Adolescent Nonsuicidal Self-Injury

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Disclosures

- I am a resident of the University of Washington/Billings Clinic Psychiatry Residency
- No one gives me any other money to have any financial interests
- If someone is interested in giving me money, I would be interested

Objectives

- Differentiate Self Harm, Suicidal Injury, and Non-suicidal Self Injury
- Understand one model of non-suicidal self injury
- Feel more comfortable screening patients with Non-suicidal Self Injury

Nonsuicidal Self-Injury Disorder

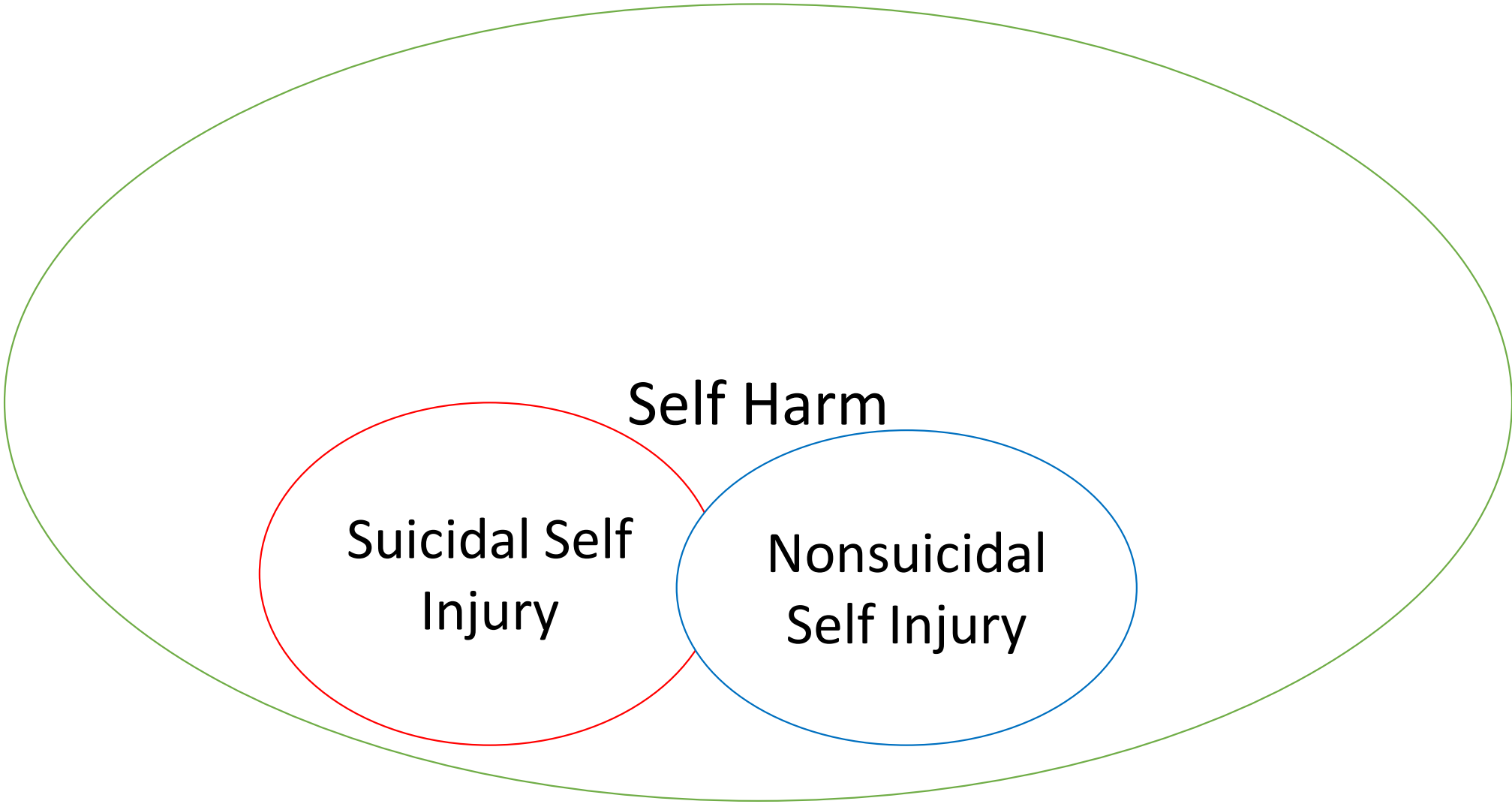
- NNSI occurring on more than 5 days in 1 year
- Engagement in self-injurious behavior is done with expectation that it will cause 1) relief from negative feelings or thoughts 2) resolution of an interpersonal problem or 3) creation of a positive mood state.
- Act is preceeded by 1) negative thoughts or feelings 2) preoccupation with planned self-injurious behavior that is hard to control 3) frequent thoughts of self-injurious behavior
- Socially sanctioned behavior (tattoes/body piercings) are excluded as is behavior done in a cultural/religious context. Common/mild behaviors are excluded (nail biting/scab picking)
- Engagement in NSSI results in clinically significant distress or problems in life functioning
- Not better explained by another disorder/diagnosis

DSM-V Definition

- Deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned, includes behaviors such as cutting, burning, biting, and scratching skin

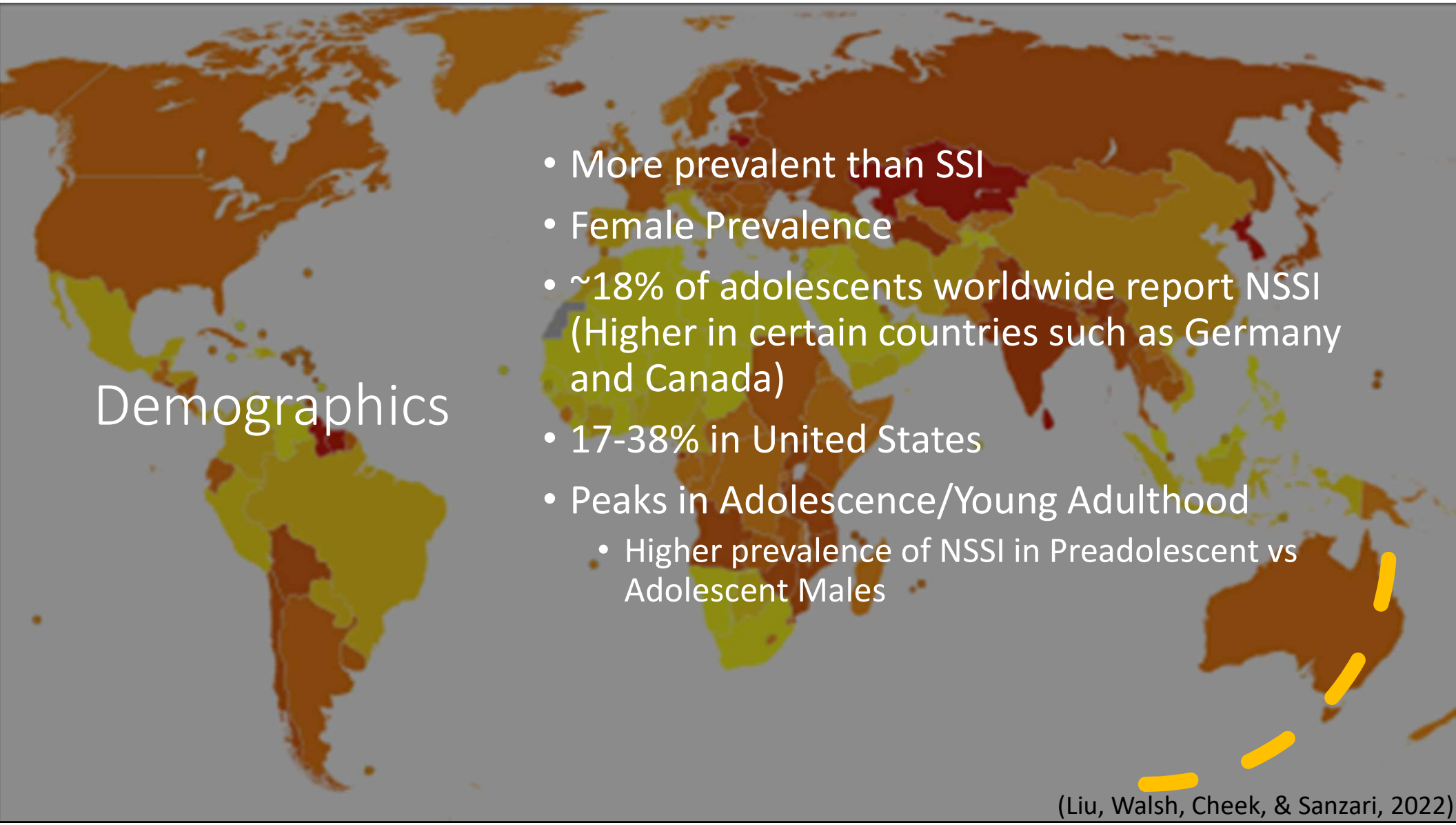
Definitions

- Self-Harm –deliberate causing of pain or damage to self
- Self injury – deliberate pain or damage with intent to cause injury or pain
- Nonsuicidal Self Injury- deliberate pain or damage without intent


Self Harm
Suicidal Self Injury
Nonsuicidal Self Injury

Demographics

- More prevalent than SSI
- Female Prevalence
- ~18% of adolescents worldwide report NSSI (Higher in certain countries such as Germany and Canada)
- 17-38% in United States
- Peaks in Adolescence/Young Adulthood
  - Higher prevalence of NSSI in Preadolescent vs Adolescent Males



(Liu, Walsh, Cheek, & Sanzari, 2022)

Risk Factors

- Demographics
  - Female, Adolescent, Unemployed, Living Alone
- Familial
  - Physical/Mental Health issues in parents, Separated parents, Child/Parent Conflict
- Mental Health
  - Anxiety/Depression, hopelessness, Cluster B, Eating Dx, Affect Regulation, Substance, Aggression,
- Hx of Abuse
- Prior Behavior
- Parental Issues
  - EtOH, ADHD, Self-criticism, “Low Degree of compatibility/diligence”

(Plener, et al., 2018)

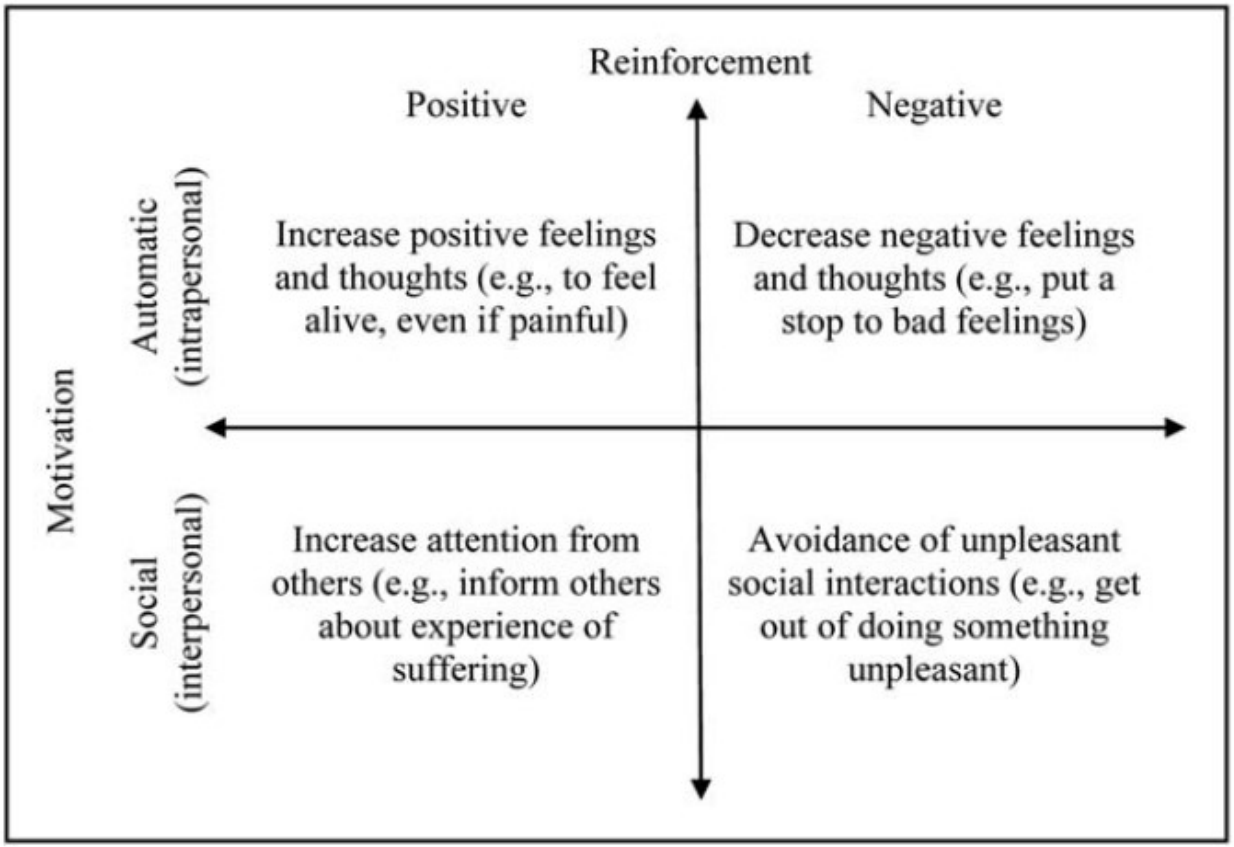
Why?

- We normally avoid pain, but sometimes our patients deliberately seek it out

- Self-injury causes a release of endogenous opioids and regulates physical pain
- Physical pain can be a distractor
- Method of control

(Hooley & Franklin, 2018)

Reinforcing NSSI

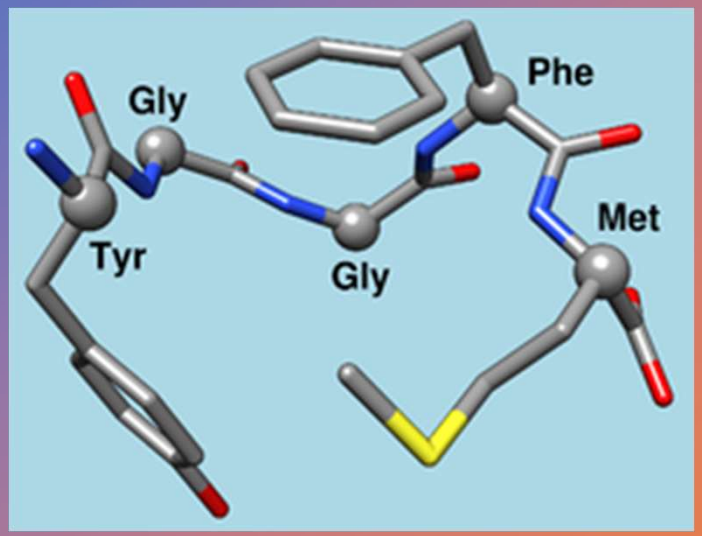


Emotion Dysregulation

- People with NSSI experience high levels of negative affect
- When negative affect becomes too high, NSSI is the regulation strategy that provides emotional relief
- (Hooley & Franklin, 2018)

Four Function Model of NSSI

- Affect dysregulation or social dysregulation precedes NSSI and SSI
- NSSI and SSI brings about some affect or social regulation



Opioid Homeostasis Model

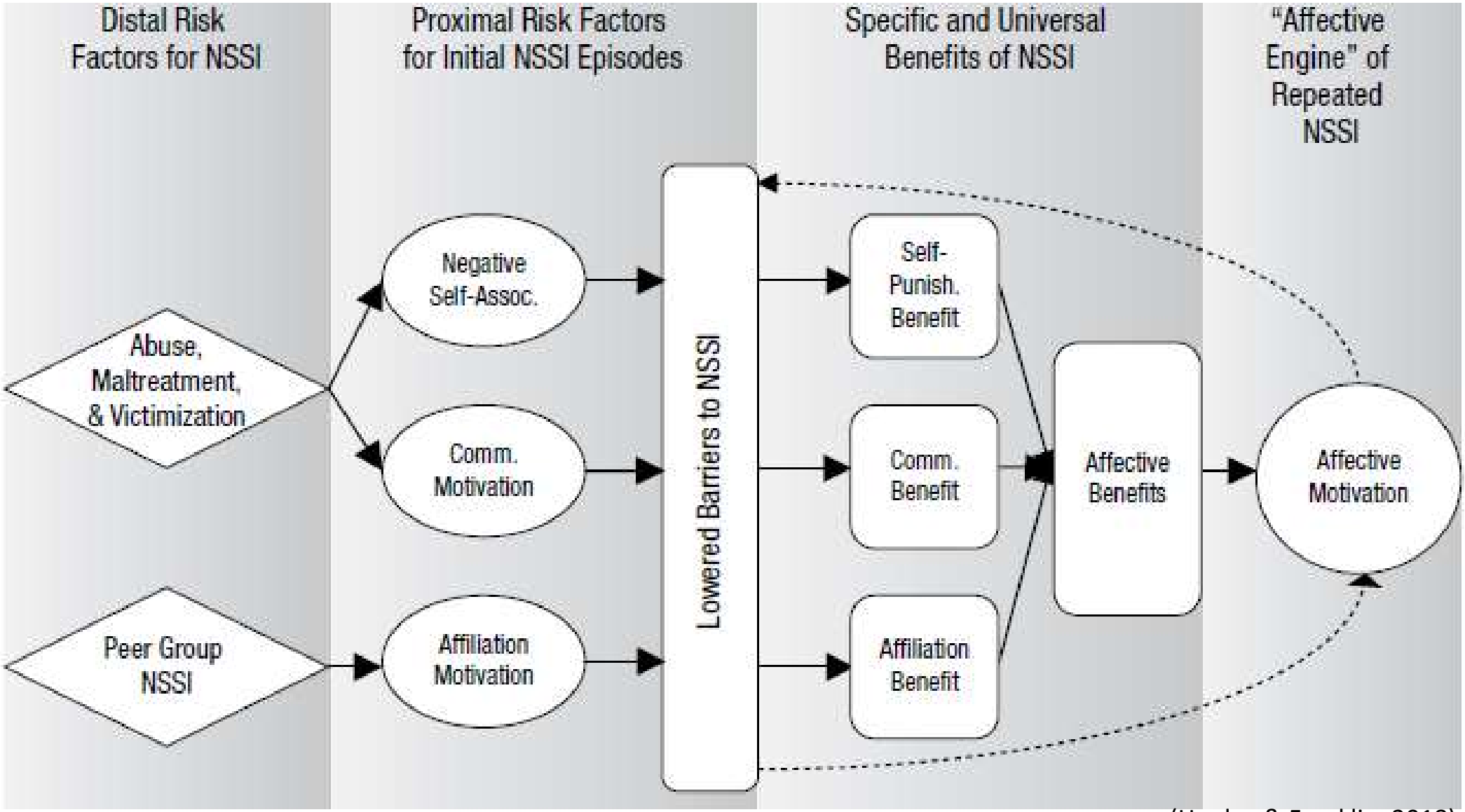
- Some populations are believed to have lower baseline endogenous opioids or be less sensitive to them
- People naturally gravitate towards activities that increase endogenous opioid release
- Doesn't explain why less damaging methods of pain/opioid release are more often pursued

Barriers/Benefits Model

(Similar to Joiner's Interpersonal Theory of Suicide)

BENEFITS	Barriers
Improve affect	Lack of Awareness
Gratifies Self-punishment desires	Positive View of Self
Peer Group Affiliation	Avoidance of Physical pain
Communicate Distress or Strength	Aversion to NSSI Stimuli
	Social Norms

JOINER'S THEORY OF SUICIDE



(Hooley & Franklin, 2018)

Assessment

Somatic Assessment First

Safety/Suicidality

Other Psychiatric Issues

Assessment

- (1) Suicidal ideation before, during, or after NSSI
- (2) Types of NSSI engaged in
- (3) Onset of NSSI
- (4) Place/location of NSSI on the body
- (5) Severity and extent of damage because of NSSI
- (6) Functions served for adolescent by NSSI
- (7) Intensity/frequency of NSSI
- (8) Repetition of NSSI
- (9) Episodic frequency of NSSI in a typical day or Week

(Pluhar, Lois, & Thomaseo, 2018)

NSSI & Suicidality

- Among clinical samples, 14-70% of adolescents report both NSSI and Attempted Suicide
- Actual numbers are unclear, but risk factors are the same for each

How to discuss this?

Table 2. Recommendations for primary care pediatricians assessing nonsuicidal self-injury in adolescents

Do	Do not
Discuss NSSI with patient in a calm and caring way.	Be overly reactive
Be nonjudgmental; validate the patient, although you may not agree with the behavior	Respond with panic, revulsion, shock, or averted gaze
Let the patient know there are people who care	Show excessive interest in the self-injurious behavior
Understand that this is a way of coping with the pain he/she feels inside	Try to stop the behavior with threats or ultimatums
Use the patient's language for NSSI	Permit the patient to relive the experiences of NSSI in detail
Be willing to listen	Promise to not tell anyone about the NSSI

(Pluhar, Lois, & Thomaseo, 2018)

Treatment?

Treatment pathway

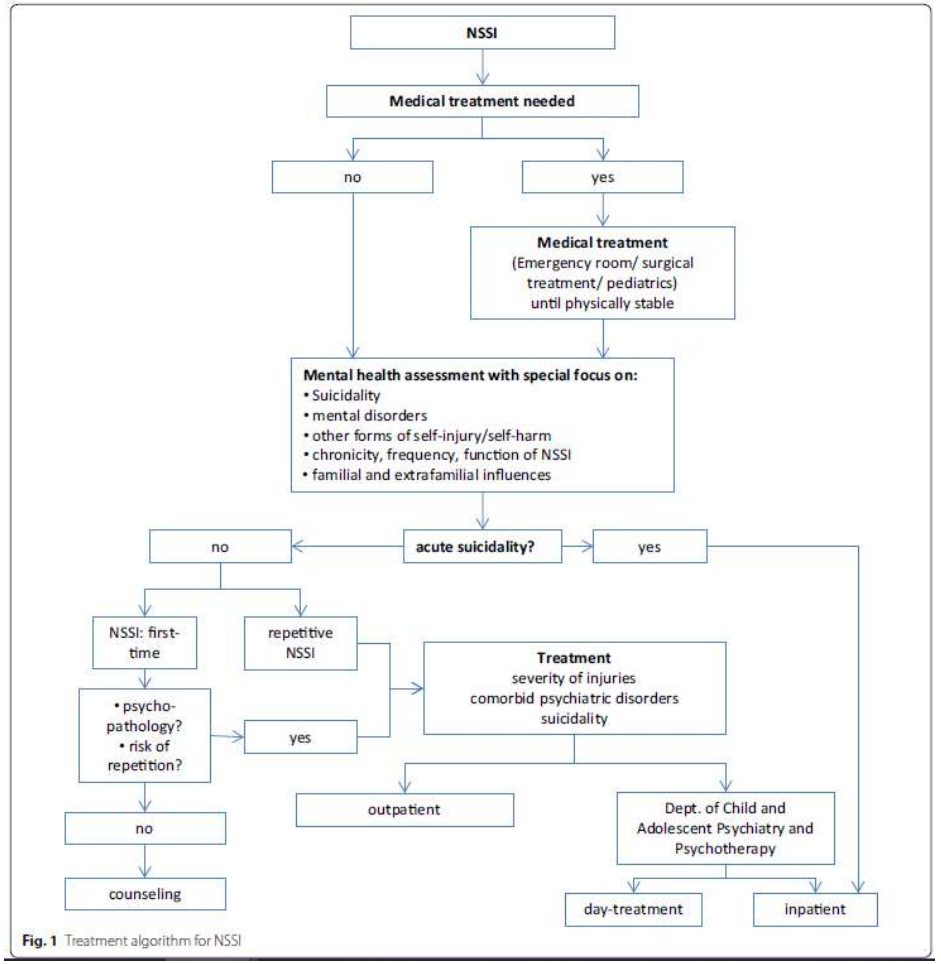


Fig. 1 Treatment algorithm for NSSI

(Plener, et al., 2016)

Psychotherapy

- Very Few RCTs evaluating just NSSI
- DBT has best data
- Emotion Regulation Group Therapy has several RCTs with good evidence

- Other forms of psychotherapy may be efficacious but haven't necessarily had NSSI studied

Table
Selected clinical trials evaluating treatments for adolescents with NSSI

Reference	Population	N	Study design	Intervention	Results
Psychotherapy approaches					
CBT					
Brent et al.[3]	Depressed adolescents aged 12-18 yrs with non-response to SSRIs	334	RCT	SSRI < SSRI + CBT; venlafaxine, venlafaxine + CBT (12 wks)	No significant difference between groups in incidence of NSSI during the study
Goodyear et al.[4]	Depressed adolescents aged 12-18 yrs with nonresponse to brief psychosocial intervention	208	RCT	SSRI vs CBT + SSRI	Decreased frequency by more than 50% (no significant difference between groups)
DBT					
Goldstein et al.[6]	Adolescents aged 14-18 years with bipolar disorder	10	Open-label trial	DBT with individual and family skills training; 24 wks followed by continuation (tapering frequency to 1 yr)	4 adolescents reported NSSI history at intake; no adolescents reported NSSI at final assessment
Mehlum et al.[8,9]	Adolescents aged 12-18 yrs with self-harm behavior	77	RCT	DBT-A (shortened form) vs EUC (19 wks)	Greater decrease in NSSI frequency in DBT-A group vs EUC; DBT-A group remained superior to EUC in decreased incidence of NSSI at 1 yr
McCauley et al.[9]	Adolescents aged 13-18 yrs with a history of suicide attempt	173	RCT	DBT vs IGST (6 mos)	50% in DBT group vs 40% in ISGT group; no NSSI at 6 mos
Pistorello et al.[10]	College students aged 18-25 yrs with baseline suicidal thoughts, history of ≥ 1 NSSI episode or suicide attempt and ≥ 3 BPD criteria	63	RCT	DBT vs OTAU (7-12 mos)	Similar incidence of NSSI during the trial; mean NSSI count was lower for DBT than for OTAU
MBT					
Rossouw and Fonagy[11]	Adolescents aged 14-17 years with depression and self-harm	80	RCT	MBT-A vs TAU	56% of adolescents in MBT-A were self-harming at 12 mos vs 86% in TAU group

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Psychotherapeutic Interventions

Table 2. Summary of Treatments and Interventions

Treatments/Interventions	Results
Dialectical behavioral therapy	Comparable to TAU
Developmental group therapy	Comparable to TAU
Cognitive-behavioral therapy	Comparable to TAU
Psychosocial assessment in the ED	Reduced incidence of future self-harm
Therapeutic assessment	Improved rate of return for follow-up care
"Meaning Making"	Clients subjectively found it helpful
Continuity of care	Clients subjectively found it helpful
Encouraging secondary education	Case studies suggested it may be helpful
Harm reduction (patient education)	Single-case study suggested it may be helpful
Psychotropic medications	Clients subjectively found it harmful
Relaxation training	Clients subjectively found it harmful
High unit expectations	Clients subjectively found it harmful
Excess attention following NSSI	Clients subjectively found it harmful

(Gonzales & Bergstrom, 2013)

Pharmacotherapy

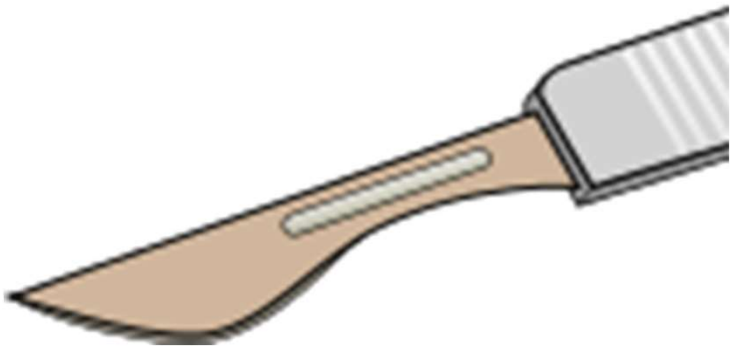
- Discontinuation of meds lowering impulse control (benzodiazepines)
- SSRIs/SNRIs similar studies
- Naltrexone
- Buprenorphine?
- Aripiprazole has 1 RCT
- Ziprasidone has non-RCT efficacy

(Turner, Austin, & Chapman, 2014)

- N-Acetylcysteine (Cullen, et al., 2018)

- **Treat comorbidities as appropriate**

Harm Reduction?



- Pragmatic Acknowledgment without moral condoning
- “Cutting the Risk” Self-Injury Workbook first posted online in 2002
- Differences between giving clean razors and staying with someone regardless of self-injury
- E-Communities and forums

- Issues with liability, legal concerns, & ethics. Could we inadvertently teach someone how to kill themselves?

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Questions?