WHY KIDS CUT

Paul VanValin, PhD
www.edencounseling.com

WARNING – YOU MAY BE TRIGGERED

- You have a history of self-injury
- You love someone who is self-injuring
- You are an anxious care provider who is working with someone who is self-injuring
- You require an organized lecture

PAUL VANVALIN

- Practicing Christian – PK
- Informed about varied church cultures
- Married 36 years to a PK
- Three married sons – 31, 28, 24 – no bio grandkids
- “Adopted” daughters and grandchildren

PV CONT.

- Student of marriage and family, stress, leadership
- Clinical Psychologist and founder of ECC in 1995
- President of Eden Family Institute, Inc. (non-profit 501C3) 1996
- Co-founder of FirstFruits Crisis Response in 2001
- DI on DISC
- INTJ on Myers Briggs
- IQ at least average

MISSION STATEMENTS

- **Paul VanValin** helps people find their true identity and to live as if they believe.
- **Eden Counseling and Consultation** provides excellent Professional Christian Counseling and Consultation and develops Innovative Services and Effective Leaders.
- **Eden Institute** equips Leaders to fulfill their Calling. Together we develop Healthy Families, Dynamic Communities, and Meaningful Legacies by integrating Biblical Truth with proven psychological principles.

PV SERVICES

- Speaker/Trainer
  - Back to the Garden Marital Workshops
  - Eden Marriage Mentor Training
  - FirstFruits Crisis Responder Training
  - ECC graduate and postgraduate training director
- Counseling and Coaching with Leaders – Phone and Skype and Intensive Assessment and Consultation
- Assessment – personal and organizational
- Coach
  - Practice Development
    - Collaboration
    - Recruiting
    - Branding
    - Business infrastructure
  - Ministry Development
    - Marriage and Family
    - Stress
    - Disaster Recovery

EDEN COUNSELING AND CONSULTATION

- 25 non-medical therapists and 6 students
- 500+ families a week – multiple specialties
- All ages, all SES – goal is to serve entire community
- Research validated treatments
  - EMDR
  - DBT
  - PCIT
  - Reminiscence Therapy
  - Kelso's Choices
  - CBT
- Employment or training – **www.edencounseling.com**

SELF-CARE BOUNDARIES

- I didn't cause this.
- I can't fix it.
- My job is to provide the best (medical care/counseling/therapy/pastoral care/parenting) that I can.
- On any given day, I am the best (doc/counselor/therapist/shrink/parent/ hair stylist) in the room.

AN ACCIDENTAL CUT

- Very Busy Day
- High Cumulative Stress
- Trying to Help by making dinner

AN ACCIDENTAL CUT

- The cut takes all of his attention
- Anxiety and external stress immediately diminish to a “0”
  - 1-10 scale, 10 is the world’s worst anxiety
- Care for the cut is time and attention consuming – other stressors are out of sight
  - Trip to the doctor – stitches – medication – ice – elevation – limited use
- For days the cut draws attention through pain and inconvenience
- Re-injury is easy and it could be kept an open wound to function as a distraction – allow infection etc.

NEUROBIOLOGY OF SELF-HARM

- Amygdala processes danger – fear and anxiety triggered -Fight or Flight or Freeze
- Frontal – Temporal cortex assesses and triggers calming
- Emotions are stronger with poor self regulation in Self-Harm
- Self-Harm is a circuit breaker – needs to be strong enough to work
- **Addictive**
- **Co-morbid OCD**
- **Meds will not change the brain**
- **Mindfulness may alter brain function to some degree**
- **Ice dive, frozen orange, tangle no physical harm**

NEUROBIOLOGY - HAPPINESS

- Brain patterns in happiness vs. distress
- Left side of Frontal Temporal Cortex – positive emotions
- Right side disgust, fear and sadness
- Single subject studies suggest that subjects at rest measure more in the negative emotion patterns, more right temporal
- Hair trigger, higher stimulation at rest
- Once activated the activity is much higher than normal subjects
- Brain does not differentiate physical from psychological pain

PERMA – MARTIN SELIGMAN

- Positive Emotions
- Engagement
- Relationships
- Meaning
- Achievement
- Pleasure and Addictions PE, sometimes A

DISSOCIATE DEFINED

- to end your relationship with or connection to someone or something : to separate (yourself) *from* someone or something
- We are using it here when a person separates from some element of current reality.

DISSOCIATION DEFINED WIKIPEDIA

- **Dissociation** is a term in psychology describing a wide array of experiences from mild detachment from immediate surroundings to more severe detachment from physical and emotional experience. It is commonly displayed on a **continuum.** In mild cases, dissociation can be regarded as a coping mechanism or defense mechanism in seeking to master, minimize or tolerate stress – including boredom or conflict. At the non-pathological end of the continuum, dissociation describes common events such as daydreaming while driving a vehicle. Further along the continuum are non-pathological altered states of consciousness.

DISSOCIATION CONTINUED

- dissociative disorders, can include: a sense that self or the world is unreal, a loss of memory (amnesia); forgetting our identity or assuming a new self (fugue); and fragmentation of identity or self into separate streams of consciousness (dissociative identity disorder, formerly termed multiple personality disorder) and complex post-traumatic stress disorder.
- some dissociative disruptions involve amnesia, other dissociative events do not.
- Dissociative disorders are typically experienced as startling, intrusions into the person's usual ways of responding or functioning.
- **They tend to be quite unsettling.**

DEFINE DEPERSONALIZATION

- a psychopathological syndrome characterized by loss of identity and feelings of unreality and strangeness about one's own behavior

DEPERSONALIZATION DISORDER

- Depersonalization disorder occurs when you persistently or repeatedly have a sense that things around you aren't real, or when you have the feeling that you're observing yourself from outside your body. Feelings of depersonalization can be very disturbing and may feel like you're losing your grip on reality or living in a dream.
- Depersonalization disorder can be severe and may interfere with relationships, work and other daily activities. Treatments for depersonalization disorder include medications and psychotherapy.

NEGATIVE DISSOCIATION, DEPERSONALIZATION AND SELF-HARM

- Depersonalization - “Emptiness” replaced with “feel alive” by blood and pain
- Dissociation and Depersonalization triggers intense fear
- Self-Harm may be used to ground
- A person has lost the “internal” grounding capacity

TERMINOLOGY IN RESEARCH

- Self-harm – the individual may or may not have suicidal intent, including overdosing
- Deliberate self harm (DSH)
- Self-injury
- Self-mutilation (SM)
- Repetitive self-harm
- Non-suicidal self-injury (NSSI) – DSM-V Section 3, Conditions Requiring Further Study

DIAGNOSTIC CRITERIA FOR NSSI

- A) The presence of five or more instances of self-inflicted tissue damage with no suicide intent
- B) One or more expectations
  - To obtain relief from a negative affective or cognitive state
  - To resolve an interpersonal difficulty
  - To induce a positive feeling state

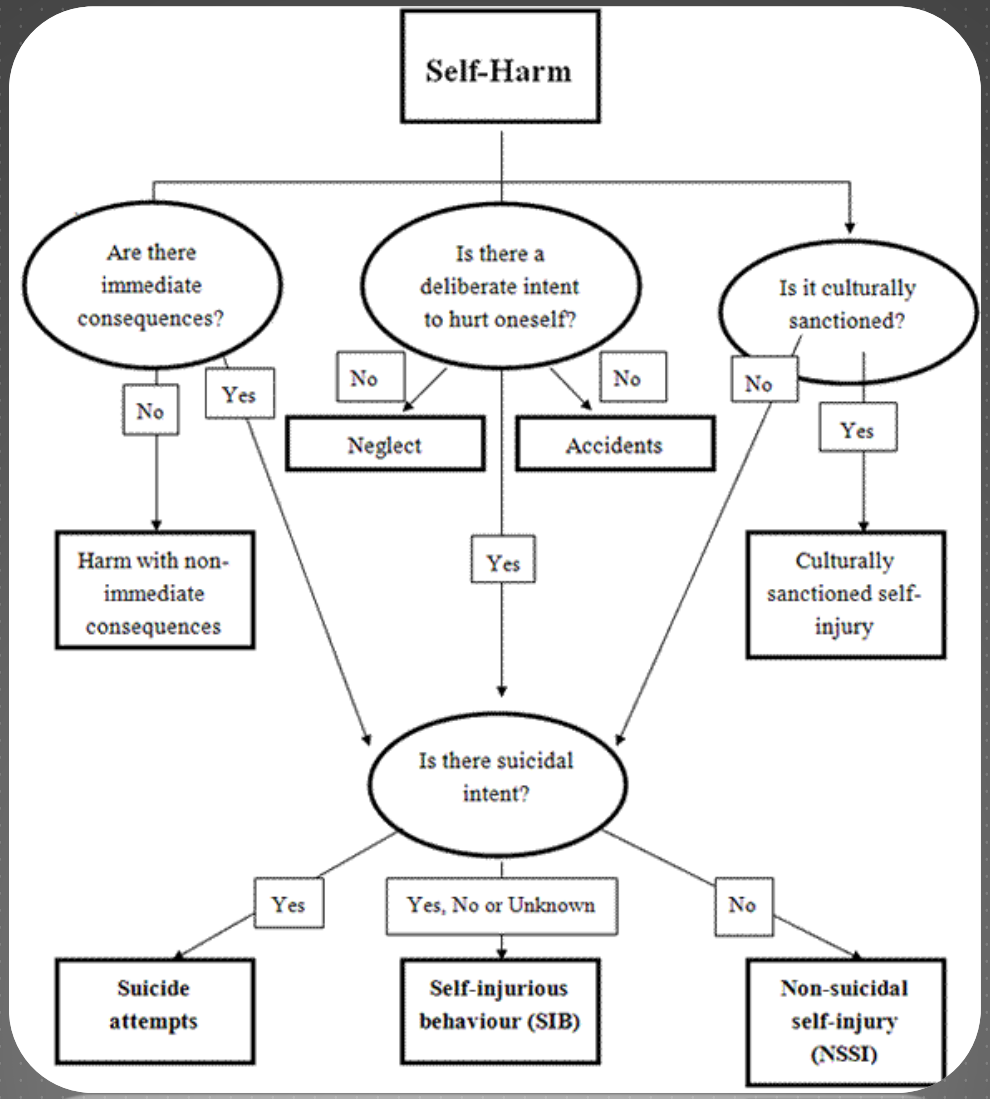
DX CRITERIA

- C) The intentional self-injury is associated with at least one of the following
  - Interpersonal difficulties or negative thoughts or feelings (dep, anx...) immediately prior the act
  - Prior to engaging in the act a period of preoccupation... difficult ot control
  - Thinking about self-injury is frequent, even if not acted upon

DX CRITERIA

- D) The behavior is not socially sanctioned. (Tattoo, body piercing, religious ritual) not picking a scab or nail biting
- E) Cause clinically significant distress or interference with personal, academic, or other areas of function
- F) The behavior does not occur exclusively in psychotic episode, delirium, substance abuse or withdrawal and is not a stereotypic pattern or better explained by other disorders

DECISION TREE



LIFETIME PREVALENCE OF NSSI

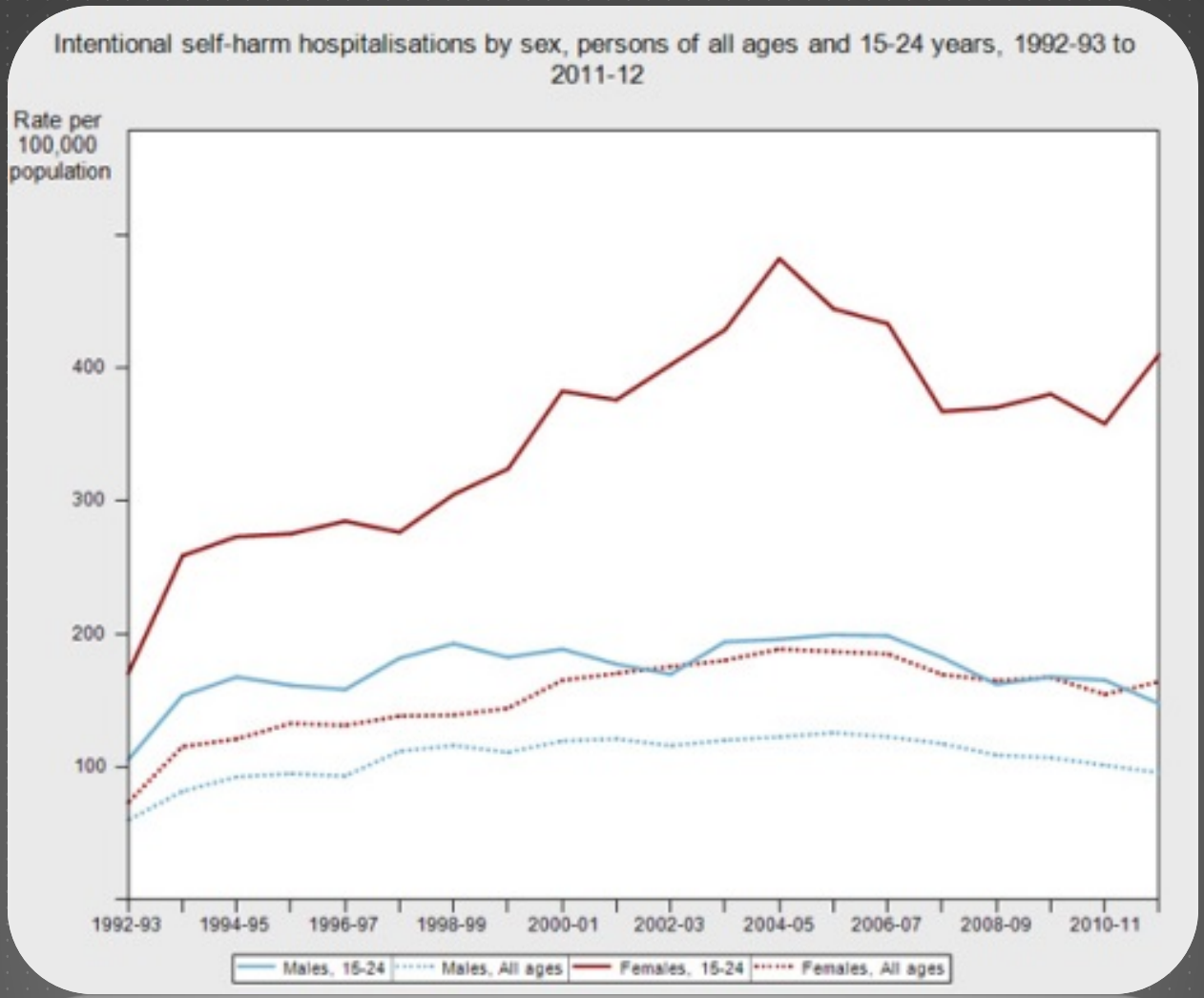
- 7.5% to 8% for preadolescents
- 12% and 23% for adolescents – "epidemic"
- Up to 29% for College Students
- Include male violence up to 50%
- "This generation seems less able to self-regulate"
- Implications for identity, sexuality, body image, self-esteem, bonding, parenting
- Are we seeing a rapid evolutionary change in brain function?
  - See Neurobiology of Childhood Trauma

ADOLESCENT COMORBIDITY

- 70% of adolescents engaging in NSSI reported at least one suicide attempt
- Commonalities: co-occurring diagnoses with mood and bipolar disorders - 42% of 65 subjects in a study with NSSI had Depressive DO
- Only 1 of the 65 had an Eating DO

INCIDENCE OF NSSI - ADULTS

- 4% of adults
- Diagnostic Criteria for Borderline Personality Disorder (BPD)
- Appears in behavior on adults who do not have BPD


Intentional self-harm hospitalisations by sex, persons of all ages and 15-24 years, 1992-93 to 2011-12
Rate per 100,000 population
400
300
200
100
1992-93
1994-95
1996-97
1998-99
2000-01
2002-03
2004-05
2006-07
2008-09
2010-11
Males, 15-24
Males, All ages
Females, 15-24
Females, All ages

BORDERLINE PERSONALITY DISORDER

- "a pervasive pattern of instability of interpersonal relationships,
- self-image,
- and affects,
- and marked impulsivity, beginning in early adulthood and present in a variety of contexts, as indicated by five (or more) of the following":

SELF-HARM AND BORDERLINE PD

- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- Identity disturbance: markedly and persistently unstable self-image or sense of self
- Impulsivity in at least two areas that are potentially self-damaging (e.g., substance abuse, binge eating, and reckless driving)
- Recurrent suicidal behavior, gestures, or threats, or **self-mutilating behavior**
- Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
- Transient, stress-related paranoid ideation or severe dissociative symptoms

PV FIRST EXPOSURE TO SELF-HARM – 1978

- No exposure as youth
- Independent developmentally disabled individuals when frustrated
- Institutionalized developmentally disabled when frustrated
- Now realize I have seen males do lots of risky activities
- Treated dozens

COUNSELING 15 YEAR OLD NSSI

- 6 months of counseling:
  - Identify stressors
  - Gain realistic expectations for relationships
  - Emotional expression and assertion
  - Emotional regulation – DBT tools
- Stops in 3 months – no reported self-harm for 2 years

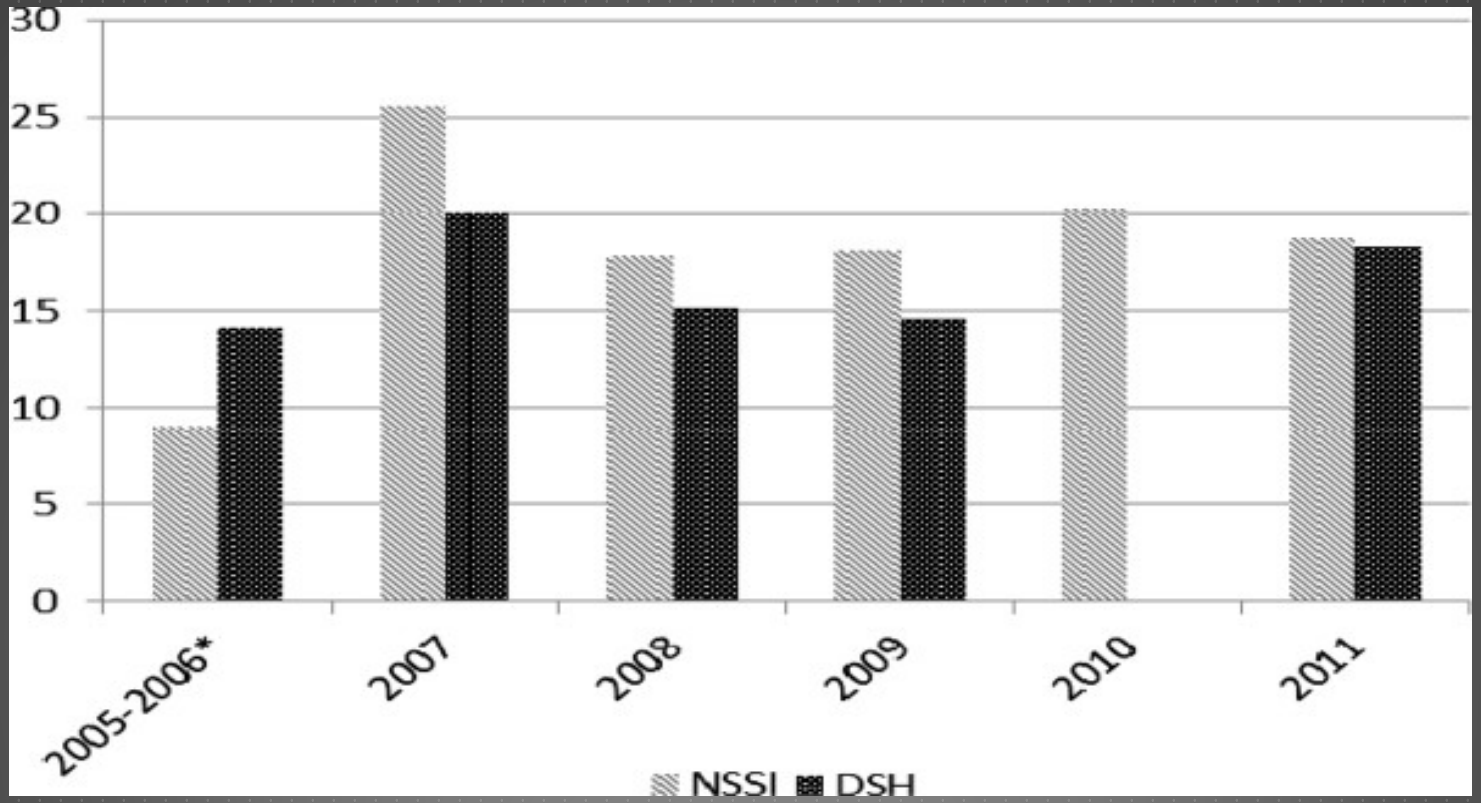
SCOPE OF THE PROBLEM - HISTORY

- Mark 5 They went across the lake to the region of the Gerasenes.
  2 When Jesus got out of the boat, a man with an impure spirit came
  from the tombs to meet him. 3 This man lived in the tombs, and no one
  could bind him anymore, not even with a chain. 4 For he had often
  been chained hand and foot, but he tore the chains apart and broke
  the irons on his feet. No one was strong enough to subdue him. 5 Night
  and day among the tombs and in the hills he would cry out and cut
  himself with stones.
- Jesus casts out demons = one redeemed and one unhappy pig farmer

SCOPE OF THE PROBLEM 2

- Goldstein et. al. sampled of 319 (65.2% women) university students to explore “escalating rates.”
  - 29.4% of students reported that they had engaged in at least 1 act of DSH
  - Rates of DSH were similar across men and women
  - Women more likely to cut, men engage in dangerous acts
- “Rising Numbers” – Wales call for education of school nurses

REVIEW OF LITERATURE - 2012



WHAT PREDICTS SELF-HARM?

- Do thoughts about self-harm and self increase or decrease SH behavior?
- Lewis, et. al. 134 clinical S's 16+. 62 had history of self harm including suicidal intent; 46.3%
- Method: 54% cutting, 19% self-hitting, 17.5% overdosing, burning 9.5%
- Cultural differences not significant

LEWIS ET. AL.

- Depressive symptoms + Attitudes towards SH (i.e. is it harmful or helpful) + perceived behavior control at time of SH
- Place self in situation to SH (alone in room) and report once in that situation he or she feels helpless to stop.
- Depression + attitudes towards SH + perceived behavioral control.
- **Other studies find SH in non-depressed S's**

WHAT MOTIVATES NSSI?

- A. Derouin & T. Bravender (2011) self-reported experience:
  - Depersonalizing experiences, under periods of extreme stress/anxiety
  - Cutting provides significant relief followed by “relaxation and repersonalization”
  - No feelings of pain during self harm for some
  - Can be addictive due to intensity and immediacy of relief
  - Preoccupation, racing thoughts, impulsivity, pain/anguish centered around need/desire to cut

MOTIVATION 2 – CULTURAL FACTORS

- Media attention could expose at-risk youth to idea of SM,
- Contagion Factor: teens try new things, follow the crowd, find acceptable behaviors, curiosity
- Common Factors: Used to be only those with **SEVERE** psychological issues, **now apparently normal** (happy, ambitious, outgoing, involved) **youth may have it for years without revealing evidence**
- Continuous exposure to **violence** in media.
- Increased violence in young people's lives (70% of deaths among American 15-24 from homicide, suicide and unintentional injury)

MOTIVATION 3 – FAMILY FACTORS

- **Violence** at home
- Childhood physical/sexual abuse
- Parental divorce/separation or dysfunctional
- Hypercritical fathers, lack of emotional warmth
- Death of parent may also be precursor to SH
- Family history of alcoholism, mental illness

MOTIVATION 4 – PERSONAL FACTORS

- Personal history of abuse and/or trauma
- Personal history of chronic illness with hospitalization in childhood
- Depression
- Recent loss
- **SOCIAL ISOLATION** found to be modifying variable among depressed youth

DOES INCREASED PAIN TOLERANCE LEAD TO MORE INTENSE SELF-HARM?

- Does increased pain tolerance increase the extent of damage needed for “therapeutic” effect?
- Cold Press (no harm) single subject study supports this
- Hard to treat as it is very effective
  - Pain as drug of choice to stop negative dissociative phenomena
  - Vs. self-harm used as a dissociative trigger to escape inner or external reality

10 TOP WAYS TO SELF-HARM - 2006

2800 college students – 17% self harm – Whitlock et al.

1. Scratch or pinch – more than 50% of subjects
2. Impact with objects – 37%
3. Cutting – just over 33% and more common in females
4. Impact with self – 25%
5. Ripped skin – 16%
6. Carving – 15%
7. Interfering with healing – 13.5%
8. Burning 12.9%
9. Rubbing objects into skin (like glass) – 12%
10. Pulling hair – trichtolomania – 11%

WHITLOCK ET AL

- 70% who repeatedly self-harm use multiple ways to self-harm
- The majority reporting between 2-4 self-injury methods used.
- Dr. V has patients that use 10 of 10.

WHAT TO LOOK FOR

- Wounds and scars
- Long sleeves, pants worn in warm weather.
- Excuses for not swimming/ participating in activities requiring skin exposure
- Mood swings
- Low self-esteem
- Poor impulse control
- Sadness
- Anxiety
- Anger

FACTORS OF CHANGE IN COUNSELING

- 10% the expectations of the client
- 15% rapport
- 25% skill/knowledge of counselor
- 50% beyond influence of counseling – this is the collaboration zone – where professional counselors have historically had little influence
- I can't fix it

GOALS FOR COUNSELING

- Self-Regulation with thoughts and feelings
- Assertion
- Communication with peers and family
- Social Function
- Social Connection
- Self-Esteem (realistic)
- Confidence (competence)
- Stop self injury when the patient wants it

INTERVENTIONS – SOCIAL SUPPORT

- Trusting relationship most crucial
- Parental involvement unless deemed unsafe (under 18)
- If over 18 with patient permission contact family member or other trusted person for support
- Active and genuine listening by therapist/family/pastor crucial for prevention and intervention
- Multi-faceted approach of primary care, mental health, family, patient, church and school where possible
- Focus on: “decrease environmental stress by increasing the feelings of connectedness to parents and social circles”

INTERVENTIONS - COUNSELING

- Identify key stressors – may take some time
- Work on communication skills and self-regulation – DBT teen group includes mindfulness training
- Learning alternatives to expressing needs/feelings
- Assertiveness training
- Reduction of caffeine/stimulants to reduce anxiety – Stimulants increase trauma activation
- If SH is life-threatening or suicidal hospitalization is required

INTERVENTIONS - COUNSELING

- Identify key stressors – may take some time
- Safety
- Work on communication skills and self-regulation – DBT teen group includes **mindfulness training**
  - Mindful eating - Raisin, 10-15 minutes
  - Prayer to release and receive (Galatians 5:19-23)

PATIENCE AND HOPE

- Anxiety increases when you first try to use other than cutting
- Anxiety increases when you first try mindfulness
- Anxiety increases when you talk about trauma
- No “pain” – no gain
- You can’t do it alone, but you can with God’s help

INTERVENTIONS CONTINUED

- Visual grounding to calm and re-personalize
- Examples at edencounseling.com, counsel tools
- PV finds it essential in the treatment of DID

COUNSELING CONT.

- Learning alternatives to expressing needs/feelings
- Assertiveness training
- Reduction of caffeine/stimulants to reduce anxiety – Stimulants increase trauma activation
- If Self Harm becomes life-threatening hospitalization is required

INTERVENTIONS - MEDICATION

- Anti- depressant
- Sleep medication
- Anti- anxiety
- Mood stabilizers
- Meds don't change trauma coping but may make positive emotions possible

PARENTING AND PREVENTION

- Maternal bonding and secure attachment helps develop self regulation
- Parents who can self-regulate raise children who can self-regulate
- Safe and calm Time, touch and attention from birth
- With no significant attachment – developmental problems – search for self sooth using external mechanisms

PARENTING AND PREVENTION

- be calm yourself
- keep a safe home, physically and emotionally
- learn to teach and instruct instead of criticize
  - I have found that…
  - I need you to keep your bottom in the chair…
- model mindful behavior
- Spend time with your child
- know your child – pay attention to signs of distress
- Share with others and seek help if needed

FOR FRIENDS

- **Do not keep this secret to yourself**
- Do not promote secrecy and isolation
- Validate but encourage getting help
- Do not try to rescue by yourself

LIMITS OF CONFIDENTIALITY AND ABUSE

- *Privileged Communication* only for lawyers and clergy
- All other *counselors/helpers* must define limits of confidentiality
- Mandated reporters must report abuse
- Churches and para-church ministries must work out their own standards and procedures

FURTHER DISCUSSION

- How are we drawing in the disenfranchised?
- What could we do?
- Would education regarding NSSI is possible?
  - Youth
  - Families
  - Staff
  - Young adults
- What could it look like?
- Do you think that you have the resources you need?
- What would help?

PARTNER WITH EDEN

- Referrals to Eden Counseling and Consultation
  - Skype and Phone counseling and coaching
  - On site Intensive Assessment and Consultation
- Run with the Children – Freedom Marathon, November 8-10 www.edenfamily.org
  - Families and youth groups raise awareness and funds for Sex Trafficked and at-risk children

PARTNER WITH EDEN

- Eden Family Programs
  - Eden Marriage Counselor and Mentor Training
  - Speaking/Teaching by Paul, Becky and Eden Staff
- Eden Leader Programs
  - Intensive Consultations – Now forming regional teams (see handout)
  - Coaching/Consultation

REFERENCES

- Youtube.com – The Silent Epidemic, Martin Seligman
- Google Nock, NSSI
- Livefaithfull.com “Why Kids Cut”
- Livefaithfull.com Counsel Tools
- Britt Nicole “When She Cries” – Album “Say It”
- DSM-V, Section III