

## Chapter 2

### Causes (*with Richard Lieberman*)

There is no single cause of NSSI in youth that reliably determines whether a child or adolescent will ultimately engage in these behaviors. Psychiatric problems and disorders often result from complex interactions of genetic predispositions, environmental events/stressors, and individual vulnerabilities, and the causes of NSSI are no different. This chapter begins with a review of several explanatory models for NSSI in youth, with a particular emphasis on the environmental/functional model, as this approach has the most support in the professional literature. Following this discussion, a comprehensive biopsychosocial framework developed by Walsh (2006) for understanding the causal variables contributing to the development of NSSI will be described. This framework leads directly to many of the recommended assessment and treatment techniques described in subsequent chapters.

### Explanatory Models for NSSI in Youth

A number of explanatory models for NSSI have been offered, and below we briefly summarize seven that have appeared most frequently in the professional literature. The models are presented in order from those with the most empirical support to those with the least, based on a recent and comprehensive critical review of the literature from 1980 through 2007 (Messer & Fremouw, 2008).

#### *The Behavioral/Environmental Model*

This model focuses on environmental contingencies that both initiate and maintain NSSI behavior (Messer & Fremouw, 2008). According to this model, NSSI occurs as a result of negative reinforcement (i.e., escaping from unpleasant or distressful feelings) or positive reinforcement (e.g., obtaining attention). This model is closely aligned with the affect regulation model and has received increasing support within the empirical literature (Messer & Fremouw, 2008). In particular, there is increasing

evidence that a functional approach to understanding and assessing NSSI is beneficial (Nock & Prinstein, 2004, 2005) and that this environmental model is useful for linking assessment to intervention. Given that this model currently has the most empirical support in the professional literature, in the next section we provide a more detailed description of it. Additional information regarding a functional approach to the assessment of NSSI is provided in Chapter 6.

### ***The Affect Regulation Model***

Several emotional states have been found to precede NSSI, including increased tension and anxiety, hostility, and feelings of depersonalization (Messer & Fremouw, 2008). Suyemoto (1998) used the term “affect regulation” in the context of NSSI to include the regulation of pain as well as anxiety and hostility. Others have used the terms “emotional regulation” or “mood regulation” in describing this model (Messer & Fremouw, 2008), although to date no general consensus regarding the accepted terminology for it has been proposed (Klonsky, 2007). There is increasing support for this model in the professional literature (Messer & Fremouw, 2008; Walsh, 2006). It also appears to be strongly related to the behavioral/environmental model.

### ***The Physiological/Biological Model***

The majority of explanatory models of NSSI emphasize the critical role of psychological factors, although recent evidence has suggested that biological factors may contribute as well (Messer & Fremouw, 2008). In particular, it has been posited that there is a biological vulnerability for engaging in NSSI either due to a dysfunctional neurotransmitter system or an abnormal psychophysiological response to NSSI that involves the reduction of tension (Haines, Williams, Brain, & Wilson, 1995; Stanley, Winchel, Molcho, Simeon, & Stanley, 1992; Winchel & Stanley, 1991). As such, there appears to be increasing evidence that biological vulnerabilities may increase the likelihood of youth engaging in NSSI (Messer & Fremouw, 2008). This issue is discussed in greater detail within the context of Walsh’s (2006) model of NSSI presented later in this chapter.

### ***The Suicide Model***

The suicide model posits that SI acts are actually attempts to forego or avoid suicide, and views NSSI and suicidal behavior to be on a continuum (Messer & Fremouw, 2008). For example, Firestone and Seiden (1990) present a continuum of negative thought patterns and behaviors that ultimately culminate in suicidal plans and attempts. It is possible that self-injury would be included in this model, although Firestone and Seiden do not explicitly mention self-injury. Research indicates that the

relationship between youth suicidal behavior and NSSI is a complex one (Jacobson & Gould, 2007). This relationship is discussed more extensively in the next chapter.

### ***The Interpersonal/Systemic Model***

This model emphasizes NSSI as being symptomatic of family or environmental dysfunction (Messer & Fremouw, 2008). For example, an adolescent is believed to engage in NSSI in an attempt to cope with this dysfunction, or possibly to gain attention from others in the individual's environment. The "system" involved may be the family, although it could be another system, such as a residential treatment facility or a hospital environment. Further, the environment may be unknowingly supporting or reinforcing NSSI behavior (Suyemoto & MacDonald, 1995). Given that there are only a few non-experimental case studies in this area (i.e., Crouch & Wright, 2004; Hartman, 1996), conclusions regarding the viability of the interpersonal/systemic model of NSSI cannot be made at this time (Messer & Fremouw, 2008).

### ***The Depersonalization Model***

This model focuses on the psychological state of dissociation or depersonalization reportedly experienced by youth who engage in NSSI (Suyemoto & MacDonald, 1995). In particular, feelings of dissociation are assumed to result from feelings of abandonment or isolation, which in turn leads to feelings of unreality or numbness. As a result, it is assumed that youth engage in NSSI to end the experience of depersonalization and regain a sense of self (Messer & Fremouw, 2008). From this theoretical perspective, it has been suggested that the scars that may result from engaging in NSSI may serve as reminders to the individual of their identity (Miller & Bashkin, 1974). Although a possible linkage between dissociation and NSSI is frequently referred to in the literature (e.g., D'Onofrio, 2007), there is little empirical support for this relationship, an issue that is discussed more extensively in Chapter 3.

### ***The Sexual/Sadomasochism Model***

This model emphasizes the importance of sexual development and sexuality concerns as primary causal mechanisms for NSSI. In this model, NSSI behavior is viewed as a means of providing sexual gratification, or as an attempt to control sexual development or punish sexual feelings (Messer & Fremouw, 2008). Additionally, NSSI within this model is associated with issues related to sexual confusion and body image (Zila & Kiselica, 2001). There is little or no empirical support for this model; much of the support that does exist stems from flawed

case studies and studies with small numbers of hospitalized females (Messer & Fremouw, 2008).

## A Functional Model of NSSI

Several important factors must be considered in discussing a functional model of NSSI. First, NSSI must be viewed within its context, in the sense that an individual is inextricably tied to his or her environment (Lloyd-Richardson, Nock, & Prinstein, 2009). To understand NSSI, it is necessary to understand why a particular behavior, at a particular time, serves a particular function for a particular individual (Suyemoto, 1998). Consequently, the reasons an individual may engage in self-injury (i.e., the function it serves) may vary over time and context. It is likely that changes may take place in youth as they experiment with self-injury, altering the functions served by it (Lloyd-Richardson et al., 2009).

Second, NSSI may serve multiple functions simultaneously (Lloyd-Richardson et al., 2009). For example, in a study evaluating motivations for both suicide attempts and NSSI in a sample of 75 women diagnosed with Borderline Personality Disorder, overall reasons for NSSI differed from those for suicide attempts, with the former endorsing an average of 10 reasons for their latest NSSI episode, most frequently described as (a) intending to express anger; (b) punishing oneself; (c) generating normal feelings; and (d) distracting oneself (Brown, Comtois, & Linehan, 2002). Although recent literature reviews provide empirical support for various functions of NSSI, the relationships (both theoretical and empirical) between these various functions remains unclear (Klonsky, 2007). Unfortunately, it can be a very challenging task to tease apart the specific and various functions NSSI may serve for an individual. However, our understanding of these possible functions is critical for altering future behaviors and improving the lives of those youth engaging in NSSI (Lloyd-Richardson et al., 2009).

A third issue involves the current lack of understanding regarding NSSI among youth. In particular, it is not clear how functional models of NSSI may be relevant to various youth populations, and to what degree, if any, they may deviate from functional models based on adult samples (Lloyd-Richardson et al., 2009). Finally, Lloyd-Richardson and colleagues (2009) mention two other factors that have limited research on the functions of NSSI. First, many authors have used the term *function* in different ways, an issue that can lead to confusion among researchers and clinicians and in explaining NSSI to individuals exhibiting it as well as to the general public. From the perspective of behavioral psychology and therapy, “function” refers to an analysis of the effects or events that cause or determine a particular behavior (Lloyd-Richardson et al., 2009). The goal of the practitioner is to examine the *antecedents* and *consequences* of a behavior to understand and treat it. It is from this behavioral (operant) tradition (Skinner, 1938, 1953) that *functional analyses* or *behavioral analyses* were derived. Much of the earlier work on

NSSI used the term *functional* more loosely, often to simply mean the purpose of or reason for a particular behavior. For example, the suggestion that NSSI serves an “anti-suicide” function says little about the antecedents or consequences of NSSI (Lloyd-Richardson et al., 2009). A second limitation is that although multiple functions of NSSI have been proposed, there have been few attempts to integrate these into a coherent theoretical model that can inform both research and practice (Lloyd-Richardson et al., 2009).

To address the issues and limitations noted above, Lloyd-Richardson and colleagues (2009) recently developed a comprehensive, four-function model of NSSI among adolescents that draws from previous work on learning theory and behavior therapy (Nock & Prinstein, 2004, 2005), as well as research on the functions of NSSI among samples of individuals with developmental disabilities (Iwata et al., 1994) and adult women diagnosed with borderline personality disorder (Brown et al., 2002). In their model, the functions of NSSI are proposed to differ along two dichotomous dimensions: (a) negative reinforcement or positive reinforcement; and (b) consequences that are either automatic (i.e., intrapersonal) or social (i.e., interpersonal) in nature.

According to this model, when an individual engages in NSSI it should serve one or more of the following four functions: (a) automatic-negative reinforcement (i.e., to reduce tension or another affective state); (b) automatic-positive reinforcement (i.e., to create a desirable physiological state); (c) social-positive reinforcement (i.e., to provide attention from others); and/or (d) social-negative reinforcement (i.e., to offer escape from interpersonal tasks or demands; Lloyd-Richardson et al., 2009). Each of these four dimensions is discussed in more detail below.

### ***Automatic-Negative Reinforcement***

This type of reinforcement refers to an individual’s use of NSSI to stop or remove a particular and undesirable emotional or cognitive state, such as to release tension or to distract from disturbing or aversive thoughts (Lloyd-Richardson et al., 2009). Consequently, the reinforcement derived from the NSSI occurs in the form of escaping or avoiding aversive thoughts and/or feelings. As such, automatic functions serve to regulate an individual’s own internal states.

Negative affect regulation is the function most often mentioned and described by theoretical and empirical reports (Lloyd-Richardson et al., 2009). A number of studies (e.g., Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Nixon, Cloutier, & Aggarwal, 2002; Rodham, Hawton, & Evans, 2004; Ross & Heath, 2002) have provided strong empirical support for an automatic-negative reinforcement model of NSSI, with commonly endorsed reasons for NSSI suggested to include “to get out my frustrations,” “to reduce emotional pain,” “to express my anger toward others,” and “to reduce tension” (Lloyd-Richardson et al., 2009). Among hospitalized youth, automatic-negative reinforcement is the function most frequently

reported (Nixon et al., 2002; Nock & Prinstein, 2004) and is the only one of the four functions significantly related to suicide attempts (Nock & Prinstein, 2005).

### ***Automatic-Positive Reinforcement***

This refers to the use of NSSI to generate some desired internal state. For example, many youth who engage in NSSI report doing so to “just feel something” (Lloyd-Richardson et al., 2009). Among a clinical sample of adolescents, this was the model’s second most endorsed function (Lloyd-Richardson et al., 2009), and individuals’ endorsement of this function is strongest in the presence of symptoms of depression and posttraumatic stress disorder (Nock & Prinstein, 2005).

### ***Social-Positive Reinforcement***

In contrast to automatic functions, which involve regulation of internal states, social functions serve to regulate an individual’s external environment. Social-positive reinforcement refers to the use of NSSI to gain attention or to access some particular social resource (Lloyd-Richardson et al., 2009). For example, the social-positive reinforcement function can be seen among youth reporting that they are engaging in NSSI “to let others know how I am feeling” and “to get my therapist to [react in a certain way].” Among a community sample of adolescents, youth who engaged in NSSI reported social-reinforcement motives almost as frequently as automatic-reinforcement motives (Lloyd-Richardson et al., 2007).

### ***Social-Negative Reinforcement***

This refers to the use of NSSI to escape from some interpersonal tasks or demands. Youth who report engaging in NSSI “to get out of going to school,” “to get other kids or adults to leave me alone,” or “to get my parents to stop fighting,” are consistent with a social-negative reinforcement function of NSSI. Although research suggests that hospitalized adolescents appear to report social functions for NSSI less frequently than automatic functions, they do report the presence of social functions with some regularity, and among community samples social functions have been endorsed as frequently as automatic functions. In addition, endorsement of social functions is associated with the report of other social concerns by adolescents as well as with symptoms of depression (Lloyd-Richardson et al., 2009).

Although a functional model has the most empirical support as a causal mechanism for the development of NSSI, neither this model nor the others reviewed in this chapter are by themselves capable of accounting for the complex and multiply determined causes presumed to lead to NSSI. To more fully understand the causes of NSSI, it is therefore necessary to have an organizational framework that includes

and integrates information from a variety of perspectives. One such framework is Walsh's (2006) biopsychosocial model of NSSI, which provides a highly useful, practical, and comprehensive conceptual foundation for understanding the causal variables of NSSI.

## **A Biopsychosocial Model of NSSI**

In this model, NSSI is viewed as the result of a complex interaction between (a) environmental, (b) biological, (c) cognitive, (d) affective, and (e) behavioral dimensions. For the large majority of individuals, all five dimensions play an important role in the emergence and recurrence of NSSI, although the precise contribution of each dimension is unique for each individual (Walsh, 2006). For example, environmental and biological dimensions may play more important causal roles in some people, whereas for others cognitive, affective, or behavioral dimensions may predominate.

### ***Environmental Dimension***

According to Walsh (2006), the environmental dimension contributing to the occurrence of NSSI includes three basic categories: (a) family historical, (b) individual historical, and (c) current environmental elements.

#### **Family Historical Elements**

Family historical elements refers to key aspects of the history of the nuclear, extended, or surrogate family that have been observed, but not directly experienced (Walsh, 2006). For example, to observe suicidal behavior among members of one's family is different from being personally suicidal. Many family historical elements have been linked by research to the later development of NSSI in youth, including mental illness, suicide, substance abuse, violence, and self-injury in the family (D'Onofrio, 2007; Favazza, 1996, 1998; Walsh, 2006).

Family environments teach children behaviors through modeling, reinforcement, extinction, and punishment on a daily basis (Walsh, 2006). Further, children actively observe adult family members and frequently imitate them. When family members respond explosively and angrily to disappointment and frustration, a child may learn to behave this way as well or may exhibit the opposite behavior (e.g., markedly inhibited in emotional expression) depending on particular family and environmental circumstances. Likewise, when family members respond to distress by engaging in self-medication through the abuse of alcohol or drugs, children may acquire these behaviors (Walsh, 2006).

Walsh (2006) suggests that self-destructive behavior is a particularly ominous pattern of behavior in family environments. When family members model self-destructive behaviors such as NSSI or suicide attempts, it conveys a variety of

unspoken messages to children, such as: “Life is overwhelmingly painful,” or “Life is not worth living,” or “Distress can be relieved by behaving self-destructively,” or “Others cannot help my pain,” or “My pain negates responsibilities I have to others.” Unfortunately, children living with family members who engage in self-destructive behavior may come to consider NSSI as a viable option when faced with life challenges.

### Individual Historical Elements

Individual historical elements include those in an individual’s personal history that have been directly experienced rather than observed (Walsh, 2006). Although there are many examples of elements in an individual’s history that may be associated with NSSI (e.g., death of parent or caregiver; loss through separation, divorce, or removal from the home), four of the most significant of these are (a) childhood adversities, (b) child maltreatment, (c) exposure, and (d) invalidating family environments.

*Childhood adversities.* The experience of trauma, particularly in childhood, frequently has a profound effect on psychological development and adaptive functioning in adolescence and correlates highly with NSSI (Conterio & Lader, 1998; Farber, 2000; van der Kolk, 2005; Yates, 2004). Childhood trauma, particularly sexual abuse, has received considerable investigation in the literature and has frequently been suggested as a primary factor in the initiation of self-destructive behaviors (Favazza, 1996; Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003; Paivio & McCulloch, 2004). Other childhood adversities that have been found to raise risk considerably in youth include being the victim of a physical attack, parental loss or deprivation, traumatic medical or surgical procedures, and being an accident victim or witness to violence in general and family violence in particular (D’Onofrio, 2007; Walsh, 2006). These traumatic experiences can flood the vulnerable child with recurrent thoughts, images, or flashbacks, which in turn can raise emotionality and tension. Those individuals who engage in NSSI often report it offers the opportunity to achieve some measure of control of these thoughts and to release tension. However, recent research suggests that trauma does not play as large a role in the development of NSSI as was previously believed (Walsh, 2006).

*Child maltreatment.* A growing body of research has addressed a child’s experience of “complex trauma” (i.e., a chronic history of emotional and physical maltreatment, neglect, or invalidating childrearing environments) and the etiology of NSSI (D’Onofrio, 2007; Linehan, 1993; van der Kolk, 2005). Child maltreatment exemplifies a toxic relational environment that poses significant risks for adaptation across biological, psychological, and interpersonal domains of development (Cicchetti & Toth, 2005). Children are particularly at risk for maltreatment if there is a history of alcoholism, mental illness, or suicide in the family (van der Kolk, 2005; Walsh, 2006).

Historically, many clinicians have suggested that trauma and the child maltreatment that typically causes it plays a central role in the development of NSSI (e.g., D’Onofrio, 2007; Favazza, 1998). Although child maltreatment can be a potential



risk factor for the development of NSSI, recent research suggests that the relationship between child maltreatment and NSSI may be overstated because the two are correlated with similar psychiatric risk factors. For example, a recent meta-analysis found that the relationship between child sexual abuse (the most commonly cited form of child maltreatment linked to NSSI) and NSSI was relatively small, and that in studies that controlled for psychiatric risk factors, childhood sexual abuse explained little or no unique variance (Klonsky & Moyer, 2008). Moreover, Walsh (2006) has identified what he views as a “sub-group” of self-injurers who convincingly deny any history of physical or sexual abuse. As such, school practitioners should not assume that child maltreatment is a necessary precursor to NSSI. More information regarding the relationship between child maltreatment and NSSI is provided in Chapter 3.

*Exposure.* Adolescents are at increased risk to experiment with NSSI if they are exposed to such behavior through a sibling, peer, the media, or the Internet (Nock & Prinstein, 2005; Walsh, 2006; Whitlock, Powers, & Eckenrode, 2006). Unlike younger children, adolescents are more apt to use peers as models for social comparison and identity development. For some youth, NSSI behaviors may provide a potent social-positive reinforcement function, in that it may gain the attention and admiration of significant others that engage in risk-taking behaviors such as NSSI, substance abuse, or eating disorders (Lloyd-Richardson et al., 2009). There appears to be a powerful bond between self-injurers that fortifies group cohesiveness and appeals to vulnerable adolescents who want desperately to feel part of a group. For many of those who self-injure, the ability to find others like themselves reduces the isolation and loneliness that so often characterizes the behavior.

For others, however, active participation in online communities may substitute for the real work required to develop positive coping and healthy relationships (D’Onofrio, 2007; Whitlock, Lader, & Conterio, 2007). For example, there has recently been a tremendous increase in Web sites devoted to individuals who engaged in NSSI posted on the Internet (D’Onofrio, 2007). Unfortunately, although research suggests that online interactions can provide needed social support for otherwise isolated youth who engage in NSSI, they may also encourage, normalize, and promote this behavior. Further, some Internet sites may add potentially lethal behaviors to the repertoires of these students, increasing their risk for accidental death or suicide (Whitlock et al., 2006). More information on the topic of the Internet and its relationship to NSSI in youth is provided in Chapter 6.

*Invalidating family environments.* Linehan (1993), in describing the family environments of individuals with borderline personality disorder, contends that in many of these families the emotional experiences of children are often at best ignored and at worst denied, ridiculed, or condemned. These invalidating environments may also be widely experienced by youth engaging in NSSI, and often have severely deleterious effects. For example, invalidating family environments may potentially result in children questioning not only the accuracy, but also the very presence of their own internal feeling states (Walsh, 2006). Additionally, such environments may reinforce only the most extreme levels of emotional responses. As noted by Walsh (2006):

If a child indicates in a subtle manner that he or she is distressed, the invalidating environment may ignore the communication. Only when the child presents with an extreme emotional behavior (e.g., a tantrum) does he or she receive a response. The entire pattern is conducive to reinforcing maladaptive behavior while extinguishing adaptive behavior. When such a pattern is repeated countless times for many years, the end result can be an emotionally dysregulated person. Such people may come to rely on self-invalidating behaviors such as self-injury to manage emotional distress. (p. 60)

### **Current Environmental Elements**

Adolescents are frequently subject to extraordinary pressures and many of these may precipitate tensions and elevate emotionality, which in turn creates the foundation for seeking relief, attention, or control through NSSI. These precipitating events may include loss (e.g., death, parental divorce, broken romance), peer conflicts or rejection, academic or disciplinary crises at school, and violent episodes or arguments with parents at home (Lieberman & Poland, 2006). According to Walsh (2006) individuals who have experienced aversive conditions in both their family and personal history may be particularly sensitive to similar problems occurring in the present. For example, a teenager who experienced loss of a parent or caregiver during childhood may be particularly reactive to losses in peer relationships that occur during adolescence. Or, an adolescent who was sexually or physically abused as a child may be extremely sensitive to threats of abuse in the present, even including normal and appropriate sexual behavior. Consequently, “the more complicated and aversive the individual’s historical context, the more vulnerable he or she is likely to be in the present to negative experiences” (p. 62).

### ***Biological Dimension***

The relationship between biology and NSSI is a complex one. For example, a number of psychiatric conditions associated with NSSI have been shown to have biological components, including depression, bipolar disorder, schizophrenia, and borderline personality disorder. Moreover, there are several physiological problems commonly associated with NSSI, including physical illness (e.g., asthma, diabetes) and sleep disorders (Walsh, 2006). Although some research suggests there are biological differences between individuals who engage in NSSI and those who do not, little or no research has addressed this issue among adolescent populations. To date, the majority of the (adult) research that has addressed the biology of NSSI has been conducted with women with borderline personality disorder and, in the majority of cases, suicidal behavior and non-suicidal self-injury were not differentiated (Jacobson & Gould, 2007).

Despite these limitations, research does suggest that a number of biological variables may play a causal role in NSSI, including biological vulnerability to emotional dysregulation, limbic system dysfunction, serotonin level dysfunction, endogenous opioid system dysfunction, and diminished pain sensitivity (Walsh, 2006). For example, it has long been theorized that lower levels of serotonin are associated

with NSSI (Favazza, 1996), and the effective use of selective serotonin reuptake inhibitors, or SSRIs (e.g., Prozac, Paxil, Zoloft, Lexipro) in reducing depression and self-injury in some individuals has provided some support for this hypothesis (Grossman & Siever, 2001). Additionally, the endogenous opioid system may not only be a key biological factor in the etiology of NSSI in youth, but may also play a central role in maintenance and repetition of it. Many adolescents report an absence of pain at the time of their self-injurious acts, and the powerful endorphin release initiated by NSSI may provide a biologically induced sense of euphoric relief or release. Similar to the tolerance developed to alcohol by individuals who consume it too frequently, repetitively engaging in self-injury often eventually results in the individual obtaining a tolerance to it, thus requiring an increase in frequency of NSSI to compensate (D'Onofrio, 2007; Grossman & Siever, 2001; Walsh, 2006). For more information on biological and neurobiological perspectives on NSSI, the reader is referred to Osuch and Payne (2009).

### ***Cognitive Dimension***

The cognitive dimension associated with NSSI corresponds with one of two basic categories: *cognitive interpretations of environmental events* and *self-generated cognitions*. The first category refers to the tendency by some individuals to engage in irrational thoughts and cognitive distortions in response to particular environmental events. For example, as noted by Walsh (2006), individuals who are victims of sexual abuse often engage in irrational thoughts focusing on self-blame (e.g., "I have should have done more to stop the abuse," or "I must have wanted it to happen since it went on so long"). There is considerable evidence that individuals high in self-derogation and self-blame are at increased risk for self-punishment and self-directed anger through NSSI (Klonsky, 2007; Klonsky & Glenn, 2009). Working with youth to relinquish such self-defeating and irrational cognitions is often a key element of effective treatment. However, it is important for those working with self-injuring youth to recognize that environmental events, even potentially traumatic ones, are problematic only if the person engaging in NSSI interprets them to be aversive, painful, or disorganizing (Walsh, 2006). Consequently, understanding the client's perceptions regarding particular environmental events is often as or more important than the events themselves.

The second major category of cognitive distortion is self-generated cognitions. In contrast to the external events and circumstances that may lead to the development of irrational thoughts described above, self-generated cognitions are triggered by internal cues (Walsh, 2006). These are thoughts that have no specific environmental causal triggers. For example, if an individual wakes up and thinks to himself, "Another day to feel awful; I wonder how I will get through it?" he is engaging in a self-generated cognition. The individual has just awakened; no particular environmental event has led to these thoughts – they are simply habitual, maladaptive patterns of thinking. Assessment of these recurring, negative, and irrational thoughts is essential and is discussed in greater detail in Chapter 6. Moreover,

for effective treatment to occur, irrational cognitions need to be identified and modified – procedures that are discussed in greater detail in Chapter 7.

Youth who engage in NSSI also exhibit a wide variety of cognitions that may trigger their acts of self-harm, and identifying them is a key step in assessment and intervention. According to Walsh (2006), thoughts that often precede occurrences of NSSI include “I have to do something,” or “I deserve this,” or “I hate my body so much,” or “This will show people that I’m really hurting,” or “This is the *only* way to deal with this problem.” Replacing such thoughts with more rational (and positive) thoughts is a critical step in getting youth to decrease and hopefully end their NSSI behaviors.

### ***Affective Dimension***

There is considerable support in the professional literature suggesting that individuals who engage in NSSI have significant problems with affect regulation (Conterio & Lader, 1998; Favazza, 1996; Fonagy, Gergely, Jurist, & Target, 2002; Yates, 2004). In other words, NSSI may be viewed as a maladaptive coping strategy designed to regulate and control an adolescent’s emotions and to relieve tension (Gratz & Roemer, 2004; Linehan, 1993; Suyemoto, 1998), elevate and relieve overwhelming negative emotions (Briere & Gil, 1998; Klonsky, 2007), and communicate difficult to express psychological distress (Gratz, 2006). Although NSSI appears most often to be performed with the intent of alleviating negative affect, there is strong support for self-derogation and self-punishment functions as well. Youth who engage in NSSI identify a wide range of emotions as preceding their acts of self-harm, including anger, contempt, sadness, tension, guilt, shame, worry, and grief (Alderman, 1997; Conterio & Lader, 1998). However, it is important to recognize that the affective dimension of NSSI is closely linked to the cognitive dimension; emotions often emerge from the distorted, irrational, and frequently self-blaming, cognitions that precede them (Walsh, 2006). As such, emotions are generally of critical importance in the assessment and treatment of NSSI.

### ***Behavioral Dimension***

The behavioral dimension includes overt actions that occur right before, accompany, and follow NSSI. Typical behavioral antecedents include family or peer conflicts, failure at an activity, isolation, sexual behavior, substance abuse, or eating-disordered behavior (Walsh, 2006). This dimension also includes actions that set the stage for NSSI, such as choosing the physical location for self-injury, securing a location to prevent interruption, and selecting a method for inflicting NSSI. It is critical that school personnel determine the temporally distant and the more immediate antecedents to NSSI, as well as the consequences students receive for engaging in it. For example, after engaging in NSSI, some individuals fall asleep immediately

afterward. Others may remain agitated and seek other forms of release, whereas some may return to normal activities. The consequences of engaging in NSSI provide a great deal of information regarding why this behavior is repeated; that is, what *function* it serves for the individual. Only after a thorough, individual, functional assessment has been completed can an effective treatment plan be developed and implemented. A more detailed discussion of the functional assessment of NSSI is provided in Chapter 6.

## **Integration of the Five Dimensions**

Although descriptive information about self-injurers is abundant in the literature, the causal pathways that lead to NSSI have been poorly articulated (D'Onofrio, 2007). Walsh (2006) proposes that each of the dimensions discussed above do not function in isolation, but are entirely interrelated and even interdependent. For example, NSSI behaviors are theorized to result from disturbances in cognition and affect; negative thoughts fuel and amplify negative emotions, which potentially lead to a variety of maladaptive coping behaviors such as NSSI, alcohol and substance abuse, and other self-destructive behaviors. Conversely, there is evidence to suggest that recurrent traumatic experiences have sustained physiological effects, including changes in brain chemistry (van der Kolk, McFarlane, & Wiesaeth, 1996). Each of these five dimensions (i.e., environmental, biological, cognitive, affective, and behavioral) must be considered by school personnel if effective assessment and treatment of youth engaging in NSSI is to occur.

## **Concluding Comments**

This chapter has explored NSSI as a multifaceted, multi-determined behavior that is the result of intricate and complex interactions. School personnel should have a thorough understanding of how the five dimensions described above contribute to the development of NSSI. These areas have important implications for assessment and treatment – issues that will be discussed in subsequent chapters. However, before discussing assessment and treatment issues the next chapter examines the prevalence of NSSI and some prominent psychiatric conditions associated with it.



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