively conclude that PST and DBT are effective approaches to treating NSSI behaviors" (Muehlenkamp, 2006). This conclusion was provisional, however, due to the lack of empirical studies, especially those including randomized controlled trials (Muehlenkamp, 2006).

Jacobson noted the importance of different treatments for teens with suicidal ideation and those with NSSI. She mentioned DBT as a possible treatment for

adolescents with borderline personality disorder (BPD) symptoms, but wrote that such treatment might not be appropriate for those with NSSI only. “It is possible that a more simplified approach to emotion regulation and/or interpersonal problem-solving skills, as opposed to the entire DBT package, may be appropriate for teens who have engaged in NSSI but not attempted suicide,” Jacobson said (Jacobson, 2008). The question this researcher raises is an important one. If DBT continues to be seen as more effective than TAU, are there parts of DBT that should become the focus for those engaging in NSSI? Or is the variety of therapies employed in DBT that covers a variety of functions of NSSI in an adolescent population? More specific study of DBT for NSSI needs to be completed.

Stanford noted that adolescents who presented with greater pathology might need a higher intensity treatment, and those who presented with impulsivity could be taught “practical skills to decrease impulsive self-harm, such as cognitive behavioural therapy or dialectical behavioural therapy” (Stanford, 2009). Crowell suggested, “Identifying whether BPD features are present” (Crowell, 2012). If so, she pointed to DBT (modified for adolescents) as possibly helpful. Interestingly, she went on to say that, “Our results are consistent with treatment-outcome studies finding that self-injuring adolescents differ from depressed teenagers and may therefore require more targeted forms of care” and cited Wilkinson, 2011 (Crowell, 2012). This may help clinicians to not simply assume that treatments that work for depression must also be appropriate for NSSI and speaks to Hawton’s 2003 suggestions that treatment for depression may also be suitable for treatment of NSSI.

After his multitude of articles published on the topic of adolescent DSH, Hawton summed up a section on psychosocial interventions by stating, “Overall, there is a shortage of information on which to base treatment recommendations for adolescents who self-harm” (Hawton, 2012). He went on to say that, “The development and assessment of new psychosocial and pharmacological interventions to reduce self-harm and suicide should be major priority, and should include internet-based interventions” (Hawton, 2012). The only light he offered is research looking at the use of DBT with clients with BPD and the need for more information concerning the efficacy of DBT with clients who exhibited NSSI but did not have other BPD symptoms.

Muehlenkamp looked at body image and its relationship to NSSI in adolescents. After determining that this was a salient factor, she speculated, “treatments that incorporate mindfulness training (e.g., DBT; Miller et al., 2007) or body acceptance methods (e.g. Walsh, 2006) may be more effective at reducing NSSI because they re-connect an individual to his or her body” (Muehlenkamp, 2012). She posited, “It is possible that this re-connection to and learned sensitivity to bodily states helps a person develop stronger body image, thereby significantly reducing the sense of bodily detachment, or objectification, required to perform NSSI” (Muehlenkamp, 2012). Her work significantly expanded on Walsh’s clinical experience with body image and NSSI. Here we see another mention of DBT, this time with a mention of the skill of mindfulness that it teaches.

Svaldi found in her clinical test with adult females that those asked to suppress their emotions when confronted with a “sadness-inducing film clip” had less of an urge to

engage in NSSI and self-punishment than those who were asked to accept their feelings (Svaldi, 2012). This type of result has been replicated by other researchers in working with adults with BPD (of which NSSI can be one feature). One aspect of DBT is acting adversely to how one feels, lending more possible support for the use of certain aspects of DBT for NSSI.

In Sweden, Andersson's research revealed that substance use along with poor self-image might be characteristic of adolescents who self-harmed. She noted that, "several treatments have shown promise, such as those focused on teaching emotion regulation, distress tolerance, interpersonal skills, and particularly the use of dialectical behavior therapy" (Andersson, 2013). She looked to Nock's 2007 work and Stanley's work, also from 2007, for this information. She also cited Jacqueline Mangnall's 2008 literature review which concluded that, "therapeutic approaches that are based on open-minded, nonjudgmental listening and on harm minimization rather than abstinence may be more effective than current treatment approaches that forbid any form of DSH" (Andersson, 2013). This sounds as if it moves toward treatment within the area of addiction, which other researchers have shown might not be the best way to conceptualize NSSI.

Bresin recommended that, "individuals who engage in NSSI who are high in negative urgency may benefit from treatment approaches designed to decrease sadness" (Bresin, 2013). He pointed to one of the modules of DBT focused on emotion regulation as a possible intervention. Bresin explained that DBT, "encourages clients to act opposite to their feelings (e.g., watch a funny movie as opposed to a sad movie when feeling sad)"

(Bresin, 2013). He went on to explain that “This type of intervention could decrease momentary sadness and thus potentially reduce the urge to engage in NSSI for individuals high in negative urgency” (Bresin, 2013). Here is more research pointing to the efficacy of a portion of DBT when used with clients experiencing NSSI. Kaess studied adverse childhood experiences (ACEs) and their relationship to NSSI. He mentioned DBT which had “been shown to be effective to enhance the ability to regulate emotions” (Kaess, 2013).

Much support for further testing of DBT as a treatment for NSSI is found in the literature. It is a very intense, and therefore, very expensive treatment. Before insurance companies would pay for this level of intervention, more empirical study must be completed. Perhaps a case could be made that the choice is between DBT and hospitalization. If so, DBT would actually become the less expensive alternative.

#### Other Interventions

In addition to PST, family therapies, group therapies, cognitive therapies, and DBT, several other interventions for NSSI have been suggested. For example, mentoring, the pairing of an adult with an adolescent, appears to offer support for those dealing with NSSI. Webb mentioned “crisis telephone help lines” and “an identified ‘parental confidant’ within the family or the school/college system” as possible ways to deal with the “adolescent’s immediate needs” (Webb, 2002). In this research, Webb introduced the ideas of hotlines and mentors in addition to TAU. Selekman offered an intervention involving “Adult inspirational others” whom Selekman had seen in other studies, “serve a major protective function for at-risk children and adolescents” (Selekman, 2009). In

addition to teachers, coaches, family members, family friends, neighbors, and community leaders, Selekman mentioned that clergy might be helpful in this capacity (Selekman, 2009). The researcher then went on to suggest practical guidelines for the aforementioned adults when coming alongside adolescents engaging in NSSI. This wisdom appears to support previous research and adds the possibility of mentoring, but again lacks empirical evidence regarding efficacy.

Having the ability to identify and express emotions may be a key to the treatment of NSSI. Spender noted that it was important to listen for the distress or other feeling that was present under the act of cutting. “Very often the young person cannot put this into words: if she could, she might not need to cut!” (Spender, 2005). This would appear to move toward helping an adolescent to increase her emotional vocabulary and assisting her to correctly interpret those emotions within herself. Van Pelt recommended that after referring an adolescent to a trained therapist, it might be possible to come alongside and “Teach students who express SIB a rich emotional vocabulary” (Van Pelt, 2005). He also suggested encouraging creative outlets such as “journaling, poetry, drawing, music, and filmmaking” (Van Pelt, 2005). In addition, youth workers could teach coping tactics, encourage students to “keep working toward the underlying causes until they’re resolved,” and be aware that the behavior sometimes recurs during times of stress (Van Pelt, 2005). This would appear to endorse Spender’s (2005) ideas, in addition to treatment of underlying causes instead of treatment of the NSSI, itself. A theme of NSSI as a symptom rather than a diagnosis appears to be emerging. Muehlenkamp supported the development of new skills in the areas of coping and distress tolerance, problem-

solving, communication, and the “identification, labelling, and verbalization of emotions,” in addition to intimacy and conflict resolution (Muehlenkamp, 2006).

Some researchers recommend emotionally based treatments. Zaki looked at NSSI in individuals with BPD and found support for further research into emotion-focused treatments. He stated that his study provided “support for the assumption that accurate emotion identification and labeling may underlie more adaptive self-regulation” (Zaki, 2013). This researcher combined acts of NSSI and urges for NSSI into one variable in order to have a large enough sample for his work. This description would fit well with the compassion-focused therapy (CFT) recommended in 2011 by Van Vliet. CFT is, “a form of cognitive behavioral therapy aimed at helping people with mental health problems that are related to shame and self-directed hostility” (Van Vliet, 2011). Van Vliet stated that, “The main goal of CFT is to change the ways individuals relate to themselves through processes that generate warmth, understanding, nonjudgment, and kindness toward the self” (Van Vliet, 2011). She characterized CFT as “a therapeutic approach that attempts to encourage self-soothing behaviors, foster self-acceptance, and help people feel connected to others,” and, as such, “CFT may be particularly well-suited to address the most common functions associated with self-injury” (Van Vliet, 2011). Van Vliet said that despite the paucity of empirical evidence surrounding treatment of NSSI, “a number of common elements for appropriate NSSI treatment can be identified” (Van Vliet, 2011). She used Heath (2008), Klonsky (2007), Gratz (2007), Nock (2006), and Laye-Gindhu (2005) to summarize the needs for improved emotion regulation, alternative strategies for coping with emotional stress, acceptance and tolerance of emotions, learning that

emotions are “transitory and not intrinsically harmful,” and “more effective ways of relating to other people” (Van Vliet, 2011). Her article went on to state that each of these needs is addressed in CFT. This intervention sounds extremely promising, but no further information about CFT and its effect on NSSI in adolescents was found. Along the similar lines as CFT, Westers did research on forgiveness and NSSI. He found that lack of self-forgiveness was associated with a greater lifetime frequency of NSSI. However, lack of forgiveness toward others had no similar association (Westers, 2012). This finding appears to lend support for the use of compassion-based therapy and DBT, however does not include any empirically tested material.

Some researchers posited that treatment for NSSI is a process, and over time, different treatments are appropriate for different phases. Bowen (2001) quoted a general framework for treatment from Rudd and Joiner (1998). This conceptualization said that regardless of the therapeutic orientation, treatment must include “crisis intervention in the form of symptom relief and crisis resolution during the beginning phase of therapy; a short-term agenda of skill development during the middle phase of therapy; and a long-term agenda of working on self-image and interpersonal functioning during the end phase of therapy” (Bowen, 2001). O’Connor found that there were several stages to an adolescent’s decision to self-harm. He suggested, “it may be important in therapy to use psychosocial interventions that differentially address the pre-motivational/motivational and the volitional phases of self-harm” (O’Connor, 2012). He suggested that CBT could be useful in, “tackling perfectionistic beliefs or brooding rumination” whereas therapy focused solely on behavior change might be used once self-harm has been enacted

(O'Connor, 2012). Although O'Connor does not use treatments with empirical evidence, it is interesting that he notes different stages when different therapies might be more effective.

One researcher looked at narrative therapy. From a study of the autobiographies of those with NSSI, Hill recommended, "conversations where difficult past events can be processed and understood within the context of a life story" (Hill, 2012). The researcher expanded on this. "These conversations should not just centre on understanding the functions of the self-harm behaviour, but also explore the underlying difficulties thus helping the adolescent to integrate and process previous traumas and understand these and other events from the broader context of a life story" (Hill, 2012). Hill advocated for more than mere skills training, but an opportunity to helpfully change and update an adolescent's narrative of her own life.

One researcher offered mentalization-based treatment for adolescents (MBT-A) as a possible therapy for NSSI. Rossouw explained, "Mentalization is the capacity to understand actions in terms of thoughts and feelings. Its enhancement is assumed to strengthen agency and self-control in those with affect dysregulation and impulse control problems" (Rossouw, 2012). Her research tested a manualized "12-month intervention program that included both individual and family therapy" (Rossouw, 2012). The results showed a 44% recovery rate of those using MBT-A against a 17% recovery rate of those receiving TAU. When interviewed by individuals who were blind to the protocol used, these rates were 57% with MBT-A and 32% with TAU. About these results, Rossouw stated, "To our knowledge, this is the first time that a treatment program specially

developed for adolescent self-harm has been shown to be significantly more effective than TAU in terms of reducing self-harm as well as depression” (Rossouw, 2012).

Rossouw also found MBT-A useful for reducing symptoms and diagnoses of BPD. The researcher did, however, note the small sample size as a limitation to the research.

Rossouw called for a randomized-controlled trial (RCT) to further test these encouraging findings. Here we add mentalization to DBT and compassion based therapy as a specific treatment showing possible increased efficacy over TAU in working with adolescents with NSSI.

One researcher tested emotion regulation training (ERT) with relation to BPD. H. Marieke Schuppert did a randomized-controlled trial with ERT. This 17-week group training for BPD (not specifically NSSI) was found to improve BPD symptoms over the period of a year. However, the statistics were not any better for ERT than for TAU (Schuppert, 2012). This makes one think that treatment must cover more than simply emotion regulation in order to be more effective than TAU for NSSI.

Some researchers have suggested the use of medication in combatting NSSI. In his 2003 article Hawton stated that “There is now some evidence for efficacy of specific selective serotonin reuptake inhibitor (SSRI) antidepressants for depression in adolescents” (Hawton, 2003). Hawton pointed out that medication had been effective in some adolescents with depression. As we have seen, Crowell (2012) cautioned against assuming that what was good for depression would also help with NSSI. Stanford did some helpful parsing in her paper, “Psychological subtyping finds pathological, impulsive, and ‘normal’ groups among adolescents who self-harm” (Stanford, 2009). For

those who were impulsive, the use of serotonin reuptake inhibitors might be efficacious (Stanford, 2009).

Some researchers have pointed out that in some ways, therapy for NSSI should mirror therapy for trauma. Kaess studied adverse childhood experiences (ACEs) and their relationship to NSSI. He noted that where trauma and PTSD symptoms were present, trauma therapy could be utilized to reduce NSSI. Here he cited Walsh's 2006 work as his source. Although Tait worked with adults in Australia, his findings may be generalizable to an adolescent population. He cautioned clinicians that "Effective therapy will require provision of a variety of adaptive strategies for clients to employ to reduce the likelihood that they will fall back upon those that are more damaging" (Tait, 2014). This was especially true since "Combating a client's self-harm behaviour may serve only to exacerbate their reliance on substance use, or using cognitive therapy to reduce ruminations may paradoxically intensify a client's drive to regulate their emotions through self-harm behaviours" (Tait, 2014). In a manner similar to trauma therapy, the client must first build adaptive coping behaviors before being asked to reduce maladaptive ones.

Researchers have also looked at how the internet might be harmful or useful in helping adolescents recover from NSSI. Kate Daine conducted such research. She concluded that "The internet may normalise self-harm, provide access to suicide content and violent imagery, and create a communication channel that can be used to bully or harass others" (Daine, 2013). However, "the internet is also used as a support network and a coping mechanism, and can connect people who are socially isolated" (Daine,

2013). She made it clear that it was not the technology that was either the problem or the panacea, but how it was put to use. This may lend more credence to the possibility of the usefulness of the internet in treatment for NSSI, although clearly the research is mixed.

Other interventions we have explored include mentoring, increasing emotional vocabulary, Compassion Focused Therapy (CFT), different approaches for different stages of therapy, narrative therapy, Mentalization-Based Treatment for Adolescents (MBT-A), Emotion Regulation Training for Adolescents (ERT), the use of medications, and trauma therapy. However, many if not most, researchers note that no one therapy will be effective with the entire NSSI population. The next section will show that just as the antecedents of self-harm behavior are varied, so must its treatment be.

#### Treatment Varies by Individual

It appears that there is no one “right” treatment for NSSI. Research increasingly points to the idea that NSSI is not a diagnosis, but a symptom. As such, it is the underlying issues that require treatment, and these vary from individual to individual. Nock and Prinstein noted that the functions of adolescent self-mutilative behavior (SMB) vary. For this reason, so should treatments. “Researchers and clinicians who develop and evaluate such treatments should consider the different antecedents, correlates, and consequences associated with each function and tailor treatments accordingly, rather than by using a one-size-fits-all approach to the treatment of SMB” (Nock, 2005). As we look for an intervention that is more effective than TAU, we must keep this assertion in mind. Perhaps there will be no one silver bullet, but many different resources available for the treatment of NSSI that has diverse roots in the adolescents who come for treatment. Like

Nock, Skegg noted that “The goal of one treatment for all—or even one treatment for all repeaters—was probably never realistic” (Skegg, 2005). Again, we hear skepticism that any one treatment can be prescribed for NSSI in adolescents. Muehlenkamp agreed with Nock (2005) and Skegg (2005) that “individuals who engage in NSSI are highly heterogeneous, so creating a standardized treatment that is effective for all will be difficult” (Muehlenkamp, 2006). Muehlenkamp also comes to the conclusion that treatment for NSSI must deal with the causes rather than the act of NSSI behavior itself.

As a growing number of researchers do, Lloyd-Richardson stated that, “understanding the specific motivations behind and individual’s NSSI may allow for the development of an informed treatment plan that may comprise a variety of psychotherapeutic options (from medication to skills training)...” (Lloyd-Richardson, 2007). In his study of personality traits and NSSI, Seth Brown suggested possible interventions based on the personality traits those with NSSI had in common. First, for those showing high neuroticism, he recommended emotion regulation and distress tolerance skills. For those with low agreeableness, Brown suggested conflict resolution, social skills, and problem solving training. In the case of clients with low conscientiousness, organization and impulse control strategies could be offered. Finally, “for those with high openness to experience, attempts to facilitate individuals to channel their curiosity and imagination into more proactive avenues may curb DSH” (S. Brown, 2009). It is interesting to reflect here on Nock’s work which was able to isolate a specific part of problem solving that was difficult for individuals engaging in NSSI. This researcher’s work makes one wonder if it is the function of NSSI that must be teased out

in order to establish an appropriate treatment regimen, or if it is qualities evident within an individual's personality upon which treatment should be based.

Klonsky agreed with earlier researchers that “therapists should assess the functions of their patients’ self-injury and use the results to inform case conceptualization and treatment planning” (Klonsky, 2009). He also suggested that, “Supplementary interventions that specifically help patients manage negative affective arousal, such as relaxation training and progressive muscle relaxation, may also help patients avoid self-injury” (Klonsky, 2009). Here we see relaxation and self-soothing techniques helpfully entering the realm of psychoeducation for those dealing with NSSI.

Prymachuk looked at the breadth of treatments employed in the UK to help adolescents with NSSI. He remarked, “Rarely is an evidence base the driving force behind the particular therapies on offer; more often than not, it is the individual theoretical and philosophical preferences of the clinician” (Prymachuk, 2010). In a nutshell, that is what I am finding. Rather than search for empirically tested treatments (which may be an undertaking doomed to failure before it commences), clinicians use whatever methods they have at their disposal in an attempt to be helpful to young people engaging in NSSI. Prymachuk concluded, “no one therapy or treatment modality seems to have an advantage” (Prymachuk, 2010). He wondered, “Maybe our notion of self-harm is too nebulous: perhaps we should be exploring the different dimensions of self-harm (such as self cutting vs. self poisoning, single attempt vs. repeated attempts, minor vs. severe cutting) in order to ascertain whether specific treatment modalities are suitable

for specific aspects of self-harm” (Prymachuk, 2010). Or, perhaps it is the function of the act that should be in question.

In the United Kingdom, Cottrell made an excellent point about looking for empirical evidence of effective treatments for NSSI.

The expectation that a high quality randomized trial will have a standardised and manualised intervention may, however, reduce therapist flexibility and therefore effectiveness when faced with a very heterogeneous condition. Self-harm is, after all, a behaviour not a diagnosis and treatment as usual may be particularly effective when dealing with a variety of underlying causes presenting through the final common pathway of self-harm (Cottrell, 2013).

It is helpful to note the need for the clinician to be flexible when working on a treatment plan with an adolescent experiencing NSSI.

With regard to treatment, what has been discerned from the research is that there are four types of therapy that show possible advantage over TAU. These include DBT, CBT, mentalization, and compassion-focused therapy. Empirical work will need to be completed before benefits over TAU can be clearly determined. But, perhaps the greater learning is that there will probably be no one treatment that will be effective for every client. The cause or function of the NSSI must be assessed and treated.

In this chapter, we have used the lens of the researcher to investigate the reasons for and possible functions of NSSI, general treatment guidelines and the possibility of specific treatments for NSSI. We have concluded that NSSI is a symptom rather than a

diagnosis, and as such, one must look for the underlying issues. It is to these issues that treatment should be addressed rather than the behavior of cutting, itself. In the next chapter, we will review this material using the lens of the clinician working with adolescents engaged in NSSI.

PART II  
A HANDBOOK FOR CLINICIANS

This section of the work is designed to assist clinicians who may be working with clients dealing with NSSI. Details on a variety of internal risk factors, external risk factors, triggers, reasons and functions, and treatment of NSSI will be discussed. The second chapter in Part II is intended as a resource for clinicians who may not be familiar with evangelical Christian culture. When treating a client who is involved in this spiritual tradition, the therapist may be helped by knowing some of the natural supports that are commonly available within evangelical Christian contexts. I will note here that it may be helpful for clinicians to take at least a cursory glance at Part I after reading the following section as an introduction. Part I shows, in greater detail, the complexity, ambiguity, and deliberate caution needed when treating an adolescent who cuts.

## CHAPTER ONE

### RISK FACTORS, REASONS, AND TREATMENTS

In this second part, we will switch from the eye of the researcher, which was discussed in detail in Part I, to looking at NSSI from the perspective of a therapist working with clients exhibiting this behavior, or attempting to determine whether or not NSSI is a part of a client's story. We will explore, in turn, internal risk factors, external risk factors, triggers, reasons/functions, and treatment.

#### **Internal Risk Factors**

When evaluating adolescent clients and helping to build up protective factors, it is important to look at internal risk factors for NSSI. Research shows that some of the internal risk factors for NSSI include: emotion regulation, depression and anxiety, borderline personality disorder features, higher suicidal ideation, negative body image, self-blame, self-hatred, and previous psychological treatment. We will look at each of these from current research.

#### Emotion Regulation

The most common element discovered in the literature that increases the likelihood of NSSI is emotion regulation, also called affective instability in relation to the DSM-IV diagnosis of Borderline Personality Disorder (discussed below). Difficulty with affect regulation was identified as a common characteristic among those with NSSI by Klonsky (2003), Laye-Gindhu (2005), Nock (2005), Townsend (2006), Lloyd-Richardson (2007) based on Nock and Prinstein's 2004 research, Heath (2008), Nock (2008),

Klonsky (2009), Newman (2009), Claes (2010), Hawton (2010), Baetens (2011), Jutengren (2011), Crowell (2012), Franklin (2012), Gregory (2012), Duggan (2013), Kaess (2013), and Straiton (2013). Hasking (2010) was a lone voice stating that emotion regulation is not related to NSSI.

### Depression and Anxiety

Many researchers have studied populations who experience NSSI and compared them to populations who do not experience NSSI. One difference that many researchers found was that those who participated in NSSI had more depressive symptoms than those who did not (Ferrance, 1975; Kahan & Pattison, 1984; Harrington, 2001; Webb, 2002; Gladstone, 2004; Laye-Gindhu, 2005; Nixon, 2008; Csorba, 2009; O'Connor, 2010; Hankin, 2011; Madge, 2011; You, 2012; Lereya, 2013; Loh, 2013; Tait, 2014). Csorba (2009) mentioned dysthymia, which could be defined as a low-level depression. Straiton listed low mood as a possible risk factor for NSSI (Straiton, 2013). Asarnow (2011) stated that the likelihood of NSSI increased when recovery from depression took longer.

A feeling of hopelessness was discussed by House (1999), Webb (2002), and Skegg (2005). Crowell (2012) noted that the level of hopelessness was higher in those with NSSI than those with depression without NSSI. Taliaferro (2012) stated that on a continuum of hopelessness NSSI was high and only those who had attempted suicide scored higher. Nock mentioned anhedonia (Nock, 2005) which is a lack of pleasure. Loh (2013) noted not only a loss of pleasure, but also lack of energy and poor concentration, other symptoms of depression according to the DSM IV.

Evidence of higher anxiety was found by Klonsky (2003), Lloyd-Richardson (2007), Csorba (2009), Klonsky (2009), Claes (2010), and Madge (2011).

Crowell (2012) was careful to note that depression might be a part of what put adolescents at risk, but the symptomatology found in those with NSSI was wider and included many things that would be diagnosed as Borderline Personality Disorder (BPD) in adults, a diagnosis traditionally not given to children or adolescents. Glenn (2011) reported that BPD features and the number of different methods used for NSSI were the only predictors of future NSSI.

#### Borderline Personality Disorder Features

Other researchers who found BPD symptoms included Klonsky (2003), and Gladstone (2004), who mentioned “personality dysfunction.” In fact Jacobson (2008) found that the psychological diagnosis most prevalent among those with NSSI was BPD. Jacobson stated that, “Symptoms of BPD include difficulty regulating anger, chronic feelings of emptiness, impulsivity, unstable relationships, affective instability, and efforts to avoid abandonment (American Psychological Association, 1994)” (Jacobson, 2008).

Some researchers noted the presence of some of these symptoms without diagnosing it as BPD. Laye-Gindhu (2005), Skegg (2005), Van Pelt (2005), Csorba (2009), Newman (2009), Claes (2010), Amey (2011), and Straiton (2013), talked about difficulty regulating anger or rage.

Feelings of emptiness were noted by Brent (1997), Nock (2005), Van Pelt (2005), Townsend (2006), and, “feel nothing” by Newman (2009), Klonsky (2009), Westers (2012), and Kaess (2013). These feelings of emptiness were often accompanied by

dissociation (Brent, 1997; Nock, 2005; Skegg, 2005; Newman, 2009; Gregory, 2012; Westers, 2012; Andersson, 2013; Hamza, 2013; Kaess, 2013).

Impulsivity was a factor that got mixed reviews from researchers with Bowen (2001), Webb (2002), Skegg (2005), Nixon (2008), Hawton (2010), Madge (2011), Crowell (2012), and You (2012) finding this in those with NSSI and Amey (2011) disagreeing and stating that impulsivity was not characteristic of those with NSSI. Amey's 2011 study showed that the emotions preceding NSSI were present up to eight hours prior to action. Janis (2009) noted that although those he worked with who experienced NSSI described themselves as impulsive, they did not test as such when he worked with them in a laboratory setting. Bresin (2013) wondered about this split and posited that perhaps the impulsivity was only present in sadness in those with NSSI. Dougherty (2009) added that those who had attempted suicide had a higher measure of impulsivity than those with NSSI.

With regard to unstable relationships, this characteristic was pointed out by Ferrence (1975), Morgan (1975), Kahan & Patison (1984), Hawton (1996), Brent (1997), Bowen (2001), Harrington (2001), Webb (2002), Klonsky (2003), Hankin (2011), Pluck (2013), and Straiton (2013).

Affective instability was identified as a common characteristic among those with NSSI by Klonsky (2003), Laye-Gindhu (2005), Nock (2005), Townsend (2006), Lloyd-Richardson (2007) based on Nock and Prinstein's 2004 research, Heath (2008), Nock (2008), Klonsky (2009), Newman (2009), Claes (2010), Hawton (2010), Baetens (2011), Jutengren (2011), Crowell (2012), Franklin (2012), Gregory (2012), Duggan (2013),

Kaess (2013), and Straiton (2013). Hasking (2010) was a lone voice stating that emotion regulation was not related to NSSI.

The final aspect of Borderline Personality Disorder to discuss is “efforts to avoid abandonment” (American Psychological Association, 1994). Bowen (2001) mentioned social isolation or rejection in relationship to NSSI. Klonsky (2003) noted a “heightened sensitivity to interpersonal rejection” as a characteristic of those with NSSI. Skegg (2005) specifically mentioned fear of abandonment. Amey spoke of “feeling rejected” (Amey, 2011). With so many factors matching those that accompany a diagnosis of BPD in adults, one wonders if it would be helpful to extend this diagnosis to adolescents so that it could be useful in treatment of those with NSSI.

#### Higher Suicidal Ideation

As discussed previously under Definition, although NSSI is not a suicide attempt, this population has been found to have more suicidal ideation than those who do not struggle with NSSI (Kahan & Pattison, 1984; House, 1999; Crowell, 2012; Loh, 2013). When Hawton compared those who cut with those who poisoned themselves, he found that fewer cutters intended to die than those who poisoned themselves (Hawton, 2010). This author believes this is another reason that self-poisoning should not be considered in the same category as cutting since the intent of the actions is different. Taliaferro (2012) noted that those with NSSI have a high degree of hopelessness, but those with the highest degree of hopelessness were those who attempted suicide.

## Negative Body Image

Issues of body image are also common among those with NSSI. Bowen (2001) mentioned “body alienation.” Bruner talked about body image and other psychological factors (Bruner, 2007). Newman (2009) pointed out “hating the body.” In 2012, Muehlekamp made the interesting observation that body image mediated both negative affect and NSSI in teenagers. One wonders if the characteristic of body image explains why some who have many risk factors for NSSI cut and others do not. Duggan (2013) worked from a different angle and found that emotion dysregulation was the mechanism through which body image influenced NSSI.

## Self-Blame

Another characteristic that researchers have found in common among those who cut is that of self-blame. Ferrance (1975) mentioned having strict values and a sense of internalized rejection. Webb (2002) talked about the presence of self-blame. Skegg (2005) talked about guilt as a trigger for NSSI as well as rage directed toward the self. Spender (2005) spoke of a need to punish oneself. Townsend related that those with NSSI often felt they deserved to be punished (Townsend, 2006). Glassman noted that a self-critical cognitive style could lead one to self-punishment through NSSI when triggered (Glassman, 2007). Wedig (2007) concurred that a self-critical cognitive style, especially when combined with high parental criticism, could often be found in those with NSSI. Self-punishment was a factor that Scoliers (2009) and Claes (2010) found in common, as did Hawton (2010). Amey (2011) spoke of self-directed anger. Swanell (2012) noted that self-blame mediated the connection between negative events in childhood (to be

discussed later) and NSSI. Westers (2012) noted a lack of self-forgiveness as common in those with NSSI. Scoring highly in being self-indicting/ oppressing and low in the area of self-accepting/exploring was common among those with NSSI according to Andersson's 2013 research. Hamza (2013) saw self-punishment as one of three major reasons for NSSI. Kaess (2013) concurred and related self-punishment to guilt, shame, and self-criticism. Interestingly, Christian (2011) stated that self-blame does not result in NSSI.

### Self-Hatred

Those participating in NSSI have also been found to have a higher level of self-hate. Skegg (2005) talked about having rage toward the self. Claes mentioned having a negative self-concept (Claes, 2010b). Self-hatred is mentioned by Amey in 2011. Andersson (2013) talked about the personality of a young person participating in NSSI as being high in "self-rejecting and destroying."

### Previous Psychological Treatment

Ferrance (1975) noted that prior involvement in psychiatric care was a characteristic more common in those with NSSI than in those without. House (1999) noted this as well, and amplified it to include especially in-patient treatment. It is interesting that previous treatment is not mentioned by any more recent researchers. One wonders if NSSI has become more mainstream or if the conditions under which such research was conducted have changed.

These are the factors that a clinician should look for in the mind and personality of a client who may be struggling with NSSI. Next we will explore external risk factors.

## **External Risk Factors**

There are also forces from the outside that can push clients toward NSSI. These include: lack of social supports or social isolation, school stress and bullying, parenting or family issues, childhood trauma, lower social and/or economic status, and substance use. Each will be discussed below.

### **Lack of Social Supports or Social Isolation**

Kahan and Pattison (1984) pointed to a disruption in or lack of social support systems as predisposing some to NSSI. Hawton added that relationships with parents and friends in addition to social isolation could trigger NSSI. Bowen identified among possible precipitating events social isolation (Bowen, 2001). Laye-Gindhu mentioned loneliness as an emotion that could become overwhelming, enticing young women to cut. Van Pelt (2005) talked about isolation as a possible contributing factor. Christian found an increase in NSSI among those who chose to cope by self-isolating (Christian, 2011). Straiton (2013) also mentioned that a trigger could be a “period of social isolation.”

Klonsky differed from other findings when he stated that NSSI was less likely in states of low negative arousal (including loneliness, sadness, and emptiness) than in states of high negative arousal such as frustrated, anxious or overwhelmed (Klonsky, 2009). Amey agreed with Klonsky with regard to states of sadness.

### **School Stress and Bullying**

School stress was mentioned as a risk factor by Hawton (1996) as “problems with school work,” and Webb (2002) as “pressure from school.” Hawton (2003) did an interesting study on days of the week when students went to the Emergency Room for

NSSI. During the school term, the number of students reporting on Mondays greatly outpaced the number of students reporting on Saturdays. When school was not in session, this was not the case. I found this to be true on a recent Monday morning when I tried to send an adolescent client of mine to be evaluated by Emergency Services. I was told they were totally overwhelmed with teens and that it was especially difficult since it was the Monday after a week of vacation from school.

Buresova found an increased negative attitude toward school (Buresova, 2013). This became particularly problematic when the grades a student received did not match his/her expectations. Bullying was discussed by Harrington (2001), Hay (2010), Jutengren (2011), Lereya (2013), and Straiton (2013) as having a direct correlation to NSSI. Noble found that students with lower trust in school officials and lower feelings of safety at school were more likely to become involved in NSSI (Noble, 2011). The population Noble isolated may be the prime targets of bullying.

#### Parenting or Family Issues

Hawton (1996) pointed to a breakdown in the relationship with parents as a possible trigger to NSSI. An association between poor parent and adolescent communication and NSSI was shown by Tulloch (1997). Bowen (2001) gave “conflict with family” as an example of a precipitating event. She also stated that loss of a parent was a risk factor for NSSI. Harrington saw arguments with parents and other family problems as stressful life issues that could trigger NSSI. This researcher also noted that a history of poor family communication could also be correlated with NSSI in adolescence (Harrington, 2001). Webb got more specific and said that poor family communication

and having no parental confidante could be correlated to NSSI (Webb, 2002). Sourander pointed to having a “broken family,” a mother with mental health problems or a mother or father with unsatisfactory well-being as being a risk factor for NSSI (Sourander, 2006). Wedig discussed the perils of high parental criticism when an adolescent maintained a self-critical attitude (Wedig, 2007). Hilt did a study in 2008 where she found that after an incident of NSSI, adolescents experienced improved relationships with their fathers. She pondered how that might reinforce the behavior. In 2010, when Hawton compared those who cut with those who poisoned themselves, he found that those who cut more frequently witnessed parental arguments. Novara’s research revealed that those with NSSI had parents who were more frequently punishing, rejecting, held “oppressive attitudes,” and were lacking in support for their children (Novara, 2010). Hankin discovered that a higher percentage of those with NSSI had mothers who experienced depression. The same was not found for fathers (Hankin, 2011). Jutengren (2011) found that harsh parenting was correlated to NSSI in girls, but not in boys. You pointed to family invalidation and showed a correlation with NSSI a year later (You, 2012). In 2013, Buresova found that those with lower quality relationships with parents had a higher likelihood of NSSI. In a study of how young people spend their time, this researcher found that high occurrence self-harmers (those who injured themselves more than five times) spent more time with peers (an extra five hours weekly), more time at sports clubs (one hour weekly), and two hours more “doing nothing” than their non-self-harming peers (Buresova, 2013). Lereya (2013) showed that domestic violence and maladaptive parenting was more common in adolescents who dealt with NSSI. Pluck

discovered a majority of those who self-harmed did not live with both biological parents and that “conflict with parents” was often given as a reason for NSSI (Pluck, 2013).

Pluck also traced family histories of NSSI, depression, substance use, mental illness and abuse (Pluck, 2013). Straiton (2013) mentioned “family problems” as a risk factor for NSSI.

### Childhood Trauma

Early research on NSSI appeared to link it directly to trauma. However, more recent research has questioned the connection. In 1997, Brent said that those with NSSI had a higher likelihood of a history of physical and sexual abuse and emotional neglect. Wiederman found NSSI was more common in those who had a childhood history of physical or sexual abuse or being a witness to violence (Wiederman, 1999). Bowen also mentioned a history of physical or sexual abuse. In addition, she added the traumas of childhood illness, and NSSI within the family, but pointed out that the trauma most highly correlated with NSSI was that of marital violence (Bowen, 2001). Harrington spoke of a history of abuse in general and knowing someone who had NSSI (Harrington, 2001). In 2004, Gladstone also wrote about a possible connection with childhood sexual abuse. Van Pelt talked about being victimized but unable to talk about the pain, in his 2005 research. Goldston looked at brain chemistry and noted changes similar to those that resulted from a history of trauma (Goldston, 2006). Townsend offered the possibility that NSSI was used by people reenacting abuse or trauma as they tried to resolve it (Townsend, 2006). Glassman looked at childhood trauma more specifically and found that not all childhood maltreatment ended up with the same likelihood of NSSI resulting.

He found that sexual abuse, physical neglect, and childhood emotional abuse were the traumas most highly correlated (Glassman, 2007). In particular, childhood emotional abuse might result in a self-critical cognitive style, which could lead an adolescent to resort to self-punishment (Glassman, 2007).

Madge (2011) studied those who acted on NSSI opposed to those who only thought about it. She found that those who acted had a higher instance of physical and sexual abuse, had experienced the NSSI or suicide of others, were more impulsive, and more frequently had worries about their sexual orientation (Madge, 2011). O'Connor also studied thinkers versus actors and found that the key difference between the two groups was that those who acted on NSSI knew someone with NSSI. This study lends support (as does Madge's) to a theory of contagion (O'Connor, 2012). Gregory talked about a group of those with NSSI using it as a way to deal with a history of trauma or loss (Gregory, 2012). Swannell determined that childhood physical abuse and neglect increased the risk for NSSI, while sexual abuse did not (Swannell, 2012). Kaess looked at childhood factors and found that antipathy from the mother or father, neglect or physical abuse from the mother, and sexual abuse all increased the possibility of NSSI in an adolescent (Kaess, 2013). Finally Tait (2014) mentioned the increase in risk as a result of sexual abuse and other trauma.

Heath, on the other hand, found no link to childhood trauma (Heath, 2007). She stated that NSSI was directly linked to "emotion dysregulation" (Heath, 2007).

### Lower Social and/or Economic Status

Ferrance (1975) posited that if society did not reward an individual with a higher social status, that individual was more likely to be involved in NSSI than someone who gained this. House (1999) stated that low social class was one predictor of repeated NSSI. Csorba's (2009) interviews revealed that social factors of loss and failure were important contributors in the minds of study subjects. In 2012, Taliaferro also mentioned the presence of lower socio-economic status (SES) among those with NSSI. Pluck (2013) found a higher ratio of adolescents who repeated NSSI among those who lived in residential care, in a youth hostel, and who were homeless—all positions of lower SES.

### Substance Use

Ferrance found a higher use of alcohol among those with NSSI (Ferrance, 1975). Kahan & Pattison mentioned drugs and alcohol in their 1984 research, as did House in 1999, and Gladstone in 2004. MacLaren (2010) found a higher likelihood of potentially addictive behaviors including drugs and alcohol, but also gambling and eating disorders were more likely in the NSSI group. In 2012, Stuart Brody did a study that found the use of immature defense mechanisms was more important than substance use as a predictor of NSSI. Brody suggested that researchers steer more toward internal than external risk factors. Crowell (2012) found a higher use of tobacco among those with NSSI. Victor (2012) took on the question of whether or not NSSI should be seen through an addiction model. She concluded that since NSSI was only negatively reinforced, and other addictions were reinforced both negatively and positively, it was better to see NSSI as an emotion regulation problem and not an addiction issue. Pluck found that a family history

of substance use was more common among those with NSSI (Pluck, 2012). Straiton (2013) mentioned “intoxication” as a possible trigger for NSSI. Tait (2013) showed that women often chose more passive methods of coping, while substance use was a more active coping method.

Although a causal link between external risk factors and NSSI cannot be drawn, there is a definite correlation between the previous outside influences and NSSI.

### **Triggers**

As for the question of what can trigger an episode of NSSI, there are many possibilities. Morgan (1975) stated that relational factors influenced 51% of such events. Hawton (1996) also pointed to relationship issues with parents and friends, and added social isolation and problems with school work as possible triggering events. Bowen stated that there was always an identifiable precipitating event that had direct impact on identity, sense of autonomy, or independence. She gave the examples of conflict with family or peer group, peer group status change, social isolation, or rejection (Bowen, 2001). She also mentioned “recent loss, peer conflict, intimacy problems, body alienation, and impulse disorder” (Bowen, 2011).

Harrington saw NSSI triggered by stressful life problems such as arguments with parents or other family problems, rejection by a boyfriend or girlfriend, or school problems like bullying (Harrington, 2001). Webb stated that personal worries like pressure from school or relationships could be a precipitant of NSSI (Webb, 2002). Hawton agreed with Webb’s analysis and pointed to school stress as a huge trigger (Hawton, 2003).

Klonsky takes us back to the relational when he talked about those with NSSI having a “heightened sensitivity to interpersonal rejection” (Klonsky, 2003). Nock (2005) talked about “feelings of emptiness, detachment, anhedonia, and a restricted range of affect.” Skegg provided a laundry list of triggers: raged toward others or the self, feelings of abandonment, guilt, desperation, ambivalence, poor problem-solving, impaired decision-making, impulsivity, inflexible thinking, hopelessness, reluctance to self-disclose, lack of positive future-directed thinking, difficulties with autobiographical memory (overly general rather than specific), neuroticism, novelty-seeking, and dissociation (Skegg, 2005).

Wedig (2007) talked about a self-critical adolescent coming into contact with high parental criticism. Sim’s 2009 research showed that adolescent females in an invalidating environment who had difficulty identifying and expressing negative emotions were likely to be triggered to participate in NSSI while boys in similar situations were not. NSSI as a response to bullying was the focus of Hay’s research in 2010. Amey pointed to angry or hostile feelings such as “self or other directed anger, self-hatred, feeling rejected, but not sadness as possible triggers for acts of NSSI (Amey, 2011). A long recovery from depression could trigger NSSI (Asarnow, 2011). Peer victimization of either gender and harsh parenting of girls was found by Jutengren (2011) to be triggering. Lewis (2011) mentioned the possibility of being triggered by internet content on cutting. Pluck (2013) takes us back to relational factors when stating that conflict with parents was the most frequently given triggering event for NSSI.

Although many different triggers are mentioned in the research, the relational issues appear to be the most salient. Difficulties within families, with a boyfriend, or even within a peer group appear to be triggering events for NSSI.

### **Reasons/Functions**

It is very important for clinicians to understand as much as possible about the reasons for and the functions of NSSI within an individual as they create an appropriate treatment plan. There are many antecedents of NSSI, but we will look at the major ones here. Brent captured the most widely stated reason or function in his statement that the goal of NSSI was, “to relieve tension precipitated by interpersonal crisis” (Brent, 1997). Bowen said that NSSI was a maladaptive attempt at self-help or a morbid form of coping. It had the effect of releasing tension, allowing one to acquire control, reconfirming the presence of ones’ body, and dulling the feelings and converting unbearable emotional pain into manageable physical pain. Klonsky (2003) noted that NSSI reduced anxiety. Gladstone said that it was a way to short-circuit by diverting painful emotions (Gladstone, 2004). Laye-Gindhu noted that it was an effective strategy to regulate chiefly negative affect that became overwhelming to the individual. She stressed that it was not about manipulation or attention-seeking (Laye-Gindhu, 2005).

Spender stated that the function of NSSI was to punish the self, get relief from a terrible state of mind, communicate to self and/or others, and manage difficult feelings (Spender, 2005). Van Pelt (2005) said it was a means to keep from killing oneself, to express interior pain, and to contextualize and manage fear, rage, emptiness, isolation, and sorrow (Van Pelt, 2005). Townsend echoed much of this when he said that the pain

made one feel alive when one felt nothing, that it was an outward expression of inward pain, that many felt they deserved to be punished, that they might be reenacting abuse or trauma in an effort to resolve it and that they might be trying to replace bad feelings with good feelings (Townsend, 2006).

Lloyd-Richardson made the point (following Nock and Prinstein, 2004) that NSSI could reduce tension, create a more desirable state, alter the environment, get a reaction from someone, get control of a situation, and stop bad feelings (Lloyd-Richardson, 2007). Csorba said it was a way to release anger and social factors like loss and failure (Csorba, 2009). Klonsky (2009) stated that NSSI could be used to relieve high arousal negative affect states like frustrated, anxious, and overwhelmed. It resulted in increased low arousal positive affect states like calm, relaxed, and relieved. Although other researchers had found that NSSI is more common among those feeling sad, lonely and empty, Klonsky stated that these low arousal negative affect states are not as likely to be dealt with through NSSI (Klonsky, 2009). For instance, Newman (2009) said that NSSI could be used to relieve feeling numb or empty in addition to stopping bad feelings, communicating desperation, gaining control and coping, quelling rage, hating the body, and communicating how badly one feels.

Scoliers saw both an external and an internal function of NSSI. Externally he called it “a cry for help” and internally he named it “a cry of pain” (Scoliers, 2009). His research showed that the latter was the more frequent function, and that it was used to relieve a terrible state of mind and punish the self (Scoliers, 2009). Claes (2010) also noted the self-punishment function along with avoiding or suppressing negative feelings.

He found that after an act of NSSI, the sense of relief increased and the feelings of anger and anxiety decreased (Claes, 2010). Hasking noted that in addition to its use for emotion regulation, NSSI was also related to coping (Hasking, 2010). Hawton (2010) echoed the emotion regulation and self-punishment purposes of NSSI. Sarno found that even if those with NSSI knew adaptive coping tools they still chose maladaptive ones (Sarno, 2010). Nock had seen this same propensity in his 2008 research and suggested that some way be sought to slow down the process of choosing a way to cope.

Gregory (2012) found three groups. A high functioning, verbal group cut because others did and for pleasure. A low functioning group cut to cope with negative emotions. A second low functioning group, this one with a history of trauma and/or loss and suicidality cut to relieve dissociation (Gregory, 2012). Westers agreed that some used NSSI to relieve feelings of numbness or emptiness (feelings that come with dissociation), and added that NSSI could also be used to rid oneself of unwanted feelings (Westers, 2012). Hamza (2013) also agreed that NSSI could function as an anti-dissociative. She added that it could be used as self-punishment or to exert “interpersonal influence” (Hamza, 2013).

Kaess also saw three functions for NSSI: to relieve the numbness or emptiness of dissociation, for affect regulation, and as self-punishment in response to guilt, shame, and self-criticism (Kaess, 2013). This final list sums up the most frequently observed reasons for NSSI. It is, however, important to keep in mind what Scourfield wrote in 2011. NSSI means different things to different people (Scourfield, 2011). For this reason, each person

must be viewed in her own context, not only in regard to risk factors and reasons, but most importantly with regard to treatment.

We have listed many different reasons for and functions of NSSI. Among these are to: deal with an interpersonal crisis, cope with stressful life events, decrease anxiety, divert painful emotions, punish the self, preserve life, manage negative affect, feel alive, communicate desperation, and deal with trauma. However, clinicians are cautioned to see each client in her own context and determine how NSSI is functioning within her unique life story.

### **Treatment**

Many different treatments have been proposed for NSSI. Perhaps the most important thing to remember about the treatment of NSSI is that there is no one appropriate treatment. Cottrell (2013) pointed out that NSSI is a behavior, not a diagnosis, as was affirmed in the publication of the *DSM 5* in 2013. It is a “heterogeneous condition” and has a variety of underlying causes. Those causes are the issues that need to be addressed in the life of an adolescent female (Cottrell, 2013). Baker (2012) reminded the reader that one size does not fit all when it comes to treatment for NSSI. Prymachuk (2010) instructed clinicians to be alert to the different dimensions of NSSI. Is it cutting or poisoning? Single incident or repeated? Minor or severe? These are the sorts of inquiries that will determine treatment (Prymachuk, 2010). In 2005, Matthew Nock said that since the functions of NSSI vary, so should the treatments. He stated, “Researchers and clinicians who develop and evaluate treatments should consider the different antecedents, correlates, and consequences associated with each function and

tailor treatments accordingly, rather than by using a one-size-fits-all approach to the treatment of SMB” (Nock, 2005). Skegg agreed that looking for a single treatment for NSSI was not realistic (Skegg, 2005) as did Muehlenkamp (2006). One thing all could agree on was stated by Ystgaard, and that was that all NSSI, no matter what its dimensions, should be taken seriously (Ystgaard, 2009). We will look at several important aspects of treatment, including: suicidality, assessment, specific therapies, and general treatment guidelines.

### Suicidality

A primary concern for all clinicians needs to be the increased rate of suicidal ideation (SI) and suicide attempts (SA) among those with NSSI over the general population. Researchers have provided some helpful clues in ascertaining the level of suicidality in a client with NSSI. Glenn pointed out that where the NSSI takes place is telling. If an adolescent participates in NSSI only in isolation, SI is usually present (Glenn, 2009). Claes added that a young woman’s attitude toward life and the future were, “important clinical makers to assess SI” (Claes, 2010). Skegg (2005) made the very practical suggestion that medications should not be prescribed in amounts that could cause death through overdose. Nock (2006) went so far as to say that although they are different, NSSI and SI co-occur often enough that any adolescent who presents with SI should be screened for NSSI. Likewise, any adolescent who presents with NSSI should be screened for SI (Nock, 2006). These very practical ideas can be a part of every screening process.

## Assessment

The research shows that how an assessment is done can result in different levels of client engagement. Since assessment can have such an important effect on the course of treatment, we discuss it here. With regard to diagnosing NSSI, Hawton stated that according to the official guidelines of the Royal College of Psychiatrists, a full psychological assessment was the most important thing that would lead to good treatment (Hawton, 1996). In her 2008 article, Heath called for the assessment of a one-time incident versus repeated NSSI. She stated that there was a big difference between these, a point that Prymachuk also made in his 2006 article. Heath also did away with the myth that all those who engage in NSSI were exposed to early childhood abuse (Heath, 2008). The clinician must not make assumptions, but must probe for the causes which might be different in each client. Klonsky agreed that in order to determine appropriate treatment, a clinician must find what function the NSSI was serving for an individual adolescent (Klonsky, 2009). Also in 2009, Stanford called for screening of mood and self-esteem issues, as well as coping strategies and impulsivity. She pointed out that the greater the pathology, the more intensive the therapy required to treat the underlying causes of NSSI. Madge added an interesting study to assessment for NSSI. She was able to show that those who thought about NSSI but did not go through with it were very similar to those who participated in NSSI once (Madge 2011). This suggests that in assessment the question “When was the last time you thought about hurting yourself?” should be asked in addition to “When was the last time you cut, burned, tried to choke yourself or interfered with wound healing?” Madge also reminded clinicians that NSSI might be

present in an adolescent without depression or any other diagnosable mental illness (Madge, 2011). Wong's studies showed that adolescents with sleep problems were more likely to deal with NSSI, SI, and SA. If an adolescent has had any sleeping issues, questions about all of the above should be asked (Wong, 2011). As could be expected from the importance of finding underlying factors, Kapur (2013) stated that good assessment is the key to a positive outcome. Ougrin (2013) was also able to determine that "careful, specific assessment can keep clients engaged in therapy" better than when a more generic diagnostic is applied (Ougrin, 2013).

#### Specific Therapies

Some researchers have tested individual therapeutic approaches to NSSI with very different levels of success. As far back as 1975, Ferrence suggested that having crisis services available 24 hours a day, 7 days a week that did not require someone to go to the Emergency Room (ER) would reduce the risk of further NSSI (Ferrence, 1975). In 1999, House stated that up to the time of his writing, no specific treatment had been shown to be both effective and reproducible. He mentioned the promise of interventions such as giving a Crisis Card (which would allow a client to be fast-tracked for services), Problem-Solving Therapy (PST) (a short, 6 session skills-based intervention), and Dialectical Behavior Therapy (DBT) which was originally designed for people with Borderline Personality Disorder (BPD) (House, 1999). In 2001, Bowen echoed House's thoughts about PST and DBT. That same year, Harrington wrote that all methods proposed to date had failed to make any difference in outcome. He specifically mentioned

that the Crisis Card and PST (at least with adults) made no difference over treatment as usual.

The following year, Miller suggested applying DBT with a family component because it was useful with suicidal clients (Miller, 2002). During that year, Webb again brought up the idea of the Crisis Card, though during the previous year Harrington had shown it was not effective (Webb, 2002). In 2003, Hawton proposed PST and CBT stating that PST was effective with adults (in conflict with Harrington's work), and CBT was effective with depression in adolescents. Hawton also stated that selective-serotonin reuptake inhibitors (SSRIs), medications often prescribed for depression, and group therapy were under investigation for their possible therapeutic effect on NSSI (Hawton, 2003). Gladstone (2004) stated that groups for adults dealing with themes of guilt, isolation, and secrecy were helpful, just as they were for depression, childhood sexual abuse and SA.

The following year, Burns affirmed that the only treatment that reduced repetition in aftercare was group therapy (Burns, 2005). In 2006, Muehlenkamp stated that that, "mechanisms of change [were] largely unknown for NSSI" (Muehlenkamp, 2006), but she recommended PST and DBT pending empirical study, hopefully in the form of a randomized controlled trial (RCT). Lloyd-Richardson in 2007 also mentioned PST in addition to a variety of other interventions ranging from medication to skills training. In 2008, Jacobson brought back the idea of DBT as effective for BPD, but said that if there was no SA present, a less rigorous therapy could be applied to those with NSSI. Milton Brown in 2009 recommended cognitive therapies which could be used for shame-

reduction. In 2009, Hazell reported that his research could not replicate the supposed advantage of group therapy. In fact, in his study, more people involved in the group therapy intervention continued to cut than in the control group (Hazell, 2009).

Klonsky again pointed to the efficacy of DBT in his 2009 article, but called for supplementary interventions such as relaxation training to manage negative arousal (Klonsky, 2009). Newman suggested cognitive therapy to combat “faulty beliefs” present in NSSI (Newman, 2009). Selekman put together a program run as a support group for schools called “Stress-Busters” (Selekman, 2009). Stanford suggested a range of therapies based on the depth of the pathology and offered CBT, DBT, and/or SSRIs as possible treatments (Stanford, 2009). In 2011, Hankin suggested methods that were effective in suicide treatment: CBT with family involvement (Hankin, 2011).

Van Vliet recommended Compassion-Focused Therapy, a form of CBT that targets shame and self-directed hostility (Van Vliet, 2011). This therapy sounds promising, but this I could find no other information on the technique. Catledge affirmed that the choice of technique depends on the individual client, but that psychoeducation for the client and family, cognitive problem-solving skills, family therapy, and DBT may all be used effectively with different clients (Catledge, 2012). Crowell cautioned the clinician not to treat NSSI as one would depression if there are features of BPD present and suggested a modified version of DBT (Crowell, 2012).

Hawton again recommended DBT in a 2012 article. Also in 2012, O’Connor suggested that CBT was useful for “brooding rumination” and “perfectionistic beliefs,” but once a client had cut, the therapist must focus on behavior change (O’Connor, 2012).

In 2013, Bresin recommended the DBT skill of acting the opposite of the emotion being experienced. This is in concert with Svaldi's study a year earlier where those asked to suppress a sad emotion experienced less of an urge for NSSI than those who were asked to accept their sad feelings (Svaldi, 2012).

In 2013, Kaess affirmed that it was the root of the NSSI that needed to determine the therapy employed. For trauma and PTSD, a clinician should use trauma therapy. If emotion regulation was the issue, then DBT should be employed. Cognitive therapy should be used to challenge dysfunctional beliefs, and there should be an element of family therapy, as well (Kaess, 2013).

Perhaps the most impressive and promising study was done by Rossouw in 2012 when she did an empirical study of mentalization-based treatment for adolescents (MBT-A). This therapy is a manualized treatment that takes place over a year and involves both the client and the family. Rossouw was able to show that 57% of those with whom MBT-A was used stopped NSSI in the course of the year while only 32% of the treatment as usual group did (Rossouw, 2012). This is the first treatment with any empirical evidence to back up its claim to be more effective with those with NSSI. Although the sample size was small, the outcome of the research is impressive. Rossouw described mentalization as "the capacity to understand actions in terms of thoughts and feelings" (Rossouw, 2012). She said it is useful in those with BPD and strengthened agency and self-control in those with affect dysregulation and impulse problems (Rossouw, 2012). Of all the treatments discussed in the literature, based on current empirical evidence, MBT-A is the only specific treatment to fare better than treatment as usual.

## General Treatment Guidelines

Much of the advice given to therapists in working with adolescent females who cut covers simply good, sound, general practice guidelines. For example, in 1975, Ferrence pointed out the importance of prolonged contact between clinician and client so that a satisfying relationship was developed. In this way self-concept would be raised. Similarly, in 1988, Figueroa stated that the most important aspect of recovery was “a primary empathic therapeutic relationship” between a therapist and a client.

Bowen, in 2001, talked about the general phases of treatment as involving first symptom relief and crisis resolution. Secondly came skill development. Finally, the therapist should focus on self-image and interpersonal functioning. In 2002, Webb offered the addition of enhancing communication within the family, helping the client to meet her psychosocial needs, and working to improve problem solving and difficulties with impulsivity. Webb also pointed out the benefit of having an “identified ‘parental confidant’ in the family or school system.” We might broaden this idea to include the church community as a possible venue for such a relationship to develop.

Laye-Gindhu, in 2005, added that therapists could teach more positive problem solving and coping and provide a place for adolescent females to safely experience their emotions. She helpfully added the advice to teach teens that “no emotion is permanent, all are survivable, and none is inherently harmful” (Laye-Gindhu, 2005). Skegg urged clinicians to monitor the client for thoughts of self-harm, identify support that is available in a crisis, to understand the meaning of the behavior, to treat psychiatric illness vigorously, to attend to substance use, to identify and work toward solving problems, to

enlist the support of family and friends, to encourage adaptive expression of emotion, to pursue an empathic relationship with the client, and to affirm home and caring for the self.

Spender (2005) also encouraged the therapist to carefully identify the problem. The clinician should “listen for the distress or other emotion underlying” the behavior. He claimed that if the client could use words to describe what she was feeling “she might not cut” (Spender, 2005). In a similar vein, Van Pelt encouraged the clinician to help the client increase her emotional vocabulary, to help her find creative outlets for her emotions such as journaling, poetry, drawing, or film. He also mentioned teaching coping tactics and continuing to work toward finding and resolving the underlying causes. Van Pelt also cautioned that the behavior sometimes recurs in times of increased stress (Van Pelt, 2005).

McAuliffe recommended increasing self-esteem, problem-solving, and coping abilities. This researcher called on therapists to both teach and model an “active, positive approach to problem-solving” (McAuliffe, 2006). In that same year, Muehlenkamp noted four areas that were “generally helpful.” First, to form a therapeutic alliance that is more team-focused rather than expert and subject. Secondly, she recommended identifying skill deficits and generating alternative coping strategies through functional assessment. Third, from a behavioral perspective, the clinician should attempt to remove reinforcement. She can help the client to develop new skills in coping, distress tolerance, problem-solving, communication, identifying, labeling and verbalizing emotions, intimacy, and conflict resolution. Finally, the therapist can assist the client in cognitive

restructuring. The researcher mentioned four common cognitive distortions: 1) that self-injury is acceptable and necessary, 2) that the body is disgusting and deserves punishment, 3) that action is needed to solve an immediate crisis, and 4) that overt action is needed to communicate feelings to others. (Muehlenkamp, 2006).

Lloyd-Richardson mentioned the importance of social support from family and friends in her 2007 work. Also, with regard to family, Wedig recommended helping parents to reduce the amount of criticism leveled at adolescent females. This research showed that having a low level of self-criticism was a protective factor (Wedig, 2007).

In 2008, Heath suggested strategies that helped the client to manage emotion regulation—specifically those which enabled the tolerance and regulation of intense emotions. Jacobson also suggested focusing on emotion regulation and interpersonal problem-solving if no suicidal ideation was present (Jacobson, 2008). Nock made the helpful observation that the difficulty in problem-solving is not generating multiple solutions to social problems, but in choosing an adaptive one. He suggested slowing down the problem-solving process so the client can choose the best one, much like what is often attempted in conduct issues (Nock, 2008).

S. Brown suggested interventions based on aspects of personality traits. If the client is high in neuroticism, therapy should focus on emotion regulation and distress tolerance. If the client is low in agreeableness, therapy should reinforce conflict resolution, social skills and problem solving. If the client is low in conscientiousness, therapy should assist with organization and impulse control. If the client scores high in openness to experience, channeling curiosity and imagination should be stressed (S.

Brown, 2009). Dougherty recommended that if no comorbidity is present, a brief therapy like skills training could suffice (Dougherty, 2009). Klonsky also added the suggestion of relaxation training including progressive muscle relaxation (Klonsky, 2009). He suggested that this would help bring success in skills to regulate intense emotion.

Newman suggested cognitive therapy (finding faulty beliefs), defining the scope and context of the NSSI, employing an empathic therapeutic relationship, and helping the client to develop direct communication skills (Newman, 2009). Selekman talked about the importance of “adult inspirational others” which can be found in teachers, coaches, clergy, or even within the family system (Selekman, 2009). Tuisku likewise emphasized the importance of family intervention to increase support for the client (Tuisku, 2009).

In 2010, Gerstein recommended therapy which is authoritative, but also warm, supportive and trustworthy (Gerstein, 2010). The clinician should ask the client for feedback on the session and clarify non-verbal expressions. This researcher stated that the ultimate good is helping a teenager to relinquish privacy and isolation in exchange for healthy connection to another (Gerstein, 2010).

Novara suggested that teaching parenting skills would help teens cope more easily with the events of their lives. In a 2010 article, Novara recommended against an overprotective parenting style. Parents should not appear to be punishing, pressuring, rejecting, disapproving or lacking in support for their teen (Novara, 2010).

Christian’s work stated that coping behavior mediated depression and self-harm in teens. A clinician would do well to encourage more social coping behaviors than those which are self-isolating. For example, talking with a friend would be more advantageous

than journaling. In this way, social support is increased and rumination, feelings of loneliness, and low self-esteem are decreased (Christian, 2011).

Greydanus recommended coping mechanisms that decreased underlying stresses and increased communication skills. Therapy during a crisis, trust between client and clinician, treating any comorbid psychiatric illnesses, and the support of family members and friends all acted to create healthier coping tools (Greydanus, 2011).

Ougrin's 2011 article made a significant contribution to the research on treatment of NSSI. He showed that when clients were engaged in therapy, there was not much of a difference in outcome between "treatment as usual" and specialized therapies (Ougrin, 2011). Therefore, looking at aspects of what was good, general practice might be very important.

When Van Vliet described CFT (Compassion-Focused Therapy), this researcher noted that the purpose was to change how individuals related both to themselves and to others. This treatment was designed to help clients relate with self-warmth, understanding, and kindness in a nonjudgmental way. Also important were the practices of self-soothing behaviors, self-acceptance, and helping people feel connected to others (Van Vliet, 2011).

Baker, whose wisdom reminds us that in treatment, one size does not fit all, said that areas to work on included coping, communicating, and relating (Baker, 2012).

Also in 2012, Hill applied some of the basic tenets of trauma theory when stating that clients needed to have conversations where different past events could be processed and understood within the context of an entire life story, rather than as discrete events. In

this manner, trauma could be integrated into the larger context of a whole life story rather than allowing the trauma to tell the entire story from its own perspective (Hill, 2012).

Muehlenkamp thought that a certain level of bodily detachment or objectification was necessary in order to employ NSSI. Therefore, things that would reconnect a teen to her body might play a role in treating NSSI. She suggested mindfulness activities and body acceptance methods might be beneficial in helping a teen create a better body image (Muehlenkamp, 2012).

Westers' work showed that clients might need to work on self-forgiveness in order to decrease NSSI behavior. Interestingly, forgiving others did not appear to be an active agent in helping those with NSSI (Westers, 2012).

Andersson suggested a model that was used in some addiction settings. Therapy that aimed to minimize harm rather than promoting abstinence from the behavior might be more effective (Andersson, 2013).

Daine looked at the use of the internet and found that it could both help and hurt those dealing with NSSI. On the positive side, some could find a support network via the internet. Others could use it as a coping tool. It could also be used to connect those who are socially isolated (Daine, 2013).

Zaki suggested that clients needed to be able to identify the emotions they were experiencing correctly. Labeling emotions correctly might underlie more adaptive means of self-regulation (Zaki, 2013).

Tait (2014) also applied a tenet of trauma therapy when emphasizing that the first thing a client must be taught is to build an adaptive coping tool. Only when that is

completed should a client be asked to give up NSSI, which is a very effective, although maladaptive, coping mechanism (Tait, 2014). This section has described in detail some of the general best practices offered for the treatment of NSSI.

In this chapter we have looked at NSSI from the perspective of a clinician in the field working with adolescent clients. We have explored internal risk factors, external risk factors, triggers, reasons/functions, and treatment. Next, we will turn to explaining evangelical Christian spiritual practices for the clinician. Once the clinician better understands the spiritual resources that a church youth worker has to offer, s/he can become a better partner in the healing process in the context of an evangelical Christian teen's whole life experience.

## CHAPTER TWO

### SPIRITUAL PRACTICES OF EVANGELICAL YOUTH WORK

When working with an adolescent who is part of an evangelical Christian church, you may have some additional allies in your effort to bring healing and wholeness. Realizing that religion is a natural support that may already be in place in your client's life may help you to provide better care. For those who are unfamiliar with evangelical Christian spiritual practices, I describe them below. You will be introduced to: daily quiet time, prayer, scripture memory, music, youth meetings, and mentoring and what is usually meant by these terms in an evangelical Christian context.

#### **Daily Quiet Time**

The "Daily Quiet Time" is a modern building block encouraged by evangelical Christian churches for Bible reading and meditation on a text and prayer. Richard Ostrander wrote about devotional life in the early twentieth century which, for many evangelical Christians, is still the model to be followed. "Devotions were in essence a dialogue between the Christian and God, with the words of the Bible serving as the script. Wrote Gordon: 'Bible reading is the listening side of prayer. In the book God speaks to us. In prayer we speak to God'" (Ostrander, 1996). Here Ostrander quoted S. D. Gordon from his work, *Quiet Talks on How to Pray*, originally published in 1929, which is available online in its entirety.

The precursors of the evangelical Christian movement deemed it very important to set aside time each day for private devotion. "As Andrew Murray explained in *Abide in*

*Christ*, the Christian could only live a fruitful life when grafted completely onto the ‘vine’ of Christ and utilizing his power. Devotions were the daily means by which the grafting of the believer onto Christ occurred” (Ostrander, 1996). The allusion here is to John 15:1-8. There is an emphasis on the individual being useful to God for the building of God’s Kingdom. “For Murray and his followers, morning devotions were a time for the Christian's spiritual battery to be recharged with divine energy, a supply that would have to sustain the believer who emerged from the inner chamber to withstand the onslaughts of the world, the flesh, and the devil” (Ostrander, 1996). It was therefore important that this happen both daily and at the beginning of each day.

An example of this can be found in the journal of Harold John Ockenga, a former pastor of Park Street Church in Boston and the first president of Gordon-Conwell Theological Seminary. He wrote, on May 2, 1926:

This morning, I studied my Bible and God wonderfully opened the 6<sup>th</sup> chapter of Matthew and fed my soul. I then went to the building to prayer and Oh such a time as we had, God and I. He did a real work in my heart this morning. He melted me up and stropped me of self, and fixed my gaze upon Jesus. It was beautiful and Oh so gentle. God gave me in prayer the answer to my prayers in again tendering my heart and overflowing it. I was in a sanctified state before but was rather dry. I thank God for the refreshing and anointing. (Rosell, 2008).

This shows the focus on starting the day with God, meditating on the Bible, spending time in prayer, and also the central nature of the relationship between the self and God.

Gregg Mast took this one step further as he said, “While each of us can and should carve out for ourselves time to be alone and devotionally reflect on the day and our lives, daily prayer is finally the time when we add our hymns and hearts, our voices and promises, to the prayer of the whole church” (Mast, 2006). I suspect that in the contemporary evangelical Christian church, there is less focus on the Daily Quiet Time as a time of unity with the whole church, and more focus on it as a time of the individual meeting with God.

Mast went on to say, “The key dimension of this daily discipline is prayer that reminds us that we are not alone, but in the company of the whole church in all times and in all places” (Mast, 2006). As we reviewed the literature concerning NSSI, we discovered that social isolation was one of the key risk factors. If there was a time every day when an adolescent could connect both with God and have a sense of connection to the wider church, one wonders how this would affect her sense of social cohesion.

This practice bears fruit in people’s lives. Mast makes the point that great hope can arise from having a time of devotion and meditation each day. He says: “In addition, daily prayer is that time and place when we are able to give thanks for the surprising ways God continues to create islands of hope and glimpses of grace in a world all too often weighed down with the heavy crosses of our day” (Mast, 2006). For a population characterized by lack of hope, the restoration of hope and “glimpses of grace” can serve as moments of redirection of the thoughts and healing. This can be an important spiritual practice for young people struggling with NSSI.

## Prayer

Prayer is another spiritual practice that can help adolescents dealing with NSSI. In the context of an evangelical Christian church, prayer can be defined as a mode of communication between an individual or group and God. This definition is in accord with Baesler's when he stated, "Fundamentally, prayer is spiritual communication to/with God" (Baesler, 2003). Some evangelical Christians would add that prayer also encompasses communication from God. Jankowski states, "William James (1902/1958) defined prayer as 'every kind of inward communion or conversation with the power recognized as divine' and called it 'real religion' (p. 352) (Jankowski, 2011).

There are some Christians who believe that the effects of prayer cannot be tested. Gerald Body, who described himself as, "a conservative Christian and a physician who has conducted many clinical trials," stated that there were theological reasons why testing prayer simply didn't work (Body, 2002). When looking specifically at experimentation done with intercessory prayer when those who were praying were not acquainted with those for whom they were interceding, Body stated, "Prayer offered to any god for an unknown person by anybody becomes no prayer at all." He also said that there is more to prayer than simply "getting what you ask for" (Body, 2002). There are times when God's answer to prayer, according to Body's theology, may be in the negative.

Those arguments notwithstanding, there continue to be empirical studies that attempt to codify the functions and results of prayer, both personal and intercessory. In 2008, Mary Bade looked at how Christian prayer can function in the process of coping. She interviewed individuals who prayed and found that prayer facilitated both what she

refers to as internal and external coping. “The internal focus end of the continuum is characterized by aiming coping effort internally (i.e., within the individual). Examples of an internal focus include ‘Calms me down,’ ‘Find hope within myself,’ and ‘Decreases my fear’” (Bade, 2008). Similarly, teaching self-soothing, increasing hopefulness and decreasing negative emotions like fear are some of the goals of therapy with adolescent females engaging in NSSI.

Bade also found that prayer provided several emotion management benefits. She further defined emotion management as, “managing distressing reactions to the problem” (Bade, 2008). She showed how her research found praying as seeking for resources such as, “assurance, courage, forgiveness, hope, patience, peace, and strength” (Bade, 2008). Other functions of prayer included, “[g]aining a sense of calm and focus,” and “meditating and reflecting,” which, “can involve emotional expression or calming” (Bade, 2008). NSSI could be, itself, defined as a method of managing distressing reactions to life, so all of Bade’s findings about prayer could pertain to ways prayer could fulfill a function similar to that of NSSI.

Further, Bade was able to see the action of cognitive reframing happening through prayer. Both the problem and the meaning of the problem were reframed for some of the pray-ers in her study. “‘Help me know that God will answer all my needs to my best interest’ and ‘Realize that what is happening in my life is good, even if it seems awful or painful at the time’ are examples of reappraisal,” Bade (2008) stated. Cognitive reframing is another technique taught by therapists using Cognitive Behavioral Therapy with adolescents with NSSI.

In a 2008 study for the purpose of helping nurses determine the positive or negative effects of prayer on those convalescing in the hospital, Hollywell stated, “Devotional prayers involving an intimate dialogue with a supportive God appear to be associated with improved optimism, wellbeing and function” (Hollywell, 2008). The author cautioned that, “Prayers that involve only pleas for help *in extremis* may, in the absence of a pre-existing faith, be associated with increased distress and possibly poorer function” (Hollywell, 2008). Therefore, it is important that the ongoing faith of the patient be assessed. For adolescents with NSSI who have a faith identity, prayer may provide an antidote to hopelessness and poor sense of self-esteem.

In a 2010 study, prayer was described as, “an imaginary social support interaction that provides individuals with resources they use to perform individual emotion management strategies” (Sharp, 2010). Sharp said that even though this “communication” was with something imagined,

interactions with God through prayer provide individuals (1) an other to whom one can express and vent anger; (2) positive reflected appraisals that help maintain self[-]esteem; (3) reinterpetive cognitions that make situations seem less threatening; (4) an other with whom one can interact to “zone out” negative emotion-inducing stimuli; and (5) an emotion management model to imitate (Sharp, 2010).

One can see how each of these aspects could be helpful to the adolescent struggling with NSSI even if the “someone” on the other end of the prayer is imaginary. From an

evangelical Christian perspective, how many more positive effects result from an interaction with the Divine.

Lambert's 2011 experiment showed that prayer increased forgiveness both in relationship to a romantic partner and to a friend (Lambert, 2011). Interestingly, Lambert's study involved the non-pray-ers having a "conversation" with an imagined parental figure. Here we see similarities with how Sharp (above) defined prayer. Those who prayed experienced a greater degree of forgiveness toward the one for whom they prayed than those who had imaginary communications. In previous chapters, we noted Wester's finding that self-forgiveness was a protective factor against NSSI. If one can learn to forgive others through prayer, perhaps one can also learn to forgive oneself in similar fashion.

A second 2011 study, this one by Jankowski, also looked at the relationship between prayer and forgiveness. This researcher stated that, "increased meditative prayer was associated with greater hope, greater hope was related to lesser adult attachment insecurity, and decreased adult attachment insecurity was associated with increased likelihood of interpersonal forgiveness" (Jankowski, 2011). When seen from this perspective, prayer increased optimism as well as forgiveness, something that therapists look at to determine risk factors for both NSSI and suicide. Jankowski also affirmed the affect regulation function of prayer. "The definition of interpersonal forgiveness as an intrapersonal process of regulating distressing emotion and then prosocially relating to the other was also supported by the findings of this study" (Jankowski, 2011). The researcher went on to say that, "[t]he novel finding in this study of hope as a facilitator of

the affect-regulating process suggests that meditation increases the person's sense that change or improvement is possible with respect to forgiveness" (Jankowski, 2011). Hope that a relationship or a situation can improve may be an important key to assisting adolescent females with NSSI.

Again, in 2011, a study by Denny showed the positive effect of prayer on depression, stated conversely, that prayer decreases the symptoms of depression. This study did not define prayer and its author cautioned that it may not be the overtly "religious" aspect of prayer that brought relief to those with depression who pray. He said, "[t]here is a growing body of evidence on the benefits of meditation on affective disorders such as stress, anxiety and to a lesser extent, depression.... It seems possible that these purely secular techniques have a similar mode of action to prayers..." (Denny, 2011). This researcher called for more study to determine what aspects of prayer led to the positive results. Regardless of how it actually works, though, this study makes it clear that prayer leads to decreased symptoms of depression and anxiety, which would be very beneficial to adolescent females with NSSI.

In his study, *Close Ties, Intercessory Prayer, and Optimism Among American Adults: Locating God in the Social Support Network*, Schafer looked at the effects of prayer as a source of help from other people. He found, "prayer from close ties (particularly non[-]kin ties) offers a benefit for future-oriented well-being that is not transmitted solely through giving advice, volunteering to help, spending face-to-face time, or giving financial assistance" (Schafer, 2013). In this study, individuals were told they were being prayed for and knew the individual who was praying for them. The

positive effects on optimism surpassed any other form of social support that Schafer tested. This might suggest to us that the prayers of youth group members for one another and the prayers of a youth worker for an adolescent female struggling with NSSI could be uniquely effective in changing that individual's outlook on life.

A 2014 study by Friese showed that those who prayed did not suffer from self-control depletion when performing a task that required emotional suppression, while those who did not pray did. Friese said, "These results are consistent with and contribute to a growing body of work attesting to the beneficial effects of praying on self-control" (Friese, 2014). Although scholars are divided about whether or not NSSI involves impulse control, increased self-control and the ability to manage emotions would certainly be a boon to those prone to NSSI.

Finally, another 2014 study, this one by Barnett, tested prayer's effect on depression and anxiety in the short and the longer term.

Results showed that participants who received the prayer intervention had significant improvements in depression and anxiety scores as measured by the Hamilton Depression and Anxiety Rating Scales (Hamilton, 1959, 1960). Additionally, participants assigned to the prayer condition had significant increases in daily spiritual experiences and optimism as determined by the Life Orientation Test (Scheier & Carver, 1985).

The results reveal that depression and anxiety decreased while spiritual experiences and optimism increased. Further, a year later, when the same groups were interviewed, those who had received prayer continued to experience decreased symptoms of depression and

anxiety and increased optimism. The study authors stated, “These studies suggest that direct person-to-person prayer may be a useful adjunctive treatment in addition to standard medical care for patients with depression and anxiety; however, further replication is necessary before recommendation” (Barnett, 2014). Although study authors would like to see their work replicated, from other studies we have seen that as long as the individual has a faith component already present in her life, she can find decreased depression and anxiety and increased optimism through both praying and being prayed for. How important this could be in the life of an adolescent female with NSSI.

We have listed above many benefits derived from prayer that would be helpful to adolescent females dealing with NSSI. Prayer can increase both internal and external coping, increase emotion management, help in cognitive reframing, increase optimism, wellbeing and function, increase forgiveness, decrease the symptoms of depression and anxiety, increase future orientation and increase self-control. If a client with a strong faith that acts positively in her life comes to therapy, it would be of great benefit if the clinician would encourage natural supports like prayer.

### **Scripture Memory**

One of the hallmarks of an evangelical Christian church is its emphasis on Bible memorization. May stated that “Evangelicals are noted for their love of the Word” (May, 2003) Emphasizing the importance of the Bible for spiritual health, he added, “The Bible, the Word of God, is the prime wellspring of spiritual life and vitality for Christians” (May, 2003). Many adolescents growing up in such a setting will be familiar with 2 Timothy 3:16-17, which says that, “All Scripture is God-breathed and is useful for

teaching, rebuking, correcting and training in righteousness, so that the servant of God may be thoroughly equipped for every good work” (NIV).

In his article, “*A noble quest: Cultivating Christian spirituality in Catholic adolescents and the usefulness of 12 pastoral practices*,” Canales referred to the 1986 National Federation for Catholic Youth Ministry report which pointed out that the use of the Bible was helpful in both deepening and nourishing adolescent faith (Canales, 2009). Canales also helpfully quoted Brueggemann from his 1997 work *The Bible Makes Sense*. Brueggemann saw the Bible as offering a new way for an adolescent to see herself. “The Bible provides [youth] with an alternative identity, an alternative way of understanding [themselves], an alternative way of relating to the world. [The sacred Scriptures] offer a radical and uncompromising challenge to [the] ordinary ways of self-understanding” (Canales, 2009). For young women who see themselves as worthless, broken, and irrevocably flawed, an alternative identity could be life-saving.

Edward P. Wimberly, in *Using Scripture in Pastoral Counseling*, said something similar. “The drawing power of the [biblical] story and its characters leads to a certain expectation, and this expectation often challenges the actual negative personal mythology that the counselee has brought...” (Wimberly, 1994, p. 26). Although Wimberly’s work is focused on working with adults and in couples and family counseling, this may be true of the adolescent as well. For young people brought up with deep familiarity with the biblical narrative, it can be useful in providing an alternative to their own views of themselves and their world.

Tan pointed out that the Bible could be used to enable someone to connect with something greater than herself or change her focal point, and, “for various purposes including the following: to comfort, clarify (guide), correct (cognitively restructure), change character, cleanse, convict (convert), and cure (or heal)” (Tan, 2007). Of what value could it be to the adolescent to connect with something greater than herself when she feels that the burden of her life is too heavy to bear alone?

Here we recognize May’s words that “It is naïve to think that the teaching of God’s Word is exempt from distortion, misuse, or misunderstanding by the learner,” but that is a possibility in any hierarchical relationship, whether it be in the counseling office or in the church (May, 2003). That is why, as Wimberly stated, “Because the Bible is making a return in many churches as an authoritative document, effort needs to be made to make sure that pastors and laypersons learn to use Bible stories in ways that facilitate growth” (Wimberly, 1994, p. 127).

So far, we have seen demonstrated a warrant for biblical teaching, but not necessarily the memorization of biblical passages. To this point, May stated, “If one of our goals in Christian education is to help learners become like Christ, then they need to become familiar enough with Bible passages that they can quote them from memory—because that’s what our Lord did” (May, 2003). May talked about the Bible as an essential, life-giving force. “Just as oxygen provides life to every cell of our physical beings, God’s Word, empowered by the Holy Spirit, should function as the ‘oxygen’ for the souls of believers, permeating every aspect of the essence of their being” (May, 2003).

Wimberly also saw the Bible as working deeply in the root of a believer's life. In his experience, "...the concern has been for how the Bible story (historical revelation) was at work in the depths of the person's life (contemporary revelation) to bring about change" (Wimberly, 1994, p. 121). In order for the Bible to grow adolescents internally, spiritually and emotionally, it must become resident in their minds and hearts. "Scripture memorization is an essential discipline for the growth of believers to maturity in Christ" (May, 2003). The Bible committed to memory, along with an eye to its meaning and application to the individual, is an avenue through which the evangelical Christian church attempts to grow its adolescents toward wholeness. So, too, can evangelical Christian youth with NSSI be helped to grow toward wholeness through Scripture memorization and comprehension. Scripture offers a new positive identity to those who study it, which can replace the negative self-concept often present in those with NSSI.

### **Music**

Another aspect of evangelical Christian youth culture is its unique music. Some would go so far as to say that youth within this group are formed by the music to which they listen (Young, 2012). This may occur at a level more literal than Young intended.

A pivotal area of research on the effects of music involves looking at the brain. In 2008, Suda did a study of the way in which music can fight the effects of stress on the individual. This researcher stated, "These findings suggest that major mode music, which induced happiness, does relieve stress effectively and may act by decreasing the post[-]stress response of the hypothalamus-pituitary-adrenal axis" (Suda, 2008). Suda went on to explain that, "Cortisol is an adrenocortical hormone and plays a central role in

physiological adaptation to various stressors” (Suda, 2008). Later research will take into account that music that induces happiness may vary widely between study participants and may not only include that written in a major mode.

In 2009, Koelsch stated that, “studies using functional neuroimaging have shown that music can modulate activity of all major limbic- and para-limbic brain structures, that is, of structures crucially involved in the initiation, generation, maintenance, termination, and modulation of emotions” (Koelsch, 2009). He went on to relate that,

These findings have implications for music-therapeutic approaches for the treatment of affective disorders, such as depression, pathologic anxiety, and post-traumatic stress disorder (PTSD) because these disorders are partly related to dysfunction of limbic structures, such as the amygdala, and para-limbic structures, such as the orbitofrontal cortex (Koelsch, 2009).

This speaks of music’s ability “to evoke and modulate emotions” (Koelsch, 2009). Using this knowledge, Koelsch showed that music can do things like, “elevate the mood in individuals with mood disorders” (Koelsch, 2009). This could be very important for adolescent females with NSSI.

Moore took this research a step further in 2013 when she focused in on what it is about music that affects the brain. She said, “[r]esults indicated that there are certain musical characteristics and experiences that produce desired neural activation patterns implicated in emotion regulation” (Moore, 2013). She considered information about the characteristics of the music itself that might make music a good intervention. She offered

“guidelines” to music therapists in that they should utilize, “music considered happy and pleasant, with predictable, consonant harmonies” (Moore, 2013).

In 2014, in an article geared toward music therapists, Stegemöller introduced the idea of neural plasticity. She stated that it is not until the early 20s that one’s brain is completely wired for life ahead (Stegemöller, 2014). In fact, during the years of adolescence, new connections are being made in the brain at a rate equal to that of the connections that are “pruned” (Stegemöller, 2014). This means that the window of time during which the brain can form new connections is much longer than originally thought. In the same article, Stegemöller showed that the levels of dopamine in the brain are affected by the use of music (Stegemöller, 2014). Dopamine is one of three major brain chemicals (along with serotonin and norepinephrine) often targeted by medication for relief of depression and anxiety, often an underlying cause of NSSI.

The above studies on the brain use the empirical evidence offered by medical testing of the brain-in-action to show that music affects the same areas of the brain as emotions. An implication that might be drawn, given more evidence, is that if one changes the music, the emotions will change, also. However, different studies are necessary to see if this holds true.

In 2004, Pelletier looked at the literature concerning stress and its response to music. This researcher defined stress as, “anxiety, fear, anger, and the physiological arousal on the ability to adapt to these conditions” (Pelletier, 2004). Upon completion of the study, Pelletier found that the greatest difference in states of arousal was found in adolescents and females. This finding supported that of earlier studies. Music could bring

about positive results in young women with NSSI who cut as a way of controlling negative emotions.

Four years later, Smith did a study in which people in a high stress job were given two different interventions in an attempt to fortify them against the difficulties of their occupation. One group listened to music while the other group had a discussion with those who understood the stress inherent in their work. Smith found that, “[p]articipants in the music relaxation intervention indicated a positive increase in feelings of relaxation and pleasantness, as well as decreased tension, immediately after the music relaxation intervention” (Smith, 2008). She was able to demonstrate that in a work setting, one instance of sitting down and listening to music before the beginning of a shift was able to decrease the level of workers’ anxiety.

Koelsch’s research in 2009 dealt with things other than how the brain works with regard to music. He also pointed out that music has the ability to distract someone and turn their attention from, “stimuli prone to evoke negative experiences (such as pain, anxiety, worry, sadness, etc.)” (Koelsch, 2009). So in addition to changing one’s emotions, it can also be used as a short-term avoidance tactic. Again, a much more adaptive method than NSSI.

Three separate studies published in 2011 detailed the ability of music to elevate the mood and decrease symptoms of depression. Boothby was able to demonstrate that, “music listening has specific efficacy in enhancing mood even when expectations of improvement are equated across groups,” in her randomized controlled trial (Boothby, 2011). Jaakko found that, “[i]ndividual music therapy combined with standard care is

effective for depression among working-age people with depression” (Jaakko, 2011). Chan’s study showed that, “[m]usic listening over a period of time helps to reduce depressive symptoms in the adult population” (Chan, 2011). Chan also found that the effect of music was cumulative and suggested a three week period of intervention (Chan, 2011). This researcher pointed out that the music should be chosen by the study subject and any style of music, as long as it is enjoyable to the listener, can be utilized (Chan, 2011). Chan’s findings are particularly germane to our study since it involved passive listening rather than a music therapy intervention, as such.

In Schafer’s 2013 study, he was able to show that people use music to regulate both arousal and mood (Schafer, 2013). It is also a way to create self-awareness (Schafer, 2013). “Emotions clearly appear in the first dimension (e.g., music conveys feelings; music can lighten my mood; music helps me better understand my thoughts and emotions), indicating that they might play an important role in achieving self-awareness, probably in terms of identity formation and self-perception, respectively” (Schafer, 2013). He also talked about the different advantages to using music as background and music as focus. Here we see music’s ability to regulate emotional arousal and mood, which is often what NSSI accomplishes. We also see music helping people to understand what they are feeling, a protective factor against NSSI.

Along with the maintenance of a pleasant level of physiological arousal, the maintenance of pleasant moods is an effect of music that might rather be utilized as a “background” strategy, that is, not requiring a deep or aware involvement in the music. The regulation of emotions, on the other

side, could be a much more conscious strategy requiring deliberate attention and devotion to the music (Schafer, 2013).

This shows the power of music that one is not even aware of listening to. When music is the focus, it can actually regulate arousal and mood, two things very much involved in the use of NSSI as a coping tool.

Another 2013 study, this one by Skanland of Norway, is entitled “Everyday music listening and affect regulation: the role of MP3 players.” She stated that, “affect regulation, [is] here understood as an individual’s efforts to maintain or change the intensity or duration of a given affect. The ability to understand and regulate affects has significant health implications, and among the tactics relevant to such regulation, engagement with music has proven to be particularly successful” (Skanland, 2013). This issue seems especially germane to adolescents, many of whom appear to be permanently attached to their earbuds. Skanland reported on some earlier work pointing to the affect regulation role music can play.

People use a variety of different strategies and tactics for mood regulation, including working out, eating, calling a friend, taking a shower, watching TV, or shopping (Thayer et al., 1994). In Thayer and colleagues’ study of mood regulation, music represented a remarkably, and unexpected, successful tactic. Participants in their study often used music as a means of mood regulation, specifically to change a bad mood, increase energy level or reduce tension (Skanland, 2013).

When one thinks about “changing a bad mood” and “reducing tension,” adolescent females engaging in NSSI come to mind as a good target for this intervention. In addition to mood regulation, music gave the listener insight into her own emotions. Skanland reported “an important aspect of the MP3 player was that it created a private space within which the informants could more easily focus on their own states of mind” (Skanland, 2013). One important aspect of therapy for those dealing with NSSI is helping them to identify their emotions and name them. Skanland pointed out that using an MP3 player may give the listener space to do that. Additionally, “[s]earching their music libraries for what ‘felt right’ also helped to clarify the informants’ moods. Finding the ‘correct’ song made it more apparent what mood they were actually in, and the music could help to illuminate, intensify and prolong this mood” (Skanland, 2013). This gives important information to someone who is not adept at naming their own emotions. In fact, “music seems to fill a prophylactic function against unwanted thoughts and emotions” (Skanland, 2013). It could be argued that NSSI is another way of dealing with “unwanted thoughts and emotions.” Skanland also discovered that listeners did not always try to change their emotional states. She reported that instead, “[b]y maintaining so-called negative affects with the help of music, furthermore, informants here gained a better understanding of their internal states. Only then could the informants successfully begin to change their moods for the better” (Skanland, 2013). So music was not necessarily a quick fix, but a part of a healthy process for mood regulation. Music may provide an even greater good. “The opportunity provided by the MP3 player to reflect on one’s mood and emotions might lead to improved insight into one’s affective life, which in turn might lead to

enhanced emotional intelligence” (Skanland, 2013). Skanland noted research showing that low emotional intelligence was linked to “mental illnesses, such as depression, alexithymia, and borderline personality disorder” (Skanland, 2013 after Grewel and Salovey, 2006). Skanland summed up her findings by stating that, “listening to music on MP3 players appears to be an easily available and efficient tactic for affect regulation and, with the exception of hearing damage, without the physical side effects of other, more harmful regulation tactics such as smoking or drinking” (Skanland, 2013). And we might add without the problems associated with NSSI.

One final bit of research was published in 2014 and entitled “The Effect of Music Listening Versus Written Reframing on Mood Management.” In this experiment, authors Sleight and McElroy gave different groups either a musical or a writing intervention in an effort to change people’s moods (Sleight, 2014). The authors found that both music and writing to reframe a situation could change moods from negative to positive or positive to negative. However, they discovered that the effect of music was stronger than that of writing, especially for women (Sleight, 2014). The researchers also found that music was more important to young adults than television or video games (Sleight, 2014). So, given a choice between offering someone with NSSI issues an intervention of writing in a journal to reframe a situation or giving them positive music to listen to, the researchers proved that the latter is potentially more powerful.

We have established the important effects music can have on mood regulation, emotional arousal, and the ability to name one’s feelings. It should be noted that evangelical Christian youth culture has its own music that comes in many different styles.

Parents may greatly prefer the lyrics of music on the Christian scene over the lyrics played on many popular radio stations.

### **Youth Meetings**

Another important aspect of life as an evangelical Christian young person is the meeting of the youth group. Usually a weekly event, groups gather for fun and often prayer and Bible study, as well. When asked about what made them continue to attend church as they grew older, a group of eight to fourteen year-olds in the United Kingdom pointed to the importance of “feeling a part of the group” (Francis, 2006). They mentioned that they enjoyed being with all ages for worship, but also that it was important to them to be with their peers for other activities (Francis, 2006). Some churches were found to have the ability to “nurture strong peer groups” (Francis, 2006) This is a primary purpose for youth groups in evangelical Christian churches.

Organized for the purpose of ministering to young people, the tradition of youth group in an evangelical Christian church setting usually involves some sort of activity to interest adolescents, and a time of study or teaching which may include looking at a biblical passage or listening to a testimony—a story of someone’s life who is considered to be somewhat more spiritually mature than those participating in the group. Young also pointed out, “As rites of passage, vacation Bible school, summer camp, and the mission trip all form a triumvirate of what can be seen as an inescapable heritage, an expected journey associated with life in the local church youth group” (Young, 2012). Here he is speaking specifically about the evangelical strand of the Christian faith.

In the words of a female adolescent whose identity is unknown to me, but whose words were reported to me by a youth leader in an evangelical Christian church, “Youth Group gets me out of my depression for an hour.” Apparently in this female adolescent’s experience, being in a different environment with a group of peers and caring adults allowed her respite from her prevailing mood of depression.

In the conclusion of a study on social relationships and self-harm, Wu reported, “More limited social networks were associated with self-harm.... Enhanced social structure and raising awareness of networking people with self-harm to community resources may be important for self-harm management in Asian societies and elsewhere” (Wu, 2013). Youth Group for adolescents involved in evangelical Christian churches might serve this community resource function.

Christian found that part of the nature of NSSI is that it is self-isolating. Therefore, she recommended countering that social isolation by providing opportunities for meaningful social interaction (Christian, 2011). She posited that participating in more group oriented activities, “could help prevent or decrease DSH by increasing social support and decreasing depressive symptoms, rumination, feelings of loneliness, and low self-esteem” (Christian, 2011). The results of our study show that youth group has the possibility of being a positive influence in the lives of those encountering NSSI. It can have social benefits as well as acting as an escape from a pervasive negative affect.

### **Mentoring**

A final aspect that many evangelical Christian churches have been importing into their youth work is the practice of mentoring, setting up an intentional relationship

between an adolescent and a caring adult who is outside the family circle but within the church family. Rhodes found churches to be particularly good places for such relationships to take place since, “religious organizations offer a potentially rich pool of caring adults who are driven by their own spiritual commitments and a strong ethic to serve others” (Rhodes, 2008). She went on to report that, “recent Census Bureau data tracking volunteer trends revealed that 43 percent of American volunteers who engaged in a mentoring relationship did so through religious organizations” (Rhodes, 2008).

Schwartz also found that churches were particularly good places to establish mentoring relationships because, “religious communities often provide ongoing encouragement and mentoring through youth outreach and services. Since social policies in general, and mentoring programs in particular, often do not reach or support the most severely disadvantaged youth, churches often play a critical supportive role” (Schwartz, 2012) Schwartz gave one example as she went on to report that, “This is particularly true in urban, black churches, which tend to be particularly active in their communities and participate in a wide range of community programs” (Schwartz, 2012). Overall, “In addition to informal relationships forged through faith-based communities, a large number of formal mentoring programs are also faith-based, either taking place in or being sponsored by a religious organization” (Schwartz, 2012).

Deutch found that an even greater impact could be brought about by having mentors involved in youth group activities. She stated, “Our findings suggest that combining group with one-on-one mentoring can provide girls with opportunities to make multiple connections....The group component may also offer a context for the

development of connectedness between mentors and mentees” (Deutch, 2013). This sense of connectedness can fight the isolating nature of NSSI. DuBois expanded on this. “Greater reported closeness with mentors was associated consistently with positive outcomes in the domain of psychological well-being (greater self-esteem and life satisfaction, fewer depressive symptoms and reports of suicidal ideation)” (DuBois, 2005).

With regard to DuBois’ finding, it is important to note that he was specifically studying natural mentoring relationships. This indicates that instead of receiving a mentor the adolescent has never met before, she begins a relationship with someone whom she knows at least tangentially. DuBois pointed out, “greater consideration should be given to instituting policies and programs that cultivate mentoring relationships between adolescents and those adults who already are salient figures in different parts of their lives such as school, extracurricular activities, and neighborhoods” (DuBois, 2005). This is exactly what happens in a mentoring program that takes place within the context of a church.

Schwartz discussed the benefits of a mentoring relationship characterized by specific attributes.

Close and enduring relationships may have a unique capacity to influence youth self-esteem. By connecting youth with a stable and supportive relationship with a caring non-parental adult, mentoring programs can provide a context in which adolescents can develop self-esteem and confidence in their abilities. These are important youth assets that are

associated with positive psychological, behavioral, and academic outcomes (Schwartz, 2012).

The benefits accrue on many levels within the adolescent. Schwartz also cautioned that while such benefits may result from relationships characterized by closeness and longevity, there can be a commensurate decline in the self-esteem of an adolescent female who is not able to bond with her adult sponsor or whose relationship with a mentor lasts less than six months to a year (Schwartz, 2012). Mentoring, like any work done with a vulnerable population, should not be undertaken lightly.

With regard to further benefits of mentoring, Liang said the following, “Engagement with authentic mentors may provide older adolescents [with] opportunities to enhance their coping capacities by learning that shortcomings and adversity are inevitable parts of life that need not stand in the way of personal and professional achievement” (Liang, 2008). These sorts of coping tools would be especially beneficial to a young girl with NSSI.

Finally, Spencer did interviews with mentoring pairs and found in one of her subject’s responses, “Her narrative also revealed that her exchanges with Gretchen [the mentor] offered her something that is increasingly being viewed as critical to healthy psychological development— opportunities for assistance with emotional regulation” (Spencer, 2009). In a faith-based program focused on helping girls whose parents are incarcerated, Rhodes found, “preliminary studies suggest that participation can lead to improvements in self-efficacy, school performance, and emotional regulation” (Rhodes,

2008). Affect regulation is one of the most frequently cited causes of NSSI. It looks as though researchers are finding that mentoring may be a way to provide an alternative.

We have looked at literature related to different aspects of traditional evangelical Christian youth work to see if it offers natural supports that mental health clinicians may be able to harness in order to help adolescent females who are cutting. Now, in a chapter designed for the youth group volunteer, will look at the other side of the coin as we move on to how the youth leaders in evangelical Christian churches can utilize specific spiritual practices to create a healing environment for adolescent females who are cutting and augment what they are learning in therapy.

## PART III

### A HANDBOOK FOR EVANGELICAL CHRISTIAN CHURCH YOUTH LEADERS

If you are a youth leader in an evangelical Christian church, this chapter is for you. If you are made aware that someone in your youth group is cutting, there are some important things for you to know and some powerful things that you can do to help in the healing process. In the following chapter, we will explore: first steps (getting your youth into therapy), Who should have this information? What is NSSI? What is the purpose of NSSI? How will a clinician treat NSSI? What I can do to help? How does youth group help? specific practices that might help with NSSI, and finally, a unit on emotions.

#### **First Steps**

Before we move into any of the background information about cutting, this section is for the leader who has no experience with non-suicidal self-injury, but is faced with an occurrence of it in her youth group. The most important thing a leader can do is to get her teen into therapy with someone who is trained in the area of cutting. This is not something that the church or the family is equipped to deal with alone.

I think one of my girls is cutting. What do I do? 1. Find a time (quickly) when you can talk with her alone—perhaps taking her out for a snack. Time sitting next to each other in a car and across the table from each other in a somewhat quiet space may enhance your teen’s ability to be open. 2. If she admits she has been cutting, calmly explain to her that this is something that her parent(s) need to know about. She has several options. She can tell her parent(s) on her own. Or she can tell her parent(s) in a conversation in which you are present. Or you can tell her parent(s) for her. In any case,

you will follow up with her parent(s). 3. When you follow up with her parent(s), be prepared with at least a short list of community resources that can help the family in this situation. Explain that this is an issue that needs professional intervention *and* that there is much you, the church, and the family can do to help the young person.

Community resources should include a list of counseling centers or professional counselors in private practice. If you are unsure of what is available in your community, it may be helpful to talk with a school guidance counselor. This does not mean discussing the particular youth in question with a guidance counselor, but simply asking to whom they generally refer their students for counseling. Pastors in your area may also have a list of therapists to whom you can refer parents, but schools may keep a list of those particularly suited to teens.

It may be helpful to tell parent(s) that when they call an agency to refer their daughter for counseling, if it's something that's important to them, they can ask if the group has any Christian counselors. The intake person may say s/he has no idea, but s/he may be able to find out if there are any therapists on staff who particularly enjoy working with Christians. This is a fair question given the nature of the bond you are hoping your teen will form with a clinician. Even if it is a public agency, religion is seen as an important protective factor within the life of certain clients. It will also be an important thing to know if a particular agency or individual accepts the parent(s) insurance. That can be established in the initial phone call unless parent(s) are prepared to pay counseling fees out-of-pocket.

### **Who Should Have This Information?**

From this point on, this paper will be directed to the youth worker in an evangelical Christian church context who interacts with adolescent females. This person will be referred to simply as a “leader” and I choose the feminine pronoun in response to much, if not most of the literature written for evangelicals, opting for the masculine pronoun.

Whether a leader is a trained clergy-person or an able volunteer from the church community, the culture of the teenager is only one of the many things a leader needs to know and understand in order to be helpful to her adolescent female charges. Because the field of knowledge is so wide, this paper will undertake to explain one small aspect of what would be helpful for a leader to know: the phenomenon of non-suicidal self-injury (NSSI).<sup>1</sup>

### **What is NSSI?**

NSSI may be undertaken by a young person by superficial cutting of the skin, burning, interfering with wound healing, or abrading the skin in some other way such as rubbing it to rawness using an eraser. Currently, the most common form of NSSI is cutting. A group of professionals was organized in 2006 to try to understand this behavior called the International Society for the Study of Self-Injury (ISSS). Within the first year of their official launch they had drafted a statement defining NSSI as “the deliberate, self-

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<sup>1</sup> This phenomenon is called by many names in the literature. This author feels that NSSI is the most specific term. Other ways to identify this behavior range from deliberate self-harm (DSH) to self-mutilation (SM) or self-mutilative behavior (SMB). Although current researchers may mean something slightly different by the use of a variety of terms, for our purposes we will use the term NSSI as defined above. “Cutting” is currently the most common example of NSSI. We may alternate with the term “self-harm,” a more general term, simply for the sake of varying a term that will be so often repeated.

inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned” (International Society for the Study of Self-Injury, 2007).

A leader may recognize that a young person has been involved in such a pursuit by noticing scars on a teen’s body. More often, though, the youth will attempt to keep her scars covered. If you have a young person who wears long sleeves and/or long pants even in the highest heat of the year or who consistently wears many bracelets on her arm or arms so that much of the forearm is covered, you may want to begin to wonder if that young person may have some scars she is hiding. Summer, and especially prom time, may give insight into whether or not a young person is harming herself on areas of her skin normally covered up by long sleeves and high-necked clothing.

The initial reaction of a leader seeing something like this for the first time may be one of disbelief or disgust. One of the reasons it is important to talk about this issue is so that the stigma of self-harm (NSSI) will not be perpetuated. Such behavior may make an adult feel afraid or angry or shocked and usually powerless. Although these may be initial reactions, it is important to move beyond these responses and see the teen as someone who is hurting. Like many other teens you may encounter on a weekly basis, the one who is engaging in NSSI is behaving in some unhealthy ways.

NSSI is most likely to appear in the lives of adolescent females around or just after the time of puberty. For this reason, it will not be as much of an issue in an elementary-aged group. The middle school or high school years are when NSSI is likely to be at its height. How likely is it to appear in your group? The research on this is varied,

but estimates run somewhere around 15 percent.<sup>2</sup> It is possible, therefore, to expect that one out of approximately seven girls in your group are either currently or were at some time engaged in NSSI behavior.

The leader needs to understand three key ideas. First, although NSSI is, by definition, not a suicide attempt (and should not be confused with one), secondly, girls who engage in self-harm may be at higher risk to make a suicide attempt at some time in their lives. This will lead to the third key idea: NSSI is *not* something that should be dealt with without the help of a trained professional. This means that the most important thing a leader can do is to carry out the process of facilitating a referral to a professional therapist for her charge who may be cutting.

Once the teenager is under professional care, we can discuss possibilities as to why a young girl might want to hurt herself in this way. Perhaps the biggest question a leader may have is why do some young women do this to themselves? It turns out that this is a very difficult question to answer. Until recently, not much research was being done on NSSI. When research began, differences in terminology and how people defined the behavior kept researchers from building on one another's work.

Today, there is still a geographic split between research done in North American and those regions it influences and research done in the United Kingdom and those who look there for leadership. In the UK, the broader terminology "deliberate self-harm" (DSH) is preferred and includes not only what the US would define as NSSI, but also

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<sup>2</sup> There is a great deal of variety on this point in the clinical literature. The author has chosen this approximation based on recent studies done in the United States among late adolescents in non-clinical (rather than inpatient) settings.

poisoning through overdose or ingestion of a potentially harmful substance. Because it would be so difficult to determine the intent of self-poisoning (how would a young girl know exactly how much of a household chemical to drink so as to harm but not kill herself?), researchers in North America have chosen not to include self-poisoning as a method of NSSI.

The guidelines offered here are based on the research currently being done in the US and Canada and the prominent definitions of NSSI in North America. This choice is for the sake of offering a clear definition, though other definitions have been discussed worldwide.

### **What is the purpose of NSSI?**

As may be predicted from the difficulty in defining NSSI, there is also much difference of opinion about what purpose NSSI serves for the one engaging in the practice. Some researchers have found that NSSI can be used as a form of self-punishment (Ferrence, 1975). It can also be used to combat relational issues (Morgan, 1975). These can be difficulties with parents or peers or could result from feeling socially isolated (Hawton, 1996). NSSI can be used to manage a feeling of emptiness (Brent, 1997). “It provides rapid (although temporary) relief from overwhelming psychological distress. Release of tension, acquiring control, reconfirming the presence of one’s body, dulling feelings, and converting unbearable emotional pain into manageable physical pain, are commonly cited reasons for SIB [self-injurious behavior]” (Bowen, 2001). Dealing with the feelings associated with being rejected by a boyfriend, being bullied and

poor communication within the family can also be reasons for NSSI (Harrington, 2001). Self-harm can be a way of dealing with the stress of school (Hawton, 2003).

The evidence from different researchers increasingly concludes that young girls use NSSI to regulate their emotions. This is especially well-stated by researcher Laye-Gindhu. She found evidence corroborating previous research which determined that “self-harm functions as an effective strategy to regulate affect [emotional state], chiefly negative or disturbing affect that becomes overwhelming or intolerable” (Laye-Gindhu, 2005). She reported that major emotions leading up to an episode of self-harm can include anger, depression, loneliness or frustration. After an incident of NSSI, guilt, shame and disgust tend to increase along with the experience of relief and emotional release. The researcher went on to state that “The most frequently endorsed motivations for self-harm in this study supported the affect regulation function of self-harm and included: reducing depression, anxiety, or stress; self-hatred and anger; self-punishment; loneliness or alienation; and distraction from problems” (Laye-Gindhu, 2005). Her findings “do not support the common and longstanding belief that self-harm is manipulative, attention-seeking behavior” (Laye-Gindhu, 2005). The author concluded that “Results from this study suggest that self-harm is an emotion-focused coping strategy that often functions to regulate affect, particularly for girls” (Laye-Gindhu, 2005).

Another researcher went on to discuss more measurable characteristics like “poor problem-solving,” “impaired decision-making,” “impulsivity, inflexible thinking [there’s only one solution], hopelessness, reluctance to self-disclose [talk about one’s issues], lack of positive future-directed thinking, and difficulties with autobiographical memory

manifested by a tendency to retrieve events from the past in an ‘over-general’ way rather than by recalling specific events.” (Skegg, 2005).

Van Pelt and Hancock, in their 2005 work directed at church youth leaders, stated:

a person may engage in SIB [self-injurious behavior] to keep from killing herself. She inflicts physical pain to express interior pain, to contextualize and perhaps manage fear, rage, emptiness, isolation, and sorrow.

Victimized adolescents who lack the capacity to talk about their pain may express their pain and depleted self-esteem with self-injurious behaviors (Van Pelt, 2005).

These authors also mentioned that girls with NSSI were more likely than the general population to have eating disorders such as anorexia or bulimia.

John Townsend, in his book *Boundaries with Teens*, listed seven functions for adolescent cutting. Townsend said, “they feel nothing, and pain makes them feel alive;” “they need a way to outwardly express inner pain;” “they feel they deserve to be punished;” “they are reenacting some abuse or trauma and trying to resolve it;” they want to replace bad feelings with good feelings;” “they want to connect with peers;” and “they may have a biochemical issue” (Townsend, 2006). Townsend’s audience for this book was the parents of teens presenting with a variety of difficult adolescent issues.

Lloyd-Richardson said that NSSI communicates and is seen as a way to gain control. “The most common reasons for NSSI included ‘to try to get a reaction from someone’, ‘to get control of a situation’, and ‘to stop bad feelings’ (Lloyd-Richardson,

2007). A different researcher (Hilt, 2008) found that girls' relationships with their fathers tended to improve after an episode of NSSI. This could support Lloyd-Richardson's idea about NSSI's usefulness for controlling a situation.

Another American researcher reported that individuals with NSSI showed hyperarousal<sup>3</sup> and "decreased distress tolerance" (Nock, 2008). Nock was also able to pinpoint that in problem solving the issue was not coming up with a number of different options, but difficulty in choosing to use one that was likely to be effective.

A researcher in Hungary found that adolescents said they used NSSI to release anger and deal with issues like loss and failure (Csorba, 2009). Another researcher found that feeling overwhelmed, frustrated and anxious decreased and feeling calm, relaxed and relieved increased after NSSI (Klonsky, 2009). Reasons for NSSI can include control and coping, quelling rage, hating the body, communicating how badly one feels, and ridding oneself of emotional emptiness and numbness (Newman, 2009, p. 204).

Negative self-concept (reporting self as less intelligent, less emotionally stable, and less physically attractive than others) could also be related to NSSI (Claes, 2010a). In what may be especially important for leaders in evangelical churches, another researcher found that perfectionistic beliefs could raise the risk of self-harm (O'Connor, 2010). Sometimes young people's religious practices can become somewhat legalistic, so this is important to note. Angry and hostile emotions like self- and other-directed anger, self-

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<sup>3</sup> Increased alertness that may result from an experience of trauma. "This condition is often evident by symptoms such as insomnia, periods of irritability, lack of concentration, anxiety about being in crowds and the tendency to be easily startled" (Wright, 2003).

hatred, and feeling rejected could also be dealt with through NSSI, whereas sadness did not lead as directly to the possibility of self-harm (Armey, 2011).

Other purposes for NSSI may include coping with a negative way of thinking about self, others and the world; the onset of depression in a teen's mother; a teen's own depression; or a lack of family support (Hankin, 2011). NSSI can also be associated with being bullied (Noble, 2011). In addition, "Where reflection on past experiences is not possible, self-harm may be the only visible alternative for adolescents faced with unmanageable emotions and memories that are painful to confront" (Hill, 2012). Teens need people to talk to so they don't feel isolated with their particular problems and issues—whether past or present.

Adolescents who experience bad feelings about their bodies who then have large-scale negative emotions may be more likely to engage in NSSI (Muehlenkamp, 2012). Another researcher found that having "a mental health problem, depressive symptoms, hopelessness, physical abuse, less parent connectedness, running away from home, and maladaptive dieting behavior" can all be associated with a greater likelihood of NSSI (Taliaferro, 2012).

In work done for a Christian institution, one researcher found that an adolescent's ability to forgive herself affected whether or not she was likely to engage in NSSI. He stated, "This suggests that self-injuring adolescents with lower levels of self-forgiveness may tend to engage in NSSI to get rid of unwanted feelings or to feel something due to feeling numb or empty" (Westers, 2012).

It has also been found that girls who have had adverse childhood experience are more likely to be involved in NSSI. These experiences could include “both maternal and paternal antipathy, maternal neglect, maternal physical abuse and any history of sexual abuse...” (Kaess, 2013). Researchers talk about “an invalidating family environment” which may be a “core factor in the development of self-harm behaviour” (Kaess, 2013).

Another interesting finding in the research was that when teens are involved in an avalanche of emotions, the ability to name them and tell them apart from each other may protect them against using NSSI to stop the bad feelings and the cycle of rumination [thinking about them over and over or obsessing about them] that often follows (Zaki, 2013). So helping teens to simply name their emotions could go a long way to help them deal with those emotions in healthy ways.

### **How will a therapist treat NSSI?**

As we have seen from the wide variety of reasons why teens practice NSSI, we will find that treatment varies accordingly. Since self-harm functions differently for different teens, one of the professional therapist’s first jobs is attempting to figure out what purpose it serves for the specific teen with whom they are working. What will help is determined by why NSSI is occurring in each teen’s personal experience.

As a baseline for professional treatment, “some authors suggest that prolonged contact which allows the patient to develop satisfying relationships and more positive self-concepts reduces the risk of repeated self-injury” (Ferrence, 1975). One of the central aspects of many (if not most) modern therapies is building a trusting relationship between the therapist and the adolescent.

Dialectical Behavioral Therapy (DBT) has shown some promise in helping teens with NSSI. DBT is “intensive, involving in its full form a year of individual treatment, group sessions, social skills training, and access to crisis contact” (House, 1999). This sort of treatment is very expensive and, in my experience, rarely available in my area on an outpatient basis. If a teen is struggling enough that she is safer in an inpatient setting, DBT may be one of the best options currently available for treating NSSI. A different researcher suggests that in addition to DBT, “Supplementary interventions that specifically help patients manage negative affective arousal, such as relaxation training and progressive muscle relaxation, may also help patients avoid self-injury” (Klonsky, 2009).

A different researcher pointed out the important elements in different phases of therapy. The beginning of therapy will be focused on the crisis at hand, the middle of therapy should focus on skill development, and the long-term objectives should be to improve self-image and relationship building (Bowen, 2001). Within the phase of skill development, the adolescent’s ability to solve problems should be a focus. One researcher figured out that it was not difficult for most adolescents with NSSI to generate different possible solutions to a problem. As mentioned previously, the issue was in choosing a workable positive solution from the different possibilities (Nock, 2008). He suggested that as is done with conduct disorders, adolescents with NSSI can be taught to slow down their thinking in order to choose a good alternative solution (Nock, 2008).

Some researchers have pointed out the importance of having the family of the adolescent involved in therapy (Harrington, 2001). Helping parents to reduce the amount

of criticism aimed at a child has been shown to help “in reducing patient relapse across a number of different disorders” (Wedig, 2007).

Another common treatment for NSSI is Cognitive Behavioral Therapy (CBT). This theory rests on the idea that how one thinks influences what one is feeling. Although humans cannot change their emotions, they do have control over their thought patterns which, to a large extent, determine their emotions. By “taking every thought captive” (2 Cor. 10:5) people can make a difference in how they are feeling. One researcher suggested that CBT may help adolescents “not only deal with urgent problems but also to develop improved problem-solving skills for the future” (Hawton, 2003).

Another researcher advocated for “an emotion-based approach in which emotions can be safely experienced” and adolescents find out that no emotion is permanent, that all are survivable and none are inherently harmful (Laye-Gindhu, 2005). This type of intervention is consistent with both DBT and CBT. It is important to remember that there is no “one-size-fits-all approach to the treatment of SMB [self-mutilative behavior]” because what causes it, what makes it continue, and what results from it are so varied (Nock, 2005).

A different researcher suggested the building of skills in coping, distress tolerance (being able to put up with negative events or emotions), problem-solving and communication along with the “identification, labelling, and verbalization of emotions,” and conflict resolution (Muehlenkamp, 2006). A different researcher concurred and said that clinicians “need to focus on helping the client to find more adaptive ways to tolerate intense emotions and regulate their emotions” (Heath, 2008).

Professionals need to be involved, and they need to evaluate if adolescents have any underlying mental health issues (Stanford, 2009). Mood disorders like depression or anxiety may be the impetus for NSSI. If so, if they can be controlled, the urge to engage in NSSI may also be controlled.

The idea of compassion focused therapy (CFT), a derivative of CBT is suggested as useful because it deals with shame and “self-directed hostility” (Van Vliet, 2011). Although this author could not find scientific research on the effectiveness of this treatment, one researcher states that CFT “attempts to encourage self-soothing behaviors, foster self-acceptance, and help people feel connected to others,” and, as such, “CFT may be particularly well-suited to address the most common functions associated with self-injury” (Van Vliet, 2011).

Yet another researcher saw the need for teens to be able to process especially the difficult aspects of their past in relationship to their whole story. Adolescents need to see that there are hard times, but that they are only part of their entire autobiography. A therapist can give a teen a place and assistance in telling their larger story and seeing how even traumatic events fit into it (Hill, 2012).

Another aspect that may need to be addressed in the life of an adolescent engaging in NSSI is body image. This has been seen more in clinical practice than in scientific research. If a teen can feel more connected to her body and develop a “stronger” body image, she may become less able to hurt herself through NSSI (Muehlenkamp, 2012).

Mentalization-based treatment for adolescents (MBT-A) assists a teen to understand “actions in terms of thoughts and feelings” (Rossouw, 2012). In a small year-long trial that included both individual and family therapy, this was found to be more effective than “treatment as usual” (Rossouw, 2012). This approach appears to warrant further testing as a viable treatment for NSSI.

As demonstrated above, a therapist has many tools to choose from in working with a teen who is engaging in NSSI. Not all treatment will be the same since each young person is an individual with her own, unique story. In my view, treatment options need not be antithetical to an evangelical Christian worldview. It is most likely that a therapist will be teaching your youth skills for emotional and relational health that could benefit all of the teens you work with. Now we will turn to specific things that you, the leader, can do to provide a healing environment for your teen.

### **What Can I Do to Help?**

After an initial referral to a professional therapist and an engagement with the family of your teen, there are still things that you can do to assist in recovery. Perhaps one of your questions is how to be in relationship with one of your youth who is cutting or engaging in some other form of NSSI. If you feel you are walking on eggshells, your teen will recognize this as phony and quite possibly call you on it. This feeling may also indicate that you are more focused on the behavior than on the person. You will be most effective when you turn to your teen and consider how she would judge your participation to be most helpful. To this end, take a posture of active listening. The goal here is not to pry into an adolescent’s inner life or the progress of her therapy, but simply

to give her a place to express what's going on for her and how she feels, should she decide to use it. Use open-ended questions (those that cannot be answered with a "yes" or a "no"), and give your teen space to either respond or not. If you have built trust as a youth leader, you may find that your charge wants to talk with you. If your teen is asking questions, it is always fair to say, "I don't know" or "That would be a great question to ask your counsellor." So don't be afraid to open the conversation.

A second valuable thing you can provide for your young person, in addition to space for her to talk, is a model of your own healthy way of dealing with emotions. Your youth will learn most from watching what she sees you doing in times of high emotion. As it is appropriate, talk with your teens about what you are feeling and what you are either doing currently or will be doing in the future with those emotions. What works for you? Will you be going for a run after your youth meeting is over? Will you be taking some time in silence for prayer? Will you go for a walk in nature and remember that the God who created the world is also the God who remains in control? Perhaps you use something artistic and create some sort of visual or performance art. Maybe you journal to get some of those big emotions out. Whatever you do in a healthy way to deal with your emotions, share that with your students, not as a "lesson" but in a real-life situation. What you do will have a much greater impact on your youth than what you say. This is a powerful tool that is not necessarily available to a therapist in a 45 minute weekly session.

Another key thing you can do to help your young person is to provide for her safety by maintaining confidentiality. You have been given the privilege of knowing

things about this young woman that would otherwise remain private. Be mindful of not mentioning anything to members of the group, whether directly and explicitly or subtly and by intimation. This information is the young woman's, and her privilege to disclose, when and with whom she sees fit. Also avoid the insidious trap of offering more than you should in the guise of a prayer request. "Please pray for one of my youth group members who is struggling," may be sufficient to call your community to prayer. God will most certainly know how to apply those intercessions as appropriate.

### **How Does Youth Group Help?**

Many evangelical Christian churches continue to hold youth group to both educate young people about Scriptural truth and give them a safe place to have fun. Often the former goal is accomplished through a Sunday School or Church School setting, and the latter through "youth group." Youth groups tend to meet outside of the regular Sunday morning worship time and are often divided according to designations within the public school system. This means that there may be a Middle School group and a High School group in a church that has enough adolescents in these birth cohorts.

One important element of youth group is that it brings young people together in a social setting that is not as rigid as school, but is still supervised so as to be protected. This can be a helpful tool in moving teens out of the isolation that so many experience during these years. This is especially important for youth who have a tendency toward depression. When the youth group does things together or works together toward a common goal, bonds of friendship can sometimes be forged between individual members that may last well into adult years.

The simple act of doing things together is another way that youth group can come alongside therapy for those with NSSI. Doing fun things may help teens to stop a negative pattern of rumination by giving them something else to think about, and can give them hope as it can offer positive anticipation of group experience. Research has shown that in some instances those who engage in NSSI spend more time “doing nothing” than those who are not involved in this behavior (Buresova, 2013). Youth group simply gives kids something to do—a reason to get out of the house and into a more public environment.

If a youth group takes on a service project, such as feeding the homeless or visiting those in nursing homes, it can contribute to a teen’s sense that she serves an important role in her world. This can help to increase the self-esteem an adolescent feels. She can also be taught about the Scriptural narrative of creation—that she was created in the image of God (Genesis 1:27), and that God sees worth in every human being (Matthew 10:31). This is something that you as a leader can model for her as you listen and encourage each member of your group.

Another important element of youth group can be peer leadership. For the young woman being groomed for leadership, this may mean special, focused attention from an adult leader and continued mentoring. For others in the group it may signify someone of their own age to whom it is okay to express their thoughts and feelings. Research has shown that adolescents are much more likely to go to their peers with problems than to their parents or teachers.

Finally, youth group can be a place for young people to be heard. There can be times in this context where what an adolescent says about herself and her world can come center stage. Whether this is in a meeting with the entire group or a mentoring session with a leading peer or an adult, giving a young girl a place to speak her mind is an important element that can come alongside therapy. Often such conversations take place in a car on the way to an activity or service project. Sometimes confidences are offered while working on a project side-by-side. Today's youth leaders may find out an adolescents' deeper thoughts through a text message or a Facebook post. Regardless of the form it takes, these are all ways a young person can be truly heard by a caring peer and/or adult.

As we have seen, youth group has many benefits for those dealing with NSSI. It is a social setting that can work against a feeling of isolation. Getting out and doing fun things can help stop a negative thought pattern. Participating in a service project can increase self-esteem. Peer leadership can bring an opportunity to be mentored. Youth group can also be a place to simply be heard. For further reading on mentoring, see suggestions on page 275.

### **Spiritual Practices**

In addition to being with your adolescent by giving her space to talk, showing her your own methods of dealing with high emotion, and involving her in youth group, there are some important spiritual practices that you can teach your teens that will help them to deal with their lives and emotions in healthy ways. For further reading on spiritual disciplines, see suggestions on page 275.

## Quiet Time

A central practice for many evangelical Christians is having a prayer time or a quiet time on a daily basis. Most advice for beginners suggests starting out one's day in this way so that it prepares the soul and does not get lost in the rush of everyday life. Elements of a quiet time practice often include reading Scripture, possibly with the guidance of a daily devotional, and silent prayer. This is a time when an adolescent can reconnect with God and have her spiritual compass recalibrated. It can be a reminder that God is in charge. The fate of the world does not rest on the teen or her actions. The story of the world is much larger than her own situation. It is also an opportunity to experience again the love of God for her.

From a non-spiritual perspective, beginning the day with a time of silent meditation serves to center the individual. It is an opportunity to empty out the previous day's bucket full of emotions so that a teen can enter the new day at an emotional equilibrium rather than at yesterday's level of high emotion. The only caveat here is that if you are working with a young woman who is depressed, it may be good to encourage her to spend less time alone and less time ruminating over the events of the previous days. In that case, some less isolating practices can be encouraged. For further reading on prayer and quiet time, see suggestions on page 276.

## Music

Another excellent method of self-soothing (something those engaged in NSSI may need to learn) is listening to or participating in music. Music is already a large part of many teens' lives. In an evangelical Christian setting, a young person can be

introduced to a large variety of genres and styles of music where the lyrics have uplifting themes. Many styles have “Christian” artists who perform that type of music. Many “secular” artists also produce songs with positive messages.

Participating in music can also be self-soothing. If your teen plays an instrument or sings, practice alone or with others can be very positive. Many evangelical churches now opt for a “worship team” rather than an organ or a piano. There may be opportunities being a member of such a team to play or sing contemporary music with an uplifting message. For further reading on music, see suggestions on page 276.

#### Scripture Memory

From the youngest of ages, evangelical Christians often encourage the memorizing of Scriptures. Choosing and memorizing verses specifically geared toward combatting anxiety or depression or loneliness or anger can be helpful. For instance, 1 Peter 5:7 says, “Cast all your anxiety on him because he cares for you.” Deuteronomy 31:8 states, “The Lord himself goes before you and will be with you; he will never leave you nor forsake you. Do not be afraid; do not be discouraged.” Ephesians 4:26 reads “‘In your anger do not sin’: Do not let the sun go down while you are still angry...” For evangelicals Christians who would characterize themselves as having a relationship with Jesus Christ, Scripture can be seen as a love letter from an inner circle relationship.

From a non-spiritual perspective, these positive affirmations can be used like coping cards in CBT. A client chooses a phrase that will combat an automatic thought she has. She writes down the challenge to the thought and when she begins to feel her emotions slide to the negative side, she takes it out and reads it to remind herself of what

is true (or at least that there is some evidence that her thoughts might not be totally realistic).

Another skill that can be practiced with teens is an ancient one called *Lectio Divina* (Divine Reading). Here, a passage of Scripture, often a narrative passage or “story” is read aloud to a group. When first heard, the listener is supposed to just let the words flow over her in silence. The same passage is read aloud a second time, and this time the listener is instructed to see if any words or phrases particularly stand out to her. After a time of silence these words or phrases can be briefly shared. The passage is read a third time and the listener is asked to take the word or phrase that stuck out to her and explore with God what that might mean to her. Here, the listener engages not only her cognitive abilities as she thinks about context and content, but her imagination as she opens her mind to hear beyond the words what might be there for her specifically on a given day. For the evangelical Christian, this may be an activity that can breach the divide between head and heart (Peace, 1998). For further reading on Scripture memory, see suggestions on page 276.

### Journaling

If you have young people who do not seem to be depressed, you may want to encourage them to journal (Peace, 1998a). This practice can become a daily habit or “when I really need it” activity. It is a way for adolescents to empty out and sort through what they are feeling. They can be encouraged to write their prayers to God and to see what they think God might be saying in reply. Some teens have used journaling to great advantage when they are especially angry or especially happy or even especially

emotional with something they can't quite describe. It is helpful to the individual to be able to name the emotion she is feeling, and journaling can assist a young person in doing this. For further reading on journaling, see suggestions on page 276.

### Taking Every Thought Captive

A teenager can also be taught to “take every thought captive” (2 Corinthians 10:5). As in CBT, she can learn to become attuned to what she is saying to herself in her mind and evaluating her thoughts as fact or fallacy. Just because she thinks something (e.g., “Everybody thinks I’m a loser.”) does not make it true. Looking for evidence of the truth of what she thinks can be an important skill for an adolescent to learn. If she can find evidence that the statement she hears in her head is only 25% true (“There are some people who think I’m a loser.”) it can change her mood and outlook on life. This may also help her self-esteem. (“There may be some people who think I’m a loser, but they’re not my friends, so I don’t care what they think about me.”) The leader can also do some reading on CBT and become familiar with the cognitive fallacies<sup>4</sup> defined in that method of treatment. This will enable her to help her adolescents take every thought captive. For further reading on Taking Every Thought Captive, see suggestions on page 276.

### A Unit on Emotions

Another way a leader could help her youth who are struggling with NSSI is to actually teach a unit on emotions in the Psalms or emotions in Scripture. She can begin

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<sup>4</sup> Typical thinking errors include: All-or-nothing thinking, Catastrophizing, Discounting the positive, Emotional reasoning, Labeling, Magnification/Minimization, Mental filter, Mind reading, Overgeneralization, Personalization, “Should” and “must” statements, and Tunnel vision. (This list is adapted with permission from Aaron T. Beck, the father of CBT, and can be found on pages 181 and 182 of Judith S. Beck’s Second Edition of *Cognitive Behavioral Therapy: Basics and Beyond* published in 2011 by the Guilford Press in New York.)

by asking what emotions are. Among other things, emotions act as signposts for what is happening inside an individual. She can also make the point that all emotions are “okay.” They are neither good nor bad to have, they simply exist. Emotions just “are.” However, we don’t have to be controlled by our emotions. They exist, but we can respond to them in any number of different ways. We can use them as information, we can act as they are leading us to, or we can act counter to the direction in which they are leading us. In other words, the important thing is how we deal with our emotions.

The leader could use the book of Psalms as a walk through emotions. In some ways, Psalms feel like reading David’s and the other composers’ private journals. One of the first steps in emotion regulation is the ability to identify different emotions. The leader can set up a series of lessons that begins with describing how the author of a particular Psalm seems to be feeling at the time it was written. For instance, in Psalm 31, the author appears to move from fear to resignation to anger to happiness to gratitude to grief to loneliness to paranoia to hope.

Once teens can identify emotions in the text at hand, the leader can ask how the teens have experienced similar emotions in their own lives. The leader can encourage the adolescents by telling them that identifying and saying what they are feeling does not have to be a mystery—it’s a skill to be learned. Teens can either share their stories of their own emotions with each other or write them on a hand out.

Finally, once emotions have been the focus of study, the leader can help the adolescent look for the emotions in their everyday lives. When a teen tells the leader a story about what is going on at school, the leader can prompt, “And how did that make

you feel?” When the adolescent is talking about struggles within the family, the leader can prompt, “And what are you feeling now when you talk about it?” As one trains oneself as a leader to ask these questions, the leader will be helping teens to name their emotions and talk about how they feel, rather than keeping it all jumbled up and bottled up inside. For further reading on emotions, see suggestions on page 277.

I hope this has been helpful to you, youth leader in an evangelical Christian church. I hope that you feel less afraid and powerless than you did before you read this. In this chapter, we have looked at getting your teen into therapy, what NSSI actually is, the many purposes of NSSI, treatment options for NSSI, what you can do to help, the power of youth group, and spiritual practices that you can teach your group. We ended with some ideas for a unit on emotions.

If you implement a few of these ideas, it is my belief that you can become an important player in the healing process for your teens. You have gifts to offer from a spiritual perspective that an adolescent is very unlikely to get in a therapeutic relationship. You can also be engaging in prayer for your youth who is cutting. I encourage you to: “Be strong and courageous. Do not be afraid; do not be discouraged, for the LORD your God will be with you wherever you go” (Joshua 1:9).

## **For Further Reading**

### **Mentoring**

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Kreider, Larry. (2014). *The Cry for Spiritual Mothers & Fathers: The Next Generation Needs You to Be a Spiritual Mentor*. Ada, MI: Regal.

### **Spiritual Disciplines**

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### **Prayer**

Pennington, Basil. (2007). *Finding Grace at the Center: The Beginning of Centering Prayer*. Woodstock, VT: Skylight Paths.

Beckmen, Richard J. (1995). *Prayer: Beginning Conversations With God*. Minneapolis MN: Augsburg Fortress Publishers.

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## **Quiet Time**

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### **Taking Every Thought Captive**

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George, Elizabeth. (2014). *Beautiful in God's Eyes for Young Women: Looking Good from the Inside Out*. Eugene, OR: Harvest House Publishers.

Scazzero, Geri. (2014). *The Emotionally Healthy Woman*. Grand Rapids, MI: Zondervan.

Hart, Dr. Archibald D. and Weber, Dr. Catherine Hart. (2008). *Is Your Teen Stressed or Depressed?: A Practical and Inspirational Guide for Parents of Hurting Teenagers*.

Nashville, TN: Thomas Nelson.

Hart, Dr. Archibald D. (2005). *Stress and Your Child*. Nashville, TN: Thomas Nelson.

### **Emotions**

Bottke, Allison (2014). *A Young Woman's Guide to Setting Boundaries: Six Steps to Help Teens\*Make Smart Choices\*Cope with Stress\*Untangle Mixed-Up Emotions*. Eugene, OR: Harvest House Publishers.

Women of Faith. (2012). *Making Peace with Your Emotions: Living Life to the Fullest*. Nashville, TN: Thomas Nelson.

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## PART IV

### CONCLUSION

#### **Conclusions**

This project has identified evidence that will introduce church workers to ongoing research on cutting and its meaning, as well as to different clinical responses. As a result of this knowledge, youth workers can be guided and empowered to feel safer and more confident in listening to and responding to adolescent females who cut. Additionally, volunteers are encouraged to draw carefully and reflectively on Christian practices familiar to them as their contribution to the care of adolescent females who cut.

Equipped with the knowledge this project offers, youth workers, even those with no clinical experience, may be helpful to teenagers experiencing NSSI. When this phenomenon is little understood, it may be difficult for an evangelical Christian church youth pastor or volunteer leader to see a role for herself in helping youth experiencing this issue. This is not to say that all of what the church youth leader has to offer will be equally useful to a teen who is dealing with cutting. We have seen that the roots of NSSI differ from individual to individual, and effective treatment must differ also. However, this project has shown that there is hope that some practices already in place in many evangelical Christian youth group settings can be helpful in promoting positive means of health through spiritual means.

The unique aspects of this project are twofold. The first is providing an exhaustive survey of the range of ways the physical act of cutting has been studied, noting that each interpretation of its meaning is coordinated with a distinct pattern of intervention. The

collection of data has been cross-disciplinary, thereby forming a more complete history of research and current best practices.

This work is unique in a second way, in examining how some spiritual practices may be helpful to youth dealing with NSSI. In fact, it encourages evangelical Christian youth workers to draw creatively, cautiously, and judiciously on the historic practices of their faith to enhance the care received by young women who cut.

This project has explored the geographic divide in the use of terminology, as well as the cross-disciplinary use of similar, yet unique terms to describe what we have chosen to call NSSI. Some of the terminology has seen change over time, yet differences persist. This project has shown the use of no less than seven different names for NSSI. Once defined, we have explored the difference between NSSI and a suicide attempt positing that NSSI may even be an effort to preserve life rather than end it.

We have shown that the prevalence of NSSI is increasing among teenagers worldwide, that the age of onset is roughly equivalent to the decreasing age of puberty, and that while earlier studies defined this as a larger problem among females, more recent research has moved toward a more equal representation between males and females over the course of a lifetime.

The existing research offers at least fifteen reasons for or functions of NSSI. These include social and environmental issues, personality traits and internal vulnerabilities (where we looked more closely at borderline personality traits and impulsivity), emotion dysregulation, lack of application of adaptive coping tools, lack of ability to name feelings and communicate them to self and others, childhood trauma, self-

punishment, the problem of contagion, sleeping issues, lower socio-economic status, substance use, eating disorders, biological factors, body image issues, and future orientation and hopelessness. Within the research there was also information debating the usefulness of various specific treatments and a wealth of good general treatment guidelines.

We then looked at the literature through the eyes of the clinician working with youth involved in NSSI. Here we found that internal risk factors included affect regulation issues, difficulty with depression and anxiety, borderline personality features, increased suicidal ideation, difficulties with body image, self-blame, self-hatred and previous psychological treatment. External risk factors were also identified. These included social isolation or lack of social supports, school stress and bullying, parenting and/or family issues, childhood trauma, lower socio-economic status, and substance use. The triggers for NSSI discussed were relational factors, problems with school work, a precipitating event with direct impact on identity or sense of autonomy, recent loss, self-criticism when combined with negative feedback, and internet content on cutting.

Once NSSI was discussed from the perspective of the researcher and the clinician, we moved on to look at specific spiritual practices prevalent within evangelical Christian church youth work. Daily quiet time, prayer, Scripture memory, music, youth meetings, and mentoring were described for those researchers and clinicians who might not be familiar with these practices.

Finally, we looked at NSSI from the perspective of the youth worker. We began by emphasizing the importance of a young person experiencing NSSI getting help to find

a trained clinician to come alongside and suggested methods for how a youth worker might interface with the family of the youth experiencing this issue. Then we attempted to define NSSI from the perspective of a layperson, focusing on the purposes of NSSI and possible treatments. We looked at spiritual practices that could be among those resources available for the care of someone who cuts. We focused on how the youth worker could, in each particular instance, explore with the person suffering ways in which one and/or another among these practices could be effective. We focused on how the youth worker could help by introducing their charges to daily quiet time, music, scripture memory, journaling, and taking every thought captive. We then suggested a unit that youth workers could teach that would look specifically at emotions and help a young person to name their emotions and hear about some possible positive ways to handle them.

### **Limitations**

Limitations of this study will be found in the fact that little empirical evidence currently exists to support the anecdotal evidence that evangelical Christian practices such as daily quiet time, prayer, scripture memory, music, youth group, and mentoring promote healing for those who cut. These are things that must be tested empirically in a future context. Additionally, the conclusions drawn here may be relevant only to that small part of the Christian church that identifies itself as “evangelical.” Whether or not the conclusions are generalizable beyond that community remains to be explored. Finally, this project is limited in that, although it is an important resource in and of itself, it is also a stepping stone to the creation of a curriculum resource that can be made available to a wider audience of church youth workers. The next step beyond the scope of this Doctor

of Ministry project is the actual crafting of a document designed for the consumption of church workers.

### **For Further Research**

In order to prove their efficacy, empirical study must be completed showing the application of specific spiritual practices in the lives of teens engaged in NSSI. Perhaps this is a subject of research that an institution such as Rosemead School of Psychology would undertake due to its dual allegiances to conservative Christian theology and psychology.

In addition, it would be most helpful if researchers across disciplines and cultures could agree on a terminology for what we are calling NSSI. In this way those working with the same phenomenon from different perspectives could benefit more easily from each other's work. I suggest the adoption of the ISSS definition of NSSI as standard across disciplines and geographic divides.

It is my hope that researchers, clinicians, and evangelical Christian youth workers find in this document information that can help educate them about the issue of non-suicidal self-injury. At the outset, I had hoped to find one, underlying antecedent to NSSI behavior, and one, specific therapy that would prove effective. I also believed that NSSI should be moved to a diagnosis in the next edition of the *DSM 5*. What I have found, instead, is that NSSI is a symptom, not a diagnosis. There are many possible reasons for self-harm behavior, and treatment must address the underlying function of NSSI in a young woman's life. Although there is no one "right answer" to NSSI, there is much hope for those who engage in it. And this hope grows brighter with the wedding of

spiritual practices to therapeutic techniques. With both the church community and the mental health establishment working hand-in-hand, young souls can be relieved of the burden of NSSI as they engage in the healing environment created by the joint forces of religion and psychotherapy.

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#### Publications

- (2004) *Radical Godliness: The Devotional Writings of Henrietta Heron*. South Hamilton, MA: Trustees of Gordon-Conwell Theological Seminary.
- (2003) *A Million for Christ: The Story of Baraca Philathea*. South Hamilton, MA: Trustees of Gordon-Conwell Theological Seminary.

#### Awards

- 2000 – Student speaker at Commencement at Gordon-Conwell Theological Seminary.
- 2000 – Phi Alpha Chi award. Gordon-Conwell Theological Seminary.
- 2000 – American Bible Society award for the Liturgical Reading of Scripture.
- 2000 – Pastoral Care and Counseling award. Gordon-Conwell Theological Seminary.

## Employment

- 2012 – present Outpatient Therapist, Lahey Health Behavioral Services, Gloucester, MA.
- 2010 – present Minister of Pastoral Care, Gloucester Assembly of God, Gloucester, MA.
- 2004 – 2009 Internet Editor Church History and Theology, Christian Book Distributors, Peabody, MA.
- 1992 – 1996 Youth Pastor, Seaview Baptist Church, Linwood, NJ.
- 1986 – 1996 Social Studies Teacher, Oakcrest High School, Mays Landing, NJ.