

Self-Injurious Behavior

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Self-Injurious Behavior

- SIB - the deliberate alteration or destruction of body tissue without conscious suicidal intent
- Previously, SIB was thought to be associated only with serious mental illness or trauma. Lately, substantial rates of SIB have been found in high functioning populations with no psychiatric diagnosis.

Four Main Categories of SIB

- Severe - extensive damage (psychotic)
 - Usually occurs suddenly with a great deal of damage
 - Patients may seem indifferent
 - Often religious theme
- Stereotyped - rhythmic
 - Institutionalized DD, seizure disorders
 - Head banging is the most common
- Socially accepted/emblematic
 - tattooing, piercing, etc...
- Superficial/moderate

Superficial/Moderate

- Compulsive:
 - Habitual, obsessive/comp rather than impulsive. Urge is resisted. (Ego-dystonic) Intrusive thoughts about contamination, inadequacy, bodily shame. Nail biting, trichotillomania, skin picking
- Episodic:
 - Occasional impulsive burning and cutting- provides a quick and effective release from stress
- Repetitive:
 - Includes rumination and planning, identification as a cutter or burner. There is little resistance to the urge. Carefully executed. Has qualities of addiction.

Superficial/Moderate

- Counter-dissociative:
 - An attempt to re-associate self with here and now reality
- Parasuicidal:
 - “suicide gesture” reflecting ambivalence about suicide or as attempt to communicate to others

Superficial/Moderate

- Skin cutting is the most common, followed by burning and hitting
- Commonly comorbid with personality disorders
- Typically includes onset in adolescence, multiple episodes, chronic, associated with depression, despair, anger, aggression, anxiety, cognitive constriction
- Predisposing factors include lack of social support, male homosexuality, AODA, suicidal ideation in women.
- Diagnosed as Impulse Control Dis NOS, or BPD

Demographics

- SIB is a common clinical phenomenon: 4% of the general population, 21% of psychiatric hospital admissions.
- Most common in adolescent females (11.2% vs. 3.2% males). Some communities report rates as high as 14-39% of adolescents.
- Poisoning and cutting account for 90% of SIB ER visits.

Self-Injurious Behavior

- Rates for behaviors, USA, per 100,000
 - Accidents coming to ER 10,000
 - Intentional self-harm to ER 157
 - Suicide 11

Demographics

- SIB in adolescents increases proportionately with consumption of cigarettes, alcohol, and drugs.
- Having friends or family members who self-injure also increases risk.
- Childhood abuse is associated with SIB.
- SIB in girls is associated with depression, anxiety, who use SIB to relieve an “unbearable” state of mind.

Demographics

- Until the 1990's, SIB was unknown to the public and carried out in private. Media outlets, including the *Internet*, have now made SIB part of mainstream culture.
- YouTube.com allows individuals to watch as the creator of the video hurts himself. Therapists who work with clients who self-injure need to become familiar with useful *Internet* sites and always ask clients about *Internet* usage.

Repetitive SIB

- Between 15-25% repeat self-harm within 1 year of the index episode and present to the same hospital. In one study looking at 11,583 clients over 10 years, 39% repeated and were at greater risk for completing suicide, especially females (3.5x higher for repeat versus single episode.)

Summary of Reasons for SIB

- Affect regulation
 - Reconnection with the body
 - Calming the body during periods of arousal (exhibit decreases in respiration, skin conductance, heart rate in response to the behavior (like concentration))
 - Validating inner pain
 - Avoiding suicide
- Communication
 - Express things which cannot be said out loud
- Control/punishment
 - Trauma re-enactment
 - Bargaining and magical thinking
 - Self-control
 - Control of others

Neurobiology

- Serotonin: impulsivity, compulsive behavior
- Opiate system: 50-66% have no pain associated with behaviors. Endogenous opioid system is abnormal.
- Dopamine: implicated in Tourette's , Lesch-Nyhan, and others

Treatment of SIB

- Clinicians should respond to SIB with low-key, respectful curiosity. Responding with shock, anger, or immediately “contracting for safety” in unlikely to further the treatment alliance.
- Do a good assessment and emphasize that new coping strategies can be learned.

Pharmacotherapy

- Virtually all studies are case studies.
- Majority of participants are Caucasian adult women
- Comorbidity was avoided
- Samples were treatment resistant
- Studies were short duration
- Most relied on client self-report
- Psychotherapy may or may not have been ongoing with the drug trial

Pharmacotherapy

- No drug approved by FDA
- Antidepressants: SSRI's
- Opiate antagonists: Naltrexone
- Atypical antipsychotics: risperidone, clozapine
- Mood stabilizers: topiramate
- Alpha-2 agonists: clonidine

Psychotherapy

- Cognitive restructuring
 - Dialectical behavior therapy (the only well-replicated successful treatment)
- Behavioral modification
- Assertiveness training
- Teaching alternative coping mechanisms
- Psychodynamic long-term partial hospital programs

Description/History

DBT is a cognitive behavioral therapy developed by Marsha Linehan in 1993. It was designed as an outpatient treatment to reduce SIB and suicidal behavior in the most severe subgroup of clients with BPD. Adaptive skills are taught. Motivation is enhanced through the reinforcement of progress and the non-reinforcement of maladaptive behaviors. A DBT outpatient consultation team is a source of support for the therapist, and serves to keep the therapist focused on the treatment goals.

Therapy Assumptions

- Clients are doing the best they can.
- Clients want to improve.
- Clients need to do better, try harder, and be more motivated to change.
- Clients have not caused all their own problems, but they need to solve them anyway.

Therapy Assumptions

- Clients lives are unbearable as they are currently being lived.
- Clients must learn new behavior in all relevant contexts.
- Clients cannot fail in therapy - the treatment fails.
- Therapists treating clients with BPD need support.

Therapeutic Techniques

- The strategy of the therapist is one of acceptance of whatever is valid about the client's concerns, viewing behaviors as the client's best efforts to cope with unbearable pain. This acceptance and validation is balanced with working on making changes.
- Change is achieved through the tension and resolution of accepting what is happening now and the necessity of changing.

Therapeutic Process

- I) Decrease life threatening behaviors, as well as behaviors that interfere with therapy - lateness, absence, interpersonal difficulties - according to the following hierarchy:
- Reduce life threatening and SIB
 - Reduce therapy interfering behaviors
 - Reduce behaviors that interfere with quality of life

Therapeutic Process

- In order to accomplish this, the therapist makes a commitment to help clients tolerate pain and be available to coach them learning new skills, including:
 - Mindfulness
 - Distress tolerance (distracting and self-soothing)
 - Interpersonal effectiveness (assertiveness, cognitive restructuring)
 - Emotion regulation (observation and identification, acceptance, reduce vulnerability to negative emotions, increase positive emotions)

Therapeutic Process

- II) Reducing post-traumatic stress
*behavioral principles of exposure for healing past trauma
- III) Increasing self-respect and achieving individual goals
*social and vocational areas are emphasized

Therapeutic Process

- Treatment consists of:
 - The above skills training group
 - Two individual sessions a week in which the client reports a daily record of behaviors
 - In vivo skills coaching (client will call when necessary)
 - There is a meeting of the DBT therapists once a week

Therapeutic Process

- Clients cannot call for 24 hours after a self-injury. Burning out therapists is a therapy interfering behavior.
- Being in the hospital is considered disruptive in meeting the goals of creating a life worth living.
- DBT takes 1 year, requires 1 hourly meeting for individual therapy, 1 hour for skills training. The therapist must meet weekly with other therapists.

Self-Help: Substitution

- Anger
 - Violence toward objects, deface picture of yourself, dance, jog, yell, stomp
- Sadness
 - Hot bath, soothing music, special treats, talk
- Depersonalization
 - Squeeze ice hard, bite into hot pepper, snap wrist with rubber band, take cold bath
- Unfocused
 - Exciting computer game, eat mindfully, investigate something closely

SIB and Suicide

- In psychotic and affective disorder clients, this may be a prodrome to suicide.
- Personality disordered clients usually self-harm to reduce tension and communicate
- Cutting, scratching, self-hitting, burning rarely cause death
- SIB's differ from suicidal clients
 - Intent
 - Degree of damage
 - Multiple methods
 - Intermittent psychic pain
 - Little constriction of affect
 - Rapid improvement
 - Optimism and sense of control

Suicide and SIB

- Intent: escape pain permanently vs. relief from unpleasant affect
- Lethality: serious damage vs. superficial
- Pattern: rarely chronic vs. chronic
- Methods: usually one method vs. multiple over time
- Level of pain: persistent vs. intermittent
- Cognition: constricted/tunnel vs. little constriction
- Post-act: no improvement vs. rapid relief
- Helplessness: central vs. sense of control

SIB and Suicide

- 29% of low risk self-injurers report varying degrees of suicidal intention, and 10% may go on to die of suicide.
- Suicide attempters who self-mutilate tend to underestimate the lethality of their suicidal behaviors. They exhibit higher levels of depression and anxiety, hopelessness, impulsivity, and suicidal ideation than suicide attempters who do not self-injure.
