Cutting: The Evolution of Self-Injury and How to Help

Derek J. Lee, MRC, CRC, LPCC-S, DBTC
Perrysburg Counseling Services, LLC
&
Allyson Heyman, Intern

Cutting and Self-injury: What is it?

Let's start with a clinical definition of self-injury:

Non-Suicidal Self-Injury (NSSI) is the intentional and direct injuring of one's body tissue without suicidal intent (Herpertz, 1995, p. 57).

Let's translate: what does that mean?

* It's a very broad area, which includes:
  * Cutting
  * Burning
  * Scratching
  * Hair pulling
  * Punching self
* It does not include:
  * Injury incurred during a suicide attempt
  * Unintentional injuries or unintended consequences of other actions

When did self-harm emerge publicly?

Thoughts?

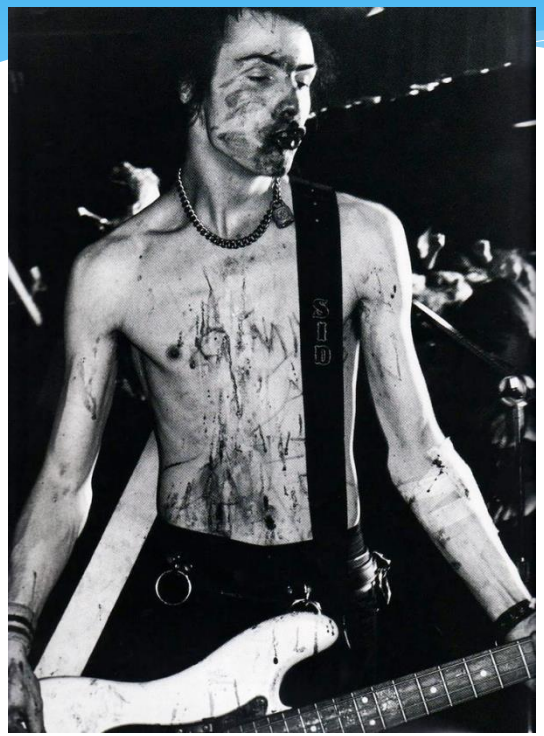
Known History of Cutting

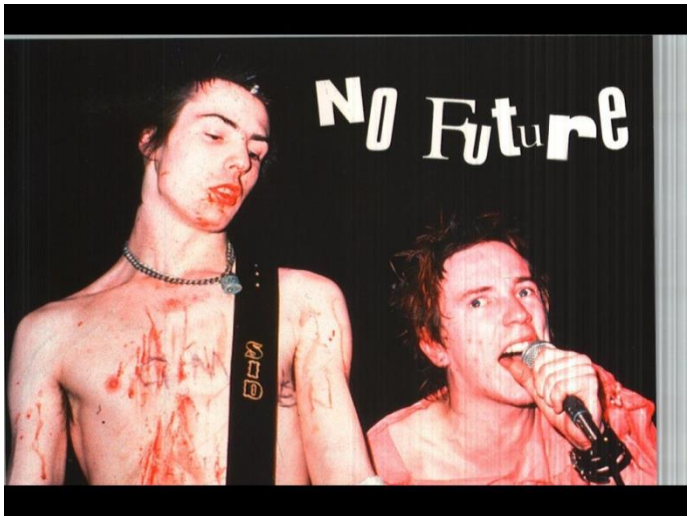
* There is very limited formal information on cutting, as it has traditionally been under-researched due to a history of being culturally taboo
* Cutting has been represented in the media since as early as the 70's, but its presence has grown proportionately to its popularity in recent years

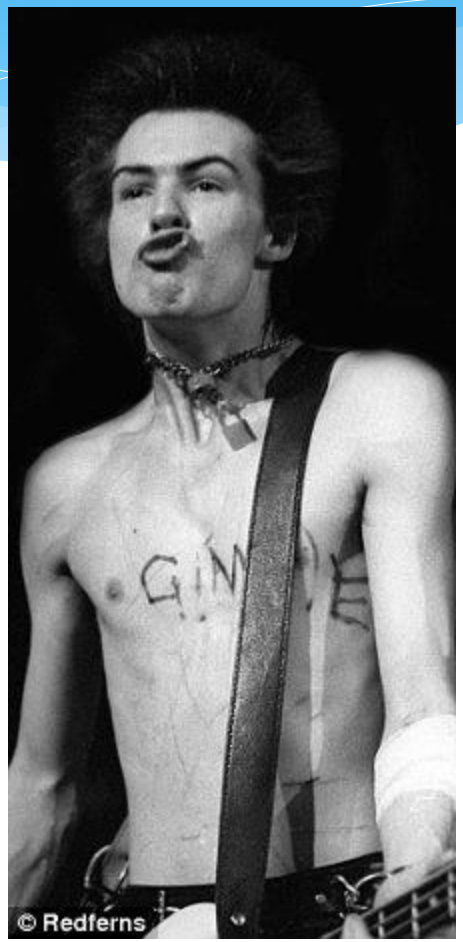
Music

* 1972 Elton John – I think I’m gonna kill myself
* 1990 Black Crows – She talks to angels
* 1994 Nine Inch Nails – Hurt
* 2002 Johnny Cash – Hurt (Rereleased)
* 2003 Nickleback – Because of you
* 2005 Foo Fighters – Razor
* 2005 Garbage – Bleed like me

Sex Pistols – Late 70's and early 80's

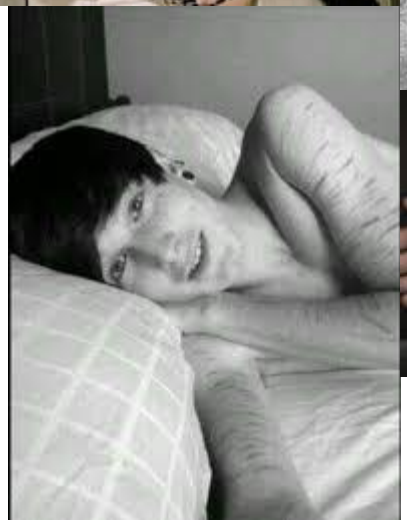


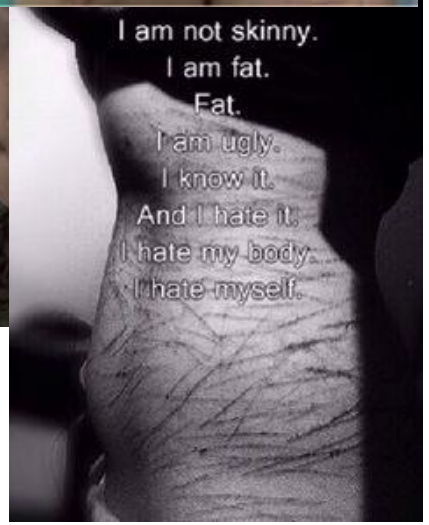




Marilyn Manson ‘89 - Present

Today's Internet & Social Media





Theories on Self-Harm and Cutting

Affect-Regulation Model

* Self-injury is a personal strategy to “alleviate acute negative affect”
* Also known as a maladaptive coping mechanism
* Tied to studies by Marsha Linehan supporting theory
* Very common among individuals with borderline personality disorder

Anti-dissociation Model

* Self-injury is “a response to dissociation or depersonalization”
* Individuals utilize self-injury as a “trigger” to either dissociate in the absence of loved ones, or as a “wake up call” to draw themselves out

Anti-Suicide Model

* NSSI is utilized as a preventative coping mechanism, in an attempt to avoid engaging in suicidal actions
* This allows the expression of suicidal thoughts while avoiding the act of suicide
* Self-harm can act as a distraction from suicide
* Can alleviate feelings of depression and anxiety
* Some studies utilizing this theory demonstrate that over 70% of adolescents engaging in NSSI attempt suicide at some point in their lives
* There is research demonstrating increased NSSI can correlate to increased suicide attempts (Nock et al., 2006)

Self-Punishment Model

* Self-harm is a way of projecting their anger and other negative feelings on themselves, effectively "punishing" themselves
* Tied to work by Linehan (1993) that looked at individuals raised in environments that influenced their tendencies to punish themselves for failure, loss, or distress.
* Closely tied to impulsivity in adolescents

Sensation Seeking Model

* NSSI in adolescents is utilized to “generate excitement or exhileration.”
* NSSI is used to gain a “rush” or provoke intense emotions of euphoria – can be tied to endorphin releases in the brain
* Lesser studied and identified my a small minority of individuals as the reason for NSSI

Interpersonal-Influence Model

* NSSI functions upon the basis of influencing or manipulating others
* Self-injury is a cry for help or an attempt to be taken seriously
* Marks are typically more visible
* These individuals are typically more aware of the reinforcement that they receive for their behavior
* Often used to avoid abandonment through guilt

Interpersonal Boundaries Model

* Based in object-relations theory
* Functionality of NSSI is drawn from lacking a sense of self and the need to separate
* This can be by:
  * Feeling and sensation
  * Marking the skin by cutting, burning, etc.

  * Is there a correlation to the popularity of tatoos?
    (just a thought)

Quick Stats

* Traditional research indicates that 4% of individuals between the ages of 14-24 have engaged in self-harm
* These numbers are believed to be skyrocketing, but the taboo nature of the topic limits accurate data collection

We do know that:

* 7% of adolescent hospitalizations are psychiatric
* Roughly 70% of those individuals report self-harm

~~How to handle cutting~~

What not to do:

* Create “No harm” or “Do no harm” contracts
* Make deals: “Promise me you won’t cut”
* Ask them not to cut based on the therapeutic relationship that you’ve developed
* Tell them to “Stop it”

Which theory is correct?

While each has its merits,

a sound understanding of all NSSI theories is necessary to appropriately treat this group as a population.

The root of cutting: myth or real

* Many have believed that cutting is rooted in a single source and is the problem in itself?

Thoughts?

Best practices in working with NSSI

DBT

Dialectical Behavioral Therapy

Most clinicians are not DBT trained, so here are some first steps that anyone can take:

How theory looks with actual clients

* Acknowledge that this can be very complicated work
* Typically, it is best handled with a two prong approach:
  * Short term - Work needs to be done to address the immediate needs and the client needs skills to REPLACE the NSSI
  * Long term – Work should explore the reasons for NSSI, leading into specific work on trauma, depression, anxiety, etc.

Short Term: Distress Tolerance & Emotional Regulation

* Distress Tolerance – based in the amygdala
  * Distress – extreme anxiety, sorrow or pain
  * Tolerance – the ability to put up with something, or how much you can put up with
* Emotional regulation – based in the pre-frontal cortex
  * Managing mood throughout the day
  * Focused on more traditional coping
  * Coping needs to be focused on client's interests and what will work for them

Distress Tolerance

* Distress Tolerance skills, or “Crisis Survival Skills,” should be focused on managing extreme emotions
* These are crisis survival strategies
* Replace NSSI!

Distress Tolerance Skills

* Will fall into multiple categories
  * Shocking/Distracting Skills
    * Often sensory based
    * Refocus the amygdala
  * Riding the wave – tolerance based
  * Self-soothing skills
* Help create a crisis kit

Shocking/Distracting

* Sensory Based Skills – Our brain is terrible at multitasking!
* Physical temperature
  * Cold shower
  * Use of ice
* Taste
  * Hot/spicy
    * Hot sauce
    * Fireballs
  * Sour
    * Warheads
    * Sour Skittles

Riding the wave

* This should be utilized with mindfulness
* Riding the wave is focused on the fact that what is happening is a biological reaction within our brain, and that this reaction will typically settle down naturally in 15-20 minutes
* The concept is to be able to reassure yourself that although your body is reacting, you are safe and that you will be fine, you just have to “ride the wave” until it settles

Crisis Survival Kit

* Assist your clients with actually creating a physical crisis survival kit
* It can include:
  * Coloring pages/crayons/colored pencils
  * Candle/lighter (if appropriate)
  * Hand cream/lotion
  * Gum
  * Stuffed animal
  * Fidget items

Questions on Distress Tolerance?

Emotional Regulation

* Emotional Regulation skills should be focused on managing fluctuating emotions throughout the day
* Are you controlling your mood, or is your mood controlling you?
* More “traditional” coping
* Focused on client interests
* Should include:
  * Distracting
  * Soothing
* Replace NSSI!

Emotional Regulation Skills

* Charting
  * Create a chart that's individualized for the client
  * Utilize the chart to rate emotion, communicate, and provide measures

  * Here's an example of a completed chart:

Coping

* Create a list of coping based on client interests
  * We start with having the client come up with a list of a dozen interests
  * Each interest is then used to create as many coping options as possible
  * Created collaboratively
  * Tested and edited based on effectiveness by the client
* Match specific coping with appropriate levels of mood

Coping Interests:

* Music
* Pets
* Softball
* Friends
* Skateboarding
* Social media
* Food
* Art
* Cooking
* Outdoors

Turning the interests into skills
Pets: I love my dog…

* Walk the dog
* Pet the dog
* Brush the dog
* Play with the dog
* Cuddle with the dog
* Paint the dog's nails
* Fetch with the dog
* Run with the dog
* Teach the dog a new trick
* Wash the dog

Coping list

* This should be created collaboratively, by the client with the clinician's help
* Come up with *at least* 50-60, knowing that at least ½ will not work
* The more you come up with, the more options you have
* Never stop creating new coping skills!
* Avoid using pre-printed lists

Additional Coping

* Distracting
  * Doodling
  * Drawing
  * Writing lyrics to favorite songs
  * Puzzles
  * Games
* Soothing
  * Bath
  * Brushing hair
  * Nap
  * Mindful activities

Questions on Emotional Regulation?

Long Term: Finding the root

* This will include the more traditional skills of counseling
* Finding the root causes of the emotions that are driving the behaviors
* Helping the client to deal with the emotions appropriately to decrease symptomology

Contingency Management

* Understanding the client's history
  * Exploring how the client's maladaptive coping skills (such as cutting) have been rewarded and reinforced
  * Examining how the "normal" adaptive skills have either been punished or ineffective

Contingency Management, con't

* Planning to effectively change the patterns
  * Set yourself up for the client's success:
    * Maintain smaller caseloads
    * Work in teams
  * Set up your client's for success:
    * Provide 24 hour crisis support
    * Deny appointments for 24 hours after using maladaptive skills, such as cutting
    * Allow client need to determine level of service (instead of standard procedures or your habits)
    * Regular and consistent validation

Questions???

References

Allen, C. (1995). Helping with deliberate self-harm: Some practical guidelines. *Journal of Mental Health*, 4:243-250.

Briere, J., & Gil, E. (1998). Self-mutilation in clinical and general population samples: Prevalence, correlates, and functions. *American Journal of Orthopsychiatry*, Vol 68(4), 609-620.

Favazza, A. R. (1992). Repetitive self-mutilation. *Psychiatric Annals*, 22: 60-63.

Favell, J. E., McGimsey, J. F., & Schell, R. M. (1982). Treatment of self-injury by providing alternate sensory activities. *Analysis and Intervention in Developmental Disabilities*, 2(1), 83-104.

References, Continued

Gratz, K. L. (2003). Risk factors for and functions of deliberate self-harm: an empirical and conceptual review. *Clinical Psychology: Science and Practice*, 10: 192–205.

Gunderson, J. G. (1984). Borderline personality disorder. *American Psychiatric Press*.

Herpertz, S., Sass, H., Favazza, A. (1997). Impulsivity in self mutilative behavior: Psychometric and biological findings. *Journal of Psychiatric Research*, 31: 451-465.

Herpertz, S. (1995). Self-injurious behaviour Psychopathological and nosological characteristics in subtypes of self-injurers. *Acta Psychiatrica Scandinavica*, 91: 57–68.

Klonsky, E. D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical psychology review*, 27(2), 226-239.

References, Continued

Laye-Gindhu, A., & Schonert-Reichl, K. A. (2005). Nonsuicidal self-harm among community adolescents: understanding the 'whats' and 'whys' of self-harm. *Journal of Youth and Adolescence*. 34: 447–457.

Linehan, M. M. (1993). Cognitive-behavioral treatment for borderline personality disorder. *Guildford Press.*

Linehan, M. M. (2000).The empirical basis of Dialectical Behavior Therapy: Development of new treatments versus evaluation of existing treatments. *Clinical Psychology: Science and Practice*, 7: 113–119

Lloyd-Richardson, E. E., Perrine, N., Dierker, L., & Kelley, M. L. (2007). Characteristics and functions of non-suicidal self-injury in a community sample of adolescents. *Psychological medicine*, 37(08), 1183-1192.

References, Continued

Muehlenkamp, J. J. (2006). Empirically supported treatments and general therapy guidelines for non-suicidal self-injury. *Journal of Mental Health Counseling*, 28(2), 166-185.

Nock, M. K., Joiner, T. E., Gordon, K. H., Lloyd-Richardson, E., & Prinstein, M. J. (2006). Non-suicidal self-injury among adolescents: Diagnostic correlates and relation to suicide attempts. *Psychiatry research*, 144(1), 65-72.

Nock, M. K. & Prinstein, M. J. (2004). A functional approach to the assessment of self-mutilative behavior. *Journal of Consulting and Clinical Psychology*. 72: 885–890.

References, Continued

Nock, M. K., & Prinstein, M. J. (2005). Contextual features and behavioral functions of self-mutilation among adolescents. *Journal of abnormal psychology*, 114(1), 140.

Suyemoto, K. L. (1998). The functions of self-mutilation. *Clinical Psychology Review*, 18(5):531-54.