Teen Self-Injury: Theories and Initial Interventions

For School Based Health Centers and School Nurses 3/20/12

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Course Objectives

Participants will be able to:

- Understand theoretical models of the development of Self-Injury (SI)
- Describe the warning signs/symptoms of SI and differentiate them from suicidal behavior
- Outline appropriate triage interventions to use in the school setting and understand treatment strategies that will likely be used by referral agencies

What is self-injury?

- SI has also been called self-harm, cutting, para-suicidal behavior, suicidal gestures and self-mutilation
- Cutting, scratching, carving, re-opening wounds, pinching, hitting, burning, scalding, hair pulling, ingesting objects, insertion, self-inflicted piercing/tattooing, head banging

What is Self-Injury?

- Injury can be done with knives, razors, glass, staples, erasers, pins/needles or any other sharp object
- Typical sites are hidden and include forearms, wrists, ankles, thighs, and abdomen

"Self injury is intentional, self-effected, low lethality bodily harm of a socially unacceptable nature, performed to reduce psychological distress."

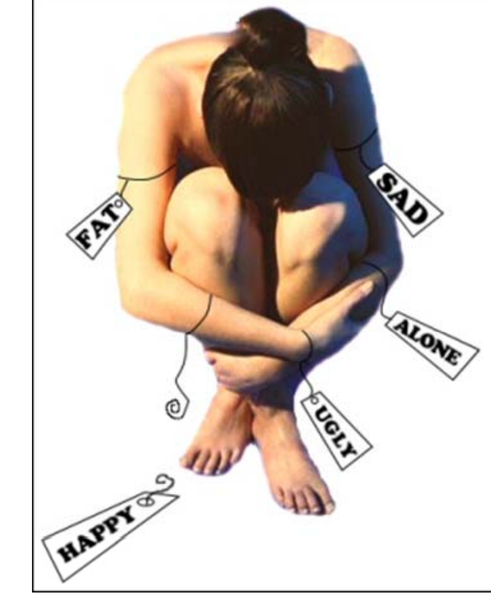
(Walsh, 2006)

Differential from “self-injurious behavior”?

- SIB most typically seen with:
  - Developmental delays
  - Autism
  - Neurological Disorders
- Typically involves stereotypies, is of longer duration, increased frequency and can involve more serious tissue/organ damage

Demographics

- Frequency of SI is believed to have increased by 120% in the past 20 years – 1,000 in 100,000
  - A person is 90x's more likely to SI than commit suicide
  - 5x's more likely to abuse ETOH than SI



Those who Self-Injure

- Typically female (64%)
- Age of onset more common in middle school than high school
- Cutting is the most common form, 10% - 16% general population reported using more than one method (50% in clinical pop.)
- Intensity – typically involves significant tissue damage and/or permanent scarring

Those who Self-Injure

- 2/3 of those who self-injure report relief from negative mood states
- Anxiety and depressive symptoms are more common in cutters than non-cutters
- Those who report no pain typically begin at a younger age, repeat more often, cut for longer periods and are at a greater risk for suicide

Characteristics of a Self-Injurer

- Low Self Esteem
- Risk taking behaviors (substances, sexual)
- Hostility
- Acute stress
- 4% of the general psychiatric population
- 14%- 19% of the general population
- Among Borderlines, 80% self-injure
- Many maintain secrecy, at least from all but a select few

Comorbidities

- Borderline Personality Disorder
- Depression
- Anxiety Disorders
- Bipolar Disorder
- Eating Disorders
- Substance Abuse
- PTSD
- Schizophrenia
- Dissociative Disorders

Differential DX: Body Modification

- Tattoos, piercing, branding, etc.
- SI if self-inflicted, not aesthetic or antiseptic
- To differentiate "art" from SI
  - Check intent (reduce stress or look good?)
  - Precipitated by strong, uncomfortable feelings?
  - Check for other forms of direct or indirect self-harm

Self-Injury vs. Suicidality

- Intent/Level of Damage
  - Intent to terminate consciousness or modify it?
- Lethality
  - Method likely to result in death?
- Frequency
  - SI is more frequent and over longer period
  - Typically a couple of years 20-30x's on average

Self-Injury vs. Suicidality

- Multiple methods
  - May vary depending on moods in same person
- Level of psychological pain
  - SI – pain is interruptible, intermittent
  - Suicidal – pain is permanent and intense
- Cognitive Flexibility
  - SI is an attempt to solve discomfort
  - Suicidal – all or nothing thinking

Self-Injury vs. Suicidality

- Helplessness/Hopelessness
  - SI have hope and self-efficacy because they can reduce distress through SI
  - Suicidal hopeless/helpless
- Core Problem
  - Suicidal – depression, rage, isolation
  - SI – body image, intense stress, inadequate self-soothing skills, peer influences

“I intended to kill something *in* me, this awful feeling like worms tunneling along my nerves. 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. The blade slipped easily, painlessly through my skin, like a hot knife through butter. 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.
(Kettlewell, 1999)

Biopsychosocial Model

- Environmental – abuse, chaos, neglect, invalidating environment
- Biological – genetic vulnerability to emotional dysregulation, limbic system dysfunction, serotonin level dysfunction, endogenous opioid system dysfunction, diminished pain sensitivity

Biopsychosocial Model

- Psychological
  - Cognitive – perfectionism, control, interpretation of events as aversive and/or disorganizing, self-blame, body dysmorphia
  - Affective – rage, shame, depression, fear, panic – all can trigger
- Behavioral – ritual of choosing location, tools, choice of self-care, telling others vs. concealing

Psychological models

- **Hostility Model**
  - Hostility is cathartic and brings relief from stress
  - Those who have an inability to overtly express anger and hostility are more likely to self-injure
  - Tension builds, they self-injure
  - Get relief from rising tension/anxiety
  - Direct anger on acceptable target - self

Psychological Models

- **Hostility Model, cont.**
  - Since anger not directed at source, it becomes internalized – plus no development of problem-solving skills
  - See self as "bad", worthy of punishment
  - Unexpressed hostility=increasing tension=anxiety

Other Contributing Factors

- Cutting can become habitual
  - Cutters can become preoccupied with their cutting behavior
- There is a culture of cutting
  - The “contagion factor”
  - Teens know friends who cut and want to try it to see what it is like
  - Friends talk to each other about what they tried

Warning Signs

- Wearing long sleeves/pants in summer
- Cuts that seem too symmetrical
- Finding collections of sharp objects in child’s room
- Friends are hurting themselves
- Blood stains on clothing
- Unusual arm bands or other camouflage
- Seek isolation when distressed

Initial Intervention/Triage (How to React)

- Don’t be judgmental
  - Remember, she was trapped
  - Had limited resources/support
  - Had limited coping mechanisms
- She chose a response
  - That relieved anxiety/tension
  - Gave her a sense of control
  - And may have activated her social or psychiatric support network

In other words, cutting is an attempt at…

Adaptive Behavior

Common Myths for Professionals

- Cutting is a suicide attempt
- They are just attention seeking
- Cutting is manipulative behavior
- They aren’t suicidal so the risk is low

Initial Therapeutic Response

- Avoid use of suicidal terminology
  - Not a gesture or attempt
  - It is a significant act but not manipulation-adaptive
- Use the student's terminology
  - Unless they significantly minimize
- Maintain a low-key dispassionate demeanor
  - Don't want to build secondary gain esp. if student is emotionally deprived

Initial Therapeutic Response

- Maintain a low-key dispassionate demeanor (cont.)
  - Don’t want an emotional response that causes shame/embarrassment
  - May reduce likelihood of open communication in future if show shock and recoil
- Maintain “Respectful Curiosity”
- Non-judgmental compassion
  - More neutral and accepting than concerned

What You Can Do

- Provide acceptance
- Make sure there is no immediate medical emergency
- Help the family maintain a balanced perspective
  - Parents are often very angry
  - Help family members take a break from the drama temporarily
- Make sure not suicidal

Suicide Assessment

- Do they feel they would be better off dead?
- Do they have wish to die?
- Do they have a plan for how to do it or just a fantasy they will die in their sleep?
- If there is a plan, is it reasonable/accessible?
- Is there a history of prior attempts?
- What has stopped them from trying?
- Recent suicides in family/community?

What You Can Do

- Do not require a “no self-injury” contract
- Help parents understand the likely gradual decline of cutting so they don’t expect immediate results
- Provide a safe zone in the school setting with unconditional access when the student needs a short break
- Refer
  - Psychologist
  - Psychiatrist
  - Inpatient if suicidal or not sure

What You Can Do

- Continue monitoring esp. prior to 1st appt.
- Work closely with outpt therapist to provide consistency across environments
- Contagion Management
  - Reduce communication about injury to peers
    - Explain it can cause harm
  - If they try to create chaos – discipline
  - Reduce visibility of scars – keep covered

What You Can Recommend

- Help them make a list of distraction techniques for future use
  - Call/text positive friend
  - Exercise
  - Journal
  - Music
  - Crafts
  - Walk outdoors

What You Can Recommend

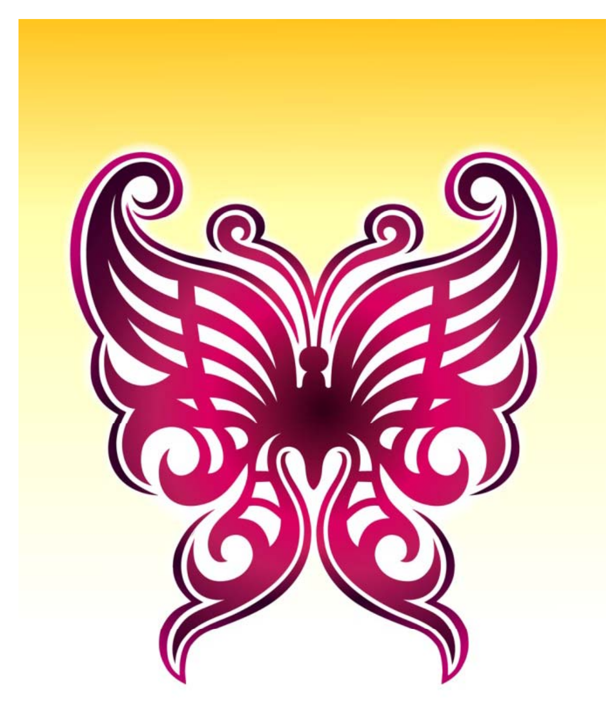
- Distraction cont:
  - Dance
  - Time with pets
  - Draw
  - Poetry
  - Scream into a pillow

What You Can Recommend

- Distraction cont:
  - Yoga
  - Relaxation/Breathing techniques
  - Daily list of “Three Good Things”
  - Watch a funny movie
  - Online games

What You Can Recommend

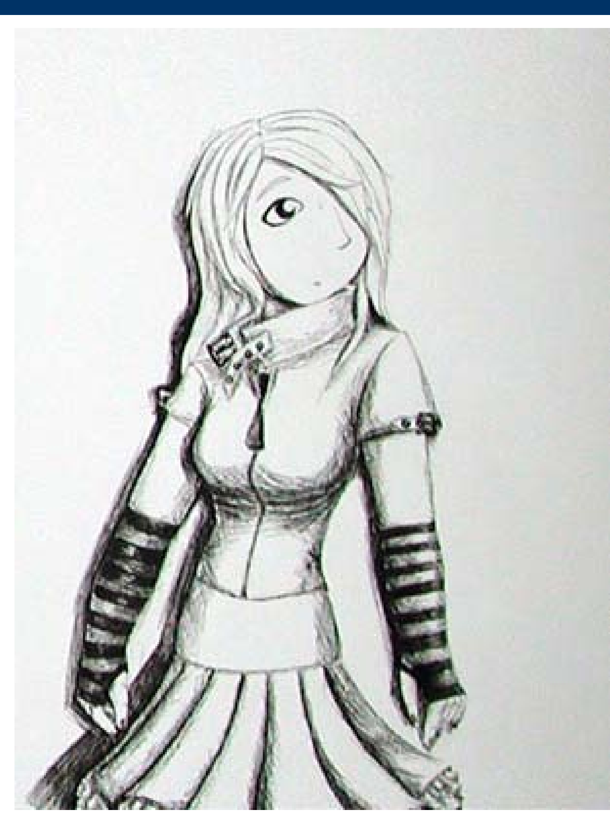
- Replacement Techniques
  - Butterfly Project
  - Writing on skin
  - Snap rubber band
  - Ice



Use of Medication

- Medications are commonly used but must be tailored to underlying dx
  - Antidepressants are common
  - If delusional, second generation antipsychotics (ex: Risperdal) may be helpful and have shown efficacy for SIB with MR/DD populations
- Meds will be of limited benefit in a negative and pathologically reinforcing environment
- Mood stabilizers are not typically first line of defense unless mood instability is a primary issue

What Happens After Referral



Treatment

- Contingency Management
- Replacement skills training
- Cognitive/Behavioral therapy
- Body Image work
- Pharmacotherapy
- Family therapy

Websites

- www.selfinjury.com
  - Links to admission for inpt in Illinois, emails and phone calls answered by prof.
- www.selfinjury.org
  - SI Bill of Rights

Websites

- Peer generated sites
  - For your own use (may be too many triggers to recommend to pts)
    - www.recoveryourlife.com
    - www.self-injury.net

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