Self-Injury in the Community: Implications for Treatment

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Overview/Objectives

I. Introduction
   I. SI defined
   II. SI in community samples/ developmental issues
II. Objectives
   I. to become familiar with current findings on SI in adolescents in the community (our research)
   II. to explore assessment and treatment implications of this work
   III. to learn about the commonalities of existing treatments in the area
III. Concluding comments

I. Introduction

Self-injury (SI) defined: Self-injury is low-lethality behavior that involves the deliberate destruction or alteration of body tissue, without conscious suicidal intent (Favazza, 1989; Haines & Williams, 1997). Self-injurious acts include skin cutting (which is Most common), skin burning, self-hitting, pinching, scratching, biting, and hair pulling (Gratz,2003; Ross & Heath, 2002). It may be repetitive/ habitual or occasional.

- Historically understood as being largely or exclusively associated with Borderline Personality Disorder or Mental Retardation (e.g., Dulit et al., 1994; Griffin et al., 1985)
- In the late 1980s Favazza (1987, 1988) explored the full range of this behaviour and suggested it was not limited to psychiatric populations
- In the 1990s it was noted that SI was increasing (Conterio & Lader, 1998; Favazza, 1998; Pipher, 1994)

SI Developmentally in Community Samples

- Favazza's work led to the study of SI in community samples.
- Although clinically SI was believed to begin in early adolescence, last for 5 -10 years for many (Favazza, 1998), and then abate studies only emerged in the 1990s/2000.
- Recent work does suggest that adults who SI admit to beginning in early adolescence (recently clinically there are reports of it beginning earlier 8-12 years).
- Pattison et al., (1997) reported a prevalence of 5% in adolescence, while Martin et al reported 9% prevalence but their definition included suicidal intent.
- In young adults Favazza (1989) found that 14% admitted to SI. Whereas, more recently Gratz (2003) reported a staggering 35% of university students admitting to this behaviour.
- In contrast, in studies of SI in the older adult community only 5% admit to currently engaging in SI (Briere & Gil, 1998; Klonsky et al., 2003).
- Gender: in clinical samples more females report SI; in community samples mixed findings

I. Introduction: Summary

- SI in community begins around puberty
- Most likely to occur during the subsequent 5-10 years
- Frequently disappears by mid adulthood
- Difference between habitual and occasional SI is unclear
- Gender differences in community samples not established

II. Objectives: Our Research

I. SI in high schools (Ross & Heath, 2002; 2003; Heath, Anderson & Ross, 2005)
II. Teachers' Attitudes (Heath & Beettam, 2005; Heath, Toste, Beettam & Wagner, 2005)
III. SI in university students (Heath & Nedecheva, 2005; Heath & Charlebois, 2005)

I. SI in High Schools

Prevalence

- Study of 440 adolescents grades 7-11 (mean age 14.5) found that approximately 20% indicated that they had hurt themselves on purpose at least once.
- Follow up interview indicated that 14% had self-injured at least once.
- Significantly more girls than boys admitted self-injuring.
- Interestingly, 25% of SI indicated they began self-injuring in grade 6 or earlier.
- 36% admitted to currently engaging in some form of SI (about 4.5% of Total).

SI in High School Students: Correlates & "Cause"

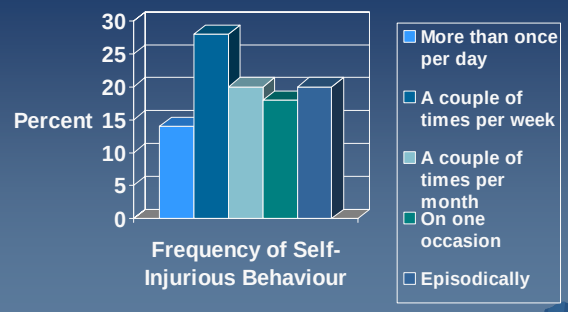
Correlates

- Individuals who engaged in SI were found to have more depressive symptoms (BDI) and anxiety (BAI) than those who did not.
- Those who engaged in SI had more negative body image and higher rates of bulimic tendencies than those who did not.

Cause

- Results suggested that SI was associated with difficulty with emotional regulation for both hostility (intropunitive and extrapunitive) and anxiety. Students stated that they felt relief and relaxed following the behaviour.

Severity of SI, Reported Frequency



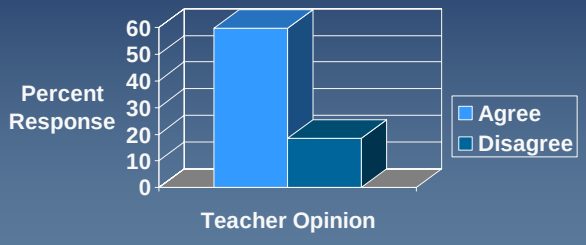
Summary: SI in High Schools

- More reports/higher prevalence than expected
- More prevalent in females than males
- Quite severe (high frequency)
- Correlated with anxiety, depression and eating disorders BUT frequently at a moderate level
- Also coping strategies of students who SI were all impulsive risk taking maladaptive coping strategies, rather than passive maladaptive coping.
- How are teachers coping with this?

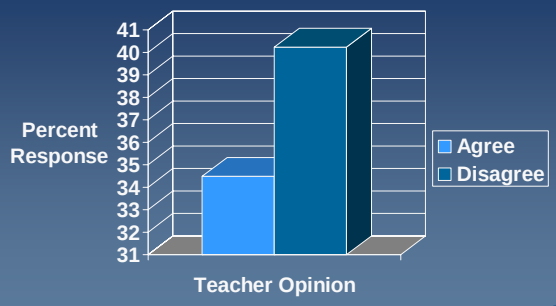
II.Teachers' Attitudes

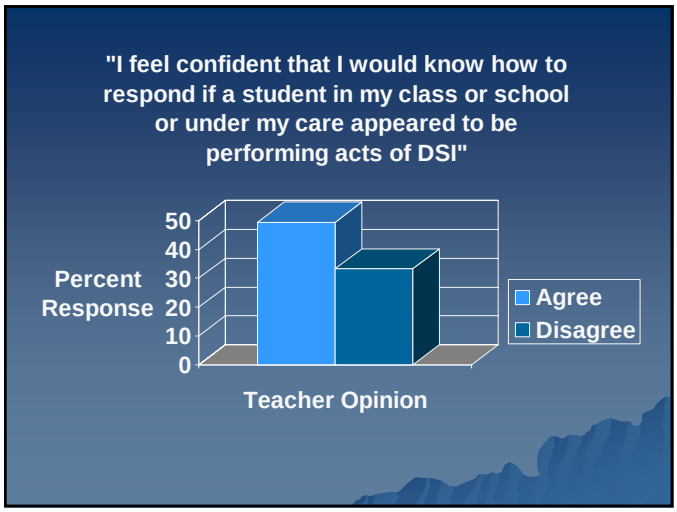
- **Teacher attitudes and knowledge**
  - 85 teachers (25 male; 60 female) filled out a questionnaire at a teachers' convention.
  - Teachers ranged in age from 23 to 66 with a mean age of 40.12.
- **Questions**
  - What are their attitudes toward this behaviour?
  - How much knowledge do teachers have regarding SI?
  - How much experience do they have with this behaviour?

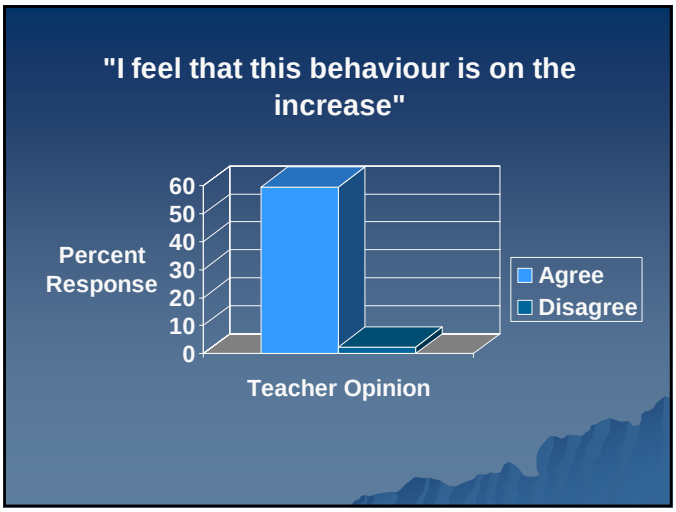
"I find the idea of a student cutting or burning their skin horrifying"



"I feel knowledgeable about the area of DSI"







Summary of Teacher Attitudes

- Teachers:
  - Negative attitude
  - Minimal Knowledge
  - High Confidence
  - High Exposure and perceived increase
- Conclusion: The teachers are very aware of this problem and feel it is on the increase. They lack knowledge but seem to have high confidence level.
- How are they dealing with these adolescents?

III. SI in University Students

- To extend our knowledge of SI in a community sample, since Gratz's (2003) finding of a 35% prevalence rate of SI seemed very high.
- Questions: Prevalence? Difference between risky behaviours and SI? Role of attachment, abuse, family history, social influence and emotion regulation.
- Study of 745 first year university students screened for risky behaviours and SI
  - 15% reported engaging in risky behaviours
  - 11% reported engaging in SI
  - 4% reported engaging a combination of risk taking behaviours and SI

SI in University Students

- Like high school students, university students report SI as a coping strategy.
  - "It calms me down"
  - "Sometimes people hurt themselves to suppress a desire to hurt others"
  - I stopped because "I realized it is an ineffective strategy"
  - "It happened when all other solutions could not help or be relied upon "

Overview of SI in University Students Research

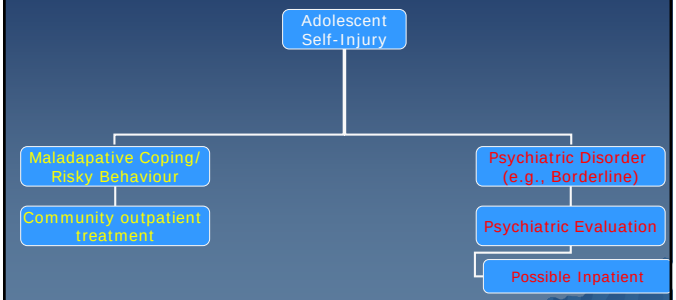
- Prevalence of 11% much more reasonable than Gratz' s 35%
- Students seem to see this as more common than we expected and as a coping strategy
- Far more effects of social influence than expected- not a private behaviour!
- Clear suggestion that RB and SI are very similar in prevalence but gender differences emerge.
- Aetiology: no difference between normals and SI in attachment, childhood trauma, sexual/physical abuse, family composition, BUT still a difference in emotional regulation.

Implications

- Increasing evidence that SI is emerging as the new "risky behaviour" maladaptive coping strategy in youth.
- Implications for Assessment: Clinicians and referral personnel (e.g., ER) need to adjust their thinking to evaluate self-injuring individuals as follows:

Current Assessment Pathway

New Assessment Pathway



Factors for Assessment

- Based on literature what factors are to be considered in this two pathway distinction?
- Some factors are largely related to the more severe type of SI while others are characteristic of more Risky Behaviour and many do not distinguish the two.
- The following assessment chart is based on the research and work of my team (Heath et al, 2002, 2003,2005a,b,c), White & Kress (2003), Gratz (2002, 2003, 2004), Carscadden (1993) and Favazza and colleagues (1998, 2001) and is in preparation for publication (Heath, Beettam, Charlebois, & Nedecheva, in prep)

Categories of Assessment	Specific Factors to Assess Psychiatric/ Risky Beh	
Suicide & Physical Injury Risk Assessment	•Suicide ideation, intent, plan, psychotic reply to complete suicide •Depression •Helplessness •Hopelessness •Any past history of suicide attempts •Social support of client •Family history of suicide •Recent stressors •Severe physical injury requiring immediate medical attention	•Assess for suicide risk •Investigate severe SI (infections, blades under the skin) •Discourage blade sharing •In what other was have you harmed yourself (Walsh, 2004; Simeon & Favazza, 2001) •Refer for immediate medical attention if infected or placing metal under skin
Mental Status Exam	•psychotic symptoms •substance abuse while injuring •dissociation •cognitive functioning	•any acute or chronic illness and its effects •sleeping patterns •flashbacks, nightmares or dissociation (sign of PTSD) •eating disorder – over or underweight •number of physicians presently treating, history of physicians •most recent consultation with a physician •present problems being treated •prescription drugs being used •over the counter medications being used •use of substances – alcohol, drugs, etc

History of Stress	•pathophysiological factors	•terminal illness •chronic illness •chronic pain •chemical dependency •psychiatric disorders •progressive debilitating disease •mental impairment
	•treatment related factors	•poor outcome to surgery, medical treatment, or psychological therapy •ingesting drugs •invasive treatments
	•situational factors	•depression •poor coping skills •family conflicts •family substance abuse •child abuse •a real or perceived experience of loss •desire for revenge for an injury •poor or disturbed self-esteem
	•(adolescence) factors of maturation	•family dynamics •peer pressure •disturbance of self-concept •Significant perceived loss •abuse history

Present Stress	•triggers •self-injury ritual •meaning for self-injurer	•examine triggers and whether they are present •ask about the frequency, duration, antecedents and consequences of self-injury •the functions, dynamics, severity of SI •understand the clients perspective on the behaviour
Coping Strategies	•other activities used to cope •strengths of the client •social supports and outlets •Private or known/shared with friends	•tracking charts for the client can help them to self-monitor antecedents, consequences, triggers, emotional states and behaviour patterns •also helps identify any activities or strategies that reduce SI behaviour
Course of Behaviour	•age of onset •Did a friend start first? •longest period free of self-injury •lifetime frequency of self-injury •current frequency of self-injury •changes in self-injury over time •emotional state when injuring dissociative or not •triggers that lead to self-injury •impulsivity of self-injury •clients desire to stop •client ability to resist the urge to self-injure •use of substances in connection with self-injuring •history of interventions tried in order to stop •family history of self-injury	Severity of Course is not always indicative of type BUT are indicative of when/where to refer

Assessment Pathway Summary

- Present research clearly suggests there are subsets of adolescents who SI. Certain key factors appear to distinguish the two although this requires further validation.
- Treatment will follow based on this.

Treatment Implications

- Many psychiatric facilities are receiving inappropriate referrals based on SI alone. Once this is recognized and understood then treatment falls into three categories.

1. Classic treatment for severe disorders where SI is just one symptom. E.g., Borderline or MDD (Psychiatric)
2. Treatment for severe maladaptive coping whereby SI is one more extreme risky behaviour that is used (Psychiatric or community). Often history of abuse, loss etc.
3. Treatment where SI is one or the only risky behaviour used as part of the adolescent impulsive pattern (community)

Treatment Implications

- Classic Treatment does not change
  - Although see "SI Bill of Rights"
- BUT for any community treatment there are certain commonalities in how adolescents who SI are treated.

Community Treatments

- All focus on learning alternatives to SI as a coping mechanism.
  - Relaxation training (some clear support)
  - Recognition of the experienced emotion and Expression Skills; Communication Skills
  - Behaviour Modification, incompatible behaviour substitution
  - CBT (challenging "emotions as unbearable" ideation)
  - Family Therapy (where possible but not essential)
  - No harm contract, controversy
- In summary, a composite of many treatments exist, BUT little empirical support exists for any of these treatments with adolescents at this time.

Closing Critical Issues

- In all treatment settings certain issues need to be acknowledged in dealing with SI:
  - Triggers (knowing the client's triggers)
  - Contagion/ Social Influence (no group work without knowing about this)
  - SI as culturally diverse
  - Professionals' & Parents' Attitudes
  - In contrast to Peers' Attitudes
  - SI should never be the FOCUS of treatment

Conclusion/Future Directions

- SI as the new risky behaviour.
  - Need for future research further differentiating the SI/RB group from more classic examples of those who engage in SI developmentally (Heath, Zelkowitz & Guzder).
  - SI needs to be understood across cultures
  - Need to research to understand the reason for the increase (social influence?).
  - Need to educate the professionals and the community about SI.
  - Finally, we need to be clear in our treatment in the community and to evaluate the effectiveness of the community treatments.

Resources/Websites

- Heath Research Team: http://www.education.mcgill.ca/heathresearchteam
- The S.A.F.E. program : http://selfinjury.com/index.html
- Self-injury and related issues: http://www.siari.co.uk
- Young people and self-harm: http://www.selfharm.org.uk
- Individuals who Self Harm work to support others who are trying to cope: http://www.selfinjury.org