Self-Harm in Teens

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Background

• No Conflicts of Interest to Disclose
• Completed Medical School Psychiatry Residency, and Child Psychiatry Fellowship
• Experience in inpatient, residential, and outpatient settings with adolescents
• Currently working on the Middle School Residential Unit and Acute Hospital Unit at Shodair Childrens Hospital
But enough about me.

Who are you?
Non-Verbal Communication

- The Ear Cup
- The Maya
- The Wrist Tap
- The Raised Hand
What is Self-Harm?

- Spectrum of activities and levels of danger
  - Most people think of cutting forearms with household objects like razors
  - Other forms – burning, punching walls, causing abrasions, overdosing, drinking too much, using drugs, smoking
  - “Culturally sanctioned” – piercings, tattooing
  - Not protecting health – not taking medications as prescribed, not flossing
  - Hiding it vs. letting others know
Non-Suicidal Self Injury

- Abbreviated NSSI
- Commonly term used in American and Canadian literature to describe “self-harm that is not suicidal in nature and is performed for the purpose of emotional regulation”
- Also defined as “deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes that are not socially sanctioned”
- The term Deliberate Self-Harm (DSH) is more commonly used in European and Australian literature
Age

• Prevalence rates of NSSI peak around 15-16 years of age and decline toward age 18
• Resolution in late adolescence or early adulthood “in most cases”
• NSSI in adolescence increases adult risk of long-term mental health issues, suicidality, and risk-taking behaviors

Will NSSI Persist Into Adulthood?

- European Child and Adolescent patients who presented with NSSI in early adolescence were re-evaluated in their early 20’s, and around half had stopped NSSI and half still had NSSI within the prior year.
  - Earlier age of onset of NSSI and longer duration of NSSI during adolescence were significantly predictive of adult Borderline Personality Disorder
  - Around half reported having had a suicide attempt
  - Results worse than other studies, speculated to be “due to initial high psychiatric impairment of this sample in adolescence”

Gender

- 70% of those who self-harm are female
- Females tend to cut or cause abrasions
- Males tend to punch walls
  - There’s a lot of wall punching that is not “for the purpose of self-harm” but for the purpose of changing emotional state, but some is for self-harm

Self-Harm and the Teenage Brain

- Poor judgment
- Impulsivity
- Poorly developed coping skills
  - Fewer options and less practice
  - Some have strong social support, some do not (or do not perceive support)
THE LAST PART
OF THE BRAIN TO DEVELOP IS THE PRE-FRONTAL CORTEX

THE DEVELOPMENT OF THE PRE-FRONTAL CORTEX
takes place between the ages of 10 to 12 and continues
into the next several years.

THE TEEN BRAIN

SOURCES:
HTTPS://WWW.RESEARCHGATE.NET/PUBLICATION/277935210_THE_AMAZING_TEEN_BRAIN
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HTTPS://WWW.NIMH.NIH.GOV/PUBLICATIONS/TEEN-BRAIN-STILL-UNDER-CONSTRUCTION/INDEX.SHTML
Judgment last to develop

There are of the brain that controls "executive functions"—including working on long-term consequences and controlling impulses—is among the last to fully mature. Brain development from childhood to adulthood:

- 5-year-old brain
- Preteen brain
- Teen brain
- 20-year-old brain

Dorsal lateral prefrontal cortex ("executive functions")

Sources:
- National Institute of Mental Health
- Paul Thompson, Ph.D., UCLA, Department of Neuro Imaging

Thomas McKay | The Denver Post
What is truly harmful?

• Adolescents cannot accurately predict lethality
  • May think a few small cuts can kill them, or may think large amounts of blood will not
  • Similarly, difficulty predicting outcomes of overdosing (some kids think 4 Tylenol pills will kill them)
  • Most superficial lacerations will heal with basic first aid, but cuts through the skin need medical attention
  • But NSSI is rarely lethal
Types of Self Harm

- Suicidal
- Non-suicidal
- Main difference is INTENT
  - ex: both might cut wrists
Why Self-Harm?

- For emotional regulation / decreasing stress
  - Physical pain blocks out the emotional pain
  - Self-soothing
  - Distraction
  - “To feel alive”
  - Because it works
  - “For attention”
Methods of Self-Injury

- NSSI is typically cutting on forearms, but also includes other sites or burning self. (Anecdotally I also see a lot of picking scabs.)
- Note it is uncommon for an individual who engages in NSSI and is suicidal to use the same method for each purpose, and they are often able to verbalize the difference
  - Ex: superficial cutting of forearms as NSSI, and attempting to overdose as suicidality
Differentiating Suicidal vs. Non-Suicidal Self Injury

• How can you tell the difference?
  • ASK
  • “What are you trying to accomplish by self harming? Is it for the purpose of killing yourself?”
  • Not mutually exclusive - NSSI is associated with increased risk of future suicide attempts
• For the purpose of this talk we will focus on Non-Suicidal Self Injury
we're all addicted to something that takes the pain away.
Risk Assessment

- Warning Signs – immediate risk
- Risk Factors – increased long term risk but do not indicate current immediate risk
- Protective Factors - decrease risk
Warning Signs for Suicide (Immediate Risk)

- 1) Suicidal Intent
- 2) Looking for a way to do it
- 3) Hopelessness

For a list of expert-recommended warning signs, see the fact sheet at the Best Practices Registry for Suicide Prevention (BPR):  http://www.sprc.org/bpr/section-II/warning-signs-suicide-prevention
Risk Factors for NSSI

• Correlates of NSSI include a history of sexual abuse, depression, anxiety, alexithymia, hostility, smoking, dissociation, suicidal ideation, and suicidal behaviors.


• Strongest: history of NSSI, Cluster B PDs, and hopelessness
  • Also: Prior SI, Exposure to peer NSSI, patient prediction, abuse, dysfunctional relationships, LGBTQ, and bullying

Risk Factors for Suicide

- Prior attempt
- NSSI
- Substance abuse
- Mood disorders
- Access to lethal means


For more: http://www.suicidology.org/ncpys/warning-signs-risk-factors
Risk Factors Common to NSSI and Suicidality

- History of trauma, abuse, or chronic stress
- High emotional sensitivity
- Few effective coping skills
- Feelings of isolation / perception of isolation
- Alcohol / substance abuse
- Mood or anxiety disorders
- Feeling worthless
Protective Factors

• Effective Mental Health Care
• Connectedness to individuals, family, community, and social institutions
• Problem-solving skills (anti-hopelessness)
• Contacts with caregivers

NSSI and Suicidality

- NSSI is a risk factor for suicidality
- The level of distress leading to NSSI is usually significantly lower than the level of distress leading to suicidality
- Many patients report NSSI is helpful to reduce distress, and in some who have considered suicide it is a way to lower distress to avoid attempting suicide

How often are patients both engaging in NSSI and truly suicidal?

- In NSSI users, 35-40% will also report some suicidality
  - This means over half of NSSI users do not have suicidality
- In NSSI users with suicidality, 80% of the time the NSSI precedes the suicidality

Prevalence Study 2005-2011

- “The search terms: self-injury, non-suicidal self-injury, NSSI, deliberate self-harm, DSH, self-harm, self-mutilation, parasuicide, prevalence, rates, adolescent, and adolescence" were used to locate articles. We restricted the search to peer reviewed, empirical articles published between January 1, 2005 and December 1, 2011… Articles were included if they were written in English, reported empirical data collected from adolescents (age range 11-18 years) within community or school settings... Studies were excluded if the sample included fewer than 100 participants or included populations with pervasive developmental disorders… Studies reporting prevalence within clinical (inpatient/outpatient/emergency department) studies were also excluded…”
Self-Injury Prevalence in Non-Clinical Adolescent Populations

My tips

• When I ask, “Any recent thoughts of self harm?” the Shodair patients are often vague. When I ask, “If 10 is totally wanting to self harm and 0 is not wanting to self harm at all, what is the highest it has been in the last 24 hours?” I often get a number that is not zero.

• I get much better information on zero to 10 scales than I do on binary “yes or no” questions

• “Do you think there is an adult you would tell if you were feeling unsafe?” Good to know who and if they are on good terms with the caregiver
My tips

• When I ask, ”Are you having suicidal thoughts?” the Shodair patients usually say no. When I ask, “If 10 is you totally want to kill yourself and 0 is you don’t want to kill yourself at all, what is the highest number you had in the last 24 hours?” I will often get a number between 3 and 5. Then follow up with assessing when it was highest why was it highest.

• I then like to ask, “How close did you come to acting on it?”
My tips

• We used to write the goals in the treatment plan as “no suicidality for one month,” which led to the clients feeling like they had to deny suicidality to be discharged. We revised the goals to say the client would "notify staff and safely manage suicidal thoughts for one month,” which led to improved communication and utilization of coping skills. When kids “think they are in trouble” they hide the behavior.