Coping Gone Wrong: Inside the World of Adolescent Self-Injury

Satellite Conference and Live Webcast
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Produced by the Alabama Department of Public Health
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Faculty

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Objectives

- **Identify non-suicidal self-injury and be able to discuss the complex relationship between these behaviors and suicidal behaviors.**
- **Know some of the possible risk factors and characteristics of young people who engage in the behavior.**

Objectives

- **Know some possible psychological and sociological factors that may contribute to this behavior.**
- **Know some of the counseling and therapeutic interventions often used with this group.**

What To Call This?

- **Self-injury**
- **Self-harm**
- **Self-inflicted violence**
- **Self-injurious behavior**
- **Self-mutilation**
- **"Cutting"**

Some Assumptions

- **Self-injury is often (mostly?) a coping mechanism to deal with psychological pain/distress.**
- **It often is adaptive.**
- **Most self-injury involves slight/modest physical damage that leaves little, if any, long-term scarring.**

Defining…

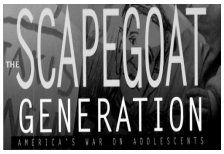
A spectrum of behaviors of self-inflicted injury.

- **Punching, hitting, biting, choking, picking at wounds, burning, stabbing, scratching.**
- **Tattoo? Body piercing?**
- **Disordered eating.**
- **Substance abuse?**
- **Suicide?**

What Are We Talking About?

- **People hurt themselves**
- **What's distinctive about our topic today?**

These Teenagers!



- **Suicide rates are lower in teenagers than in their parents' age group.**
- **Substance abuse is more common in adults than in teenagers.**
- **Workplace shootings more common than school shootings.**

How About Us?

- **How do we hurt ourselves?**
- **How do we express our deepest emotional pain?**
- **What happens to us when we don't?**
- **Are our adaptive behaviors necessarily healthier than cutting?**

Self-Injury

For our purposes:

Deliberate harm inflicted by a person upon his or her own skin and surface tissues, without suicidal intent, and related to expression of emotional pain or an attempt to end an episode of emotional numbness. The behavior is culturally/socially unacceptable, but may be tolerated and approved in a sub-group.

Methods

- Scratching & pinching with fingernails or other objects to the point of bleeding.
- Cutting
- Punching or banging to point of bruise/bleed.
- Males: Punching wall or object.
- Females: More likely to injure wrists/thighs

Demographics

How would we know?

What we think we might know:

- Classically associated with Borderline Personality Disorder
- Associated with emotional abuse
- Gender differences unclear but likely due, in part or all, by observer bias
- Most associated with adolescents and young adulthood

Classic (Old) Understanding of Who Self-Injures

- Patients with serious, persistent disturbance/mental illness (outpatient, inpatient, day treat.)
- Patients in psych emergency rooms
- Incarcerated adults.
- Youth in special education, residential treatment, juvenile detention.
- Borderline Personality Disorder

Beginning In the 1990s…

Seen in broader population outside of psychiatric/incarcerated groups.

- Youth in middle & high schools, regular ed, often high functioning
- College / University students
- Adults in general population

Demographics

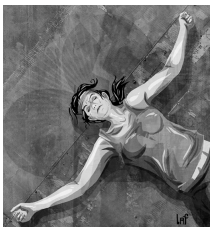
- Undergraduate college students: 9.8% report at least one episode of cutting or burning selves.
- Expanded to head-banging, scratching self, hitting self, 32%. (2000 study)

Most Agree…

Previously commonly believed to be associated only with severe psychiatric illness, now it is too commonplace to be regarded as the product of severe psychiatric illness.

Risk Factors

- Mental health problems
  - Depression
  - Conduct disorder
  - Personality disorder
- Substance abuse
- Loss of parent or loved one
- Turbulent romantic relationships



Psychiatric Disorders, Teens, SIB

Disorder	Prevalence in sample of 89 with SIB
Major depression	42%
PTSD	24%
Generalized Anxiety	16%
ANY INTERNALIZING	52%
Conduct Disorder	49%
Oppositional Defiant	45%
ANY EXTERNALIZING	63%

Source: Nock, Joiner, Gordon, et al. Non-suicidal self-injury among adolescents: diagnostic correlates and relationship to suicide attempts. Psychiatry Res 2006; 144(1):68.

Substance Disorders, Teens, SIB

Disorder	Prevalence in sample of 89 with SIB
Alcohol abuse	18%
Alcohol dependence	17%
Nicotine dependence	39%
Marijuana abuse	13%
Marijuana dependence	30%
ANY SUBSTANCE ABUSE D/O	60%

Source: Nock, Joiner, Gordon, et al. Non-suicidal self-injury among adolescents: diagnostic correlates and relationship to suicide attempts. Psychiatry Res 2006; 144(1):68.

There is No Profile.

So, here's a profile.

- Emotional and somewhat self-oriented.
- Emotional environment discourages expression of anger, sadness.
- Highly sensitive about interpersonal status. Sensitive to rejection.
- Lack of healthy outlet (perhaps combined with romanticizing of personal pain)

Self-Injury and Suicide

- This behavior is not usually suicidal in intent.
- Most is not a precursor to suicide.
- Don't know if this group is more prone to become suicidal or to commit suicide.
- Certainly not immune from suicide, but…
- Self-injury can be a way of coping with suicidal feelings, even preventing, suicide

Suicide Risk

- 70% of adolescents who engaged in SIB had made one suicide attempt; 55% had made multiple attempts.
- Cannot conclude person is at risk for suicide because of behavior.
- Cannot conclude person is not at risk for suicide because of behavior.
- Should assess suicide risk as one would any young person who is believed to be in emotional distress.

(Source: Nock, Joiner, Gordon, et al. Non-suicidal self-injury among adolescents: diagnostic correlates and relationship to suicide attempts. Psychiatry Res 2006; 144(1):68.

9 Points of Distinction: Self-Injury and Suicide (Barent W. Walsh, 2006)

Issue	Suicide attempt	Self-injury
1. Intent	Escape pain, terminate consciousness	Relief from unpleasant affect (tension, anger, emptiness)
2. Damage/lethality	Serious physical damage, lethal means	Little damage, nonlethal means
3. Chronic, repetitive pattern?	Not typical (Overdose exception)	Typically, yes.

9 Points of Distinction: Self-Injury and Suicide (Barent W. Walsh, 2006)

Issue	Suicide attempt	Self-injury
4. Multiple methods of injury?	Not typically	Typically, yes
5. Level of psychological pain?	Unendurable, persistent	Variable, but often uncomfortable, intermittent.
6. Constriction of cognition?	Extreme: Suicide as only way out.	Little or no: Choices seen as available.

9 Points of Distinction: Self-Injury and Suicide (Barent W. Walsh, 2006)

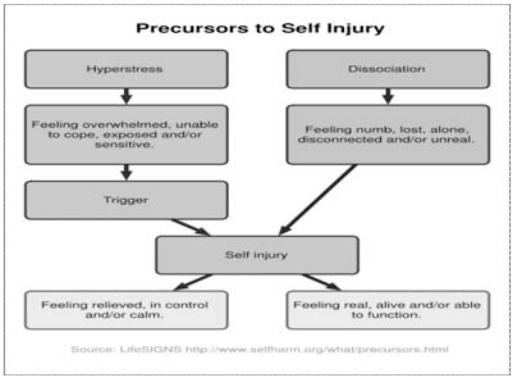
Issue	Suicide attempt	Self-injury
7. Hopelessness / helplessness?	Yes. Central to suicidality.	Periods of optimism and self-control.
8. Decrease in discomfort after act?	No / not without treatment	Routine rapid improvement.
9. The core problem.	Depression, rage about inescapable, unendurable pain.	Body alienation, body image, temporary relief from episode of psych pain.

Methods

Suicides, ages 15-24, all races, both sexes	Self-injury
• Firearm (60%) • Suffocation (25%) • Poisoning (6%) • Fall (3%) • Other (2%) • Drowning (1%) • Fire/burn • Transportation • Cut/pierce (0.4%)	• Cutting, scratching • Excoriation of wound • Self-hitting • Self-burning • Head-banging • Self-inflicted tattoos • Other

What Does Self-Injury Do?

- It relieves, at least partly and temporarily, overwhelming emotional pain.
- It ends numbness, depersonalization, derealization.
- NOT attention seeking, typically.
- NOT manipulative, typically.



Indirect Self-Harm

- Substance abuse
- Eating disorder

- Risk-taking (physical, sexual)
- Medication/treatment discontinuance or abuse

Self-Injury: Middle & High School

Ross & Heath (2004). Studied 440 youth from urban and suburban Canadian high schools.

- 14% reported self-injury
- Of these, 64% were girls, 36% boys.
- Higher scores for depression and anxiety.
- 13%-at least once a day
- 28%-a couple of times/week.
- 19%-a couple of times a month

Self-Injury: Middle & High School

Ross & Heath (2004).

- 59% started in 7th or 8th grade
- 25% started 6th grade or earlier
- Good news: 64% had stopped

The New Self-Injurers

Barent Walsh's observations (I concur!)

- Both genders, females>males, 2:1
- No ethnic, racial, economic pattern
- Start as early as 11-12.
- Have considerable strengths and function adequately, or well.
- Most: not special ed, not discipline problems, no history of psych treatment

The New Self-Injurers

- Often introduced to cutting by friend(s)
- Quickly come to rely on it after trying it.
- Lack healthy coping skills.
- Body hatred (body alienation) not nearly as common.
- Deny (convincingly) history of sexual/physical abuse.
- More prone to give up the behavior after awhile (highly influenced by peers.)

I intended to kill something in me, this awful feeling … So when I discovered the razor blade, cutting, if you'll believe me, was my gesture of hope. That first time, when I was twelve, was like some kind of miracle, a revelation…As swift and pure as a stroke of lightning, it wrought an absolute and pristine division between before and after. All the chaos, the sound and fury, the uncertainty and confusion and despair—all of it evaporated in an instant, and I was for that moment grounded, coherent, whole. Here is the irreducible self. I drew the line in the sand, marked my body as mine, its flesh and its blood under my command.

--C. Kettlewell, Skin Game, 1999

What's Going On?

- Favazza (1996). Self-induced body modifications occur in multiple world cultures correct or prevent "a destabilizing condition that threatens the community." (Angry gods, haunting, conflicts of all sorts, onset of adulthood, immoral or sinful behavior, ecological disasters, etc.)

What's Going On?

- Feminist analyses: Self-injury linked to increasingly unachievable standards of feminine beauty.
- According to these authors (Dworkin, Shaw, et.al.) self injury can be viewed as an act of empowerment and body reclamation.

What's Going On?

- Environmental influences: Stress, multitasking, divorce rates, etc.)
- Media influences: Exposure to self-injury, confessional interviews (Angelina Jolie, Princess Diana), websites, chat rooms.
- Short answer: We don't know.

Body Piercing, Tattooing, Etc.

Is this a variant of the same phenomenon?

- Seems to have increased during about the same recent time period.
- Similar themes: Still mostly unacceptable to polite society. Role of skin. But PAIN not usually the goal, nor is interruption of distress.

Helping

Considerations For Youth Counselors and Advocates

- Confidentiality: Does self-injury trigger a need-to-know disclosure to parents or other third parties?
- What further assessment might be triggered when a counselor learns that a student is self-injuring?
  - Suicide assessment?
  - Family?
  - Substance abuse?

- At what point does the school or agency counselor recommend or seek referral to outside professional?

Responses To Youth Disclosing Self-Injury

- Avoid bundling self-injury with suicidality. Consider a separate suicide assessment.
- Avoid labeling it as "suicide gesture" or "suicide attempt." Avoid the language of suicidality when referring to the behavior.
- Default to the position that the behavior is not attention seeking and not manipulative.

Responses To Youth Disclosing Self-Injury

- Generally: Use the language the student uses. If she says "cut myself" say "cut yourself."
- Try to determine the parameters of the self-injury:
  - How often?
  - Where on body?
  - How deep?
  - What feelings trigger it?

Responses To Student Disclosing Self-Injury

- Don't insist on seeing injury. (Should you ask? Invite?)

Responses To Student Disclosing Self-Injury

The counselor's demeanor

Typical

- **Intense concern and effusive support**
- **Condemnation, ridicule, threats**
- **Recoil, shock, avoidance, judgment**
- **Anguish, fear, panic**

Hot Response/ Cool Response

- **The hot response**
- **The cool response**
  - **"Big deal." "So what." "What else you got?"**

Balanced Response

- **Low key, calm, but not minimizing**
- **Concerned but not panic.**
- **Responsible**
- **Respectful**
- **Nonjudgmental compassion**
- **Humility**
- **Refrain from premature conclusions, labeling, interpretation, refraining.**
- **I have seen this before and I want to help and I'm not going to add my anxiety to your problems**

Some Things To Say…

- **A lot of the people I've met who do this do it because it helps them feel better when they're really upset. Is that true of you?**
- **Sometimes people start feeling spacey and kind of zoned out and this brings them back to reality. Is that true of you?**
- **I won't tell you I understand what you're feeling, but I want to.**

- **Good time to go through the limits of confidentiality.**
- **Negotiate parental involvement.**

Care Plan

- Role of outside clinicians.
- Your role when outside clinicians are involved.
- Communication among the parties: student, parents, outside clinician, other school personnel. (Really need to try to contain the latter.)

Major Therapeutic Approaches

- Cognitive-behavioral
- Replacement skills
- Body image work
- Identifying trigger events
- Helping find a way to understand what happens.

Major Therapeutic Approaches

- Finding new ways to vent, express the psychic pain.
- Educating others in their lives, helping people manage their responses.
- Medication
- Family treatment

Thank You

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Upcoming Conferences and Programs

Alternative and Complementary Therapies in Women's Health Care
Thursday, June 19, 2008
1:00 - 3:00 p.m. (Central Time)

Improving Disaster Communications: Connecting Poison Control with Public Health
Tuesday, July 22, 2008
12:00 - 1:30 p.m. (Central Time)