SELF INJURY BASICS

Presented for Bucks County Life by
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Self-Injury

"Don't always know why I self-injure. Sometimes it's used as distraction from the pain or anxiety I'm feeling. Sometimes I use it as a way of saying with my body what I can't say with words. At times there are no words for what is going on inside me. Other times I use self-injury as a way of releasing the anxiety and panic I am feeling. And sometimes I use it as a way of punishing myself for whatever it is at that moment for which I feel I need to be punished." [44 Yr Old Female, 24 years SIB]

http://www.palace.net/~llama/psych/quot.html

What is Self-Injury

- A pattern of physically harming oneself intentionally
- An unhealthy coping skill
  - attempting to rrelieve, avoid, or discharge emotional pain
- Typically in the form of cutting, scratching, or burning one's self, this can also be in the form of pulling one's hair, skin picking, biting, slapping, pinching, or punching one's self or banging one's head
- An addictive behavior

What Self Injury Is

- Suyemoto & MacDonald (1995) suggest that the most valid models explain SIB as an:

1. Expression of overwhelming affect
2. An attempt to control affect
3. An attempt to stop depersonalization
4. An attempt to create a boundary and sense of identity

What Self-Injury IS NOT

- A suicide attempt
- A brief or one time event
- Just a way to get attention
- An attack on others

Types of Self-Injury

- **Compulsive Self-Injury**
  - More closely associated with OCD
  - Includes Trichtillomania (Hair pulling), skin picking and excoriation when it is done to remove perceived faults in the skin
- **Impulsive Self-Injury**
  - Episodic Self-Harm
    - Occurs once in a while
    - Person does not think about SI otherwise
    - Person does not see self as a self-injurer
    - Episodic Self-Harm can become Repetitive
  - Repetitive Self-Harm
    - Rumination on SI even when not engaged in the behavior
    - Self-identification as a self-injurer
    - Impulsive in nature
    - Reflex response to any sort of stress, even positive

Warning Signs of Self-Injury

http://aces.nmsu.edu/pubs/_i/I104/

- Marks on the body, such as cuts or burn marks (including scars) on arms, legs, abdomen, or feet.
- Cutting instruments found among belongings, such as razors, knives, and pins/needles.
- Hearing of friends or peers who are cutting themselves.
- Wearing long pants and long-sleeve shirts consistently (even in warm weather).
- Wearing thick wristbands that are never removed.
- Blood stains on clothing.
- Secretive or elusive behavior.
- Spending lengthy periods of time alone.

Self-Injury

- **Key behaviors to be vigilant of**
  - Dissociative responses/Numbness
  - Lack of emotional insight/expression
  - Gathering self-harming materials
  - Denial/avoidance of topics related to self-injury
  - Appearance of marks/scars or injuries

Self-Injury

"Patients who harm themselves are more likely to be female, to have a history of self-harm, to have experienced physical or sexual abuse and to have been diagnosed with borderline personality disorder."

(Giles, Rey, Simpson, Denshire, 2001)

Risk Versus Protective Factors: Making it a Fair Fight

Risk	Protective
Environmental	
Greater maltreatment + greater inexpressivity + higher levels of affect intensity/reactivity	Skills for maintaining relationships
Sexual abuse, emotional neglect, and physical abuse (Briere & Gil, 1998; Gratz, 2006)	No history of abuse
Earlier abuse, and chaotic family conditions are predictive of amount and severity of cutting (Van der Kolk, 2005)	Stable family conditions
No memory of feeling loved or special predicted inability to control impulse to cut (Van der Kolk, 2005)	Memories of feeling loved or special

Risk	Protective
Parental alcoholism or depression (Walsh & Rosen, 1988)	No history of parental substance abuse or depression
Invalidating Environment (Linehan 1993)	Validating environment (Ray, 2005; Linehan, 1993)

Risk

- **Sex and Age**
  - Females age 16 to 25
  - Onset typically age 13-14
  - Duration is typically 10 to 15 years, although it may continue for decades
  - Progressing SIB increases risk of accidental suicide
- **Biological**
  - Fewer platelet binding sites-related to Seratonin

(Favazza, 1998; Favazza, et al, 1992; Simeon & Favazza, 2001; Favazza & Conterio, 1988; Ray, 2005; Ross & Heath, 2002; Walsh & Rosen, 1988)

Protective

- Males/Above 25 years of age
- Early intervention
- Later onset
- SSRI's (Simeon, et al, 1993)

Risk

- **Psychological/Client**
  - Adopting an identity as a cutter or burner = more severe level of pathology (Muehlenkamp, 2005)
  - Physical illness or surgery at a young age (Briere & Gil, 1998)
  - Perfectionism (Favazza & Rosenthal, 1993)
  - A history of self injury (Ray, 2005)
  - Lower levels of positive affect intensity/reactivity (Gratz, 2006)

Protective

- Has not integrated self-injury into identity
- Good health/No history of surgery at a young age
- Acceptance of weaknesses/faults
- No history of self-injury
- The ability to modulate emotions
- Reduced vulnerability to emotionality (Linehan, 1993)
- Ability to experience positive affect and pleasure

Risk

- **Comorbidity**
  - Dissociative disorders
  - Post-Traumatic Stress disorder (Favazza, 1996)
  - Borderline Personality disorder (Favazza, 1996; Linehan, 1993; Suyemoto, 1998; Walsh & Rosen, 1988)
  - 50%–60% report having or having had an Eating disorder (Darche, 1990; Favazza & Conterio, 1989; Favazza, DeRosear & Conerio, 1989)
  - Substance Use disorders (Favazza & Conterio, 1989)

Protective

- Absence of Dissociative disorders
- Absence of PTSD or ASD
- Absence of BPD
- Absence of or recovery from eating disorders [Caution of transferring addictions—"Clinicians report that when one behavior ceases (either the SIB or the eating disorder) the other emerges, which suggests that these two behaviors may be closely related or even different manifestations of similar underlying problems" (Cross, 1993)]
- Absence of/recovery from substance use disorders (Caution of transferring addictions)

Risk

- Depressive disorders (Kahan & Pattison, 1984; Ross & Heath, 2002)
- Obsessive-Compulsive disorder (Yaryura-Tobias, Neziroelu & Kaplan, 1995)
- Those who are in a psychotic state (mainly young adult males; Ray 2005)
- Children with developmental delays/Autism (Ray, 2005)

Protective

- Absence of mood disorders
- Absence of OCD
- No state psychosis
- Normal IQ/Skills for communicating feelings

Self-Injury Versus Suicidality

Self-Injury

- Absence of suicidal thoughts, plans, or intent
- Use of non-lethal methods and/or means
- 59%–72% do not have suicidal thoughts at the time of the SIB and 15%–45% of self-injurers do not have a history of suicide attempts (Muehlenkamp, 2005)
- Seeks to feel better (Favazza, 1998)
- An alternative to suicide (Ray, 2005)
- Regular, frequent use as a coping skill

Suicidality

- Presence of suicidal thoughts, plans, or intent
- Use of lethal method and means
- Attempts are both with or without chronic thoughts, wishes or fantasies
- Seeks to end all feelings (Favazza, 1998)
- A decision to end one's life
- Irregular and infrequent attempts

Basic Tips for Responding to Self-Injury*

- React to SI like it's SI, not like it's suicidality
- Recognize the lethality involved in some self-injury
- Offer to reduce access to means
- Initiate communication
- Ask about triggers to cutting and alternatives
- Ask to see and help care for injuries

*all of these must be done dialectically, to avoid a negative outcome!

History Lesson

- There is no diagnosis for self injury, self injury is a SYMPTOM of another disorder. Common disorders are:
  - Psychotic disorders
  - Behavioral disorders such as Oppositional Defiant Disorder, intermittant Explosive Disorder, etc.
  - Developmental Disorders such as Autism, PDD
  - Most frequently is Borderline Personality Disorder

History Lesson

- What is Borderline Personality Disorder? (BPD)
  - A cluster of symptoms
  - A diagnosis given to those 18+
  - Personality vs other mh disorders
  - Coined by Freud

The Layperson's understanding

- It's a bird, it's a plane its:
- Bipolar!
- Schizophrenia!
- Multiple Personality Disorder!
- Manipulation, laziness, confusion…

The Field's understanding

- It's a bird, it's a plane, it's…
  - Untreatable
    - Often, these clients do NOT see a problem with their behaviors, only with other's behaviors, making it difficult to motivate them to change
  - Clients we don't want
    - The stigma around BPD can be harsh, rejecting & critical, & poses a barrier to our client's treatment
  - It's not for those under 18
    - Many clinicians treating clients with BPD are not qualified to do so, have received no special training, & sometimes lack the consultation and/or supervision necessary to prevent burnout & keep our clients safe

The 9 Symptoms of BPD

1) Frantic efforts to avoid real or imagined abandonment
2) A pattern of unstable & intense interpersonal relationships alternating between idealization & devaluation
3) Identity disturbance: markedly & persistently unstable self-image or sense of self
4) Impulsivity in a least 2 areas that are potentially self damaging (spending, sex, sub use, eating, etc.)
5) Recurrent suicidal behaviors, gestures, threats or self mutilating behavior
6) Affective instability due to a marked reactivity of mood
7) Chronic feelings of emptiness
8) Inappropriate intense anger
9) Transient, stress related paranoid ideation or severe dissociative symptoms

PD Expert's Understanding

- To live a life analogous to a soap opera is to live the life of a borderline personality.

- One response to feeling abandoned is to abandon yourself.

----Theodore Millon

Another Expert's Understanding

- "In a sense, the borderline is like an emotional explorer who carries only a sketchy map of interpersonal relations; he finds it extremely difficult to gauge the optimal psychic distance from others, particularly significant others. To compensate, he caroms back and forth from clinging dependency to angry manipulation, from gushes of gratitude to fits of irrational anger. He fears abandonment, so he clings; he fears engulfment, so he pushes away. He craves intimacy and is terrified of it at the same time. He winds up repelling those with whom he most wants to connect."

- **Source:** *I Hate You, Don't Leave Me* by Jerold J, Kriesman, MD, and Hal Straus

Marsha Linehan's Understanding

- "The anger is often elicited when a caregiver or lover is seen as neglectful, withholding, uncaring, or abandoning. Such expressions of anger are often followed by shame and guilt and contribute to the feeling they have of being evil."

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--Marsha Linehan

The sufferer's understanding

- "Being a borderline feels like eternal hell. Nothing less. Pain, anger, confusion, hurt, never knowing how I'm gonna feel from one minute to the next. Hurting because I hurt those who I love. Feeling misunderstood. Analyzing everything. Nothing gives me pleasure. Once in a great while I will get "too happy" and then anxious because of that. Then I self-medicate with alcohol. Then I physically hurt myself. Then I feel guilty because of that. Shame. Wanting to die but not being able to kill myself because I'd feel too much guilt for those I'd hurt, and then feeling angry about that so I cut myself or O.D. to make all the feelings go away. Stress!" ---missy

The Sufferer's Understanding

- "DBT's catchphrase of developing a life worth living means you're not just surviving; rather, you have good reasons for living. I'm also getting better at keeping another dialectic in mind: On the one hand, the disorder decimates all relationships and social functions, so you're basically wandering in the wasteland of your own failure, and yet you have to keep walking through it, gathering the small bits of life that can eventually go into creating a life worth living. To be in the desolate badlands while envisioning the lush tropics without being totally triggered again isn't easy, especially when life seems so effortless for everyone else."

-----Kiera Van Gelder, *The Buddha and the Borderline: My Recovery from Borderline Personality Disorder through Dialectical Behavior Therapy, Buddhism, and Online Dating*

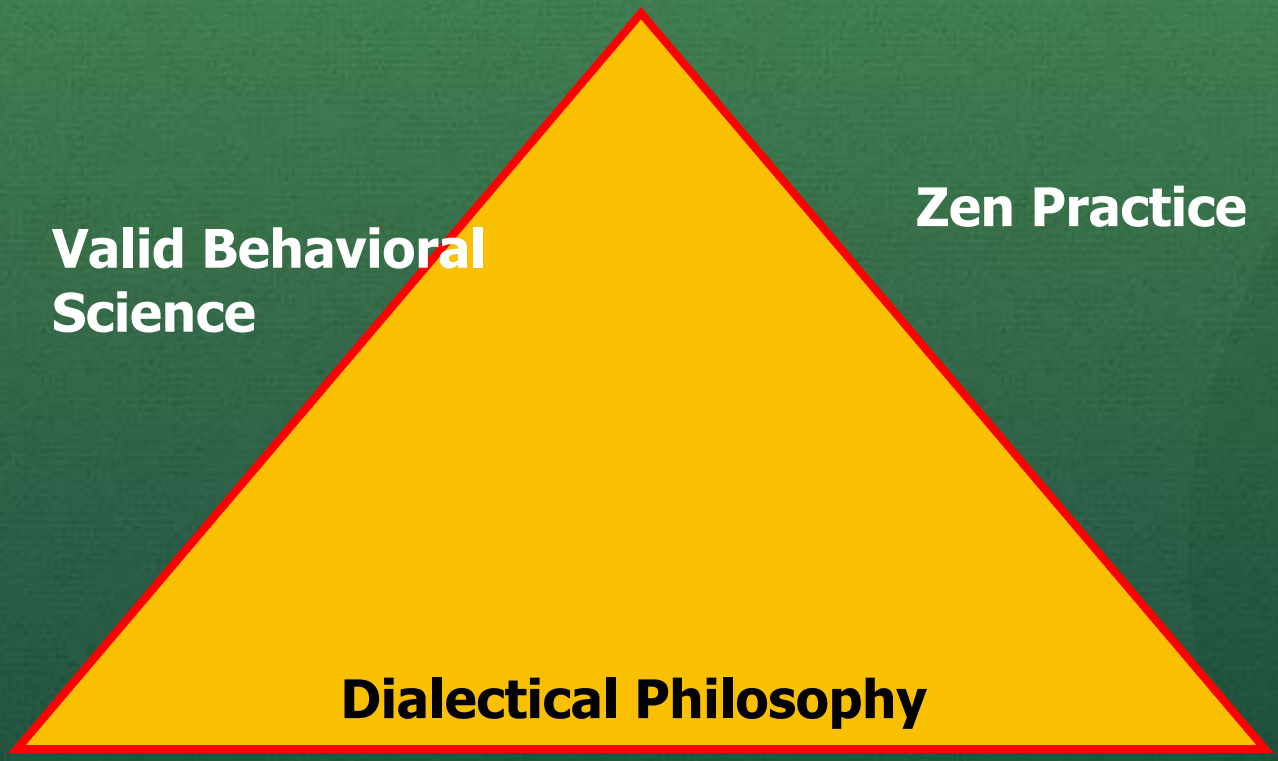
A Loved One's Perspective

- Frustration
- Fear
- Invalidation
- Giving up
- Giving in
- Exhaustion
- Confusion
- Walking on eggshells

Dialectic Behavior Therapy: Introductory Theory

- Some of the following slides are borrowed from an internal training created by Shannon Olson from the Larkin Center, IL, & based on the work of Marsha Linehan, WA

A Philosophical Approach



Zen-Eastern Traditional Philosophies & Practice

- Clients learn to be more aware of themselves, how they think, how & why they feel emotions, how they influence their environment & vice versa through:
  - Meditation
  - Relaxation
  - Awareness

To Build A Life Worth Living

- The ultimate goal of **D**ialectical **B**ehavior **T**herapy.
- The goal of every client & therapist(s) working together as a collaborative team.

The Evidence Base

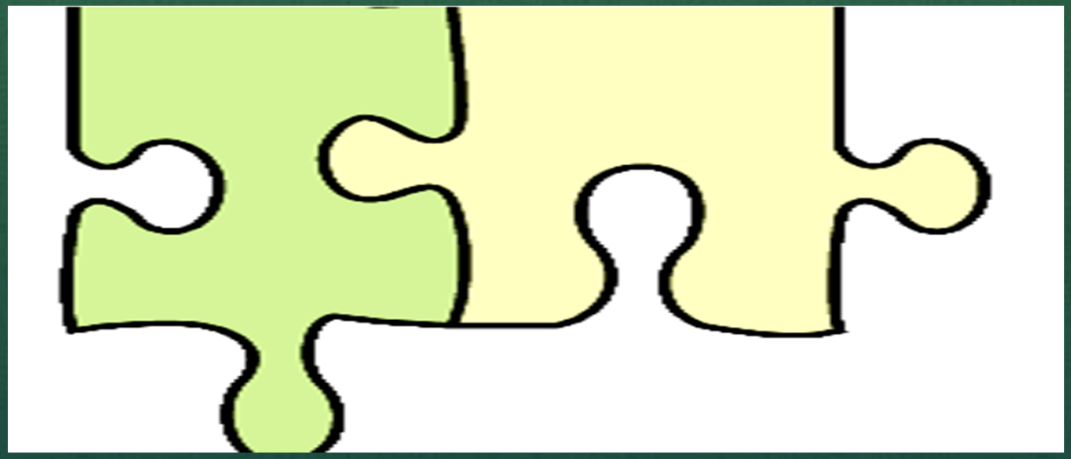
- Since it's inception in 1992, multiple studies have proven DBT is a valuable tx model for reducing suicidality, SIBs, volatile emotions, & interpersonal conflict with adult female populations
- Over the past 5 years or so, more professionals are applying DBT to a younger population, & although controlled experiments are needed, preliminary studies show promise for similar results

DBT Assumptions about Clients

- Clients are doing the best they can in the moment.
- Clients want to improve.
- Clients must learn new behaviors in all relevant contexts.
- Clients cannot fail in DBT.
- Clients may not have caused all of their own problems, but they have to solve them anyway.
- Clients need to do better, try harder and/or be more motivated to change.
- The lives of clients are unbearable as they are currently being lived.

Biosocial Theory

- **Nature vs. Nurture:** Takes each individual's **environment** & **genetic** make up into account & puts them together in order for us to know where they are coming from, what skills they already have & which skills they still need to learn.



Nature & Nurture Combine

Emotional Vulnerability

+

Invalidating Environment

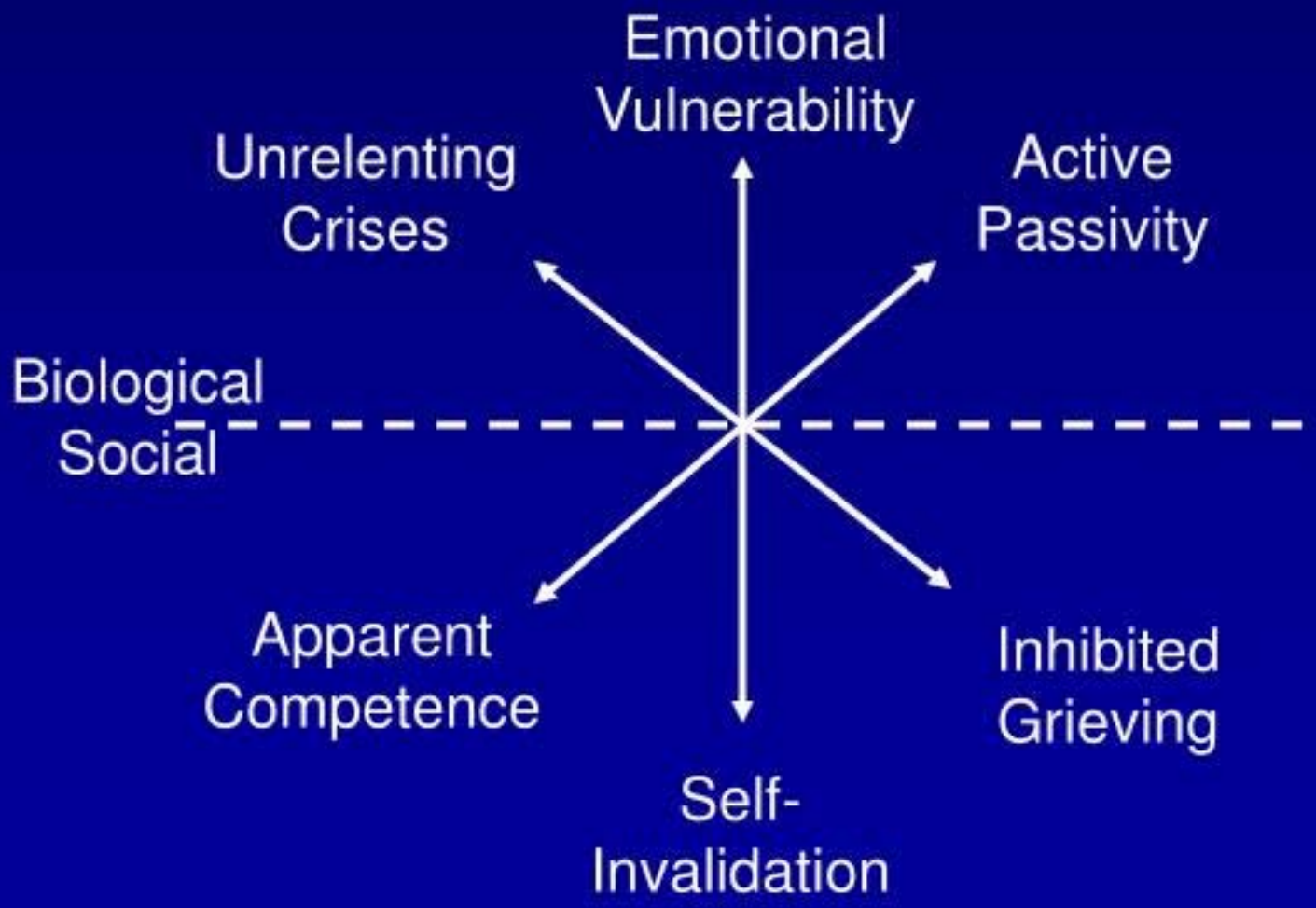
_____

BPD

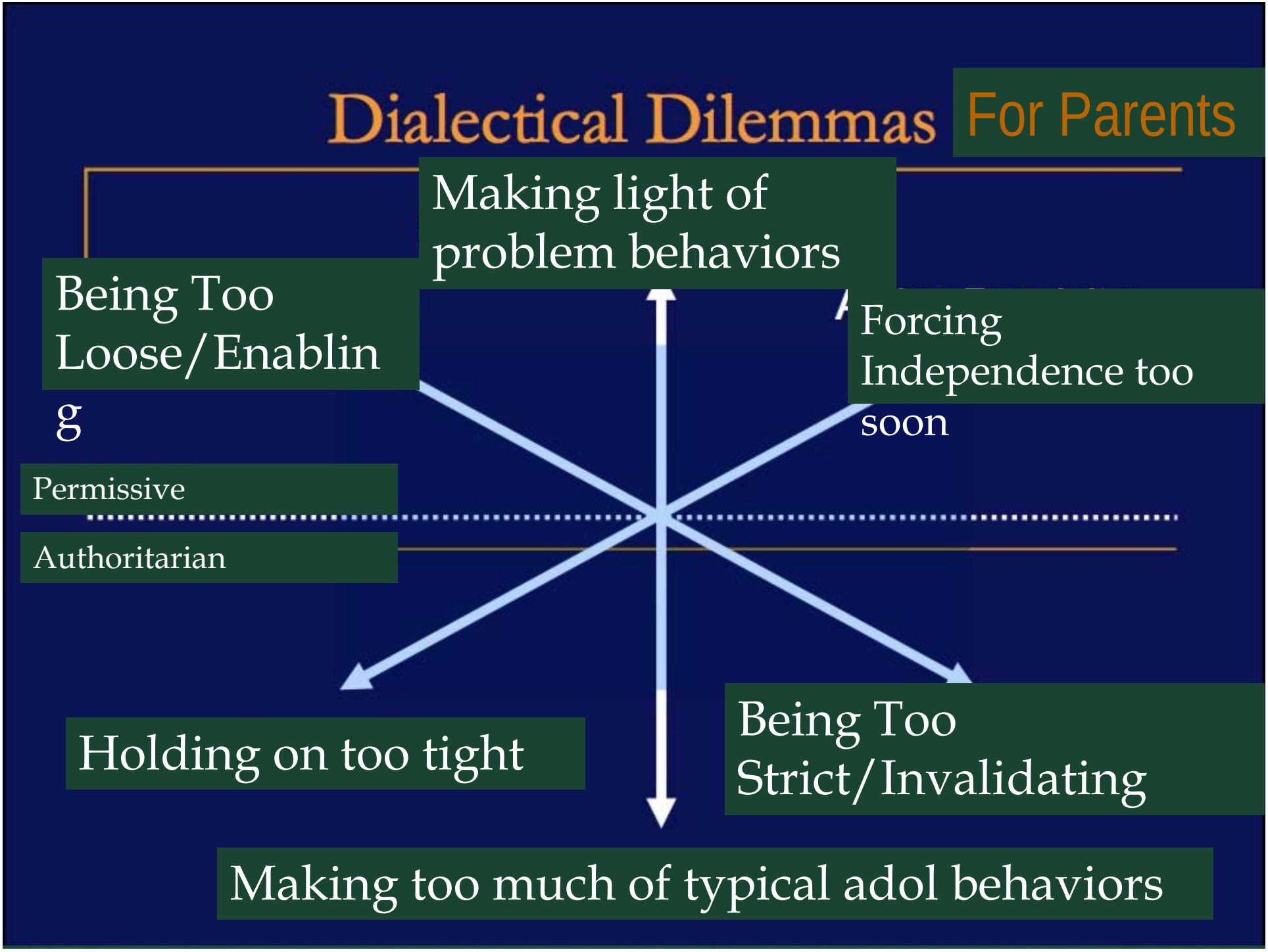
So What is "Dialectics"

- Reality is composed of opposing forces & a synthesis is necessary to balance & evolve a new reality
- 2 ideas that appear opposite AND can be true at the same time
- The "Dialectic" in DBT is super important for helping sufferers stay balanced, in control, and in reality

Common Behavioral Patterns: "Dialectical Dilemmas"



Dialectical Dilemmas For Parents



Practicing Dialectics

- Accept no absolute truths: look for the balance that is truth while validating feelings and perspective
- Remain open to the possibility that we could be wrong
- Consider the “and” in every situation

Guiding Dialectic of DBT

- **Acceptance & Change**
  - Ex: A person is doing the best they can in the moment **&** they need to do better.
  - How can we accept the person where he/she is **&** ask him/her to change?
    - We understand, or validate what they are doing based on who they are, what they've been taught or what is in their history **AND** believe that they must be more skillful to have a better life.

VALIDATION

- Validation is:
  - Finding the kernel of truth or wisdom in the person's behavior (no matter how bad it is)
  - Seeing the world from the person's point of view, and ***saying*** so! Validation does not necessarily mean you:
    - Agree with the person
    - Approve of the person's behavior, or
    - Convey warmth

Tools for VALIDATING

- **Staying Awake**: Unbiased listening & observing-Just be quiet & stay focused on the person.
- **Accurate Reflection**-saying back to them what they told you, but in different words & **without** judgment.
- **Verbalizing the unspoken emotions, thoughts or behavior patterns**- Ask for clarification and be careful not to assume what a person is feeling.
- **Validation in terms of past learning or biological dysfunction**-what the person has been previously taught or in the context of their mental illness, learning disorders, mental impairment, etc
- **Validation in terms of present context or normative functioning**-Understand where they are coming from in terms of what they are going through right now or their stage in life & development
- **Radical Genuineness**-Being kind & real at the same time.

Common Mistakes of Family Members

- Punishing self harm
- Taking the person's behavior personally
- Trying to control the person
- Invalidating the person's feelings
- Expecting change quickly and obviously
- Reinforcing the wrong behavior
- Enabling or avoiding unhealthy behaviors/attitudes

Family Members: Tips for Coping

- Practice and encourage dialectical thinking
- Expect slow and steady change
- Accept powerlessness over the situation; Tolerate uncomfortability in self and others
- Prioritize the person's therapy
- Practice and encourage validation
- Set and adhere to clear and consistent limits
- Try to stay within your role
- Ask about what skills help and encourage their use, without forcing or controlling their use

Modalities for DBT

- Skills Training Group
  - Between-Group Consultation
- Individual Therapy
- Family Therapy/Group
- Medication
- Hospitalization/Day Programs

Replacing Problem Behavior

Targets to Increase	Targets to Decrease
Core Mindfulness	Identity Confusion Emptiness
Interpersonal Effectiveness	Interpersonal Chaos Fears of Abandonment
Emotion Regulation	Labile Affect Inappropriate Anger
Distress Tolerance	Impulsivity Suicide threats/attempts Parasuicide

The End

- Further reading for families:

"Dialectical Behavior Therapy FAQs"
www.Behavioraltech.org/aboutus/whatisdbt.cfm

The self injury foundation: http://selfinjuryfoundation.org/parents.html

I Hate you Don't Leave Me: Understanding the Borderline Personality. Jerold J. Kreisman & Hal Straus.
http://www.amazon.com/Hate-You-Dont-Leave-Understanding-Personality/dp/0399536213

Stop Walking on Eggshells: Taking Your Life Back When Someone You Care About Has Borderline Personality Disorder. Paul Mason MS & Randi Kreger.
http://www.amazon.com/Stop-Walking-Eggshells-Borderline-Personality/dp/1572246901/ref=sr_1_1?s=books&ie=UTF8&qid=1414521815&sr=1-1&keywords=stop+walking+on+eggshells

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