

# **Incorporating Expressive Arts Techniques Into the Treatment of Adolescent Self-Injury**

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Self-injury is defined as “deliberate violence towards one’s body that has a purpose other than suicide” (Connors, 2000, p. 8). Self-injury takes many forms; however, the most common include cutting, burning, picking, scratching, tearing at cuticles, and interfering with the healing of wounds. Some adolescents may also report head banging, biting, pulling eyelashes, and/or hair pulling.

Non-suicidal self-injury in adolescents is receiving increased attention in the media and mental health fields. The period of adolescence represents a time of transition and growth, which may make children particularly susceptible to self-injury (Lloyd-Richardson et al., 2008). Recent studies have suggested prevalence rates ranging from 12-39% in the general population (Zoroglu et al., 2003; Lloyd-Richardson, Pierrine, Dierker, & Kelley, 2007) and as high as 61% in clinically-referred adolescents (DiClemente et al., 1991). This is compared to a rate of 1-4% in the general adult population and up to 21% in a clinical sample of adults (Briere & Gil, 1998).

Individual variables, such as general perfectionism, low self-esteem, coping skills, emotion regulation, age, psychopathology, and trauma history, have been associated with self-injury (Briere & Gil, 1998; Chapman, Gratz, & Brown, 2006; Claes et al., 2010; O’Connor, Rasmussen, Miles, & Hawton, 2009, see Connors, 2000 for a review), although the exact mechanisms underlying these relationships are not yet

clearly understood and may be moderated by age or other mental health issues (Hasking et al., 2010). A recent study (Prinstein et al., 2010) found a relationship between peer influence and self-injury, suggesting that over time, adolescents' risk-taking can impact the likelihood of their peers' own risk-taking.

The two most common reasons adolescents cite for their self-harm are to control overwhelming emotions and/or escape from feeling numb or empty (Hollander, 2008). Thus, self-harm is used as a coping skill where what normally brings physical pain conversely brings relief from emotional pain. Other reasons that adolescents self-harm may include:

- To exhibit control over something in their lives
- To punish themselves
- To upset parents
- To avoid putting feelings into words (Shapiro, 2008)

It is important for clinicians to understand that while self-harm is not a healthy means of coping, it can be an effective means of managing difficult emotions. For these teens, emotions are felt deeply, and self-harm may feel like the only way to regain control over these emotions and restore balance. Furthermore, adolescents who resort to self-harm lack more adaptive skills needed to manage and express their feelings (Hollander, 2008).

### **Assessment of Self-Injury**

A referral for treatment, whether self-referral or from an adult in the adolescent's life, does not necessarily mean that an adolescent will accept help. The shame and secrecy that often surrounds self-injury is a further block to treatment. Rather than asking many questions which may be perceived by the adolescent as threatening, clinicians are likely to better understand the history, onset, and current nature of the self-injury by conveying concern and an openness to listen. D'Onofrio (2007) recommends a four-stage process of conducting a comprehensive assessment: (1) containment, (2) engagement, (3) assessment, and (4) planning next steps.

First and foremost in the stage of *containment* is ensuring the adolescent's safety. Determining whether the adolescent is in immediate physical danger is of paramount importance. "Respectful curiosity" which suggests interest in the person and the problem, is a helpful skill. As part of the containment stage, it is important to manage the responses of those around the adolescent. This may include parents, siblings, teachers, and friends.

Next, the clinician's role is to *engage* the adolescent. Tips for this phase include using the client's words to convey respect and understanding and empowering the client by expressing curiosity without demanding information. The clinician can gauge the adolescent's comfort level in therapy by asking about prior treatment attempts and assessing likes and dislikes of these attempts. If a client is coming into treatment involuntarily, the clinician may consider asking the adolescent if she would like to involve the referring adult in the initial meeting. When engaging the client in a discussion of self-injury, Connors (2000) recommends simple questions such as, "Can you tell me anything about the times when you hurt yourself?", or "I'm glad you told me

about what you are doing to your body. Are you feeling okay about having told me?”. Questions to help adolescents determine the extent to which they would like to discuss their self-injury might include, “Do you feel it would be helpful to talk more about your cutting”, “Do you have a sense of how self-injury works for you?”, or “Would it help you to learn more about self-injury?” (p. 372-373).

During the *assessment* phase, the goal is to gather information about the adolescent in a variety of functional areas. This can be achieved by asking both the adolescent and people close to her about behavior, affect, cognition, biology/psychiatry, and environment. Questions used to obtain this information are available in a number of sources (Farber, 2000; Farber & Simeon, 2001; Walsh, 2006; review in D’Onofrio, 2007). Symptom scales are also helpful assessment tools. A recent publication by Craigen and colleagues (2010) outlines measures that clinicians can use to more formally assess for self-injury.

Finally, the clinician works with the client to *plan the next steps* in treatment. During this last stage of the assessment process, immediate needs are identified and ongoing treatment goals are determined. By including the client in this process, the clinician conveys the message that the adolescent’s input is valued and important, and this facilitates the client’s engagement in treatment.

### **Treatment of Self-Injury**

Willingness to seek treatment is the first step towards receiving assistance with self-injury. Few studies have explored the variables associated with treatment-seeking behavior in self-injuring adolescents; those that examined this issue found that

adolescents were more likely to seek help from close relationships rather than treatment providers (De Leo & Heller, 2004; Evan, Hawton, & Rodham, 2005; Nixon, Cloutier, & Jansson, 2008). This finding was supported by a more recent study that concluded that less than 20% of self-injuring adolescents would seek support from their schools (Heath, Baxter, Toste, & McLouth, 2010). Thus, the literature suggests that adolescents are hesitant to seek treatment from mental health professionals. As a result, many self-harming adolescents may come into treatment unwillingly or for a related, but separate issue.

Getting adolescents into treatment can be difficult enough; next, the provider must determine how to treat the self-harming adolescent. The power of the therapeutic relationship cannot be underestimated when working with this client population; some clinicians have suggested that it may be *the* most important factor when working with a self-harming client (Bateman & Fonahy, 2004; Connors, 2000; Linehan, 1993). Relationships are often an area of difficulty for clients who self-harm (D'Onofrio, 2007). Thus, the therapeutic relationship is often seen by the client as the most important aspect of treatment, whereas clinicians may have different views. One study found that while clinicians ranked open discussions, skills building, and psychotherapy as the most helpful strategies in treatment of self-injury, clients ranked a long-term working relationship with a provider, open discussions, and access to caring individuals as the most helpful strategies (Huband & Tantum, 2004).

Once a trusting therapeutic relationship has been established, clinicians may utilize a range of treatment strategies to help adolescents who self-injure, including cognitive behavioral treatment (CBT), dialectical behavior therapy (DBT), multisystemic

therapy, interpersonal group therapy, and hypnosis (Whitlock, Eells, Cummings, & Purington, 2009). A fact sheet for families, published by the American Academy of Child & Adolescent Psychiatry (1999), lists a variety of treatment goals. Tolerance of the present moment, identification and acceptance of feelings, distraction by journaling, drawing, or thought-stopping techniques, self-soothing in positive ways, relaxation and stress management, and the development of positive social skills are among these goals. These approaches are related to the empirically validated treatments of self-injury in adults; however, little empirical research exists to validate these approaches with adolescents.

Further, a literature search of play therapy techniques to address self-injury yielded no results. This seems to be contraindicated, as the research on treating children and adolescents recommends a creative approach to addressing mental health issues. While encouraging adolescents to engage in journaling or drawing outside of sessions can be useful, some adolescents do not find that these activities are enough for them to stop self-injury. The following section outlines several expressive arts activities that can be used in the treatment of adolescent self-injury.

### **Life Charting**

The life chart is an activity used in treating bipolar disorder (Basco, 2005). With this activity, the client and therapist identify times of depression and mania and events that occurred around these incidents. Clients draw a horizontal line in the middle of a page to symbolize their baseline, or typical mood. Then, they draw peaks and valleys above and below the lines to symbolize times of depression/dysthymia and mania/hypomania. Once these experiences are drawn, the therapist assists the client in

adding triggers, associated symptoms, and life events. Life charts are useful in helping to identify signs, triggers, and patterns of symptomatology. Similarly, life charting is an activity that can help self-injuring clients. For adolescents, giving them the opportunity to express their creativity during the activity can also be beneficial. One adolescent, Meghan, chose to draw her life chart on poster board using different colors and drawing pictures. This chart helped Meghan identify the onset of her cutting, triggers, and patterns of her self-harming. For example, she realized that she began cutting shortly after relocating to a new state and school. Times when she felt lonely were highly triggering for her to cut. Through this chart, Meghan was able to talk about the loneliness she frequently felt for the first time.

### **Self-esteem Mandala**

The self-esteem mandala is a twist on the commonly used mandala activity, which has been shown to reduce anxiety and promote physical and mental well-being (Curry & Kasser, 2005). The word *mandala* is Sanskrit for “circle” or “completion” and represents wholeness. Mandalas are circles with patterns inside, and are used in therapy to reflect the inner self. They have been represented in the literature as an art therapy activity used to promote healing and creativity in youth with histories of trauma (Green, 2007), and attention deficit hyperactivity disorder (Smitheman-Brown, 2006). Jungian theory respects symbolic communication as a way to promote ego stability (Jung, 1959).

Tina reported pulling out eyelashes when she felt anxious. She made steady progress in cognitive-behavioral techniques to manage her anxiety, but she still felt tremendous shame about her self-injury, particularly following an incident where a friend

witnessed her pulling out eyelashes. Tina was having difficulty identifying things about herself that she liked; for several weeks, she focused her therapy sessions on the ways in which she was disappointing others, making herself look ugly, and failing to manage her anxiety. Tina was instructed to choose a mandala pattern that she would color. Any color that she chose to use was representative of a characteristic about herself that she liked. Over several weeks, Tina began her sessions by identifying something she liked about herself and coloring in her mandala using a color to symbolize her trait. She identified characteristics such as independent, not afraid to ask for help, a good friend, creative, and determined. She was amazed at the beauty of the mandala once it was finished and told her therapist, "It's like all of these traits make me beautiful too." She chose to hang this mandala in her room as a reminder, and it was frequently referred to during subsequent therapy sessions. Further, Tina came to incorporate her mandala into her coping thoughts when she was feeling anxious and wanting to self-harm.

### **Distraction Box Therapy**

DBT teaches the skill of distraction as a way to help manage overwhelming emotions. Distraction is, quite literally, doing other things to keep oneself from self-harming. Distraction techniques can help take clients' focus off of the pain and give clients time to find an appropriate coping skill (McKay, Wood, and Brantley, 2007). Clients are taught to calm the urge to harm themselves by learning to match the healthier behaviors to how they are feeling in the moment. For example, a client who self-harms when sad may consider a soothing behavior, such as taking a bubble bath or making tea, whereas the client who self-harms when angry might try to tear a phone book or stomp her feet. Then, the therapist helps the client identify a list of distracting

actions, called a “distraction plan”. This plan also encompasses pleasurable activities that can be done in place of self-harm. The “big list of pleasurable activities” (McKay et al., 2007) lists over one hundred enjoyable activities that can be done instead of self-harm.

A distraction plan is often written down, but for adolescents, adding creativity to this process can be useful. A third client, Melissa, struggled to use her distraction plan as it was written on a piece of paper. She told this writer that she wanted to use the plan but that it “didn’t feel like real things I can do” in the moment when she wanted to pick at her skin. This writer had Melissa create a distraction box. In this box, Melissa placed items that reminded her of steps in her distraction plan. She included a rock to represent walks on a trail by her house, a washcloth to represent taking a bath, a CD to represent relaxing music, and movie stubs to represent a social activity. She also wrote cognitive distraction ideas on slips of paper, including counting, various coping thoughts, and the phone numbers of several friends. She reported an increased sense of commitment to her plan and kept the box by her bed. Over time, Melissa added to her distraction box, for example, she put mementos of positive experiences in her life, such as a thank you card from a teacher and a ribbon from a horse race. She told her therapist that these reminders helped her generate coping thoughts and promoted self-esteem.

### **The “My Body Needs...” Activity**

For an adolescent who self-injures, learning to treat her body better is an important part of treatment (Shapiro, 2008). The “My Body Needs...” activity allows for the therapist to learn more about clients’ body image while also promoting elements of

self-care that the client has already incorporated into daily life. This activity can take more than one session to complete, depending on the discussions that ensue. First, the client is instructed to draw a picture of herself. Then the clinician asks questions related to body-image, such as:

- What parts of your body do you like?
- What parts of your body do you wish were different?
- When you look at yourself in the mirror, what do you see?
- What do you think others see when they look at you?

Following this discussion, the therapist helps the client identify ways in which she cares for different parts of her body. These are written or drawn on the picture and are meant as direct opposites to the self-harm. For example, a client may draw/write about nutrition and nourishment near the mouth or stomach. Near the arms or legs, exercise may be identified. Dental care, medical care, sleep, personal hygiene, mental health treatment, and appropriately dressing for the weather may also be included.

Melissa struggled with issues of self-care, particularly because her method of self-harm included picking at scabs as her body tried to heal from injuries. This activity took several sessions to complete, as it led to in-depth discussions about body image, self-esteem, and desires to lose weight. Once moving onto the self-care aspect of the activity, Melissa was encouraged to realize the ways in which she did, in fact, care for herself, including daily showers, clean clothes, healthy diet, and regular medical care. Further, Melissa was reminded that mental health treatment is also a method of self-care, something she had not considered before.

## **Self-esteem Sticky Notes**

Another self-esteem activity that can be useful with this population is the self-esteem sticky notes. This activity involves the client as well as important individuals in her life. The client takes two pads of sticky notes home. On the first pad, the client identifies things she likes about herself. Each sticky note has one characteristic or trait on it. The client and therapist can make a game out of this and work towards a reward (i.e., one point per sticky note). The second pad is for people in the client's life. She gives sticky notes to others and asks them to identify things they like about her. The client then posts these notes in places she will regularly see them: her room, locker, car, refrigerator, and/or bathroom.

Tina easily identified things she likes about herself, but did not believe that others would be able to complete the activity. She struggled to compete with her other siblings who were more prolific in sports and more outgoing with peers. She asked her parents, best friend, and guidance counselor to complete her sticky notes. She came into therapy the following week, surprised and excited to report that her parents had, in fact, been able to identify things they liked about her and of which they were proud. This activity led to a discussion about her views and interpretation of her parents' interactions and expectations of her. She kept her parents' sticky notes in her planner so that she could see them several times throughout the day.

## **Care Tags**

The goal of "Care Tags" with self-harming adolescents is to help them identify clues to their feelings and what it is that they need when these feelings occur (Smith, 2008). The idea behind the activity is that unlike clothes that come with a tag to inform

the owner of the care instructions, individuals do not have such care instructions. With the help of the therapist, the client creates care tags that include the following statement:

“When I \_\_\_\_\_(behavior, action, or situation), I am feeling \_\_\_\_\_, and I need \_\_\_\_\_.” (Smith, 2008, p. 57)

This activity can be particularly useful with clients who do not have a clear understanding of either their feelings or what they need when they feel certain emotions. For Meghan, this activity was difficult. She could easily identify her feelings but not the behavior/action/situation, or the needs associated with the emotion. The therapist helped her work backwards by asking questions such as, “How would I know you were feeling sad?” and “What would help the sadness go away?”. Over time, this activity allowed Meghan to better understand her urges to cut. Whereas she sometimes wanted to cut when she was angry, she more often cut when she was sad. In therapy, she was able to determine that when she was feeling sad, she needed to “get the sadness out”. This led to a distraction plan where Meghan identified crying and writing in a journal as ways to safely get her sadness out.

## **Conclusion**

Research suggests that self-injury is common in adolescents, yet there is little published on effective treatments for this population. There is, however, much research to suggest the usefulness of incorporating expressive arts techniques into child and adolescent treatment. Therefore, using expressive arts activities would appear to benefit

self-harming adolescents more so than adult treatments alone. The activities described in this article can be used in conjunction with CBT and DBT skills, as well as other psychotherapy modalities.

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