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Self Harm and Suicidality

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The slide has a dark blue header bar with the title "What is Self-Harm?" in white text. The main content area is white with a list of bullet points. The Seattle Children's logo is located in the bottom left corner. The decorative dotted circle pattern from the title slide is visible in the top right corner of the slide.

What is Self-Harm?

- Intentional destruction of body tissue that is:
 - socially unacceptable
 - i.e. not a tattoo or piercing
 - typically done without a conscious suicidal intent

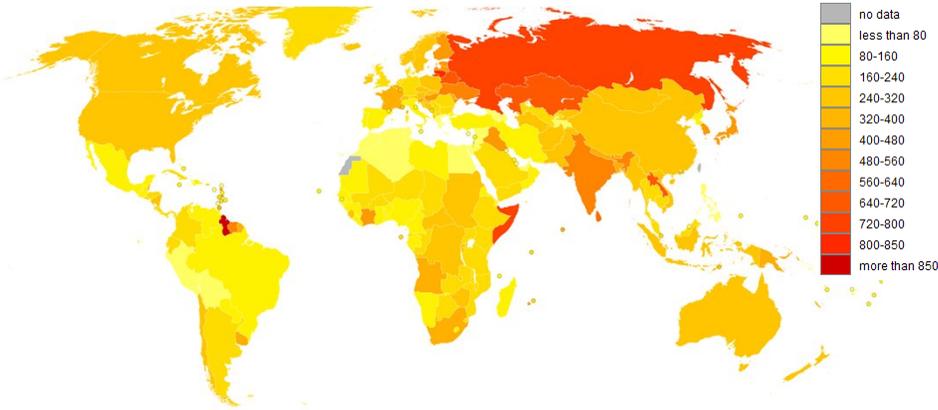
Self Harm Behavior: Examples

- **Self harm with minimal visible injury:**
 - denying self a necessity
 - deliberate recklessness
- **lower lethality self harm with injury:**
 - biting, scratching, needle sticks, picking scabs
 - hitting, pinching, hair pulling
- **higher lethality self harm with injury:**
 - hanging, shooting, poisoning, drowning,
 - skin cutting, burning, overdose

Frequency of self-harm in the US

- Adolescent population: about 15%
- Adult population: about 4%
- Adolescent occurrence has increased
 - 46% of one group of US 9th and 10th graders reported to have performed one self harm behavior in last year
 - 14% were self-cutting
 - 12% burned their skin

Self Injury Occurs Worldwide



Age adjusted disability associated life years (DALY) for self injury per 100,000 people, per 2004 WHO data

image by "Local_Profil"



CASE study: "Child and Adolescent Self Harm in Europe"

- 30,476 surveyed throughout Europe and Australia
 - Kids aged 15 and 16 years
 - Roughly 4,000 kids per country
 - School based anonymous survey
 - Results published in 2008



N Madge, E Hewitt et al, 2008

CASE: Reasons cited for self-harm

- to get relief from terrible state of mind (71%)
- to die (59%)
- to punish myself (44%)
- to show how desperate I was feeling (~35%)
- to find out whether someone really loved me (~35%)

Other Reinforcers for Self Harm

- Negative reinforcers: Avoidance
 - People
 - School work/unpleasant activities
 - Punishment
- Positive reinforcers:
 - Attention – making others angry or getting noticed
 - Feeling part of a group
 - Release of endogenous opiates

CASE: cultural influences on deliberate self-harm

- **Self Harm rates in Australia and England were almost identical to rates in US adolescents**
 - 17% of females
 - ~5% of males
- **Other countries had different rates**
 - Netherlands: 6% of females, 2% of males
 - Hungary: 10% of females, 3% of males

CASE: self-harm planning

- Self harm is often planned out by adolescents
 - About ½ decided to self harm within an hour of action
 - 23% decided to self harm more than an hour beforehand
 - 29% made decision to self harm more than a week beforehand
- Over ½ have repeatedly self harmed

CASE: Other aspects of teen self-harm

- It happens at home
 - 83% of self harm episodes occurred at home
- Doctors rarely know about it
 - only ~12% ever led to a medical evaluation
- Friends/family often know about it
 - ~75% of the time someone else knew about the self harm
- Occurrence is rarely influenced by substance abuse
 - 1 in 5 occurred while using alcohol
 - 1 in 12 occurred while using other drugs

Characteristics of Self-Harmers

- Experience frequent, intense negative emotion
- Self-critical
 - including disgust/anger with body shape or appearance
- Any psychiatric illness
 - anxiety more often found than depression
- Suicidal history
 - 50% of self injurers report having made at least one suicide attempt
- Childhood abuse
 - only a mild relationship to the occurrence self injury
- Difficulty experiencing or expressing emotions
 - alexithymia

So What Does Cutting Mean?

- Cutting is:
 - always a sign of psychological distress
 - usually a coping mechanism
 - sometimes an adolescent social experiment
 - can be a sign that at risk for a subsequent suicide attempt

Beyond self harm

Suicidal thoughts, plans and actions

Suicidality in Young People is Common

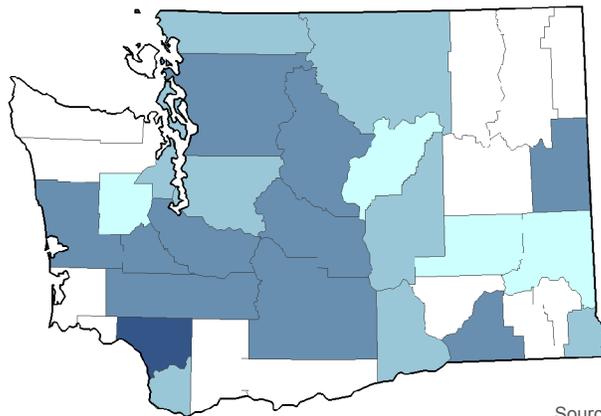
Seattle High school students (and the US general comparison) in past 12 months:

- 13.3% (17.0%) seriously considered suicide
- 10.1% (13.6%) made a suicide plan
- 8.0% (8.0%) attempted suicide
- 3.7% (2.7%) needed MD treatment for an attempt

per 2013 YRBS by CDC



Percent of 10th graders who seriously considered suicide in past 12 months (2010)



Source: YBRS and datacenter.kidscount.org



□ No Data ■ 13.3% - 15.1% ■ 15.2% - 17.4% ■ 17.5% - 19.9% ■ 20.0% - 23.3%

“Suicidality” not strongly predictive of completion risk

- Suicide completions are rare
 - Overall rate of ~0.005% of kids age 10-19
 - About one completion for every 1000 attempts
 - ~1/2 of suicide completers have made no prior attempts
- Difficult to recognize serious risk
 - No choice but to take all occurrences of suicidal thoughts seriously
 - Fortunately, most self harm is not suicidal in intent

Perspective: Completed Suicide Methods in U.S. children

- About 2000 adolescent suicide deaths per year
 - Strangulation (hanging) and firearms used in ~90% of youth suicide completions
 - Overdoses account for ~7% of completions
 - All other causes account for ~3% of completions

What about cutting as a form of suicide?

- Cutting (such as wrists) is actually a rare way for suicide to occur
 - Falls within that 3% “other” category

Dealing with cutting and self harm

- Get the adolescent alone for a discussion
- Learn how often this happens
- Ask if other forms of self harm occur
- Always ask about the intention behind the behavior
 - “Tell me about the last time you cut.”
 - “When you decided to cut yourself, what did you think would happen”
 - “How does cutting help you?”

The Cutting Interview Continued

- Find out what they see as the benefits of cutting
- Ask how long that benefit lasts
 - typically hear, “a few minutes”
 - motivational interview opportunity
- Ask if a substitute experience helped them in the same way, would they want to try it
 - Usually looking for a strong sensory “jolt”

Replacement Sensory Experience Examples

- Taste: “atomic fireball”, cinnamon gum
- Touch: apply lotion, warm bath, rubber band wrist snap
- Hear: loud music, play loud instrument
- Smell: “aromatherapy,” incense
- Sight: action or violent movie, online videos

Get Them to the Therapist

- If having enough psychological distress to be self-harming, default recommendation is to refer to a counselor

Getting someone to go to a counselor

- Have to sell the counselor to the adolescent
 - Find what bothers them, and sell the adolescent on that point
 - for instance if hiding the cosmetic appearance of cutting (i.e. on thighs), say want to give her options to manage distress that she doesn't have to hide
 - Describe it as an audition
 - if don't like first couple of meetings, try someone else
 - Describe as the quickest way you know of to get them feeling better

Therapy for Self Harm Behaviors

- What leads to positive change for a self-harming patient?
 - Trusting therapeutic relationship
 - Building emotion regulation skills
 - Cognitive restructuring
 - Behavioral skills training

Suicidality

- Asking is part of every depression evaluation
- Start broad
 - “Ever wish that you weren’t around?”
 - “Ever thought about killing yourself?”
- Get specific
 - “In the past month, have you thought about killing yourself?”
 - “Have you made any plans for how you would kill yourself? What would you do?”

Suicidal Ideation (SI) risk factors

- Self harm (as previously described)
- Disruptive disorders in children < 12 years old
- Aggressiveness in males in general
- Panic attacks in females
- Bullying, both perpetrators and victims
 - especially chronic victims

(Winsper, et al., JAACAP, vol 51:3, March 2012)

Suicide Attempt Risk Factors

- mood disorders
- anxiety disorders
- substance abuse
- runaway behavior
- LGTB youth
- history of being abused
- female sex (male to female ratio is 1.6 to 1)
 - however males more likely to complete suicide

Increased Risk: Going from Ideation to Attempt

- Severe or enduring hopelessness
- Isolation
- Reluctance to discuss suicidal thoughts
- Preoccupation with death

Suicide in Younger Children

- Understanding the finality of death is not an essential ingredient in determining suicidality
 - Understanding of death can fluctuate
- Preschoolers can be considered suicidal if they wish to carry out a self destructive act with the goal of causing death despite not knowing the finality of death
- Suicidal behavior in prepuberty predicts suicidal behavior in adolescents

Suicide Attempts often Repeat

- 31-50% of adolescent suicide attempters reattempt suicide (Shaffer & Piacentini, 1994)
- 27% of males and 21% of females reattempt within 3 months of their first attempt (Lewinsohn et al., 1996)
- TASA Study: N=124, open trial, 40% of suicidal events occurred within 4 wks of intake (Brent, et al., JAACAP, 48:10, October 2009)

Increased Risk: Going from Attempts to Suicide Completion

- Repeated suicide attempts
- Medically serious attempts
- Taking actions to prevent or promote discovery of attempt

Epidemiology for Completed Suicide

- 3rd leading cause of death in adolescents
- Approx 2000 US adolescent commit suicide each year
 - 100-200 attempts per completion
- 90% who commit suicide had an associated psychiatric disorder (on retrospective review)
- More than half had a psychiatric disorder for at least 2 years

Completed Suicide Epidemiology

- Prepubertal suicides ratio 3 to 1 male to female
- Age 15-19 yr olds ratio 4.5 to 1 male to female
- American Indian/Alaska Native males have the highest suicide rate

Risk Factors for Completed Suicide in Adolescent Males

- Previous suicide attempts (increases rate 30 fold)
- Age 16 or older
 - Peak age 19-23
- Associated mood disorder (increases 9 fold with major depressive disorder)
- Associated substance abuse (increases 7 fold)
- Disruptive behavior

Risk Factors for Completed Suicide in Adolescent Females

Mood disorders

- Major depression increases risk about 20 fold
- Previous suicide attempts

General Risk Factors For Suicide

- Family history of suicidal behavior
 - 5 fold greater risk on adolescent boys, 3 fold greater risk on adolescent girls
- Parental mental health problems
- Parental substance abuse

General Risk Factors For Suicide

- Gay or bisexual orientation
- Exposure to real or fictional accounts of suicide is a risk factor for vulnerable teenagers
- History of child abuse
- Personality disorder (antisocial, borderline)
- Chronic medical illnesses (eg. diabetes, epilepsy)
- Victim of bullying (eg. cyberbullying)

Immediate Risk Factors

- Agitation
- Intoxication
 - Substance and/or alcohol abuse significantly increases risk in age 16 and older
- Stressful life event
- Access to means

Events Preceding Adolescent Suicide

- Family difficulty
- Loss of a romantic relationship
- Disciplinary problems at school or legally
- Academic difficulty
- Giving away prized possessions

Most adolescent suicides appear to be impulsive

Assessment In The Office

- Questionnaires to screen for depression, suicidal preoccupations, and previous suicidal behavior
 - Follow up suicidality positive items on the scales
- Interview separately from the parent
 - Important with adolescents
- Collateral History

Screening Scales

- Broad Screening
 - PSC-17
 - Others like CBCL, BASC for a fee
- Narrow Screening/Diagnostic aide for depression
 - PHQ-9 for adolescents
 - SMFQ for kids over age 6
 - Others like CDI, CDRS-R for a fee
- Can measure response to treatments

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns: - +

(Healthcare professional. For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____



Initial Questions

- Is there anything that has been stressing you lately?
- How have things been going with school, friends, parents?
 - HEADSS (Home, Education and Employment, Activities, Drugs, Sexuality, Suicide risk)

Ask Your Questions Directly

- Has it stressed you out to the point of having thoughts about not wanting to live?
- Have you ever thought about killing yourself or wished you were dead?
- Have you ever done anything on purpose to hurt or kill yourself?

If Yes, Get More Details

- Asking does not cause distress or ↑suicidality
- Nature of past and present thoughts and behaviors
- Intent (i.e. believes a suicide plan will work)
- Who Knows (hidden is worse)
- If you were to kill yourself, how would you do it?
- Accessibility of means (eg. weapons in the home)
- Response of the family
- Stressful events/conflicts (eg. bullying)
- Evaluate motivating feelings (resolved or not)

Moderate to High Risk Situations:

- Planned or recent attempt with high probability of lethality
- Statement of intent to kill oneself
- No future orientation
- Agitation
- Severe hopelessness
- Impulsivity and profoundly dysphoric mood with mood disorder, psychosis or substance use
- Regret that attempt not completed
- **Lack of social support**

If Moderate or High Risk Of Suicide:

Immediate mental health evaluation is necessary

- ER
- Hospitalization
 - Note that this is not clearly shown to reduce long term suicide risks
- Home/family monitoring

After ER Visit

High failure rate to keep mental health referral appointment after ER discharge

- Medical practitioner can enhance continuity and adherence by maintaining contact even after referrals are made

Lower Risk, But Risk Still Exists

- Self harm with no suicidal intent
- Depressive symptoms with no suicidal thoughts
- Dysfunction or distress from emotional or behavioral symptoms
- Desire to resolve recent stressor/conflict
- Hope for the future
- Good social support

BATHE

- Establish the **B**ackground situation “tell me what has been happening”
- Find out how it is **A**ffecting them emotionally “how does that make you feel?”
- Establish the main problem “what is **T**roubling you the most?”
- Ask about current ways of coping “how are you **H**andling this?”
- Use **E**mpathic listening and response throughout

If Lower Risk:

- Validation and letting them know you will help
- Refer for further evaluation and treatment
- Inform appropriate people when there is a risk of suicide – safety takes precedence over confidentiality
- Help family identify potential precipitants and begin process of problem solving

Acute Management

- Adequate supervision and support available
- Securing or disposing potentially lethal means (most common method is firearm)
- Limiting access to alcohol or disinhibiting substances
- Value of “no suicide contracts” not known
- Phone calls during transition time
- Safety Planning
 - What to do/who to call if urge returns

Safety/Crisis Plan

- Identify triggers
- Identify early warning signs
- Identify possible interventions (eg. distress tolerance skills)
- People to turn to for help

Mental health referral appointment

Example for an Adolescent

My triggers are:

- Pressure to do things that are above my ability
- Feeling unwanted/rejected by friends.
- Social worries
- When others aren't concrete about what they expect from me.

My early warning signs are:

- I become argumentative.
- I bite my lip or fingers
- I sigh loudly
- I raise my voice

When my parents/caregivers notice my early warning signs, they can:

- Talk to me
- Ask how I am feeling
- Ask "how can I help"
- Give me a hug

When I notice my early warning signs, I will try to:

- Play guitar
- Listen to IPOD
- Practice deep breathing
- Journal

If I am unable to help myself or accept help from my family/caregivers, then our crisis plan is:

- Call therapist
- Call grandparents
- Call county crisis line
- Call 911 if emergency.



Example for Younger Child

CRISIS TRIGGERS, WARNING SIGNS, AND INTERVENTIONS

My triggers are:

1. When kids call me names
2. Getting scratched/hurt
3. Feeling scared or mad
4. Waiting a long time

My early warning signs are:

1. Yelling
2. Telling people to 'stop'
3. Posturing at people
4. Having trouble listening to people

Things I can do when I notice my early warning signs:

1. Punch a pillow
2. Take a big breath
3. Color, and/or distract myself
4. Eat a snack

If I am unable to help myself I can call:

1. My Aunt Kelly
2. Therapist
3. After-Hours Crisis Line - 206.726.2191



Psychotherapy Tailored to Particular Needs = Decreasing Risk Factors

- Cognitive Behavioral Therapy
- Interpersonal Psychotherapy
- Dialectical Behavioral Therapy (only psychotherapy effective in reducing suicidal behavior in adults with borderline personality disorder)
- Psychodynamic therapy
- Family Therapy

Psychopharmacology

Medications can help with associated symptoms, but will not resolve suicide ideation itself

Reality of the Situation

- Suicidal risks can be reduced, but unrealistic to think can be 100% eliminated
- Risk factors provide guidance in assessment
- Adolescents may have their own agenda – information they provide can be dishonest
- Safety planning is key

Key Points To Take Away:

If there is any question, err on the side of safety

Definitely send to the ER or call for help:

- If suicidal ideation is persistent
- Serious lethality in thought or attempt
- Agitation with suicidal thoughts
- Clear lack of social support with safety plan
- Efforts made to minimize chance of intervention or discovery with an attempt
- Regret of attempt completion
- Severe hopelessness

AACAP checklist before discharging an adolescent who has attempted suicide.

- Caution patient and family about disinhibiting effects of drugs or alcohol
- Check that *firearms and lethal medications can be* effectively secured or removed
- Check that there is a *supportive person at home*
- Check that a *follow-up appointment has been* scheduled

AACAP Practice Parameters for the Assessment and Treatment of Children and Adolescents With Suicidal Behavior, July 2001



Helpful References

Shain, et al., "Suicide and Suicide Attempts in Adolescents" *Pediatrics*, 120(3) Sept 2007.

www.aacap.org: AACAP Practice Parameters for the Assessment and Treatment of Children and Adolescents With Suicidal Behavior, July 2001

www.teenscreen.org: community based mental health screening program

www.thetrevorproject.org: offers resources for LGBT youth

www.afsp.org/schools: American Foundation of Suicide Prevention – resources for schools



