A Smile on Her Lips, and Cuts on Her Hips

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With thanks to Dr. Karina O’Brien
Outline

- Dr. Tyler Black
  - The Language, Numbers, and Causes of Self-Injury
  - Asking About Self Injury
  - Treatment Approaches to Self Injury
The Language of Self-Injury

Unintentional Self-Injury

* Self-Injurious Behaviours (SIB)
* Non-Suicidal Self-Injury (NSSI)
* Suicide Attempt
* Suicide

Accidents and traumas with no intention of self-injury.

Includes risk-taking behaviours:
- accidental alcohol overdose
- accidental firearm discharge
- choking out injuries

May even result in death.
The Language of Self-Injury

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- Suicide

Usually the terminology used for persons with intellectual disabilities.

- Hair Pulling
- Skin Picking
- Head Banging
- Self-biting
The Language of Self-Injury

- Unintentional Self-Injury
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The preferred nomenclature for any intentional self-injury which has a motivation other than death.

Formerly “parasuicide”.

Therapeutic Cutting, Burning, Purging, Strangulation, Non-lethal Overdoses, Running away unsafely
The Language of Self-Injury

* Unintentional Self-Injury
* Self-Injurious Behaviours (SIB)
* Non-Suicidal Self-Injury (NSSI)

Suicide Attempt

* Suicide

Any self-directed behaviour with the intent of death of self. Lethality of the behaviour must be present, unless the person is impaired by age of intellectual disability.

The behaviour must have been undertaken.
The Language of Self-Injury

- Unintentional Self-Injury
- Self-Injurious Behaviours (SIB)
- Non-Suicidal Self-Injury (NSSI)
- Suicide Attempt

An intentional self-directed behaviour that results in death of self.
Among adults, NSSI is rare:
* 4-6% in early adulthood, decreasing to < 1%

Among adolescents, likely much more common
* Studies vary: general agreement between 15-30% in any year
* “Have you ever tried?”
  * Numbers are definitely rising
  * Recent studies suggest 35.6% to 50% (!)

The Numbers of Self Injury

<table>
<thead>
<tr>
<th></th>
<th>Grade 9</th>
<th>Grade 12</th>
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</thead>
<tbody>
<tr>
<td><strong>Perform NSSI</strong></td>
<td>Females 2x</td>
<td>Females 4x</td>
</tr>
<tr>
<td><strong>Threaten NSSI</strong></td>
<td>Females 2x</td>
<td>Females 5x</td>
</tr>
<tr>
<td><strong>Talk about NSSI</strong></td>
<td>Females 4x</td>
<td>Females 4x</td>
</tr>
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The Numbers of Self Injury

* Age of Onset
  * Consistently found to be 12-14 years of age

The Numbers of Self Injury

* The Course of NSSI:
  * Very few studies
  * McLean Study of Adult Development (18-35)
    * Borderline Personality Disorder
    * 81% engaged in NSSI at baseline
    * 26% engaged in NSSI at 6-year follow-up

* ?? Peaks in adolescence, declines thereafter ??

The Numbers of Self Injury

- Risk factors for Self-Injury
  - Depressive Symptoms
  - Family Loneliness
  - Victimization

Abuse and NSSI

- Study of 1,432 Adolescents with ED (Stanford)
  - 40% engage in SIB regularly

Feelings and Experiences Associated with NSSI

Before
* anxiety and hostility > sadness > anxiety > hostility

After
* Relief
* Guilt
* Disappointment
The Science of Self-Injury

* Does NSSI come from biology?
  * Most repetitive self-injurers have impulsivity problems
    * Shoplifting
    * Drug and alcohol abuse
    * Bulemic eating disorders
    * Sexual Promiscuity

* Impulsivity is a highly genetic trait that relates to a known brain region (frontal lobe)

The Science of Self-Injury

* Endorphins and NSSI
  * Low opioid levels in individuals with NSSI
  * Release of opioids during episodes of NSSI
  * Altered pain sensitivity during episodes of NSSI

* Suicide victims’ brains had 9x more endorphin receptors than did non-suicide victims

How can Self-Injurious Behaviours "Make you feel better?"

Endorphins

B-endorphin & met-enkephalin

Relief
The Science of Self-Injury

* Endorphins and NSSI

Genetic Susceptibility to NSSI → Trauma → Opioid Release → Sensitivity → NSSI to release Opioids

The Science of Self-Injury

*Those who have a *history of suicidality and self harm* have less endorphins in their spinal fluid than those who only have a history of suicidality.


*People who self-injure report greater euphoria when given synthetic opioids than those who do not.*


*Endorphins also trigger the *dopamine reward pathway*, suggesting a biological cause for “addictive patterns”

The Science of Self-Injury


MATH! SOON GO!

-15min -5min EVENT 15 min 40min
The Science of Self-Injury

Figure 1. Mean salivary cortisol levels including their standard errors in the NSSI group (n = 14) and the healthy control group (n = 14) during the TSST. Times of cortisol measurement were 15 min before (T0) and again shortly before (T1) the TSST, as well as 0 (T2), 15 (T3), and 40 min (T4) after the stressor.

The Science of Self-Injury

* It gets messy…

Willour et al. *Molecular Psychiatry* advance online publication 22 March 2011; doi: 10.1038/mp.2011.4
Motivations Behind Self-Injurious Behaviour

“It puts a punctuation mark on what I’m feeling on the inside!”

“It’s a way to have control over my body because I can’t control anything else in my life”

“I usually feel like I have a black hole in the pit of my stomach, at least if I feel pain it’s better than feeling nothing”

“I feel relieved and less anxious after I cut. The emotional pain slowly slips away into the physical pain”
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“I feel relieved and less anxious after I cut. The emotional pain slowly slips away into the physical pain.”

“It makes me feel better!”
Every youth wants to succeed.

Self Injury is the youth’s best attempt at success. We need to redefine success and help direct towards it.

NO CHILD WANTS TO BE A FAILURE!
The Case for Suicide and Self-Injury Screening Expansion
Youth Distress

The following questions and discussion items are based on the McCreary Centre AHS

* BC Study! (4th one done, 2008)
* 29,000 BC Students Grade 7-12
  * 50 of BC’s 59 School districts.
Prevalence

“so much stress [they] could not function”
14% (1 in 7 adolescents)

“despair such that [they] wondered if anything was worthwhile”
6% (1 in 17 adolescents)

Females 2x as likely to report the above
Prevalence

Extreme stress and despair by age

- Extreme stress:
  - 12 or younger: 3%
  - 13: 7%
  - 14: 9%
  - 15: 12%
  - 16: 14%
  - 17: 17%
  - 18 years old: 18%

- Extreme despair:
  - 12 or younger: 4%
  - 13: 6%
  - 14: 7%
  - 15: 7%
  - 16: 7%
  - 17: 7%
  - 18 years old: 7%
Why don’t these children see us in Mental Health?

Reasons for not accessing mental health services (among youth who needed them)

- Thought/hoped the problem would go away: 56%
- Didn’t want parents to know: 43%
- Didn’t know where to go: 30%
- Afraid someone I know might see me: 23%
- Afraid of what a Dr. would say/do: 21%
- I didn’t think I could afford it: 11%
- Had no transportation: 8%
- Parent/guardian would not take me: 7%
- I am not treated with respect there: 3%
- I couldn’t go when it was open: 3%
Screening for Suicide and Self Injury
Early Detection and Screening

Early Signs of Suicide

<table>
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<tr>
<th>“IS PATH WARM”</th>
<th>Description</th>
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<tbody>
<tr>
<td>I</td>
<td>Ideation</td>
</tr>
<tr>
<td>S</td>
<td>Substance Abuse</td>
</tr>
<tr>
<td>P</td>
<td>Purposelessness</td>
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<tr>
<td>A</td>
<td>Anxiety</td>
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<td>“Trapped”</td>
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<td>H</td>
<td>Hopelessness</td>
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<td>W</td>
<td>Withdrawal</td>
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<td>A</td>
<td>Anger</td>
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<tr>
<td>R</td>
<td>Recklessness</td>
</tr>
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<td>M</td>
<td>Major Mood Change</td>
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Age-appropriate considerations

* Risk of completed suicide <10y is **very** low
  
  Therefore, *asking about suicidal thinking should likely start after age 10*

* Rate of **significant stress** <10y is ~3-5%

* Rate of **despair** <10y is 2-4%
  
  Therefore, *it makes sense to consider asking about stress and feeling hopeless at any age!
Can I harm youth by asking about suicide?

* Studies tell us “no”
* The best study (n=2500) in 2005 showed:
  * No distress at the time of asking
  * No distress 3 days or 3 weeks after asking
  * Children who were depressed or suicidal felt better after being asked this question even in a survey.

Should we ask about suicide?

- Most studies tell us “yes”
- Screening vs. spontaneous report
  7x more likely to discover suicidal thinking or self injury
- Only 25% of completed suicides occur in people who have recently accessed mental health services

We are missing the majority of truly at-risk kids!

How easy is it?

* It’s normal to feel uncomfortable asking about mental health issues, especially suicide and self injury.
* In reality, anybody can do it.
* Many successful crisis programs use youth volunteers who are as young as 13!

Don’t be intimidated.
How to do it?

* Check in with stress and distress
  * “How have things been going for you?”
  * “ Anything stressing you out right now?”

* Check in with despair/hopelessness
  * “How do you think things are going?”
  * “What things are you looking forward to? “
  * “ Anything you’re worried about?”
Every now and then(*), check in with suicidal thinking:

- Normalize: “Every now and then, people can have really low, sad thoughts.”
- Support: “It’s important to reach out during these times to get help.”
- Ask: “Have you had any really negative thoughts, like about death or dying?”

* This isn’t a script! The “normalize, support, ask” model is the important part
Treatment

THIS SPACE LEFT INTENTIONALLY BLANK
Assessment

* Engage in assessment with the youth regarding the functions of the self harm
* Common purposes of self harm (from Gratz & Chapman, 2009)
  * To feel better (e.g., distract from emotional pain, express an intense emotional experience, release negative feelings and tension)
  * To make emotional pain clearer (e.g., have a visual image on their body)
  * To punish oneself
  * To end dissociation
  * To get a rush of adrenaline
  * To communicate feelings/needs to others
Assessment

- Learn about what the youth does when he or she self harms (what do they use, where do they damage their body and under what circumstances, when)
- Internet usage
- Chain analysis can be another useful strategy, both as an assessment tool and as an intervention strategy
- Problem solving is done during or after chain analysis during treatment
- Asking the teen to begin self monitoring of self harm urges
Psychoeducation

- Psychoeducation is important for the youth and for parents
- Model compassion, non-blaming, non-stigmatizing
- Teaching about the functions of self harm
- Teaching that the patient needs to learn new ways of coping
Motivational Enhancement

- Pros & Cons
- Teaching about how habit forming self harm can be
- Self harm doesn’t solve problems (and can create new ones!)
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<th>Tolerating Distress</th>
<th>Not Tolerating Distress</th>
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<td><strong>Pros</strong></td>
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<td><strong>Cons</strong></td>
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Treatment Planning

- We do not want to engage in REINFORCING unintentional self-harming behaviour.

- It is important to not focus on the self-injury itself, rather the distress, difficulties, emotions, or events that led to the self-injury.

- Self-Injury should not:
  - Terminate treatment of other conditions
  - Result in “expulsion” from any health, school, or social program
  - Activate a “crisis response system” with mega-attention
Resources

* www.sioutreach.org

* Psychoeducation, self help strategies