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GP

Dunedin

## Saturday, August 10, 2019

(Room 7)

16:30 - 17:30 WS #134: Red Flags for GPs: Self Harm and Sexual Abuse - What Can We Do?

17:35 - 18:30 WS #144: Red Flags for GPs: Self Harm and Sexual Abuse - What Can We Do? (Repeated)

# Self harm and sexual abuse.

# Dr Jill McIlraith

**General practioner and**

**forensic sexual assault examiner (MEDSAC) x 19 years**

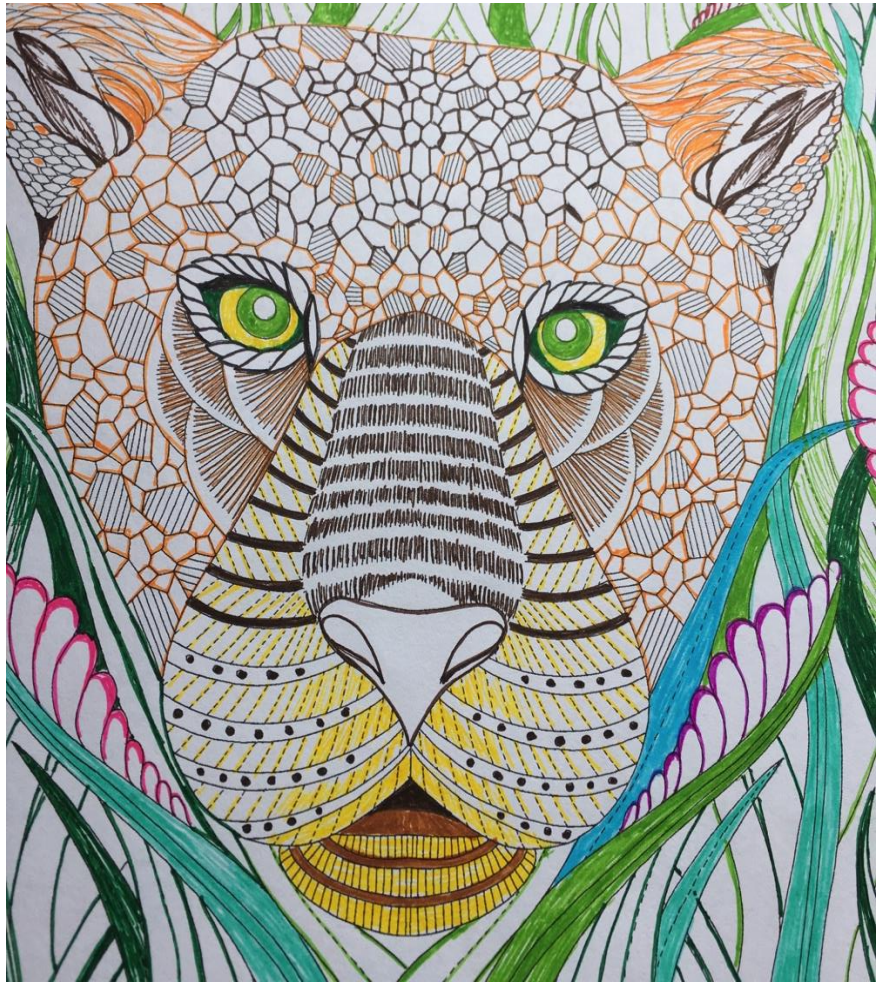
**CMESouth, August 2019**

# Disclosures and Acknowledgements.

No commercial conflicts.

This talk acknowledges the work of Diane Clare, consultant clinical psychologist from Nelson and her APEX© model of Alternatives to Self-Harm (mindbusiness21@gmail.com)

Draws on presentations at MEDSAC Update, 2018.



# Our human heritage…harming each other

If sex work = oldest industry in the world,

rape = oldest crime and most enduring weapon of war then

child sexual abuse is the most hidden and most damaging; one of the 10 most significant adverse childhood experiences (ACEs)

# Sexual assault and abuse is not new


As old as mankind -

Multiple mentions of rape in Roman and Greek mythology and in the Bible.

Recognized as a sexual crime in 12th Century but marital rape only in 1990's

# Sexual abuse is not about sex---

- It is about power, control, hate, anger, narcissism and domestic conflict
- It is often about entitlement and inter-generational behavioural patterns
- And it is a coalescing of violence, alcohol, vulnerability and predatory behaviour.
- It always leaves scars……

# Jane's story:

- Patient x 25 years, bright, articulate, good insight into who she is and why
- Dysfunctional and disrupted childhood which included sexual abuse and neglect.
- Sexually and physically assaulted as a teen
- Started cutting – forearms, thighs and lower legs, abdomen as a teen
- Has continued to do so intermittently – often multiple incisions requiring lots of suturing
- Latest episode this year triggered by threats of harm to her and daughters
- Manage each episode over several visits…….

# How common is self harm:

- 16-18% of population at some time (USA)
- 20-24% of ED presentations (NZ)
- 48% of adolescents with mental health problems will self harm at some stage
- Starts age 13-14 yrs, boys=girls but late adolescent, female >> male
- Maori=Pakeha (but Maori > Pakeha for suicide)
- Most at risk = LGBTQI adolescents
- Minority will self harm in multiple ways

# NZ sexual assault statistics.

- Only 9% of sexual assaults present to police = least likely crime to be reported.
- Large attrition through the process:

-No offence 34% (8% - false complaints)

-No suspect ID'ed 11%

-Suspect warned, not charged, file open 24%

-Charges laid 31%

-Conviction 13%

**(From "Real Rape" to Real Justice – prosecuting Rape in NZ. Ed McDonald and Tinsley. Victoria Uni Press. NZ Law Foundation and NZ Law Commission. 2011.)**

# Outcomes.

- 10% -- allegation withdrawn.
- 15% -- case still being investigated.
- 15% -- plead guilty.
- 5% -- plead not guilty and acquitted.
- 65% – not prosecuted - not enough evidence, can't give reliable account of what happened, can't find assailant, issues of consent, witness reliability, "regret sex" etc.
- Decision not to prosecute does not mean nothing happened – just not likely to reach threshhold needed for court.

# Self-harm - features

- Non-suicidal
- Intentional
- Culturally unacceptable
- Immediate and direct destruction of bodily tissue
- Low lethality
- Can include self-poisoning or self-injury
- Plays a role in coping – as a survival strategy
- Adversely regarded and badly managed  in health system

Nice guidelines 2012 + Garish JA and Wilson MS 2015

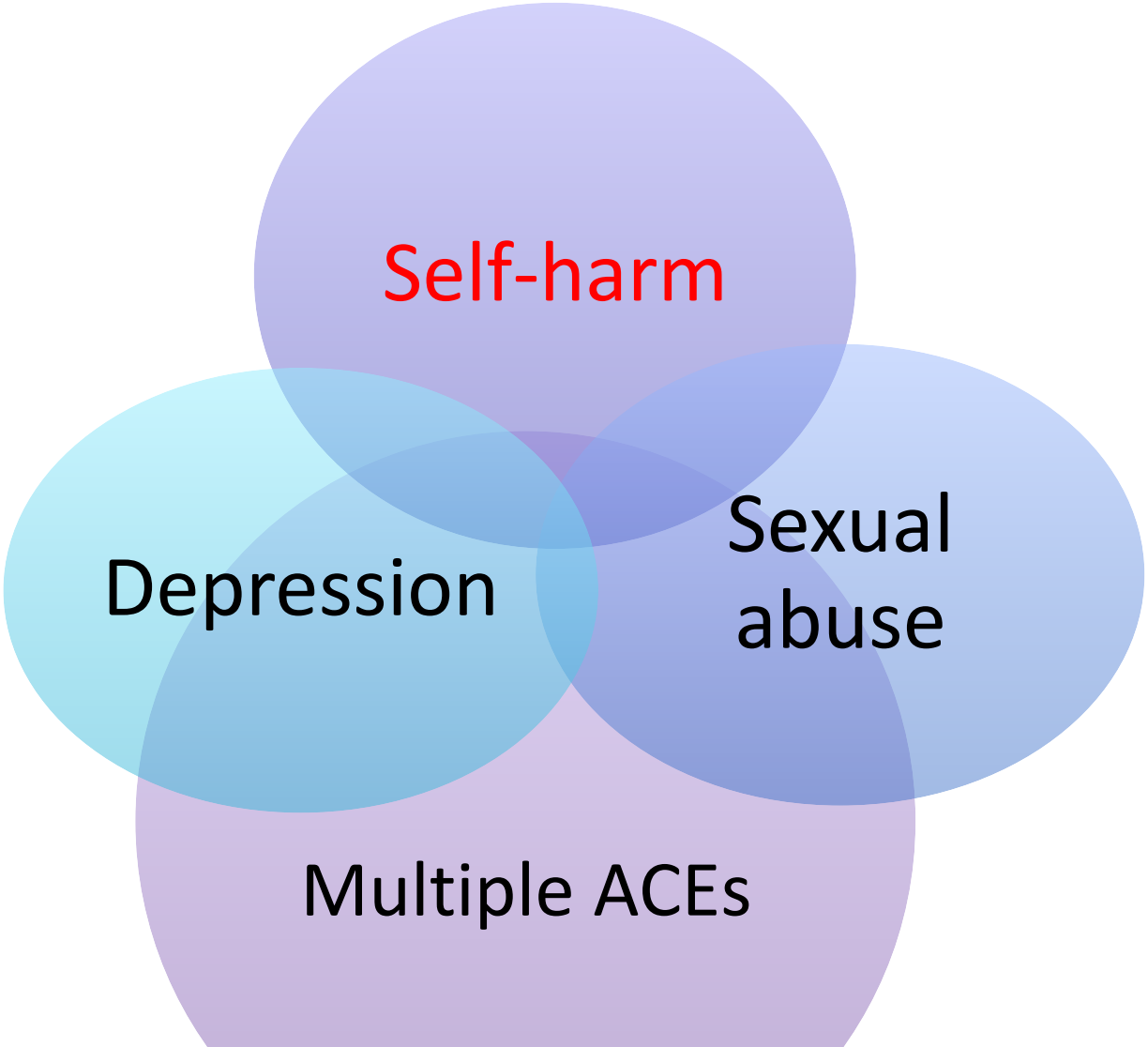
# Correlations:

Strongest: poor mental health particularly depression

- Low stress tolerance
- Inability to regulate emotions
- Adverse childhood events
- Sexual abuse

Single most protective factor: strong attachment to parents.

# The layers that underpin self-harm:



# Walk in their shoes…..

“My pain was an enormous, invisible thing that I carried awkwardly around.

Where on earth was I to put it?”

Richard Shepherd, **Unnatural Causes**,
Penguin Random House UK, 2018

# Models to manage self harm

- Several:

- Punitive/ behavioural – “just don’t do it”
- ED model – narrow medical model – “just stitch them up and send them home” +/- EPS
- CBT – focusing on reframing emotional response
- Dialectical – mindfulness, new skills to increase stress tolerance

None easy to use and none suitable for general practice.

# APEX model – adapted for GP land.

- A – attitude – how we as doctors/nurses react
- P – purpose – what role does self harm play for this person (focus on the patient, not the act)
- E- emotional first aid kit – what can they focus on instead (supports, resources, distractions)
- X – contract with their self (matching emotional first aid kit with alternatives)

# Our attitude determines the success of the interaction.

- Calm, de-escalate, no negative comments or tut-tutting, non-punitive, be kind and matter-of-fact – be curious about why this person is who they are right now
- Treat them as you would any other injury

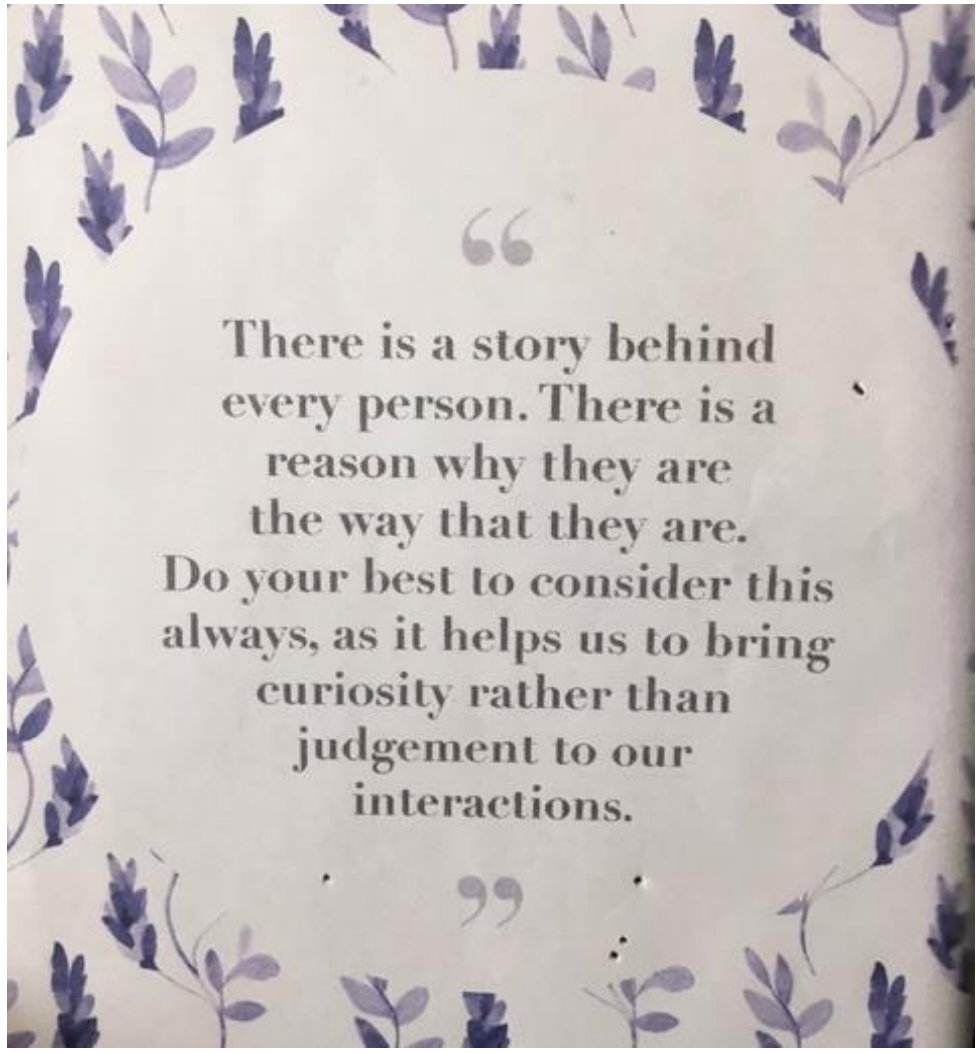
  (local anesthetic dilemma)
- The person is not the problem, the problem is the problem – externalize it
- Tackle it over several visits…

# Purpose of self-harming

Self-harm always in a context:

What was happening before the injury?

How does injuring yourself help?



# 8 C's + 1 of self injury's role

Coping and crisis intervention (safer than other things)
Calming and comforting (puts my inside pain outside)
Control
Cleansing
Confirmation of existence (feel alive, gives me a buzz)
Creating comfortable numbness (think about the pain only)
Chastisement (guilt about what has happened to them)
Communication (expresses frustration, lets other see my pain)
+ Conformity – often cited as the 9th reason (friends are doing it)

# Emotional tool-kit

- Physical – activities (bouncing ball, rubber band around wrist) walking, playing music, push-ups, ice cold water
- Externalising mentally – writing(what happened vs how you feels about it), painting, breathing, reading list of your good ideas
- Nature + spiritual well being – religion, animals (stroking pet gives good sensory feedback), gratitude log, shouting at the trees, ocean, their bedroom wall
- Supports – family, friends, organisations, encouraging connectedness (you are not alone in the world)

# Self-contract based on their emotional took-kit.

Simple things that are specific and achievable:

“I will stroke the back of my hand 10 x instead of cutting that arm”

“I choose to take extra care of this small piece of skin and will nurture it by putting cream on it”

“I will phone a friend, go for a walk, make toast”

“Before self-harming, I will drink two glass of cold water”

# Distraction strategies as emotional replacements

- Hold ice cubes in your hand
- Eat chilli
- Take a red felt pen and draw cutting marks
- Tap yourself hard on the knee or pull your ear lobe
- Run on the spot really fast for as long as you can
- Hold your breathe as long as you can while counting - then breathe out and relax all your muscles and close your eyes.

# Tips for applying the APEX model in 15 minutes chunks.

- Ensure the GP team, from reception staff to junior doctors, are positive and caring when a self-harming patient presents. First reactions count - model the behaviour we expect.
- If bleeding, put patient in a private space eg treatment room.
- While cleaning, suturing, treating injury ask about what is happening for them and why they self-injured at this time.

# Tips…. continued

- Don’t be overwhelmed – do what needs to be done (+ fill out the ACC form)
- Get patient back within 1-2 days to check wound – gives you chance to continue the why and what tools they can use to replace self-harm’s role in their life
- Get them back for removal of sutures a week later – flag the ACC part charge if necessary.
- Never ask them to promise not to do it again and don’t be afraid of talking about it openly next time seen.

# Adverse childhood experiences

- We can't change ACEs but asking about them, and acknowledging them, is very helpful and can lessen future self harm.

- 35% drop in ED and doctor visits after patients were asked about adverse childhood experiences- being asked and being able to tell someone = very healing.

Heather Larkin , Vincent J. Felitti & Robert F. Anda (2014) Social Work and Adverse Childhood Experiences Research: Implications for Practice and Health Policy, Social Work in
Public Health, 29:1, 1-16, DOI: 10.1080/19371918.2011.619433

# In summary:

- Self –injury is not attention seeking – it is a manifestation of complicated distress: past sexual abuse, mental ill health and adverse childhood experiences
- It's role may be to prevent more serious self harm eg suicide
- Don't trivialize it, don't criticize it, don't dramatize it– be pragmatic, calm and caring
- Don't send them to ED unless really unavoidable
- Aim is not to stop it happening ever again, but to lessen the harm and help them find other strategies.
- Ask about adverse childhood experiences.

" People will forget what you said, people will forget what you did, but people will never forget how you made them feel"

Questions and comments