Self Harm and Suicidality in Kids

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Disclosures

I have had not had any financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial service(s) discussed in this activity.
Self-Harm Behavior

(photo from K Skegg, 2005)
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
Examples of Self Harm Behavior

- Minimal visible injury:
  - denying self a necessity
  - deliberate recklessness

- Injury and low lethality:
  - biting, scratching, needle sticks, picking scabs
  - hitting, pinching, hair pulling

- Injury and higher lethality:
  - hanging, shooting, poisoning, drowning,
  - skin cutting, burning, overdose

from K Skegg, 2005
Frequency of self-harm in the US

• Adolescent population: about 15%
  ▫ More females than males
  ▫ Self cutting and burning were most common
• Adult population: about 4%

From Klonsky ED and Muehlenkamp JJ 2007
Cultural influences on self-harm

• **Australia, England rates almost identical to US adolescents**
  ▫ 17% of females, ~5% of males

• **Other countries have different rates**
  ▫ Netherlands: 6% of females, 2% of males
  ▫ Hungary: 10% of females, 3% of males
Self Harm Behaviors Occur Worldwide

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

image by wikipedia and “Local_Profil”
Characteristics of People Who Self Harm

- Experience frequent, intense negative emotions
- Self-critical
  - including disgust/anger with body shape or appearance
- Any psychiatric illness
  - anxiety more often than depression
- Suicidality
  - 50% report at least one suicide attempt
- Slightly more likely to have had childhood abuse
- Difficulty experiencing or expressing emotions
  - “alexithymia”
Other Reasons for Self Harm

• A cut or burn is painful, distracting
  ▫ Physically hard to focus on previously distressing thoughts
• Releases endogenous opiates in response
  ▫ Can be experienced as reinforcing
• Social reinforcement
  ▫ Groups of teenage girls talking about their cutting
Self-harm environment

- Often planned out in advance
  - 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

Other aspects of teen self-harm

- It happens at home
  - 83% within the home
- Doctors rarely know
  - only ~12% ever get a medical evaluation
- Friends/family often know
  - ~75% of the time someone else knows 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

So What Does Cutting Mean to Me?

Cutting is:
- always a sign of psychological distress
- usually a coping mechanism
- sometimes an adolescent social experiment
- signal of risk for a subsequent suicide attempt
Self Harm and Suicide

- To patients, self harm may be reported as their alternative to suicide
- Studies find self harm more strongly predicts adolescent suicide attempts than a diagnosis of depression or anxiety
  - Mechanism may be habituation to self-inflicted pain and violent actions

Klonsky ED, May AM, Glenn CR, 2013
Cutting and suicide

- Cutting (such as wrists) is extremely common form of self-harm in adolescents
  - 64% of all female self-harmers
  - 15% of all male self-harmers
    - Boys hit themselves instead (55%)
- Cutting is actually a very rare way for suicide to occur
  - Well under 3% of all suicide completions

Barrocas AL, Hankin BL, Young JF, Abela JR. 2012
What to do with cutting and self harm

• Get the adolescent alone for a discussion
• Find out 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 Self-Harm Interview Continued

- Find out what they see as the benefits
- 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, most kids should get referred 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

Slee N et al 2007
Suicide
Assessing Suicide Risks In The Office

- Questionnaires to screen for depression, suicidal preoccupations, and previous suicidal behavior
  - Follow up suicidality positive items on the scales
  - PHQ-9 final question...
- Interview separately from the parent
  - Important with adolescents
- Collateral History
Initial Questions

• “Is there anything that has been stressing you lately?”

• “How have things been going with school, friends, parents?”
  ▫ HEADSS (Home, Education/Employment, Activities, Drugs, Sexuality, Suicide risk)
  ▫ Note that asking about suicidal thoughts does not cause distress or ↑ suicidality
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?”
If “Yes,” Get More Details

- Nature of past and present thoughts and behaviors
- Intent (i.e. believes a suicide plan will work)
- Who Else Knows
- 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)
BATHE

- Establish the Background situation “tell me what has been happening”
- Find out how it is Affecting them emotionally “how does that make you feel?”
- Establish the main problem “what is Troubling you the most?”
- Ask about current ways of coping “how are you Handling this?”
- Use Empathic listening and response throughout
Screening Scales Help Gather Info

• 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

• Suicidality rating scales exist, but preferred that providers do the asking directly---shows you care
**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)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Almost always</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

(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 ________
Why Ask? Because Suicidality in Young People is Very Common

<table>
<thead>
<tr>
<th>9th-12th grade student responses</th>
<th>US</th>
<th>Seattle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seriously considered suicide</td>
<td>15.8%</td>
<td>11.4%</td>
</tr>
<tr>
<td>Made a suicide plan</td>
<td>12.8%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td>7.8%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Attempt required treatment</td>
<td>2.4%</td>
<td>2.7%</td>
</tr>
</tbody>
</table>

Per 2011 YRBS by CDC
Epidemiology for Adolescent Suicide

• Approx 2000 US adolescents commit suicide each year
  ▫ ~1000 attempts per completion
  ▫ Overall rate of ~0.005% of kids age 10-19
  ▫ Strangulation (hanging) and firearms in ~90%
  ▫ Overdoses account for ~7% of completions
  ▫ ~1/2 of suicide completers have made no prior attempts
Completed Suicide age 10-24 in U.S.

- About 4600 suicide deaths per year age 10-24
- 3rd leading cause of death in 15-24 year olds
- 100-200 attempts per completion
  - Young adults tend to be more likely to succeed in their attempts...
- 157,000 annual ED visits for self-inflicted injury
  - =34 self-injury patients in the ED/suicide death

Source: CDC
Suicide Rates* per 100,000 population, all ages, by County, 2000-2006

*All rates are age-adjusted to the standard 2000 population. Rates based on less than 20 deaths are statistically unreliable and are suppressed (see legend above) Source CDC
Fatality Rate by Suicide Method in US All Ages, 2005-2009

Source: CDC
Most Common Suicide Attempt Means in those age 10-24

- **Fatal**
  - Firearm 45.5%
  - Suffocation 38.9%
  - Poisoning 8%

- **Nonfatal**
  - Poisoning 45.3%
  - Cutting/piercing 26.3%
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
Increasing Risks: Going from Ideation to Attempt

- Severe or enduring hopelessness
- Isolation
- Reluctance to discuss suicidal thoughts
- Preoccupation with death
Suicide in Young Children

- Understanding the finality of death is not an essential ingredient
  - 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
- Suicidal behavior in prepuberty predicts suicidal behavior in adolescence
Re-Attempting Suicide

- 31-50% of adolescent suicide attempters will 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)
Increasing Risks: Going from Attempts to Completion

- Repeated suicide attempts
- Medically serious attempts
- Taking actions to prevent or promote discovery of the attempt
  - A more decisive rather than impulsive act
Which Youths Complete Suicide

- **Boys**
  - Prepubertal suicide ratio 3 to 1 male to female
  - Adolescent suicide ratio 4.5 to 1 male to female
- **American Indian/Alaska Natives**
  - Native American males have the highest suicide rate
Risk Factors for Completed Suicide in Adolescent Females

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

Shaffer et al., 1996
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
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 have impulsive triggers
After Gathering Information, then what?
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
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
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

• Getting them into therapy
  ▫ Families often fail to follow through with mental health referral appointment after ER discharge

• Medical home can enhance adherence by maintaining contact even after referrals are made
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
• Keep in contact during transition time
• Safety Planning
  ▫ What to do/who to call if urge returns
  ▫ Do not rely on a “no suicide contract”
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
CPP 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.
CPP 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
Instructing parents on home safety

General Home Safety Recommendations after a Child Crisis Event

The following safety tips may help to keep things safe right now after an escalated crisis event, and help to reduce further escalations/crises:

1. In the home environment, maintain a "low-key" atmosphere while maintaining regular routines
2. Follow your typical house rules, but pick your battles appropriately, for example:
   - immediately intervene with aggressive or dangerous behaviors
   - if your child is just using oppositional words, it may be wise to ignore those behaviors
3. Provide appropriate supervision until the child's crisis is resolved
4. Make a crisis prevention plan by identifying likely triggers for a crisis (such as an argument), and plan with your child what the preferred actions would be for the next time the triggers occur (such as calling a friend, engaging in a distracting activity or going to a personal space)
5. Encourage your child to attend school, unless otherwise directed by your provider
6. Make sure that you and your child attend the next scheduled appointment with their provider
7. Administer medications as directed by your child's medical or psychiatric provider
8. Go into each day/evening with a plan for how time will be spent—this should help prevent boredom and arguments in the moment
9. Secure and lock up all medications and objects your child could use to hurt him/herself and/or use to attempt suicide. When locking up items, ensure your child does not have knowledge of their location, the location of the key, or the combination to any padlock used to secure them. This includes:
   - Sharp objects like knives and razors
   - Materials that can be used for strangulation attempts, such as belts, cords, ropes and sheets
   - Firearms and ammunition (locked and kept in separate/different locations from each other)
   - All medications of all family members, including all over the counter medicines. If your child takes medication of any type, you should administer it for the time being (unless instructed to stop it by your care provider)

In the event of another crisis, please do the following:

- If you believe that you, your child, or another person is no longer safe as a result of your child's behavior, call 911 to have your child transported to the emergency department closest to your home
- Consider calling your local county crisis hotline, which are listed at www.dhs.wa.gov/dhhv/mhcrisis
- Consider making an outreach to the national suicide hotline: 1-800-784-2433

www.palforkids.org
Psychotherapy can ↓ Risk Factors

- Cognitive Behavioral Therapy
- Interpersonal Psychotherapy
- Dialectical Behavioral Therapy
- Psychodynamic therapy
- Family Therapy
Psychopharmacology

Medications can help with associated symptoms

Consider SSRIs like fluoxetine to treat depression or anxiety

But, medications will not resolve suicidality itself
Reality of the Situation

- Suicidal risk can only be reduced, not eliminated
- Risk factors only provide guidance
- Adolescents may have their own agenda – information provided can be subjective or falsified
  - “Contract for Safety” is unreliable and not a substitute for other strategies
- 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 failed suicide 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
Helpful References

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