Adolescent Non-Suicidal Self-Injury: Analysis of the Youth Risk Behavior Survey Trends

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Self-injury is a significant issue with a variety of psychological, social, legal and ethical consequences and implications (Froeschle & Moyer, 2004; McAllister, 2003; Nock & Mendes, 2008; White Kress, Drouhard, & Costin, 2006). Self-injurious behavior is commonly associated with the cutting, bruising or burning of the skin. It also can include trichotillomania, interfering with wound healing and extreme nail biting (Klonsky & Olino, 2008; Zila & Kiselica, 2001). In assessing severity, it is important to note that self-inflicted wounds typically do not require any medical attention, as those who engage in self-injury will usually care for any open wounds in order to prevent infection (Walsh, 2006). The typical duration of a self-injurious act is usually less than 30 minutes, resulting in immediate relief from the emotional turmoil precipitating the behavior (Alderman, 1997; Gratz, 2007). It is difficult to estimate the prevalence of self-injury for many reasons. Nock (2009) noted that reports indicating increased estimates in this behavior derive from "anecdotal reports and estimates from small cross-sectional studies" (p. 81). Given the many ethical and legal ramifications involved in working with clients that self-injure, it is important to understand how self-injury typically manifests itself, how it affects differing populations based on gender and cultural differences, and the level of danger it truly represents to the person choosing to utilize it.

Treatment of Self-Injury

If self-injury is left untreated, increased severity and possible suicidality or suicide attempts may occur; therefore, it is important to recognize self-injury and treat the client appropriately and quickly in order to prevent complications. Knowledge with regard to possible presentation of self-injurious behavior as it pertains to intersections of gender, age and ethnicity also is important. Additionally, clinicians must recognize typical signs of self-injurious behaviors in relationship to diagnostic criteria. The likelihood of self-injurious behavior as a coping mechanism becomes more prevalent within certain psychological issues. The diagnoses most commonly associated with self-injury include major depression, borderline personality disorder, post-traumatic stress disorder and eating disorders (Klonsky & Muehienkamp, 2007; Marx & Sloan, 2002; Nehls, 1998; Sansone & Levitt, 2002; Sargent, 2003). Self-injury has been found to be associated with acute stress related to relational aggression, abuse and dating violence (Hays, Craigen, Knight, Healey, & Sikes, 2009; Turnage, Jacinto, & Kirven, 2003). Since self-injury also can be co-morbid with suicidality, selected psychological and emotional states will be reviewed separately in terms of their individual indicators related to self-injury, and their effects on the severity of possible danger or harm to provide a framework for the importance of data related to populations not typically studied in association with self-injurious behaviors.

Self-injury has commonly been associated with the diagnosis of borderline personality disorder (BPD), although this association may relate more to ongoing trauma issues (Alderman, 1997; Naomi, 2002). Given the continued prevalence of the diagnosis in relation to self-injury, attention to self-injury with BPD is warranted. Those who are diagnosed with BPD, or display borderline features, and are engaging in self-injury typically display other self-destructive behaviors and decision making (Gratz, 2006; Sansone, Wiederman & Sansone, 1998), tend to have unresolved anger that is noticeable in everyday relations, and also may exhibit a need to distract themselves from their emotions (M. Brown, Comtois, & Linehan, 2002). These characteristics will be prominent over other clinical symptoms associated with BPD. BPD also is more commonly diagnosed among females, as is self-injurious behavior (Lundh et al., 2007). If indeed self-injurious behaviors are associated with a history

of trauma, perhaps the presentation of self-injurious behaviors are overlooked when working with male clients due to the association of self-injury with BPD.

Gender and Self-Injury

Potential gender differences in the presentation of self-injury may exist for various reasons. Past studies focusing on particular forms of self-injury have focused on potentially unrepresentative female-only samples, thus misrepresenting the existence of a more diverse population of those engaged in self-injurious behaviors (Marchetto, 2006). Some research proposes that males are just as likely as females to self-injure and perhaps go about it differently or are more secretive (Gratz, 2001). Marchetto's study of 516 individuals engaged in skin-cutting as a form of self-injury found "no evidence for an overrepresentation of women" (p. 453). Other research supports this notion that there may not be a gender difference among certain types of self-injurious behavior (Izutsu et al., 2006; Muehlenkamp & Gutierrez, 2007). In addition, a recent study found no gender differences in prevalence of self-injury among college students, but noted that far fewer men were willing to complete the study (Heath, Toste, Nedecheva, & Charlebois, 2008). Furthermore, these authors warned against inaccurately interpreting the above issues as meaning a lower prevalence of self-injury exists among males. Seemingly, female adolescents are more likely to self-report instances of self-injury than male adolescents (Heath, Schaub, Holly, & Nixon, 2008), and male self-injurers are not diagnosed and conceptualized the same as females that self-injure (Healey, Trepal, & Emelianchik-Key, 2010). With these two compounding factors, males that self-injure are at a disadvantage to receive help with their self-injurious behaviors.