SEEING RED
YOUTH SELF-INJURIOUS BEHAVIOR
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WORKING DEFINITION OF SELF-INJURY

“It is the deliberate mutilation of one’s own body, with the intent to cause injury or damage, but without intent to kill oneself. The self injurer typically experiences an overwhelming impulse to cut or burn, in conjunction with increase in tension. This is followed by psychic relief after the injury is completed.”

V.J. Turner, 2002
Secret Scars
WHAT WE WILL COVER TODAY:

1. Scope and Causes
   a. Signs and Symptoms
   b. Demographics of Self-Injuror
   c. Motivations
   d. Desired Outcomes

2. Three Categories of Self-Injury
WHAT WE WILL COVER TODAY:

3. Common Tools and Techniques
   a. Types of Injuries
   b. Methods of Injury
   c. Not So Common

4. First Point of Contact
   a. Medical Concerns
   b. First Encounter Dos-Don’ts

5. Guiding the Child and Family to Professionals

6. Diagnosing

7. Self-Injury as Chronic Addition

8. Treatment Options

9. Suicide and Self-Injury
SCOPE AND CAUSES

• Signs and Symptoms
  • 80% involves stabbing or cutting the skin with a sharp object (Mental Health Foundation, 2006)
  • Typically use areas of the body that are easily covered up.
  • Unable to explain injuries
  • Knows others who self harm
  • Exhibit mental health disorders frequently associated with self-injury.
World-map showing the **disability-adjusted life year**, which is a measure of each country's disease burden, for self-inflicted injuries per 100,000 inhabitants in 2004.

- less than 80
- 80–160
- 160–240
- 240–320
- 320–400
- 400–480
- 480–560
- 560–640
- 640–720
- 720–800
- 800–850
- more than 850

DEMOGRAPHICS AND CHARACTERISTICS

- Frequently suffer from a variety of psychiatric disorders trauma depression anxiety substance abuse and borderline personality disorder.
- Most frequently at 12-15 years of age (Klonsky E.D., 2007)
- Many have other compulsive disorders
- 41% are bullemics, 35% are anorexic (these acts can also release endorphins) (Briere J & E Gil, 1998)
- High instance of trauma, desire to alter affect (like cocaine) (Briere, 2000)
- Females tend to report more self-injury than males, but some studies dispute this claim (Affinity Healthcare 2008)
- Highest rates: Females 13-24 years old, Males 12-34 years old (WHO/Euro 1998)
- Frequently they have a difficult time expressing emotions or were simply refuse to do so
MOTIVATIONS – “WHAT’S IN IT FOR ME?”

Social Reinforcement, External
- To avoid being with people
- To get a reaction, even if it’s negative
- To let others see your pain
- To belong
- Helps to foster a sense of control

Autonomic, Internal
- To stop bad feelings
- To relieve feeling numb or empty
- To feel anything, even pain
- To punish yourself
- To feel relaxed (Natural opiate)

(Prevention Researcher, 2010)
I think my greatest fear is to be forgotten. A teacher I had last year doesn’t even remember my name — it makes me think that no one remembers me. How do I know I exist? At least I know I exist when I cut. (Self-injury message board post)
Guilt, shame and further emotional distress because they self-harmed

Temporary Relief

Relieve emotional distress by self-harming

Inability to cope with emotional distress

Emotional Distress
THREE CATEGORIES OF SELF-INJURERS

• Self-Injury as Culture
• Self-Injury as Situational Coping
• Self-Injury as Chronic Addiction
SELF-INJURY AS CULTURE
SELF-INJURY AS CULTURE

Contagion Factor

Social Re-Enforcer
SELF-INJURY AS CULTURE

justbabyscars
SELF-INJURY AS CULTURE
SELF-INJURY AS CULTURE

I CAN'T SLEEP CUZ MY PILLOW IS TOO WEI!
SELF-INJURY AS CULTURE
SELF-INJURY AS CULTURE
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SELF-INJURY AS CULTURE
SELF-INJURY AS SITUATIONAL COPING MECHANISM

May be used as a coping mechanism during a period or time in their lives but discontinued for a variety of reasons.

“Shame and embarrassment that go with this coping strategy often make people regret they use it and move on to more adaptive ways of dealing with severe stress.”

National Alliance on Mental Health, 2012
Addiction is a primary, progressive, chronic and potentially fatal disease caused by chemical changes in the brain. It changes the way a person thinks, feels, and acts. It makes recreational use impossible. The disease of addiction impacts those close to the addict.

Begins for one reason, continues for another
COMMON TOOLS AND TECHNIQUES OF SELF-INJURY

Figure 1: Preferred Methods of Self-Injury by Vote
COMMON TOOLS AND TECHNIQUES

- Cutting
- Scratch
- Friction Burns
- Use of Blade to Cut
- Burning with Lighter or Heated Object
- May have a cutter kit
- Chemical burns
IT’S NOT ALWAYS OBVIOUS

Look for other clues that they may be cutting.

Mental health characteristics common to those who self injure

ASK, ASK

LISTEN, LISTEN, LISTEN, LISTEN
FIRST POINT OF CONTACT

• Do approach in a calm, caring manner
• Do have non-judgmental compassion for their experience
• Do use student’s language for the self-injury
• Don’t show shock or revulsion (some injuries may be severe)
• Don’t show excessive interest in self-injurious behavior

(J. Tosta, M. A.; N. Heath, Ph. D)
ASSESSING LEVEL OF RISK

• Suicide Risk Assessment
  • Youth should be immediately considered as high risk if they show indications of:
    • Suicide intent
    • Suicide plan
    • History of personal attempt or family/friend suicide

• Injury Risk Assessment
  • Determine the level of severity of physical injury
  • Despite not meeting criteria for suicide risk, the level of severity of NSSI may indicate that the youth is at a higher risk for severe physical injury or death

• Assessment of Co-Occurring Conditions
  • Can be complex and require a lot of time and expertise, but presence of co-occurring conditions can increase severity
  • Screening measures can be helpful for related conditions
    • Anxiety and/or depression
    • Borderline Personality Disorder
    • Trauma or abuse
    • Eating Disorder
    • Substance abuse

DIAGNOSTIC ISSUES

Self Injury does not have a separate classification, and is typically associated with other diagnosis. These include:

- Depression
- Borderline Personality Disorder
- Post Traumatic Stress Disorder
- Eating Disorders
- Reactive Attachment Disorder
- Autism
- Obsessive Compulsive Disorder
TREATMENT

Psychological/Therapy

1. General - treat underlying concerns (trauma, depression) with the intent of resolving issues and reducing or eliminating the self-harm

   Psychotherapy

2. Specific - methods which focus on the self-harming behavior with goal of managing and replacing self-harm behaviors

   Cognitive Behavioral Therapy (CBT)
   Dialectical behavioral Therapy (DBT)

Medication

Not typically used to directly treat self-harming behaviors; may not be advised because they can mask the emotions which are maintaining the behaviors.

May be used to treat depressive symptoms.

Self-Injury Treatment Centers
NIKI’S DATA

Overall % of subjects who have engaged in self harm: 43%
- Male: 19%
- Female: 56%

Overall % of subjects who have engaged in self-harm w/history of suicide attempt: 58%
- Male: 25%
- Female: 64%

Overall % of subjects who have not engaged in self harm w/ history of suicide attempt: 5%
- Male: 10%
- Female: 3%
NIKI’S DATA (CONTINUED):
MOST FREQUENTLY OCCURRING DIAGNOSES BY GENDER

Males with Self Harm Behaviors

75%-Oppositional Defiant Disorder/Disruptive Behavior Disorder/Conduct Disorder
50%-Depression
50%-Post Traumatic Stress Disorder
50%-Attention Deficit/Hyperactivity Disorder

Females with Self Harm Behavior

86%-Depression
41%-Generalized Anxiety Disorder
23%-Post Traumatic Stress Disorder
WHAT IS THE RELATIONSHIP BETWEEN SELF-HARM BEHAVIOR AND SUICIDE?

-13% of adolescents engage in self-harm, with 10% of all adolescents attempting suicide. (1)

-Self-harm is one of the strongest predictors for eventual suicide in adolescence, increasing the risk by 10x. (2)

-Those who attempt suicide tend to utilize higher lethality methods such as self-poisoning, while those who self-harm without suicidal intent tend to use low-lethality methods such as self-cutting. (3)

-Up to 70% of adolescents who self-harm without suicidal intent also attempt suicide at some point. (4)