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The Antecedents, Treatment Strategies and Motivations of Self-harm among Teenagers: Case of Bridge for Youth, Minneapolis, USA

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Abstract: This paper is a culmination of a practicum report by the author done at the Bridge for youth facility in Minneapolis, USA. The Bridge for youth is one of the first places in the United States for youth in need of shelter and support. It is a leader in the provision of comprehensive shelter, counseling, and housing services and a model organization in the community serving youth in crisis in the US. It is assumed that the findings and recommendation therapy strategies from this study could be applied elsewhere within the subset of teenage population. This paper has three objectives with regard to examining self-harm among teenagers at the facility. The first objective is to establish the prevalence and the attributes of self-harm among the study population. The second objective is to examine the antecedents of self-harm with treatment strategies and lastly; to evaluate the motivations for self-harm among teenagers. The researcher used three techniques in solution-focused therapy including; the miracle question, exception question, and scaling questions. These approaches are based on open-minded, non-judgmental listening and on harm minimization rather than abstinence. Psychotherapy primarily involved altering emotion regulation strategies. Generally, treatment recommendations focused on assisting self-injurers to broaden their range of coping strategies, and improve problem-solving capabilities. The researcher also used Solution focused brief therapy and Narrative therapy, in which data was collected from both parents and children who participated in treatment.
Keywords: Self-harm, Psychotherapy, psychopathology, pharmacological treatment.

INTRODUCTION

Self-harm is a deliberate direct injuring of the body tissue, done mostly without suicidal intentions. The term is used in the more recent literature as an attempt to be more neutral. The older literature, especially that which predates Diagnostic and Statistical manual of mental Disorders (DSM-IV-TR), used the term 'self-mutilation'. The term is synonymous with 'self-injury'. The most common form of self-harm is ingestion of drugs but also covers a wide range of behaviors including, but not limited to burning, skin cutting, scratching, hitting body parts, interference of wound healing, hair pulling(trichotillomania). Behaviors associated with substance abuse and eating disorders are usually not considered self-harm because the resulting tissue damage is ordinarily an unintentional side effect. However, the boundaries are not always clear-cut and in some cases behaviors that usually fall outside the boundaries of self-harm may indeed represent self-harm if performed with explicit intent to cause tissue damage.

Although suicide is not the intention of self-harm, the relationship between self-harm and suicide is complex because self-harming behavior may be potentially life threatening. There is also increased risk of suicide in individuals who self-harm as it contributes 40%-60% of suicides, but generalizing self-harmers to be suicidal is in majority of cases inaccurate.

A review of recent literature defines the phenomenon in divergent ways. While some describe deliberate self-harm as existing only when there is clear intent not to kill oneself [1]. Others define it in just the opposite way saying it only exists when there is clear intent to kill oneself [2, 3]. Favazza [4] agrees and describes self-harm behavior as a morbid form of self-help that is antithetical to suicide. In fact, one model of self-harm [5] is named the "anti-suicide" model and focuses on self-harm as an active coping mechanism used to avoid suicide.

For this paper the term self-harm will be used for those whose intent may be or not to kill them. The assessment of "intent" is subjective and its determination may be difficult but exploring intent is essential to gaining an understanding of the nature of this disturbing phenomenon. Self-harm among teenagers is manifested in activities such as; attempts of

suicide or suicide, use of illicit drugs, alcoholism, ingestion of toxic substances and drug abuse.

THE ANTECEDENT OF SELF-HARM

Self-harm occurs when a person face overwhelming or distressing feelings that they do not know what to do with. Self-harm temporarily relieves intense feelings pressure, or anxiety. Some report it is a means to control and manage pain-unlike the pain experienced through physical or sexual abuse [6]. It provides away to break emotional numbness (the self-anesthesia that allows someone to cut without feeling pain). It is a way to ask for help in an indirect way or draw attention to the need for help. Self-harm among teenagers is common and the rate may be increasing. Although the reasons precipitating self-harm are complex, literature has revealed that primary antecedent or situation preceding an instance of deliberate self-harm was some form of tension build up. Both depression and anxiety are commonly seen in people who engage in self-harm.

Build-up tension and Anxiety

Although the reasons precipitating self-harm are complex, all of the literature examined revealed that primary antecedent or situation preceding an instance of deliberate self-harm was some form of tension build up. Both depression and anxiety are commonly seen in people who engage in self-harm, but anxiety/tension has been found to maintain a substantial unique relationship to self-harm over and above depression [7]. This antecedent is dramatically substantiated in statements made by those who self-harm.

One female stated, "I feel like a pressure cooker that's going to explode. Cutting and bleeding sufficiently is like letting out the steam. If I do this to my satisfaction, I feel immediate relief, as if injected with valium something. It helps stop the inner turmoil for a while" [8]. Andover, Pepper, Ryabchanko, Orrico, and Gibb [9] were the first to investigate differences in anxiety and depression among self-harmers who cut themselves and those who self-harm in other ways. They confirmed that those who self-harm generally had significantly more depression and anxiety symptoms than the control group. When they differentiated self-cutters from those who engage in other forms of deliberate self-harm, they found that self-cutters reported significantly more anxiety than the other self-harmers, but have similar levels of depression.

Hostility and Impulsivity

Ross and Health [10] studied a group of 122 adolescents in two schools who self-harmed. The results showed that while a small group of adolescents reported only feelings of anxiety, more than two thirds of those who self-harmed indicated hostility and anxiety prior to acts of self-harm. The results of this study lend support for the hostility model of self-harm as outlined by Herpertz, Sass, and Favazza [11]. This model postulates that an individual turns to self-harm because of an ability to overtly express anger, which in turn leads to rising tension. One further finding of Ross and Health [12] was that self-harmers had greater levels of both extra punitive hostility (e.g., Cynical, resentful, easily angered) and Intro punitive hostility (e.g., self-doubt, guilt, and self-criticism). This tendency to be easily angered while at the same time, experiencing self-dislike and guilt may result in self-hostility. Castille and colleagues **[**13] at Widmer University, studied maladaptive schemas for those who self-harm and found that one of the four schemas that distinguished self-harmers was an underlying belief that he or she lacks self-control and is impulsive (p=0.0008). The researchers concluded that this inherent impulsivity might render the self-harmer unable to cope with unbearable affect and cognitions in more adaptive ways.

Depersonalization and De-realization

Gratz, Conrad and Roemer [14] examined risk factors for self-harm in a population of college students and found the most significant predictor was dissociative episodes. The idea of feelings of unreality or lack of a feeling state, as triggers to self-harm has also been documented in qualitative studies [15, 16]. Harmony, one of the participants in Machoian's **[17]** study, described this state as being in the twilight zone and stated "Oh God, like you're in a fog. It's like you're, it's like I'm looking at the world but I don't feel like I'm here. It's like this big cloud in front of me. Do you know what I mean?" Cutting seems to end the dissociative episode and bring the self-harmer back to a sense of realness.

Childhood Trauma

Childhood trauma is predominantly featured in discussion of predisposing factors for self-harm, and the association has a long history with ample evidence [18-20]. The presence of childhood trauma has been shown to precipitate self-harm in childhood and in later life of the self-harming patients that Zanari and colleagues [21] studied, 32.8% first harmed themselves as children (12 years of age or younger), 30.2 % as adolescents, and 37% as adults. The results of their study suggested that when self-harm begins in childhood, the course of self-harm may be particularly malignant.

SELF-HARM TREATMENT STRATEGIES

Self-injury in adolescents has recently been recognized as a commonly occurring phenomenon. Therapeutic approaches based on open-minded, non-judgmental listening and on harm minimization rather than abstinence may be more effective than current treatment approaches that forbid any form of self-harm. "While parents usually urge their teens to stop immediately, that's not necessarily a good idea", said

Karnik, who specializes in adolescents. Teens say self-harm gives them relief from emotional pain and there may be some truth to that, Karnik said, "self-injury is almost like a pressure valve for them without it you have to ask, what that kid is going to do now?" We have to work with them to give them better strategies to relieve their stress and anxiety." some strategies that could help include journaling, exercise, psychotherapy, cognitive behavior therapy and medications.

Consequently, there are few randomized, controlled trials for the specific treatment of non-suicidal injurious behavior in adolescents. In adults, the therapeutic intervention with the most research demonstrating efficacy in reducing self-harming behavior is dialectical behavior therapy (DBT). DBT uses a combination on individual and group therapy to teach skills in emotional regulation, interpersonal effectiveness, distress tolerance, core-mindfulness and self-management. The intensive treatment requires the individual clinician to be on call for those patients at all times. DBT has been adapted for adolescents with features of borderline personality.

Treatment is based on a thorough psychiatric evaluation, with a focus on acute safety issues, suicidal risk, and clarification of comorbid psychiatric conditions. Treating self-harm involves determining the needs that the behavior fulfills and helping the adolescent devise other healthier ways to meet those needs. For example, if self-harm helps a teen to calm down, what other techniques might provide the same result? The psychiatrist might recommend that self-harmers develop mindful awareness skills, practice deep breathing exercises, use ice on their wrist to produce a physical distraction, talk to a friend about emotions or exercise strenuously. Improving affective language and other communication skills can be key in reducing self-harm. Since adolescents engaging in self-harm often have poor problem-solving abilities, it is important to improve these skills as well.

Involving family in the support and treatment of adolescents with non-suicidal self-injurious intent is also very important. Poor communication with family has been associated with suicidal behavior in some adolescents. Improving the family's understanding of self-harm can be useful in decreasing conflicts; it can be helpful for the family to learn de-escalation strategies and expand listening and communication skills. Family members can also help with safety plans and practicing problem solving skills.

Pharmacological treatment of self-harm should primarily focus on any underlying psychiatric disorders. Currently, there are no specific medications approved for the treatment of self-harm. Since depression and anxiety often accompany self-harm identifying and treating these disorders should be top priority. Concerns about an increase in suicidal thoughts with adolescents using antidepressant medication should be reviewed with teens and their parents. While the protective effects of antidepressants appear to outweigh the risk of increased suicidal thoughts, medication use should be monitored regularly. Additional precautions are helpful when prescribing medications for self-harming teenagers. Prescribing larger quantities of potentially lethal medication should be avoided and benzodiazepines should be used cautiously due to the potential for behavior disinhibition.

MOTIVATIONS FOR SELF-HARM

While the act of self-harm may seem irrational, those who engage in self-harm often explain their behavior in ways that possess a situated internal logic [22]. For example, a female age 23 refers in her statement "I injure myself to try to calm down; to try to escape painful memories of my abuse, to try and take control of my emotions, to try to feel safe, to stop the nightmare and day mares" [23]. The following are some reasons given by many self-harmers for their behavior.

Relief from tension

The rapid and dramatic reduction of tension following an act of self-harm has been well documented [24-27]. Although it seems counterintuitive, the self-harm action itself seems to result in immediate release and relief, and there is biological evidence that self-harmers experience a physiological stress reduction after an episode that may last as long as 24 hours [28]. Sachsse, Vonder Heyde and Huether [29] were able to demonstrate the physiological stress reduction that follows an act of self-harm. They assessed the urine cortisol level of one self-harming woman for 86 consecutive nights she generally showed low cortisol excretion; however, whenever her cortisol level rose above 20ug, she performed one of the several acts of deliberate self-harm. Subsequently, an instantaneous return to her baseline low cortisol levels was observed. These authors concluded that the results provide some evidence that episodes of self-harm may occur as a response to hyperactivity of the central stress sensitive neuroendocrine systems. Thus, they lend some neurobiological weight to the assumption that self-harm may be regarded as an unusual but physiologically effective coping strategy for regaining control over an otherwise uncontrollable stress response. Further studies are needed to confirm this finding but it provides preliminary evidence that self-harm may have some psychobiological antecedents.

Failed Communication

Failed communication refers to failure to give necessary attention to the needs of the affected person. Machoian [30], described cutting as a means of gaining a response when speaking voices fail. One of the girls

interviewed in her qualitative study stated, "If it's an actualization of pain, you know….The most basic is that even if you tell people that something is wrong, a lot of times, they won't, they won't know how wrong. But all they'll do is see a cut along a vein, and they get the message right away" (p 25). These qualitative findings were indirectly supported by Castille and colleagues [31], who found a strong correlation between self-harm and a broad pervasive schema of social isolation and alienation (p=0.0008). It seems that those who self-harm feel that no one is able to be emotionally supportive and provide them with the understanding and affection. In the absence of caring listeners, it may be that self-harmers feel the need to turn to a more dramatic communication method. Potter [38] suggested that the body is used as text and serves to communicate something that is difficult to articulate in conventional modes.

Caregivers' Negative Attitude

Patients who present for treatment of self-harm are often critical of their treatment and describe negative attitudes of their caregivers [32, 33]. Negative reactions of the health professionals to women who self-harm are paradoxical and unintended consequence. Machoian's [34] qualitative inquiry of adolescent girls revealed that as soon as girls who self-harm discover the efficacy of this language they are denigrated for knowing it. Many therapists and nurses find that they need to manage their own reactions even as they attempt to manage the self-harm behaviors of their patients [35]. Shaw [36] explained that clinicians seem to lose sight of the conceptualization of self-harm as an attempt to control psychological distress and, instead view the behavior as psychological blackmail. Hopkins [37] interviewed nurse key informants in her ethnographic study and found that these nurses perceived self-harmers as impending the functioning of the busy medical admissions units because of their complex and time-consuming needs. She concluded that people who self-harm are seen as having reduced entitlement to care.

CONCLUSION

The paper review indicates self-harm among teenagers is common and the rate may be increasing. Moreover, while teenagers who self-harm may not have severe psychopathology, those presenting with self-harming behaviors should have a thorough psychiatric assessment that includes screening for suicidal ideation and risk factors. It is important to family and other interpersonal supporters to formulate and implement treatment recommendations for each case they have given the reasons for self-harm. The researcher recommends that pharmacological treatment should focus on treating underlying psychiatric disorders. Lastly, it is recommended that psychotherapeutic treatment be offered to teenagers for understanding self-harm and adaptive utilization of various coping strategies.

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