Non-Suicidal Self-Injury in Adolescents

by

Serena R. Pettersen

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APPROVED BY Bruce Hardy

Dedication

For my supportive and endlessly patient husband, who has never let me give up.

For my mother, who instilled in me a belief that I could do anything I put my mind to.

For my father, who taught me the value of the pursuit of higher education.

For my wonderful teaching partner, without whom I would not be where I am today.

Abstract

This paper is an exploration of Non-Suicidal Self-Injury (NSSI) in adolescents to provide counsellors with a better understanding of the scope of NSSI through a behavioral and trauma-informed lens, as well as familiarize them with the efficacy of different counselling approaches used to treat NSSI. NSSI is prevalent among adolescents and can be addressed through counselling, however there is limited research available on targeted treatments for NSSI. The paper concludes with a proposed 7-part group counselling plan for adolescents who are engaging in NSSI.

Keywords: Non-Suicidal Self-Injury, adolescents, counselling strategies, emotion regulation, Dialectical Behavior Therapy

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Chapter 1: Introduction

Background to the Problem

Non-Suicidal Self-Injury (NSSI) is most prevalent among adolescents and young adults occurring within populations of people with or without psychiatric disorders (Nock, 2009). It is associated with higher suicide risk (Nock, 2009) and typically involves cutting or carving the skin (Nock, 2010; Mckenzie & Gross, 2014), but can also include burning/branding, and hitting (Muehlenkamp, J. J., Claes, L., Havertape, L., & Plener, P. L., 2017), head banging, breaking bones, hair pulling, nail biting resulting in bleeding, and interfering with wound healing (Mckenzie & Gross, 2014). NSSI behaviors peak at the ages of 15 – 16 and significantly decrease from ages 15 – 29. Research indicates that 17 – 18% of adolescents have engaged in NSSI at least once in their lifetime (Brown & Plener, 2017) and 1.5 – 6.7% of those adolescents meet the DSM V (Diagnostic and Statistical Manual of Mental Disorders 5th edition) proposed criteria for NSSI disorder (Brown & Plener, 2017).

Those who experience interpersonal trauma are at risk of engaging NSSI as they are more prone to experiencing higher levels of emotional dysregulation, self-criticism, and dissociation (Horowitz & Stermac, 2018). Specifically, childhood abuse can lead to increased emotional reactivity and interfere with the development of emotional coping skills, learning of effective problem solving, and communication skills leaving them vulnerable to maladaptive coping skills (Nock, 2009). The long-term use of NSSI puts adolescents at risk of losing skills *(*Buelens, T., Luyckx, K., Gandhi, A., Kiekens, G., & Claes, L., 2019). By actively avoiding situations that make them want to engage in NSSI, adolescents experience a decline in their abilities to cope

with distress over time (Garisch, J. A., Wilson, M. S., O'Connell, A., & Robinson, K.., 2017), putting them at further risk of needing to use maladaptive coping skills in the future. Of further concern, adolescents who engage in repetitive NSSI appear to be at a higher risk of continuing to engage in maladaptive emotion regulation strategies even after ceasing NSSI behaviors (Brown & Plener, 2017).

One of the challenges when reviewing research about NSSI is inclusion criteria. Until the release of the DSM V, NSSI was categorized as a symptom within other diagnoses. Due to its high prevalence and the level of distress and impairment individuals experience, NSSI is being reconsidered as a standalone disorder (Bently et al., 2014). As a result of the lack of clarity around what qualifies as NSSI, researchers worldwide have used different criteria to determine who will be included in studies about NSSI resulting in lack of clarity and certainty when considering results (Mehlenkamp et al., 2017). This includes challenges due to the conflation of NSSI and suicide (Whitlock, J., Exner-Cortens, D., & Purington, A., 2014) resulting in miscategorizing or confusion of behaviors leading to less targeted and therefore less effective treatment (Whitlock et al., 2014).

The most used type of treatment is Dialectical Behavior Therapy for Adolescent (DBT-A). Research shows that it may have the most efficacy for adolescents with co-morbid diagnosis (Glen et al., 2019; Plener et al. 2016). Emotion focused and emotion regulation approaches have also been found to show clinically significant reductions in NSSI behaviors (Bjureberg, J et al., 2018; Turner, B. J., Austin, S. B., Alexander, & Chapman, L., 2014). There is also research showing the efficacy of including elements of different forms of family therapy and/or parent coaching alongside NSSI treatment (Glenn et al., 2019; Mahtani, S., Hasking, P., & Melvin, G. A., 2019; Schade, 2013).

Statement of the Problem

Researchers have explored NSSI from a variety of perspectives including behavioral, biological, neurological, and attachment and until recently, NSSI was not even recognized in the DSM V as occurring without the presence of a personality or other disorder (Muehlenkamp et al., 2017). This has resulted in gaps in research about prevalence rates, assessment, and treatment of NSSI (Hooley & Franklin, 2018). There is currently no universally accepted best practice for treating NSSI in adolescents (Kaess, M., Edinger, A., Fischer-Waldschmidt, G., Parzer, P., Brunner, R., & Resch, F., 2020).

Purpose of the Paper

Through a three-part literature review, this study aims to help counsellors develop a deeper understanding about the treatment of NSSI in adolescents. This will be done through examining the literature about functions and models for understanding NSSI, issues and factors pertinent to adolescents, and examining the efficacy of current treatment practices.

Research Question

This paper sets out to answer the question: what are the best counselling practices for adolescents who are engaging in NSSI? The paper concludes with a group counselling curriculum based on the most prevalent issues found in the research and draws on strategies presented in the treatment models with the most efficacy.

Significance of the Study

NSSI is most prevalent in the adolescent and young adult years (Nock, 2010; Mckenzie & Gross, 2014). While some adolescents only engage in NSSI behaviour once, for others it is an ongoing behaviour and is indicative of deeper challenges that could continue as maladaptive emotion regulation skills in one form or another later in life (Brown & Plener, 2017).

Counsellors working with adolescents should be informed about NSSI, its functions, and treatment options as it is a common issue. This study will provide counsellors who work with adolescents the necessary background information and understanding of treatment efficacy to facilitate effective interventions in a group setting with adolescents who are engaging in NSSI.

Definition of Terms

Adolescent: referring to an individual who is aged 12 – 19 (Stellar et al., 2013; Glenn et al., 2019)

Emotional dysregulation: occurs in response to an internal (recalling an incident) or external (encountering an angry person) experience resulting in a feeling, followed by a thought and a physiological response (elevated heart beat) resulting in a behaviour (avoidance) (Pederson & Pederson, 2017; Van Dijk, 2020b).

Emotion regulation: is the process of tuning into your emotions, acknowledging and understanding them, and using strategies to help you manage your response (Pederson & Pederson, 2017; Van Dijk, 2020b).

Mindfulness: is focusing on one thing at a time, being the in the present moment with full attention and acceptance. It is also about trying to adopt an attitude of curiosity, acceptance, and openness toward what you are experiencing (Pederson & Pederson, 2017).

Non-Suicidal Self-Injury: the intentional destruction of one's own bodily tissue within the intent to die (Nock, 2009).

Shame: is connected deeply to our sense of self and our identity. When we experience shame, it prevents us from being in the present and evaluate ourselves negatively. It tells us that we are inherently wrong, bad, unloveable, stupid, etc. (Mahtani et al., 2018.).

Outline of the Remainder of the Paper

Chapter 2 will explore research around NSSI with the intention of providing the reader with a foundation of knowledge about NSSI and the current research about adolescents and explore treatment models. This will include prevalence, forms, the proposed DSM V criteria for NSSI Disorder, models of understanding, functions, and challenges with international, cross-culturally, and socioeconomic comparisons. Following this will be an examination of factors specific to adolescents engaging in NSSI including risk and protective factors, long term effects, a discussion of the research around gender differences, LGBTQ+ issues, the influences of social media, and how NSSI appears in specific psychiatric disorders in adolescents. The chapter will conclude with an overview of the efficacy of various therapies used in the treatment of NSSI in adolescents. Chapter 3 will provide a summary of the research and the recommendations including a group counselling treatment plan.

Chapter 2: Literature Review

Introduction

This chapter will explore the literature and research related to NSSI, NSSI in adolescents, and counselling strategies for NSSI in adolescents.

Review of Research Literature

Understanding Non-Suicidal Self-Injury

The overarching term 'self-injurious thoughts and behaviors' can be divided into two categories: Non-Suicidal Self-Injury (NSSI) and suicidal self-injury. Both impair an individual's ability to live well socially, emotionally, and cognitively (Glenn et al., 2019), but are distinct because of intent (Klonsky, D. E., Victor, S. E., & Saffer, B. Y., 2014). While some researchers have differentiated NSSI from suicidal behaviours and behaviours that have unintended harmful consequences, for instance smoking (Nock, 2009), others have included NSSI on a spectrum of behaviors that range from indirectly harming oneself such as smoking, overeating, and alcohol use, to directly self-harming for instance NSSI or suicide attempts, as they have found some evidence that similar mechanisms drive distinct modes of self-harming (Bentley et al., 2014). Body modifications that are in line with an individual's cultures (i.e. tattoos, scarification) are not classified as NSSI (Nock, 2009). For the purposes of this paper, NSSI will be defined as "the deliberate destruction of one's own body tissue in the absence of intent to die" (Nock, 2009, p. 78).

Typically beginning in early adolescent, NSSI occurs within a wide range of psychiatric disorders, as well as in people without disorders (Nock, 2009). It is most prevalent among adolescents and young adults and typically involves cutting or carving the skin (Nock, 2010;

Mckenzie & Gross, 2014), but can also include burning/branding, hitting/banging (Muehlenkamp, 2017), head banging, breaking bones, hair pulling, nail biting resulting in bleeding, and interfering with wound healing (Mckenzie & Gross, 2014). Common sites for NSSI are the arms, legs, stomach, hands, and chest (Muehlenkamp, 2017). Reported prevalence rates vary due to different criteria and definitions used for each individual study (Hooley & Franklin, 2018; Franklin et al., 2010). 1 – 4% of adults report history of engaging in NSSI at some point in their lifetime (Nock, 2009), while 13 – 23% of adolescents report a history (Nock, 2009). In an analysis of 16 studies, Zetterqvist (2015) found a community prevalence rate of 1.5% to 5.6% in children and adolescents. Of these, 3.1-6.7% met the proposed DSM V criteria for NSSID. In clinical samples of adolescents and adults, prevalence rates ranged from 36.9% to 50% (Zetterqvist, 2015). Past research has suggested that NSSI is more prevalent in women and in those of sexual and gender minorities (Hooley & Frankllin, 2018). Limitations have been noted in male samples as the data available has largely focused on non-clinical samples (Victor, S. E., Hipwell, A. E., Stepp, S. D., & Scott, L. N., 2019).

NSSI was first introduced to the DSM in its 5th edition as an area needing further study (Muehlenkamp et al., 2017). The proposed criteria are as follows:

1. The individual has engaged in NSSI on 5 or more days in the last year with the absence of suicidal intent
2. The individual uses self-injury to:
    a. relieve negative thoughts or feelings
    b. to resolve interpersonal difficulty and/or
    c. obtain a state of feeling positive
3. The self-injury is associated with at least one of the following:

   a. Interpersonal difficulties or negative thoughts or feelings
   b. Prior to engaging, the individual has thoughts about the act that are difficult to control
   c. Frequent thoughts about self-injury
4. The behavior is not socially sanctioned
5. The behavior or consequences cause clinically significant distress or interferes with important areas of life
6. The behavior does not happen exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal. In individuals with a neurodevelopmental disorder, the behavior is not part of a pattern of repetitive stereotypies. The behavior is not better explained by another mental disorder or medical condition (e.g., psychotic disorder, autism spectrum disorder, intellectual disability, trichotillomania) (American Psychiatric Association, 2013).

NSSI can occur alongside externalizing and internalizing disorders including major depressive disorder, PTSD, generalized anxiety disorder, obsessive compulsive disorder, substance use, eating disorders (Muehlenkamp et al., 2017), personality disorders (Bentley et al., 2014), or in the absence of a psychiatric disorder/diagnosis (Hooley & Franklin, 2018). Previously, NSSI was most commonly associated with BPD (Hooley & Franklin, 2018), however research has determined that NSSI can occur in the absence of other BPD symptoms (Glenn & Klonsky, 2013). Due to its high prevalence and association with distress and impairment, NSSI is now listed as an area requiring further study as a disorder in the DSM V. (Bentley et al., 2014). The shift in the DSM came with 4 reasons:

1) Research is indicating that NSSI can occur without BPD and there is a danger in adolescents/individuals being diagnosed with BPD is they self-injure and therefore receive the incorrect interventions.

2) There needs to be a clear distinction between NSSI and suicide as they are often conflated, even in the DSM. Distinguishing between the two could help with suicide risk assessment.

3) Having a distinct category would create research funding opportunities that only existed for NSSI research within the context of BPD.

4) Making a standardized criterion would lead to more research that could build a collective body of knowledge.

Currently it is difficult to compare studies as different standards are used in NSSI research (Glenn & Klonsky, 2013) and the proposed criteria have been scrutinized for its reliability and validity which yielded inconsistent results across studies (Muehlenkamp et al., 2017). Despite these challenges, researchers feel that it is important to develop clear criterion, especially for adolescent patients as they have the highest prevalence of NSSI (Muehlenkamp et al., 2017). In saying this, researchers warn to be cautious when using the proposed criteria, as with any disorder, there is a risk to over pathologize individuals who engage in NSSI especially if it is infrequent. The importance of this lies in diagnosis and access to research-based interventions as needed. This will only come with more research around the proposed criteria (Muehlenkamp et al., 2017).

NSSI is not a failed suicide attempt, but rather a coping mechanism (Hooley & Franklin, 2018) in persons who "develop intra- or interpersonal vulnerabilities that predispose them to respond to challenging or stressful events with affective or social dysregulation, creating a need

to use NSSI or some other extreme behavior to modulate their experience" (Nock, 2009, p.80). These individuals may be "experiencing emotions at a high intensity, [have] underlying difficulty in self-regulation when experiencing intense emotions, […]paucity of skills to regulate their emotions, and/or [have] poor ability or low threshold for tolerating distress" (Garisch et al., 2017, p. 99). Ford and Gomez (2015) found similar characteristics of persons engaging in NSSI…[including] "

> (a) physiological hyperarousal in situations eliciting frustration; (b) attempts to suppress unpleasant thoughts and feelings; (c) low tolerance for and difficulty in recovering from distress; (d) difficulty with interpersonal communication and problem solving; (e) self-deprecation and an intention to self-punish; (f) impulsivity; and (g) heightened tolerance for and diminished sensitivity to physical pain, and a paradoxical analgesic reaction to pain" (p. 235).

Higher levels of self-criticism are common in people who engage in NSSI. A negative sense of self is a trait developed overtime, connected to things such as depression resulting from other factors including abuse, parental criticism, and mistreatment. (Hooley & Franklin, 2018). "NSSI researchers have established that the relationships between these adverse caregiving experiences and NSSI are often mediated by affect regulation and self- punitive pathways" (Mahtani et al., 2019, p. 755). These experiences of trauma and/or hardship often involve the violation of a person's boundaries and rights. It communicates the message "that one's intrinsic and interpersonal identities are insignificant, unlovable or inherently bad" (Mahtani et al., 2019, p. 755). These types of environments can create shame through the punishing of emotional expression and/or the development of adaptive emotion regulation strategies. As a result, children and youth do not have the opportunities to learn about their emotions, including feelings

of shame, nor learn how to accept them and develop skills to regulate them (Baetens, I., Claes, L., Hasking, P., Smits, D., Grietens, H., Onghena, P., & Martin, G., 2015; Mahtani et al., 2019).

Models of Understanding

Four-Functions Model.

The four-function model (Nock, 2009) was proposed as a framework of understanding NSSI to address gaps in research. This model has two main tenants: emotion regulation or social regulation. The NSSI behaviour serves to modify these things (Hooley & Franklin, 2018). It comes from a functional behaviour perspective that examines behaviors as being influenced or controlled by antecedents and consequences, or the events that happened immediately before behavior and immediately following a behavior (Nock, 2009). In the first tenant, emotion regulation, Nock (2009) proposes that a possible function of NSSI is intrapersonal negative reinforcement wherein an individual uses NSSI to decrease or distract the individual from thoughts or feelings. Intrapersonal positive reinforcement is another function of emotion regulation when a person uses NSSI to obtain feelings or stimulation. Social regulation is the other tenant of this model. Interpersonal positive reinforcement, serves to seek help by communicating distress, while interpersonal negative reinforcement serves to aid the individual to get out/avoid social situations when they engage in NSSI (Nock, 2009).

While the theories presented in Nock's model (2009) lend themselves well to experimental testing, there are limitations. The four functions model was developed by researchers thorough an examination of research on the functions of NSSI behaviors in individuals with developmental disabilities (Hooley & Franklin, 2018). There would be questions as to whether these theories could be generalized to neurotypical individuals who engage in NSSI. Further, this model does not explain every factor that could contribute to an

individual engaging in NSSI, such as biological factors or environmental influences (Hooley & Franklin, 2018). It does however present a more robust survey of these types of behaviors than past research, including the inclusion of social functions (Hooley & Franklin, 2018).

Benefits and Barriers Model.

Hooley and Franklin (2018) propose a model that expands upon the research done by Nock (2009). They propose that emotion regulation plays a smaller role in the onset of NSSI, but a more significant role in maintaining the behavior (Hooley & Franklin, 2018). Their research sets out to explore the benefits that people experience from engaging in NSSI and the barriers that exist to prevent many people from using this behavior. Their proposed model is called the Benefits and Barriers Model (Hooley & Franklin, 2018).

The first benefit described is that NSSI improves emotion. People engaging in NSSI may not realize this at the time of initial engagement but learn that it improves their emotions and therefore continue to engage in it (Hooley & Franklin, 2018). The second benefit proposed is that NSSI fulfills a desire for self-punishment (Hooley & Franklin, 2018). The third benefit NSSI provides is peer group association, which suggests that a person might engage in NSSI to gain access to or maintain access to a group of peers, there is however, evidence that this is an uncommon benefit (Hooley & Franklin, 2018). Finally, the fourth benefit of NSSI described is communication. While the behavior can communicate distress, it can also communicate and signal strength. In a review of other research these authors found that there was an increased perceived social support by youth who engage in an NSSI the day after doing such acts (Hooley & Franklin, 2018).

Hooley and Franklin (2018) suggest five barriers to an individual engaging in NSSI. First, lack of awareness or exposure to NSSI is a barrier to engaging in it. The second barrier

proposed is having a positive view of self, meaning if a person holds themselves in high regard, they do what they can to protect themselves and do not engage in destructive behavior. The third barrier is physical pain. Those who overcome this barrier do so through an increased pain tolerance or a willingness to experience pain that might be related to an individual's biology (Hooley & Franklin, 2018). The fourth barrier they suggest is an aversion to NSSI stimuli, such as blood and wounds. They suggest three mechanisms that help individuals overcome aversion including exposure overtime decreases aversion, overtime stimuli become affiliated with relief, and finally, for some people the motivation to engage in this behavior overrides the aversion (Hooley & Franklin, 2018). The fifth barrier, considered to be a major barrier, is around social norms. Some individuals overcome this by engaging in NSSI in private. Others become part of a group where an NSSI is acceptable. In other cases, people may go against social norms purposefully as a means of communicating their distress or their strength (Hooley & Franklin, 2018).

Other Research on Functions.

Mckenzie and Gross (2014), aim to create a more explicit understanding of the role of emotions in NSSI. In a review of studies, they found that before engaging in NSSI individuals experienced “high-activation negative emotions” (p. 210) such as tension, anxiety, angry, nervousness, sadness or self-hatred, but afterward experienced a decrease in these feelings, thus regulating emotion (Mckenzie & Gross, 2014). They propose this experience could be due to one or more of the following mechanisms: selecting or modifying the environment (avoiding going into or engaging in a situation that may cause more stress or alter the demands someone is putting on them); shifting attention (shift emotional pain to physical pain); changing thoughts

about self or environment (relief anxiety or stress; self-punishment); modulating physiological responses (endorphin release) (Mckenzie & Gross, 2014).

Ford and Gomez (2015) proposed that all functions of NSSI are emotion regulation strategies. Emotion relief, generating feelings, numbing feelings, and self-punishment serve to directly regulate emotions, while the interpersonal conflict/stressors are merely antecedents to NSSI behaviors in that they cause the distressed state that requires emotion regulation.

Further research by Bentley et al. (2014), also examines the connection between emotion and physical pain. The mechanism they proposed is referred to as pain offset relief, wherein physical pain generates relief from emotional pain, which is different than distraction. However, distraction is another potential mechanism for emotion regulation that has been proposed (Bentley et al., 2014). Further, for other individuals, engaging in NSSI is a way for them to experience emotions that they might not otherwise be able to feel (i.e. 'cutting at the only way to feel alive').

Mckenzie and Gross (2014) caution that for individuals who engage in NSSI habitually, physiological mechanisms may be particularly important. They propose that

> "differences in levels of endogenous opioids may be either the cause or the result of NSSI – individuals may be engaging in NSSI in order to release endogenous opioids as a way of making up for a natural deficit, or lower levels may be the result of repeated NSSI" (Mckenzie & Gross, 2014, p. 216).

Meaning that a better understanding of an individual's physiology could be helpful in creating targeted treatments.

Horowitz and Stermac (2018) found that those with more severe trauma referenced or endorsed more overall functions and more specific functions of NSSI that were not as relevant to

those with less trauma. Interpersonal functions were found to have the strongest relationship with the severity of trauma. This makes sense given the interpersonal challenges that occur in those who have experienced interpersonal maltreatment or trauma (Horowitz & Stermac, 2018). Further, they found that self-punishment was a highly endorsed function by those with more severe trauma, but more research is needed to explore why this is the case. Finally, they found that those with high levels of trauma, anti-dissociation was also a function (Horowitz & Stermac, 2018). Experiences of interpersonal trauma increases emotional dysregulation, self-criticism, and dissociation (Horowitz & Stermac, 2018) putting individuals at risk of engaging in NSSI.

These variations of function may be accounted for by an individual's history of interpersonal trauma (Horowitz & Stermac, 2018). Nock (2009) notes:

> "Childhood abuse may lead to increased emotional reactivity and an inability to manage such a response, which is then (maladaptively) managed using NSSI. Factors such as childhood abuse also can prevent the developing child from learning effective social-problem-solving or communication skills, thus contributing to the interpersonal vulnerabilities" (Nock, 2009, p. 80).

Further, research has found that "significant correlations were observed between trauma severity and the following functions [of NSSI]: affect regulation, interpersonal boundaries, self-care, anti-dissociation, and marking distress" (Horowitz & Stermac, 2018, p. 239).

Despite the breadth of research there are still gaps in understanding NSSI behaviors (Hooley & Franklin, 2018).While researchers have proposed several different models for understanding NSSI, functions, and driving factors/mechanisms (Nock, 2009; Hooley & Franklin, 2018), the emotional regulating model with the function of coping with emotional pain and distress has been highly endorsed, but there have not been extensive clinical studies to

further understand exactly how it is a mechanism or exactly how it works in relation to NSSI (Bentley et al., 2014; Buelens et al., 2019; Hooley & Franklin, 2018; Mckenzie & Gross, 2014). These gaps in research continue to contribute to challenges in assessment and treatment (Hooley & Franklin, 2018).

International Considerations

Overall, there is a lack of cross-nation comparisons of NSSI making it difficult to draw culturally comparative conclusions (Muehlenkamp et al., 2012). Different countries and areas use different assessment criteria and therefore different inclusion criteria for studies (Muehlenkamp et al., 2012) resulting in significant variation in prevalence rates (Mannekote Thippaiah et al., 2020), but the available research has been able to draw some conclusions. A meta-analysis based on data from 119 countries, including Canada, New Zealand, some countries in Europe, the Middle East and parts of Asia, showed that the collective prevalence rate of NSSI was 17.2% in adolescents, 13.4% in young adults and 5.5% in adults (Swannell et al. 2014). In their review, Mannekote Thippaiah et al. (2020) found some common and unique factors to be causing, contributing to or triggering NSSI internationally including "psychological, psychopathological, family based, societal, psychosocial and cultural factors" (Mannekote Thippaiah et al., 2020, p. 8). Socioeconomic and cultural factors include poverty and being unable to meet the basic needs of one's self or of their family. Psychological factors include fear of being stigmatized, shame, guilt, and helplessness. Further, challenges in developing countries such as rapid modernization, shifting work force, technology compound to increase risk. Compounded by poor public support systems, such as suicide helplines or mental health resources, these factors increase barriers to seeking help. Additionally "feelings of social marginalization due to oppression, corruption, communal violence, terrorism or ineffective

public/community/government actions all directly or indirectly lead to high-stress states, conferring risk" (Mannekote Thippaiah et al., 2020, p. 8). There are two implications with the difficulty of cross-cultural studies surround NSSI. First, a more thorough examination of the challenges and difference from culture to culture, and even within different socioeconomic statuses, would lead to counsellors being more informed about culturally sensitive approaches when working with clients engaging in NSSI. The second implication is the clear need for a standardized criteria for inclusion in studies about NSSI in order to be able to accurately compare this issue worldwide.

NSSI in Adolescents

Non-suicidal self-injury is most prevalent in youth and young adults with research indicating that 17-18% of adolescents have engaged in NSSI at least once in their lifetime and 1.5 to 6.7% of those adolescents meet the DSM V proposed criteria for NSSI Disorder (Brown & Plener, 2017). NSSI behaviors peak at the age of 15-16 and significantly decrease from ages 15 – 29. Less is known about NSSI in younger age groups, such as those under 14 years of age. This lack of knowledge about the younger age group includes not knowing the factors that contribute to onset, short term continued use, nor why the behavior stops (Stallard et al., 2013).

Research has found that adolescents who are vulnerable to NSSI behaviors experience overwhelmingly distressing emotional responses to their internal experiences and are seeking to avoid this distress. The emotion being avoided could range from anger to shame to sadness. Further "increased emotional reactivity/lability without a well-developed control system may place adolescents at heightened risk for engaging in extreme emotion regulation strategies, such as NSSI" (Glenn & Klonsky, 2013, p. 497). Elevated levels of impulsivity and reactivity due to their developmental phase put adolescents at even further risk for developing NSSI (Brown &

Plener, 2017). Supporting this hypothesis, the most reported/endorsed functions of NSSI by youth are affect regulation and self-punishment (Robinson et al., 2019).

Risk Factors and Protective Factors

There are several risk factors that may indicate when an adolescent is more likely to engage in NSSI as a coping mechanism. These risk factors do not necessarily mean that an adolescent will engage in NSSI, but rather that they may be vulnerable to being overwhelmed by the psychological distress they experience in relation to abuse, trauma, violence and/or aggression (Buelens et al., 2019; Emelianchik-Key, K., Byrd, R. J., & La Guardia, A. C., 2016). The risk factors that may have the strongest effect on adolescents include having a history of NSSI, personality disorders, depression, or hopelessness (Rasmussen, S., Hawton, K., Philpott-Morgan, S., & O'Connor, R. C.., 2016). Other factors include "disrupted identity formation, negative self-representation, peer/parental rejection, alienation and low body regard (i.e. body esteem, connection to one's body)" (Mahtani et al., 2019, p. 755). Research suggests that these factors are connected to shame, which may be an important factor connected to NSSI, and can be the result of abuse, trauma, and aversive parenting. Adolescents "who have been subjected to frequent abuse, neglectful and/or invalidating relational experiences with their caregivers may be predisposed toward experiencing increased shame" (Mahtani et al., 2019, p. 755). Children and adolescents in an invalidating environment may develop maladaptive coping mechanisms in response to their shame as they experience fewer learning opportunities to recognize and regulate this shame. Compounded further by observing parents engaging in maladaptive coping skills, children in invalidating environments are at a higher risk of engaging in NSSI (Robinson et al., 2019).

Family factors that increase the risk of NSSI behaviors include adverse childhood experiences such as physical abuse, sexual abuse (moderately linked), parental neglect/deprivation, high levels of parental critique or apathy (Hooley & Franklin, 2018), perceived lack of parental emotional support, (Baetens et al., 2015; Hooley & Franklin, 2018), poor quality of attachment to parents, and harsh parental punishment (Victor et al., 2019). Some of these factors are directly related to NSSI, while others are correlated. An individual's perception of both a highly critical and low support family environment fosters highly critical standards for self and self-criticism (Baetens et al., 2015, p. 496)**.** Research has found that individuals who engage in NSSI have high levels of self-criticism (Victor et al., 2019).

Experiences of bullying (Brown & Plener, 2017; Claes et al., 2015; Hooley & Franklin, 2018), peer victimization (Claes et al., 2015; Victor et al., 2019) and negative beliefs about peers are associated with onset of NSSI (Victor et al., 2019). Mediated by depression (Claes, L., Luyckx, K., Baetens, I., Van de Ven, M., & Witteman, C., 2015) the impact of peer victimization on an individual's social self-worth or low social self-worth increases the risk of NSSI (Victor et al., 2019). Experiencing frequent victimization and not having the ability or resources to react in a way that helps mitigate or resolve the situation, can result in stress, depression, anger, fear, and other internalizing factors leading an adolescent to turn to NSSI to cope with the emotions (Claes et al., 2015;Victor et al., 2019)**.** These factors also create risk for self-criticism which, again is associated with NSSI (Victor et al., 2019)**.**

Referred to as social contagion, exposure to the self-injury of others has been identified as a risk factor for adolescents engaging in NSSI (Hooley & Franklin, 2018). Initial engagement in NSSI may be highly influenced by social contagion (Brown & Plener, 2017; Nock, 2009; Wolff, J., Frazier, E. A., Esposito-Smythers, C., Burke, T., Sloan, E., & Spirito, A., 2013) and

exposure to NSSI is difficult to avoid. It is portrayed in television shows, movies, and shared via social media. Most who engage in NSSI report that they first learned about NSSI from a peer, family or the media (Nock, 2009).

Research indicates that there are factors in an adolescent's life that work to protect them from the risk of engaging in NSSI. One such factor is the level of perceived parental support. When an adolescent feels that a parent or parents are supportive of them, it can serve to reduce the risk of the onset and/or maintenance of NSSI (Baetens et al., 2015; Claes et al., 2015). Confiding in an adult may be an important protective factor. "A more supportive family environment, open communication between parents and their children and modelling of adaptive coping might also explain why youth who disclosed to adults reported better psychosocial functioning over time" (Hasking, P., Rees, C. S., Martin, G., & Quigley, J., 2015, p. 7). Support seeking has been found to be a significant protective factor (Thomassin et al., 2019). Additionally, by increasing both adaptive coping skills and a belief in their own ability to use alternative coping skills can potentially reduce the severity of NSSI (Hasking et al., 2015). Other protective factors include having problem solving skills, friendships, (Rasmussen et al., 2016) and the ability to positively reframe difficult situations (Thomassin et al., 2017).

Long Term Effects and Consequences

Adolescents who engage in NSSI are at risk of experiencing an erosion of skills overtime, through a feedback loop created during the process of engaging in NSSI (Buelens et al., 2019). By actively avoiding situations or emotions that cause them distress, adolescents experience a decline in their abilities to cope with distress over time (Garisch et al., 2017), putting them at further risk or needing to use maladaptive coping skills in the future. This is concerning as research indicates that the more intense the emotions, the more intense the dysregulation, the

higher risk of NSSI (Rasmussen et al., 2016). Meaning that an individual could get 'stuck' in a cycle of avoidance, intense emotions, and NSSI behaviors. A study by Robinson et al. (2019) proposes three possible ways that NSSI impacts emotional regulation for adolescents overtime. First, it is quick and reenforcing. NSSI creates a shortcut or quick fix for intolerable emotions where the individual does not have to experience stress or learn to cope with it. Second, as NSSI decreases the ability or opportunity for an individual to regulate their emotions, it also erodes their belief that they can tolerate distress and learn other strategies. Third, it can decrease interpersonal supports and connections as they pull away to avoid rejection or judgements from family and friends. Additionally, it could make them relate more closely to peers who are also using ineffective skills (Robinson et al., 2019). Further, "adolescents with repetitive NSSI seem to be at high risk to be continuing dysfunctional emotion regulation strategies, even after cessation of NSSI" (Brown & Plener, 2017, p.20). Meaning that even once an adolescent stops engaging in NSSI, it does not necessarily mean that they have developed healthy coping mechanisms, but rather it could mean they could have moved onto another maladaptive coping mechanism or, alternatively, that the stressors have ceased and they will return to a maladaptive mechanism in the future when stressed.

Gender Differences: Female, Male, LGBTQ+

While there appears to be no difference in most NSSI characteristics (body location, recent frequency, severity, and impulsivity) between males and females (Victor et al, 2018), research has found that forms of NSSI may differ between males and females. Females appear more likely to engage in cutting (Robinson et al., 2019; Baetens et al., 2015; Hooley & Franklin, 2018; (Victor et al., 2018), pinching, rubbing (Victor et al., 2018) and scratching (Robinson et al., 2019; Victor et al., 2018), while males may be more likely to engage in outwardly aggressive

behaviors causing bodily harm like fighting (Hooley & Franklin, 2018), hitting themselves against a wall (Baetens et al., 2015; Hooley & Franklin, 2018), and burning or branding (Victor et al., 2018).

Differences of NSSI as reported in males and females "may be due to the gendered implications of aggression; physical aggression may be socially acceptable for males, providing a socially sanctioned and covert methods for NSSI" (Victor et al., p. 54). For example, kicking or punching walls, which may not be a recognized method of NSSI, can lead to significant injury. When asked why they engage in NSSI females are more likely to express inward reasons and males are more likely to express outward reasons. However, again this reporting could be due to gendered socialization (Emelianchik-Key et al., 2016) and should be interpreted cautiously when exploring NSSI in adolescents of any gender.

One study found that males who seek treatment may present differently than females and this could result in minimization or being overlooked by clinicians (Victor et al., 2018). Additionally, it was found that males are more likely to be diagnosed with a substance use disorder, meaning that overall, males could be resorting to different maladaptive coping strategies making NSSI less likely to appear the same way it does in females (Victor et al., 2018, p. 57). Males were less likely to report affect regulation or internal factors as function of NSSI (Victor et al., 2018). Additionally, males report having fewer urges, but it is also possible that they may be less likely to report them (Victor et al., 2018). "Understanding symptom severity and impairment in self-injuring males may require focusing on constructs that are not typically related to NSSI in female-dominant samples, such as physical aggression or substance use" (Victor et al., 2018, p. 58).

Both school aged males and females reported social factors that impact their NSSI behaviors in a study which found that insecure attachments increased the likelihood for boys and girls developing NSSI behaviors (Stallard et al., 2013). For boys, regular experiences of bullying meant they were twice as likely to report thoughts of self-injury continuing overtime (Stallard et al., 2013). Boys with avoidant attachments and girls with anxious peer attachments were found to be twice as likely to engage in NSSI behaviors. For both males and females, social factors that play a role in influencing NSSI can include dysfunctional relationships, being bullied by peers, social contagion (for the first incident on NSSI). However, NSSI is maintained over time by personal factors and dysfunction (Brown & Plener, 2017).

There is an ongoing discourse about whether there are differences of NSSI behaviors amongst adolescents of different genders. Limits in existing research include a focus on non-clinical samples, lack of representation of males in clinical samples, limited scope of assessment tools, gaps in research based on outcomes of treatment and how it differs in males and females (Victor et al., 2018). Past research around NSSI has focused almost exclusively on females, creating a challenge when looking at trends, as it appears that females engage in NSSI at much higher rates than males (Hooley & Franklin, 2018). More current research proposes conflicting information about prevalence when looking at gender. Some report higher rates in females (Robinson et al., 2019), others report the same rates for females and males (Baetens et al., 2015; Claes et al., 2015). It is possible that females are more likely to seek help and therefore, there is more visibility in this gender (Victor et al., 2018). There is research that is beginning to indicate males are just as likely to engage in NSSI as females, but that it manifests differently or they hide it and do not seek help (Hooley & Franklin, 2018). It is possible that the current proposed

criteria for NSSI Disorder, may fail to capture male NSSI (Victor et al., 2018), thus further distorting the future available data.

Regardless, there is evidence that NSSI thoughts and behaviors are evident as early as 12 and 13 years old (Stallard et al., 2013). Girls and boys "reported similar ages of onset for NSSI, rates of wanting to stop NSSI, identifying NSSI as a problem, rituals or substances with NSSI, and dissociation or suicidal thoughts with NSSI, as well as similar rates of social NSSI functions" (Victor et al., 2018, p. 57). The importance of this information is that earlier intervention programs are needed to target these younger age groups (Stallard et al., 2013).

LGBTQ+.

Adolescents who identify as Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ+) have higher rates of NSSI behaviors. As members of a minority group, they may not see their own values, beliefs, or life experiences reflected in the perceived social norm (Sornberger, M., Smith, N., Toste, J., & Heath, N., 2013). This lack of validation, accompanied by harassment, abuse, or discrimination by their peers means that LGBTQ+ adolescents are three times more likely to report self-harm than their heterosexual peers (Rehman, 2020; Sornberger et al., 2013). In addition, these students may have troubled relationships with family members who reject their sexual orientation (Williams, 2019). They may have to conceal their sexual orientation, avoid certain social situations, develop a negative self-view, and experience a diminishment of self-efficacy (Sornberger et al., 2013). This can often lead to developing feelings of anger, sadness, or shame, and it turn makes them more vulnerable to anxiety, depression, mood disorders, self-stigma, disordered eating, risky behavior, suicidality (Sornberger et al., 2013) and other maladaptive coping strategies such NSSI (Rehman, 2020). Sornberger at al. (2013) urge caution when examining rates of NSSI in those who identify as

LGBTQ+ in order to avoid pathologizing the community. They suggest more research is needed to better understand this, but that currently the "overall pattern of results does not suggest that LGBTQ individuals are deficient in the use of adaptive coping strategies … but rather, the range of coping strategies used by LGBTQ individuals … appears to be equal to or greater than that of heterosexual individuals" (Sornberger et al., 2013, p. 580) and in attempting to use a variety of coping skills, they are simply more at risk for using NSSI. (Sornberger et al., 2013).

Social Media

Adolescents are increasingly using social media as a way of reaching out for support and empathy around their NSSI behaviors (Dyson, M. P., Hartling, L., Shulhan, J., Chisholm, A., Milne, A., Sundar, P., Scott, S. D., & Newton, A. S., 2016; Picardo, J., McKenzie, S. K., Collings, S., & Jenkin, G., 2020). In a systematic review of Instagram content tagged with NSSI related tags (#cutting, #selfharm), Picardo et al., (2020) found a variety of images that included pictures of wounds, selfies, drawings, memes, short videos, text images, objects/paraphernalia, and quotes (Picardo et al., 2020). They found a high level of engagement (likes and comments) with images of NSSI (Picardo et al., 2020). While Brown et al. (2018) found more severe pictures garnered more comments (more social reinforcement) (Brown, R C, Fischer, T., Goldwich, A. D., Keller, F., Young, R., & Plener, P. L., 2018). In their review, Brown et al. (2018) found that 10% of images associated with NSSI hashtags contained explicit NSSI images. 90% contained wounds of a mild or moderate nature, while severe wounds where less common (Brown et al., 2018).

This increase of online activity related to NSSI has drawn concern due to a perceived negative impact it might cause (Lewis & Seko, 2016). Potential harm was found in the risk of triggering NSSI or maintenance of the behaviors which can occurs through creation of groups

that serve to further isolate individuals from supports (Dyson et al., 2016). This reinforcement and/or maintenance of NSSI behaviors can occur through normalization (Lewis & Seko, 2016) and minimization of severity of NSSI behaviors (Dyson et al., 2016), lack of messaging about recovery in posts, validation of 'self-injurer' identity, competition to become the most 'authentic' self-injurer, sharing of maintenance strategies (how to conceal, self first aid, how to avoid infection), and sharing of different NSSI methods (Lewis & Seko, 2016). Individuals may be exposed to provocation and/or mocking (Dyson et al., 2016) and stigmatization through the hostility of others (harassment, mocking, hateful comments) (Lewis & Seko, 2016) that serve to further reinforce the behaviors. Further, exposure to explicit images online can result in triggering urges for some individuals (Dyson et al., 2016; Lewis & Seko, 2016).

In their review of multiple studies Lewis and Seko (2016) and Dyson et al. (2016) identified potential benefits for young people using social media to view and discuss NSSI, as well as the potential harms. Potential benefits include stigmatization through the ability to easily look up information on an otherwise stigmatized issue, anonymity in the communication of feelings (Dyson et al., 2016). Mitigation of social isolation can occur through allowing space for individuals to share with others (Lewis & Seko, 2016) and can create membership or sense of belonging with other individuals of a group or platform providing some with a sense of purpose, feeling understood, and feeling accepted (Dyson et al., 2016). Other benefits may include encouragement for recovery, advice on how abstain (Dyson et al., 2016; Lewis & Seko, 2016), and encouraging comments (Dyson et al., 2016). In their review, Brown et al. (2018) found that most comments on images associated with NSSI were empathetic and supportive. Some adolescents reported that viewing images of NSSI helped calm their urgers to self-injure (Lewis

& Seko, 2016). Further, adolescents may experience feelings of competence when shifting from seeking support to providing support to others (Dyson et al., 2016).

NSSI in Adolescents with Psychiatric Disorders

Findings indicate that the likelihood of engaging in NSSI increases with psychiatric disorders. NSSI in adolescence is commonly associated with borderline personality disorder (BPD), eating disorders (Emelianchik-Key et al., 2016), and Attention Deficit-Hyperactivity Disorder (ADHD) (Allely, 2014; Balázs, J., Gyori, D., Horváth, L. O., Mészáros, G., & Szentiványi, D., 2018)

Borderline Personality Disorder.

BPD in adolescents is characterized by impulsivity and self-damaging symptoms (Hessels, C. J., Laceulle, O. M., Van Aken, M. A. G., Resch, F., & Kaess, M., 2018) and is significantly associated with a "lack of emotional clarity, rejection of one's emotions, a high degree of interference with goal-directed behavior, aspects [that] directly relate to the lack of emotional regulation" (Perez, S., Lorca, F., & Marco, J. H., 2020, p. 11). While NSSI is associated with a wide range of diagnosis, there is evidence that these behaviors can be a long lasting and repetitive precursor to BPD in adolescents (Hessels et al., 2018). Some research indicates that NSSI is most commonly associated with BPD due to unresolved issues of trauma (Emelianchik-Key et al., 2016). Additionally, parental apathy, neglect, abuse, and bullying are all risk factors for NSSI and BPD (Hessels et al., 2018). There is evidence that sexual abuse and emotional neglect (adverse childhood experiences or ACES) are associated with BPD and research indicates a correlation between ACES and NSSI (Hessels et al., 2018).

The use of NSSI by those with BPD is as a means of reconnecting with the present when dealing with "overactivation and involuntary recall of traumatic info due to traumatic events and

having dissociated painful memories" (Perez et al., 2020, p. 11). This could be partly due to being prone to distress or having low distress tolerance (Perez et al., 2020). These adolescents are at particularly high risk for having fewer skills for coping with their distress due to past experiences. Therefore "understanding particularly early relational experiences is important to be able to reduce environmental risks early in the course of the developmental pathways of BPD, where NSSI disorder can be considered as a precursor" (Hessels et al., 2018, p. 3).

Eating Disorders.

Between 24% and 55.2% of eating disorder (ED) patients report engaging in NSSI behaviors. 13.6% - 42.1% in those with restrictive anorexia nervosa, 27.8% - 68.1% in purging types of anorexia nervosa, 26% - 55.2% in bulimia nervosa, 26.2% in eating disorders NOS, and 19.8% in binge eating disorders (Pérez, S., Marco, J. H., & Cañabate, M., 2018). While some research shows a higher association between restrictive ED behaviors and NSSI, other research indicates a higher frequency of NSSI in binge-purge ED patients. Some findings show that body image dissatisfaction was higher and self-esteem lower in groups that engage in NSSI. Those engaging in NSSI likely to have more negative views of body, than those with ED who do not (Pérez et al., 2018).

Banging, cutting, scratching, biting, and burning (least frequent) (Pérez et al., 2018) were among the most commonly reported NSSI behaviors in those with an ED. "Affect regulation, self-punishment, anti-suicide, managing distress, and anti-dissociation" (Pérez et al., 2018, p. 36) were the most commonly cited intrapersonal reasons for ED patients engaging in NSSI. Pérez et al. (2018) noted other research revealed similar findings about the intrapersonal functions of NSSI in ED patients with the most reported function being emotion regulation and self-punishment. Interpersonal functions reported including "seeking self-care after self-harm

practices and searching for interpersonal boundaries" (Pérez et al., 2018, p. 36). In persons with ED, NSSI appears to be highly multi-functional behavior.

A lot of the research in this area considers ED behaviors to be indirect harm, while NSSI is considered to be direct harm to self (Fox, K. R., Wang, S. B., Boccagno, C., Haynos, A. F., Kleiman, E., & Hooley, J. M., 2019). However, there is an emerging hypothesis that ED behaviors may have explicitly self-injuring motivations for some (Fox et al., 2019). Some report engaging in ED behaviors with knowledge and/or hope of dying sooner and have higher level of thoughts in engaging with these behaviors to die (Fox et al., 2019). While NSSI and ED are considered to be non-suicidal, there are reports from some of suicidal thoughts and knowledge that their behaviors could shorter their life (Fox et al., 2019). This complex relationship between NSSI, ED, and suicidal thoughts are important to understand when looking at treatment for NSSI in individuals with ED.

Attention Deficit Hyperactivity Disorder.

Symptoms of ADHD have negative impacts in the day-to-day life of an adolescent including difficulty with paying "attention during tasks at school or in homework, …conflict with parents, teachers and peers due to hyperactivity and impulsivity…[leading to] low self-esteem, frustration and depressed mood" (Balázs et al., 2018, p. 7). Further, a diagnosis of ADHD while school aged increase the risk for "antisocial development, drug misuse, pathological aggression, and social and academic exclusion" (Allely 2014, p. 9). A review of studies by Allely (2014), found an association between NSSI and ADHD, suggesting that ADHD may be a potential risk factor for later NSSI. These outcomes can serve as a mediator between depression, ADHD, and NSSI behaviors increasing the chance that an individual with ADHD will engage in NSSI (Balázs et al., 2018).

Counselling Strategies and Treatment for NSSI in Adolescents

There are a number of considerations to make when treating NSSI in adolescents including assessment, prevention strategies, and the efficacy of the chosen therapeutic approach.

Assessment, Screening Tools, and Interviewing

When interviewing an adolescent regarding NSSI there are important pieces of information to obtain in order to develop a plan. Following the principals of a Functional Behaviour Assessment would assist in gathering some of the necessary information (Garisch et al., 2017). This would include thorough questioning to determine the frequency, durations, and intensity of the NSSI, details of a recent NSSI incident (have them tell the story of the day before it took place and over hours after the NSSI incident), identifying and exploring the physical, behavioral, interpersonal, intrapersonal, emotional, and cognitive processes that took place before the NSSI event (Plener et al., 2016; Garisch et al., 2017) and determination of the interpersonal/intrapersonal short- and long-term consequences of the NSSI is necessary (Garisch et al., 2017). To obtain accurate information, adolescents should be interviewed without anyone else present, and gather history of behaviors from external people including family members in a separate setting (Plener et al., 2016).

When assessing NSSI, there are several tools available (Garisch et al., 2017; Whitlock et al., 2014). One of the challenges however, is that research tools for assessing NSSI in community populations are limited and often conflate NSSI with suicide (Whitlock et al., 2014). Both the Deliberate Self-Harm Inventory (DSHI) and the Functional Assessment of Self-Mutilation (FASM) were designed to assess basic NSSI characteristics like specific NSSI behaviors, frequency, and severity. Additionally, the FASM assesses for length of contemplation before engaging in NSSI, if NSSI occurred while under the influence of alcohol or drugs,

physical pain occurring during the injury, and a section, that has been widely tested, for determining function (Whitlock et al., 2014). The Inventory of Statements About Self- Injury also includes several items that aim to measure primary NSSI characteristics and has a comprehensive section on the function of the behavior. Other assessments include the Self-Harm Behavior Questionnaire, Self-Injurious Thoughts and Behaviors Interview (SITBI), and Suicide Attempt Self-Injury Interview (Whitlock et al., 2014). The Non-Suicidal Self-Injury–Assessment Tool (NSSI-AT) which clearly separates NSSI and suicidal behaviors, includes sections that assess NSSI characteristics which are lacking in other tools. This assessment tool includes motivations for initiating NSSI, contexts for the behavior, variation in severity, disclosure, and help-seeking (Whitlock et al., 2014).

Prevention

Currently there is no empirically validated system for determining if someone is at risk of engaging in self injury in the future (Bentley et al., 2014). Extensive research and long-term studies are needed for such a tool to be created. This type of research would help predict specific factors for the functioning of an individual's NSSI behavior. Further it could be used to help create a system of screening for clinicians when working with youth and adolescents to identify individuals who are at risk of NSSI, address the skills better ahead of time, and help provide prevention. (Bentley et al., 2014). However, there are number of challenges facing prevention programs including recruitment and identification, difficultly specifically targeting vulnerable factors, and challenges with measuring the impact of the interventions (Beauchaine, T. P., Hinshaw, S. P., & Bridge, J. A, 2019). In their work, Beauchaine at al. (2019) suggested the following elements for a prevention model:

1) Deal with maltreatment and abuse (through Child Protection if needed) or dealing with family level dynamics
2) Emotion dysregulation (not impulsivity) should be the primary target – the reasons for this: reduce likelihood of internalizing behaviors developing, treatment of impulsivity with pharmaceuticals is short-term
3) Work to address internalizing and externalizing pathology; address peer victimization
4) Parent training to target inconsistent structure/rules/boundaries, harsh punishments, punitive environments; parents have to model and modulate behavioral and emotional responses; parental peer group monitoring; reduce maltreatment, emotional invalidation; increase positive interactions between parent and child

Dialectical Behavior Therapy for Adolescents

Dialectical Behavior Therapy (DBT) was originally designed for adult with BPD but has been adapted and modified for other groups including adolescents with or without BPD (Glenn et al., 2019). It is designed to reduce both NSSI and trauma-related symptoms such as dissociation, depression, guilt or shame, (Ford & Gómez, 2015, p. 250) by "reduc[ing] emotional, interpersonal, and behavioral dysregulation that leads to maladaptive behaviors" (Glenn et al., 2019) such as NSSI thoughts and behaviors. In its full form, it consists of weekly individual therapy, weekly multifamily group skills training that includes mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness skills, telephone coaching with a therapist as needed, and weekly consultation with the treatment team (Glenn et al., 2019; Turner et al., 2014).

Dialectical Behavior Therapy for Adolescent (DBT-A) may have most efficacy for treating NSSI in adolescents with co-morbid diagnoses (Glen et al., 2019; Plener et al., 2016). In an interview done by Glenn at al. (2019) they found adolescents who participated in DBT-A group reported significant lower frequency of NSSI when compared to other groups who participated in other types of therapy including weekly therapy ranging from psychodynamic therapy to CBT plus medication if it was needed. Researchers do caution in the direct comparison because DBT-A provides a higher dose of treatment given the inclusion of family group skills in the treatment plan. They also found that adolescents receiving DBT-A were more likely to participate in the treatment and remained in treatment longer (Glenn et al., 2019).

However, in a review of 16 studies by Turner et al. (2014), the efficacy of DBT in treating NSSI was mixed. “In a previous study, DBT was not superior to community treatment provided by experts for reducing NSSI. In addition, DBT is an intensive (group and individual components) and lengthy (typically 1 year) treatment that may not be feasible in many settings. Therefore, DBT may not be efficient or desirable if more focused and less time-intensive treatments can better address NSSI. Moreover, given that rates of NSSI are higher than rates of BPD among adolescents, the field is in great need of short-term treatments that efficiently and effectively treat NSSI” (Glenn & Klonsky, 2013, p. 499).

Emotional Focused Group Therapy

Emotion Focused Group Therapy (ERGT) is a 14 week group therapy format that focused on the development of emotion regulation and acceptance skills, strategies to identify goals and values that are important to the individual (Turner et al., 2014). In their review, Turner et al. (2014) found ERGT yielded a significant reduction of NSSI behaviors as compared to ‘treatment as usual.’

Cognitive Based Therapy

The Cognitive Based Therapy (CBT) approach to reducing self-injury "focuses on restructuring maladaptive thinking patterns an enhancing emotional regulation, problem solving, and communication skills to increase adaptive coping" (Glenn et al., 2019, p. 378). There are two types of CBT that is used for NSSI behavior in adolescents including individual and individual plus family (Glenn et al., 2019). In a review of intervention options, CBT was found to not be as effective in treating NSSI behaviors in adolescents (Glenn et al., 2019). There is some evidence that cognitive analytic therapy (CAT), and mentalization based treatment for adolescents (MBT-A) have some efficacy in the reduction of NSSI behaviors (Plener et al., 2016). Manual-assisted cognitive therapy, which is brief therapy model (6 sessions) focused on structured problem solving, has limited research directly targeting NSSI available for evaluation. In their review, Turner et al. (2014) were able to find one study that showed a significant reduction in NSSI behaviors in adult females with BPD.

The Reframe It program is a 10-week online CBT treatment/package that specifically focuses on self-injurious thoughts and behaviors. The study on this program had a very small sample size therefore making it difficult to determine if the reduction in behaviors is significant or it could be generalized (Glenn et al., 2019).

"The Cutting Down Programme" (CDP), adapted from manual-assisted cognitive-behavior therapy, takes place over 8 – 12 sessions, once per week with 4 modules – 1: promoting therapy motivation, 2: identifying reason for NSSI, 3: trialing alternate behaviors, 4: stabilizing alternate behaviors. Parental involvement is not required, but available as needed. In a study of this program, it was found that patients had similar results of reduction in NSSI behaviors

compared to the “treatment as usual” group, while receiving fewer therapy sessions with CDP (Kaess et al., 2020).

Family Therapy

Validation and emotional acceptance are the foundation of emotion regulation and are needed for limiting emotional avoidance and controlling strategies such as NSSI and other impulsive emotion regulation strategies (Hooley & Franklin, 2018). The role of the parent includes validation of emotional experiences and creating environment that accepts emotions rather than avoids them. It is important for families to participate and gain an understanding of the connection between emotion regulation NSSI as it can help them understand why their child has been engaging in this behavior. (Hooley & Franklin, 2018) and how to respond their child’s emotional distress more effectively (Baetens et al, 2015; Mahtani et al., 2019). There are several types of family therapy to consider when examining interventions to reduce NSSI in adolescents.

Integrated family therapy is informed by CBT, DBT, and family therapy approaches and works to integrate these approaches into a family-based intervention. One of the treatment programs is called Safe Alternatives for Teens and Youth (SAFETY). It is a 12-week family centered intervention that has two therapists one for the adolescents and one for the parents or guardians and they employ a variety of techniques and interventions individually tailored to each family situation be conduct treatment in the home initially and work to increase the family’s motivation to engage in actively reducing behaviors as well as reducing behavioral barriers to care. They target a range of skills and techniques to the increased social support, explore activities, work on cognitive restructuring, and build distress tolerance. It did not have a significant impact on NSSI and is considered experimental at this time. Given the small sample

size further studies with larger groups of adolescents and families are needed. (Glenn et al., 2019).

Emotionally Focused Family Therapy (EFFT), grounded in attachment theory, places a focus on increasing parental caregiver responsiveness to their child resulting in the creation a of a more secure attachment (Schade, 2013). As NSSI often involves parental and family dynamics, family therapy may be effective for increasing support for a wide range of youth disorders, including NSSI and managing affect/emotion regulation. EFFT helps address primary emotion which is important. If only the NSSI behavior is targeted then individual may replace it with another maladaptive coping skills (Schade, 2013). EFFT takes place over 8 – 12 sessions that would be flexible for which family members attend as the therapist helps the family explore different dynamics. It requires that the family wants change and would not be conducive in a family where abuse is present (Schade, 2013)

Parent training, specifically a program called Resourceful Adolescents Parent Program, is a brief four session treatment that includes psychoeducation for parents, parent training, and strategies for addressing family conflict affectively it has had positive effects and has been classified as having probable efficacy for reducing NSSI behaviors in adolescence (Glenn et al., 2019).

A review of studies looking at family therapy, which was limited, found the results for reducing NSSI to be mixed (Glenn et al., 2019). When evaluating family therapy and its efficacy for reducing NSSI, it is difficult to say exactly what interventions and length of time or amount of therapy is needed, therefore, further studies or examination of studies is needed to help clarify what are the necessary parts of family therapy that make this intervention work (Glenn et al., 2019).

Emotion Regulation Individual Therapy for Adolescents

Emotion Regulation Individual Therapy for Adolescents (ERITA) is a 12-week acceptance-based behavioral individual therapy adapted from emotion regulation group therapy for adults with NSSI (Bjureberg et al., 2018). Initially delivered in person during a pilot study, that saw parent(s) participating in a parallel online parent program to increase their skills for interacting with their child, ERITA has been adapted to an online only version (Bjureberg et al., 2018). The program is completely web-based with educational texts, animated figures, illustrations, case examples, and interactive materials and a mobile app that adolescents used to report self-destructive behaviors and impulses or protective factors that helped them avoid it. The mobile app had also provided weekly homework reminders and had built in assistance with skills learned in online courses (impulse control strategies, emotional awareness, distraction strategies). Weekly contact and reminders from a psychologist were provided to review the participants' progress, responses, helped with problem solving and guide them through to the program, and aided the parents. Adolescent participation was associated with medium to large improvements with NSSI frequency reduction, emotion regulation difficulties, and global functioning. Parent participation resulted in parents being able to find ways to change their behavioral response to their children's distress (Bjureberg et al., 2018).

Online Delivery of Programs

The STAR – Self-Injury: Treatment, Assessment, Recovery program, an online delivery program, is a study in progress, expected to be completed in Oct. 2021 (Kaess et al., 2019). Another internet based program, which is an adaptation of Emotion Regulation individual Therapy for Adolescents is also a study in progress (Morthorst et al., 2021).

Considerations for Approaches and Interventions

Currently, there is no conclusive evidence that the use of pharmaceuticals to treat NSSI decreases engagement in NSSI, and research has not yet reached a conclusion about one specific treatment for NSSI in adolescents (Bentley et al., 2014; Plener et al., 2016). Present guidelines are to use an integrative response that focuses on "psychoeducation, identifying trigger and maintaining factors and providing alternative skills" (Plener et al., 2016). Additionally, if shame-related functioning is connected to NSSI behavior the following targets may be helpful: "instituting more adaptive shame and distress regulation strategies, decreasing tendencies to be overly self-evaluative or self- focused, intervening in unhelpful shame-related patterns in thinking and behaving, and, increasing resilience in the face of invalidating messages that may trigger shame" (Mahtani et al., 2019, p. 767). Interventions like dialectical behavior therapy, schema- focused therapy, acceptance-based emotion regulation therapy and compassion-focused therapy target some of these factors (Mahtani et al., 2019). Other interventions may "also place a larger emphasis on reconstructing an individual's negative self-view and working with their self-criticism. In doing so, this could act as a protective factor or barrier to engaging in NSSI (Baetens et al., 2015; Hooley & Franklin, 2018; Whitlock et al., 2014).

Behavioral interventions are also relevant for adolescents coping with NSSI. Functionally relevant interventions include mindful emotional awareness, distress tolerance training, cognitive restructuring, reappraisal, behavioral activation, savoring. When the avoidance of uncomfortable emotions is identified as a function working with the individual to be more comfortable and willing to experience and accept their negative emotions would be a target for treatment (Bentley et al., 2014). Using distress tolerance training would serve to increase an individual's ability to tolerate and accept these intense emotional experiences rather than employing avoidance or

escape mechanisms (Bentley, et al., 2014). If the function of the behavior is social negative reinforcement and social positive reinforcement the interventions could include interpersonal skills training, distress tolerance training, problem solving skills training (Bentley et al., 2014). Also important is identifying and rehearsing functionally equivalent adaptive behaviors (Bentley et al., 2014). Finally, part of the therapeutic process would include identifying dysfunctional or distorted beliefs (i.e. cutting is the only way to feel alive) and cognitive restructuring reappraisal strategies are a way to approach changing these beliefs (Bentley, et al., 2014).

Other considerations for treatment include the importance of therapeutic relationship between the counsellor and the adolescent (Garisch et al., 2017). Validation needs to be consistent and the use of radical genuineness or sharing emotional reaction to the client's experiences (a technique from DBT) is recommended (Garisch et al., 2017). Further, it is recommended to explore suicidality and consider a full mental health assessment, if necessary, to look at comorbid mental diagnoses (Plener et al., 2016).

Summary

There is a large body of research that explores the many areas of NSSI. Despite this, there remain elements that a not entirely understood, including assessment and treatment (Hooley & Franklin, 2018). As there is no current universally accepted best practice for treating NSSI (Kaess et al., 2020) and reviews of studies have found there to be varying efficacy in different approaches to treating NSSI, Chapter 3 of this paper will put forward a proposed group therapy plan that draws on therapies with the most efficacy for treating NSSI in adolescents.

Chapter 3: Summary, Recommendations and Conclusions

Summary

NSSI is most prevalent in the adolescent and young adult years (Nock, 2010; Mckenzie & Gross, 2014) peaking at ages 15-16 (Brown & Plener, 2017). Research proposes several different models and theories for understanding this behaviour. Nock (2009) and Hooley and Franklin (2018) suggest that NSSI is a mechanism for emotion and social regulation. Mckenzie and Gross (2014) propose multiple mechanisms including shifting attention, modifying environment, and modulating physiological responses. Ford and Gomez (2015) hypothesis that all functions of NSSI are emotion regulation strategies. Bentley et al, (2014) suggest the pain offset relief model where in physical pain generates relief from emotional pain. The common factor in each proposed model is that NSSI is employed as a mechanism to in some way cope with or shift a distressing emotional response. Individuals who experience higher levels of self-criticism and shame, resulting from a negative self-concept that developed from abuse, parental criticism, and mistreatment are more susceptible to turning toward NSSI has a maladaptive coping mechanism (Hooley & Franklin, 2018; Mahtani et al., 2019). Individuals who experience this type of interpersonal trauma may be prevented from developing problem solving skills and learning how to express and communicate their emotional distress (Horowitz & Stermac, 2018). Further, these types of environments teach a child that their feelings and experiences are invalid and inherently bad, and therefore they are inherently bad and unloveable (Mahtani et al., 2019).

For some individuals, NSSI becomes a recurring maladaptive behaviour (Brown & Plener, 2017). As it is a common issue among adolescents, counsellors working with this age group should be informed about NSSI, its possible roots and functions and treatment options.

While currently there are no universally accepted best practices for treating NSSI in adolescents (Kaess et al., 2020), an integrated approach is recommended. Psychoeducation, along with developing an understanding of triggers, maintaining factors, learning alternate skills (Plenner et al., 2016), working with shame-related patterns, and increasing distress tolerance (Mahtani et al., 2019) are all necessary components to a therapeutic treatment plan. Interventions based in therapies like dialectical behavior therapy, schema- focused therapy, acceptance-based emotion regulation therapy and compassion-focused therapy can be utilized to incorporate these elements (Mahtani et al., 2019).

Recommendations

The purpose of this chapter is to outline the 7-part group counselling therapy plan for a group of adolescents who are engaging in NSSI that integrates elements of therapeutic approaches that have been proven to have efficacy in treating NSSI in adolescents. Each session will include learning targets, reflection on individual progress, group discussions, skills practice, and homework. The sessions will last 1.5 hours with optional check-in time for individuals at the beginning of the session for 10 minutes. Participants will be encouraged to utilize this individual check-in time to follow up on goals and discuss challenges. Every session will begin with a circle share out prompted by a question and will conclude with a structured check-out. To help guide facilitators verbal cues are indicated by italics throughout the lesson plans.

This group is based on a referral model wherein adolescents are referred by a mental health or medical professional. There is an optional, but highly recommended, parental session provided (Appendix A). Before attending, potential participants are screened to ensure the group setting will be supportive of them and their needs. Adolescents who are deemed to have complex

needs requiring psychiatric treatment or moderate to high suicidality would require higher levels of support and therefore would not be included in this group.

Session One: Why are you here?

Targets: I can identify why I am here. I can explain how I feel about being here. I can identify what my goals are for my time in this group.

The first session will focus on setting up the group and normalization of NSSI. This includes introductions, group guideline settings, discussion, normalization, and personal goal setting.

At the beginning of the session participants will be welcomed into the space and have an opportunity to select a seat. The group facilitators will introduce themselves and explain their roles. Although they received an explanation of confidentiality and its limits prior to joining the group, confidentiality will be reviewed again. Participants will introduce themselves by saying their name, pronouns, and finish the following statement: "my favourite way to spend free time is…".

The facilitators will share with the group of the targets of the day. Together, the group will establish a set of norms and guidelines (Appendix B) (Breskin, 2011). A further discussion with group members about anything missing from the list (i.e. phone usage in group, side talk, taking breaks) will follow. It is important for all group members to understand that by attending this group, they are agreeing to the group rules. They will be reminded that they have the right to withdraw their consent at any time and no longer attend the group.

Two discussion questions will be presented to the group. Each member, including the facilitators, will answer: *how do you feel about being here? What do you hope to get out of this group? What reservations or concerns do you have about attending this group?* These questions

will help everyone to start getting to know one another and begin exploring areas for growth (Terry, 2011). The facilitators will be able to gather information to help adjust their planning, if necessary, know what the participants are working toward, and create safety and reassurance about any concerns. Through the discussion of these questions, other group members will be able to hear from their peers about their experiences. They will begin to understand that they are not alone in their struggles with NSSI. Beginning the process of normalization about NSSI is a way to reduce shame for the participants and create a space where they feel more comfortable and safer to share.

Each group member will receive a journal for personal use to record their thoughts about discussions, write goals, and complete homework. Participants will know that they can choose to leave the journal with the facilitators and use their phone or other device to record homework outside of group. This is an important option to provide as some adolescents may be concerned about the confidentiality of their journal if they bring it home. They will be assured that the information they record would only be read by facilitators with their permission. The next activity will be for the participants to take some time to write down their initial thoughts about a goal or goals they are hoping to achieve during this time in the group.

The first homework assignment for the group is to start tracking their NSSI behaviour. Group members will have the option of completing a paper form (Appendix C), an electronic log (Appendix C), or simply taking notes on their phone. Explain that each mode of recording has limits in terms of confidentiality; meaning that whenever you document or record personal data, there is a chance someone else may see it. This assignment will be ongoing throughout the course of the group and participants may find value in continuing to track their behaviour and urges even after the group ends. *By tracking your behaviour, you can begin to see patterns and*

learn important information about yourself. For the next two weeks note when you have thoughts/urges of NSSI and/or when you self-injury. Note the date, time, and what happened before. Show an example of how to complete a paper log and ask if anyone has any questions, concerns, or wonderings.

Close the group by asking each member to share one thing they are looking forward to in the next week.

Session 2: Distress Tolerance

Target: I can understand what a crisis survival skill is. I can identify crisis survival skills that may be helpful to me. I can select two skills I will try this week.

Crisis Survival skills are needed when there is a problem that needs to be solved right away, such as a short-term stressful event or traumatic moment. These are skills needed when there is an urge to engage in self-injurious behavior, such as NSSI (Pederson & Pederson, 2017). Ask the group members *what are you already doing to help yourself cope in a more effective way than NSSI?* Drawing on what is already working can help participates see where they have strength, and also allows them to hear other coping strategies. Explain to the group that today's session is all about exploring different in-the-moment strategies they can use to help manage their NSSI when urges are strong. The list of strategies that the members ultimately create will be personalized to them as they try new things to determine what works well and does not. Give the group members the TIP Skills hand out (Appendix D) (Linehan, 2015) and review these skills with them.

The next set of skills the group will explore are distraction and self-soothing (Van Dijk, 2020a). Work with the group to brainstorm a list of distraction techniques together (activities, generating neutral thoughts, music, etc.). Next, group members will have an opportunity to try

different self-soothing strategies based on their senses. Set up around the room are stations, one for each sense. Sight has pictures of nature, hearing has headphones and a laptop set up with soft music queued, touch has a soft pillow and a micro fleece blanket, taste has some mint gum and chocolate, smell has a candle and essential oil. Participants are encouraged to try each station for several minutes and engage in each activity quietly. The goal is to see which types of activities are the most soothing for them. After the experience, the group will return to the circle and will be asked to share. *What was that experience like for you? What did you notice as you engaged each sense? Was there one or two that were most comforting? What are some other activities that you have access to that could engage your senses?*

The next strategy to introduce to the group is called Pros and Cons. Tell the group that they are going to create a pros and cons list for engaging in NSSI together on a white board and give them a worksheet to fill out during the exercise (Appendix E) (Van Dijk, 2020a). Ask the group *what the pros to not engaging in NSSI? What are the cons of using NSSI? What are the pros of engaging in NSSI? What are the cons of not using NSSI?* Doing this activity will help the adolescents remember reasons why they do not want to engage in the behavior. Having them write it down will help them remember it better, as well as provide a visual support to reference later (Van Dijk, 2020a).

As a closing activity, ask the group members to reflect on the skills and strategies they learned about during the session. Ask each member to share at least two of the skills they are willing to commit to trying before the next session – even if they do not experience a crisis. Group members are also asked to continue tracking their NSSI thoughts and behaviors and are reminded to bring their logs for next week's session.

Session 3: Understanding NSSI

Target: I can begin to identify some of my triggers. I can understand factors that contribute to my vulnerability of certain triggers.

The purpose of this session is to explore the functions of NSSI and help group members begin to think about the function NSSI serves in their life as well to continue to normalization and reduce shame around their behaviors.

NSSI can serve different functions for each person or even multiple functions for one person. Generally, it is used to regulate emotions in some way as a result of different things that happen in our environment. Ask group members *what are some of the times that notice you use NSSI? What are somethings, events, or circumstance where you experience strong urges to use NSSI?* During this conversation, facilitators may need to prompt individuals to identify specifics (i.e. adolescent: "I do it when my parents make me mad." Facilitator: "can you tell us more about what it looks like when your parents make you mad? What happens/What do they do?"). In doing this, facilitators can help the adolescents identify more specific situations and dynamics that are triggers for them.

At this point, participants should have two weeks of data they have collected. Ask them to pull up their logs for reference. Ask *do you notice any patterns when you look at the information you have gathered? Are there common people, place, events, etc. that you see coming up?* Share that b*eing able to recognize triggers is important, not so that we avoid them, but so that we learn how to support ourselves when we know a trigger might be coming up or when we have been triggered.*

Ask *of the trigger that you have been able to identify, do you have urges to self-injure or self-injure every time that trigger comes up? Why not? What makes the difference*. This an

exercise to not only find exceptions and to reflect on their skills, but also to help participants increase their awareness to when they are more vulnerable to NSSI. Work together to identify the specific events leading up to a NSSI event they share. Talk about what their day was like leading up to that event. Help them to identify other contributing factors (did they sleep well the night before? Did they have a fight or disagreement with a partner/friend/parent earlier? What had their meals looked like throughout the day?).

As a closing exercise, the group will participate in a guided meditation script (Appendix F) (Hahn, 2019). This is an opportunity to practice an explicit strategy. They will be encouraged to keep tracking their NSSI urges and behaviors over the next week and utilize the Crisis Survival and Self-Soothing skills learned in the previous week.

Session 4: Emotion Regulation

Target: I can label my emotions. I can identify how stress causes emotion dysregulation. I can understand how emotion dysregulation impacts my thoughts and behaviour.

This session is structured to help develop a deeper understanding of the ways they experience dysregulation and that NSSI is a response to this experience. The session will begin with a circle of sharing 'one thing that went well this week while trying a skill or strategy and why it went well.'

The first activity of the day will involve facilitators providing psychoeducation on stress and emotional regulation. Begin by asking the group *what is a stressful experience you have had. How did you feel afterward? What was your response?* After the discussion, the facilitators will talk about emotion regulation. *Emotion regulation is the process of tuning into your emotions, acknowledging and understanding them, and using strategies to help you manage your response. Emotion dysregulation occurs in response to an internal (recalling an incident) or external*

(encountering an angry person) experience resulting in a feeling, followed by a thought and a physiological response (elevated heartbeat) resulting in a behaviour (avoidance). Emotion regulation is not about controlling one's emotions, but rather understanding how to become more accepting of them and learning strategies to respond to them (Pederson & Pederson, 2017; Van Dijk, 2020b). Check with the group members for understanding.

One of the first strategies that we are going to learn together is called "name it, to tame it." By learning to recognize our emotions and label them as they 'show up' we can take away their power (Conway, 2021). To increase emotional awareness and develop the ability to name their emotions, the group will do an activity about primary and secondary emotions. Primary emotions are a feeling or reaction to something that happens, while secondary emotions are a feeling about that feeling (Akerman, 2021). Together with the adolescents, make a list of primary emotions. Explain that we have emotional responses, or judgements about our emotions. These are called secondary emotions. Brainstorm a list of secondary emotions together and write them on the whiteboard. The group will work together through a set of scenarios to determine the emotions a person might be experiencing (your mom has to work double shifts; you get into a fight with a friend; you forgot to complete an assignment after your teacher gave you an extension…). Ask the participants to think back to the event they shared earlier and try to label the emotion they experienced from the primary list, and then secondary emotional reaction. If they feel comfortable, they can share. Ask the group *is there a scenario or event you can think of that ended in self-injury? What do you notice now about your emotions during that time when looking back?*

As a closing activity have group members share one thing they plan to do for themselves in the next week. Homework for the following week will be to continue documentation. In

addition, they will be asked to write down what emotions may have been present around thoughts and/or actions of NSSI.

Session 5: Mindfulness & Radical Acceptance

Targets: I can understand the purpose of mindfulness. I can engage in a mindfulness practice. I can understand the meaning of radical acceptance. I can engage in a practice of radical acceptance.

Many individuals have heard of mindfulness and may have different understandings and preconceived ideas of what it might be. Ask the group *what comes to mind when you hear the word 'mindfulness'?* Asking this question will help the facilitators have a better understanding of where group members may have blocks or challenges when engaging in mindfulness activities.

Mindfulness is focusing on one thing at a time, being the in the present moment with full attention and acceptance. Step into the present moment by focusing on what is happening within yourself and what is happening around you. It is also about trying to adopt an attitude of curiosity, acceptance, and openness toward what you are experiencing (Pederson & Pederson, 2017). On a whiteboard write and share the four steps to practicing mindfulness: 1) choose a focus, 2) begin focusing on that activity, 3) notice when your attention wanders, 4) bring your attention back. Repeat steps 3 and 4 for the length of the activity (Van Dijk, 2020c).

So how is this all connected? Mindfulness actually helps increases our ability to regulate our emotions. Overtime, it allows us to observe and notice what is happening inside of us and respond to them without judgement. By being more in tune, we can catch ourselves and make conscious decisions about what we want to do rather than reacting and using unhelpful behaviours such as NSSI. (Pederson & Pederson, 2017)

The first group practice of mindfulness will be breathing. *This is an accessible and practical practice. It is something that an individual can do anywhere, at any time*. Prompt the group to sit in a comfortable but alert position, hands in lap or resting on knees/legs, and eyes open with a soft gaze toward the floor or their lap. Remind them of the 4 steps. *This practice will take place for 1 minute. The goal is to focus on breathing, notice when your thoughts wander, and bring your attention back to your breathing. If there is a time during the practice you feel yourself becoming overwhelmed by emotions, you may need a strategy to help return yourself to the present. Try squeezing your thigh and pushing your feet into the ground.* Afterward, ask the group *what did you notice during that practice?* Work with any self-judgement that comes up. Facilitators should validate the challenges or frustration individuals bring up.

Next, the group will work together to create a list of activities that they can practice mindfulness in. Have each group member record the list and circle the top two activities they would like to attempt before next week's session. Remind them the goal is not to practice mindfulness for the entire time (i.e. if they choose drawing, they do not need to practice for 20 minutes, rather they would choose short periods of time within the activity to practice the 4 steps of mindfulness. Ask them to record their experience with it during the week.

The next part of the session will explore the skill of radical acceptance. Facilitate a group discussion about the differences between acceptance and approval. The skill of radical acceptance is the decision to accept reality and the present situation (Van Dijk, 2020a). *"It is what it is" does not mean that we approve of the situation that it happening, but rather we accept that this emotion or circumstance is occurring right now*. Include discussion about exceptions to this idea (i.e. immediate threat or danger to their well-being). Explore ways to practice this skill with smaller, less distressing scenarios first (Van Dijk, 2020a). Some examples

include having to wait in line, sitting in a lesson in class 5 minutes longer than you would like to, and other minor inconveniences. *The goal of radical acceptance is to increase our ability to tolerate situations that may have otherwise caused painful emotions*. *Like any other skill, we have to build it up slowly.* Make space for conversation about this skill and for group members to disagree about it.

Close the session with a share out about something they are grateful for in their life right now.

Session 6: Working with Shame

Targets: I can notice where shame appears in my life. I can identify the stories that shame tells me about myself.

Write the words 'guilt' and 'shame' on a whiteboard. Ask the group if anyone would like to try to explain what guilt is. *Guilt is an emotional that we feel as a result of a specific event. Its purpose is to help us determine right from wrong and/or how to make amends. Shame, however, is different. Shame is connected deeply to our sense of self and our identity. When we experience shame, it prevents us from being in the present and makes us evaluate ourselves negatively. It tells us that we are inherently wrong, bad, unloveable, stupid, etc*.(Mahtani et al., 2018).

The group will work together to build upon the activities completed over the last few weeks. The purpose of this is to explore how shame gets in the way of recognizing and experiencing primary emotions, which is necessary for emotional regulation. Depersonalized scenarios can help create safety. Together, look at a few scenarios where things did not go well for a person. First, identify the primary emotion that person might be feeling, and then identify what shame might be telling them. For example: a youth has failed a math test because they did not study. The group might identify that the person could feel sad, disappointed, angry, or

indifferent. When shame shows up it might say things like “you are stupid,” “you are lazy,” “why do you even bother trying.” Explain to the group that the purpose of this is to help increase their awareness of how shame can get in the way of being able to connect with their emotions and experience them.

Engage the group in a check-in by asking *what did you notice during that activity? What came up for you? Did you make any connections?* This may be a time that self-disclosure could help for the process of the group. One or both facilitators could share that they too have experiences of shame in their lives. It will be important to monitor how group members are doing. Validate their experiences of emotion, discomfort, and challenges to stay regulated during these conversations. Provide encouragement, and reflect when strategies are being used.

The next activity is designed to show group members different ways, other than NSSI, to respond to shame. With the group create a list of self-compassionate counter phrases to shame phrases (Ortis, 2019). For example: “I am stupid” becomes “Math is really difficult, and I feel like I have to work really hard to understand it”; “I am lazy” becomes “I am feeling overwhelmed and do not know where to start”; “I shouldn’t feel this way” becomes “I can feel however I feel right now.” Suggest that group members document these counter phrases either in their journal or by taking a note in their phone. Ask the group *what is a way that you could have access to these phrases in a time when shame shows up?*

Another strategy for dealing with shame is coming back into your body (Ortis, 2019). Explain to the group *as mentioned before, shame prevents us from being in the present, therefore when shame shows up, we need to return ourselves to our body. We can do this through engaging in a practice of mindfulness or somatic experiencing. What are some ways you could*

help yourself return to being in the present? This could be drawing, breathing, walking, yoga, or stretching.

As an experiment the group members will be asked to try using self-compassion phrases when they notice shame coming up over the next week. Ask that they try to document their experience using this strategy. Remind the group that this is a new idea and new practice to them, so it will not be perfect, nor will it ever be. Next week the group will share out the challenges they may experience when using it. There is no judgment around the 'success' or 'failure' for the use of this strategy.

For closing, use the Guided Self-Compassion meditation script (Appendix G) (Rockman & Hurley, 2015). Afterward, ask the group *what is a hope that you have for yourself over the next week?*

Session 7: Reflection and Closing

Target: I can reflect on my progress toward my goal. I can identify what strategies are working well for me. I can share the areas that are still difficult for me and how I plan to support myself after the group ends.

The last session of this group will aim to bring closure through reflection and build hope for the future through examining growth.

First, members will be asked to share out their experience using the shame counter-statement strategy. Next, the group will reflect on their personal experiences during their time in the group (Terry, 2011). Ask the following questions allowing time for each member to share between each one: *what has your experience been like as a member of this group? What has been the most helpful and least helpful thing about being in this group? What have you learned about yourself? How do you view the growth you have made?* Ask them to reflect on how they

are feeling about termination (*what are some of the different feelings people are having about this group coming to an end?)* (Terry, 2011). Ask them to reference the goals they wrote during the first session, reflect on the growth they have made, and how they see themselves continuing to work on these goals moving forward.

The final termination activity is called the Hope and Appreciation List (Terry, 2011). Each member from the group, including facilitators, will have a sheet of paper with their name and two columns labelled 'hope' and 'appreciation' (Appendix H). The papers will be circulated, and each member will write one hope they have for the person and one thing they appreciate about them. Remind the group that this is one last opportunity to connect with that person and that this feedback will be helpful for them in the future (Terry, 2011). After the papers circulate, each member will share out one hope and appreciation that they would like to add for themselves.

Conclusions

Non-suicidal self-injury is a distressing maladaptive coping mechanism most prevalent among adolescents (Nock, 2010; Mckenzie & Gross, 2014), and while researchers have explored this topic at great length to develop an understanding about this behavior, why it happens, and its functions, there is no clear path for treatment (Kaess et al., 2020). There is hope that the recent inclusion of NSSI in the DSM V as an area for further consideration means that in the future researchers will be better able to design studies that exclusively examine NSSI with consistent criteria resulting in more accurate findings about best treatment practices (Bentely et al., 2014). In the meantime, counsellors who work with adolescents need to develop a deeper understanding of NSSI in order to offer the best integrated therapeutic approach.

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Appendix A

Topics for Parent Workshop

- Psycho Education about NSSI
    - prevalence
    - functions
    - methods/form
    - social media
- Emotion Focused Parent Strategies
    - how to reflect your child's emotion
    - validating language frameworks (Hooley & Franklin, 2018; Schade, 2013)
- Managing conflict and emotionally charged situations (Glenn et al., 2019)
    - Conflict management
    - Deescalating
    - Self-awareness

Appendix B

Group Therapy Guidelines from APA

1. Confidentiality
Anything said between any two or more group members at any time is part of the group and is confidential. I understand that everything said in group is confidential. I agree to keep secret the names of other members of the group and what is said in the group. I agree to keep secret anything which occurs between or among group members. I understand that there is an exception to this confidentiality which applies to the group leader. If the group leader believes that someone is in danger, the leader has a professional obligation to take direct action in order to keep everyone safe.
I agree not to keep secret from the group anything which occurs within the group. Anything which occurs between or among any members is part of the group is kept secret from anyone outside of the group but is not kept secret from the group. This also applies to any individual meetings you may have with a group leader. I understand that if I violate this confidentiality I could be removed from the group.

2. Privacy (The Stop Rule)
No group member is ever required to answer any question, to participate in any activity, or to tell anything. If I am asked questions or asked to participate in an activity which makes me feel uncomfortable, I understand that I have the right to pass, that is, the right to refuse. I agree that will never pressure other group members to participate in any discussion or activity after the member has passed or refused. I understand that the group leader is obliged to protect this right. I also understand that I will benefit more from group the more I am able to take risks in sharing and participating.

3. Dignity
No group member is ever humiliated, hazed, or abused in any way. I agree to avoid this destructive behavior.

4. Violence or intimidation
Violence or intimidation toward other group members is never tolerated. I understand that I must never be violent or intimidating toward other group members and that if I threaten to harm persons or property I will be asked to leave the group.

5. Alcohol and Other Drugs
Group members cannot participate in the group under the influence of alcohol or other mind altering drugs. When under the influence of chemicals, persons do not have access to their emotions and have less control over their behavior. I understand that if the leader believes that I am under the influence of alcohol or other drugs, I will be asked to leave the group.

6. Exclusive relationships

Dating and other exclusive relationships between or among group members are not a good idea. The relationships can make other group members feel left out. When a couple breaks up, for example, this can be most painful and may make it impossible for these people to continue in the group. Since anything which occurs between or among group members is part of the group, members who are dating or in very exclusive relationships may be embarrassed when their intimate moments are discussed in the group.

7. Gossip
Gossip and secret grudges can be very destructive in a group. I agree that if I have something to say to another group member, I will try to say it to the member directly rather than talk about him/ her behind his/her back.

8. Attendance
I agree that I will attend every meeting unless an emergency arises. If an emergency should arise I will notify the group leader prior to the meeting to tell him or her that I will be unable to attend. I understand that the group leader will tell the group what has happened. I understand that if I have three unexcused absences, my continued group membership will be discussed.

9. Internet Connectivity
I feel very strongly that the members of the group should form and participate in an online group limited to the group members. Of course, the same cautionary notes apply to the internet communications in terms of both confidentiality and inter-group sharing. (I have used this model very successfully, and it significantly enhances a healthy form of interconnection.)

10. Responsibilities
I understand that it is the group leader's responsibility to enforce these procedures and guidelines. The group may, when it wishes, propose other procedures and guidelines which will be up to the group to monitor.

11. Termination
Usually, group members decide, within the group, with the leader, when it is time to leave the group. Sometimes it is necessary for a group member to leave the group unexpectedly. This can cause group members to wonder if they have harmed the leaving member. I promise that if I must leave the group unexpectedly, I will come to a last group meeting and tell the members that I am leaving and say goodbye. I agree to announce this at the beginning of the last meeting so that the group has time to ask questions and say goodbye. If I decide to leave the group the group members may express their concerns but also respect the decision of the person wishing to leave. I have read the procedures and guidelines for group and agree to be bound by them while I am a member of the group

Appendix C

Behaviour Tracking Log

Date	Time	Location	Urge or Self-Injury	Method	What Happened before? (Trigger)	Other

Appendix D

TIP Skills Handout

To reduce your emotions fast.

T – tip the temperature of your face with cold water (to calm down fast)

- Hold your breath, put your face in a bowl of cold water, or hold a cold pack on your eyes and cheeks
- Hold for 30 seconds
- Do not use water colder than 10 degrees C

I – intense exercise (to calm your body when activate by emotion

- Engage in intense exercise, if even only for a short period
- Use your body's stored energy by running, jumping, lighting weights, speed walking, etc.

P – Paced breathing (slow your breathing down)

- Deep belly breathing
- Slow your inhales and exhales down to 5 – 6 breaths per minute
- Make your exhales longer than your inhales

P – Paired Muscle Relaxation (pairing relaxation with exhaling to calm down)

- While inhaling tense you body
- Notice the tension
- While exhaling, think the word 'relax'
- Release the tension and notice the difference of how it feels

Consult your doctor if you are using these techniques and you have a heart or medical condition,

or a lower heart rate, an eating disorder, or are on medications.

Why cold water?

When you put your full face in cold water or put cold water on your eyes cheeks, and hold your breath, your brain is being told that you are diving underwater. The 'dive response' takes 15 – 30 seconds to start and slows your heart rate and redirects blood flow to your heart and brain. It can actually help regulate your emotions and can be used when you are having very strong urges to engage in dangerous behaviours.

Appendix E

Pros and Cons Handout

Pros of not using NSSI	**Cons of using NSSI**
Pros of using NSSI	**Cons of not using NSSI**

Appendix F

Guided Meditation for Anxiety – 5 Senses

15 minutes

Start by noticing your breath…not doing anything to change your breathing…just shifting our attention on the breath. Notice the inhale… and exhale… as your breath enters… and leaves the body.
This is a Five Sense mediation. Starting with the sense of touch. Notice how your body is supported by whatever you're sitting on. Whether you're on the ground or chair... notice where your body is touching whatever you are sitting on.
Next bring awareness to your feet. Notice the ground beneath your feet. If you're wearing shoes or socks notice how your feet feel inside the shoes or socks.
Bring your awareness to your clothing… become aware of how your clothing is resting on your body… notice the texture of your clothing.
Bring your awareness to your inhales and exhales.
Bring our awareness to your sense of sound. Just notice any sounds that you hear outside of the building you're in… and you might not notice any and that's fine…
Next bring your awareness to the sounds inside the building… you may hear a conversation or the air handling unit. Just notice what you hear.
Bring your awareness to your sense of smell. Notice anything you might smell or not smell.
Bring your awareness to the sense of taste...and similar to smell it might be that you notice a sense of taste or it might be that you notice the absence of a taste…
Last, bring your attention to the sense of sight. Just look around the room where you are. Notice five colors in the room that are either pleasing or neutral. Identify three different surfaces that have different textures…flat, smooth wall… or the flat smooth surface of a glass window…rough texture of the carpet…just notice different textures.
And finally with sense of sight… notice three different shapes…just look around the room and notice different shapes that you see…
We'll close our practice with three inhales and exhales….
Inhaling…1,2,3,4
Exhaling…1,2,3,4
Inhaling…1,2,3,4
Exhaling…1,2,3,4
Inhaling…1,2,3,4
Exhaling…1,2,3,4

Appendix G

Loving Kindness Meditation

Sit comfortably in your chair, upright, and relaxed. You may close your eyes or soften your gaze toward the ground. Take a few deep breaths as you settle and bring yourself into this moment. If it feels comfortable, place a hand or both over your heart as a reminder to show kindness to yourself.
Turn your attention inward, notice your heartbeat, the tension and relaxation as your belly and chest rise and fall with each breath.
If you become overwhelmed at any time, turn your attention back to your breath.
Notice the sensations you are holding in your body, your shoulders, your jaw, forehead, legs.
Notice the emotions you are holding in your body, worry about what is to come, sadness about what has passed.
Offer yourself compassion because of what you are holding in your body: May I be safe. May I be peaceful. May I be kind to myself. May I accept myself as I am.
Notice when your mind wanders and return yourself gently to these words.
May I be safe. May I be peaceful. May I be kind to myself. May I accept myself as I am.
Take a few more breaths, keeping your body quiet, repeating the words as you wish.
When you are ready, you can open your eyes and return your attention back to the room.

Appendix H

Hope and Appreciation Termination Activity

Name: _____

Hope	Appreciation