Understanding Adolescent Self-Injury

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on Self-Injury and Recovery
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LEARNING OBJECTIVES

Background	• Definition and taxonomy • Basic prevalence and function
Common presentation in adolescents	• Forms and locations • Risk factors
Comorbidity	• Comorbidity • Relationship to suicidality
Detection and intervention	• Detection • RAEER model • Common treatment
Resources	

NON-SUICIDAL SELF-INJURY (NSSI)

Deliberate, direct, and self-inflicted destruction of body tissue resulting in immediate tissue damage, for purposes not socially sanctioned and without suicidal intent.

NSSI IN CONTEXT: DIRECT AND INDIRECT SELF-HARM

Direct self-harm

- Suicide attempts
- Major self-injury (e.g. self-enucleation, autocastration)
- Atypical self-injury (mutilation of the face, eyes, breasts, genitals or multiple sutures)

Common forms of SI **Indirect self-harm**

- Substance abuse
- Eating disorders
- Unhealthy risk taking
- Use or misuse of prescription drugs
- Other

WHY WORRY ABOUT IT?

Harbinger of other more lethal conditions

- **Indicates underlying distress that may increase risk for suicide thoughts and behaviors and / or other chronic conditions**

It can cause unintended severe injury

It can lead to lasting disfiguration

It can be contagious

It is stressful for those who love and/or live with someone who uses it

BASICS

Lifetime NSSI estimates range from 7% – 25.6% (up to 65% in clinical populations). Recent review shows:

- 17.2% among adolescents
- 13.4% among young adults
- 5.5% among adults
  - 75-80% of all report NSSI is repeat (25% single incident)
  - An estimated 6-10% are current and repeat

Much more likely to report being bisexual or questioning

MOST COMMON SELF-INJURY BEHAVIORS (17%-50%)

- Severely scratching or pinching skin with fingernails or other objects
- Cutting wrists, arms, legs, torso or other areas of the body
- Banging or punching objects to the point of bruising or bleeding
- Punching or banging oneself to the point of bruising or bleeding
- Biting to the point that bleeding occurs or marks remain on skin

LESS COMMON SELF-INJURY BEHAVIORS (8%-12%)

- Ripping or tearing skin
- Pulling out hair, eyelashes, or eyebrows with the overt intention of hurting oneself
- Intentionally preventing wounds from healing
- Burning wrists, hands, arms, legs, torso or other areas of the body
- Rubbing glass into skin or stuck sharp objects such as needles, pins, and staples into the skin

MOST COMMON LOCATIONS

- Arms
- Wrist
- Hands
- Thighs
- Stomach
- Calves
- Ankle

DIFFERENCES IN SELF-INJURY BY GENDER

- Females are more likely than males to cut and scratch
- Males are more likely to punch themselves or objects with conscious self-injury intention
- Females are more likely to injure alone than males
- Males are more likely to injure in groups or to let others injure them as part of their ritual
- Females are much more likely to seek and receive mental health treatment

A FEW OTHER THINGS TO NOTE

About 20% of individuals who SI, report doing so more severely than intended	• Assess for experience with this • Discuss safety measures
Most (68%) report injuring in private but some do injure as part of group membership or ritual	• Assess extent of group engagement
Often episodic; periods of high or low activity	• Do not assume out of risk zone even if long lapse since last injury episode • Assess periodically
Can become habitual or “addictive” for about 1/3 of individuals – most common high prevalence users and those with forms considered high lethality.	• Assess degree of entrenchment and use harm reduction models as needed

PRIMARY RISK FACTORS

- History of trauma/abuse/neglect
- Individuals with history of emotion dysregulation or sensitivity (often Individuals high in emotion detection/generation but low in emotion regulation capacity)
- Tendency toward negative cognitive style and rumination
- Presence of other MH conditions, such as depression, anxiety and disordered eating.
- Low affective family environments
- Low self-compassion

see Jacobson & Gould, 2007 and Rodham & Hawton, 2008 for reviews of NSSI in adolescents; Heath, Toste, Nedecheva, & Charlebois, 2008

LINK TO OTHER CONDITIONS AND SUICIDE

COMORBIDITY

Associated in clinical samples with:

- PTSD
- Anxiety disorders
- Depression
- Disordered eating
- Obsessive-compulsive disorder
- Substance abuse

Moderate association with non-psychiatric risk behaviors

- Sexual risk taking
- Alcohol use
- Non-prescription medical drug use

Was added to the DSM V as a condition in need of additional research

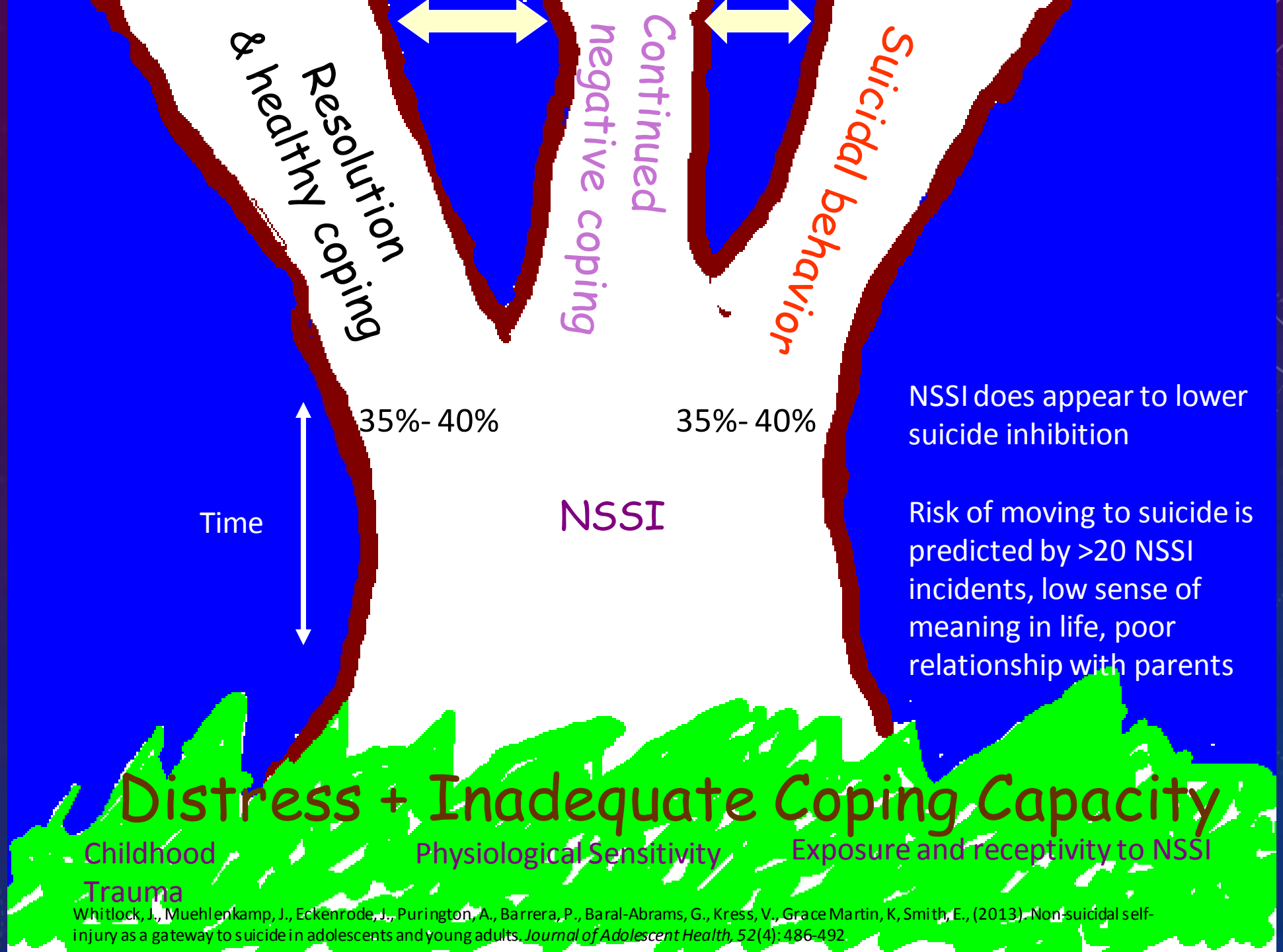
DOES SELF-INJURY LEAD TO SUICIDE?

No

Self-injury is a way of managing feelings

Self-injury is a risk factor for suicide so suicidal intent should be assessed

A history of self-injury can make it easier to actually take the steps of attempting or committing suicide if the individual begins to feel suicidal



Whitlock, J., Muehlenkamp, J., Eckenrode, J., Purington, A., Barrera, P., Baral-Abrams, G., Kress, V., Grace Martin, K, Smith, E., (2013). Non-suicidal self-injury as a gateway to suicide in adolescents and young adults. *Journal of Adolescent Health, 52*(4): 486-492.

WHY?

HOW DOES IT HELP?

Regulate negative affect or no affect (to deal with feelings)

Social communication / belonging

Self-punishment and deterrence

Sensation seeking

Self-distraction

REGULATE NEGATIVE AFFECT

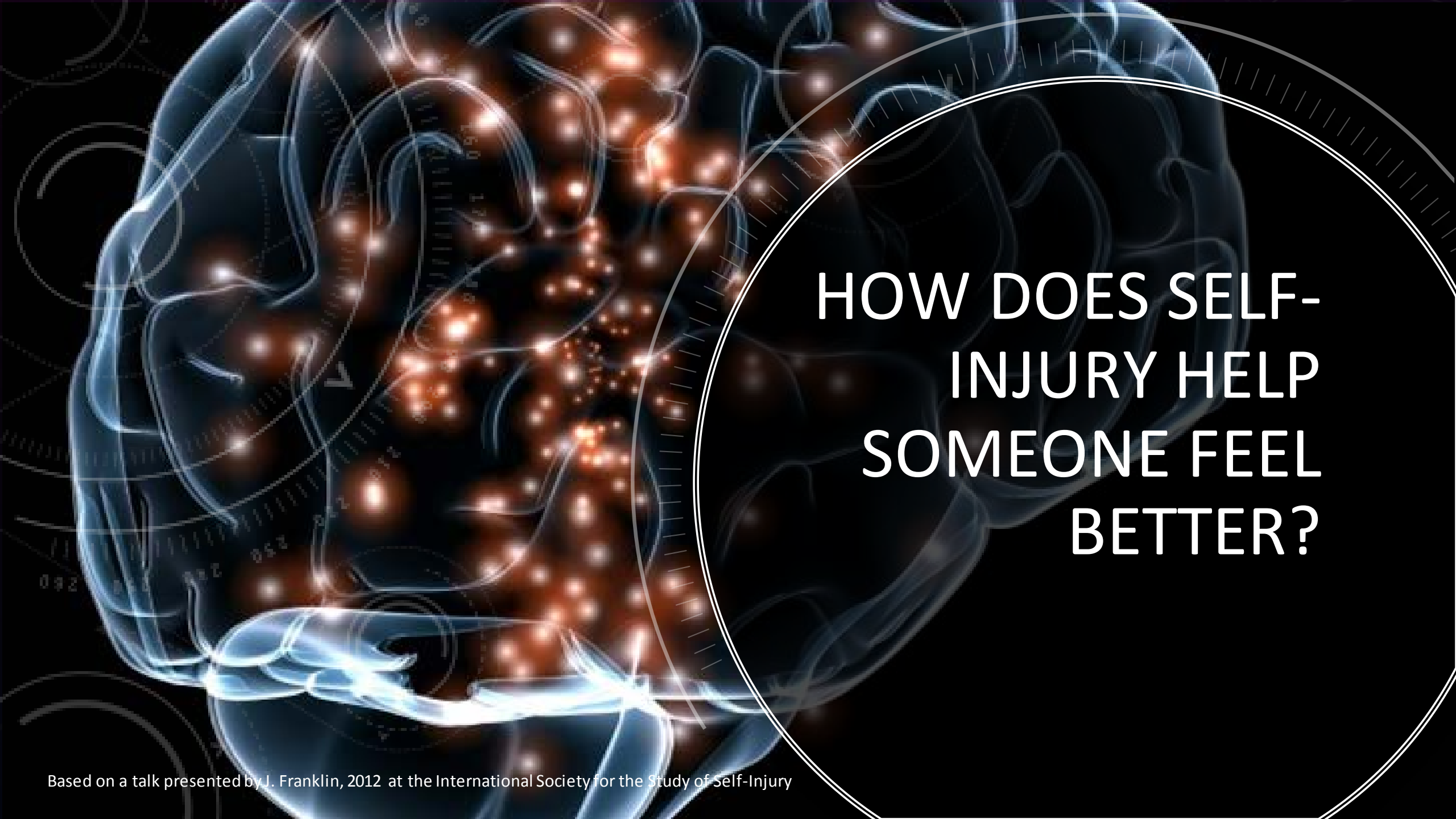
- To cope with uncomfortable feelings (50.8%)
- To relieve stress or pressure (43.2%)
- To deal with frustration (36.8%)
- To change emotion into something physical (35.6%)
- To deal with anger (24.8%)
- To help me cry (11.1%)
- To feel something (26.6%)

Social communication / belonging

- **In hopes that someone** will notice (18.3%)
- To shock or hurt someone (5.9%)
- Because my friends hurt themselves (2.5%)

Sensation seeking

- Uncontrollable urge (16.8%)
- Because it feels good (15.7%)
- To get a rush or surge of energy (11.2%)
- Because I like the way it looks (5.0%)



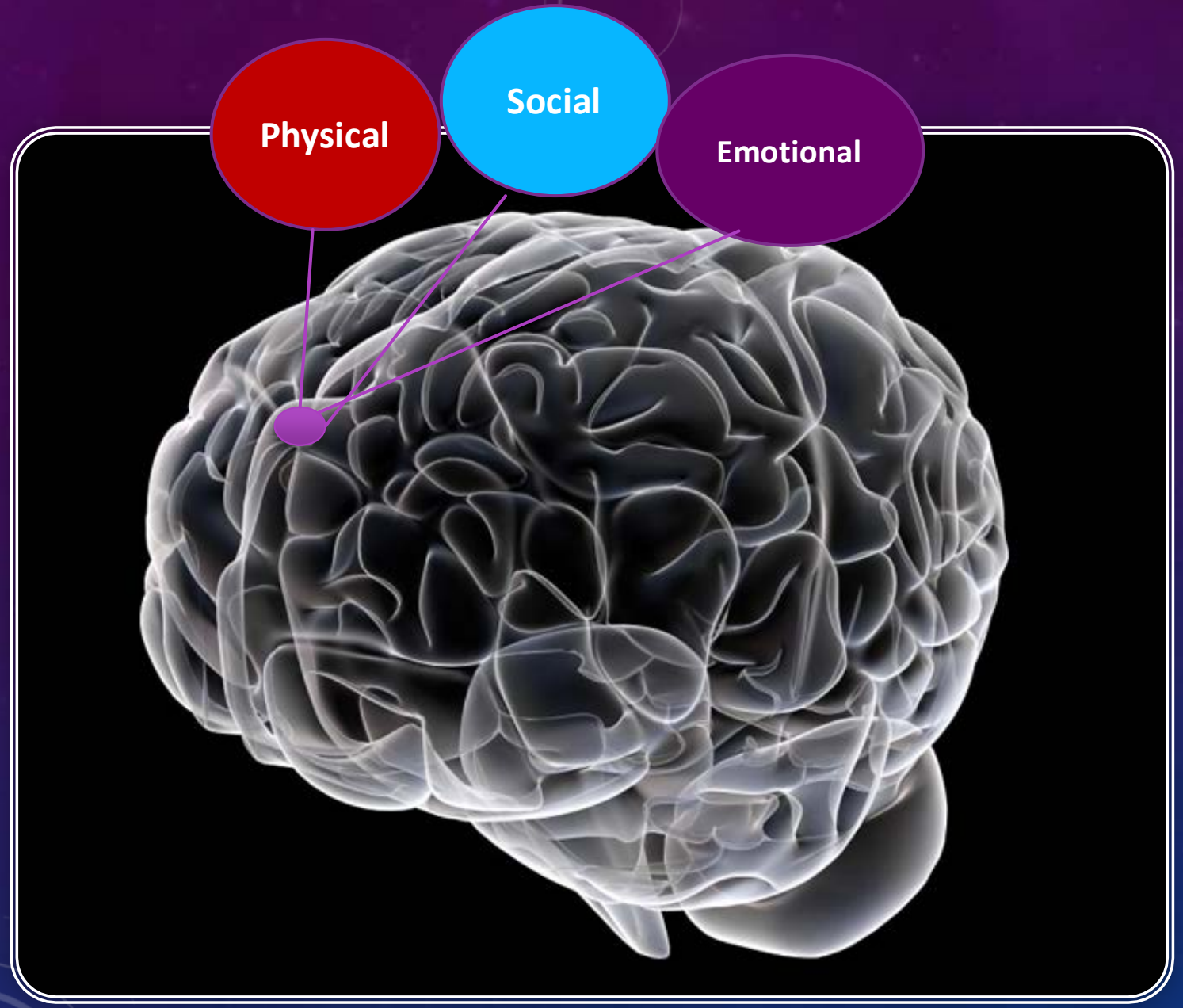
HOW DOES SELF-INJURY HELP SOMEONE FEEL BETTER?

Based on a talk presented by J. Franklin, 2012 at the International Society for the Study of Self-Injury

WHAT BIOLOGICAL AND NEUROLOGICAL STUDIES TELL US

Studies of the biological and neurological basis of self-injury show that people who self-injure possess:

- Higher physiological reactivity to emotional stimulus
- Difficulty down regulating negative emotions regardless of source / association
- Less physical pain perception when emotionally aroused



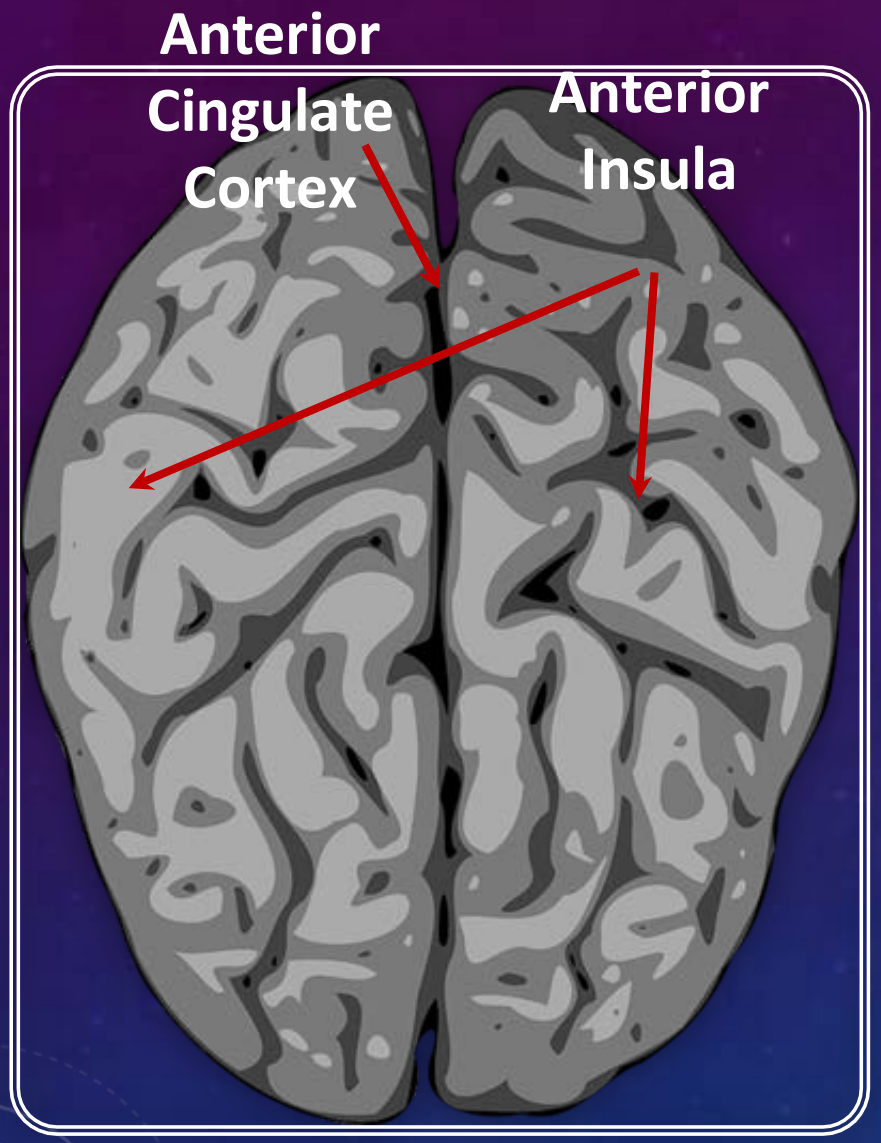
PAIN OFFSET

Neural Reuse Theory

- Neural circuits established for one purpose become redeployed during evolution to serve additional purposes

- One neural circuit can serve multiple functions and these can be very general (e.g., core affect

KEY BRAIN PLAYERS: ACC AN



- Process visceral information
- Strongly tied to affect
- Strongly implicated in the ‘affective component’ of pain

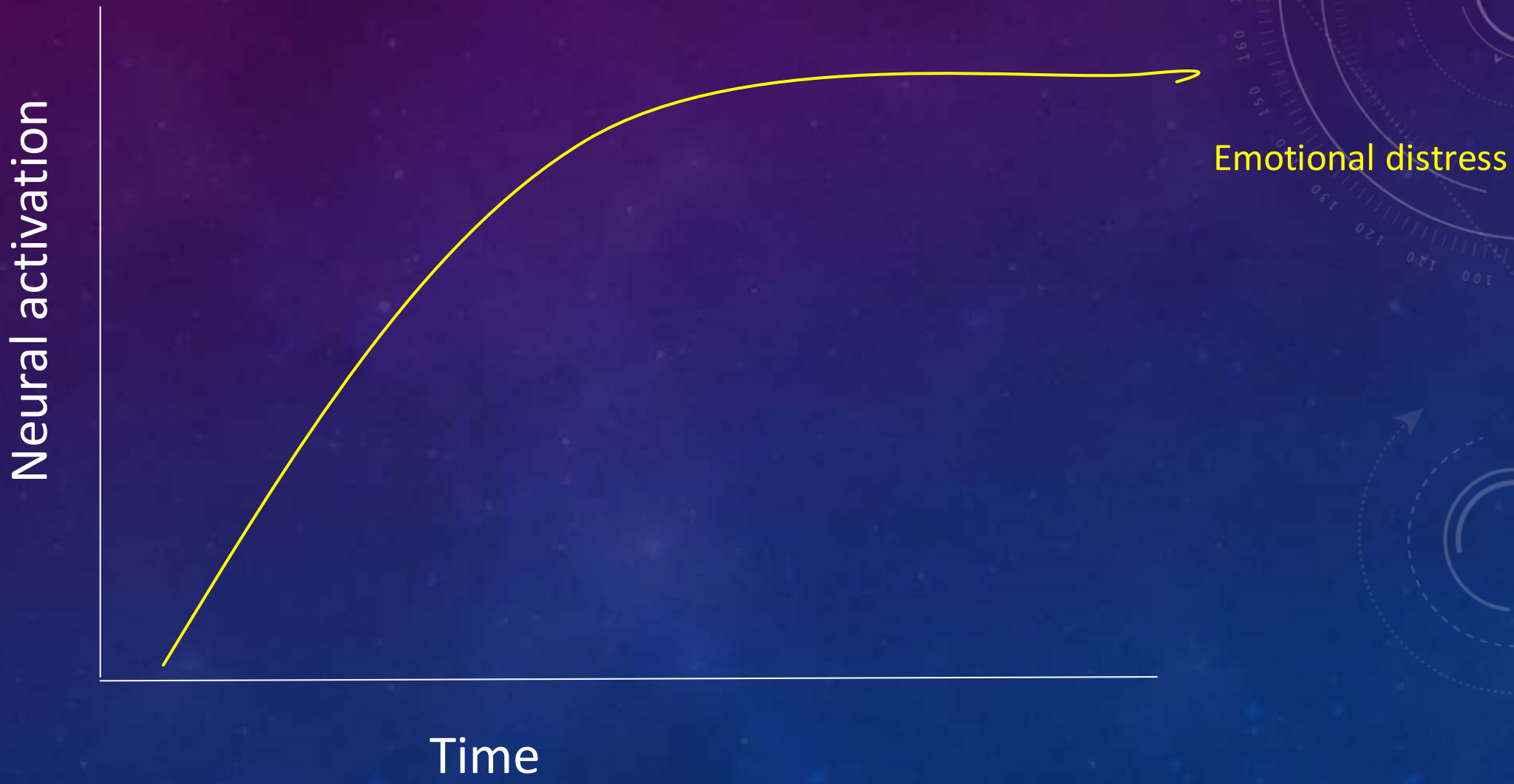
SOCIAL AND PHYSICAL PAIN OVERLAP

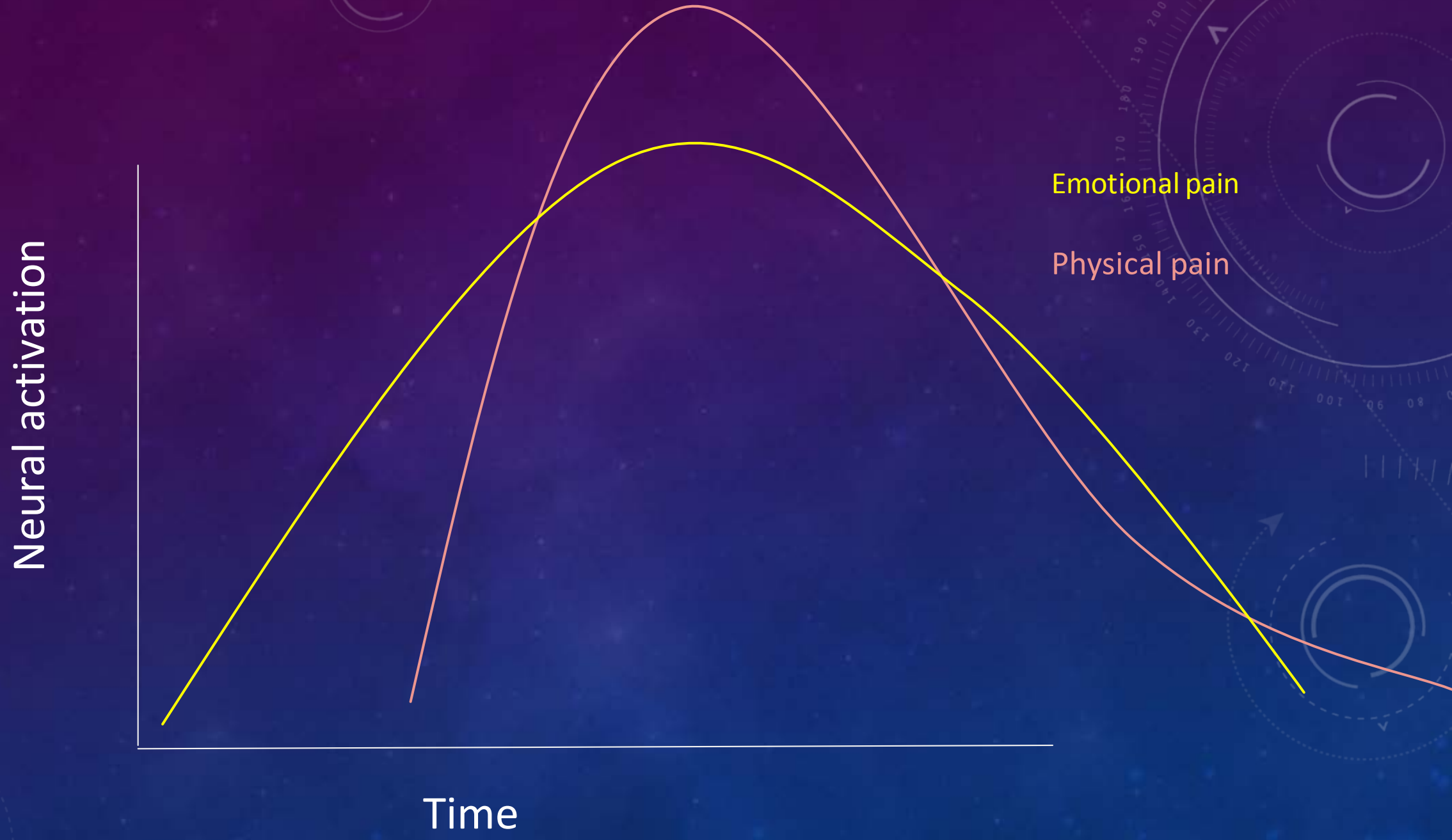
ACC/AI are pain perception areas and targeted for pain reduction by some medications (e.g. Tylenol)

Targeting these areas also leads to decreases in perceived social / emotional pain (DeWall et al., 2010)

Leads to some odd interpretations and brain tricks

Holding a cup of warm coffee while meeting someone new tends to increase likelihood of describing that person as “warm”
(Bargh et al., 2010)


Neural activation
Emotional distress
Time


Neural activation
Time
Emotional pain
Physical pain

TAKE AWAYS

- **Pain onset.**When a knife, flame, or similar stimulus hits the skin, it causes pain
- **Pain offset (or removal/reduction).** Once pain source is removed or even reduced slightly, the sufferer feels *much* better. This is can lead to a very pleasant feeling often labeled “relief.”
- **Emotional and physical pain perception are yoked**. Physical and emotional pain are processed in the same part of the brain. When one decreases so does the other .

Small Decrease in Pain Intensity

Powerful Decrease in Pain Perception

Reduced negative feelings and enhanced positive feelings

CONTAGION

SELF-INJURY CAN BE CONTAGIOUS AMONG YOUNG PEOPLE

It is particularly contagious in institutional settings and schools

Young people who have a lot of emotional ups and downs or who struggle with other mental health challenges are at higher than average risk of adopting the practice via contagion

HANDLING CONTAGION WITHIN THE ORGANIZATION

1

Limit overt discussion and display of fresh wounds

2

Focus group sessions on underlying feelings and other ways of handling feelings rather than self-injury or the particular reasons someone injures

3

Identify and engage the individual(s) at the "epicentre" as partners in not spreading the behaviour, if possible

INTERVENTION AND TREATMENT

COMMON TREATMENT APPROACHES

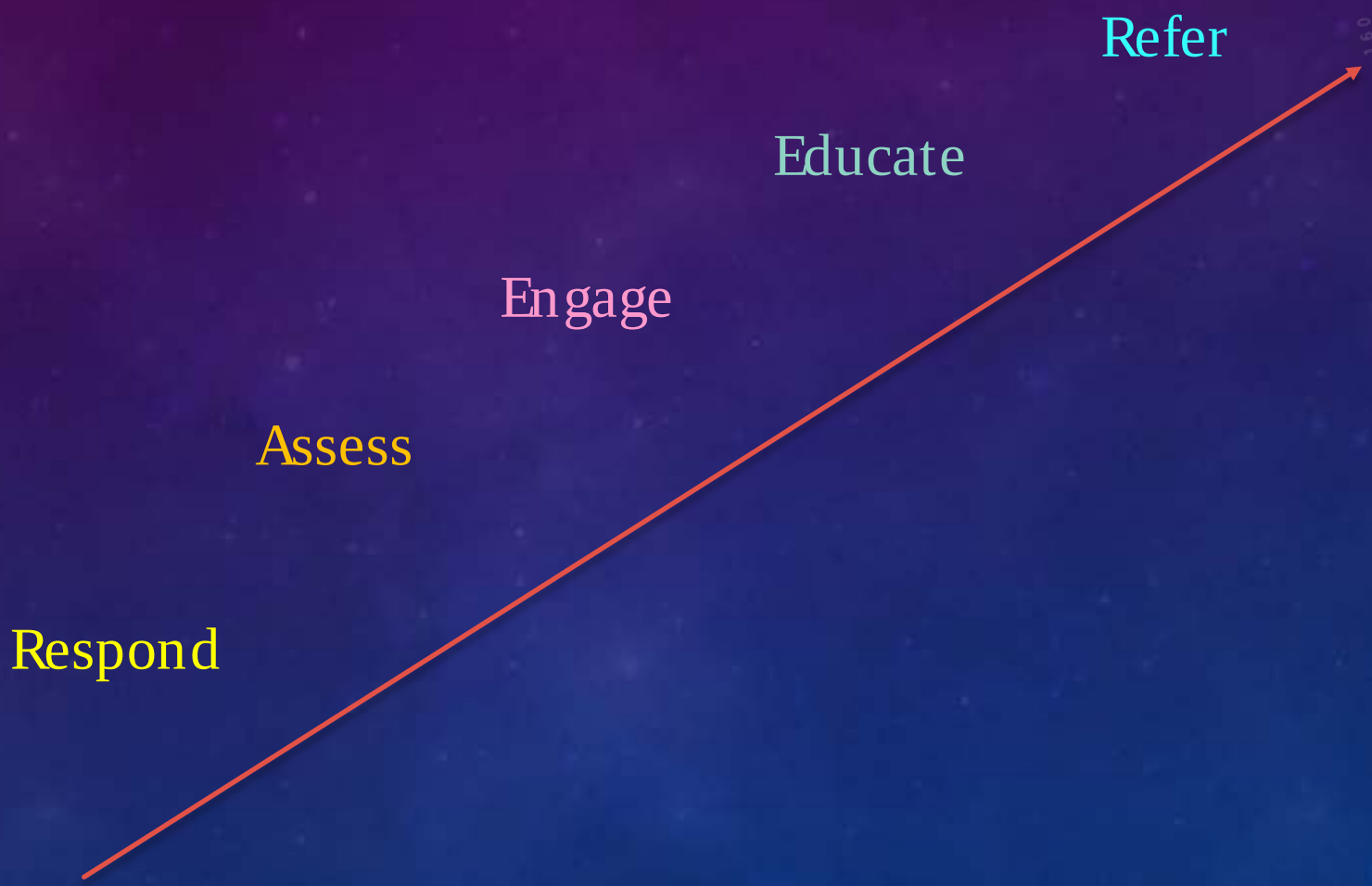
Treatment modality	Focus / components
Brief intervention	Information, practical advice
Interpersonal psychotherapy	Targets interpersonal and family problems
Problem solving therapy	Promotes positive and rational problem solving
Dialectical behavioral therapy	Focus on mindfulness, present centered awareness, self-awareness
Cognitive behavioral therapy	Focus on surfacing core beliefs & questioning
Family therapy / systems therapy	Systems approach to understanding and intervening in family dynamics
Collaborative therapy / Illness management and recovery model	Consumer focused goals, strength based, Engagement of social ecology

CORE COMPONENTS

Emotion literacy, acceptance and regulati

- Working with negative cognition and self-regard
- Low aversion to pain, blood
- Tolerating distress / adversity
- Present moment awareness
- Increase coping repertoires
- Engages social ecology and contexts
- Skill practice in untriggered environment

BASIC INTERVENTION MODEL: RAEER



RESPOND

Respond non-judgmentally, immediately and directly

Remain calm and dispassionate

Use “respectful curiosity”

- ✓ How does self-injury help you?
- ✓ Who do you feel comfortable talking to about what you are feeling?

Be clear about what has to happen next and provide choices when possible

“Sarah, I noticed the cuts on your arms just now. It looks like you may be cutting. Usually people do this to feel better when they have feelings they do not want or like. Is this what is happening for you?”

~

“I understand that it may be hard for you to share your feelings, this can be a hard thing to talk about. How about if you and I go talk to the guidance counselor together about what you are feeling? I am sure we can come up with some good ways to help.”

RESPECTFUL CURIOSITY

"It seems like you may be having strong feelings right now. Can you help me understand what feelings you are having or what is stressing you out right now?"

"Can you help me understand how does self-injury help you feel better?"

"Can you help me understand what kinds of things trigger a desire to hurt yourself?"

"When you resist the temptation to hurt yourself, what do you tell yourself or do that works?"

KEY ELEMENTS

Focus on the feelings rather than the behavior

Remain calm and dispassionate

Use “respectful curiosity

- ✓ How does self-injury help you?
- ✓ Who do you feel comfortable talking to about what you are feeling?

Be clear about what has to happen next and provide choices when possible

ASSESS

- Environmental
  - Past and present context
  - Trauma history
- Biological
  - Serotonin or endogenous opioid level dysfunction?
- Cognitive
  - Interpretation bias, flashbacks
- Affective
  - Preference for negative emotion
  - Aversion to positive emotion
- Behavioral
  - Identification with tools or rituals
  - Body as canvas behaviors

ENGAGE

Point people on staff or in the community with expertise or knowledge in this area

The person who injures and supportive peers – directly address the issue and contagion

Family – determine whether NSSI is frequent or high lethality quality or if protocol warrants parental notification.

EDUCATE

Staff

Parents if indicated

Individual who self-injures

- Managing unintended damage
- Resources for understanding why he/she injures and how to manage / stop (do not assume they know)
- Importance of treatment in stopping (in moderate to high severity cases)

REFER

TO LOCAL TREATMENT SPECIALISTS

RESOURCES

CRPSIR Website:
www.selfinjury.bctr.cornell.edu
Written Materials
Protocol
Assessment Tools
Web-Based Training


Q
A

Thank You
For Joining Us!

Family Engagement in Substance Use Disorder Services
Tuesday, July 31st 1pm-2pm

From ACEs to Assets: Supporting the Growth of Resilience to Improve Education, Health, and Wellness Outcomes
Wednesday, August 1st 12pm-1pm