



Editors' Comment

Entering adolescence brings with it many joys and many challenges. Along with the promise of independence come developmental challenges brought on by the physical changes of puberty, the growing importance of social pressures, the temptations of experimenting with sex, drugs and alcohol, and the need to establish one's own identity. While most teenagers cope successfully with this phase of development, some may encounter difficulties. Those who find themselves overwhelmed by depressed or anxious feelings may seek relief of tension by engaging in self-injurious behaviors. In this issue of the *NYU Child Study Letter*, we discuss the relationship of self-injurious behavior to other emotional problems as well as its prevalence, symptoms, risk factors and treatment strategies.

AG/HSK

Introduction

It is estimated that one to two million people in the United States intentionally and repeatedly bruise, cut, burn, mark, scratch, and mutilate different parts of their own bodies.¹ This estimate represents only the adolescents and adults who actually seek help for the behavior. Since the wounds inflicted are not intended to be life-threatening, often do not require medical attention, and are frequently dismissed as "accidental," clinicians and researchers believe that many people engage in acts of self-inflicted violence who are never treated or included in mental health statistics. In recent years, however, there appears to be a dramatic increase in the number of younger and older adolescents

SELF-INJURIOUS BEHAVIOR

who engage in self-injurious behavior (SIB).² Family members and friends are justifiably confused, angry, and frightened by the idea of a teenager deliberately and repeatedly hurting his or her own body.

Adolescents who self-harm experience tremendous tension and anxiety before the act along with an intense preoccupation with thoughts of injuring themselves. Many people report that the impulse to injure is irresistible and cannot be thwarted. The teenager may feel little or no pain as the cut, burn or scratch is inflicted. There can be feelings of gratification, relief, comfort, and even arousal after the act of self-harm. Despite the fact that many teens are psychologically invested in the behavior and feel helpless to stop, self-injurious behavior can be reduced and eventually extinguished. Often, a combination of individual and family therapy, self-help strategies, self-injurious behavior substitutes, medication, and the use of community resources and support groups can help individuals re-claim a healthy sense of control over their bodies.

Case Vignettes

When Debbie turned 12 years old, she began to menstruate and to become physically mature. Instead of feeling excited by these normal developmental changes, she remembered feeling extremely anxious and angry. Several months later, she began to secretly scratch her inner thighs and chest in response to these feelings, and as a way to manage them. She would either use her fingernail or a pen cap, and would scratch "just deep enough to make it bleed and leave behind a mark." Debbie realized that the behavior increased whenever a family member commented on her physical development or when she got her menstrual period.

For 17-year-old Charlie, his father's promotion at work meant another move to a new neighborhood and school. These relocations were always challenging and anxiety-producing. Charlie described his parents as "workaholics" who chose to work long hours. Charlie was frequently alone in his new house and had a difficult time making new friends. As a way to "feel better and handle stress," Charlie made small cuts on his forearms with a razorblade and burned himself with a lighter. In addition, Charlie picked at wounds until they became infected. He reported that he was "unable to let the wounds heal."

Symptoms of self-injurious behavior

Adolescents who engage in self-injurious behavior are performing deliberate and repetitive acts of physical harm to their own bodies.³ The behavior is usually done secretly and privately. It may be planned and ritualistically performed or it may occur impulsively and without forethought. The most common manifestation of self-injury is cutting and slashing.⁴ Although most self-harmers have a preferred method, many teenagers who habitually hurt themselves do so in a variety of ways. Other common forms of self-injurious behavior include: burning the skin; limb-hitting and bruising; head-banging; picking at wounds; peeling the skin; deep biting; severe skin scratching; nail and cuticle biting; pulling out hair; bone breaking; swallowing sharp objects; and inserting sharp objects or toxic liquids into the body. The most targeted body parts are the upper limbs.

Adolescents may use razorblades, scissors, and knives to cut the skin, and cigarettes, lighters, and matches to burn



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themselves. They can also take seemingly benign objects such as paperclips, pen caps, jewelry, fingernails, and nail clippers, and turn them into self-harming tools.

Contrary to popular belief, tattoos and body piercings are not considered forms of self-injurious behavior. This is because they are performed by someone else, in a social context, and are primarily designed to beautify the body.⁵ However, teenagers who allow piercings to become infected and then pick at the wounds, or secretly pierce or tattoo their own bodies to relieve anxiety or "feel better" are engaging in self-injury.

The wounds from self-injurious behavior are, by definition, not life-threatening and are not intended to be manifestations of suicidal ideation or suicidal gesturing.⁶ The severity of the injury is usually measured by three factors: the extent of the damage; the level of medical intervention it requires; and the location of the wound.⁷ Many injuries leave only superficial damage to the first layer of skin and require nothing more than cleansing the area. Other injuries may break the skin, creating minor to significant bleeding. Some wounds require stitches, and the most serious wounds may require complex repair, leading to disfigurement and scarring.

Although some teenagers claim that it's "cool" or "brave" to self-injure, most adolescents who hurt themselves feel some sense of shame and repulsion about self-harming. They think the behavior is "weird or crazy," but feel alienated and isolated, and feel powerless to stop. They are usually reluctant to disclose what they are doing. These individuals often present as depressed, anxious and overwhelmed. Some teens present with false bravado and appear angry, defensive or uncaring. Often, adolescents who hurt themselves may be engaging in other forms of self-destructive behavior including: reckless driving; shoplifting, sexual promiscuity or unprotected sex, substance abuse, and eating-disordered behaviors.

Anyone who engages in self-harm is desperately trying to cope with overwhelming feelings and thoughts. Self-inflicted violence is meant to soothe, alleviate anxiety, and increase a sense of power and control. Ironically, as the behavior escalates, it actually exacerbates feelings of disempowerment, alienation, and helplessness.

Who is likely to engage in self-injurious behavior

Both males and females engage in self-injurious behavior. Self-harm often begins in early adolescence, peaks between the ages of eighteen and twenty-four, and decreases as the person enters the thirties and forties. There are, however, cases of self-harm occurring in much younger children and continuing into middle age. Adolescents are particularly vulnerable as they face many difficult and inherently stressful developmental challenges. The body undergoes profound change during adolescence. It is a time of physiological and psychological turbulence and uncertainty. Faced with abrupt and embarrassing changes, teens can feel a loss of control of their bodies. For many adolescents, experiencing a sense of alienation from their own bodies becomes a powerful catalyst for and predictor of self-injurious behavior.⁸ In addition, teenagers struggle with the need for peer acceptance, shifting peer allegiances, a greater desire for autonomy and control, and complicated decisions and conflicts that demand resolution.

Within this overwhelming context, adolescents are at even greater risk when their parents are physically or emotionally unavailable to them. In some families, there may be unhealthy communication, parental alcoholism, untreated mental illness, financial stress, domestic violence, and parental neglect or prolonged absences. Teens are unable to negotiate these challenges, process their feelings, and articulate their needs without the guidance, support, and feedback of a nurturing caretaker. They simply do not have the required coping skills to manage on their own, and they discover that self-injurious behavior is one way to deal with life.

Teenagers who have undiagnosed and untreated depression and anxiety are more likely to engage in self-harming behaviors as a way to self-soothe and self-medicate. Teens who struggle with low self-esteem and feelings of worthlessness are equally at risk. Adolescents with Dissociative Disorders, Posttraumatic Stress Disorder (PTSD), substance abuse problems and eating disorders are at increased risk to cut or burn. One of the greatest risk factors is a history of physical, emotional or sexual abuse.⁹

Trauma survivors learn to internalize their rage and dissociate or "check out" to escape pain. In addition, they have had their perpetrators model a blatant disregard for the safety and well-being of their bodies. This combination of experiences almost inevitably sets the stage for some form of self-destructive behavior.

Understanding self-harm

Self-harm is first, and foremost, a coping strategy. It manages overwhelming thoughts and feelings by short-circuiting them. Often, an individual's behavior will be triggered by a simple life event. The event will create negative thoughts such as "I will always be a failure" and negative feelings such as rage or despair. Without the tools to handle these thoughts and feelings, tremendous tension and anxiety are produced. As the tension builds, the adolescent begins to dissociate or zone out, looking for an escape. Once the teen has dissociated, he or she is able to hurt the body without experiencing any real pain. The dissociative process allows teenagers to detach from their own bodies, their environment and their behavior. As the body is injured, they immediately experience positive effects. The negative thoughts and feelings are forgotten and a fleeting sense of control is reclaimed.

Perhaps, most importantly, the body responds to the trauma of injury by releasing endorphins: naturally occurring opiates.¹⁰ The release of endorphins allows the teenager to feel "high," "euphoric" and "relieved." The shock of seeing blood helps some teenagers feel "alive and real." Unfortunately, the positive effects are always followed by negative outcomes including: a loss of control, a feeling of failure, shame and guilt, depression and self-hatred. Some adolescents have no conscious memory of hurting themselves and are actually frightened when they discover a wound. Others report that they can "watch themselves" engage in self-harm, but they feel "powerless" to stop the process. These negative outcomes leave the teen emotionally vulnerable and primed to be triggered by the next "threatening" event. This helps to explain the repetitive or cyclical nature of self-injurious behavior.¹¹

There are many other reasons why people self-harm. It has already been described as a way to re-claim control over the body. For some, self-harm is a way to punish the body for physically maturing or for its "participation" in sexual abuse. Most adolescent survivors of abuse do not blame their perpetrators. They tend to introject the experience and blame themselves and their own bodies for sexual trauma. Self-harm is a way to externally express internalized rage. Self-harm can also be a re-enactment of trauma.¹² Many teenagers hurt their bodies in ways that replicate earlier abuse. The location and nature of the wound often tell a non-verbal story about the abuse.

Creating a mark or an injury is a way to make internal, invisible wounds, external and visible. It lets others bear witness to the pain, making it more tangible and real for the adolescent. A wound affirms the reality and validity of internal pain. Self-harm also provides the opportunity for self-care.¹³ Wounds can be washed, bandaged, and lovingly attended to as part of the ritual. In some ways, this replicates prior abuse: the body is comforted after it is hurt. Some teens create wounds as "event markers." It is a concrete way to remember something important or traumatic that has happened to them. Sometimes old scars unlock stories about important events from the past. It is also a way to create euphoria, security, and a sense of identity. It is always a cry for help. It should always be taken seriously and never ignored. It is imperative that family and friends talk openly about self-injurious behavior when they suspect it is occurring. Talking non-judgmentally about the behavior helps to reduce the shame and secrecy that often surrounds self-harm. Talking to someone provides a sense of hope and often leads to resources that can provide genuine help. Acknowledging that the behavior exists is the first step towards recovery.

Treatment Strategies

Psychotherapy. It is extremely important to work with a helping professional who has an expertise in self-injurious behavior or related disorders. Psychotherapy can provide a non-judgmental and supportive environment where self-injury can be openly processed and the meaning behind the injury can be explored. Trained

therapists can provide safer, alternative ways to communicate, self-soothe, and cope. The use of journaling, art therapy, relaxation techniques, visualizations, cognitive re-framing, and affect management are all recommended and useful. Appropriate contracts that encourage the teenager to write, draw, exercise and self-soothe before engaging in self-injurious behavior are more effective than contracts that demand the immediate cessation of the behavior.¹⁴ When the self-injury is severe, the teenager is unable to integrate strategies and abide by a safety contract, or additional problems such as substance abuse or a threatening eating disorder are evident, inpatient treatment is often required.

In addition to working with a trained therapist some teens are able to utilize resources such as personal journaling and drawing, meditation, spiritual support, and healthy self-injurious behavior substitutes such as physical exercise.

Psychopharmacology. When self-injurious behavior connects to untreated depression or anxiety, medication can be extremely useful. Anti-depressants can dramatically reduce the negative feelings and cognitions associated with the cycle of self-harm. Anxiolytics prevent the escalation of panic and generalized anxiety, which decreases the need for dissociation and self-injury. Providing a pharmacological safety net may also allow adolescents to process painful trauma memories without becoming flooded or overwhelmed.

Conclusion

Self-injurious behavior can be reduced and eventually extinguished once the adolescent is ready to embrace alternative behaviors designed to promote healthier communication, self-comfort and genuine healing.

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RECOMMENDED READINGS

- The Scarred Soul*
T. Alderman
New Harbinger Publications, 1997
- When the Body is the Target: Self-Harm, Pain and Traumatic Attachment*
J. Wegscheider Hyman
Temple University Press, 1999
- Bodies Under Siege: Self Mutilation in Culture and Psychiatry*
A.R. Favazza
Johns Hopkins University Press, 1987
- Skin Game*
C. Kettlewell
Griffin Trade Paperback, 2000
- Women Who Hurt Themselves*
D. Miller
BasicBooks, 1994

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