Cases:

Joan Goodman LCSW-C: Introduction

Joan Goodman LCSW-C, BCD. Joan obtained her bachelor's degree in psychology from the George Washington University in 1976, and her Master's in Social Work from the Catholic University of America in 1979. Licensed in both Maryland and the District of Columbia, she has received extensive postgraduate training in the Advanced Studies Program from Georgetown University Medical Center from 1995-2002. Joan is a member of the Academy of Certified Social Workers and is designated Diplomate in Clinical Social Work, the highest level of recognition available through professional societies. In 2005, Joan joined a panel of experts at USA Today, as well as, provided training to the Montgomery County Fatality Committee on adolescent depression and suicide. Joan is a graduate of Leadership Montgomery Class of 1996, and was the Chairperson for the Montgomery County Youth Workers Training Committee for 17 years. She has been interviewed for the Washington Post, the Bethesda Magazine, the Gazette newspapers and has been featured on local television news and radio shows. In 2009, she founded the Adolescent Self Injury Foundation (ASIF). She has been called upon to serve as an expert witness for the Maryland State Attorney's Office, trained counselors, teachers, nurses and administrators of schools and has been the keynote speaker for professional and lay audiences. Today, Joan maintains a private practice as an adolescent specialist in Rockville, Maryland.

Last 30 yrs IN MoCo

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Adolescent Depression, Self-Injury, and Suicide Hand-Out

I. Warning Signs of Adolescent Depression

1. Change in academic performance
2. Truancy/Delinquency
3. Loss of interest in activities
4. Withdrawal from family and friends
5. Teen appears lonely, isolated, lacking a sense of belonging, disconnected
6. Drug and Alcohol use or abuse
7. Disobedience-lying behavior-rebellious against authority
8. Difficulty concentrating
9. Self-destructive behavior (i.e. reckless driving, driving under the influence)
10. Self-mutilation-often done in isolation/secrecy (i.e. scratching, cutting, carving body, self-piercing)
11. Increased sexual activity
12. Running away
13. Grief
14. Feeling guilt, shame and making self-derogatory comments
15. Feeling helpless, hopeless, pessimistic about future
16. Chronic boredom when teen is alone
17. Neglect of personal appearances (i.e. not bathing, washing hair)
18. Overwhelming pressure to succeed, perfectionist
19. Fear of loss of control
20. Family history of past depression/suicide, personal past history of depression/suicide
21. Confusion/anxiety about sexual development or orientation

II. Symptoms of Clinical Depression

1. Feeling sad, helpless, hopeless
2. Changes in eating habits, resulting in losing or gaining weight
3. Changes in sleep: chronic insomnia, sleeping all the time, inability to fall asleep and stay asleep
4. Inability to sit still: hand-wringing; or slow body movements, slow speech
5. Fatigue
6. Difficulty concentrating
7. Feeling anxious, irritable, fearful
8. Poor self-esteem
9. Headaches/ stomach aches; somatic problems
10. Difficulty making decisions

www.adolescentselfinjuryfoundation.com

III. Warning Signs of Adolescent Suicide and Para-Suicide (Self-Injury):

1. Para-suicide: Self-mutilation: scratching, cutting, carving body, head banging, self-piercing of nose, ears, tongue
2. Teen feels helpless, hopeless, and pessimistic about future- sees no way out
3. Suicidal Ideation- having thoughts of suicide without physical action
4. Dropping hints, giving away prized possessions, writing a will, saying "good-bye"
5. Expressing a wish to die, wishing he/she was never born
6. Suicidal Threat- making threat of suicide, or physical actions taken that indicate self-harm but does not indicate conscious intent
7. Suicidal Gesture- Actions taken that indicate they are thinking about, or ***planning to attempt suicide***; yet it is an action taken that in itself does not cause death.
   It is often a form of ***communication*** of the teen's despair, rather than a conscious intent to kill oneself. Examples are: self-mutilation, a small overdose of pills, etc.
8. Suicide Attempt- Physical action taken with the conscious intent of suicide that does ***not*** result in their death.
9. Pre-occupation with thoughts of suicide and death
10. Past suicide attempts, family history of suicide
11. Teen feels overwhelmed, confused, unable to cope with problems and their situation
12. Irrational thinking-suicide is "the right answer" to teen's problems
13. Changes in mood
14. Themes of death and suicide in writings and drawings at home or school
15. Wearing long sleeves all the time, refusal to wear shorts, sleeveless tops, bathing suits to hide self-injurious cuts and scars on body

IV. Risk Factors + Stressors for adolescent depression/self-injury/ suicide

1. Changes in teen's peer relationships**
2. Fight with parents/ friends**
3. Parent is disappointed in the teen, resulting in teen feeling "bad" about self**
4. Separation/ Divorce **
5. Parents put teen "in the middle" of each parent during separation and divorce**
6. Ongoing parental conflict.***
7. Break-up of a love relationship***
8. Having an alcoholic/addicted parent**
9. Single parent family***
10. Teen is estrangement from 2nd parent in divorce**
11. Insecure attachment to mother***
12. Personal rejection from love interest***
13. Teen is harassed at school by peers over their appearance, sexuality, stature, etc.
14. Recent move**
15. Death of family, friend, or pet***
16. Having a family member who committed suicide-teen could believe that suicide is the way that their family deals with problems*
17. Failing a test*
18. Being fired from a job*
19. Teen feels alone in the world**
20. Teen has eating disorder.**
21. Physical and sexual abuse

V. How to assess for Self-Injury:

1. Have you ever in your life hurt yourself (on purpose) in any way?

If teen answers "yes": continue with:

2. When did this happen? How old were you? What grade were you in?
3. Where were you when you did it?
4. What did you do?
5. What did you use to hurt yourself?
6. Why do you think you did that?
7. Was it a suicide attempt? Were you suicidal?
8. Were you trying to feel better? What function did it serve: Did it work?)
9. Did you ever tell anyone about it?
10. How many episodes of self injury have you had in your whole life?
11. How did you feel and think about it?
12. Did this behavior concern you at all? (I.e. is it ***OK*** for you that you do this?)
14. What are you feeling when you are hurting yourself?
15. When is the last time you hurt yourself in any way?
16. When was the last time you had an urge to hurt yourself in any way?

If teen reveals that she has "hurt herself" more than a few times, and/or if self-injury has occurred over a long period of time; this indicates that the problem is chronic in nature. Professional mental health treatment is often necessary to help the teen learn to stop their self-injury.

VI. Assessment for Suicide

[Be gentle and non-judgmental. Go slowly. Do NOT act impatient, angry, or disappointed to their answers, or lack there of.]

1. How do you rate your mood on the depression scale of 1-10?
2. Do you ever hurt yourself in any way? (If yes, why, what, where?)
3. Do you ever wish you weren't alive?
4. Do you ever wish you were never born?
5. Do you ever wish you were dead?
6. Do you ever think of suicide?
7. Do ever think of how you would do it?
8. Do you have the means and the opportunity to do it? Have you made plans to act on these thoughts?
9. Have you ever tried to kill yourself in your life? (If yes, then how, where and when?).
10. Have you told anyone about this? How did they respond? Who is your support system?
11. Do you feel safe?
12. Can you sign contract for safety right now?

When making assessment:
Be gentle and non-judgmental.
Go slowly.
Be matter-of fact-yet calm
Do NOT act impatient, angry, or disappointed to their answers, or lack there of.

VII. How to know when teen is in immanent danger of suicide?

1. Teen is helpless, hopeless, and pessimistic
2. Teen has had a recent loss or stressful situation occur
3. Teen has given away his/her prize possessions
4. Teen has written will or suicide note to say good-bye
5. Teen has poor coping skills
6. Teen has history of substance use or abuse
7. Teen has history of suicidal gestures/attempts
8. Teen has expressed a wish to die, or a wish to escape the pain they feel
9. Teen has a ***plan for suicide: (method/time/place)***
10. Teen has ***expressed imminent intent to hurt self***
11. Teen has ***access to the planned means to commit suicide***
12. Teen ***cannot contract for safety***

- He/she should not be left alone

-He should be taken to a psychiatric hospital or an Emergency Room as soon as possible for an evaluation.

If you see these warning signs-ASK
Asking about suicide does NOT put the idea in someone's head. It is already there.
A suicidal teen will feel relief when they talk about it.
Often, teen doesn't want to die, but he wants the pain to stop.
Do NOT DENY the problem!
Do not "enable" the teen to hurt himself by making excuses for behavior.
Address parental denial when it exists.
[It is in the spring that we see the ***highest percentage of adolescent depression and suicide.***
-Most of the school shootings by teens have occurred in the SPRING.]

VIII. Effective Treatment Plan

1. Clinical evaluation with follow-up psychotherapy.
2. Teen participates in weekly individual+ adolescent group psychotherapy.
3. To address parental denial and improve parental effectiveness, parents need to be actively involved in teen's treatment. [I.e. family therapy/ Mother attends "Mother's Group" to enhance effectiveness in parenting ability while improving communication with teen.]
4. Cognitive behavior therapy+ (DBT) + Attachment Theory are the treatments of choice.
5. A psychiatric medication evaluation is necessary to effectively treat adolescent self-injury, as well as teen depression, self-injury, suicide, eating disorders, and substance abuse.
6. If teen involved in substance abuse: teen should attend weekly out-patient substance abuse program with weekly urinalysis.
7. If teen has eating disorder-a nutritionist and eating disorder pediatrician should be added to treatment team.
8. If teen is refusing to cooperate with treatment plan and symptoms are acute, a psychiatric hospitalization is usually necessary to ensure teen's safety while promoting teen's full cooperation to all aspects of the treatment plan.
9. School Counselor/nurse/administrator should be teen's "touch-stone" during school hours and should have full access to communicate with all clinicians involved in teen's care.

IX. *Suggested Reading List*:

1. The Scarred Soul: Understanding and Ending Self-Inflicted Violence
   Tracy Alderman, Ph.D. 1997.
2. Bodies Under Siege - Self-Mutilation in Culture and Psychiatry
   Armando R. Favazza, MD. 1987.
3. Cutting the Pain Away
   Anne Holmes.
4. The Luckiest Little Girl in the World
   Steven Levenkron. 1997.
5. Women Who Hurt Themselves - A Book of Hope and Understanding
   Dusty Miller. 1994.
6. The Skin Game
   Caroline Kettlewell. (These are her memoirs.)
7. Cut
   Patricia McCormick. 2001.
8. Cutting
   Steven Levenkron. 1999.
9. The Bright Red Stream
   Marile Strong. 1999.
10. Women Living with Self-Injury
    Jane Wegscheider Hyman. 1999.
11. Healing with Hurt Within: Understand and Relieve the Suffering Behind Self-Destructive Behavior
    Jan Sutton. 1999.
12. Self-Injurious Behaviors: Assessment and Treatment
    Daphne Simeon. 1999.
13. Everything You Need to Know About Self-Mutilation: A Helping Book for Teens Who Hurt Themselves
    Gina Ng. 1999.

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For parents-What to do when your child self-injures

Dr. Armando Favazza (1987-Author of "Bodies Under Siege") defines self-injury as an impulsive act that causes bodily harm to one's own body. It is often known as para-suicide, since it often is an attempt at coping to save one's life, rather than being a means of suicide to kill oneself. (Yet, one can NEVER assume this, so you should always ask "Was this an attempt of suicide?")

I. Common Forms of Adolescent Self-Injury:

Cutting and burning are the most common. Other forms of self-injury include: hair-pulling (Trichotillomania), self-biting, face-picking, self-hitting, head banging, severe skin scratching, bone breaking, or picking scabs that interfere with wound healing.

II. Warning Signs of Adolescent Self-Injury:

1. *Wearing long sleeves/ long pants, even in hot weather*
2. *Avoiding exposure of certain body parts or demanding complete privacy when getting undressed*
3. *Refusal to wear sleeveless or short sleeve tops, shorts, bathing suits; even on hot days*
4. *Wearing wrist warmers that cover the entire wrist*
5. *Wearing inches of bracelets to cover wrists*
6. *Wearing gloves where the fingers are cut off, this the entire hand and wrist are covered up.*
7. *Putting thumb holes in sweatshirts so that entire hand and wrist are covered.*
8. *Having knives, razors, box-cutters in bedroom, backpacks, purse, or hidden in shoes or clothing.*
9. *Unexplained bruises and cuts, bandages followed by flimsy excuses "I was climbing a fence," or "the cat scratched me."*
10. *Cuts that are lined up, or are in some kind of design or pattern*

III. How SHOULD a Parent Respond to Self-Injury?

Remain CALM. Do NOT YELL at your child. (This will certainly drive them away)Remember, when a teen self-injures she/he is CRYING OUT: "I CAN'T COPE!!" So, parents should be as loving and empathic as you can.

Stay focused on the teen's PAIN (and NOT YOUR OWN!)Teens need reassurance from you that "Everything is going to be OK and that you are going to get them the help that is necessary for him to improve."

Teens need to SEE and feel that their parents CAN COPE with this problem.

Offer to hold your teen. If you are rebuffed, try again at another time.

NEVER personalize this rejection. (You might be trying to hug a porcupine).

Teens fear that you will judge them in a negative way, or think less of them. Reassure them of your love and admiration for their courage for sharing this information with you. Their wounds MUST be inspected by an adult for infection. If teen refuses to show it to you, let her/him choose between you, their medical doctor, teacher, school nurse, therapist. MIRROR your teen's emotions. Your ultimate Goal: for your child to be able to come to you for comfort when she has any urges to hurt herself.

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Eating Disorders in Adolescence

Suspicious behaviors:

1. Intense fear of weight gain
2. Refusal to maintain normal body weight
3. Distorted body image=teen feels fat when she isn't
4. Amenorrhea (3 consecutive cycles)
5. Cutting out breakfast and lunch
6. Denial of eating problems
7. Teen taking pride in eating less than peers
8. Inability to eat certain foods (pizza, cheese, french fries, butter)
9. Inability to eat alone-given the opportunity to not eat, they won't
10. Hiding food
11. Secret binge eating/ closet eating
12. Self-induced vomiting
13. Fasting
14. Laxative / diuretic Abuse
15. Excessive exercise, inability to deter from exercise schedule
16. Depressed moods
17. Calorie counting
18. Overeating one day, withholding food the next (out of guilt)
19. Dental/medical problems

Signs of Clinical Depression

1. Sadness
2. Feeling helpless and hopeless
3. Difficulty concentrating
4. Sleep disturbances
5. Fluctuation of moods between apathy and talkativeness
6. Poor self esteem
7. Overreaction to criticism
8. Inappropriate guilt
9. Pessimism about future
10. Family history of depression, suicide, alcoholism or eating disorders
11. Death wishes, suicidal thoughts, plans or attempts
12. Ruminating thoughts, worries, fears

Understanding Adolescent Self-Injury

Clinical Corner *by Joan Goodman, LCSW-C, BCD*

Mental Health From the Viewpoint of an MHA Professional Member

Understanding Adolescent Self-Injury

After twenty years in private psychotherapy practice, specializing in the treatment of adolescents, I have grown to view my clinical practice as a microcosm of the adolescent world. Adolescent self-injury is one such behavior that appeared in my office in the spring of 1996.

I was first referred a few teenagers who hurt themselves. I had never experienced it before and it seemed like a small trickle –perhaps a fad. I wasn't sure where to begin as this was not a subject taught in graduate school. I recognized that it was important not to concentrate on the image of the teen's act of "self-harm" in order to proceed. I knew enough back then to never tell a teenager "to just STOP," because that could instantly create a control battle, causing the teen to want to do it more. One never wins a control battle with a teenager. That was the premise I started from and over the years, as I discovered that this "trickle" was becoming a tidal wave, I developed techniques that would effectively treat this behavior.

Adolescent self-injury is an extremely complicated behavior that often serves many functions simultaneously. It has different meanings for each teenager. What makes this behavior even more challenging to treat is the denial of its seriousness, along with built-in resistance that can accompany it. Many teens see nothing wrong with it. They like it. It becomes a form of self-medication. This is because the brain releases endorphins when someone is extremely stressed and self-injures. Like rigorous exercise, it can produce a sense of rapid relief. These teens do NOT WANT TO STOP. Self-injury becomes addictive when it becomes repetitive. For this reason, it is important to slowly help the teenager find some place in his or her thinking where the idea of self-injury is "not ok." This helps the teen see his or her behavior as society sees it: as a problem, not an achievement.

Many of these teens are perfectionists and appear to "have it all together." They get all A's, take advanced classes, always have a smile on their faces, and have to prove to the world every day that they can do everything. It is not OK for them to reach out for help, because they are supposed to be perfect. Since this is the same profile of a teenager with anorexia, clinicians should not be surprised if the self-injury stops and eating disorders surface. Both conditions give the teenager a feeling of "control" when their life feels "out of control."

Teens often use self-injury as a distraction to their painful emotional life. One 16 year old girl explained, "if you have a toothache, have someone stomp on your foot." A 13 year old girl told me her cutting was easier than feeling her emotional pain. Feeling physical pain is easier than feeling emotional pain. She has control of when, how hard, or how long she hurts herself; whereas she has NO CONTROL over how she feels inside. Additionally, cleaning and bandaging the wound creates a sense to the teen that she is "doing something" about her pain, while distracting her from the issue that triggered the self-injury.

The act of self-harm can bring someone back from dissociation, which often accompanies the self-harm. Each injury is a way to cry out "I can't cope, and I need help!"

Physical wounds serve as evidence to these teens and the world that their pain is real. If their wound can't be seen or touched, their emotional pain does not exist. One 14 year old needed to see her own blood to be able to "get the bad parts out." Another teen needed to see, feel and sometimes taste her own blood in order to believe her pain was real.

The most common form of self-injury is cutting or burning oneself. Other forms of self-injury include: hair pulling, face picking, self-hitting, head banging, severe skin scratching, bone breaking, or interfering with wound healing.

Common warning signs of adolescents who self-injure include: wearing long sleeves /pants all the time, avoiding exposure of certain areas or demanding complete privacy when getting undressed, refusal to wear shorts, short sleeves, sleeveless shirts, or bathing suits even on warm days, wearing a wrist warmer or heavy bracelets (to cover scars on wrists), unexplained bruises, cuts, bandages, and frequent accidents followed by flimsy excuses.

Since self-injury is often a way to manage either depression or mood swings, assessments (psychiatric and physical) assist in determining treatment strategies.

Joan Goodman, LCSW-C, BCD, is a clinical social worker who specializes in treating adolescents and their parents. She is currently writing a book on self-injurious behavior in teens.

***CLINICAL CORNER** is written by mental health professionals who are members of the Mental Health Association. We invite our professional members to submit articles between 400-600 words.*

Deadline for submissions for the winter issue is November 30, 2004.

Submit articles to:
Editor, MHA News
1000 Twinbrook Pkwy.
Rockville, MD 20851

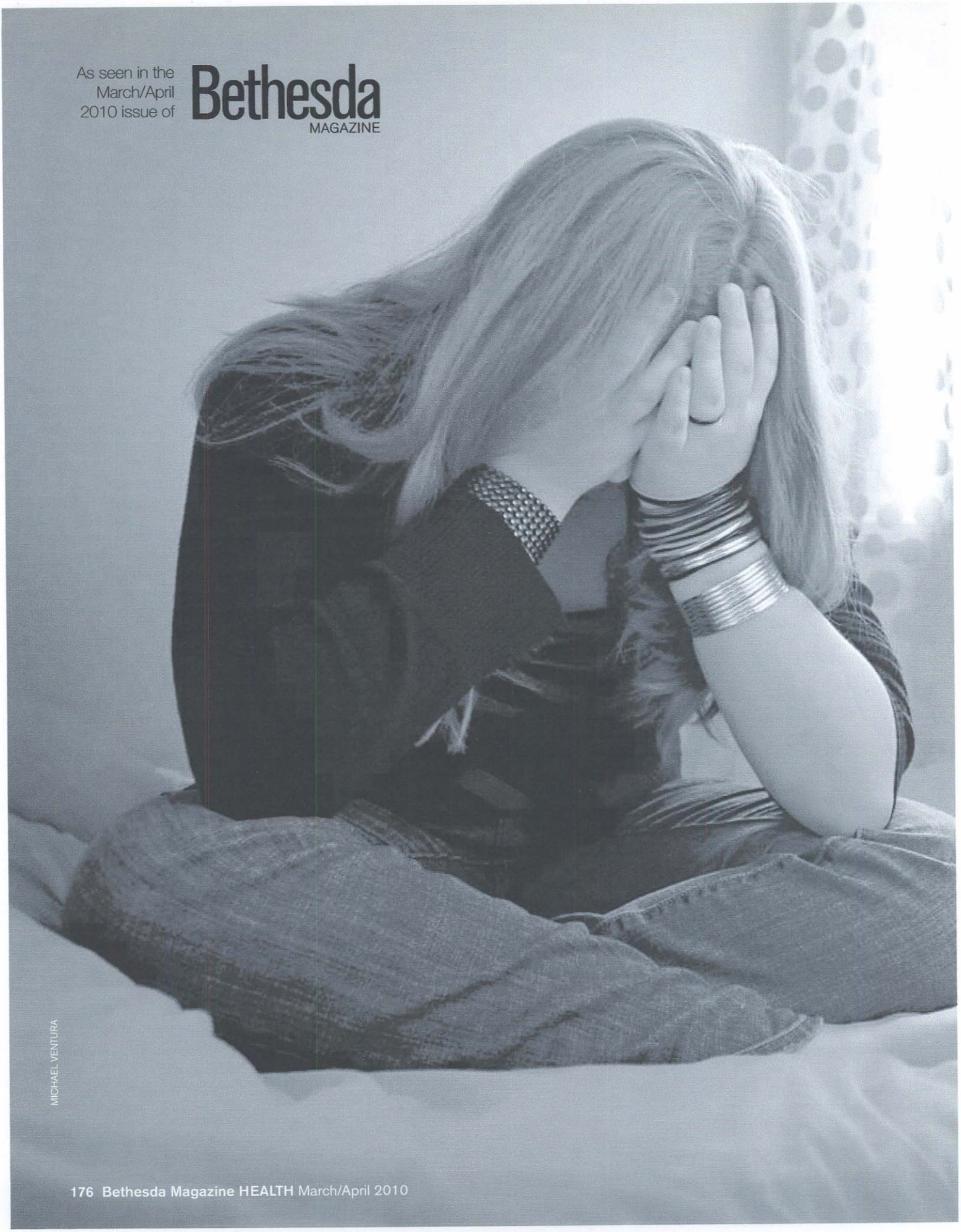
NAME _____

WHAT DO YOU KNOW ABOUT SUICIDE?

For each of the following statements, circle T if you believe the statement is true or circle F if you believe the statement is false.

1.	People who talk about suicide rarely commit it.	T	F
2.	Most people, at one time or another, have had suicidal impulses.	T	F
3.	It is impossible to recognize a potential suicide.	T	F
4.	Suicidal threats run in the family.	T	F
5.	Suicide occurs much more often among the very rich and the very poor than among the rest of the population.	T	F
6.	In the United States, the suicide rate for males stands almost three times higher than the rate for females.	T	F
7.	The risk of suicide stays the same throughout the year.	T	F
8.	Suicides increase during gloomy weather.	T	F
9.	Most suicides occur at night.	T	F
10.	It is best to avoid the subject of suicide altogether, especially around someone who is suicidal.	T	F
11.	Nothing can stop suicidal persons who have made the decision to kill themselves.	T	F
12.	A person who is truly suicidal does not give any warning.	T	F
13.	Improvement after the immediate suicidal crisis has ended means that the risk of suicide is over.	T	F
14.	Once a person demonstrates suicidal tendencies, he will be suicidal for the rest of his life.	T	F
15.	Every threat or attempt at suicide is a serious, genuine cry for help.	T	F
16.	Suicide ranks as one of the leading causes of death among the fifteen to nineteen year old age group.	T	F
17.	Suicidal persons are insane.	T	F
18.	Suicidal patients have every intention of dying.	T	F
19.	Most people who fail in their attempted suicide never try again.	T	F
20.	A person who is using suicide threats as a way to get attention should be told to go ahead.	T	F
21.	Once a suicidal crisis is over, the best thing to do is forget about it.	T	F
22.	Usually a person who has attempted suicide makes increasingly lethal attempts, even with treatment.	T	F
23.	Suicide rates decrease during times of war.	T	F

As seen in the March/April 2010 issue of Bethesda MAGAZINE



MICHAEL VENTURA

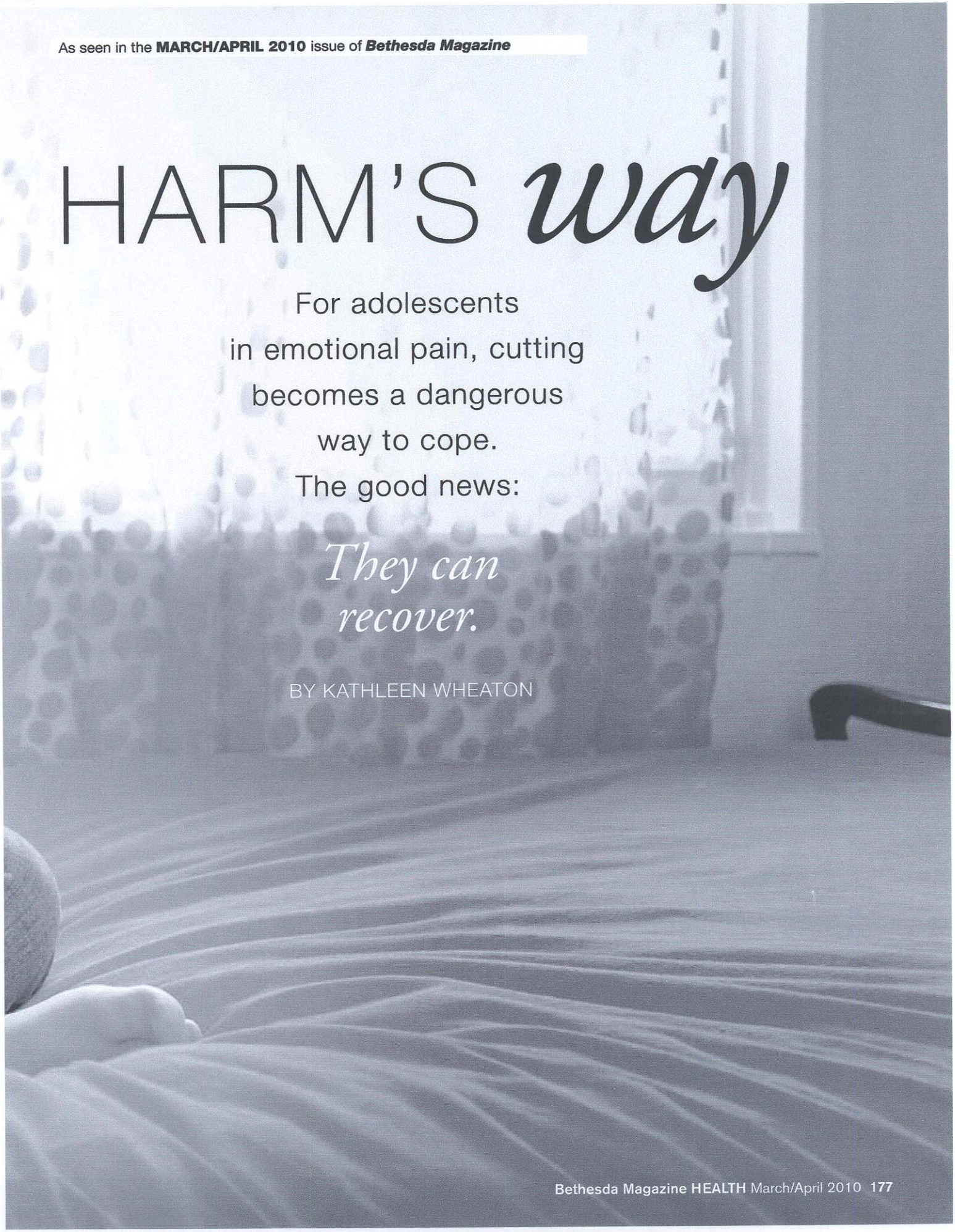
As seen in the **MARCH/APRIL 2010** issue of ***Bethesda Magazine***

HARM'S *way*

For adolescents in emotional pain, cutting becomes a dangerous way to cope. The good news:

They can recover.

BY KATHLEEN WHEATON



As seen in the **MARCH/APRIL 2010** issue of ***Bethesda Magazine***

On the day after Valentine's Day, 2005, Christine went into her bathroom and made some shallow cuts on her upper thigh with the broken-off top to a pen. The scratches scarcely drew blood. But the relief she felt from her overwhelming emotions was like "stubbing your toe when your arm is broken. Suddenly, your arm doesn't hurt so much."

A ninth-grader at a private school in Kensington at the time, Christine was a pretty, auburn-haired 14-year-old who played the harp and enjoyed theater class. But the previous 24 hours had been painful. Earlier that day she had written a note to a close friend, thanking her for saving her from suicide.

"She didn't actually stop me from killing myself," says Christine, who, along with others in this story, asked that her real name not be used. "But I was very dependent on her, and I saw her as a reason for living—I was a bit melodramatic."

Her friend never got the note, but school authorities did and they called Christine's mother, who picked her up from play rehearsal and drove her to a local emergency room. Diagnosed with severe depression, she signed an agreement not to harm herself and to begin psychotherapy.

During her evaluation, Christine was asked to remove the dozens of bracelets she wore, so that her arms could be examined for evidence of cutting. "I never had [cut]," Christine says, but the exam made her wonder. "I thought that if people were doing it, it must work."

That night, as she and her mother drove home from the hospital, she felt exhausted from the experience of confronting the feelings she so often had managed to hide. The last straw, for Christine, was her mother's seeming preoccupation with what others would think. "It was like I was going to ruin her reputation as a good mother when people found out she had a crazy daughter," she says.

The next day, she experimented with cutting. "I was scared," she says, "but I thought I knew what I was getting into."

Joan Goodman, a clinical social worker and adolescent specialist in Rockville, has evaluated and/or treated nearly 400 adolescent self-injurers in Montgomery County in the past 14 years. Each has told her, in some way, the same thing: that physical pain is easier to deal with than emotional pain.

Goodman first began seeing teen self-injuries in her practice in 1996—the same year Princess Diana of Wales publicly admitted cutting herself during her unhappy marriage. Subsequent confessions by celebrities such as Johnny Depp and Angelina Jolie, as well as depictions of cutting in movies such as *Thirteen*, have led some parents to worry that the behavior is contagious, or a fad. An informal poll of Bethesda-area teens suggests a widespread awareness of cutting, including personally knowing another teen who has done it.

Statistics are difficult to come by, in part because the behavior is often kept secret. A 2007 study at the Miriam Hospital and Warren Alpert Medical School of Brown University in Providence, R.I., found that among 633 high school students, 28 percent reported injuring themselves moderately to severely at least once in the past year, with cutting the most frequent method.

Some public school districts, such as the Los Angeles Unified School District, have reported recent increases in students referred for non-suicidal self-injury. Montgomery County Public Schools does not keep such records, but Walt Whitman High School resource counselor Fran Landau says her office began seeing cases of cutting 10 years ago, and "more of it in the past five." She says students who are not already in therapy are referred to the Montgomery County Crisis Center, and usually enter treatment from there.

Cutting can be a reaction to stress or social problems that are beyond a young person's ability to cope, according to Dr. Steven Israel, medical director of Potomac Ridge Behavioral Health in Rockville. Or, he says, it can reflect a psychiatric illness, such as depression. Either way, self-injury as a "solution" can quickly become another serious problem. And "stopping the cutting doesn't necessarily make the underlying problems go away."

Goodman says cutting is not a new phenomenon. She points out that bloodletting was used as a means of getting rid of evil spirits centuries ago. But, she says, cutting has come out of the closet in recent years, much as anorexia and bulimia did in the '80s, with teens more inclined to talk about it.

Goodman acknowledges that a young person who hears about cutting might be tempted to try it. But continued self-injury holds no appeal for those who aren't troubled, she says. "I've had kids say to me, 'I tried that, and it hurt. It's stupid, and I'm not going to do it again,'" she says. "I have yet to meet a child so happy that they've had to cut themselves."

But, she says, for a teen who finds that cutting "works"—like exercise, it releases mood-lifting endorphins—"the behavior is highly addictive and can easily take over a young person's life."

For Christine, cutting became an obsession. But in order to continue to find that release, she found she had to cut herself deeper, using sharper implements. "I eventually built up to scissors," she says. "I thought I was being courageous."

She began carrying sharp implements with her, going into the nearest bathroom and cutting herself, usually on the upper thigh where nobody could see it, as often as two or three times a day. "It was a way to scream and cry and moan," she says, "without making a sound."

As seen in the **MARCH/APRIL 2010** issue of ***Bethesda Magazine***

PATRICE GILBERT

"A **successful recovery** is rarely a straight line. Just as a teen learns how to cut, each self-injurer needs time and **strategies to learn how to stop.**"

—Joan Goodman,
a Rockville clinical social worker and adolescent specialist, pictured with her therapy dog Cozmo

Paradoxically, one motivation for teens to cut themselves is to hide their emotional pain from their parents, Goodman says. "To the outside world, it may look like the family's perfect: two educated, hardworking, successful parents, a nice house," she says. "Many of these young people are also high performers who excel in many activities. They feel tremendous pressure to achieve and be perfect—it's not OK for them to not be OK."

Many parents don't realize that something is seriously wrong until they discover that their child is cutting.

Linda was stunned when her daughter, Jessica, then a high school sophomore, got into the car after field hockey practice one day and announced she had something to tell her: She had been cutting herself for the past six months. A Bethesda native in her mid-50s who exudes cheerful competence, Linda describes Jessica at 15 as a girl who appeared to have no problems: attractive, athletic, charismatic—somebody others confided in. "I must have had some vague idea of what cutting was, because I didn't say, 'What's that?' " Linda recalls. "I said, 'I'm glad you told me, and don't worry—we'll get you some help.'

"But inside, I was dying."

Jessica, now a 21-year-old college junior, says that far from feeling popular in high school, she was a "traveler" who fit in nowhere. "I was the person that people went to with their problems because they knew they could trust me," she says, "but I never felt comfortable trusting anyone else."

She had "heard about cutting from

random people, but had never really taken it into consideration" until she had a huge fight with her father one night and couldn't stop crying. She can't even remember what the fight was about, but afterward she took a razor and cut her wrist. The physical pain immediately relieved her mental distress, and soon she was cutting at least once a week—"sometimes every day, depending on how bad my state of mind was."

Cutting, Goodman says, "provides teens with a false sense of control by allowing them to choose when, where and how much they will hurt. And because it makes them feel better, the young person will often say, 'What's wrong with it? I'm not hurting anybody else.'"

Jessica didn't see a problem with cutting until six months in, when she had trouble stopping the bleeding. She realized she needed help. She hadn't told her mother because "I was afraid she would get mad, which would have made me cut more. I literally could not deal with anyone yelling at me or feeling disappointed in me."

> "It's important for parents not **to feel defensive** or like a failure, but to feel that [cutting] is a danger sign that needs to be **looked at with understanding** and the intention of solving it to make it better."
>
> **—Dr. Steven Israel,**
> medical director of Potomac Ridge Behavioral Health in Rockville

As Jessica recalls the scene in the car, her mother began to cry and said she would do anything to help her. As soon as they got home, Linda got on the phone and started setting up appointments. "It was exactly what I needed," Jessica says. "She gave me the support I needed to begin my recovery."

Recovery was a long process, however. Jessica entered both individual and group therapy and took medication for what was diagnosed as clinical depression and bipolar disorder. "But then she would feel better and take herself off the medication," Linda says.

Israel, who is a psychiatrist, says teens as well as parents can be resistant to the idea of medication if depression or a mood disorder is diagnosed. "I often hear kids say, 'I don't want to have my mind controlled by medicine—I like my edge,'" he says. "So what I say to that—especially for kids around here, where there's a lot of interest in science—is that just as electrons have different energy levels and orbits, [medicine] increases the time that kids are in their best

state. That stability frees them to develop their own inner resources."

A 2004 study published by Cornell University in Ithaca, N.Y., found self-injurious behavior most often begins in early adolescence. Cecilia, a soft-spoken 14-year-old from Rockville, says she began cutting herself in eighth grade, after her emotionally troubled younger sister attempted suicide and was hospitalized.

"It gave me something else to think about," she says. In contrast to her more dramatic sibling, Cecilia describes herself as a low-key person who "doesn't like a lot of people crowded around me or looking at me."

She recalls seeing an episode about cutting on the teen soap opera *Degrassi*, but was not really thinking about the TV show on the September day when she began idly scratching her arm with a safety pin. After a while, she stopped and began to cry—not because of the pain or fear that she would seriously injure herself, but because she worried about adding to her family's troubles.

"I just wanted to keep out of my parents' hair so they didn't have to worry about me," she says with a sigh. "First they had one bad kid, and now they had two."

Cecilia didn't cut herself again until January, after her sister was released from the hospital and life at home became stressful again. Finally, she confided in a therapist who had come to their home to work with her sister. The therapist recommended that Cecilia be hospitalized, and it was there, she says, that her cutting worsened. Although inpatients were not allowed to have sharp objects, she quickly learned how to fashion one from a broken plastic utensil. Cecilia's hospital roommate told on her, and she was watched even more closely.

The next few months, for Cecilia, were a blur of repeated hospitalizations and outpatient treatment. She missed most of the second half of eighth grade. But despite her almost desperate efforts to find or fashion sharp objects (her parents by this time had locked away knives, scissors, even thumbtacks), she says her cutting was never an attempt to kill herself. On the contrary, "it made me feel better."

Goodman says cutting is often an attempt to get through the moment, rather than a suicidal gesture. However, because self-injuring teens are emotionally fragile, she says, "it is crucial to ask whether a recent episode of self-injury was a suicide attempt."

Although some teens appear defiant or even exhibitionistic about cutting—writing about it on Facebook, for example—all the young people interviewed mentioned feeling shame. "You become very secretive and fake with everyone you love," says Christine, the Kensington girl, "which just adds to the guilt and the feelings of why you need to cut."

Warning signs, according to Goodman, include wearing bracelets, watches or wristbands that are never taken off;

wearing long sleeves even in summer; or making excuses for not putting on a bathing suit or going to the beach. When cuts are visible, a teen may dismiss them as cat scratches, even if the cuts are suspiciously straight and parallel.

Often, self-injurers seem to be simultaneously hiding and crying out for help.

Max, 22, an athletic and genial former football player from Silver Spring, says he never fit the "emo" stereotype. But in the winter of his freshman year in college, he cut his face with a paring knife after a longtime friend rejected his romantic overtures. Although the cuts soon healed, he couldn't get the girl out of his head, and a few months later he made deeper wounds in the same spot. "I just wanted it to be visible, so that everyone would know I was hurting," he says. "But I ended up lying and saying I got hurt playing football."

After spotting the girl at a party with another guy, he got drunk and slashed his wrists, this time hiding the scars with an athletic sleeve. "The rush [of cutting] only lasts a few seconds, so you have to keep doing it," he says. "Not only was I hiding the problem of not being able to get over the girl, but I was hiding another of self-mutilation."

One day, when his friend dropped by to borrow something, he felt he couldn't stand the secrecy any longer. He pulled off the sleeve and showed her his wounds. "She was pretty shocked," Max says. "She knew that I liked her, but not that I was gashing myself over it." He says they're still friends, although they never talk about that day.

Max decided to seek psychological help, realizing he probably had needed it for years. "Starting in middle school," he says, "I tried for the longest time to tell my mom and dad I was depressed, but they just wouldn't buy it."

Experts who work with teens agree that adolescent self-injury is highly treatable when parents, teachers and mental health professionals work together. Walt Whitman High School counselor Jenny Higgins says that while Montgomery County does not require parents to allow schools to be in contact with a student's therapist, "those who do allow it get the best wraparound support for their child."

"It's important for parents not to feel defensive or like a failure," Israel says,

that needs to be looked at with understanding and the intention of solving it to make it better."

Goodman has provided symposia and seminars to mental health professionals, teachers, parents and teens on the subject of self-injury. She says the revelation that a teen is cutting should be met with concern and as much calm as a parent can muster, and professional help should be sought as soon as possible. Recovery, she says, doesn't happen quickly; it is a process that can take months or years. "Life is not a race, and a successful recovery is rarely a straight line," she says. "Just as a teen learns how to cut, each self-injurer needs time and strategies to learn how to stop."

Alternative coping strategies can include everything from art and journal-writing to snapping a rubber band or holding ice cubes instead of cutting. Recovery is accomplished, Goodman says, when teens can identify and express their feelings in words.

And for recalcitrant teens who stonewall an individual therapist, a weekly group therapy meeting can melt their resolve not to talk. "They come into a group of peers," Goodman says, "and you can't get them to stop talking."

> "I don't want to forget [the scars], or what I've been through, and I like seeing them slowly fade away."
>
> —**Christine**, from Kensington

Jessica says her therapist urged her to try group therapy for a couple of years before she agreed to it. "I was scared of having people look at me like I was crazy," she says, "but I met other people my age who were going through similar things, and I felt like I was no longer alone."

Christine also ended up in group therapy. "When you start group, you're really afraid of being judged by others," she says. "But once you create those bonds and share so much of yourself, and get so much in return, you share so much more than the story of a scar.... Even when we talked about superficial things, about how much homework we had, there was still that understanding."

Christine eventually was diagnosed with bipolar disorder and hospitalized in 2006. She saw several psychiatrists and tried various medications, including lithium. At 19, she has not cut for more than a year. "With me, it's not even a day-to-day thing, it's more hour to hour, but I'm getting there," she says. "I feel pretty damn good now, for the most part."

She attends junior college and has begun playing the harp again—an instrument she dropped during the chaos of her high school years. She also goes to yoga each day. She used to feel self-conscious about her scars, and tried over-the-counter creams to make them less noticeable. But now, "I don't want to forget them, or what I've been through," she says, "and I like seeing them slowly fade away."

Max also stopped cutting and is study-

ing for a master's degree in education. He has a girlfriend and a circle of friends. Recently, he learned his father also suffers from clinical depression and has taken medication for years. Thinking back to his efforts to convince his parents of his depression, "I think they just didn't want to believe their son would have this problem," he says.

Last summer, after her third release from the hospital, Cecilia decided she wanted to stop cutting. "I knew it was bad and that I was hurting my parents," she says with the same quiet nonchalance with which she described her first self-injury. "I knew I wanted to do something different."

She has not cut since entering ninth grade, and says that high school is better than middle school. "You have a lot more freedom." Only once has she run into another girl aware of her problem. "She looked at all the cuts on my arm and said, 'You're showing.' I looked at her funny, but I knew what she meant. And she said, 'It's OK. I do it, too. I won't tell anybody.' "

Asked what advice she would give parents of self-injurers, Cecilia doesn't hesitate: "The first thing you should do is give your kid a hug."

Linda, Jessica's mom, joined a therapy group for mothers. "As a parent, it helps you to understand where your child is coming from," she says. "There were times I couldn't deal with her, and when my husband couldn't deal with her, so we'd be like a tag-team. But I do think she knows we've tried. Once she said, 'Mom, you're really good at handling all this now.' "

Jessica recovered enough to feel ready to go away to college, but her first year was tough. "I still have my problems," she says, "but I work through them without even thinking about cutting. I look down at my wrist and wonder why I ever did it. I will have my scars for the rest of my life." B

Kathleen Wheaton lives in Bethesda and writes frequently for Bethesda Magazine.

For more information, help or referrals:

Montgomery County Crisis Center
1301 Piccard Dr., Rockville, 240-777-4000, www.montgomerycountymd.gov/hhstmpl.asp?url=/content/hhs/crisis_center/default.asp

Mental Health Association of Montgomery County
1000 Twinbrook Parkway, Rockville, 301-424-0656, www.mhac.org

Montgomery County Youth Hotline:
301-738-9697

Self Abuse Finally Ends (S.A.F.E.) Alternatives
Lists treatment agencies and therapists across the United States, books and other resources. www.selfinjury.com

Adolescent Self Injury Foundation
Offers information, local resources and forums for teens and parents. www.adolescentselfinjuryfoundation.com