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Fact versus Fiction

Bringing Self-Injury into the Light

Caitlin's parents were at their wits' end. Whose wouldn't be? Their daughter had been cutting herself several times a week for a year and a half. All their well-intended attempts at helping her had failed.

"I just don't know what to do at this point," said Caitlin's dad. "We've tried everything: individual therapy, family therapy, all sorts of different medications. We even sent her to a different school. We tried grounding her. We got so desperate we even locked up all the sharp objects in the house. Nothing has worked. I don't think she wants to stop—she must like the attention or something."

Caitlin's mom chimed in: "She's such a good kid. I know she's unhappy. I just wish that she and her therapist could find the reason for her cutting. What does it mean to her? I think if she knew why she did it, she'd be able to stop."

Most of the parents who have sought my consultation, like you, have been caring and loving people who are frustrated and worried sick. It's hard to stay calm when your children seem to be stuck in scary behavior. You experience strong emotions that feel nearly unbearable. And when you're emotionally aroused in this way, the climate is right for you to make errors in thinking and judgment. Your need for answers to aid you through these troubled times can lead you to cling to erroneous conclusions that help lower your anxiety and make sense of the emotional chaos but take you off the right path.

This atmosphere of confusion and misunderstanding has given rise to

numerous myths that circulate among laypeople and in the media. Therapists themselves have contributed to these myths; however, we now have more sufficient scientific research that helps us understand what is behind self-injury.

Gaining a new understanding of why your children would do something so inconceivable as cutting themselves is much more important than you may believe right now. Of course, you may be much more interested in getting straight to what you can do to make this behavior stop. But acquiring a new perspective on the purpose that self-injury serves for your child is an important foundation for eliminating this disturbing behavior. A new perspective will direct you to effective treatment and help you facilitate change in your child's behavior by doing some things differently yourself. That's why in this chapter we will examine some of the myths and misconceptions you might have about self-injury and some of the paths you may find yourself going down that keep you from truly understanding the troubles your child is having. The many misunderstandings that parents, pediatricians, and therapists have about deliberate self-harm are a primary reason that children don't get appropriate treatment in a timely way.

Consider Cynthia, a 22-year-old college student who has engaged in self-injurious behavior since the age of 13. Over the weekend Cynthia's roommate noticed the cuts on her arm and told the dorm counselor. Cynthia came to my office only because her dean ordered her to get a psychological consultation before she would be allowed to return to the dormitory.

"I've had therapy since I was a kid, and it hasn't helped with the cutting," Cynthia told me.

"I've just become resigned to the fact that this is part of my life. You know, when I cut myself it really doesn't hurt, but it just seems to help. I'm not even sure I want to stop anymore."

"Cutting has been part of your life for almost a decade," I said. "You have been clear with me about how it helps you calm down, so I can imagine you have mixed feelings about giving it up."

"Yes, in some ways it's like an old friend who is a bit troublesome but who is always there when you need her."

Cynthia's a little older than the patients I usually see. For the most part in this book I will be talking about teenagers, because the vast majority of people who engage in deliberate self-harm begin it in adolescence—and that's when you're most likely to be trying to understand and eliminate it from your child's life. I want to leave no doubt in your mind that you should seek professional help for your child if you know, or reading this book confirms your suspicion, that your teenager has been engaging in self-injury.

In most cases self-injury begins in adolescence, and that's the time to take action.

While some kids only experiment with the behavior, for most it will continue into the early adult years and even into midlife and beyond unless prompt and effective psychological treatment is sought. That can be difficult to pursue when misconceptions get in the way.

Myths about Self-Injury

Please keep the following ideas in mind when you read about these myths. First, in psychology nothing is absolute or certain, so in a few instances what is a *myth* when applied to an entire population can be a *fact* in an individual case. Second, most of our behavior is influenced by many factors, including our past history, our current needs, and our long- and short-term goals. Not all these factors have an equal influence. Some have a minor role in keeping the behavior going, while others exert a powerful effect.

Myth 1: They Do It to Get Attention

According to some researchers, fewer than 4% of adolescents deliberately hurt themselves to get attention. Yet it's the most common reason that parents and some therapists give to account for the behavior—despite the fact that often an adolescent is self-injuring for months before an adult even notices. Misconceptions of this kind derail treatment and prolong both the adolescent's and the parents' distress, as they did for Erin and her family.

ERIN: NOT FOR ATTENTION

Erin, age 13, was a very likable and extremely bright girl who seemed to have some anxiety in social situations. She had been hospitalized numerous times over the last 6 months for self-injury and suicidal thinking. The psychiatrist in charge of her care reported that Erin had been cutting herself for the past 2 years, but that it had come to her parents' attention only about 8 months ago. When I asked the psychiatrist if he had any ideas about why Erin injured herself, he replied with confidence that he, the previous clinicians, and Erin's parents were all convinced that she did it to get attention.

How could a young girl be seeking attention through a behavior that she had kept secret for well over a year? When I posed this question to the

psychiatrist, he realized immediately that he may have leapt too quickly to his conclusion. So how is it that smart, well-trained, competent clinicians and caring, loving parents so often make this mistake? It's hard to know for sure, but here are some possibilities.

Even "Delicate Cutting" Is Self-Soothing

First, the majority of self-injurious behavior involves relatively superficial wounds. Some clinicians refer to superficial cutting or scratching as "delicate cutting"—giving the impression that the adolescent is taking care not to hurt herself seriously, but only to cause enough damage to get people to notice. But these superficial wounds have the self-soothing effect that these adolescents seek. (I discuss the smaller group of more serious self-injurers later in this chapter.)

Parents' Proximity

A second reason parents might get off track about self-injury has to do with the context in which the behavior occurs. Once you realize that your child is self-injuring, you will probably become more vigilant about her mood changes and emotional states, staying near her. If she hurts herself when you're close, it would be easy to assume she did it to capture your attention. Many parents have told me how they know their child is having emotional trouble, but when they try to help, the child often rebukes them or denies that anything is wrong. The parents know that this is untrue, so they stay close at hand. In a matter of minutes the child self-injures right in the next room, and the parents rush in to help. The child is a little calmer now and somewhat more willing to talk. The parents conclude that she hurt herself to get the attention she is now willing to accept.

Parents are often both relieved and annoyed by this sequence of events—relieved that their child was open with them but annoyed because they felt manipulated by the behavior. They conclude that the self-injury is a manipulative ploy to get them to pay attention. Their frustration is compounded because of their thwarted attempts to help.

There's another explanation for this sequence of events.

Adolescents Want Privacy

The alternative explanation rests on two factors. The first is the normal tendency of adolescents to seek privacy concerning their emotional lives. This

is especially true for those in the early to middle stages of adolescence. For boys, early to midadolescence ranges from 13 to 16 years of age; for girls it's a little earlier, from 11 to 15. Hallmarks of this stage of development are the phrases "I don't want to talk about it" and "Everything is fine"—the second of which often doesn't square with what you see.

At this point in their lives, adolescents feel a real need to be separate and independent from their parents. As they negotiate these new waters, they often confuse asking for help with childlike dependency. These kids pull hard against any current that might make them feel like a younger child. They have not learned to differentiate between mature dependency, which includes the capacity to ask for help and advice, and a pseudoindependence that places a premium on going it alone. For the most part, kids in this stage of development try to keep their parents out of their business. While they may wear outlandish clothes and behave in ways that are "over the top," they rarely intend to promote closer scrutiny from their parents. Ironically, it is just such behavior that often invites adults in to set limits.

At an age when their mantras are "I don't want to talk about it" and "Everything's fine," teenagers rarely seek parental attention—much less help.

More Emotion Than They Can Handle

The second point that supports an alternative explanation for Erin's behavior has to do with the way these kids experience emotional distress. By and large, adolescents who self-injure are extremely reactive people: they feel things very deeply and are prone to becoming emotionally overwhelmed quickly. They possess powerful emotional systems without the tools to manage them—it's as if they have Ferrari engines and Toyota Corolla transmissions. They have great difficulty harnessing their powerful emotions in the service of clear thinking and problem solving. When they're emotionally charged up, they lack the capacity to skillfully ask for help or to take in new information that may alleviate their current distress. What they want to solve, and to solve quickly, is how awful they feel in the moment.

Kids who self-injure have the emotional engine of a Ferrari with the transmission of a Toyota Corolla.

Self-injury often provides immediate relief from this feeling of emotional turmoil. With that relief comes a degree of calmness that enables them to be more available and reasonable with their parents. The change in demeanor, coupled with the

parents' presence, makes it seem as if they injured themselves to get attention, but it's almost always about getting immediate relief from emotional distress. (Those cases where it doesn't provide emotional relief are discussed in Chapter 3.)

Myth 2: Everyone's Doing It

Deliberate self-injury has been part of the adolescent scene for many years. My clinical experience and that of my colleagues suggest that it's on the rise, but we don't know for sure. We are uncertain for at least three reasons.

Deliberate Self-Injury Has Often Been Mistakenly Documented as a Suicide Attempt

Since suicide attempts appear to be on the rise, when self-injury gets mistaken for attempted suicide, it seems erroneously that self-injury is on the rise more than it actually is. Marie's story from the Introduction highlights the different experience teens have when they are actively suicidal, as opposed to using self-injury to soothe themselves.

I can't emphasize enough the importance of a thorough assessment by a qualified mental health professional to sort out this issue. Most of the adolescents I treat are quite clear about how different these two experiences feel for them. (Often the adults around them, who are worried, baffled, and at their wits' end, are inadvertently generating the confusion.) They tell me that they deliberately self-injure when they just can't stand how painful life feels a minute longer. They may wish they were dead, but they have no intention of killing themselves. In contrast, when they are feeling suicidal, they do intend to end their lives. But don't try to make this distinction in your own children. Seek a professional's help.

The distinction between suicidal feelings and the intent to feel better by self-injuring should be made only by a professional.

No Firm Criteria

Some researchers employ a rather narrow view of what constitutes NSSI, while others use the broadest of criteria. Consequently, the percentages given for adolescents in the general population who self-injure range from

14 to 18%; for adolescents who are hospitalized for psychiatric reasons, the range is 40 to 61%. As clinicians' and researchers' attention is drawn more and more to this area, I believe it won't be too long before we have more definitive answers to these questions.

Today's Kids Seem Less Secretive about It

While we don't know for sure whether self-injury is on the rise, in my experience adolescents used to be more secretive about it in years past; it would have been unusual for a child to speak about such behavior even to his closest friend. Parents often remained unaware of a child's self-injury until his psychiatric hospitalization for some other reason. As time went on, stories of self-injury crept into the media, both in news reports about teenage health issues and in the adolescent music and movie culture. In a way self-injury has been "normalized." As a consequence, adolescents are much more likely to disclose their self-injurious behavior to friends and to discuss how it makes them feel better in the short run. In addition, a number of websites are devoted to self-injury. We don't know whether these sites help children stop self-injury or induce them to keep it up, but it's another route by which self-injury has "come out of the closet."

The good news about self-injury coming out of the closet is that researchers began to study the problem in an attempt both to understand it and to develop more effective treatments. The not-so-good news is that as more adolescents became aware of the behavior, more tried it out in a moment of emotional turmoil. Unfortunately, for a significant number of adolescents, the behavior worked all too well in helping them regain their psychological equilibrium. In the media and in the adolescent culture, self-injury is often portrayed in ways that glamorize or romanticize it rather than address its devastating long-term consequences. In addition there are social media sites that also glorify and rationalize self-injury. You may even have come to believe from these portrayals that self-injury is a worrisome behavior that your children will outgrow once they're out of their teens. Sadly, this is not true. The child who self-injures is in significant emotional distress and needs professional guidance.

The fact that self-injury has come out of the closet is a mixed blessing: it has opened a path to more research but also may have introduced teens to a behavior that soothes emotional distress in the short term but with devastating long-term consequences.

Myth 3: Peer Pressure Is the Main Culprit

While kids who cut themselves are often friends with other adolescents who do the same, peer pressure probably has little effect in keeping the behavior going. For adolescents, and in particular female teenagers, the peer group is a place to air their problems. It's not unusual for one teenager to tell another about her personal experience with self-injury or to let on that another friend has tried it. Teens can also find out about it from the media. In fact, preliminary data suggest that about 52% of kids learn about self-injury from a friend or the media.

Peer Pressure as Scapegoat

Peer pressure has been used to explain many kinds of adolescent behavior, often without merit. For example, it's often been cited as a reason adolescents use alcohol and drugs. While peer pressure can probably make someone use these substances on a few occasions, it's more typical for kids who are involved in substance use or abuse to seek each other out, thereby creating a new peer group. A similar pattern probably occurs with self-injury.

As adolescents describe it, only their friends have the insight and ability to understand and help them. It's true that cliques are an important part of adolescent life, and I don't want to downplay the importance of a child's feeling of belonging and support. I find, however, that a social group offers its members an abundance of understanding and compassion but not much in the way of help in changing undesirable behaviors. The problem is more likely to be solved from the inside out: when kids stop self-injuring, they will be more likely to find new friends, rather than new friends in their group somehow helping them to stop self-injuring, as Melanie's story shows.

MELANIE: "I LIKE THESE NEW FRIENDS BETTER"

Melanie had been in treatment for 8 months and hadn't cut herself for the past three. She started the session with an upbeat story about a concert she had attended with some friends.

"Did you go with Dee and Nick?" I asked.

"No, I actually don't see them much anymore," she replied.

"I know your parents worked very hard to stop you from hanging out with them. Is that why?"

"No way," she told me. "When they wouldn't let me see them, I just did it behind their backs. I don't pick their friends; why should they pick mine?

Adolescents generally don't start injuring themselves because of the influence of friends. They are more likely to choose friends who share their behavior.

They thought I was being influenced by Dee and Nick, like I don't have a brain of my own. I don't know, I just feel like I'm changing and I like these new friends better."

Myth 4: Drugs and Alcohol Increase the Likelihood of Self-Injury

Self-injury soothes emotional distress, just as drugs and alcohol do. So the behavior, especially in a child who self-injures as a way to regulate emotions, would rarely be triggered by drug or alcohol use. What happened to Vicki illustrates how they serve the same purpose.

I had been meeting with Vicki, a 16-year-old high school junior, in DBT for the last 4 months. She came to therapy for cutting, but she often had problems with drinking also. As we worked on reducing her self-injury, we noticed that she began drinking more.

"You know, I think I might be drinking as a substitute for cutting," she told me in one session.

"I think you're on to something, since both behaviors seem to be geared toward helping you feel less anxious around friends," I replied. "I think we'd better target your drinking along with your cutting behavior."

While most self-injurers experience high degrees of self-loathing and significant amounts of intense self-critical thoughts, there is a relatively small group of self-injurers who hurt themselves from severe self-hatred and contempt and for whom self-injury is about relieving guilt through physical pain. These children have often suffered sexual abuse, and they're more likely to harm themselves in the context of substance use.

John, a 19-year-old college freshman, came in to talk with me about his self-injurious behavior. He had been sexually abused by a cousin from age 7 to age 11. John prided himself on his academics and had done very well through high school.

"I never cut myself before. It just seemed to start around exam time first semester. I put a lot of pressure on myself to perform, and I was really stressed out," he told me.

"Tell me about the first time," I prodded.

"I was studying for my math final. I'm usually very good at math, but I just couldn't seem to get the concepts. One night I just got really frustrated and began to drink in my room. The next thing I knew, I just was feeling all this intense self-hatred. Without thinking I picked up my X-Acto knife and began cutting."

Myth 5: Certain Kids Manage Physical Pain More Easily Than Emotional Pain

Frequently when I ask adolescents about their self-injurious behavior, they tell me that it's easier for them to bear physical pain than emotional pain. Like an alchemist of old, they claim to be able to turn emotional pain into physical pain. It does seem like a good idea to change a problem you can't solve into one that you can. But when I ask them if their self-injurious behavior hurts, typically the answer is no. So how can it be easier to manage physical pain than emotional pain if there is no physical pain? I'm convinced from my numerous discussions with these kids that they are not deliberately distorting their experience. How can we reconcile this seeming conundrum?

In all likelihood the mechanism that provides the relief for these children has to do with the neuropsychological effect of self-injury. Typically self-injurers report a state of calmness or significantly less internal turmoil after self-injury. This sense of soothing is the most common experience that kids have at the moment of self-injury. While we do not yet have a full understanding of how this works, it seems that some people, when emotionally revved up, experience a sense of calmness and relief when they damage skin tissue. There are currently two competing neurobiological mechanisms that may explain the sense of calmness and relief they experience. The first theory explains the calmness as a result of opiate-like endorphins that are released at the moment of tissue damage. As many of you know, opiates have the effect of inducing sedation and a kind of emotional quietude. These kids, however, explain their experience in a different way: they claim that physical pain is easier to manage than emotional pain. This experience can potentially be explained by the second theory, which is called "pain offset theory." The current research on pain offset has produced some startling new findings.

It turns out that the part of the brain that manages emotional pain also helps in managing physical pain. Drs. Jill Hooley and Joe Franklin in the Department of Psychology at Harvard have been studying this phenomenon, and they came up with some significant insights. Pain offset is a psychological phenomenon that has been known for years. It seems that soon after we incur tissue damage and we regulate, we are often calmer than we were before the damage occurred.

To study this phenomenon the researchers did an experiment with self-injurers and non-self-injurers who were free from psychological disturbances. The experiment included getting baseline measurements of mental states and then inflicting a bit of pain (cold on a fingertip) and measuring

how long the subject could stand the pain before needing to remove his or her finger from the painful situation. Following the removal from the pain, measurements were taken to reassess mental states. It was no surprise that the self-injurers felt relief after the painful situation and in fact reported being calmer than they were before the experimental pain was introduced. What was a surprise, however, was that the control group reported an equal amount of calmness after experiencing the painful experimental condition. The researchers concluded that self-injury, as a way to calmness, was a universal phenomenon and that as an emotion regulation strategy it would work for all of us. Another finding was that, as a group, self-injurers were likely to endure more pain than non-self-injurers.

So what might differentiate self-injurers from the control group? It turned out on investigation that the single most important difference between the groups was the degree to which they were self-critical. As a group self-injurers had a much more negative, self-critical view of themselves. Self-injurers by and large demonstrated more self-loathing and a harsher view of themselves than the control group. It was this view, and this view alone, that differentiated the two groups and seemed to correlate with the longer time self-insurers could withstand the painful research condition.

To take this a step further the researchers devised a short psychological intervention (about 10 minutes) that might shift the self-injurers' views of themselves, at least temporarily. They asked them whether they could embody some positive trait, like empathy or loyalty, or had demonstrated this ability through recent behavior. Immediately after saying yes, they showed a reduced ability to withstand the painful condition for as long as they had before the intervention. So while self-injury can work for everyone, what differentiates those who engage in the behavior from those who do not has to do only with the negative self-concepts of self-injurers.

The effect of this intervention was so powerful and immediate that my colleagues and I are currently trying to incorporate it into our own program. Notably, though, the intervention wouldn't work if the self-injurers were asked something like "Are you empathic?" or "Do you usually/always show empathy?" When self-critical teens are asked to view themselves in these broad strokes, they quickly shift into a negative self-concept.

Research has shown that self-injury can make most people calmer after emotional turmoil, but what differentiates those who actually engage in the behavior from those who don't is that self-injurers are comparatively more self-critical.

Deliberate self-harm may cause the brain to switch from focusing on emotional distress to the management of physical pain. And so in a

way these adolescents are right that they can manage emotional pain more easily than physical pain, but what helps them do this is their very critical view of themselves. Whatever the neurobiological mechanisms that make self-injury a powerful emotion regulation strategy, we need to keep in mind that why people say they do things and why they actually do things can be two different kettles of fish.

The Mustard Test

Both psychologists and marketing professionals know that the reasons people give for their behavior and the true motivation behind it are often vastly different. If you place a particular brand of mustard on the top corner shelf in a grocery store, for example, and then ask people why they bought that brand, they may tell you it's because of its fabulous taste. If you then put that brand on the bottom shelf, the very same customers might buy a different brand now sitting on the top corner shelf. If you ask them why they bought the second brand, they may tell you it's because of its wonderful taste. Clearly, though, the mustard's place on the shelf was what determined which brand customers purchased.

Psychologists have developed *attribution theory* to explain this kind of behavior. Simply put, attribution theory examines the ways in which our beliefs are related or unrelated to why we do the things we do and how our beliefs can influence our behavior and our sense of ourselves. Our attributions can be divided into two categories. *Internal attributions* comprise our beliefs about what kind of person we are, and *external attributions* focus on our beliefs about factors that influence our behavior from the outside. For example, if I run in a race and I do well, I may tell myself that I did well because I trained hard and I am naturally gifted. This would be an example of an internal attribution. On the other hand, if I tell myself that I did well because the field of runners that day was poor, that would be an example of an external attribution. So how might all this relate to our dilemma?

When adolescents tell me they experience no pain at the time of self-injury but that they self-injure because they manage physical pain better than emotional pain, I gently point out that they may be foreclosing on a fuller understanding of their behavior. Pain offset theory may explain the neurobiological aspect of self-injury, but the psychological reasons for engaging in the behavior are more critical in helping an adolescent move beyond it. These kids believe (and it's true) that they can't effectively manage emotional pain, which they often experience as a personal weakness. Believing that they can manage physical pain is a positive aspect of their personality,

and so their focus becomes self-injury as a way to harness that strength. They explain their behavior based on the internal attribution that they can manage physical pain more competently than emotional pain. While this explanation has validity, it doesn't go far enough in explaining their self-injury.

Myth 6: It's a Failed Suicide Attempt

If I had written this book 15 or 20 years ago, Myth 6 would have been first on the list. Thankfully, most clinicians now are better able to differentiate self-injury from self-harm with the intent to die. This determination can be a complex clinical endeavor, however, and the bottom line is that if you're worried, you should get your child evaluated. Most kids who are suicidal let someone close to them know about it. The notion that if someone were really going to kill himself he wouldn't tell anyone is a myth. Furthermore, as you well know, things can change pretty rapidly with teenagers, so even if you had a consultation, get another one if your worry comes back.

Suicide is the third leading cause of death among adolescents (after car accidents and murder). While we have some clear ideas about risk factors for suicide, many kids have risk factors and never make a suicide attempt. However, we now have some new evidence that NSSI is a powerful risk factor that predicts future suicidal behavior better than any other risk factor. See also the list in Chapter 3 of self-injuring behaviors that may predispose an adolescent to suicide attempts.

More often than not, deliberate self-harm is not a failed or halfhearted suicide attempt. But as with Marie, described in the Introduction, some kids

Risk Factors for Suicide

- Psychological troubles like major depression, bipolar disorder, borderline personality disorder (BPD), or anxiety disorders.
- Substance use.
- Severe family problems.
- A recent loss—for example, a breakup of a romantic relationship, a move, or a change in school.
- The recent suicide of another adolescent in the community.
- Impulsive or risky behaviors.
- Self-injury.
- Struggling with issues about sexual orientation.

have both experienced suicidal thoughts *and* injured themselves. And then there are kids who injure themselves as a type of suicide prevention. As I mentioned before, only a qualified mental health professional can make this determination. It's critical that any child who is self-injuring undergo a thorough suicide assessment by a qualified professional. If your child is struggling with suicide, your treatment team and you will need to stay vigilant about any evidence of worsening mood, talk of hopelessness, or references to wanting to die or feeling like a burden.

A New Approach to Understanding Why Your Child Is Self-Injuring

For children to hurt themselves in an attempt to feel better is so counterintuitive that it's only natural to look for an explanation beneath the surface. Surely something else—some hidden, unresolved need—must be causing the behavior. But the search for such hidden meaning has given rise to many of the myths just discussed. It has also led therapists away from a key concept: hurting themselves does make some kids feel better in a very specific way at the moment they do it.

Since the time of Sigmund Freud, psychologists have been interested in the *meaning* hidden in a person's actions. This kind of detective work can be an important tool in psychotherapy, but it can lead therapists and patients on a wild goose chase where self-injury is concerned. Recognizing the *function* of these kids' self-harm, rather than only trying to ferret out a symbolic *meaning* or *seeing the behavior as an unconscious communication,* is the new understanding that makes it possible to help them give up this behavior. When we understand the purpose their self-harm has been serving, we can help kids find a healthier way to achieve the same goal—both in treatment and in support of that treatment at home.

Let me give you an example.

TAMAR AND THE PUPPY

Tamar is a very bright college student who has a long history of self-injury and eating-disordered behavior. She has had several tries at more conventional individual talk therapies aimed at helping her understand the meaning of her eating-disordered behavior. Her parents divorced when she was in elementary school. Her mother and father are two high-powered professionals who travel often as part of their work. While Tamar had a good relation-

ship with her parents, she felt they pressured her to conform to their ideas of success. Her eating-disordered behavior reached a level where she couldn't remain at college and had to return home to live with her mother, although she often spent time at her father's house. After several hospitalizations, she began outpatient psychotherapy with me. An especially difficult problem for Tamar was binge eating in the middle of the night. At one point she had made some gains in this area by using skills she had learned in therapy with me, but we were not sure what *triggered* the behavior or what *function* it served for her. About 3 months into our meetings, she began to backslide. It was a puzzle to both of us.

She started one of her sessions by saying, "I think I know why I started to binge again. It has to do with my father coming home from his business trips. I get really tense when he's home. I just know that he wishes I would get my act together. He doesn't understand how much I'm struggling."

As the therapy hour progressed, I learned that Tamar had recently acquired a puppy that she was in the process of housebreaking. As part of the training, Tamar would get up in the middle of the night to take the puppy outside. She told me that she was always fearful of waking her father on these late-night trips with the puppy. Furthermore, she complained of how intolerant her parents were of her puppy's behavior and said she would become stressed and tense in response to their criticisms. When we went step by step looking at what happened when she took the puppy out, we learned the following:

Tamar would get extremely tense when she noticed that her puppy might have to go out. As we talked, she realized that when she went down the stairs and out the front door she didn't binge, but when she went down the stairs and out the back door through the kitchen, she did. It seemed that seeing the refrigerator was the trigger for bingeing. If she didn't see the refrigerator, she stood a better chance of accessing her new skills to help her manage her stress. The function of her bingeing, it became clear, was to reduce her stress. The remedy, then, was simply to go out the front door.

This is the type of solution that becomes accessible in treating self-injury when we look at its function rather than try to discover its buried meaning. With the trigger out of the picture and a better understanding of the function her bingeing had for her, we were able to develop a treatment strategy that would make Tamar's bingeing a thing of the past. If I had focused exclusively on the *meaning* of Tamar's bingeing in relation to the complicated feelings she had about her father, her eating disorder would no doubt have continued much longer. I had to assess the *function* of Tamar's

1. To find the *meaning* of the behavior, ask "Why?" Answers are generally: "I cut myself because I hate myself" or "I deserve to be punished" or "She needs to show people how much she hurts."
2. To find the *function* of the behavior, ask "What reinforces the behavior?" The most frequent answer to that question is that it changes the individual's painful emotional state, providing some sense of relief.

behavior and also work at understanding her beliefs about the behavior. Once we had decreased the binge-eating behavior we were in a better position to tackle Tamar's complicated relationship with her dad.

When speaking with your child's therapist, listen carefully to how the clinician is thinking about your child's self-injury so that you can differentiate the meaning of a behavior from its function.

The Road to a New Therapy

The psychological theories that informed most of my earlier career were variations on psychoanalytic concepts first proposed by Freud, then refined and expanded over the years by many of his followers. As I mentioned, this kind of therapy is very useful for some kinds of psychological problems, but it did not prove useful for the adolescents I was seeing who were self-harming. My task as a therapist at that time was to help my patients understand the reasons and meaning behind their behavior. I saw a person's troubled behavior as a symptom of some deeper underlying psychological problem. The idea here was that if I could help my patients understand the meaning of their behavior, or develop insight, it would lead them to confront that underlying issue. They would then be better able to choose a more adaptive way of managing and resolving what was troubling them.

The problem was that unearthing buried psychological problems so that the teenager could develop insight took a very long time—time during which the teen's self-destructive behavior continued. To make matters worse, it wasn't always possible to find the right insight or combination of insights that would aid the child in recovery. The adolescent and the therapist might examine the recurrent patterns in the child's relationships with friends, for example. The goal would be for the adolescent to understand what specific needs were not being met in these relationships and how the

child was contributing to this problem. The idea was that with this insight, the child could alter his or her friendship patterns, thus reducing negative emotions that led to self-harm. Of course even if our understanding was correct, it didn't take into consideration whether the adolescent had the skill sets necessary to alter the behavior. A more direct approach would involve the therapist and the teen monitoring and addressing the child's self-harming behavior as the problem that must be solved first.

Good therapists, however, have been taking the more indirect route for years with reasonable results. My own experience is that though the more indirect tactics are viable, it takes longer to resolve self-harm behavior using them. In addition, even when some of the kids had that "Aha!" moment, they didn't have the emotional skills to overcome their problem. Also, while therapists working in this manner explored the meaning that teens uncovered for hurting themselves, they could miss the powerfully reinforcing nature of self-punishment. *Understanding* that you hate yourself doesn't stop you from hurting yourself. I needed a way to help these kids stop hurting themselves as quickly as possible.

When I began to read about a treatment called dialectical behavior therapy, or DBT, I knew it could be the answer I'd been hoping for. DBT has two major strengths (as well as many others, which you'll read about in later chapters) that address self-injury effectively and efficiently:

Understanding that they hate themselves does not stop teens from self-injuring.

1. *It targets the problematic behavior directly.* It does not spend time seeking out hidden meanings or ask the teen or anyone else to attribute the behavior to symbolic motivations. It looks directly at what self-injury does for the teen when she does it and gives her other ways to achieve the same goal. As I'll explain further in Chapter 2 and beyond, the purpose self-injury serves is the obvious one, as counterintuitive as it may seem: At the moment when your teenager does it, cutting or burning herself makes her feel better, not physically but *emotionally*.

2. *DBT recognizes that conflict between the teen, who finds self-injury useful, and the parents and therapist, who want the behavior to stop, poses a major obstacle to change.* Misconceptions and conflicting viewpoints about self-injury generate tense and ineffective relationships in therapy. You're undoubtedly well aware that they cause unnecessary distress for you and your child. The "dialectic" in DBT is a way of finding a middle ground where you (and the therapist) can work toward change. On the one hand,

you convey to the teen that you understand her emotional pain and her need to relieve it, while on the other hand, you nudge her toward eliminating self-injury by giving her new ways to alleviate the pain.

I hope you can see from this simplified explanation that DBT is nothing if not practical. The goal for DBT therapists is the same as it is for you: to help your teenager stop hurting herself. The element that you've been lacking so far is the "how." DBT supplies that by offering your teen better ways to ease her emotional pain. This book will show you how you can adopt DBT's principles and strategies to contribute to the effectiveness of your child's treatment. But first, let me introduce a couple of teenagers who illustrate the two points just made.

AISHA: WEAVING TOGETHER MULTIPLE POINTS OF VIEW

It's difficult to bear the uncertainty about what guides the troubled actions of our loved ones. In these moments we're likely to jump to conclusions. Our thinking tends to become rigid and constricted, so we can't take in additional information that could help us. We can also lose our ability to logically sort things out, so we become overwhelmed and helpless. As much as we want to do something, anything, to help our suffering child, inertia wins out more often than not.

To complicate things even more, you and your child's other parent may not be on the same page. Often one parent's thinking becomes rigid and constricted while the other parent feels emotionally overwhelmed, which can lead to an ineffective parenting approach: "Houston, we have a problem." The single parent faces much the same dilemma, alternating between hopelessness and a rigid certainty in thinking—neither of which can help the suffering child. My work with Aisha is a good example of how things can get derailed and how to get them back on track.

Fifteen-year-old Aisha lived with her dad, stepmother, and younger brother and sister. She had minimal contact with her mother, who lived in another state. Aisha's stepmom had worked hard to forge a relationship with her and in many ways has been successful in negotiating these very tricky waters. As every stepparent knows, this is not an easy task. After the stepmom had been in the house for a while and things seemed to be settling down, she decided to pursue an advanced degree in business. This had been a dream of hers for several years, which she had put on hold while she took on the responsibilities of a stepmother. Aisha's stepmother was a confident, no-nonsense kind of person, and she reveled in the demands of graduate school.

Aisha's dad, a quiet and thoughtful man, valued peace and harmony in his family life. He told me that often he was puzzled by his daughter's periodic emotional outbursts, and downright angry about her cutting. I saw Aisha with her father and stepmother in a one-time consultation. Aisha had just returned home after a 5-day inpatient stay that was precipitated by her cutting herself after a family quarrel.

"So does anyone have a theory about what this self-injurious behavior is all about?" I asked.

Almost simultaneously Aisha's father and stepmother began speaking.

"It's not rocket science, Dr. Hollander," Aisha's father said with a clear tone of frustration and annoyance in his voice. "Aisha picks those times when her stepmom is overloaded with schoolwork and just can't devote the time she usually spends with the kids. It's not easy juggling full-time family obligations with graduate school. She's only human; she can't do everything. Aisha needs to understand that and stop trying to be the center of attention."

Aisha's stepmom went on to say, "It's almost like clockwork. Exam time comes around or I have a paper due, and that's when we can almost count on Aisha finding a way to cut. She is so predictable. She just has to have my attention all the time."

"That's not true!" Aisha sobbed. "I don't want your attention. Stop saying that. I hate the attention I get when I cut. I have tried everything to stop cutting and I just can't do it!"

Clearly Aisha felt misunderstood by her parents but couldn't offer an alternative explanation for her self-injury. In the absence of another explanation, the parents held tightly to their point of view, leaving Aisha with what appeared to be empty denials. The standoff left everyone feeling frustrated and tense. The more Aisha denied her cutting as a bid for attention, the more her parents leveled evidence to support their point of view.

There had to be more to the story. First, let's consider behavior as transactional, rather than a simple interaction. Interactive behavior is static: My response causes you to respond in a certain way, and then I respond in a certain way. When behavior is reviewed as transactional, on the other hand, we are paying attention to the ways each person's behavior influences the other's. In other words, my behavior influences you, and your response influences you, so that there is a snowball effect. For example, the more Aisha's parents found evidence to support their point of view, the more Aisha redoubled her emotionally charged responses to counter her parents' perspective. These charged denials by Aisha had the consequence of increasing her parents' strident belief that she was self-injuring for attention. The par-

ents' theory made good sense, yet Aisha's side was equally compelling. What occurs too often in these conversational standoffs is that each person starts to bring more and more energy and insistence—and loudness—to bolster his or her own position, while the capacity to understand the other person's point of view goes out the window. I imagine that a few of you reading this know all too well what I am describing here.

Understanding behavior as transactional rather than as a simple linear interaction can help us see how the responses to self-injury can make the problem worse.

The key to success in moments like these is for you to stand back and work at gathering more information. I will focus on how to negotiate these tricky moments in later chapters. For now, the essential idea is to detach yourself from your point of view and to bring some genuine curiosity and interest to the situation at hand. Give up on being "right." Try instead to develop an effective collaboration on the issues facing you and your child. Work at truly taking in your child's point of view and finding the truth in her position. I refer to this as "weaving in multiple points of view." In doing so we are discovering the kernel of truth in each person's perspective and working at bringing it all together to form a more complete view of the situation. You can always come back to your point of view later.

Of course this is easier said than done, especially when your emotions are running high and your child's welfare is at stake. When you can let go of your piece of the truth and work at developing a more complete view of things, however, I promise you that the tension and frustration will begin to decrease. I've seen it happen again and again. It works best when everybody involved is willing to do the same; but even if just one party makes the shift, it can be beneficial for everybody.

To form the most complete view of your teen's self-injury, find the kernel of truth in each person's point of view and then bring all of these kernels together.

"It seems like you guys are stuck," I said to Aisha's family. "No two ways about it, things can get pretty hectic at home with everybody so busy. What is it like for each of you?"

Aisha's stepmom spoke first: "I do what I can for my family—they really are my first priority—but when my schoolwork requires my attention, it becomes a real tug-of-war about how I'm going to divide my time. I have to admit, I can get pretty irritable and short on patience in those moments."

Aisha's dad chimed in: "I guess we all start walking on eggshells so as not to disturb my wife during the high-stress periods. You know, one wrong move and she's liable to bite your head off!" he added, only half joking.

The key to taking in other points of view to help solve a serious problem is understanding that

1. You may have developed a rigid adherence to your own position.
2. You are not betraying yourself by being curious about other people's opinions.
3. It's of little importance to be "right"; the only thing that matters is gathering information to help solve the crisis.
4. Taking pieces of other people's viewpoints plus pieces of your own, at least temporarily, may yield a fuller picture than any single person's viewpoint can.

Aisha jumped in: "I really get feeling pretty crazy with all the tension when my stepmom is under all that pressure. It seems like the whole house, me included, is vibrating with stress. Sometimes I just can't take it."

"Does your cutting give you some relief from all that stress?" I asked.

"*Yes!*" Aisha answered immediately.

Clearly, it was Aisha's response to the tension in the house rather than her wish for attention that generated her self-injury. Her parents' theory, while in many ways logical, was wrong. In part, their own frustration helped lock them into a logical but false conclusion. Like the majority of adolescents who self-injure, Aisha used cutting as a way to bring relief from the awful emotional tension that she felt inside. Only when her parents were able to reevaluate their position could they respond to her with genuine empathy. And when they understood the function of her cutting, they could begin to come up with better ways to manage the tension in their household.

JANINE: VALIDATING THE TEEN'S EMOTIONAL EXPERIENCE

As mentioned above, the other major strength of DBT is that it tackles the behavior directly because it is based on understanding that the behavior serves the teen's need to alleviate emotional pain and gives the teen better ways to meet that need than harming herself. The first and most important step toward accomplishing that goal is to ensure that you validate the way your child feels. Janine's story illustrates this.

"You just don't get it! Lizzie is my best friend, and she understands me better than anybody else," Janine exclaimed through her tears.

"She's no best friend as far as I'm concerned," countered Janine's dad.

"I don't think she's a friend at all! What kind of friend supports you cutting yourself?"

"She doesn't support my cutting. She just talks with me about my problems," Janine explained through her sobs.

This is the beginning of a conversation that is guaranteed to go nowhere. I hope you can recognize the truths in Janine's position and the truths in her father's as well. What is missing in the dialogue is *validation*—that is, communicating that you understand and value the wisdom in the other person's point of view. Validation means communicating that you understand the other person's experience. This doesn't mean that you have to *share* the opinion.

For example, Janine's dad need only say that he understands how valuable Lizzie's friendship is to her. Validation is like fertilizer for relationships: it keeps them growing. It nurtures and enhances them so the more arid times are easier to bear. Furthermore, after he validates Janine's experience, he will be in a better position to raise his concerns about Lizzie and have them heard. The concept of validation may seem simple, but I have found it to be the single most difficult skill to teach to parents and the most important one for them to acquire.

Validation is like fertilizer for relationships—it keeps them growing. It nurtures and enhances the relationship so the more arid times are easier to bear.

These brief stories give you a glimpse into why self-injury can be so difficult to eliminate. By its paradoxical nature it creates conflicts and misunderstandings—between parent and child, between parents, and between child and therapist—that can stand in the way of change. You need a way to bridge the gap between opposing points of view if you are to work together toward change. And unless everyone—your teen, you, and the teen's therapist—understands and validates the teen's emotional experience, the teen is not likely to be receptive. If you can't see that she's in a lot of pain and that self-injury is her attempt to soothe herself, why would she trust your advice on how to "get better"? It would be like telling her to throw away her crutches and cut off her cast because you didn't understand that she had broken her leg.

Of course emotional pain isn't visible. Let's move on to a discussion that will bring to light how your child became vulnerable to the emotional pain that urged her to start injuring herself.