NEW DEVELOPMENTS IN UNDERSTANDING AND TREATING SELF-INJURY

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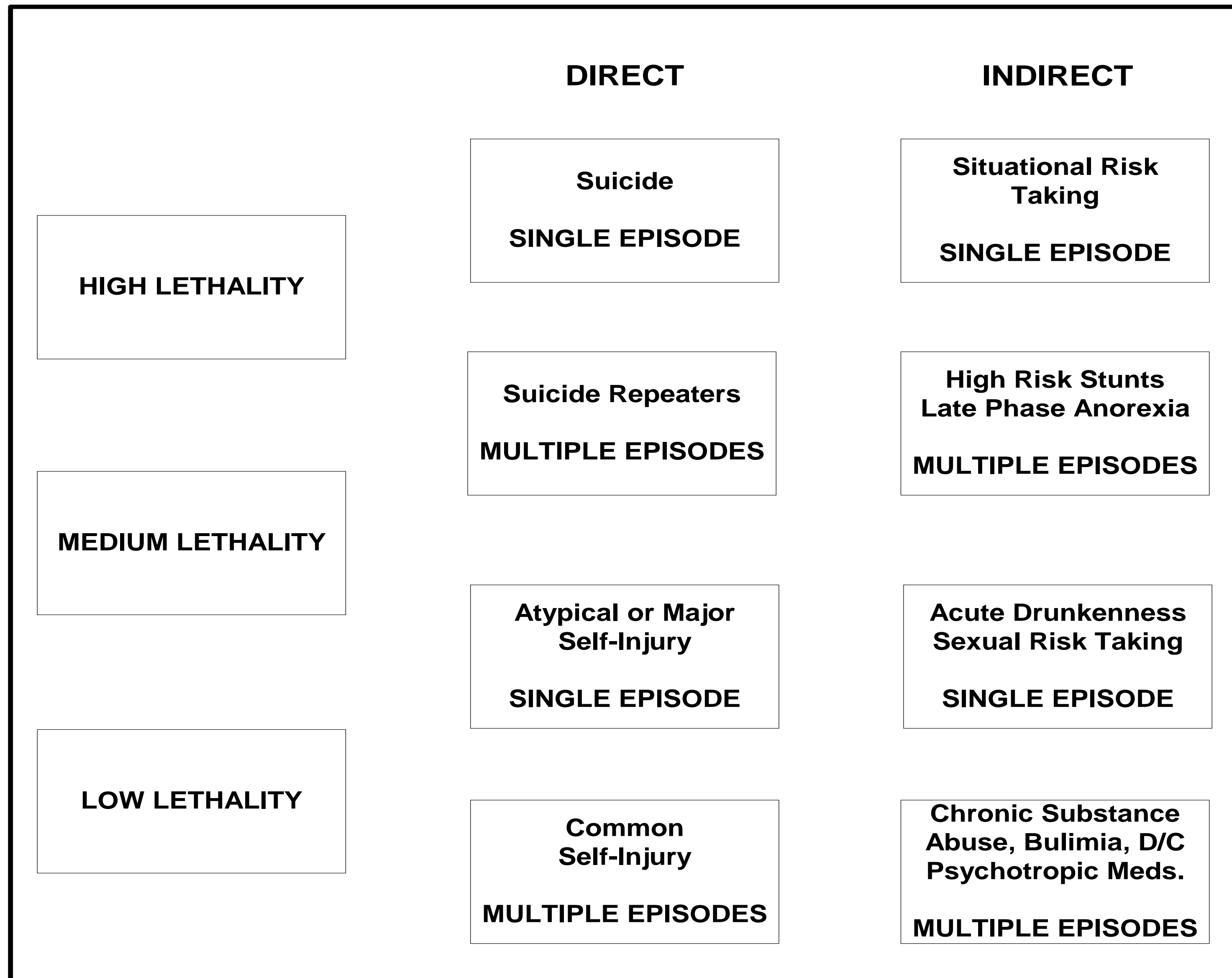
DIFFERENTIAL CLASSIFICATION OF SELF-DAMAGING BEHAVIOR



Modified, Pattison & Kahan [1983]

Checklist for Direct and Indirect Self-Harm Behaviors

Check those which the client reports having done at any time

DIRECT SELF-HARM

— Suicide attempts (e.g. overdose, hanging, jumping from a height, use of a gun)

— Major self-mutilation (e.g. self-enucleation, autocastration)

— Self-mutilation (e.g. mutilation of the face, eyes, genitals, breasts, or damage involving multiple sutures)

— Common forms of self-injury (e.g. wrist, arm and leg cutting, self-burning, self-hitting, excoration)

INDIRECT SELF-HARM

Substance abuse

— alcohol abuse

— marijuana use

— cocaine use

— inhalant use (e.g. glue, gasoline)

— hallucinogen, ecstasy, etc.

— IV drug use

Eating disordered behavior

— anorexia nervosa

— bulimia

— obesity

— other; specify:

— Physical risk taking (e.g. getting into a car with strangers, walking alone in a dangerous area)

— Sexual risk taking (e.g. having sex with strangers, unprotected anal sex)

— Unauthorized discontinuance of psychotropic medications

— Misuse/Abuse of prescribed psychotropic medications

— Other form of indirect self-harm; specify:

Differentiating Suicide Attempts From Self-Injurious Behavior

Assessment Focus	Suicide Attempt (Shneidman)	Self-Injury (Walsh)
1. What was the expressed and unexpressed intent of the act?	•To escape pain; terminate consciousness	•Relief from unpleasant affect (tension, anger, emptiness, deadness)
2. What was the level of physical damage and potential lethality?	•Serious physical damage Lethal means of self-injury	•Little physical damage; Non-lethal means used
3. Is there a chronic, repetitive pattern of self-injurious acts?	•Rarely a chronic repetition Some overdose repeatedly;	•Frequently a chronic, high rate pattern
4. Have multiple methods of self-injury been used over time?	•Usually one method	•Usually more than one method over time
5. What is the level of psychological pain?	•Unendurable, persistent,	•Uncomfortable, intermittent
6. Is there constriction of cognition?	•Extreme constriction; suicide as the only way out; tunnel vision; seeking a final solution	•Little or no constriction; choices available; seeking a temporary solution
7. Do they feel hopeless and helpless?	•Hopelessness and helplessness are central to their dilemma	•Periods of optimism and some sense of control over their own situations
8. Was there a decrease in discomfort following the act?	•No immediate improvement; treatment required for improvement	•Rapid improvement; rapid return to usual cognition and affect; successful “alteration of consciousness”
9. What is the core problem?	•Depression, rage about their inescapable, unendurable pain	•Body alienation; exceptionally poor body image for clinical populations

The Increased Prevalence of Self-Injury in the United States

Prevalence Estimates:

- Early 1980's — 400 per 100,000 in population (Pattison & Kahan, 1983)
- Late 1980's — 750 per 100,000 in population (Favazza, 1988)
- Late 1990's —1000 per 100,000 in population (Favazza, 1998)
- Mid 2000's — An estimated 150,000 to 360,000 adolescents in the U.S. self-injure (National Association of Secondary School Principals, 2004). Also data from the 2003 Massachusetts YRBS indicated that 18% of high school students in Massachusetts reported having self-injured during the past year.

The Increased Prevalence of Self-Injury in the United States

Groups in Which Self-Injury Was Commonly Reported (1960-1990)

- Outpatients with serious emotional disturbance or mental illness
- Persons representing at psychiatric emergency rooms
- Seriously and persistently mentally ill persons in day treatment or partial hospitalization programs.
- Seriously and persistently mentally ill adults living in community-based residential or supported housing programs
- Patients in short and long-term psychiatric units
- Youth in special education schools or residential programs
- Prison inmates

Note: These groups, of course, are not mutually exclusive. For example, individuals can be discharged from hospitals or prisons and become clients in residential or outpatient settings, or vice versa.

The Increased Prevalence of Self-Injury in the United States

New Groups in Which Self-Injury is Now Commonly Occurring (1990's to Present

- Youth in middle and high schools serving regular education students
- Young adults enrolled in colleges and universities
- Adults in the community at large

Some Speculations Regarding the Increased Prevalence of Self-Injury

I. Socio-Cultural Influences

- School and work environments are fraught with high stress.
- Multi-tasking life styles are conducive to persistent low-level stress and anxiety.
- Heavy emphasis on competition in schools and the workplace is conducive to isolation and distrust.
- Youth enter into intimate relationships at an earlier age, resulting in a level of emotional intensity for which they may not be prepared.
- The media heavily market a reliance on over-the-counter and prescription medications to alter mood, achieve desired feeling states, induce sleep etc.
- Modification of consciousness in viewed as something that can be quickly and affordably achieved via use of alcohol or street drugs.
- Families, schools, and peers rarely teach healthy self-soothing skills

Some Speculations Regarding the Increased Prevalence of Self-Injury

II. Direct Modeling Influences in the Media

- Popular television shows and movies portray self-injurers (e.g. *Girl Interrupted, Thirteen*)
- Music videos have frequently portrayed self-injurious acts
- People prominent in the media have reported self-injuring (e.g. Angelina Jolie, Princess Diana)
- Most television talk shows have featured self-injury as a topic
- Many chat rooms are dedicated to the topic of self-injury
- Many websites focus on self-injury. All too many provide extensive examples of poetry, artwork, and even photographs describing or depicting self-injurious acts, wounds, or scars

Some Speculations Regarding the Increased Prevalence of Self-Injury

III. Adolescent Peer Group Dimensions

- Adolescents routinely experience powerful emotions and lack the coping skills to manage them.
- Adolescent peer groups view extensive substance use as a normative rite of passage.
- Substance use often begins at early ages, in middle and even grammar school.
- Adolescents place high value on being viewed as “outrageous outsiders” by peers and adults.
- Peer group cohesion is enhanced by behaviors that adults condemn or fear.
- Youth are action-oriented. Self-injury is dramatic, visible, and produces immediate results. Adolescents are desensitized to self-injury because of peer group’s endorsement of body piercing, tattoos, brandings, and scarifications. Self-injury is viewed as “not much different” from these popular forms of body art or modification.

Some Speculations Regarding the Increased Prevalence of Self-Injury

IV. Internal Psychological Elements

- Self-injury works; it (temporarily) reduces tension and restores a sense of psychological equilibrium.
- Self-injury has powerful communication aspects.
- Self-injury provides a sense of control and empowerment

Eight Levels of Care in the Treatment of Self-Injury

Definition: "Self-Injury is intentional, non-life-threatening, self-effected bodily harm or disfigurement of a socially unacceptable nature, performed to reduce psychological distress."- (Walsh, 2005)

I. The Informal Response

- The Importance of Language
- Interpersonal Demeanor

Eight Levels of Care in the Treatment of Self-Injury

II. Crisis Intervention

- Level of Physical Damage
- Bodily Location

III. Behavioral Assessment/Contingency Management

- Environmental, Cognitive, Affective and Behavioral Concomitants
- Managing Reinforcers and Aversive Consequences

Eight Levels of Care in the Treatment of Self-Injury

IV. Replacement Skills Training

- Negative Replacement Behaviors
- Mindful Breathing
- Visualization
- Physical Exercise
- Writing
- Artistic Expression
- Playing or Listening to Music
- Communicating With Others
- Diversion Techniques

Eight Levels of Care in the Treatment of Self-Injury

V. Cognitive Treatment

- Identifying Triggers and Using Them to Practice Replacement Skills
- Identifying Automatic Thoughts, Intermediate Beliefs, and Core Beliefs that Support Self-Injury
- Replacing Negative Cognitions with Adaptive Thoughts and Beliefs
- The Key Role of Body Image

Eight Levels of Care in the Treatment of Self-Injury

VI. Exposure Treatment for Resolution of Trauma

- The Link Between Sexual Abuse, Body Alienation, and Recurrent Self-Injury
- Resolving the Effects of Trauma via Exposure Treatment
- Other Sources for Body Alienation and Related Self-Injury

VII. Group Treatment of Contagion

- Avoiding Group Activities that Promote Contagion
- Using Groups for Skills Training

Eight Levels of Care in the Treatment of Self-Injury

VIII. Family Treatment

- Teaching Families to Understand and Manage Self-Injury Strategically
- Resolving Family Dilemmas that Support Self-Injury
- Teaching Families Replacement Skills

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