

Suicidal and Non-Suicidal Self-Injury in Adolescents

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DBT: Evidence-Based Treatment

- **More than 2 dozen studies**
- **14 randomized controlled trials**
- **Adults (including elderly) & adolescents**
- **Women and men**
- **Outpatient, inpatient, day tx., forensics**
- **BPD, BPD features, mixed PD**
- **Suicide attempts, parasuicidal behaviors**
- **Substance abuse, eating disorders, depression, dissociation, panic & other anxiety disorders**

Initial Outpatient Studies

DBT better than “treatment as usual”:

- **Decreased:**

- # of parasuicides, % with parasuicide, medical risk of parasuicide
- Psychiatric inpatient days
- Anger
- Overall costs

- **Increased:**

- Treatment retention
- Social adjustment
- Global adjustment

Linehan et al. (1991, 1993, 1994)

Costs and Efficiency

- **Clear one-year cost savings**
- **Several studies suggest DBT costs about 50% of treatment as usual**
- **Savings comes primarily from lower inpatient, emergency, and medical utilization**
- **Treatment with high utilizers saves more**
- **Cost savings compounds over time**

Diagnosis and Assessment Issues

Borderline Personality Disorder

Emotion Dysregulation

- Affective lability
- Problems with anger

Interpersonal Dysregulation

- Chaotic relationships
- Fears of abandonment

Self Dysregulation

- Identity/difficulties with sense of self
- Sense of emptiness

Behavioral Dysregulation

- Parasuicidal behavior
- Impulsive behavior

Cognitive Dysregulation

- Dissociative behavior/transient paranoia

Parasuicide

- **Descriptive term: function must be assessed (may lead to fewer pejorative assumptions about intent)**
- **Involves an *intent* to cause harm to self (some deliberate action)**
- **Results in *acute* or immediate injury**
 - **Tissue damage (internal or external)**
 - **Ingestion of poisons or drugs or medicine over a reasonable dose or prescription**
 - **May be risk in the absence of medical intervention**

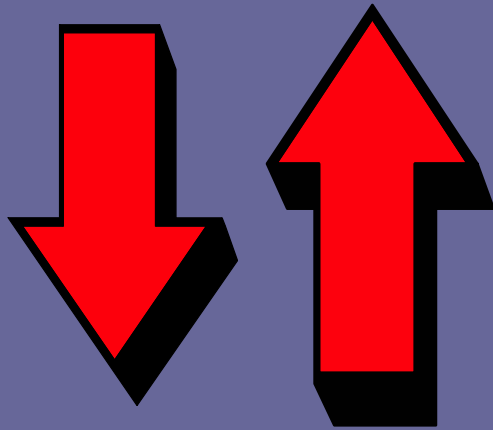
**Bio-social or Transactional
Model for the Development
and Maintenance of
Borderline Personality Disorder**

**In DBT, Borderline Personality
Disorder is:**

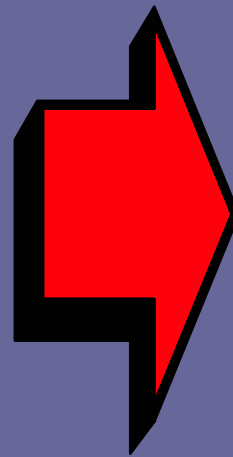
**A Pervasive Dysfunction of the
Emotion Regulation System**

Biosocial Theory of BPD

Emotion
Dysfunction



Invalidating
Environment

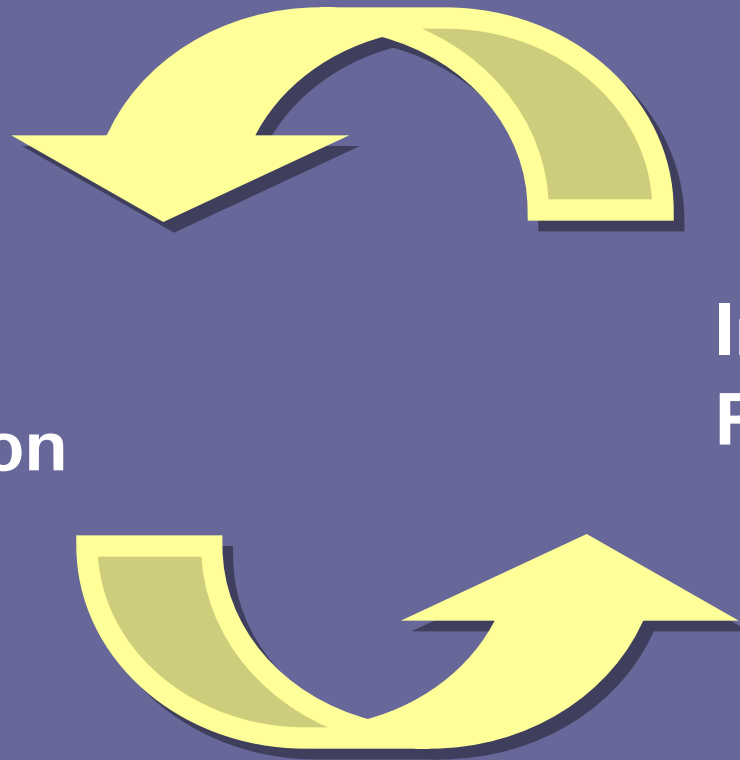


Pervasive
Emotion
Dysfunction

Transactional Model: Factors Influence Each Other (Reciprocal)

Individual
Emotion
Dysregulation

Invalidating
Responses



Emotion Vulnerability Requires the Presence of All Three Factors:

1. High sensitivity

- High level of discrimination of stimuli with an emotional valence

2. High reactivity

- When discriminated, reactions are extreme

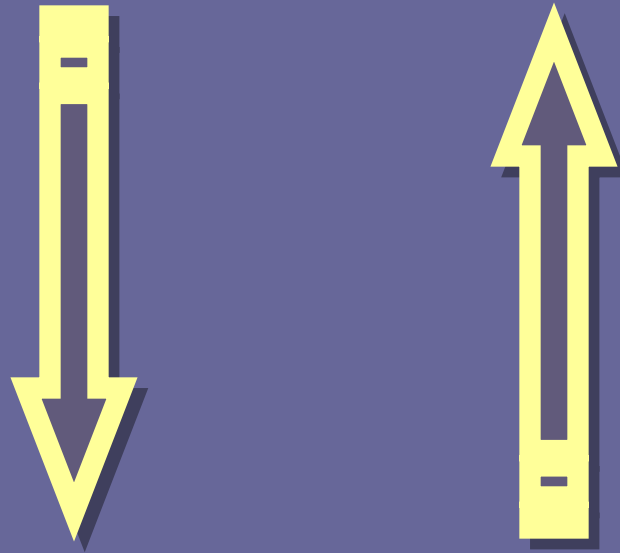
3. Slow return to baseline

- Slow return leaves the individual vulnerable to the next emotional stimulus

Emotion Modulation

- **Physiological modulation (increasing or decreasing physiological arousal associated with emotional arousal)**
- **Attention modulation**
- **Urge, impulse, and habit modulation/inhibition**
- **Cognitive modulation (focus on goals, objectives and values rather than short-term escape from discomfort/pain)**
- **Self-awareness and self-modulation**

Emotion Vulnerability



Inability to Modulate Emotions

Severe Distress is Predicated On:

1. Combination of all three:

a) Sensitivity

b) Reactivity

c) Slow return to baseline

PLUS

2. Inability to modulate emotions (lack of skillful self-management)

PLUS

3. Invalidating social/family environment

Invalidating Environment

Pervasive communication that valid responses of the individual, especially private ones (e.g., emotions, thoughts, wants) are incorrect, inaccurate, faulty, inappropriate or otherwise invalid

Validating Family Environment

- Legitimizes the experiences of the members of the family, especially private ones (emotions, wants & desires, thoughts, beliefs, sensations, etc.)
- Validates those experiences **EVEN** when they are quite discrepant from others'
- **Accepts:** tolerates/appreciates differences; does not try to change or control
- Does not use aversive control strategies
- Communicates acceptance and caring
- Facilitates problem solving and coping

Validating Behaviors

- **Validate the “valid”**
- ***Invalidate* the “invalid”**
- **Do not require agreement**
- **Are not necessarily without criticism**
- **Are not necessarily pleasant**

Invalidating Social/Family Environment

- Employs high levels of aversive control
- Pervasively rejects/punishes valid behaviors, especially “self” behaviors
 - Intrinsically motivated or free-operant behavior
- Punishes “accurate” and/or normative expressions of emotion & pain
- May intermittently reinforce problem or pain escalation
- May minimize the difficulty of tasks or of tolerating pain, or over-simplify problem solving

Invalidation is More Likely When:

- Behavior communicates private experience
- Behavior is “self-generated” (i.e., not under control of the immediate social environment)
- Behavior puts demands on others above the level they *prefer*
- Others do not have the *ability* to meet the level of need communicated
- Individual has different wants, emotions, beliefs, activities, etc., from the others

Consequences of Pervasive Invalidation

- **The individual does not learn to:**
 - Label her or his private experiences in a normative way
 - Express emotions accurately
 - Communicate pain effectively
 - Seek help effectively
 - Tolerate distress en route to alleviating distress
 - Effectively regulate emotions
 - Solve moderate to difficult problems
 - Trust her or his own experiences as valid
 - Develop a coherent “self”

- **Instead, the individual learns to:**
 - **Actively self-invalidate and look to her or his social environment for cues about how to feel, think, what to want, how to respond**
 - **Oscillate between inhibition/self-invalidation (e.g., minimizing own distress) and the extreme expression of suffering (requiring others to assist)**
 - **Paradoxically hold perfectionistic standards, and often unrealistic goals and expectations**
 - **Judge own “failure” harshly**
 - **Respond to “failures” with rapid negative arousal**

Remember:

In DBT, problem behaviors are assumed to *function* to regulate emotions, or are a natural *consequence* of emotion dysregulation. So, even those behaviors that push limits must be addressed within this assumption (chain analysis, solution analysis, commitment, practice), not primarily with aversive control or simple contingency clarification.