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Psychiatry and Addictions Case Conference

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Adolescent Self-Harm

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October 6, 2022

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Integrated Care Training Program
UW Psychiatry & Behavioral Sciences

project ECHO

Speaker disclosures

✓ Dr. Liu has no conflicts of interest to disclose

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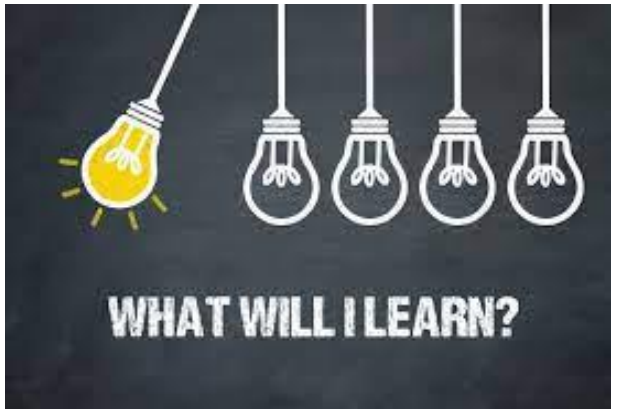
Learning Objectives

1. Describe adolescent self-harm
2. Assess intentional self-injury
3. Make treatment recommendations



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Case Examples

- JK – 18F GAD, MDD, chronic illness, hx of suicidal ideations (no attempts), started experimenting with cutting/scratching w/a serrated knife soon after 18th birthday (x2 total).

- KS – 16 (FAB, non-binary) MDD, GAD, Soc Anx, BPD, hx of multiple suicide attempts and extensive self-harm. Inpt psych admission after swallowing 30 straight pins.

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Self-Harm: intentional self-injury*

- Suicidal attempts (non-zero intent to die)
- Non-Suicidal Self-Injury (NSSI) or Deliberate Self-Harm (DSH)
- Self-injury w/undetermined intent

- Example self-injurious behaviors
  - Cutting, picking, head banging, biting, scratching, burning, hitting, etc.
  - Intentional poisoning, strangulation, overdosing, etc.

*Excluding self-stimulating or repetitive behaviors that may inflict significant injury in individual with significant developmental delay or autism or behaviors are compulsive (e.g., trichotillomania).

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Background – Prevalence

- Gillies et al., 2018: Meta-analysis of 172 community datasets from 41 countries (~600K teens 12 -18 yo) reporting self harm between 1990 – 2015.
- Lifetime prevalence = 17% (US, 21%); increased over time
- Mean age of onset = 12.8 yo; prevalence increased with age
- More prevalent among girls than boys (1.72)
- Cutting is the most common type of self-harm (45% of participants), followed by prevention of healing
- 1-2 incidents is the modal frequency (47% of participants)

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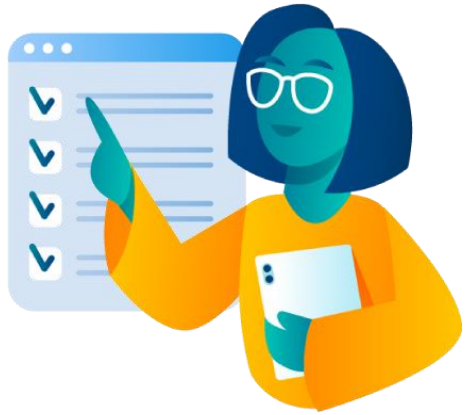
Background - Risks

- Self-harm associated with increased risks for…
  - Suicidal ideations x6
  - Suicide attempt x 9
  - Suicide death x10 (regardless of intent)
- Risk is even higher for youth w/frequent self-harm
- Top reason for self-harm were
  - “to obtain relief from feelings or thoughts”
  - “to punish oneself”
  - “To let someone know or get a reaction”
  - “wanting to die” or as a method of coping
  - “to feel something even if it was pain”

Assessment – the 5 W's

- What – self-harm behavior and severity of injury
  - *What do you do to hurt yourself? What do you cut/scratch with?*
- When – recency, primacy, chronicity
  - *How often do you cut yourself? When did you start?*
  - *How long have you been cutting? Have you ever tried to quit?*
- Where – location of injury, location of SH behavior engagement
  - *Where do you cut on yourself?*
- Why – function of behavior (e.g., emotion regulation, communication)
  - *Did you have thoughts about killing yourself or hoped that you might die?*
  - *What does SH do for you? Does it help?*
  - *People SH for many different reasons, why do you do it? (e.g., for relief, to feel something, to let my feelings out, to communicate/express myself, it's a habit/addicted)*
- Who – who knows? (e.g., parents, friends, no one)
  - *Who knows about your cutting? Have you told anyone?*



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Assessment Pitfalls

Dos 

- F/u on questionnaires (PHQ9)
- Interview teen alone
- Be matter of fact
- Show concern
- Validate
- Make a f/u plan (possibly…)
  - Inform parents
  - Safety planning
  - Consult
  - Refer
  - Reassess

Don’ts 

- Ignore or do nothing
- Use euphemisms
- Be alarmist or reactive
- Lecture or be judgmental
- Over normalize SH
- Promise to keep the teen’s secret no matter what
- Forget to assess for suicidality

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Treatment Recommendations

- Adolescent self-harm does improve with treatment
- **DBT**, CBT, Mentalization-Based Therapy
- Components most predictive of improvement: Family involvement and treatment dose
  - Get parents involved
  - Get teen into an evidence-based treatment program
- Parent recommendations:
  - Remove means: Unscheduled, regular, but transparent room sweeps
  - Non-reactive response, minimal attention to self-harm communication

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Questions?

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