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(Room 10)

8:30 - 9:25 WS #91: Self Harm in Primary Care

9:35 - 10:30 WS #103: Self Harm in Primary Care (Repeated)

Diving into the Wound:

The fundamentals of self-harm in primary care

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Hurt

I hurt myself today to see if I'd still feel.
I focus on the pain - the only thing that's real.
The needle tears a hole, the old familiar sting;
Try to kill it all away, but I remember, everything.

What have I become, my sweetest friend?
Everyone I know goes away in the end.
And you could have it all my empire of dirt
I will let you down I will make you hurt ...

I wear this crown of thorns upon my liar's chair
Full of broken thoughts I cannot repair.
Beneath the stains of time, the feelings disappear .
You are someone else, I am still right here.

Outline

1. Definition
2. Prevalence
3. Risk factors
4. Function
5. Self-Harm vs Suicide
6. Practical Recommendations
7. Recommended readings

What is deliberate self-harm (DSH)?

- *Definition* – “the deliberate, direct destruction of body tissue, without conscious suicidal intent.” (Gratz, 2003)

- Self-harm or self-mutilation can take several forms, including, but not limited to:
  - Cutting (70-97%)
  - Hitting, banging or bruising self (21-44%)
  - Burning (15-35%)
  - Skin picking (including re-opening wounds)
  - Hair pulling - trichotillomania
  - Taking pills or other dangerous substances
  - Compulsive piercing or tattooing

- *NB:* Many use more than one method

The "Cutting" Edge Facts

Prevalence & Incidents Rates

- Secrecy around DSH prevents accurate stats; numbers are likely an underestimation
- In USA and UK 3-4% of non-clinical population DSH, with up to 1% reporting a severe history
- Between 14% to 38% of U.S. students intentionally cut or injure themselves
- About 13-15% of USA, Canada, and UK 15-and 16-year olds DSH a least once
- A study of 9th and 10th graders found that 46% had performed at least one DSH behaviour within the past year, including 14% who had cut or carved skin and 12% who had burned skin (Lloyd-Richardson, et al., 2007, in Psychological Medicine).

NZ trends of hospitalisation for DSH by sex/ethnic group

- The rate rose by 4.6% between 2004–2013 across all ethnic groups
- Since 2004, Māori consistently higher than other ethnic groups.
- Women to men - 2:1 ratio.
- 1:3 are youth (15–24 years), 75% females

- More info on http://www.moh.govt.nz

Who is most likely to self-harm?

- Typical profile - a female, adolescent or young adult, single, intelligent, from a middle to upper-middle class SES who cuts on her wrists or arms (Favazza & Conterio, 1989)
- BUT male rates are increasing (Gratz, 2001)
- Gender differences in methods: women - cut, men - burn or hit
- Age of onset around age 13 or 14 (90%)
- Rates are higher in Caucasians than non-Caucasians, a trend consistent across psychiatric, forensic, & non-clinical populations
- Helpless or powerless in social and psychological sense (e.g. Minority groups)

Psychological Characteristics

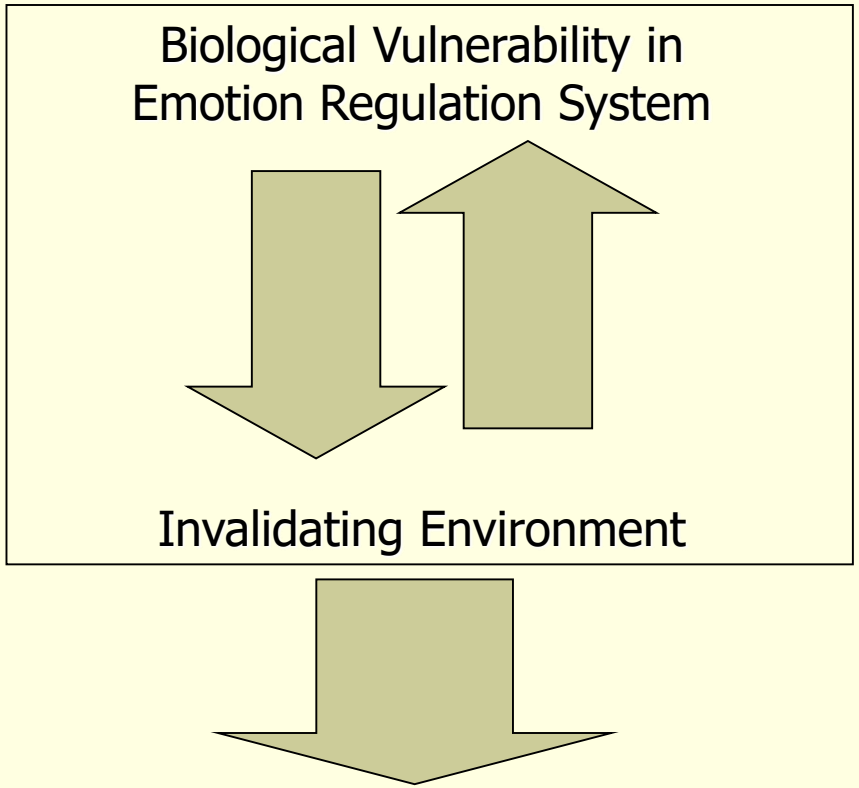
- Negative emotionality:
  - Frequent and intense negative emotion; score highly on measures of negative temperament, emotion dysregulation, depression, and anxiety
- Emotion and regulatory skill deficits
  - Alexithymic (have difficulty identifying or understanding emotions)
  - Tendency to dissociate whereby the experience of emotion is impaired (Gratz et al.,2002; Zlotnick et al., 1996);
  - Less mindful, or aware, of their emotions (Lundh, Karim, & Quilisch, 2007; Zlotnick et al.,1996)
  - Have trouble expressing emotions (Gratz, 2006) – disconnect
- Self-derogation:
  - Prone to be self-critical or experience intense self-directed anger or dislike (Klonsky et al., 2003).
  - Distorted/ Rigid self and other image. At very high risk.

Psychiatric Diagnosis

- Presence of self-injury does not imply any particular diagnosis.
- Individuals who DSH are diagnostically heterogeneous and may experience a range of psychological disorders
- 20% of adult psychiatric patients DSH and 40–80% of adolescent psychiatric patients
- Dependent on drugs or alcohol
- Strong co-morbidity with Personality Disorder (esp. BPD)
- Anxiety more strongly related to DSH than depression
- Research shows the strongest link to Hx of sexual abuse
- Hx of neglect (partial link)
- Hx of physical abuse (partial link)

DBT's View of Emotion Dysregulation

- Biosocial Theory of BPD:



Function of DSH:

Why people do it to themselves?

Model	Description of function
1. Affect Regulation	To alleviate acute negative affect or aversive affective arousal, including sexual.
2. Anti-dissociation	To end the experience of depersonalization or dissociation (e.g. song “Hurt”)
3. Anti-suicide	To replace, substitute impulse to suicide
4. Interpersonal boundaries	To assert ones autonomy or a distinction between self and other
5. Interpersonal-Influence	To seek help, or influence others
6. Self-punishment	To derogate or express anger towards oneself. Can be self-soothing.
7. Sexual Model	To get sexual gratification or release or to punish sexual feelings (sexual confusion)
8. Sensation seeking	To generate exhilaration or excitement

Is DSH a suicide attempt?

- The majority of DSH people are not actively suicidal
- Suicide attempts by those who DSH often involve a different method than the preferred method of self-injury, e.g. overdosing on drugs (Stanley, et al., 2001).

- BUT:
  - Suicides often result from failure to cope with emotional pain, as DSH will never fix it
  - May be accidental due to chronic self-harm (parasuicide)
  - 50% of all people who kill themselves have a history of DSH, an episode having occurred within the year before death in 20-25%.
  - DSH clients who report being repulsed by life, having greater amounts of apathy, self-criticality, fewer connections to family, and less fear about suicide are more likely to attempt suicide

Is DSH a suicide attempt?

Core Qs	Suicide Attempt	DSH
1. Intent	To die; to terminate consciousness	Relief from unpleasant affect (e.g., anger, tension, sadness, etc.)
2. Damage and lethality	Serious physical damage; lethal means of self-harm	Little physical damage and/or non-lethal means used
3. Chronicity of behavior	Rarely chronic repetition; some overdose repeatedly	Frequent, chronic high-rate pattern

Is DSH a suicide attempt?

Core Qs	Suicide Attempt	DSH
4. Methods	Usually one method	Usually more than one method/ Ritualized
5. Pattern of psychological pain	Unendurable and persistent	Uncomfortable and intermittent
6. Constricted cognition	Extreme constriction; suicide is the only way out; seeking a final solution	Little or no constriction; choices available; seeking a temporary solution

Is DSH a suicide attempt?

Core Qs	Suicide Attempt	DSH
7. Pervasiveness of affect	Hopelessness and helplessness are central	Periods of optimism and some sense of control
8. Consequence of act	No immediate improvement; treatment required for improvement	Rapid improvement; rapid return to usual cognition and affect
9. Core problem?	Depression and/or rage about inescapable unendurable pain	Varied

What treatments are effective?

- Dialectical Behaviour Therapy (DBT), Psychodynamic Therapy, CAT
  - Research has also failed to find differences in the reduction of DSH between DBT and other treatments (Linehan et al., 2006)

- Share common therapeutic techniques:
  - Functional assessments
  - Teaching specific skills (e.g., problem-solving, distress tolerance, assertive communication)
  - Behavioural interventions (e.g., exposure, activity scheduling, removing re-enforcers)
  - implementing cognitive restructuring

- Pharmacotherapy
  - No known studies that evaluate the effectiveness of different medications in reducing DSH.
  - Used as ad-hoc (e.g. impulse control, Axis I).

Cold glass, how you insert yourself between myself and myself.

I scratch like a cat.

That blood that runs is dark fruit - an effect, a cosmetic.

You smile. No, it is not fatal.

"The Other", Sylvia Plath

"My whole experience of these episodes was that someone else was doing it; it was like 'I know this is coming, I'm out of control, somebody help me; where are you, God?' " "I felt totally empty, like the Tin Man; I had no way to communicate what was going on, no way, no way to understand it."

Dr. Marsha Linehan

Practical Recommendations: Don't

"The rescue of drowning people is in their own hands"
Old soviet comic slogan

- Don't take responsibility or try to "save" patients
- Don't Inadvertently **reinforce** the DSH behaviours:
  - Change clinical decisions in response to threats
  - Give out personal phone numbers or emails - boundaries
  - Treat client as different from other clients
- Don't judge client or assume self injury is *necessarily* manipulative
- Don't call it "parasuicidal gestures"
- Don't assume this is a phase that clients will outgrow or that they are **not** thinking about suicide
- Don't tell them to stop (i.e., get into a power struggle)

Practical Recommendations: Do's

I. Initial assessment

- The principle of 4 "C"s:
  - Be Cool, Collected, Caring, Consistent
- Name DSH for what it is – cutting, burning, mutilation
- Take behaviours seriously and explore SI/ intent to die
- Ask about other forms of self-injury
- Screen for depression, anxiety, psychosis, substance use and history of DSH.
- Include family members and collaterals
- Conduct medical examination – type, location, severity
  - Often GPs or RN are the only ones that have seen the extent of an injury (*record* details)
- *Remain aware:* The size, type or seriousness of a wound isn't a measure of the size of the pain inside

Practical Recommendations: Do's

II. Establishing a working relationship

- Remain non-reactive and matter of fact
- Validate person's disclosure and painful feelings
  - *"I bet it was not easy to tell me"*
- Validate their feelings and struggle, but not their actions
  - *"You may not have caused all of your own problems, but you have to solve them anyway." (drowning metaphor)*
- Be kind and interested – you are a model on how to deal with it
- Develop their reflective skills and awareness
  - *"What do you make of it?"*

- Your goal is to help the client to discover aspects of their functioning that are operating outside of their awareness and causing difficulties
  - Don't say "you", say "we"

Practical Recommendations: Do's

- Appropriate use of "pop" culture references may:
  - Lead to client feeling less stigmatized
  - Establish common ground/rapport
  - http://self-injury.net/media/famous-self-injurers
- Clients can connect through such references enabling discussion of delicate issues. Clients may feel more comfortable discussing "characters" than themselves. May be useful with younger clients.
- Be careful not to glamorize DSH and point out that most celebrity figures end up unhappy




Pop and media examples of DSH

Movies

- *Thirteen (teenagers)*
- *Secretary (adult content)*
- *Secret Cutting* (teen, made for TV)

Songs

- Hurt by *Nine Inch Nails*: “I hurt myself today, to see if I still feel, I focus on the pain, the only thing that’s real”

- Iris by *Goo Goo Dolls*: “Yeah, you bleed just to know you’re alive.”

Practical Recommendations: Do's

- III. Identify the psychological effects of DSH:
  - Give list of yes/no statements to client
  - *"Does it help?"* "*How does it make you feel?"*
    - Hurting myself makes me feel different from others
    - Hurting myself makes me feel in control and calms me down
    - Hurting myself makes me forget about things that stress me out
    - Hurting myself makes me feel invigorated
    - I hurt myself because it is a way of "cleansing"
    - I feel like I am doing something that I shouldn't and feel ashamed
    - Other_____
  - Ask how long the effect or "benefit" of DSH lasts
  - Educate (remind) client that "benefit" of DSH is short lived. Make parallel to drugs and the "tolerance" issue (i.e. frequency and dose)

Emotional Experience Log

___ Anger	___ Frustration	___ Hopelessness	___ Calmness
___Isolation	___Alienation	___ Shame	___ Relief
___ Numbness	___ Anxiety	___ Happiness	___ Disconnection
___ Depression	___Hostility	___ Tension	___ Elation
___ Guilt	___ Loneliness	___ Emptiness	___ Euphoria
___Fear	___ Sadness	___ _____	___ _____

“B” - before; “D” - during; “A” - after

Practical Recommendations: Do's

- IV. Identify risk factors leading to DSH and feelings:
  - "*Are you aware what type of situations made you do it? What events made you more vulnerable to rely on self-harm?"*
  - Question client regarding psychosocial stressors and "triggers"
  - How quickly/ impulsive was DSH
  - Ritual and means
  - Conduct simple "chain" analysis

Chain analysis of DSH event

Vulnerability (over prior 24 hrs; can be changed)

Prompting event

Links – thoughts, feelings and behaviours

Problem behaviour

Ways to prevent prompting event in the future

Skilful alternative behaviours

Consequences for self and environment

Practical Recommendations: Do's

- V. Appeal to strengths and common sense
  - Help clients identify healthy "distress tolerance" alternatives to dealing with their feelings based on prior **successful** coping
  - *"You have dealt with difficult situations before, right?"*
  - Emphasise non-harming aspects of life to develop self-worth
  - Help clients create a list of effective coping techniques when they want to DSH

Distress Tolerance Activities

- List of effective coping techniques:

  - Holding a ice pack
  - Standing under very cold or contrast shower
  - Snapping rubber band on your wrist
  - Listening to very loud music,
  - Squeezing rubber ball very hard
  - Riping a phone book
  - Exercising (walk, run, get tired)
  - Making an art (painting, sculpting, drawing)
  - Playing with a pet
  - Meditating
  - Talking to a friend or Writing in a diary
  - Watching a movie
  - Others _____

Practical Recommendations: Do's

- VI. Manage your own response to the patient:
  - Accept and understand your feelings
    - Distress
    - Disgust
    - Distancing
    - Fear
    - Anger and blame
    - Feeling helpless, ineffective, and incompetent
    - Seek support and guidance from senior colleagues

- ***NB: These emotional responses are all healthy . . . just not useful to the client***

Why Recognize your feelings towards DSH?

- Reduce anxiety, frustration and/or over-responsibility in staff. Makes it easier to tolerate/ less personalize.
- Once you recognize that – you are flexible in your response.
- Improves management by anticipating problem areas for clients that are not clearly articulated.
- Helps improves boundary maintenance, and avoid staff acting-out and burn-out.

Summary of main points

- DSH is not suicidality
- Complex behaviour for numerous functions
- They are people not problems to be solved
- Management involves
  - Managing client
  - Managing self

THE END.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"No Doc, I'm afraid it's your time that's up"

Recommended Books & Articles

- Conterio, K., & Lader, W., Bodily Harm.
- Gratz, K.L. (2003) Risk factors for and functions of deliberate self-harm: An empirical and conceptual review. APA, D12.
- D'Onofrio, A. Adolescent Self-Injury: A Comprehensive Guide for Counsellors and Health Care Professionals.
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