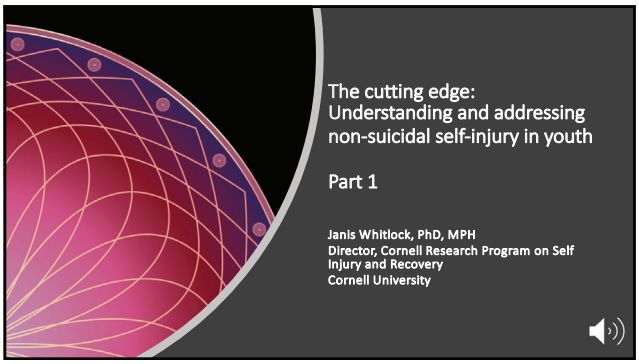
The cutting edge:
Understanding and addressing non-suicidal self-injury in youth
Part 1
Janis Whitlock, PhD, MPH
Director, Cornell Research Program on Self Injury and Recovery
Cornell University

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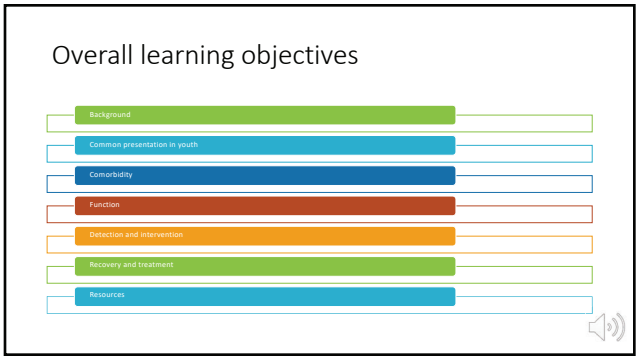
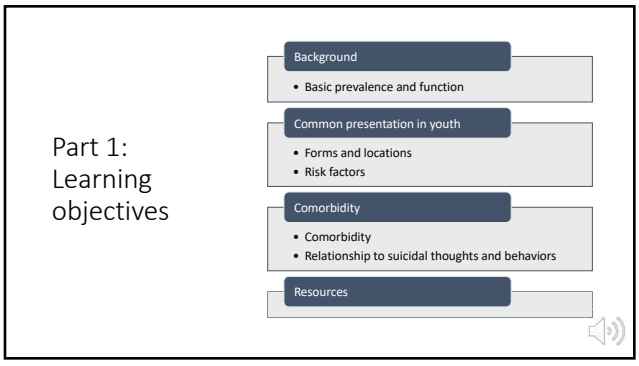

Overall learning objectives
Background
Common presentation in youth
Comorbidity
Function
Detection and intervention
Recovery and treatment
Resources

2


Part 1: Learning objectives
Background
• Basic prevalence and function
Common presentation in youth
• Forms and locations
• Risk factors
Comorbidity
• Comorbidity
• Relationship to suicidal thoughts and behaviors
Resources

3

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.

4

What do you know?

5

Self-injury Is Much More Common Among Females Than Males

6


Self-injury Is Much More Common Among Females Than Males
False
Studies are divided on this. Many studies show no gender differences; when there are gender differences present, it is slightly more females than males.

7


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

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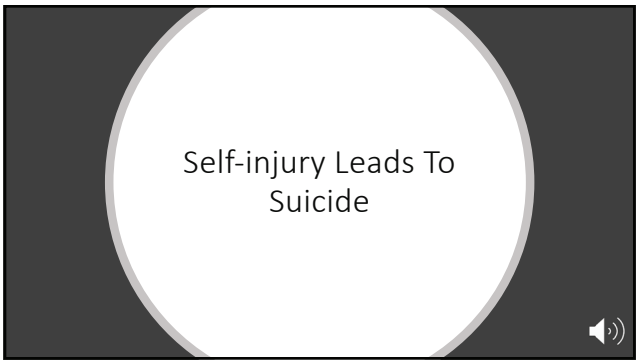
Self-injury Leads To Suicide

9

Self-injury Leads To Suicide

- False
- Self-injury is a way of managing feelings
- A history of self-injury can make it easier to actually take the steps of attempting or completing suicide if the individual begins to feel suicidal

10

Risks Associated With Moving From Non-Suicidal Self-Injury To Suicide

Greater lifetime frequency of self-injury → Sense of meaninglessness in life → Sense of disconnectedness / poor relationship with guardians/ parents

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Implications

- NSSI and suicide share presentation, risk factors and signal underlying distress
- They are not, however, the same phenomenon. As such protocols for managing need to differ
- Accurate assessment of intent and function of wounds is critical; suicide assessment is always indicated

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Disordered Eating Is the Most Common Co-occurring Disorder With Self-injury

13

Disordered Eating Is the Most Common Co-occurring Disorder With Self-injury

- True
- About 25% of the people who self-injure will also have an eating disorder
- Most common type of eating disorder is Bulimia
- In some studies, people who self-injure have no other co-occurring conditions at all
- Other common co-occurring disorders include: Anxiety, Borderline Personality Disorder, and Depression

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It Is Common To Start and Stop Self-Injury

15


It Is Common To Start and Stop Self-Injury
True
Self-injury is often cyclical, meaning that people go in and out of periods of actively self-injuring
Having not self-injured in a long while does not mean someone is "done" injuring; it can start again

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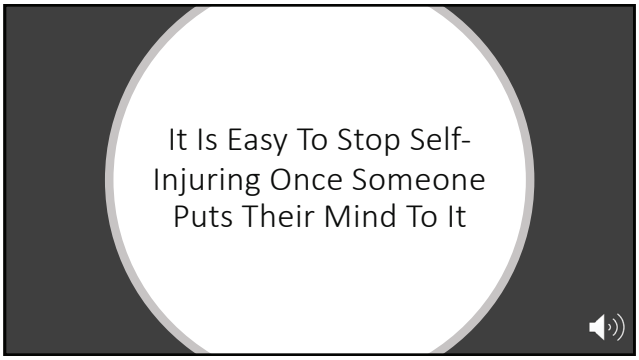
It Is Easy To Stop Self-Injuring Once Someone Puts Their Mind To It

17


It Is Easy To Stop Self-Injuring Once Someone Puts Their Mind To It
False
Self-injury quickly fulfills multiple core desires that are difficult to replace (to feel better, to express distress, to communicate without using words, or to get a rush or high, for example)
There are multiple neurological and physiological patterns associated with self-injury that can reinforce the behaviour and make it difficult to change

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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

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Less common self-injury behaviors (8%-12%)

- Ripping or tearing skin
- Pulling out hair, eyelashes
- 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

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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

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Research consistently shows that sexual orientation is the most powerful demographic correlate to self-injury

It is particularly prevalent among bisexual females

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Most common locations

Arms | Wrist | Hands | Thighs

Stomach | Calves | Ankle

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A few other things to note

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
About 20% of individuals who SI, report doing so more severely than intended	• Assess for experience with this • Discuss safety measures

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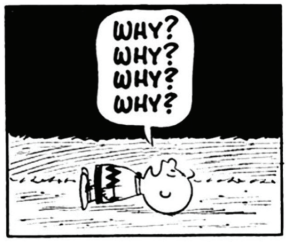
Why?

25

- Why this, why now?
- What factors predict individual risk?
- What triggers an episode?
- Why does it help



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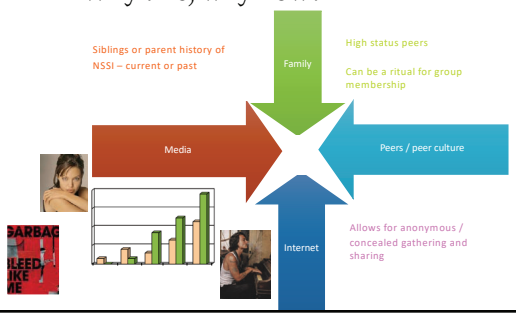
Why this, why now?



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Non-suicidal self-injury: the body as a canvas for self-expression

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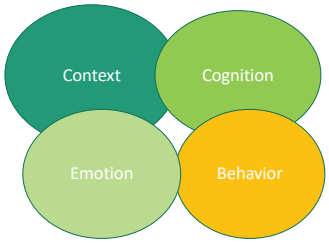
What factors predict risk?



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Contextual Factors

- History of emotional, sexual, or physical abuse
- Traumatic event(s)
- Chronic perceived stress or disruption (usually family, peers, performance)
- Low expressed emotion in family environment
- Exposure to NSSI as a positive activity

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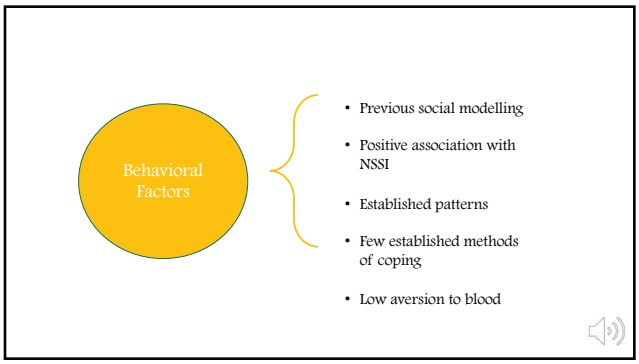
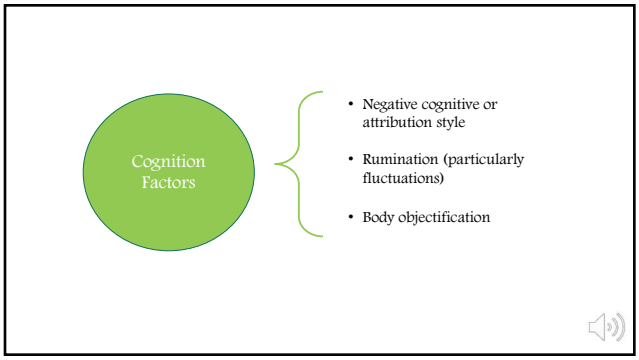

Behavioral Factors
• Previous social modelling
• Positive association with NSSI
• Established patterns
• Few established methods of coping
• Low aversion to blood

31


Cognition Factors
• Negative cognitive or attribution style
• Rumination (particularly fluctuations)
• Body objectification

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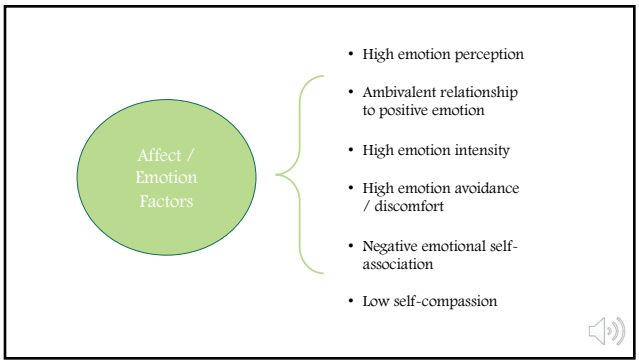
Affect / Emotion Factors
• High emotion perception
• Ambivalent relationship to positive emotion
• High emotion intensity
• High emotion avoidance / discomfort
• Negative emotional self-association
• Low self-compassion

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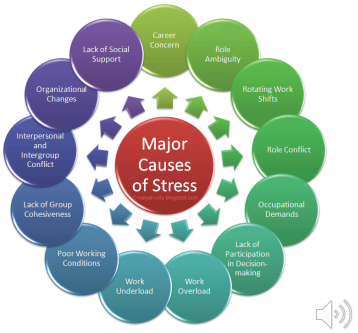
What triggers an episode?



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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

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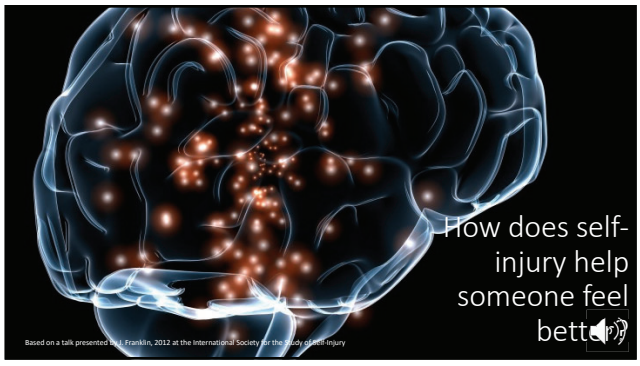

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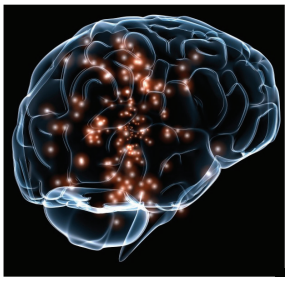
What Biological and Neurological Studies Tell Us

- 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



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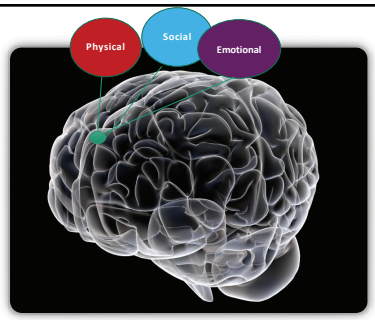

Pain offset

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

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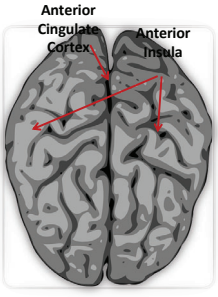

Key brain players: ACC and AI

Both regulate a) physical perception of physical stimuli and b) perceptions of emotion, particularly social exchange

Leads to some interesting phenomena:

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

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So…….

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

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Why is it so hard to stop?

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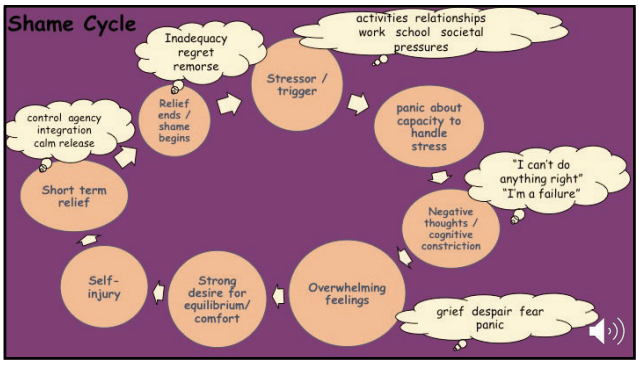

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Self-Injury Can Be Contagious Among Young People

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

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Intervention

Means restriction can be helpful for suicidality but is not terribly effective with NSSI

This is because there are so many different ways to self-injure

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Handling Contagion

Limit	Focus	Identify and engage
Limit overt discussion and display of fresh wounds	Focus group sessions on underlying feelings and other ways of handling feelings rather than self-injury or the particular reasons someone injures	Identify and engage the individual(s) at the "epicentre" as partners in not spreading the behaviour, if possible

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Stay tuned for part 2
Detection and intervention
• Detection
• Intervention/protocols
• Common treatment
• Resources

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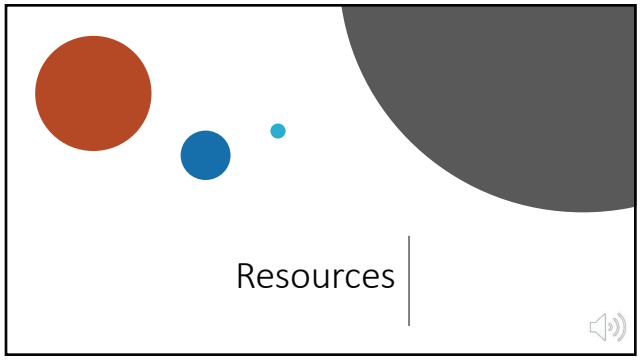
Resources

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CRPSIR website
• www.selfinjury.bctr.cornell.edu
The Skeletons in My Closet
We help understand, detect, treat, and prevent self-injury.
Self Injury

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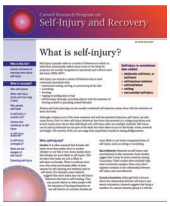

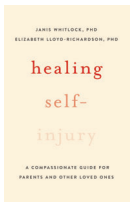

Written materials

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Web-based training

NSSI 101

- 8-9 hour
- Self paced or facilitated
  - Certificate (Cornell certificate &/or NASW CEU, .8)
- Brief primer
- Parent psychoeducatioal workshop

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resources

Websites:

- Cornell Research Program on Self-Injurious Behaviors: www.crpsib.com
- CRPSIR training page: http://www.selfinjury.bctr.cornell.edu/training.html
- S.A.F.E. Alternatives: http://www.selfinjury.com/index.html
- The National Self-Harm Network (UK): http://www.selfharm.org.uk/default.aspa
- The American Self-Harm Information Clearinghouse (ASHIC): http://www.selfinjury.org/indexnet.html
- Resources for addressing mental health issues in schools: http://smhp.psych.ucla.edu/
- Heart math: :http://www.heartmath.org/about-us/overview.html
- Collaborative for academic, social and emotional learning http://www.casel.org

Books & articles:

- All books by Barent Walsh and Matthew Selekman and
- Conterio, K., & Lader, W. (1998). *Bodily harm: The breakthrough treatment program for self-injurers.* New York: Hyperion Press
- Whitlock, J.L., Lader, W., Conterio, K. (2007). The internet and self-injury: What psychotherapists should know. *Journal of Clinical Psychology/In Session 63*: 1135-1143. (available at www.crpsib.com)

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