

SELF-INJURY: THE WHY, HOW, AND WHEN YOUNG PEOPLE HURT THEMSELVES, AND WHAT WE CAN DO.

By Garry King

Acknowledgements

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Disclaimer

The diagnosis and treatment of mental illness requires a trained, qualified mental health professional. Information contained in this presentation is intended for educational purposes only and not to be used as a diagnosis or assessment tool.

It should not used as a substitute for professional diagnosis and treatment of any mental illness.

Categories

- 1) Stereotypic NSSI – driven, fixed and countless acts. Linked to persons with a developmental disability, and other biological disorders.
- 2) Major NSSI – major, infrequent acts resulting in significant tissue damage (castration, amputation, etc). Linked to psychosis.
- 3) **Moderate / superficial NSSI – repetitive, episodic acts – low lethality and slight tissue damage.** (Favazza, 1996).

What it's not

- This means that tattoos and body piercings are not included in these definitions. Nor are cultural or religious practices such as sorry cuts among some Indigenous communities in Australia or flagellants practice of self whipping amongst some Catholics in the Philippines.

NSSI & Suicidal Behaviour

- It is distinct from suicide as the “intent” and “motivation” is different. However, it is also a risk factor for suicidal behaviour (Brausch & Gutierrez, 2010).
- NSSI as a risk factor of suicidal behaviour – longer history of NSSI; more methods; absence of pain while NSSI. (Goldstein & Poling 2012 STAR Conference USA)
- The longer a person engages in NSSI, and the more methods used, the more likely they are to attempt suicide (Hollander, 2008).

Differences in NSSI & Suicide

	Self Injury	Suicide
Intention - includes both motivation and intent	To relieve overwhelming emotional pain	To end unbearable pain; to die
Method	Usually non-lethal	Lethal or thought to be
Potential to be fatal	Unlikely; perceived to be non-fatal	Highly likely or perceived to be
Frequency	Frequent - daily to monthly. Repeated over time.	Likely to be single or occasional attempt.
	Anxiety / panic may trigger	Depression may trigger

- Typical Pattern of NSSI.
- Onset in late adolescence (getting earlier)
 - Multiple recurrent episodes
 - Low lethality
 - Harm deliberately inflicted upon body.
 - Distinguished from suicide based on the absence of the apparent intent to kill oneself.
- (Varma 2011)

- Summary of Factors that May Elevate Risk of Suicide
- Childhood sexual abuse (Chapman, Gratz, & Turner, 2014)
 - Use of dangerous Self Injury methods
 - Severe Self Injury
 - History of alcohol use, alongside current depression (Jenkins, Singer, Conner, Calhoun, & Diamond, 2014)
 - For adolescents, peer victimization (Heilbron & Prinstein, 2010)

Are they attention seeking?

- It is often hidden and secretive (challenges the “they just want attention” thinking). Generally go to great lengths to hide what they have been doing.
- They will often wear clothes that cover their wounds.
- Estimates are 1 in 3 tell anyone.

- Only 4% self injure for attention (Hollander, 2008)

- The words Attention Seeking need to be replaced with Attention Needing.

Examples of NSSI

- Cutting (the most common method) (Klonsky et al., 2011)
– often using razor blades through to the blade off their pencil sharpener. Common injury sites: arms, hands, wrists, thighs, stomach, calves, head, and fingers (Whitlock et al., 2006)
- Burning – burning of the skin, often with lighters
- Poisoning – Paracetamol is the most commonly used drug (Sood et al, 2013).

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Summary of Factors that May Elevate Risk of Suicide

- Use of websites that encourage Self Injury (Mitchell et al., 2014; see Lewis et al., 2012)
- Hopelessness (Chapman, Gratz, Turner, 2014)
- Critical self-talk (Gilbert et al., 2010)
- Distorted self-image (Kerr & Muehlenkamp, 2010)
- Repeated Self Injury (Kakhnovets et al., 2010)

Why

“Findings support the view that self-harm is a maladaptive coping strategy.....”
(Lewis & Santor, 2010).

Why

- To humanize
- To communicate
- Experimentation and curiosity

Prevalence

- Most research indicates a figure of 10% - 20% of young people having self-injured at some stage.
- Lifetime prevalence rates are 17% of females and 12% of males aged 15 to 19 years
- (Martin & Swannell, 2010).

U.S.A. Statistics

- 14 – 39% of community adolescent samples.
 - 40 – 60% of adolescent psychiatric samples.
- (Goldstein & Poling, 2012)

Number of Episodes

- 1 episode – 29%
 - 1 - 3 episodes – 33%
 - 3 + episodes – 38%
- (Nixon, Jansson & Cloutier, 2008)

In Australia, Lawrence found "Of those adolescents that had self-harmed in the previous 12 months, 61.6% had self-harmed more than four times at any time in the past" (Lawrence et al, 2015).

Risk Factors

- Emotional neglect and / or abuse
- Physical and / or sexual abuse
- Neglect
- Family violence
- Intense negative emotions such as anger, loneliness and fear
- Comorbid psychological disorders
- Low self-esteem; self-derogation
- Exposure to peer NSSI models
- Poor communication or social skills

(Juhnke, Granello & Granello 2011)

Protective Factors

- Appropriate expression of negative emotions
- Supportive parents
- Positive social network support
- Access to mental health services
- Positive adult role models
- Parental engagement in the treatment of young people who NSSI
- Participation in healthy social outlets (clubs, sports)

(Juhnke, Granello & Granello 2011)

Signs – What to look for.

- Frequent injuries with suspicious explanations
- Inappropriate clothing – jumpers in summer
- Excessive bangles, wristbands, etc
- Low emotion regulation
- Extreme sensitivity to rejection
- Self defeating
- Relationship problems
- Avoiding sports

Signs – What to look for.

- Excessive risk taking
- Discovery of implements – broken razors, etc
- Blood on clothing, towels or tissues
- Using first aid kits
- Increased time with NSSI peers
- Itchy under clothes (healing)
- Withdrawing from activities they previously enjoyed
- Increased time alone

Those most at risk.

- 1) A quick reaction
- 2) A very big reaction – impends cognitive processing
- 3) Long lasting reactions
- 4) Sensitive to rejection and aloneness.

Distraction Techniques

- Counting to 10 backwards (preferably in another language)
- “Thought stopping”
- Breathing Exercises
- Journaling

Distraction Techniques

- Drawing
- Using Ice
- Using Rubber Bands
- Red Marker Pens

(American Academy of Child & Adolescent Psychiatry).

Medications

- There are no pharmacological interventions specifically for self injury rather they are targeted to depression and anxiety which often co-exist with it. Anti-depressants, mood stabilizers and anti-anxiety medications are the most common (Nock, 2010).

Therapy

At present, there are no evidence-based counseling or therapy approaches that have consistently proven efficacious in the treatment of self-injury, although various cognitive and behavioral treatment approaches have demonstrated promise.

Therapy

Established treatment approaches for self-injury include:-

- Cognitive Behavioural Therapy (CBT),
- Dialectical Behavior Therapy (DBT),
- Motivational Interviewing,
- Family therapy,
- Functional assessment and matching of coping skills, and Play
- and Expressive therapy.

Therapy

- Problem Solving Therapy (PST)
- Interpersonal Therapy (IPT)

Recovered Memory Therapy is NOT recommended.

(The Royal Australian and New Zealand College of Psychiatrists, August 2009)

Soothing

- Vision
- Hearing
- Smell
- Taste
- Touch
- Exercise

(Adapted from Linehan, 1993 & 2014).

Online Search

- In 2013 there were 42,000,000 global Google searches for NSSI, Self-Harm, Self-Injury, etc.
- A research study was undertaken on those websites most utilised by young people. They required a minimum of 1,000 hits per month.

Online Search

- Only 9.6% of websites were endorsed by health or academic institutions.
- 73.7% reinforced at least one common myth about NSSI.
- 8% maintained that NSSI is an attention seeking act.

(Lewis, Mahdy, Michal & Arbuthnott, 2014)

Limiting Contagion

- Work with the young person to limit their communication about the behaviour with others.
- Ensure teachers do not comment on any individual's NSSI behaviour in front of other students.
- Refrain from group treatment for support group interventions for NSSI young people.
- Developing school policies on the use of Facebook and other social media.

(Juhnke, Granello & Granello, 2011)

What can I do!!!! - Teachers

- If necessary get medical help.
- Report the matter to Deputy Principal \ Guidance Counsellor.
- Have first-aid supplies on hand – Admin Office.
- Encourage the young person to seek help as the urge increases.
- Get the young person to utilise strategies learned in counselling.
- Teach social skills.
- Comply with school NSSI policy.

Prevention Strategies

- Recognise and respond. Early intervention is vital.
- Enhance social connectedness of those most at risk.
- Enhance young person's capacity to cope with and regulate emotions and impulses.
- Offer parent / family training programs on identification and appropriate responses.
- Enhance communication skills and strategies eg crapometer; chill cards.

- Teach critical thinking, decision making and coping skills.
- Avoid strategies aimed primarily at raising knowledge of forms and practices. (Single-shot awareness-raising strategies may increase the behaviour they are trying to stop).
- Promote help-seeking behaviours.

(Cornell University Research Program, 2010)

Resilience

- Research suggests that continuity of self harming behaviour is linked to the individual's level of resilience. This has important preventative and clinical implications.

(Rotolone & Martin, 2012)

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