Responding To Patients’ Behavioral Health In General Medical Settings: Non-Suicidal Self Injury

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Disclosure

- The presenter has no financial arrangement related to the content of this continuing education activity.
Objectives

At the completion of this activity, participants will be able to:

- Identify the key issues in detecting and assessing non-suicidal self injury (NSSI);
- Describe the general etiology of NSSI;
- Apply strategies to assist patients with a plan for self care or further treatment.
Participant Survey

• What is your work setting?
  • Primary Care
  • Specialty Care
  • Emergency Department
  • Medical/Surgical hospital
  • ICU
  • Health Promotion
  • Behavioral Health
  • Social Work
  • Other, please specify:
Participant Survey

• What is your current position?
  • Physician or mid-level provider
  • Nursing
  • Medical Support/Medical Assistant
  • Manager/director
  • Administrative Support
  • Community Health Worker or Health Education
  • Behavioral Health Clinician or Social Worker
  • Other, please specify:
Why address behavioral health in general medical settings?

• 18% of all general hospital discharges have a BH disorder coded as a secondary condition.

• Nearly 45% of ED patients screened positive for a DSM-IV diagnosis.

• 13% of ED patients not presenting with psychiatric complaints screened positive for suicidal ideation.

• 18% of patients met criteria for PTSD 6 months after cardiac surgery.

• Only 41% of people with a mental disorder use mental health services in any given year.

• The median length of delay from symptom onset to seeking behavioral health treatment is 10 years.
Why address behavioral health in general medical settings?

• BH conditions significantly affect treatment adherence and health outcomes.

• Health care providers and staff have a unique potential to encourage patients to:
  • Access appropriate professional care;
  • Engage in self-help and other support strategies
Defining the Problem

• Behavioral health problems that most significantly impact health and health behavior across population:

  • Anxiety
  • Substance Use Disorders
  • Depression
  • Trauma
How to assess and assist

• Assess for risk of suicide or harm:
  • Suicidal thoughts and behaviors
  • Severe substance intoxication or withdrawal
  • Aggressive or violent behavior (perpetrator or victim)
  • Non-suicidal self-injury
Definition of Non-Suicidal Self Injury (NSSI)

• Deliberate, self-inflicted destruction of body tissue resulting in immediate damage, without suicidal intent and for purposes not culturally sanctioned.

• Self-injury can include a variety of behaviors but these are most common:
  • intentional carving or cutting of the skin
  • subdermal tissue scratching
  • burning
  • banging or punching objects or oneself with the intention of hurting oneself
  • embedding objects under the skin
All of the following are considered non-suicidal self-injury except:

A. Self-asphyxiation.
B. Intentional cutting, burning or deeply scratching the skin without suicidal intent.
C. Piercing the skin for culturally sanctioned reasons.
D. Both A and C.
Prevalence of Non-Suicidal Self Injury

- 4% in general adult population
- 21% in adult psychiatric inpatient population
- Findings range from 14-39% in adolescent community samples
- Findings range from 40-61% in adolescent psychiatric inpatient samples
- 17% of US college students
- 30-40% of people who self-injure are male.
Correlates and Contextual Factors

• NSSI has been associated with:
  • Depression and anxiety
  • History of trauma or traumatic loss
  • History of suicide attempts
  • Loneliness or social isolation
  • Perfectionism

• NSSI is likely to:
  • Be impulsive, rather than premeditated;
  • Not cause much physical pain;
  • Perform a stress coping function
## Four-Function Model of Self-Injury

<table>
<thead>
<tr>
<th></th>
<th>Positive Reinforcement</th>
<th>Negative Reinforcement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Automatic</strong></td>
<td><strong>To feel something – to get a rush.</strong></td>
<td><strong>To get rid of bad feelings...to distract myself from bad thoughts.</strong></td>
</tr>
<tr>
<td></td>
<td>Correlates: PTSD, MDD</td>
<td>Correlates: Hx of suicide attempts, hopelessness</td>
</tr>
<tr>
<td><strong>Social</strong></td>
<td><strong>To get attention...to let others know how bad I’m feeling.</strong></td>
<td><strong>To get others to leave me alone...get out of having to do something.</strong></td>
</tr>
<tr>
<td><strong>(Intrapersonal)</strong></td>
<td>Correlates: perfectionism, social concerns, MDD</td>
<td>Correlates: perfectionism, social concerns, MDD</td>
</tr>
</tbody>
</table>

Note: Each cell contains examples of reasons adolescents commonly endorse for each function, as well as several correlates of each function (See Nock & Prinstein, 2004, 2005).
Implications of the Functional Model

• Motivations for self-injury vary, and are not limited to “manipulation” or attention-seeking.”
• Self-injury can be understood in a stress-response paradigm.
• Self-injury is an attempt to cope with stress and resulting distress.
• Emotion dysregulation is a central feature of self-injury.
• Other maladaptive coping behaviors may co-occur with self-injury.
• Because of the functional role of NSSI, stress and distress should be addressed before stopping the NSSI behavior.
The Four-Function Model of Self-Injury shows that for the person who self-injures, NSSI is:

A. Primarily a means to control other people.
B. A suicide attempt.
C. An attempt to obtain a desired state or escape a distressing state.
D. A life-threatening behavior that must be immediately stopped.
Self-injury: Clarifying the Misconceptions

• NSSI occurs among both adolescents and adults, males and females.
• Although people who self-injure are at higher risk for suicidal behavior, NSSI is a distinct, separate behavior.
• Self-injury is a (maladaptive) coping behavior and does not indicate the presence of a particular mental disorder.
• Self-injury may or may not be related to a history of trauma.
• Self-injury is not just manipulation or attention-seeking, but it indicates the presence of significant emotional distress that warrants healthcare attention and response.
Treatment Approaches

• Behavior Therapy
  • Functional analysis and behavior change plan
  • Extensive literature with developmentally disabled populations

• Dialectical Behavior Therapy
  • Elements of behavioral, cognitive, interpersonal, and client-centered therapy
  • Balance between behavior change and acceptance

• Outpatient psychotherapy
  • May be as effective as DBT if well-designed and delivered

• Pharmacotherapy
  • For related depression, anxiety, or trauma-related disorders
Assessment of NSSI in the General Medical Setting

• Approach as you would any other clinical assessment, with calm, concerned interest.

• Always assess for suicide risk while bearing in mind that for the patient, NSSI may be quite distinct from suicidal thought and behavior.

• Screen for substance use, especially alcohol.

• Brief assessment of NSSI in a medical setting:
  • Type(s) of NSSI and parts of the body affected;
  • Level of physical damage and need for medical care;
  • Duration and frequency;
  • What is the functionality of NSSI for the patient?
  • What is the patient’s level of motivation for change?

• For more thorough assessment to support treatment, see Walsh (2007).
How to assess and assist

• Listen nonjudgmentally
  • Key **nonverbal skills** to show you are actively listening:
    • Attentiveness
    • Comfortable eye contact
    • Open body posture
    • Being seated
    • Sitting next to the person rather than directly opposite
    • Refocus attention from computer, writing, etc.
  • Focus on understanding the symptoms for what they are.
  • Empathize with emotions the person is feeling about his or her beliefs and experiences.
  • Take care not to make assumptions; ask first.
How to assess and assist

• Give reassurance and information
  • Basic info about their specific problem;
  • General info about potential resources;
  • Recognize the person may have struggled with the problem for a long time, and feels ashamed to talk about it.
  • While expressing concern and recognition of the person’s distress, also try to convey a sense of hope and normalizing of their experience, e.g.:
    “This is something many people have experienced, and there are things that can help.”
  • Look for simple, practical ideas that will help.
When assisting a patient in the general medical setting who engages in non-suicidal self injury:

A. Respond calmly and nonjudgmentally.
B. Assess what purpose the behavior serves.
C. Help them identify a practical way to cope effectively with stress/distress.
D. Do all of the above.
How to assess and assist

• Encourage appropriate professional help

  • Provide a simple explanation of medical or pharmacological treatments or counseling/therapy.
  • Describe specific resources in the area you are familiar with, or a person such as a social worker who has more detailed knowledge of services.
  • Offer to help with a referral
  • Consider any specialized peer support programs in the area.
  • Consider traditional or culturally-based healing if appropriate to the person’s values.
How to assess and assist

• Encourage self-help and other support strategies, for example:

  • Exercise
  • Relaxation and Meditation
  • Support groups
  • Self-help books based on cognitive behavioral therapy (CBT)
  • Family, friends, faith, and other social networks
  • Community groups and cultural activities
Instilling hope

• Adopt and transmit a recovery and resilience perspective:
  • Persons with behavioral health challenges can live full and rewarding lives and contribute to their community.
  • The person is not a problem to be fixed.
  • Symptoms may fluctuate in severity or remit entirely.
  • Functional abilities can increase even if symptoms are still present.
  • Nonlinear change processes can be influenced by building strengths, creating access to supports, and fostering a holistic approach to health.
Being Effective

• Consistently support the patient over time
  • Identify a simple action step the patient is likely to successfully complete, and build it into the care plan.
  • Support patient behavior that builds recovery.
  • Support patient behavior that builds resilience.
• Team communication
• Appropriate documentation
• Dealing with staff turnover
Being Effective

- Making effective referrals
  - Be prepared
  - Ask the patient
  - Give encouragement and information
  - Be thorough in communicating the referral
  - Follow up
  - Re-evaluate and try again
Being Effective

• Use a team approach
  • Utilize individual strengths
  • Consider capacities of specific disciplines
  • Establish leadership/management support

• Divide tasks
  • Screening
  • Data management
  • Identifying information and resources
  • Communication
  • Managing referrals
Being prepared

• Data – patient and population
  • Query your clinic/hospital data systems, if possible
  • Literature on BH co-morbidity for your clinical population

• Screening
  • Use the available tools – alcohol and depression screens are commonly available
  • Compile screening data

• Resources
  • Collect and organize info
  • Utilize social services and “local experts”
  • Take advantage of available consultation

• Training, e.g. Mental Health First Aid
Find or Host a Course

www.MentalHealthFirstAid.org

Mental Health First Aid is an in-person training that teaches you how to help people developing a mental illness or in a crisis.

Mental Health First Aid teaches you:

- Signs of addictions and mental illnesses
- Impact of mental and substance use disorders
- 5-step action plan to assess a situation and help
- Local resources and where to turn for help

Help us train more veterans and first responders in Mental Health First Aid.
Support Black Dog Ride.

DONATE TO BLACK DOG RIDE

Sign up for a Mental Health First Aid class near you

FIND A COURSE

Ready to become a Mental Health First Aid Instructor?
Apply for Instructor Training

DONATE NOW

“...I've taken regular first aid, and I've used both, but certainly the opportunities to use Mental Health First Aid are much more abundant.”


Mental Health Association of Maryland, Missouri Department of Mental Health, and National Council for Behavioral Health (2013) *Mental Health First Aid USA, Revised First Edition*.

National Council for Behavioral Health and Missouri Department of Mental Health (2015) *Mental Health First Aid USA Eight Hour Teaching Notes, Revised*. 
References


