

Teens and Deliberate Self-Harm: Findings from the Cutting Edge

A review of contemporary literature by Kate Fogarty

What is Self-Injuring Behavior?

Self-injury is viewed as a contemporary “teen disorder”¹ due to its recent attention as it affects anywhere from 2 to 10% of adolescents in the United States, Britain, and other parts of Europe^{2,3,4}. Self-injury (also known as non-suicidal self-injury/NSSI, cutting, deliberate self-harm, and self-mutilation) involves causing intentional harm to oneself by bruising, cutting, burning, scratching, banging, ripping or pulling skin or hair, ingesting toxic substances, and even breaking bones². These behaviors are usually brought on by teens’ feelings of low self-worth, stress, frustration in handling strong emotions, and anxiety^{2,4}. Youth workers and practitioners find cutting to be the most prevalent type of self-injury⁵.

What Self-Injuring Behavior is NOT

Self-injury is different from more “culturally sanctioned”² forms of self-decoration such as tattooing and piercing (although extreme cases of self-decoration may be motivated by similar emotional states and some consider tattooing and piercing to be a type of self-mutilation). It is not the same as suicidal behavior². Self-harmers are more prone to think about or attempt suicide, but self-injuring behavior is not a sign of suicidal intent, rather a way to relieve stress or a “highly functional alternative to suicide”² (p. 409).

Why a “Teen” Disorder?

Twelve years old is the typical age at which self-harm begins³, with a peak age period between 16 and 25 years⁵. Self-harm seems to follow the same pattern as other problem behaviors in adolescence: for example, starting in early adolescence, peaking in middle adolescence and phasing out in early adulthood². There is a second, more rare, pattern in which self-harm starts in early childhood and continues through adulthood. Others classify self-harm into three patterns of: *episodic* – occurring one or several times; (2) *repetitive* – occurring on a regular basis; and (3) *compulsive* – when a teen feels he or she is “unable to stop”⁶.

What Proportion of Teens Self-Injure?

To date, reliable estimates of self-harm prevalence in the U.S. are lacking². Also, most cases of teen self-injury are not easily detected by service professionals³. What we do know is that one-fifth of clinical samples, 4% of the population at large, and 1.8% of 15-35 year-olds in the U.S. engage in self-injuring behavior^{2,5}. A large study in Britain found about 10% of 11- 25 year-olds self-injured².

Why do teens injure themselves?

Teens who harm themselves have difficulty controlling their emotions, handling stress and tension and self cutting behaviors are a means to deal with angry, anxious, and depressed



feelings⁵. Often their behavior is a way to deal with trauma experienced growing up⁵. Self-harming teens are likely to experience bullying and have low self-esteem. They may have also experienced abuse at home or parental divorce. Self-injuring is also linked with post-traumatic stress disorder, depression, anxiety, eating disorders, and borderline personality disorder². In their own view, teens who engage in non-suicidal self-injury most commonly do so to “get a reaction from someone”, “get control of a situation”, and “stop bad feelings”⁷.

A popular psychophysiological explanation of why some teens self-harm is that the pain of self-injury causes the release of endorphins, thus producing a natural “high” for temporary relief from emotional distress and frustration. This explanation, combined with an understanding of adolescent brain development and teens’ propensity to addiction, also lends to understanding why they sometimes become addicted to self-harming behaviors⁵.

Intervening with Teens who Self-Injure

Although teens most commonly outgrow self-harming behaviors by adulthood³ may leave limited physical scars, teens’ self-harming behavior is a cry for help to alleviate the underlying causes. When it comes to self-injury, professionals agree that prevention supersedes intervention^{3,5}.

Due to the secretive way in which some teens engage in self-injuring behaviors, open dialogue between youth and adults (in families and in the community) is crucial. This could involve examining for signs and asking teens about any signs witnessed in a non-accusatory tone (for example, saying, “I noticed a razorblade on your nightstand. Could you tell me about that?”). We know that less than 2% of teens in the U.S. self-harm. However, your teen may have a friend or peer who self-harms. Also, “social contagion” has been found among adolescents who self-harm; in other words, susceptible teens learn behaviors from their peers who self-harm².

Signs that a teen may be engaging in self-injuring behaviors include⁸:

- Razor blades, scissors, pins, lighters and other sharp objects present in room or on their person.
- Unexplained frequent injuries
- Acting isolated, withdrawn or bored
- Low self-esteem and expressions of self-hatred
- Difficulty handling feelings and emotions
- Secretive, especially when asked about injuries

When dealing with teens that self-harm, it is preferable to take an assets-based perspective over a pathological one⁵. Teens that self-harm are often ashamed of their behavior and fear being labeled as psychopathic. Mental health and medical professionals are likely to label self-harming teens’ behavior as “attention seeking..., manipulative, or time wasting”³ (p.14). Teens who self-harm may feel guilty and concerned that the public would view them as dangerous and unfit to volunteer or work in service professions³. However, the good news is in a study of teens who self-harm and share about their struggles on Internet message boards, a majority was largely positive about receiving psychological help².

Ultimately, the goal of intervention is to help teens with self-harming behaviors to improve interpersonal communication, handle interpersonal conflicts, and be better able to express emotions. A multidisciplinary (support groups, family therapists, social workers, teachers, counselors, psychologists etc.) and ecological (individual, family, school, community) approach

is most effective⁵. This may involve individual and family therapy. Ultimately help the youth by improving his/her social environment.

Suggested Resources

Website: The site below, although from the United Kingdom, contains useful suggestions and information, and reflects the recent attention (past 3 years) that the UK has given adolescent self-harm, based on recent research findings which have affected children and educational policy.

National Children's Bureau, U.K. <http://www.selfharm.org.uk/default.aspa>

Video: The following video has been reviewed by scholars from the American Psychological Association (APA) and is available from the APA for the cost of \$99.95.

Lader, W. (2006). Self-Injury. Washington, DC: American Psychological Association Video Series, Specific Treatments for Specific Populations

Program/Intervention: This program has been around for 20 years and continues to be applied today for treatment of adolescent self-harm.

S.A.F.E. Alternatives (Self-Abuse Finally Ends), founded by Karen, Conterio, Administrative Director.

References

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