Working with People Who Self-Injure:

A Resource Guide for Helping Professionals

By Tracy Riley

(The current version reflects minor revisions I completed in 2019, specifically corrections of typos and minor wording changes made to improve flow and readability.)

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Acknowledgments

My work in the area of self-injury began in the spring of 2006 when I was hired for a short 3-month contract to develop educational materials on the subject of self-injury for students and counselling staff at Queen's University. I would like to thank Dr. Michael Condra and Dr. Carol Harris for their roles in giving me that opportunity and for their support of me in various ways before and since that time. I would also like to acknowledge funding the department received that year through the Women's Campus Safety Grant (Ontario Ministry of Training, Colleges, and Universities), as it, too, made possible that work.

My interests in working with emotion, in mindfulness, and in compassion began, in essence, a very long time ago, long before I learned these particular expressions and terms.

I acknowledge all the many people and paths that have led both to the writing of this resource and to the paths I am currently on in my work and in my life more generally. I carry within my heart and express outwardly my sincere and deep gratitude to many people, for many things.

Never underestimate the power of love, steadfastness in love, and gift.

The beauty of a thing is its depth and meaning being revealed. To perceive that beauty, you need an eye for both appearances and for the invisible radiance of a thing. You also need the capacity to be affected.

—Thomas Moore, *Dark Nights of the Soul*, 2004, p. 223

Contents

Introduction

My warm welcome to you.

Book's Purpose

I wrote this resource guide to help you in your work—to help you feel knowledgeable, capable, competent, and supported when working with people who self-injure. My aim is to provide you with tools that are clear and concise, to create a resource that is short-enough that you will not require a large amount of time to read it, yet that is in-depth enough that it doesn't get tossed into the pile of the mediocre and merely collect dust. I want this resource to be *helpful, useful, and beneficial to you personally*—something that will lead you to conclude, "Reading that book was worthwhile".

I have read many times and been told that many helping professionals across the spectrum lack adequate information about self-injury and how to best assist someone who is self-injuring. As a result, they also feel less confident, if not somewhat lost, and this undoubtedly creates added stress. I would like to help to ease that. My hope is that the more informed helpers are, the more encouraged, strengthened, and less stressed or distressed they will feel when encountering a person who self-injures.

My firm conviction is that one logical thing to do to support healing and well-being is to offer, generate, and inspire understanding, compassion, and benevolence in our care for and handling of one another. This applies to our support of each other at both organizational and peer to peer levels, as well as in our direct and indirect work of aiming to assist those experiencing distress—and specific to the topic of this book, to those who are intentionally injuring themselves.

Organization

The book is organized into two main sections. In Part One, the focus is on providing information to help with understanding self-injury, as well as to set the stage for directions for helping work. In Part Two, the focus is on conceptual and practical information to guide you in your efforts to be of assistance to those who self-injure.

Part One

Understanding

Section One

Self-Injury: Definition, Classification, & Prevalence

Definition and Classification

Let's begin by defining self-injury and the parameters for the type of self-injury this resource guide addresses.

Self-injury is the intentional hurting of one's body tissue done by oneself in a physical way without conscious suicidal intent and for purposes not socially sanctioned.[1]

There are three broad populations of people who self-injure. These are organized in terms of the context in which the self-injury is taking place: (1) those who self-injure in the context of experiencing significant cognitive impairments such as in the case of having a developmental disorder; (2) those who self-injure in the context of experiencing psychosis; and (3) those who self-injure outside of the above contexts and where the self-injury appears to be linked to and occurs in the context of emotional distress.

In the case of developmental disorders, the self-injury is sometimes referred to as stereotypic. In the case of psychosis, the self-injury is sometimes referred to as major. In the case of the last group, where self-injury is linked to emotional distress, the self-injury is sometimes referred to as typical self-injury or non-suicidal self-injury. This latter category is the type of self-injury that is the focus of this guide.

Generally speaking, self-injury falls outside the realm of what is currently viewed as socially acceptable behaviour.[2,3] Common forms that self-injury may take include cutting, hitting, bruising, scratching, scraping, burning, and/or picking. Other forms can include interfering with wound healing, head banging, excessive hair pulling, biting, swallowing or inserting sharp, toxic, or otherwise harmful objects into one's body, and breaking bones. Common body areas include arms, hands, wrists, legs, and stomach. Although research is limited, the typical age of onset appears to be early adolescence. Of course, there are always exceptions.[4]

If you search for research information about self-injury, you will find that it is also referred to by

several other terms. Examples include *deliberate self-harm [DSH]*, *deliberate self-injury*, and *non-suicidal self-injury [NSSI].*[5]

When they do talk about it, people who self-injure will refer to the self-injury and what they do in different ways. It is helpful to pay attention to how people refer to the self-injury that they do and, as a general guide (within reason), to work with their language. So, for example, if a person calls the self-injury "cutting" then "cutting" is a good term to use as opposed to responding to him/her with a term like "self-mutilation". A guiding principle for selecting what language to use in your interactions is to use the language that will be experienced by the individual who self-injures as comfortable, authentic, and respectful.

Prevalence

Adolescents

Jennifer Muehlenkamp and colleagues conducted a review of empirical research studies to determine international prevalence rates of self-injury.[6] They reviewed studies that were published between 2005 and 2011 and that measured prevalence rates of non-suicidal self-injury among adolescents (ages 11 to 18) from community and school samples in various countries around the world. They found

- **There was a mean lifetime prevalence rate of non-suicidal self-injury among adolescents of 18 percent (SD = 7.3)**. Therefore, not quite 1 in 5 adolescents reported engaging in non-suicidal self-injury *at some point in time.*

- Some studies used a single item measure to assess the prevalence of self-injury (a single item question that asked for a dichotomous yes or no response). Combining studies that used only a single item measure, the authors found **an average lifetime prevalence of 12.5 percent (SD = 4.5)**.

- Other studies used a multiple item measure to assess a history of self-injury (e.g. a behaviour checklist). Combining these studies, the authors found **an average lifetime prevalence of 23.6 percent (SD = 8.3)**.

The authors noted that *how* the prevalence of self-injury was assessed strongly affected the results. The method used to measure self-injury (e.g., single-item versus multi-item method), the timeframe used to assess prevalence (e.g., self-injury within the past 12 months or at any time during one's life), as well as how an affirmative response is defined (e.g., an affirmative

response being defined as ever intentionally hurting oneself, even once, versus being defined as 5 or more incidents of self-injury), all contributed to what results were found.

The authors also noted that contrary what is sometimes reported in the media (that self-injury is "on the rise"), over the last five years of the research review's timeframe, the mean global prevalence rates of self-injury appear to have been relatively stable.

College and University Populations

Among college and university populations, Whitlock et al. (2006) found that 17 percent of students reported having self-injured at some point in time and 7.3 percent of students reported deliberately injuring themselves within the last year.[7] In contrast, Gratz, Conrad, and Roemer (2002) found a substantially higher prevalence within a sample of undergraduate students where 38 percent reported a history of self-injury, 18 percent reported having harmed themselves more than 10 times in the past, and 10 percent reported having harmed themselves more than 100 times.[8]

As with other populations, additional research is needed on prevalence in university and college populations, including research that examines the relationship between assessment method and results that was raised in the section on adolescents above. Additionally, for all populations research is needed that determines and distinguishes between different trajectories of self-injury. This could include distinguishing between people who self-injure only a few times over their lives from those who self-injure multiple times, as well as distinguishing between people who self-injure within a short and discrete period of time in their lives (e.g., 1 week, 3 months, a year) from those who self-injure over longer periods of time (e.g., 2 to 5 years or longer).

Adults

Among adults in the United States, approximately 4 to 5.9 percent of adults in the general population and 21 percent of adults in a clinical population have reported deliberately injuring themselves.[9,10,11] Across large-scale studies, no significant gender differences or only very small gender differences have been found.[12,13] Additionally, in a study of prevalence of self-injury among adults in the United States published in 2011, there was no relationship found between the prevalence of self-injury and ethnicity, household income, or education history.[14]

[1] Klonsky, E. D. (2011). Non-suicidal self-injury in united states adults: Prevalence, sociodemographics, topography and functions. *Psychological Medicine, 41*(9), 1981-1986. doi:10.1017/S0033291710002497

[2] Connors, R. (2000). *Self-injury: Psychotherapy with people who engage in self-inflicted violence.* New Jersey: Jason Aronson.

[3] Whitlock, J., Eckenrode, J., & Silverman, D. (2006). Self-injurious behaviors in a college population. *Pediatrics*, 117(6), 1939-1948.

[4] For a review, see: Klonsky, E. D., & Muehlenkamp, J. J. (2007). Self-injury: A research review for the practitioner. *Journal of Clinical Psychology, 63*(11), 1045-1056. doi:10.1002/jclp.20412

[5] The following article mentions some of the international trends with respect to which terms tend to be used and how they tend to be defined: Muehlenkamp, J. J., Claes, L., Havertape, L., & Plener, P. L. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health, 6*(10), 1-9.

[6] Muehlenkamp, J. J., Claes, L., Havertape, L., & Plener, P. L. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health*, 6(10), 1-9.

[7] Whitlock, J., Eckenrode, J., & Silverman, D. (2006). Self-injurious behaviors in a college population. *Pediatrics*, 117(6), 1939-1948. doi:10.1542/peds.2005-2543

[8] Gratz, K. L., Conrad, S. D., & Roemer, L. (2002). Risk factors for deliberate self-harm among college students. *American Journal of Orthopsychiatry, 72*(1), 128-140.

[9] Briere, J., & Gil, E. (1998). Self-mutilation in clinical and general population samples: Prevalence, correlates, and functions. *American Journal of Orthopsychiatry, 68*(4), 609-620.

[10] Klonsky, E. D., Oltmanns, T. F., & Turkheimer, E. (2003). Deliberate self-harm in a nonclinical population: Prevalence and psychological correlates. *American Journal of Psychiatry, 160*(8), 1501-1508.

[11] Klonsky, E. D. (2011). Non-suicidal self-injury in United States adults: Prevalence, sociodemographics, topography and functions. *Psychological Medicine, 41*(9), 1981-1986. doi:10.1017/S0033291710002497

[12] Klonsky, E. D. (2011). Non-suicidal self-injury in united states adults: Prevalence, sociodemographics, topography and functions. Psychological Medicine, 41(9), 1981-1986. doi:10.1017/S0033291710002497

[13] Klonsky, E. D., & Muehlenkamp, J. J. (2007). Self-injury: A research review for the practitioner. *Journal of Clinical Psychology, 63*(11), 1045-1056. doi:10.1002/jclp.20412

[14] Klonsky, E. D. (2011). Non-suicidal self-injury in united states adults: Prevalence, sociodemographics, topography and functions. Psychological Medicine, 41(9), 1981-1986. doi:10.1017/S0033291710002497

Section Two

Self-Injury as Self-Hurt

Generally speaking, when people first hear about self-injury, for example, in a media blurb or through a friend of a friend, they often will have at least some reaction of puzzlement. Questions many people might wonder are: "Why would people deliberately injure themselves? Why would they do that to themselves?" Indeed, some, if not many people might think "here is a behaviour that just doesn't make sense". After all, who would want to deliberately inflict pain on themselves —or experience more pain than they have to? When people have this reaction, they are likely reacting to the most obvious aspect of self-injury: that it involves the direct infliction of harm.

It is very true that self-injury has what I often refer to as a self-hurt side. That is to say, self-injury does involve negative aspects that provide reasons to feel concern. At the very least, it generally speaks of someone who is suffering, which is reason for feeling caring concern. In addition, it does inflict physical harm. Sometimes this harm is substantial and other times minor —although there is always the risk, even in attempts at minor harm, that greater damage is done than was intended, either through the initial injury itself or as the result of a later infection.

Self-injury has other "self-hurt" aspects as well. Examples of difficult things that self-injury is both associated with and may contribute to include depression, feelings of shame, increased suicide risk, and longer term decreased coping.

In their book, *Freedom from Self-Harm* [1], Kim Gratz and Alexander Chapman wrote about the idea that repeated self-injury over time can also result in "coping muscle atrophy"[2], that is, people's skills and resources for coping in ways other than self-injury can weaken and lose their strength when self-injury is the regular or dominant coping behaviour that is utilized. The "coping in non self-harming ways muscles" don't get enough exercise. Of course, it is also often the case that people who self-injure have not had the chance or ability yet to develop strong coping in non self-harming ways muscles, nor necessarily had enough of the skills and resources needed to support this—a topic we will explore in detail a bit later (See Section Six: The Need for Relief: Etiology/Contributing Factors*).*

[1] Gratz, K. L., & Chapman, A. L. (2009). *Freedom from self-harm : Overcoming self-injury with skills from DBT and other treatments.* Oakland, CA: New Harbinger Publications.

[2] See p. 100.

Section Three

Self-Injury's Relationship with Suicide

Most self-injury is a survival technique…it is not typically an expression of the wish or decision to die.
—Pamela Deiter, Sarah Nicholls, & Laurie Anne Pearlman[1]

We have already seen that built-in to the definition of self-injury is the specifier that it is done without the intention of committing suicide, that the self-injury we are talking about is not intended to be a suicide attempt. Although self-injury has frequently been perceived as an attempt to commit suicide, it is now generally understood that self-injury is not an attempt to end one's life.[2,3,4,5] Instead of offering a final escape from distress, self-injury typically offers "a way to stay alive and keep going after achieving…temporary relief from distress"[6]. Burstow (1992) described it as "fundamentally a way of living…a means to get through the day"[7].

This is not to say, however, that a relationship between self-injury and suicide is absent. People who self-injure

- may be at higher risk of suicide[8]
- may be currently suicidal or become suicidal[9,10,11,12]
- may, in some instances, be practicing or planning for suicide[13]
- may inflict injuries that lead to death without the explicit intent of suicide (e.g., by overdose, infection, or complications from severe injuries)[14]
- or may never become suicidal.

With respect to the second last bullet, these instances are thought to be fairly rare; although we do not really know, and, in the case of severe bleeding or an overdose, would be hard-pressed to determine if a person's death was accidental or deliberate and intentional.

Potential Red Flags

In addition to all the usual risk factors and indicators involved in suicide assessment, some potential flags specific to self-injury that might indicate a concern or shift toward increased

suicide risk are

- The sudden onset of new self-destructive behaviour outside of the usual pattern[15]
- A person reporting that self-injury is no longer producing the desired helpful effect. This is a concern because if the person's distress hasn't decreased or his/her other coping skills increased, the person might feel quite scared or overwhelmed when self-injury doesn't provide him/her with relief in the way it usually does.[16]

When one or more of these are noted, careful exploration and assessment should follow.[17]

Good Assessment is Key

Ultimately, the take home message here is that **good assessment is key**. While self-injury may not be a suicide attempt in and of itself, this does not mean definitively that the person is not at risk nor that they will not become at risk. Some people who self-injure can be assumed to be at risk for planned or unplanned suicide[18] and many people who self-injure are not suicidal. Assessment of level of suicide risk is essential.

Questions You Might Ask

To aid in not making assumptions abut self-injury and suicide risk, you might try asking the individual about deliberate attempts to hurt him/herself first, then learn more about what those have been about. There are many helpful questions you can use as you tease apart self-injury and suicide. I'm providing a few suggestions here to give you a starting point. Ideas of questions you might ask include:

- Have you ever tried to hurt yourself on purpose?
- What did you do? (one kind of method or more than one?)
- How often have you hurt yourself? (once, more than once?) When?
- When you did that, what were you aiming to do? Were you trying to kill yourself or something different?

Finding a Balance

It is important to find ways to neither over-react nor over-respond in the face of self-injury such as by insisting a person promise to not self-injure or pushing for hospitalization (especially

against a person's will). At the same time, it is important to not under-respond if a person is at high risk of killing him/herself.[19] Levels of response need to be appropriately geared toward the level of suicide risk. A mistake helpers have sometimes made is to view and treat people who self-injure as if they are in imminent danger of killing themselves when they are not. Such over-responses are not helpful to the person seeking help, and typically will not aid the person in decreasing self-injury.[20]

For suggestions on providing support to a person who self-injures and is experiencing a state of crisis, see Section Eleven: Assisting During a Self-Injury Crisis.

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[1] Quote from p. 1187 of Deiter, P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-injury and self capacities: Assisting an individual in crisis. *Journal of Clinical Psychology, 56*(9), 1173-1191.

[2] Burstow, B. (1992). Self-Mutilation. In *Radical feminist therapy: Working in the context of violence* (pp. 187-201). London: Sage Publications Inc.

[3] Connors, R. E. (2000). *Self-injury: Psychotherapy with people who engage in self-inflicted violence.* New Jersey: Jason Aronson.

[4] Deiter, P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-injury and self capacities: Assisting an individual in crisis. *Journal of Clinical Psychology, 56*(9), 1173-1191.

[5] Smith, G, Cox, D, & Saradjian, J. (1998). *Women and self-harm.* London: The Women's Press.

[6] Connors, R. E. (2000). *Self-injury: Psychotherapy with people who engage in self-inflicted violence.* New Jersey: Jason Aronson. Quote from page 36.

[7] Burstow, B. (1992). Self-Mutilation. In *Radical feminist therapy: Working in the context of violence* (pp. 187-201). London: Sage Publications Inc. Quote from page 190.

[8] Klonsky, E. D., & Muehlenkamp, J. J. (2007). Self-injury: A research review for the practitioner. *Journal of Clinical Psychology, 63*(11), 1045-1056. doi:10.1002/jclp.20412

[9] Briere, J., & Gil, E. (1998). Self-mutilation in clinical and general population samples: Prevalence, correlates, and functions. *American Journal of Orthopsychiatry, 68*(4), 609-620.

[10] Connors, R. E. (2000). *Self-injury: Psychotherapy with people who engage in self-inflicted violence.* New Jersey: Jason Aronson.

[11] Garrison, C. Z., Addy, C. L., McKeown, R. E., Cuffe, S. P., Jackson, K. L., & Waller, J. L. (1993). Nonsuicidal physically self-damaging acts in adolescents. *Journal of Child and Family Studies, 2*(4), 339-352.

[12] Ivanhoff, A., Linehan, M. M., & Brown, M. (2001). Dialectical behavior therapy for impulsive self-injurious behaviors. In D. Simeon & E. Hollander (Eds.), *Self-injurious behaviors: Assessment and treatment* (pp. 149-73). Washington, DC: American Psychiatric Publishing, Inc.

[13] Briere, J., & Gil, E. (1998). Self-mutilation in clinical and general population samples: Prevalence, correlates, and functions. *American Journal of Orthopsychiatry, 68*(4), 609-620.

[14] Deiter, P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-injury and self capacities: Assisting an individual in crisis. *Journal of Clinical Psychology, 56*(9), 1173-1191.

[15] Deiter, P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-injury and self capacities: Assisting an individual in crisis. *Journal of Clinical Psychology, 56*(9), 1173-1191.

[16] Walsh, B. (2006). *Treating self-injury: A practical guide.* New York: The Guildford Press.

[17] Deiter, P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-injury and self capacities: Assisting an individual in crisis. *Journal of Clinical Psychology, 56*(9), 1173-1191.

[18] Deiter, P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-injury and self capacities: Assisting an individual in crisis. *Journal of Clinical Psychology, 56*(9), 1173-1191.

[19] Alderman, T. (1997). *The scarred soul: Understanding and ending self-inflicted violence.* Oakland, CA: New Harbinger Publications.

[20] Alderman, T. (1997). *The scarred soul: Understanding and ending self-inflicted violence.* Oakland, CA: New Harbinger Publications.

Section Four

Self-Injury as Self-Help: Functions and Meanings

...The experience of self-injury, globally, is remarkably similar, and, in detail, diverse.
—Robin Connors[1]

Now we are going to turn our attention to the idea that self-injury is also about self-help. I wrote earlier that until people better understand self-injury, they often feel some puzzlement about why someone would—in their words—"do such a thing"? Indeed, a common and somewhat understandable myth out there is that self-injury doesn't make sense. It is at this juncture that I hope to dispel some of the puzzlement, and further, the myth. Even though it may be difficult to comprehend, a key concept to understand is that self-injury has had at least some point, if not often, a kind of helpful function for a person. As a result, in addition to self-injury having a self-hurt side, you can think of self-injury as encompassing a self-help side as well.

At a fundamental level, self-injury is, in part, an adaptive, meaningful, and life-preserving strategy used to cope with distressing states.[2,3] Although it involves intentional, physical hurting of oneself, it is also often done first and foremost with the general aim or purpose of gaining and experiencing relief. That self-injury serves the general purpose of relief offers a foundation for understanding self-injury as an attempt at self-help and creating solutions—even though some of the results are harmful and the benefits (e.g., a sense of relief) are often short-lived.

People who self-injure report a number of ways in which self-injury assists them—functions that self-injury has or purposes that it serves. The following list provides examples of the variety of meanings and functions self-injury can have and is based on what people who self-injure have said.[4] (These are drawn from multiple sources.[5,6,7,8,9,10])

Self-injury may serve to temporarily help the individual

- manage stress
- distract self from painful memories or feelings
- manage conflict

- focus attention
- increase/establish sense of autonomy and control
- return to reality
- feel reassurance that one is human (flesh and blood)
- self-nurture
- release pent-up feelings
- express anger
- demonstrate or express one's experience to oneself
- punish self or others
- protect self or others
- deal with sexual feelings (enhance or inhibit)
- communicate
- influence others
- get relief from feelings
- prevent disclosure
- stop, induce, or prevent dissociation
- feel euphoric, high, excited
- physically express pain
- replicate elements of an abusive situation or trauma (reenactment)
- release tension
- appease or manage multiple personalities
- get relief from alienation
- obtain needed recognition, attention, or other forms of connection from others
- control the mind when it is racing
- feel relaxed
- feel in control
- reduce tension
- feel less depressed
- feel real
- feel less lonely
- gain purification, transcendence, or penance
- respond to voices
- respond to evil spirits
- feel closer to someone who hurt the individual
- express feelings and needs
- cope
- organize self

- regain homeostasis
- feel special
- feel comforted
- invoke a sense of safety
- reduce unbearable tension
- survive

Reviewing this list, I remember one client I worked with telling me that were it not for self-injury, he believed he would not still be alive today. He said that self-injury helped him to cope and to stay alive and keep living; it even helped him to stave off suicidal thoughts and urges. Another client told me how the concrete physical pain that self-injury produced and tolerating that pain made her feel more able to tolerate and bear the other awful emotional pain and suffering she was experiencing in her life. She said something to the effect of, "If I can tolerate and manage the pain of self-injury, then I tell myself, surely I can manage and tolerate and cope with the pain in my life." Both of these individuals described self-injuring as helping them to cope with stressful and distressing states.

In a research review, David Klonsky[11] organized the functions of self-injury into seven macro categories: affect regulation, anti-dissociation, anti-suicide, interpersonal boundaries, interpersonal influence, self-punishment, and sensation-seeking. The following list provides descriptions for each main type of function as summarized by Klonsky[12] :

- *Affect regulation:* where self-injury functions to alleviate acute negative affect or affective arousal
- *Anti-dissociation (or "feeling generation"):* where self-injury functions to interrupt a dissociative episode or feelings of depersonalization (for e.g., helping a person to feel "more real" again).
- *Anti-suicide*: where self-injury functions as a coping strategy to help a person resist urges to attempt suicide
- *Interpersonal influence:* where self-injury functions to in some way influence another person, for example, to gain needed attention or to be taken seriously[13]
- *Interpersonal boundaries:* where self-injury functions to affirm the boundaries of one's self such as to assist with a sense of being an individual separate from others
- *Self-punishment:* where self-injury functions to express anger or derogation toward oneself. For some individuals, it is believed this may be self-soothing (i.e., provide relief) through fulfilling the need one feels to be punished or hurt in some way.

- *Sensation-seeking:* where self-injury functions to generate excitement or exhilaration. (Klonsky noted that this function is not readily evident in clinical populations although it has been examined often in the empirical literature.)

Of important note, when reviewing evidence for each of these types of functions, Klonsky found **strongest support for self-injury serving an affect regulation function**—that is, where self-injury functions to alleviate acute negative affect or affective arousal in a person. Second, there was also **fairly strong support for a self-punishment function of self-injury**, where self-injury functions to express anger or derogation toward oneself. The other types of functions in Klonsky's review received modest support.[14] Interestingly, the findings of the meta-review were also generally consistent regardless of the characteristics of the population sampled. Regardless of whether participants were from samples of clinical, non-clinical, forensic, adult, adolescent, male or female populations, the findings were similar.[15]

People who self-injure may report (or come to understand) that self-injury is serving one main function for them, or it may be serving more than one. The particular function or functions for a person may stay the same or potentially change over time[16] so it is helpful to be curious about the nature of self-injury's function(s) at any one time, as well as over time, and to recognize that there may be one or multiple functions going on. Of course, each person will have his/her own detailed and unique stories of what function(s) self-injury is/are serving, what "to release tension" or "to punish myself" or "to deal with anger" means in his/her life, what it looks like, what happens, and factors influencing how it has come to be.

In instances where self-injury is serving more than one function, you might inquire if, of these functions, one seems to have more weight or primacy than another. Klonsky examined this question in a follow-up study[17] and found that the majority of participants (85%) reported that affect regulation functions of self-injury were primary for them. Although many participants endorsed self-injury as also serving self-punishment functions, only a minority (15%) said that self-punishment was the primary function that self-injury was serving.

A key take-home message is that self-Injury always serves a purpose. Self-injury is a purposeful behaviour and this purpose is most often fundamentally about bringing relief to the person in the moment in some way. This applies even when the function of the self-injury is not immediately apparent (to the person who is self-injuring, for example).

Understanding what function(s) self-injury is having for a given person helps inform case conceptualization and provides key information for shaping a vision and goals for helping work: both your own ideas of what might help, as well as what you and your client come up with

together.[18]

To close this section, I want to bring into the landscape the idea that the need for relief is both a normal and a shared human experience; ultimately, no one wants to suffer and we all want to feel okay. When working with people who self-injure (and people in general), I find it helpful to hold this in mind (and heart). It creates this nice way for points of connection, ways to join, to feel compassion, to empathize, to understand.

In the next section, we will look at the affect regulation function of self-injury in more detail and at common dynamics involved in self-injury.

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[1] Quote from p. 28 of Connors, R. (2000). *Self-injury: Psychotherapy with people who engage in self-inflicted violence.* New Jersey: Jason Aronson.

[2] Connors, R. (2000). *Self-injury: Psychotherapy with people who engage in self-inflicted violence.* New Jersey: Jason Aronson.

[3] Deiter, P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-injury and self capacities: Assisting an individual in crisis. *Journal of Clinical Psychology, 56*(9), 1173-1191.

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Section Five

Common Dynamics

In the previous section I wrote that self-injury can be understood as functional, serving to provide temporary relief to a person from distressing or stressful states. A common dynamic involved in self-injury includes a sequence whereby there is something emotion-related a person is needing relief from followed by an attempt to gain relief.

Common affect states people report experiencing prior to self-injuring seem to include feeling overwhelmed, sad, hurt emotionally, frustrated, and anxious. Common states people report experiencing after self-injury seem to include feeling relief, anger at self[1], and calmness.[2]

In the case of cutting, there is some data to suggest that there is a significant relationship between (1) the nature and magnitude of emotional change from before to after self-injury and (2) the lifetime number of episodes of cutting.[3] In essence, the more relieved and relaxed individuals felt after self-injury compared to before and the less overwhelmed and frustrated they felt after self-injury compared to before, the higher the number of episodes of cutting they reported having had in their lives to date. This is intriguing correlational data, although causation about the nature of the relationship should not be concluded or assumed.

In 2006, Alexander Chapman, Kim Gratz, and Milton Brown published an article in which they provided a theoretical framework for understanding self-injury.[4] The framework is based on behavioural theory and the overarching premise is that self-injury helps the individual to escape, manage, or regulate emotions. They called this the *Experiential Avoidance Model of Deliberate Self-Harm.* It was developed as an attempt to synthesize research on self-injury and to provide a clinically useful resource.

In this model, there is a basic affective sequence involved in self-injury where there is first some kind of stimulus that elicits an emotional response in a person (e.g., anger, numbness, shame). This emotional response is experienced as negative and is something that the person feels a strong need to move away from or to gain relief from. The need to move away from the emotional response is referred to in the model as avoidance. The person accomplishes moving away from the emotional response by deliberately injuring themselves. After self-injuring, and

because of self-injuring, the person feels relief in some way.

Stimulus → Emotional Response → Avoidance → Self-Injury → Temporary Relief

By definition, the feeling of relief the person gets negatively reinforces the self-injury. The self-injury brings the person into a more desirable state, at least temporarily, by providing them with some relief from (or removal of) an inner experience that is very difficult or distressing. Because self-injury helps or works, it makes it more likely a person will turn to self-injury again when the need arises. It also follows that if a person tries self-injury and it doesn't work or help in some way, the person is ultimately less likely to turn to self-injury again in the future.

Although not outlined explicitly in the model, an additional issue to note is that, for at least some individuals, what follows feelings of relief are feelings of shame or other unpleasant and self-condemning kinds of experiences and feelings. So first a person will feel some relief, and then some time after that s/he may experience a decline in mood and experience additional difficult thoughts and feelings.

… Temporary Relief → Shame …

The model also incorporates the idea that over time people may get used to—in a sense to habituate to—the undesirable effects of self-injury, which is to say a person may sort of tune out the negative aspects of self-injury somewhat or downplay them. Also, over time, certain emotional responses may come to cue a person to self-injure in a fairly automatic way. So for example, at that first or early sign of stress or anger, a person may turn fairly automatically to self-injury.

Finally, the model incorporates the idea that there are other factors and vulnerabilities that may exist and contribute to a person's experiences and, by extension, the dynamics and the sequence often seen in self-injury. For example, a person who has difficulty coping when emotionally aroused (e.g., such as by having difficulty finding a way to feel soothed, reassured, or calmed) may be more likely to experience the emotional arousal as threatening because it is hard to find a way to get out of it and feel eased. The experience of threat may lead to a heightened need to try to escape such as through self-injury.

Although this model highlights some of the dynamics that may be involved in self-injury, none of this is to suggest that change is not possible. I want to emphasize that change is possible and things can improve for a person who is struggling in these ways.

Because of the emotional sequences and attempts to manage emotional states that the model outlines, I think we can view this model as essentially an affect regulation model of self-injury. Whether or not intended, its mention of experiential avoidance invites consideration of an important element that is both involved in and related to affect regulation: specifically, the nature of a person's relationship to the emotions s/he has. In my opinion, this is a very important element and therapeutic concept to understand and explore—something we will look at later when we explore ways of helping.

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Section Six

The Need for Relief: Etiology/Contributing Factors

Research to date suggests that self-injury is best understood as having multiple determinants.[1] These can include environmental, psychological, and biological factors that interact with and influence each other and may contribute to a person self-injuring. Contributing factors can affect the presence and levels of distress individuals experience, as well as their capacities to cope including in non self-harming ways. There is some evidence that risk factors can be significantly different between men and women.[2,3]

With respect to **environmental factors**, there are a multitude of difficult circumstances and experiences of adversity that are noted as being possible contributing factors to self-injury. These may have happened in the distant or recent past with significant impacts on present experience. Examples include

- childhood abuse and/or neglect[4,5,6,7,8,9,10]
- childhood loss, separation, placement outside the home, surgery, significant illness, and family alcoholism[11,12]
- parental criticism[13]
- sexual assault during adulthood[14]
- other significant stressors such as academic pressures, family conflicts, cross-cultural stresses[15,16,17,18]
- the repeated experience of invalidation[19,20]

Please note that these are examples only and that not all individuals who self-injure report a history of abuse: many do, many do not.[21] It's important to be aware of possible contributing factors but to not make assumptions about what they are for a given individual.

It has been suggested that difficult circumstances such as those above may contribute to self-injury through the psychological impacts they can have on a person, which are also associated with self-injury. (For example, childhood abuse and the lack of consistently physically and emotionally safe caregivers can contribute to emotion dysregulation; emotion dysregulation is a

psychological factor associated with self-injury.) The concept may be especially relevant when considered in a developmental context.[22]

A person who was abused or witnessed abuse while growing up or who lost a significant attachment figure or who was chronically stressed or who experienced a loss of health during childhood—this person is much more likely to feel less safe in the world, less trusting, more stressed, less hopeful, and/or more easily overwhelmed. The reasons for this can have to do with both neuropsychological and biological impacts of their experiences. Such a person may have a tendency to feel worse about him/herself, to have less support, or to be less able to believe that care and support exist or will be there for him/her. Such a person may have concluded he/she is bad and is deserving of harsh treatment or punishment, whether physically or emotionally or both. Any combination of these things can make life feel (and be) quite hard. It can result in both having a lot to try to cope with, as well as not necessarily having as many developed inner and outer resources to aid with coping. Having a lack of resources for coping including inner resources such as having a strong learned sense of self-worth, safenes and reassurance, or self-efficacy may make a person more vulnerable to coping via self-harmful methods.

With respect to **psychological factors**, there are several factors that have been found to be associated with self-injury and are hypothesized to be contributing factors for at least some individuals:

- insecure parental attachment[23]
- dissociation[24]
- difficulties with the experience, awareness, understanding, and expression of emotions[25,26]
- overgeneralization[27,28]
- the experience of more frequent and intense negative emotions[29]
- self-criticism (in the context of childhood emotional abuse[30], as well as separately, among young women[31])
- self-derogation[32]
- shame[33]

These psychological factors can largely be summarized as falling under the rubric of *impaired self-capacities*, which have also been found to be associated with self-injury and hypothesized as factors contributing to the need to self-injure and/or to the maintenance of the behaviour.[34] In brief, impaired self-capacities include emotion dysregulation, as well as difficulties in the areas

of identity and relatedness.[35,36,37]

We will explore self-capacities in more detail in the section below. They constitute an extremely valuable concept for working with people who self-injure (as well as for much other work). As we have already begun to see, struggles related to self-capacities—such as the experience of negative thoughts and feelings about and toward oneself and the experience of emotions and states that are experienced as aversive and distressing and that lead to feeling a strong need for escape or relief—these help to lay the foundation for our understanding of self-injury, as well as for our helping work.

Self-Capacities: A Treasure Chest for Our Work

As noted, people who self-injure may have fewer resources to rely on when faced with difficult circumstances, external resources and internal resources included. Self-capacities can be thought of as an internal resource. They are "inner abilities"[38] that help people to

1) maintain a sense of connection with others
2) experience, tolerate, and integrate strong affect, and
3) maintain a sense of self as viable, benign, and positive.[39]

Thus, self-capacities help people in the areas of relatedness, affect regulation, and identity.[40] They are required "in order to maintain a sense of self and to maintain internal balance"[41]. Self-capacities as inner resources are also, undoubtedly, at least in part, affected by external factors and circumstances.

It is proposed that a person with strong self-capacities is more likely to be able to be successful in the following tasks[42]

- **To maintain a sense of connection:** to "form and maintain meaningful relationships with other people that are not disturbed by inappropriate projections, inordinate fear of abandonment, or activities that intentionally or inadvertently challenge or subvert normal self-other connections"[43];
- **To tolerate strong affect:** to "tolerate and control strong (especially negative) emotions without resorting to avoidance strategies such as dissociation, substance abuse, or external tension-reducing behaviors"[44] such as self-injury;
- **To maintain positive self-regard and sense of self-worth:** to "maintain a sense of personal identity and self-awareness that is relatively stable across affects, situations, and interactions with other people"[45].

Self-capacities may be impaired (not yet fully developed) in many people who self-injure. In a study by Pamela Deiter, Sarah Nicholls, and Laurie Anne Pearlman (2000), both childhood abuse and self-injury were found to be associated with impairment in self-capacities.[46] The greatest impairment was found in individuals who reported a history that included both childhood abuse and self-injury. The next greatest impairment was found in individuals with a history that included self-injury but not childhood abuse. The third greatest impairment was found in individuals who reported a history of childhood abuse and no self-injury.

The findings support the theory that self-capacities are not fully developed when someone grows up in an abusive environment[47,48]: "The adult survivor with impaired self-capacities may live in alienation instead of connection, experience terrible affects that he or she cannot soothe, and experience him or herself as toxic, unworthy of living or unable to live"[49]. Self-injury may be viewed "as one adaptation that helps the survivor live through the inner life that has resulted from the original abusive environment"[50].

The findings also highlight some additional important points: (1) that individuals may have impairments in self-capacities *regardless* of whether they report histories of childhood abuse and (2) that people who self-injure may have such impairments. This was also observed in a study of prevalence, correlates and functions of self-mutilation conducted by John Briere & Eliana Gil (1998).[51]

It is believed that addressing the distress resulting from impaired self-capacities and facilitating the building of self-capacities so that an individual can maintain a sense of connection with others; experience, tolerate, and integrate strong affect; and maintain a sense of self as viable, benign, and positive will help support the cessation of self-injury.[52]

Self-Capacities and Capacities to Cope are Malleable and (Can) Change

Generally speaking, self-capacities and capacities to cope are malleable and can change. It is also the case that capacities to cope are related to both internal and external resources and factors.

You, I, and each person we encounter in our lives is always navigating whatever is happening in life and utilizing our resources and capacities for coping. Sometimes, perhaps for long periods of time, you might not really notice or give this idea much thought. At other times, perhaps due to certain experiences or factors occurring, you might find yourself acutely aware of the topic of "coping" and "capacities to cope". You might find yourself acutely aware of the interplay

occurring between your self and your internal and external circumstances over which you have varying degrees of choice and control—from very little to quite a lot.

During these times and in general, you may find yourself engaged in a process that is twofold. The process involves (1) recognizing the *limits* of one's capacities to cope (we can only do so much in a day no matter who we are) and trying to function well within those limits; and (2) trying to *enhance and support* one's capacities to cope so that we can manage better, perhaps to feel more okay or well. In a certain way, this is not unlike the acceptance versus change dialectic highlighted in some psychotherapies (dialectical-behaviour therapy and acceptance and commitment therapy, as two examples), or, more aptly, this entails a focus on both acceptance *and* change.

A metaphor that could be used to describe the concept of a person's capacity to cope is that of fluctuating levels of water in a well where the water level represents a person's capacity to cope at any given time and the water represents resources a person has available to draw on to cope. Resources (the water) include both internal and external things such as having access to and the ability to maintain supportive connections with others, a strong sense of self-worth, positive views of the world, effective ways of tolerating and dealing with strong emotions, financial resources, good health, adequate sleep and nutrition.

The *level* of water in the well—*a person's capacity to cope*—varies. It is influenced by a wide variety of factors such as past and current experiences and the positive and/or negative effects of them. It can have a higher or lower current baseline than someone else's due to factors such as pervasive experiences that are either positive and nourishing or negative and extremely stressful. Water levels always have the capacity to fluctuate or change.

When the water level is high and the well is full, a person is more readily able to cope with a larger volume of difficulty or stress (acknowledging that there are some difficulties that are extremely hard to cope with even when starting with a completely full well). As water levels lower, it is increasingly difficult to cope with the same amount of difficulty or stress and it becomes harder to cope with lesser amounts of difficulty or stress as well.

The point is not to quantify difficulties per se or even resources to cope but instead to highlight the idea that a person's capacity to cope is fluid and can be influenced by many things—both external and internal circumstances and resources. There is an influencing relationship between circumstances (positive, negative, past, present), capacities to cope, and what one actually does (e.g., how one copes, feels, experiences, thinks).

We can apply the metaphor of the well to self-injury by adding five additional words: replacing "capacities to cope" with "capacities to cope in non self-harmful ways". When difficult circumstances exceed one's (non self-harmful) resources to cope, a person may be more likely to turn to coping methods that help in the short-term but that also inflict self-harm. This is not to say each person will do this but it is to suggest his/her level of vulnerability may be higher.

John Briere has explained this concept using the image of two scales sitting on a balance[53]: sitting on the scale on the left is the pain one carries; on the right is one's capacity to handle pain. When the pain one carries outweighs one's capacity to handle the pain, a person is more likely to turn to tension-reducing behaviours such as bingeing, purging, the use of mood-altering substances, or self-injury in order to cope. He reminds everyone, in essence, "The only reason you don't self-injure is because you don't have to"[54]. The only reason you do not injure yourself (or cope in other self-harmful ways) is because your capacities to cope in non self-harmful ways (and all that has contributed to them) have managed to stay above the difficulties life has thrown you.

Closing to Part One

Given that the contributing factors to self-injury will vary to some degree for each person, it is important to not assume that self-injury is always related to only one specific factor, type of experience, or event.[55] The goal is to remain open to and validating of the many circumstances, both subtle and overt, that can adversely impact the human spirit, dampen it down, hurt it, inflict deep stress and harm. These include, though are not limited to, all forms of oppression such as those related to race, age, gender, sexual orientation, socioeconomic status, and culture. Remaining open to multiple potential influences on the development of self-injury will better position you to hear the story that needs to be heard, to help the person whose story it is to also hear it, and to more respectfully and effectively direct a search for solutions. A narrow, closed view of what contributes to self-injury will do a disservice to people seeking help as well as to those trying to assist.

Invitation

As we finish Part One of this guide, the portion focused on providing information about self-injury to assist you with understanding and with having a knowledge base that will be clinically and practically useful, I would like to invite you to pause and consider the following question:

- What might all of this mean for helping work? How does this information inform directions in which helping work might go, things you might be working on?

Now, as you ponder this, perhaps go make yourself a cup of tea or go for a gentle walk. Congratulate yourself: you're halfway through and about to enter "the next chapter" of growing your resources for this work.

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Part Two

Helping

Section Seven

General Framework

Did you enjoy your cup of tea?

Invitation

I closed *Part One* of this guide with an invitation to you, a general question to consider. As we begin *Part Two*, the portion focused on providing you with a framework and tools for your work of providing assistance to those who self-injure, I'd like to invite you to pause and consider a related question, this time:

- What is the goal when you are working with someone who self-injures?

General Framework

In *Part One*, we explored how a typical dynamic involved in self-injury includes a sequence whereby there is something a person is needing relief from followed by an attempt to gain relief via self-injuring. I explained how there are a variety of more specific functions that people describe self-injury serving and that the two over-arching functions that self-injury often entails include an affect regulation function (where self-injury functions to alleviate acute negative affect or affective arousal in a person) or a self-punishment function (where self-injury functions to express anger or derogation toward oneself). We also looked at how difficulties with self-capacities are very common among people who self-injure, including difficulties in the areas of emotion regulation, identity, and relatedness—and these difficulties can contribute to increased distress and thereby an increased load with which one is trying to cope. We finished by highlighting that any given person can only cope with so much at any given time. A person who self-injures is no different and is also generally trying to manage as best they can in coping with her/his inner and outer worlds.

Helping involves addressing the many aspects of the need for relief, in addition to work focused on the self-injury itself. As a general framework for helping (and where the ultimate goal is that a person no longer self-injures), you can think of two main routes for helping work:

- to find and do non self-harmful alternatives
- to alleviate contributors to self-injury

This means that the topics focused on in helping work will be both on the self-injury and on other things. Ultimately, I'll go out on a fairly solid limb and suggest that an overarching focus for your work is on the strengthening of capacities to cope and self-capacities.

Operationalizing this into general tools, there is a wide variety of things we might draw upon:

- functional assessments of self-injury
- skill development, problem-solving
- understanding cognitive-affective sequences (to open a door…)
- understanding, exploring, and working with dynamics between inner parts/aspects of the self
- behavioural strategies: "doing something differently"
- empathic reflection, non-judgment, active listening
- processing past relationships and difficult experiences
- building current positive relationships and experiences of positive (or soothing) affect
- increasing awareness, expression, understanding, and acceptance of emotions
- increasing mindfulness *and* self-compassion

It is important to remember that not all individuals will feel ready to or want to stop self-injuring. Where a person is at in relation to the self-injury (including their readiness to try to stop) will also influence the nature of and approach to the work.

So what do we focus on and when? Which topics? Which areas?

The focus of counselling work may be on one area much more than another, may fluidly move between topic areas over both short and long spans of time, and needs to be guided by what is salient for the client—their goals, hopes, and needs. Thus, self-injury itself may or may not be the dominant topic of focus at any given time.

For some clients, working on factors related to difficult circumstances or on factors that impair one's capacity to cope may result in a decrease in self-injury. For others, direct focus on self-injury—both understanding it (which relates to other factors) and working on concrete ways to decrease it and cope in alternative ways will be what is most helpful. Likely, work will often entail movement between different topics and areas of focus and goals. It may be helpful to visualize this work and these areas as like a web—a network of interrelationships and connections where

changes in one aspect may effect changes in another. For clients who are feeling quite overwhelmed and are having difficulty coping in non self-harmful ways (and/or are thinking about suicide), it may be important to help the person gain greater stability, coping skills, and hope before working much on difficult circumstances such as traumatic material or experiences of invalidation.[1]

Questions to Consider:

- What is salient for the client?
- What are the client's goals, hopes, and needs?
- What might increase self-injury? Decrease it?
- What might offer relief? Is there anything we could do first/now that would really offer some big or significant relief?
- What is the client's level of risk with respect to his/her safety?
- Is there anything that if we did not address it now would result in the client being at a significant level of risk with respect to his/her safety? (e.g., suicidal ideation, high risk behaviours, abusive situation etc.)

When working with people who self-injure, it is also important to avoid the pitfall where self-injury, in strictly behavioural terms, and stopping the behaviour become the exclusive focus of all counselling work. When the self-injurious behaviour becomes the exclusive focus, this can have the effect of reducing the person you are working with to or equating him/her with this one symptom or difficulty. Even when self-injury is the focus, try to find ways to maintain a wide, rich view, to express interest in and acknowledge this person in their fullness and complexity.

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[1] Ivanhoff, A., Linehan, M. M., & Brown, M. (2001). Dialectical behavior therapy for impulsive self-injurious behaviors. In D. Simeon & E. Hollander (Eds.), *Self-injurious behaviors: Assessment and treatment* (pp. 149-73). Washington, DC: American Psychiatric Publishing, Inc.

Section Eight

Stance

Research suggests that validating environments are <u>vital</u> to the development of resilience.
—M. Kostakos, 2005 (emphasis added)[1]

As we have established, individuals who are injuring themselves often feel tremendous shame. They may not tell anyone about their self-injury or they may share this information with difficulty (and great courage). When they do share, they may be met with scorn, disgust, anger, or be treated as "a freak". Additionally, they may themselves fear that they *are* "a freak", "crazy", or as separated from humankind.[2,3,4,5,6,7,8] Alternatively, individuals may have disclosed that they self-injure to several people and by the time they reach your office, may be perceived as "difficult" or not be taken seriously and may feel very alienated but in increasing pain. I can personally attest to meeting people who self-injure who have as a collective experienced virtually all of the above.

When asked what would be helpful, people who intentionally injure themselves have listed compassionate, non-shaming listening, and calm interest.[9] In a qualitative study that explored women's experiences of dialectical behaviour therapy, the women, all of whom had a history of self-injury, described the therapist's understanding, respect, and validation as key components that helped them along with learning various cognitive and behavioural skills.[10] In contrast, people who tell others about their self-injury are sometimes met by professional helpers and non-professionals alike with reactions of disgust, blame, unreasonable demands, shaming, criticism and/or attempts to take away a person's control or minimize a person's opportunities for choosing. These responses are not helpful[11,12] and may be highly triggering—reminiscent and surfacing—of past experiences of trauma, abuse, or invalidation for people who have experienced these.

I would like to suggest that a key tool for working with people who self-injure is found within the intrapersonal and interpersonal stance that you bring, that the practical, concrete techniques of helping start with the practical, concrete, essential skills of offering a foundation for high quality human connection (and a stance that is expansive).

A stance that is expansive means remembering the whole person, remembering that the person is wider than his/her self-injury, and avoiding the pitfall where self-injury in strictly behavioural terms and stopping the behaviour become the exclusive focus of the work. An expansive stance also means that, in general, the focus is not to take something away per se but rather to cultivate new possibilities for doing and being, ones that enhance options, a sense of well-being, and that alleviate the need to turn to self-injury or other harmful activities to cope.

Qualities for you to cultivate and offer in your interactions with those who self-injure include being

- calm
- non-judgmental (non-blaming, non-shaming)
- compassionate
- respectful, respectfully curious
- validating
- attentive
- valuing of a person in his/her experiences and humanness
- non-coercive
  and
- (gently) hopeful

I have another invitation for you. Pause for a moment and take three deep, calming breaths. Next, read through the list of these qualities slowly, one at a time, and take a moment to imagine each one. Imagine being calm. Imagine being non-judgmental. Imagine being compassionate... Next, imagine meeting someone who has these qualities and who is meeting you with these qualities in a gentle, inviting way. What does that feel like for you? Whatever your experience, notice that gently. Notice also if can you imagine that it might feel differently for some others.

For some people, imagining having the qualities on the above list or being met by someone else who is offering these qualities evokes feelings of calmness, peacefulness, and a sense of safeness and reassurance. For some others, imagining either of these scenarios can evoke discomfort, feelings of unease or even of fear.

Two additional qualities that I will add to the list above then include: (1) wisdom and (2) attunement. We cultivate wisdom to understand, for example, that—for many reasons not limited to but including people's developmental and learning histories and ways they have adapted to cope—the respectful, suitable, important qualities we aim to bring as part of our stance may involve complex, mixed, or varied emotional reactions in a person with whom we

are meeting. (This occurs in the same way that we, too, can have complex, mixed, and various reactions inside ourselves in various situations for various reasons that are not limited to but including related to our own developmental and learning histories.)

We cultivate attunement—a noticing and awareness of moment-to-moment experience and what is arising—for many therapeutic reasons, two of which are: (1) to help a person learn to notice, bring curiosity, (and even to understand) his/her own experiences (emotions, physical/bodily sensations, shifts in states, cognitions); and (2) to be aware of and sensitive (or helpfully responsive) to feelings of safeness and lack of safeness that are arising in a person moment to moment as well.

No matter which therapeutic orientation(s) or particular techniques a helper may use or suggest (acknowledging the need to be astute around issues of safety), no matter your specific role in helping, cultivating and offering qualities of high quality human connection is important. People deserve to be treated this way. It is often counter to what those who self-injure have experienced or currently experience internally and/or externally, and it may help to serve as a kind of healing antidote over time—something that through the repeated experience of (and practice with) can become internalized. It is a prerequisite to trust, to rapport, positive risk taking, disclosing information, and sharing. It promotes physical and mental health. *It also helps with building self-capacities (and capacities to cope).*

We could say that everything therapeutic (goals and paths to support them) is built on from here. If you are feeling a bit lost in your work with a person who is self-injuring, some good news is that if you were to do nothing else than to provide high quality human connection, this alone would provide a meaningful, worthwhile, valuable service.

In the next section, we will turn our attention to tools and resources you might utilize when the focus of your interactions is on the self-injury itself.

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Section Nine

When the Focus is on Self-Injury

In this section, we will turn our attention to tools and resources you might utilize when the focus of your interactions with a person who self-injures is on the self-injury itself. A caveat is that it is *inevitable* this focus will take you directly into other realms whether those of emotion regulation/ resiliency, self-identity, and relatedness with self and others (i.e., self-capacities); or past or present life difficulties (e.g., conflict with others, stress, past trauma or abuse, housing, school, or work issues).

I have organized this section into four parts:

- Inviting Conversation
- Exploring Self-injury: Assessment and Enhancing Understanding
- Exploring the Decision to Stop
- How to Stop: Finding and Doing Alternatives

Inviting Conversation

A person who self-injures may feel embarrassed, ashamed, or scared to talk about it. In addition, sometimes clients do not come to counselling for the purpose of dealing with self-injury or present it as the reason they are coming. Instead, they might reveal self-injury later after more trust has been established and/or when doors are opened inviting the person to share.[1]

When meeting new clients, it may be useful to ask about self-injury as part of gathering information and assessment. By asking, you open a door for clients who injure themselves to admit to or talk about it, whether on that day or at a later date. When you do not open a door by raising the topic, clients may be too embarrassed, ashamed, shy, or scared to bring the topic up themselves or it may take longer before they do.[2,3]

Our *stance* and the questions we ask can open a door for clients to talk about self-injury. What are your ideas for questions you might ask?

Here are some sample ideas:

- Do you ever do anything to help yourself cope that you are not happy with?
- When things get really hard, do you ever try to cope in a way that also hurts yourself?
- Some people who are in the kind of pain you are describing hurt themselves sometimes as a way to cope. Have you ever tried to cope in that way before?

When inviting conversation, it might be important to consider the issue of suggestibility and how prone a person you are working with may be to this, that is, how likely it is that a person might try coping via self-injury after the idea has been introduced although they had not previously coped in this way. One way to help avoid this might be to ask a question like the following:

- Do you ever do anything to help yourself cope that you are not happy with?

Exploring Self-Injury: Assessment and Enhancing Understanding

There are many aspects of self-injury that can be explored. These can facilitate awareness, articulation (expression, finding/using words), sharing, and understanding both about the experience and process of self-injury and about other aspects of a person's life. Ideas may come up through these conversations that lead to fruitful avenues for counselling work. Exploring self-injury provides a gateway to assessment, as well as to working with cognitive-affective sequences and needs.

It is important not to equate this exploration with "ending self-injury now". A person may or may not currently be ready to stop self-injuring or to self-injure less. Similarly, a person may be ready to talk about self-injury and explore aspects of it, or s/he may not be ready to talk about it much. It is important to meet the client where s/he is at and work at a pace that is comfortable.

Aspects of the experience of self-injury one might explore include[4,5,6]

- antecedents to self-injury, e.g., triggers, events, feeling states, thoughts
- what happens during self-injury, e.g., forms of self-injury, feelings, thoughts, presence/absence of pain
- what happens after
- meanings and functions
- patterns
- exceptions to patterns

- possible links to other experiences, e.g., past or present difficult circumstances and the impact of these.

Aspects of the experience of self-injury one might wish to learn about as part of an overall assessment process include[7]

- History of self-injury: age of onset, type(s), functions, wounds per episode, frequency of episodes, duration of the problem, body area(s), extent of physical damage, other forms of self-harm
- Details of recent self-injury: physical location of self-injury (on body and in what setting), social context
- Antecedents and consequences: historical, environmental, cognitive, affective, and behavioural aspects
- Other details: e.g., how does the person feel about his/her body?

An overarching aim of exploration is making links—to past and present, to what happens, to how self-injury unfolds. *A very important goal through this process of reflection and discovery is to convey that self-injury makes sense*, and to help the person come to understand this for him/herself.[8,9]

To convey and hold firm to the belief that self-injury makes sense and to help understand the specifics of how it does for a given individual are viewed as important, central tasks in working with those who injure themselves.[10,11] By realizing how self-injury makes sense through the functions it serves and one's challenges and vulnerabilities, we may discover what might need to develop or change so that self-injury is no longer needed.[12]

Sometimes people will be able to articulate functions and understandings of their self-injury fairly easily; for others, it will be hard. They may feel puzzled and it may take some time. They may initially be unaware of why they injure themselves.[13,14,15] In addition, the reasons and understandings people have and share may change over time as a function, perhaps, of the reasons themselves changing or as the complexity of experience is articulated and unfolds or both.[16]

Ideas for Questions to Ask

On the following pages, ideas are provided for questions you might ask a person to facilitate exploration of the role of self-injury in his/her life. The questions are drawn, inspired, and/or adapted from print materials [e.g.,17,18,19,20] and conversations with colleagues. They are generally

not focused on active exploration of alternatives to self-injuring although they may lead to or spark ideas for this.

The questions are loosely organized around some of the aspects of self-injury listed above[21] (e.g., antecedents, what happens during self-injury, what happens after, meanings and functions), although there can be overlap in the kinds of information derived from questions listed in each category. For example, asking about how a person was feeling before, during, and after self-injury may lead to greater understanding of the functions of self-injury (even though I have listed those questions under separate headings below). You might think of all questions as starting points, runways from which conversations may take flight.

In general, the question ideas provided use the generic term, self-injury; however, as previously discussed, in practice it is usually useful to use the words the client uses. If a client refers to their self-injury as cutting, then ask questions about "cutting", rather than about "self-injury". Also as previously discussed, the task of exploring needs to be fully rooted in the aspiration and task of offering a stance that is expansive and offers the qualities for high quality human connection.

Antecedents

- Are there any particular things that happen to you or thoughts or feelings you experience when you are more likely to injure yourself?
- Do you know if there are certain times when you are more likely to injure yourself? What is happening during those times? Can you tell me more about that, what you've noticed?
- Are there any particular times of the day when it happens?
- Are there any particular situations or events that make the urge to self-injure really strong?
- Have you noticed if self-injury is connected with certain feelings?
- Are you aware of any particular feelings you have right before you injure yourself?
- What do you remember thinking and feeling before you last self-injured?
- Are there certain times of the year when you are more likely to self-injure? (If yes,) Do you have a sense of what that might be connected to?
- Think about the minutes, hours, and days before you injured yourself. What was going on? Was anything important changing? Was anyone important missing or acting differently?

Was there anything that happened—like an event, an anniversary, a conversation, a television show—that stirred things up?

- When did the idea of self-injury first come to mind? How did you move from thinking about self-injury to doing it?
- Did it seem like the self-injury would help? What problem was the self-injury meant to solve?

What Happens During

- What do you feel while you are hurting yourself? Any thoughts that you have?
- Do you experience pain when you self-injure? Some people do and some people don't.

What Happens After

- How do you feel immediately after you self-injure? Do you feel primarily one thing or do you have a mix of feelings?
- How do you feel a bit later? Does it stay the same or change?
- Did the self-injury bring any relief? In what way(s)?
- What do you remember thinking afterward?
- Sometimes people describe initially feeling a bit better in some way, like feeling a sense of relief, but then they feel worse, often feeling down on themselves or feeling shame. Does any of that fit with your experience? If so, in which ways?

Meanings and Functions

- If you could give a voice to your self-injury, what would it say about your situation?
- How do you think self-injury helps you?
- Is there anything that makes self-injury particularly helpful or important to you?
- Many people who hurt themselves find that it helps them in some way. Does that fit your experience or is your experience different?
- What is your best guess as to how or why self-injury helps you cope?

- Does self-injury have a particular meaning for you?
- Often, self-injury serves some function or even more than one. Do you have any ideas about what functions it serves for you?
- Is it possible you did this because you needed some relief or some kind of help?
- What changed or became different as a result of self-injuring?
- Do you have a sense of what the self-injury gave you?

Patterns

- How often do you injure yourself?
- What have you noticed about when and how you hurt yourself?
- I've noticed that you seem to injure yourself when … Does that fit for you? Is that something you've noticed too? What do you know about that pattern?

Other

- Do you remember the first time you injured yourself?
- Where did you first learn how to injure yourself?
- What effect does self-injury have on your relationships with others (family members, friends, housemates)?
- Do you know anyone else who injures themselves?

Exploring the Decision to Stop Self-Injuring

When exploring the decision to stop self-injuring, we are, in essence, assessing individuals' motivation to change, factors such as their readiness to change, their level of confidence in themselves, fears they may have and other barriers. We are also aiming both to enhance their motivation to change and to recognize and work at alleviating barriers to change.

The decision to stop self-injuring (to make efforts to stop) rests in the control of the person who injures themselves. A person may or may not be ready to stop injuring themselves, may want to

stop and also likely feels ambivalent about stopping.[22,23] Find out where a person is at in terms of these and encourage conversation that explores any ambivalence the person feels—pros and cons, fears, concerns, hopes. By "surfacing the ambivalence"[24], hearing about the inner conflict and different sides, you invite all of the client to be part of the process and can provide a venue where all of the client can be heard. As Bonnie Burstow asserted, "it is pointless and indeed damaging to work with half a client. The other half needs to be heard and has to be party to any agreement"[25] .

When exploring ambivalence, be careful that you do this in a way such that the person is not in the position of having to argue in favour of self-injury or to dig his/her heels in to defend it. When people do not feel they have to vehemently defend the self-injury, there is more room ultimately for them to be able to move away from it - to not have to hold onto it so tightly.

As part of these conversations, you may explore together what the reasons are for why the person wants to stop. At this point, does the person want to stop because others are pressuring him/her, to reduce feelings of shame, because it no longer works like it used to, because s/he wants to take good care of him/herself in ways that do not also hurt him/herself, a combination of these, or something different? Tracy Alderman[26] suggested one of the most positive reasons to stop is a desire to be healthier physically and psychologically.

We remember again here that self-injury is serving a purpose. In order for self-injury to end without being replaced by other self-hurtful coping strategies such as drugs or alcohol abuse, other ways of having needs met and/or solutions for difficult circumstances need to be developed and to be effective. When a person has not yet stopped or has great difficulty stopping despite wanting to stop, it may be that the person feels very afraid or has not yet found suitable, effective alternatives.[27]

Examples of questions you might ask are[28]

- What are the good things about self-injuring?
- What are the less good things about it?
- What concerns you the most about self-injuring? In the short-term? In the long-term?
- What makes you think you need to do something about self-injuring?
- What are the reasons you would like to stop self-injuring?

- What would be the good things about no longer self-injuring?
- When self-injury is no longer part of how you cope, what else might change in your life?
- What are you thinking about your self-injury at this point?
- Would you like to talk about other things that might work?
- You could add some other ways to cope, along with hurting yourself. Would that feel useful?
- To what extent does it feel important to you to no longer self-injure?
- What would have to happen for it to become more important for you to work at eliminating self-injury? (if applicable)
- How confident do you feel that you could not self-injure (even if the pull toward self-injuring in the moment was there)? What would make you more confident about stopping?
- Do you have any fears about stopping self-injury? What would be needed to help address and alleviate those fears?

For a very helpful resource on working with ambivalence and helping to enhance people's motivation to make positive changes, please see Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change (Second ed.).* New York: The Guilford Press. (The generic form of several of the questions above were selected from this excellent resource.)

Reducing Harm

If a person is not ready to stop self-injuring, they might be willing and can be encouraged to do things to reduce the harm inflicted and take better care of themselves during self-injury. This is based on the common clinical approach of harm reduction where the goal is to decrease the adverse health, social, and economic consequences of a specific behaviour such as alcohol or drug use without requiring complete abstinence from that behaviour. Harm reduction emphasizes practical, short-term, achievable improvements that can reduce threats to the health and well-being of a person engaging in a harmful behaviour. It does not rule out the possibility of abstinence in the future and emphasizes respect for human dignity.[29] In the case of self-injury, some suggestions for reducing harm include[30]

- Using cutting instruments that are clean

- Not using cutting instruments that someone else has used (not sharing)
- Washing and bandaging wounds
- Seeking medical assistance for care of injuries when needed
- Not drinking alcohol or using drugs when self-injuring

Harm can also be reduced by decreasing self-injury in some way. Suggestions for small steps a person might try include[31]

- Injuring oneself slightly less severely
- Putting off self-injury somewhat longer than typical, for example, waiting half an hour longer, or another hour
- Reclaiming one small part of their body that they normally hurt and no longer injuring that one part
- Where the client injures themselves with friends, slightly decrease the amount or percentage done with friends

How to Stop: Finding and Doing Alternatives

This sub-section focuses primarily on those things that may help a person avoid self-injury in the short-term, that is, in moments when the urge to self-injure is strong or likely to be strong. By learning to repeatedly avoid self-injury in the short-term, a person may also then learn to avoid it over the long haul.

There are several ways in which a person may experiment with making changes to decrease or avoid self-injury by disrupting patterns involved. These may include changing or being differently with behaviours, thoughts, and feelings, or with changing circumstances where possible as well. Exploring the cognitive-affective sequences involved in self-injury, as well as the environmental context, can provide ideas for entry points into possible changes. Trying something different in one area, even if something very small, can produce changes in other areas as well.[32,33]

In addition to the ultimate benefit of preventing or avoiding self-injury, finding and doing alternatives disrupts typical patterns and can have many positive benefits even when self-injury eventually or sometimes occurs. Possible benefits include increased options or sense of options, increased length of time before self-injury—both of which may lead to increased sense of control and self-efficacy, that is, greater belief and realization that one can make changes, however tiny or large, and that self-injury can stop; increased awareness of what is happening in the moment internally and externally; and acquisition of new skills for coping and being in relationship with oneself that are less harmful or not harmful toward oneself (or others).

The magnitude of seemingly tiny changes must be underscored. Tiny changes are huge and change via tiny, baby steps is progress. It is commendable and just fine. It may also be strongly advisable.[34]

It may be helpful to find alternatives that "fit the function"[35] the self-injury has. If a person is feeling agitated and self-injury helps them feel calm, it may be helpful to explore alternatives that serve a similar purpose, helping a person to feel calmer rather than more excited or worked up.[36] It may also be helpful to find alternatives that the client perceives as sensible and practical, as well, ideally, as having the potential for success.[37]

Clients sometimes come up with great ideas and sometimes benefit from being given ideas to consider and try out. When self-injury has helped to bring about relief in the past, it may sometimes be difficult for a person to think of anything else to do other than self-injure that could potentially bring about feelings of relief.[38] Below are suggestions for questions to help clients come up with their own ideas, as well as for things a person might decide to try.

Question Ideas

(Sources: [39],[40],[41],[42].)

- Can you tell me about a time when cutting tried to engage you but you tried something else instead? Can you think of anything you told yourself that helped you to do something different instead?
- Are there times when you feel the urge to self-injure but somehow you don't? (If yes,) How does that happen? What makes those times different from the times you do hurt yourself?
- When you avoid the urge to injure yourself, what do you tell yourself or do that works?
- What else do you think might work?
- What else have you tried to stop self-injuring?
- If [cutting, burning, …] yourself helps [relieve tension], what else do you think might be useful in those moments to get [tension relief]? What else could you try?
- In the times when you want to self-injure but don't, what do you do instead? What helps? Are you aware of how you do that?
- What is the first clue or "red flag" that indicates self-injury will follow [an antecedent]? Is it

possible to do anything differently at that point? What is one small, even tiny, thing you could imagine doing differently at that point? What might help you to try that?

- What personal strengths do you have that will help you to succeed at not self-injuring? (or at delaying self-injury or at whatever the current goal is)

- Use "the miracle question" as a tool (or some version of it) (see[43] for more information; also[44]):

  Invite clients to imagine a miracle has happened. "I have a strange, perhaps unusual question, a question that takes some imagination . . . Suppose . . . After we finish here, you go home tonight, watch TV, do your usual chores, etc., and then go to bed and to sleep . . . And, while you are sleeping, a miracle happens . . . And, the problems that brought you here are solved, just like that! . . . Once you wake up in the morning, … how will you go about discovering that this miracle has happened to you? OR …how will your best friend know that this miracle happened to you?"[45]

  Have clients describe in detail what their miracle pictures are like.

  Ask if any pieces of the miracle pictures have been happening already—even a little bit. "When was the most recent time (perhaps days, hours, weeks) that you can remember when things were sort of like this day after the miracle?"[46]

  If clients describe ways the miracle has already been happening, questions you might follow up with include: "Are you aware of how you did that?"[47]; "What did you tell yourself to pull that off?"[48]; "What will you have to continue to do to get that to happen more often?"[49]; "If you were to pretend, even for a little while, that a small portion of the miracle had occurred, what one or two things would you be doing differently?"[50].

Suggestions for Things A Person Might Try

Tracy Alderman[51] suggests several ideas for disrupting patterns of self-injury:

- When there is a particular time of day or particular place at which a person is more likely to injure themselves, they could decide to try changing where they are or who they are with at those times. Alderman provides the example of a woman who usually injured herself in the early evening when she got home from work. She made a plan to go to a friend's house after work for a visit and this greatly decreased the likelihood that she would injure herself.

- A person could decide to get rid of or make substantially less accessible any items they use to injure themselves, for example, by putting them in a place that is out of sight and hard to access such as a box at the back of a top shelf in a closet. This way, when the urge to injure oneself is very strong, more steps are needed (more disruptions to the usual pattern) before self-injuring, which may also decrease the likelihood of self-injury at times.

- A person could also try changing other elements involved in the process or routine of self-injuring. As examples: if they always injure themselves in the bathroom, they could try doing it only in the living room; they could add another step to their routine, such as forcing oneself to go for a 10 minute walk or run outside first, have a cool shower, call a friend, do a breathing or visualization exercise, write in a journal for 20 minutes, listen to three favourite or inspiring songs, play a musical instrument for 5 minutes, complete an errand, wash the dishes etc..

A person might find it helpful when they feel the urge to self-injure to stop and ask themselves some questions. One woman found it helpful to ask herself the following questions when trying to avoid self-injury[52]:

- Why do I feel I need to hurt myself? What has brought me to this point?
- Have I been here before? What did I do to deal with it? How did I feel then?
- What have I done to ease this discomfort so far? What else can I do that won't hurt me?
- How do I feel right now?
- How will I feel when I am hurting myself?
- How will I feel after hurting myself? How will I feel tomorrow morning?
- Can I avoid this stressor, or deal with it better in the future?
- Do I need to hurt myself?

Ideas for In-the-Moment Alternatives to Self-injury

The following is a list of ideas for in-the-moment alternatives to self-injury drawn from several resources[53, 54,55, 56] as well as conversations with colleagues.

- Go somewhere. Make a list of as many environments as you can think of where you are least likely to injure yourself. These might be particular parts of your living space, certain

places at work or school, places in the community like a gym, pool, arena, coffee shop or store, library, a park, friends' or family members' homes. When you feel like injuring yourself or sense that the urge to do so may be coming on, go to one of the places on your list.[57]

- Put away or remove harmful items. Think about the items you use to injure yourself. Write a list of ways you could make these items as inaccessible as possible. Decide how you will make these items inaccessible and do it. Write or talk with someone trusted about what you did, how you felt, what you feel like now, and any thoughts, concerns, or questions you now have.[58]

- Call, write, email, message, or visit someone. Make a list of people with whom you could spend time, talk to, have some fun with, or to receive help or support. To whom could you safely reach out when you feel like injuring yourself? Write their names and numbers down. Try contacting one or more of these people.[59] Talk about the urge to self-injure, how you're feeling, or about something totally different. Leave a message for friends if they are not home when you call.

- Call a support line.

- Do something physically active: run, swim, go for a slow or fast walk, do yard work, dance (how you are feeling, how you would like to feel, or something different), play a sport (basketball, soccer, squash…), shred paper, play drums or other musical instruments, bike, hike, rollerblade, skate, lift weights, do yoga, vacuum your living space or wash the floors…

- Focus your attention on your breath, do a breathing, relaxation, or visualization exercise, meditate.

- Make the muscles in your body as tight as you can all at once or certain groups of muscles at one time. Hold them tightly for 10 seconds, then release. Notice how your muscles relax and release. Repeat this procedure until your body feels more relaxed.

- Have a bath or shower. Splash water on your face. Wash your face.

- Give yourself a gentle massage.

- Read a book or magazine, watch a video, do a puzzle, play with a pet, look at or touch/hold a favourite object of beauty.

- Get a task done on your to-do list.
- Draw, paint, write (a poem, a song, a piece in your journal, a letter to someone), sew, sculpt with clay, sing, play a musical instrument, or do something else creative. Express how you are feeling or thinking, what is happening, what has happened, how you would like to feel, or something different—anything that is on your mind/heart or that interests you.
- If you are feeling angry, hit or punch a pillow safely, yell, rip up old phone books, rant and rave into a tape recorder, do something physically active that is safe.
- Change the temperature of your environment or go to an environment with a different temperature.
- Rock yourself, wrap yourself up lovingly in a cozy blanket, eat a favourite food, drink a favourite herbal tea, play comforting music.
- Look around the environment you are in and describe what you see—tune in to sounds you hear and name them, smells you notice and describe them, colours you see, things you tactilely feel.
- Wait for 10 minutes before injuring yourself and focus on getting through those 10 minutes. At the end of 10 minutes, try getting through another 10 minutes. If 10 minutes is too hard, try 5 minutes, or 1 minute at a time.
- Hold an object that has positive meaning for you—perhaps something that reminds you of someone who cares about you or of beauty, hope, inspiration, a nice experience, a loved pet.
- Play an audiotape or videotape of yourself that you have previously recorded indicating all the reasons why you like yourself and do not want to hurt yourself. [60]
- Treat yourself with kindness, gentleness, compassion, and respect even if in this moment you believe you don't deserve it. You deserve to be treated lovingly.
- Write on small pieces of paper all the possible things you would be willing to try doing instead of injuring yourself. Write one idea on each piece of paper. Put these into a jar or box—you might want to leave the container plain or decorate it. When you feel like injuring yourself, go to the container, pull out one piece of paper, and do the suggestion that is written on it.

- Make a tool kit for yourself and use it. Put in it all the things that you think might be helpful to you. Examples might include: this list, meaningful photographs, markers, paint, paper, a puzzle, a favourite book, favourite quotes, a tape or cd you made of your favourite music, letters or cards from others that are special to you, a list of phone numbers and addresses of friends, a rock or other object that has positive meaning for you…

- Give yourself permission to do what you need to do to take care of yourself and not self-injure.

Self-Injury Substitutes

Below is a list of activities that resemble self-injury in some way but typically do not cause physical damage although some can inflict physical pain or hurt. Barent Walsh[61] referred to this category of activities as "negative replacement behaviours"[62], noted that they are controversial, and described pros and cons of them being used.

Some people who injure themselves find these types of activities are helpful in avoiding self-injury, at least in the short-term while they are working on other things that also eventually help. Other people don't find these activities helpful. For some, doing these activities makes it harder to avoid self-injury and may "cue actual self-injury"[63] after trying them. This may be because of the activities' similarities to self-injury.[64]

As for my own opinion and approach, I generally do not recommend the use of self-injury substitutes or suggest them to clients, particularly if they cause or mimic pain or harm. In addition to concerns listed above, I do not recommend these substitutes because of their sometimes inherent or implied infliction of harm toward one's self; certain negative replacement behaviours are too similar to characteristics of physical or emotional abuse--something that is at odds with an ultimate goal of a caring, non-harming wish and approach to one's relationship with oneself. Having said this, I also appreciate the potential usefulness of these behaviours from a harm reduction perspective and might consider suggesting them as a last resort but in this light.

In general, my preference and approach is to focus gently and repeatedly on helping a person to cultivate self-compassion and on finding ways to take care of oneself that are nourishing, helpful for the person, and that do not cause or mimic to the person or to anyone else physical or emotional harm. A negative replacement behaviour that I am agreeable to would be something like gently stroking a body part (e.g., instead of injuring it) and trying to offer it care and love—that is, trying to connect to qualities of caring and gentleness toward one's self. Of course, whether this strategy is actually a negative replacement behaviour is debatable

(whether it actually “resembles self-injury” in some way). More likely, I have morphed it into a direct attempt at conjuring up qualities of caring toward oneself.

Because of various concerns about negative replacement behaviours, it is generally advisable to suggest them as a last resort when there are compelling reasons to do so (such as for harm reduction reasons when the person finds one of these behaviours to be particularly helpful to them). It is also generally advisable to not suggest negative replacement behaviours as a starting place, especially for those activities on the list that may mimic inflicting, or actually inflict, physical pain.

When I work with people who self-injure and do utilize negative replacement behaviours (typically because they have “brought these with them”, they’ve read about them somewhere or someone has suggested them), I don’t criticize them for what they are doing or tell them to stop. Instead, I focus on learning about what this is like for these individuals. When the timing feels right, I try to offer and help the person find alternatives that are nourishing, that do not resemble self-injury, and that do not cause harm.

Examples of Negative Replacement Behaviours[65,66]

- Instead of cutting, burning, or bruising yourself, colour your body to resemble what would have happened if you did self-injure. For example, draw long red lines on your arms instead of cutting. Make sure to use nontoxic art supplies for this activity.
- Briefly hold an ice cube in your hand or plunge your arm into a bucket of ice water. The pain from the ice will somewhat resemble pain from self-injury; however, the result to your body will not be as detrimental.
- Apply a topical stimulant to a body area in order to create tactile sensation without injury (e.g., one that creates a cooling sensation).
- Apply a temporary tattoo and scratch it off with a finger nail.
- Gently stroke a body part with a soft brush.
- Draw a picture depicting self-injury of a body area or write about self-injury of a body area in detail without injuring yourself.
- Dictate a self-injury routine into a recording device without self-injuring.
- Snap an elastic band on an area you would previously injure.

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Section Ten

Enhancing Self-Capacities: Working with Emotion, Cultivating Mindfulness and Compassion

What we can do, however, is allow ourselves to open to the fullness of our humanity. We can make room for it all.
—Ram Dass and Paul Gorman[1]

In Section Seven, I wrote that a general framework for helping work with people who self-injure is to try to alleviate contributors to self-injury, as well as to find non-harmful alternatives for the self-injury itself. I also suggested that a significant focus for helping work is the strengthening of self-capacities. This is because people who self-injure often have difficulties in at least some area with respect to self-capacities and these difficulties may contribute to a vulnerability toward self-injury and/or the dynamics involved in self-injury.

In Section Six, I explained that self-capacities are inner abilities that help us to navigate the relationships we have within and between our inner and external worlds. They include the abilities to maintain a sense of connection with others; to experience, tolerate, and integrate emotions (including intense emotions) without having to utilize (or over-utilize) avoidance strategies[2]; and to maintain a sense of self that includes positive self-regard and an enduring sense of self-worth.

Within psychotherapy approaches, there are many helpful ways to work at building self-capacities. The purpose of this section is not to provide a broad survey of them but instead to briefly introduce you to ideas within three topic areas that might inform and inspire you on the journey of enhancing self-capacities. The topic areas I will focus on are working with emotion, mindfulness, and compassion.

Working with Emotion

Above all, emotional wisdom involves knowing when to be changed by emotion and when to change emotion.
—Leslie Greenberg[3]

When working with people who self-injure, helping them work with their emotions is integral. This includes exploring and working with these individuals' views of emotions, their relationships to themselves in response to the emotions they experience, their experiences of specific emotions themselves, as well as how they respond to specific emotions.

Fruitful questions and general topics for you to ask and explore with clients include:

- What is your relationship to your emotions?
- What is your view of emotions (and specific ones)?
- What is your relationship to yourself when you are experiencing emotions?
- Does your relationship to yourself change depending on the type of emotion you are experiencing? If so, how?
- Does it affect your view of your self, your view of your connection to others, your relationship to others? If so, how?
- What do you do, think, or feel after you have a specific emotion?[4]

In general, as clients talk about their answers, it is likely they will describe feeling badly about or uncomfortable with the emotions they experience, or badly about themselves in relation to some of their emotions, overwhelmed or underwhelmed by them, or unsure of what they are feeling or what feelings they have.

When talking about and working with emotions, what we are trying to foster in individuals are skills in **awareness, understanding, honouring and navigating** emotion (and emotion-related experiencing)**:**

- helping people to be **aware** of what they are feeling and to be able to express this awareness
- helping people to **understand** what they are feeling, what the feelings are about, what useful information they hold, what might be contributing to the feelings

- helping people to be **honouring** of the feelings, to be validating of them, to view them not as bad per se but as holding information to glean and work with; to be able to accept, too, in a respectful way, that they are there
- and finally, helping people to **navigate** their emotions including deciding how to act, what to do or not do, how to respond.

This is important because usually individuals who self-injure have difficulty with one or more aspects of the above.

With respect to education on emotion, as well as a stance toward emotions, concepts that are useful to teach and foster include:

- The idea that fundamentally emotions are not bad and a person is not bad for experiencing them; that it is understandable to feel things, including to feel upset about things or excited about things. "Emotions are an essential aspect of being human."[5]

- The idea that emotions are *functional*, that emotions provide valuable information to us, help us to understand ourselves and our world, and have a signaling function. We can then use this information, *along with our other thinking capacities*, to help navigate our world. As Leslie Greenberg so beautifully writes, it is "this integration of head and heart that makes humans wiser than our intellects alone"[6]. (For some individuals who self-injure, it can be a revelation to hear that emotions can be useful, functional, and, even when overwhelming or distressing, not a sign that the individuals are seriously flawed or bad.)

- The idea that some emotions are *primary*, as like our first response to a stimulus without interference, and that other emotions are secondary, often emotions we are having in response or defense to our other (primary) emotions and to our views of them or of ourselves. For example, a person who self-injures might feel deep sadness in response to a loss (a primary emotion) but then ashamed for feeling this way (a secondary emotion) because of a belief that it is wrong somehow to feel the sadness. It is useful to help individuals reflect on where an emotion is coming from and what it is about in order to understand how to respond to it, what to do next. In the example above, the sadness is core and the person may need to acknowledge, allow, and express it as part of his/her pain or grief. With respect to the shame, the person may need to try to alleviate by learning over time in a deep way that it is understandable and okay to feel the sadness, not wrong or bad. Any emotion can be primary or secondary.[7]

- The idea that a skill to develop in relation to emotion is not so much to try to have rigid control over emotions or to vehemently try to avoid, shun, or stuff away emotions but instead to try to attend to what is happening (or might happen) and to decide what is the best way to respond and act. In teaching this, we are encouraging individuals to discover ways of responding to their emotions that are *more friendly toward emotion*, more open toward emotion, more accepting and tolerant of emotion, and we are aiming to help people feel more capable and willing to acknowledge and feel emotion. At the same time, we are certainly also supporting and helping people to develop ways to try to modulate or change emotion as needed in ways that are helpful.

It is important to remember that when working with emotions, although we might be trying to help people be able to modulate feelings they have in health-full ways, we are also often trying to help people have a *new relationship* with their emotions themselves. This work involves processes that fall under the rubrics of emotion regulation and emotional intelligence.[8,9,10] It also all points clearly in the direction of strengthening self-capacities. Interestingly, when individuals develop in the area of working with emotion, they tend to also strengthen their sense of identity, self-worth, and the ability to abide more compassionately with themselves and possibly with others as well.

It is not uncommon that explorations in these realms will lead to conversations about how life circumstances have shaped people's views and experience of emotions. For some individuals, because of abusive or emotionally intolerant environments, emotion may be experienced as frightening, or as something that is hard to access, or as something that can be very overwhelming because they have had so little experience of a safe, reassuring, calming, caring other when upset. Additionally, receiving caring and kindness from another person now (such as from yourself) may also be frightening for a person or may tap into a well of immense grief for the caring and reassuring experiences s/he had either none of or so little of when growing up. Having said this, for some people, the shift to a different way of being in relationship to emotions comes with relatively greater ease.

Whatever the case, when working with people who self-injure, the process of helping people work with emotions, of trying to have a new kind of relationship to emotions, and by extension, to themselves, is something that requires sensitivity, understanding, and gentleness on everyone's part as it has the potential to be evocative, nuanced, and complex. *It is important to remember that this work is a process;* it develops and unfolds over time.

Mindfulness

Mindfulness describes moment-to-moment awareness of one's experience combined with an attitude of openness, curiosity, and non-judgement. Non-judgment means that we do not condemn, reject, criticize, shame or be harsh toward whatever we are noticing in our awareness in the moment.[11] (This does not mean, however, that we cannot and do not have preferences in life nor that we have to passively accept everything we observe.[12])

Awareness of what is happening in the present moment can include just about anything—feelings, sensations, thoughts, sounds, colours, or other details of the world you exist in in any given moment: all can become an observation in your awareness. When practicing mindfulness, we can give our attention an anchor, something for it to try to focus on, such as our breath, an object (like a candle, a leaf, or a stone), or a sound (such as the sound of birds or even traffic). Because we strive to refrain from judging as good or bad whatever we observe, mindfulness can be thought of as "observing and only observing"[13].

Jon Kabat-Zinn has described mindfulness as the cultivation of presence.[14] Although mindfulness is something we cultivate through our effort and intention, at the same time, it isn't something we create; rather, it's a quality and a way of being that we already have. We simply need to intentionally re-connect to it.

Mindfulness has been taught in a variety of contexts including in group programs geared toward assisting people with stress reduction[15] and/or who are having emotion regulation difficulties. (The teaching of mindfulness within dialectical behaviour therapy is an example of the latter.[16])

The cultivation and practice of mindfulness can occur in formal and informal ways. Examples of formal mindfulness meditation practices are the body scan mediation and an awareness of breathing meditation. Informal practices occur when individuals draw on a state of mindfulness as they go through the activities of their day-to-day life. This might include even pausing briefly to focus their attention on the sensations of breathing—in and out—for five breaths, and bringing their attention back to their breath gently whenever they notice their mind has wandered.

When practicing mindfulness meditation(s), I believe it is important that each person's own direct experience be the authority of what mindfulness offers in his or her life. Nevertheless, many people have found these kinds of practices to be helpful to them in some way. Examples include feeling greater calm and inner strength, increased energy, improved concentration and ability to navigate emotions; feeling less anxious or less depressed, and less reactive to

stressful situations. Regular mindfulness practices have also improved individuals' immune functioning, sleep, ability to regulate emotions, and other aspects of physical and psychological health and well-being.[17]

Although they are not the same, there are some complementary parallels between certain attitudes within mindfulness (or its "stance") and qualities we are trying to foster more generally in working with emotion (and in people's relationships with emotion). In both, we are trying to foster qualities of openness, an ability to be aware of, attentive to, and even to abide in a non-reactive way with some aspect of present moment experience—and this includes as applied to the present moment experience of emotion.

In Section Five, I introduced the experiential avoidance model of deliberate self-harm by Champman, Gratz, and Brown[18]. In it, there is a basic affective sequence involved in self-injury where there is first some kind of stimulus that elicits an emotional response in a person (e.g., anger, numbness, shame). This emotional response is experienced as negative and is something that the person feels a strong need to move away from or to gain relief from. The person accomplishes moving away from the emotional response by deliberately injuring themselves. After self-injuring, and because of self-injuring, the person feels relief in some way.

Part of our work assisting people who self-injure is to help change the affective sequence that people experience.

In mindfulness, people learn to observe sensations such as emotions without condemning them (and without condemning themselves). People learn to observe what is there and, in a sense, to allow what is there to be as it is, without reacting to, denying, or minimizing the sensation, and without needing to quickly run away from the sensation because of a feeling of threat. From this observing place, people can then also make deliberate and conscious decisions about what might be a helpful (and non-harmful) response to the sensations (including emotions) that are there.

The skills of observing experience without condemning it and being able to stay with (or tolerate) sensation while observing it may provide one avenue for helping people who self-injure to develop a cognitive-affective sequence that is different than in the experiential avoidance model above. The new sequence will still include emotion but hopefully without condemnation toward emotion or toward oneself and with a greater ability to tolerate the sensations that are there. It is hoped that these changes might alleviate some of the feelings of threat a person might be feeling. It is also hoped that this alleviation will give the person more breathing room to find ways to cope that are non-harming, caring, and easing and that lead to better feelings about

him/herself (in contrast to feelings of shame).

Mindfulness can often help with calming the mind and body and can aid with developing soothing compassion. However, when practicing mindfulness (and with compassion practices as well) difficult emotions, thoughts, sensations and memories can also be present or arise. There are many reasons for this. Sometimes the reasons related to mindfulness can be different from those related to compassion. Nevertheless, in both instances, part of what is happening is that people are tuning in to themselves. Mindfulness is an invitation to be present with whatever is there. When individuals slow down and make contact with themselves, their bodies (all the different parts), and the sensations and feelings they do have, sometimes strongly distressing feelings, sensations, or thoughts are what is there. These are things people may often try to keep out of their immediate awareness for various reasons: because of life responsibilities, tasks, or out of a need for a break or space from them; sometimes it can be due to fear, shame, other hard thoughts and feelings, being very overwhelmed, or due to a combination of all of the above.

It is extremely important for you as a helper to be aware of the possible emotional destabilization and threat people might experience when slowing down and tuning in as through mindfulness. Wisdom, sensitivity, support, pacing, modifications, time for processing, are all relevant and important here. A rationale for this relates to the aim of working within a therapeutic window where clients are neither underwhelmed and unengaged nor overwhelmed psychically and emotionally.[19] Although there can be merit in helping people to face and engage with material that may be slightly outside of their comfort zone, we don't want people to end up feeling completely overwhelmed by their internal experience nor to experience the high distress, disorganization, and/or difficulty functioning that can accompany being so overwhelmed.

To use mindfulness in your work, it is important that you learn about it and experience it in your own life. Practicing mindfulness in your own life will be part of what helps you to learn and integrate it with authenticity into your work with others. Mindfulness is a big topic and this is only a short introduction, presented here as something potentially useful that you might want to explore further, later, in much greater depth.

Compassion

I heard someone say once, "just assume the answer to every question is compassion".
—Gregory Boyle[20]

It may sound strange, but I generally try to avoid using the term "self-compassion" while counseling others because it creates a standard against which we all inevitably fail. Self-compassion isn't a "thing" that we either have or don't have. Instead, as a practitioner and as a therapist, I try to remain open to emotional pain and breathe kindness into it, one moment after the next.
—Christopher K. Germer[21]

Compassion is "a sensitivity to the suffering of self and others with a deep wish and commitment to relieve the suffering"[22]. Compassion involves certain skills that can also be found in mindfulness such as the ability, openness, and willingness to recognize pain, suffering, or discomfort and to abide with it. Compassion also involves a caring response to the suffering in our awareness. We feel moved by the pain and suffering of oneself and others rather than feeling indifferent (or feeling other qualities of non-care). Additionally, compassion involves motivation—a desire and willingness to respond to the suffering, to try to alleviate the pain or suffering in a helpful way.

In a nutshell, compassion is an aspect of caring in life that deals specifically with suffering. It includes both a sensitivity to the suffering of one's self and others, as well as a deep wish and motivation toward alleviating the suffering.

Compassion can involve feelings such as warmth, support, care, concern, and kindness toward the being who is suffering, as well as feeling moved to act in ways that might provide relief and comfort to this being in some way. This means that compassion can also involve courage.

Self-compassion is compassion directed toward our self from our self and thus is an aspect of how we relate and respond to ourselves. It is an aspect of caring in life that deals specifically with how we relate to our own being when in the face of suffering we are experiencing.

Self-compassion includes a sensitivity to our own suffering, as well as a deep wish and motivation toward alleviating the suffering. It can involve feelings of warmth, support, care, concern, and kindness directed toward our being (our self) from our self. It also can include being moved from this caring orientation to act in ways that might provide relief to ourselves or comfort to ourselves in a healthy, non-harming way. (Self-compassion is not meant to exist in a vacuum. Rather, we aim to cultivate and have a place for both compassion for others and compassion for self.)

As described above, we can direct compassion toward others, toward ourselves, and we can also receive compassion (through warmth, actions, etc) from others and from ourselves. Sometimes people have trouble experiencing compassion in one or more of these ways. Some people fear receiving compassion from others or from themselves. In a study by Paul Gilbert and colleagues, both the fear of receiving compassion from others and the fear of receiving compassion from oneself were associated with self-coldness, self-criticism, insecure attachment, depression, anxiety, and stress.[23]

Returning to self-capacities, given that many individuals who self-injure have difficulty maintaining feelings of connectedness with others or with themselves, and/or have difficulties maintaining positive self-regard or sense of self-worth, it is likely that therapeutic work in the realm of compassion will be relevant. Although the specifics will vary from individual to individual, it is likely that for many individuals a fear or discomfort around *receiving* compassion, whether from themselves or from others, will be common. Additionally, not yet well developed self-compassion is likely to be another common theme.

Many psychotherapies are compassion-oriented and there are interventions within them that are specifically aimed at fostering greater compassion for others and/or for oneself.[24] Compassion-focused therapy is a therapy focused very specifically on the cultivation of compassion and on the fears, resistances, and blocks to compassion, including self-compassion, which many people experience for understandable reasons. Compassion-focused therapy is an integrative, multimodal approach to therapy and draws on evolutionary theory; social, developmental, and Buddhist psychology, and neuroscience. This includes a conceptual model of people having three main affect regulation systems: one that is associated with threat and protection, a second that is associated with drive, resource-seeking and excitement, and a third that is associated with contentment, soothing, connectedness, and safeness.[25] A goal of compassion-focused therapy is to assist people with experiencing balance among these affect systems such that their threat system is not working over-time and that people are able to experience, activate, and dwell within (and/or return to) the contentment system, as one example.[26]

Compassion-focused therapy utilizes what has been coined *compassionate mind training*--specific activities that are designed to help people develop compassionate attributes and skills, with a particular emphasis on those that influence affect regulation.[27]

In compassion-focused therapy, compassion has several attributes: care for well-being, sensitivity, sympathy, distress tolerance, empathy, and non-judgment. Below are descriptions for each attribute as described by Paul Gilbert [28]:

- **Care for well-being**—a motivation to be caring for the purpose of alleviating distress and to support the well-being and flourishing of the being (or beings) to whom one is directing care. (Recall that individuals can direct compassion from themselves to themselves or from themselves toward others.)
- **Sensitivity**—recognizing and being sensitive to distress and needs including those feelings and needs in the being(s) to whom one is directing caring
- **Sympathy**—being emotionally engaged and moved by the feelings and distress of the being to whom one is directing care (as opposed to being emotionally distant or passive)
- **Distress Tolerance**—being able to contain, abide with, and tolerate emotion (including complex or high levels of emotion) rather than to avoid, fearfully move away from, shut down, deny, or invalidate the person experiencing emotion.
- **Empathy**—effortfully "working to understand the meanings, functions, and origins of another person's inner world so that one can see it from their point of view"[29]. Applied to oneself, empathy has to do with standing back from and effortfully working to understand one's own feelings and thoughts.
- **Non-Judgment**—means not condemning, criticizing, rejecting, being harsh toward, or shaming. (As stated earlier, this does not mean we cannot nor do not have certain preferences.)

The attributes of compassion can be cultivated through the development of skills in how we focus, work with, and/or utilize attention, reasoning, behaviour, imagery, feeling, and sensation.

For a succinct overview of compassion-focused therapy that provides more detailed information, I encourage you to seek out a short article that Paul Gilbert wrote titled, "Introducing Compassion-Focused Therapy"[30]. (Reference information is provided at the end of this section.)

Compassion-focused therapy is very much about working with emotion, decreasing shame and significant self-criticism, as well as increasing experiences of contentment, soothing, acceptance, and warmth. By extension, compassion-focused therapy is very much about enhancing self-capacities. It comes as no surprise, then, that it has been proposed as being helpful in working with people who self-injure.[31]

Whether it is compassion-focused therapy specifically that is utilized or compassion-oriented therapies more generally, it is my view that these approaches provide a rich resource for assisting individuals who self-injure with the building and strengthening of self-capacities in a respectful, honouring way. It is also my view that these approaches can assist us in understanding and working with the depth, challenge, and complexity of factors that can lead

people to feel what they feel. This includes when people feel fear of compassion, fear of other certain emotions or experiences (including positive ones), and/or when people feel inner pain and grief in response to receiving kindness from others.

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[1] Quote from p. 140 of Dass, R., & Gorman, P. (1985). *How can I help?* New York: Alfred A. Knopf.

[2] Examples of avoidance strategies include dissociation, substance abuse, perpetually shutting out emotions through a variety of means.

[3] Quote from p. xvi of Greenberg, L. (2002). *Emotion-focused therapy: Coaching clients to work through their feelings.* Washington: American Psychological Association.

[4] Question paraphrased slightly from p. 17 of Leahy, R. L., Tirch, D., & Napolitano, L. A. (2011). *Emotion regulation in psychotherapy: A practitioner's guide.* New York: The Guilford Press.

[5] Quote from p. 11 of Greenberg, L. (2002). *Emotion-focused therapy: Coaching clients to work through their feelings.* Washington: American Psychological Association.

[6] Quote from p. 5 of Greenberg, L. (2002). *Emotion-focused therapy: Coaching clients to work through their feelings.* Washington: American Psychological Association.

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[20] Quote from p. 62 of Boyle, G. (2010). *Tattoos on the heart: The power of boundless compassion.* New York.

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Section Eleven

Assisting During a Self-Injury Crisis

In 2000, Pamela Deiter, Sarah Nicholls, and Laurie Anne Pearlman published an article called, "Self-Injury and Self-Capacities: Assisting an Individual in Crisis".[1] In it, the authors discussed concepts for working with people who injure themselves in general. They also presented a therapeutic framework for use specifically when individuals who injure themselves are in a state of crisis. The framework they presented consists of four organizing principles intended to guide work with the individual in a respectful, helpful, purposeful way:

- Return control to the individual in crisis to whatever extent is possible, and help the client to regain a sense of having control
- Interview for and assess self-capacities
- Develop short-term strategies to shore up self-capacities
- Link self-injury to an external or internal antecedent event

In this section, I will elaborate on each of these principles. I will also provide a brief discussion on the topic of using safety contracts with clients. If you have access to academic journals, I encourage you to have a look at the article mentioned above by Pamela Deiter and colleagues.

Principle One: Help Clients (Re)Gain a Sense of Control

In your role as a helper, it is fundamentally important that as you work with a client to help him/her feel and be safer, you not take control away from the person you are trying to help, rather, that you help the client to have control and to regain a sense of having control to whatever extent is possible. This means working with the client to determine what s/he needs and what might help, and making this as collaborative a process as possible where the client can have lots of input into next steps, directing and making as many decisions as possible. Sometimes a client may be very overwhelmed and unable to do this. In these instances, the helper may need to be more directive or highly directive. Nevertheless, this, too, can be done in a way that is respectful and helps the client to feel a greater sense of things being in control and feeling safer.

If you must advocate for treatment that the client does not want in order to try to protect the client from dying by suicide, clearly communicate to the client the motivations for your advocacy and actions. Pamela Deiter and colleagues recommended that you "carefully explain [to the client] the dilemma of balancing control and safety and invite the client to help solve the problem in some way on which you can both agree. Identify every decision that remains under the client's control and work together to make those decisions…[F]orcing unwanted treatment may have some damaging effects. If such a course must be pursued, it is important to acknowledge that you know you may be causing some harm, but that you don't know another, better way to solve the immediate problem"[2]. Ultimately, it is preferable that a client is in agreement with whatever decisions are made regarding immediate plans for the next while. Providing a person who is injuring themselves and is in a state of crisis more time and a slower pace may be needed to achieve this and may facilitate this process.

Principles 2 and 3: Assess and Shore Up Self-Capacities

Assessing self-capacities can help to guide meaning making of an incident of self-injury and planning for increased safety. Although building self-capacities can take time, developing short-term strategies to help shore-up self-capacities even in small ways can help to stabilize a crisis and to focus a client's attention on self-care either after or while going through a difficult time.

Self-capacities to assess for and try to help strengthen include abilities in the areas of maintaining a sense of connection with others, coping with strong affect, and having a sense of oneself as positive, of inherent worth, and capable. Below, suggestions for each of these are discussed in turn.

i) Maintaining a Sense of Connection

A person who experiences impairment in the ability to maintain a sense of connection with others may feel a sense of profound alienation from others, emptiness, or as if "exiled to the outside, looking in at life"[3]. To assess and work at building up the ability to maintain a sense of connection, you could explore messages or voices the person recalls from important others—past and present. Are they caring or cruel, supportive or threatening? Try to amplify any caring or supportive messages and focus on the person associated with them. The goal is to help clients to identify an object or person that is viewed as benevolent, protective, and available that they can reach out to (phone, visit, email) or hold in their mind (or hand) for comfort and support. To aid in (re)connection, you might ask certain questions:

- Can you think of a person or a pet that cares about you or who makes you feel cared for,

comforted, or loved?

- Can you bring this [caring other] to mind right now? Describe for me what you see. (What does the other look like, sound like, etc.?)
- Can you imagine that they are here with you right now and wanting to offer you comfort and care?
- What things are they saying to you?
- Can you call on this person (or pet) to stay with you (literally or in spirit) for the next while to offer you care and remind you that you are cared about and are not alone?

If a person finds the above too difficult, s/he might benefit from physically holding an object. This could be an object associated with a human being such as a photograph, letter, piece of clothing, or an object from nature such as a rock, shell, or seed. Alternatively, a person may gain a sense of connection to others through a piece of music, artwork, a book, or poem. Even a business card with a kind word or words written on the back may help foster a sense of connection.

ii) Tolerating Strong Affect

Individuals who experience impairment in the ability to tolerate strong affect may be afraid of or numb to strong feelings. They may appear as depressed, emotionally detached or anxious and avoidant. They may be involved in one or more tension reducing behaviours (e.g., substance use). They may have intense or seeming "overreactions" when strong feelings come up (including acting in seemingly out-of-control ways) or they may "remain numbed, vigilant to the risk of feeling stimulation, and may avoid losing control by experiencing no feelings at all"[4]. You may assess this capacity through observing a person's reactions to the present situation, as well as by asking questions about the person's experience of feelings or that invite an emotional response.

- What feelings are you aware of having as you go through your day?
- Are you aware of having any feelings? [If yes:] What are they?
- How do you usually respond when you have strong feelings, e.g., of anger, sadness, loneliness?
- What is comforting or helpful to you when you are feeling upset?

- Do you ever feel pretty good? When do you feel that way? What is different when you feel that way?

There are many strategies one can use to deal with feelings. You can help clients to come up with a few safe, simple, practical strategies they could use over the next while to cope with strong feelings. Quiet, soothing activities could include making tea, taking a bath, listening to music, preparing a nice meal (chopping vegetables etc.), washing dishes, working in a garden, doing an art activity, looking at or visiting a beautiful scene, imagining a safe and pleasant place, cuddling with a pet, reading a book, watching a video, going for a gentle walk, doing a breathing or mindfulness exercise. Tension reducing activities might include more vigorous physical activity, crying, tearing up paper, etc.. (See "Ideas for In-the-Moment Alternatives to Self-injury" for additional suggestions.)

As noted by Deiter and colleagues, these activities are not inherently curative and "suggesting them as solutions to deep internal pain can seem superficial"[5]. It is "important to recognize…that the client feels like things are unbearable inside"[6]. One goal in crisis intervention is to find some way to help this person "feel even a little bit better, even just for a while"[7]. As a helper, you want to work with this person to make what feels unbearable even a tiny bit more bearable, if only for the next few hours, or the next day—and you need to do this without minimizing the extent of the pain or difficulty your client may be experiencing. You need to find a way to make suggestions that may seem superficial in light of a client's pain have value and meaning for the client at the present time and in a fully validating view of her/his pain. By doing this, you help the client to both feel that s/he is being truly heard and understood and to take baby steps toward gaining increased capacities to cope, both in general, and in ways that do not inflict self-harm.

iii) Maintaining Positive Self-Regard and Self-Worth

Individuals who experience impairment in the ability to maintain a view of themselves as benign and positive may have difficulty believing they are "essentially decent, deserving, and worthy of living"[8]. They may perceive criticism, loss, failure, or other triggering external events as evidence of themselves as repulsive, bad, toxic, inherently flawed and, in cases when they have been abused or experienced other traumatic events, as evidence that they deserved the abuse or trauma.

Assessment may include asking and observing how the person views him/herself via how s/he speaks about him/herself and possibly what s/he communicates with his/her body language.

- What words does the client use to describe him/herself?

- What expectations does the client have for self-care, achievement, or positive things in life?
- How does the client view suicide?
- How does the client make sense of unfair or unkind treatment by others?
- Can the client think of anything positive or valuable about themselves? Can the client remember or imagine having such a thought?

There are many subtle and overt ways you can plants seeds to support enhancing the capacity to maintain positive self-regard and self-worth:

- convey counter beliefs and values to those that reflect low self-worth such as conveying that the client is deserving of good things, support, rest, to be heard, etc.
- explore the client's positive qualities, achievements, interests, etc. so long as this does not feel too intolerable for the client (i.e., does not invoke too strongly painful feelings such as shame, loathing, or rage)
- explore the client's positive values (e.g., to treat others respectfully and with understanding) and see if there is any room for the client to apply such values to him/herself—to treat oneself with the same respect and care

Principle 4: Linking Self-Injury to an Antecedent to the Self-Injury

Helping a client to identify an antecedent to the self-injury promotes self-understanding and awareness, and conveys that there is logic to self-injury—that self-injury makes sense. This provides a strong and reassuring counter to the concerns and possible messages from other sources that someone who self-injures is "crazy" or that self-injury "makes no sense," is "out-of-control," or happens "out- of-nowhere/for no reason". For ideas of questions one might use to explore antecedents, please refer to the section, "Exploring Self-Injury: Assessment and Enhancing Understanding".

A Note on the Use of Contracts

The use of contracts that require a client to abstain from self-injury is generally not recommended and may not lessen the occurrence of self-injury.[9,10,11,12]

> "For the most part, clients are unable to stop self-injuring until they have acquired

> effective replacement skills. Asking them to forgo the behaviour before they have incorporated these skills is requesting the near impossible. The expectation (or demand) is that they endure their usual intense level of emotional distress (or emptiness) without using their preferred management technique. This is generally asking way too much." —Barent Walsh[13]

Such contracts may create undue pressure on clients and may set a client up for feelings of failure, intensify feelings of shame and discouragement, leave them feeling that they cannot be honest about their self-injury with the helper, that they have failed or disappointed the helper, and/or that they feel they have a lack of choice or say.[14, 15, 16]

There are, of course, exceptions. Sometimes clients find that contracts are helpful or may ask to set one up. When contracts are used, it may be helpful for clients to pick something they will contract to do when the urge to self-injure is strong rather than to agree that they will not self-injure. They could make a contract to call at least one person or to walk for 20 minutes outside —choosing something that will hopefully increase the likelihood that they will be able to avoid self-injury.[17, 18, 19] The focus here is on how individuals can protect themselves or take good care of themselves when they experience a pull toward self-injuring. Robin Connors recommended that instead of having a contract between client and helper, clients be encouraged to make a contract with themselves, to which a helper is a witness.[20] Barent Walsh recommended including a "hold harmless" provision[21], that is, to make clear that there is no negative penalty if a person is not able to fulfill the contract.

Helpers must emphasize to clients that if things don't go as hoped (i.e., if the person self-injures or doesn't do some part of the contract/goal/plan), it is okay to come back, to tell the helper, and to talk about it. The helper will not think less of the client and it can be helpful to talk with the helper about what has occurred. Together, you can explore what happened, possibilities for what might work better next time, and come up with a different plan, which may or may not involve using a contract.

If you sense that some kind of contract or agreement might be useful, you could ask the client what s/he thinks and go from there:

- Do you think making a contract with yourself (or with me) would help you to not hurt yourself?

[1] Deiter, P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-injury and self capacities: Assisting an individual in crisis. *Journal of Clinical Psychology, 56*(9), 1173-1191.

[2] Quote from p. 1184 of Deiter, P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-injury and self capacities: Assisting an individual in crisis. *Journal of Clinical Psychology, 56*(9), 1173-1191.

[3] Quote from p. 1184 of Deiter, P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-injury and self capacities: Assisting an individual in crisis. *Journal of Clinical Psychology, 56*(9), 1173-1191.

[4] Quote from p. 1185 of Deiter, P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-injury and self capacities: Assisting an individual in crisis. *Journal of Clinical Psychology, 56*(9), 1173-1191.

[5] Quote from p. 1185 of Deiter, P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-injury and self capacities: Assisting an individual in crisis. *Journal of Clinical Psychology, 56*(9), 1173-1191.

[6] Quote from p. 1185 of Deiter, P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-injury and self capacities: Assisting an individual in crisis. *Journal of Clinical Psychology, 56*(9), 1173-1191.

[7] Quote from p. 1185 of Deiter, P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-injury and self capacities: Assisting an individual in crisis. *Journal of Clinical Psychology, 56*(9), 1173-1191.

[8] Quote from p. 1186 of Deiter, P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-injury and self capacities: Assisting an individual in crisis. *Journal of Clinical Psychology, 56*(9), 1173-1191.

[9] Alderman, T. (1997). *The scarred soul: Understanding and ending self-inflicted violence.* Oakland, CA: New Harbinger Publications.

[10] Burstow, B. (1992). Self-Mutilation. In *Radical feminist therapy: Working in the context of violence* (pp. 187-201). London: Sage Publications Inc.

[11] Connors, R. E. (2000). *Self-injury: Psychotherapy with people who engage in self-inflicted violence.* New Jersey: Jason Aronson.

[12] Walsh, B. (2006). *Treating self-injury: A practical guide.* New York: The Guildford Press.

[13] Quote from p. 122 of Walsh, B. (2006). *Treating self-injury: A practical guide.* New York: The Guildford Press.

[14] Alderman, T. (1997). *The scarred soul: Understanding and ending self-inflicted violence.* Oakland, CA: New Harbinger Publications.

[15] Connors, R. E. (2000). *Self-injury: Psychotherapy with people who engage in self-inflicted violence.* New Jersey: Jason Aronson.

[16] Walsh, B. (2006). *Treating self-injury: A practical guide.* New York: The Guildford Press.

[17] Alderman, T. (1997). *The scarred soul: Understanding and ending self-inflicted violence.* Oakland, CA: New Harbinger Publications.

[18] Connors, R. E. (2000). *Self-injury: Psychotherapy with people who engage in self-inflicted violence.* New Jersey: Jason Aronson.

[19] Walsh, B. (2006). *Treating self-injury: A practical guide.* New York: The Guildford Press.

[20] Connors, R. E. (2000). *Self-injury: Psychotherapy with people who engage in self-inflicted violence.* New Jersey: Jason Aronson.

[21] From pp. 121-122 of Walsh, B. (2006). *Treating self-injury: A practical guide.* New York: The Guildford Press.

Section Twelve

Capturing the Essence

To move toward closing, I would like to invite you to a little challenge. If after reading this book, you had to capture the essence of the topic of working with people who self-injure, perhaps by writing a few brief sentences or a short poem, what might you say?

If you feel up for sharing, I would enjoy hearing what you came up with. (You can find my contact information at www.inspiringconnections.ca).

Some time ago (in 2008), I challenged myself to do this exercise while reflecting on all the material to date. I tried to capture the essence within a structured poem (specifically within one to two sets of three lines each, and with the first line of each set containing 5 syllables, the second containing 7 syllables, and the third containing 5 syllables). This was how I captured the essence at the time:

what is the essence?
feel bad, need relief, need more
or less of something

to help: gentleness
attend this layer that – like
weaving thread dark bright

So far, for me, it still feels about right.

Section Thirteen

Resources

To find a non-exhaustive collection of resources related to topics covered in this guide, please visit my website at www.inspiringconnections.ca.

There you will find several types of resources such as articles and musings I've written, a list of external resources (such as books, websites, and videos), a glossary of terms, and more.

The resources are updated on an on-going basis. Some materials are geared to those in the role of providing helping services; others are geared toward personal learning and development.

As with this resource guide, my hope is that the compendium of resources will be of usefulness and benefit to you and to others.

I close by offering to you kind wishes.