WORKING WITH YOUTH AT RISK FOR SELF-HARM

October 2017

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- Challenges
- Status & trends in youth suicide
- Competencies
- Risk factors

- Assessment
- Treatment/Safety Planning
- Therapeutic issues
  - Relationship & Rapport
  - Modalities

THE BIG LIST OF CHALLENGES

A leading cause of death

Suicidality is nearly universal among teenagers

Creates dilemmas and tensions in treatment

Inadequate treatment resources

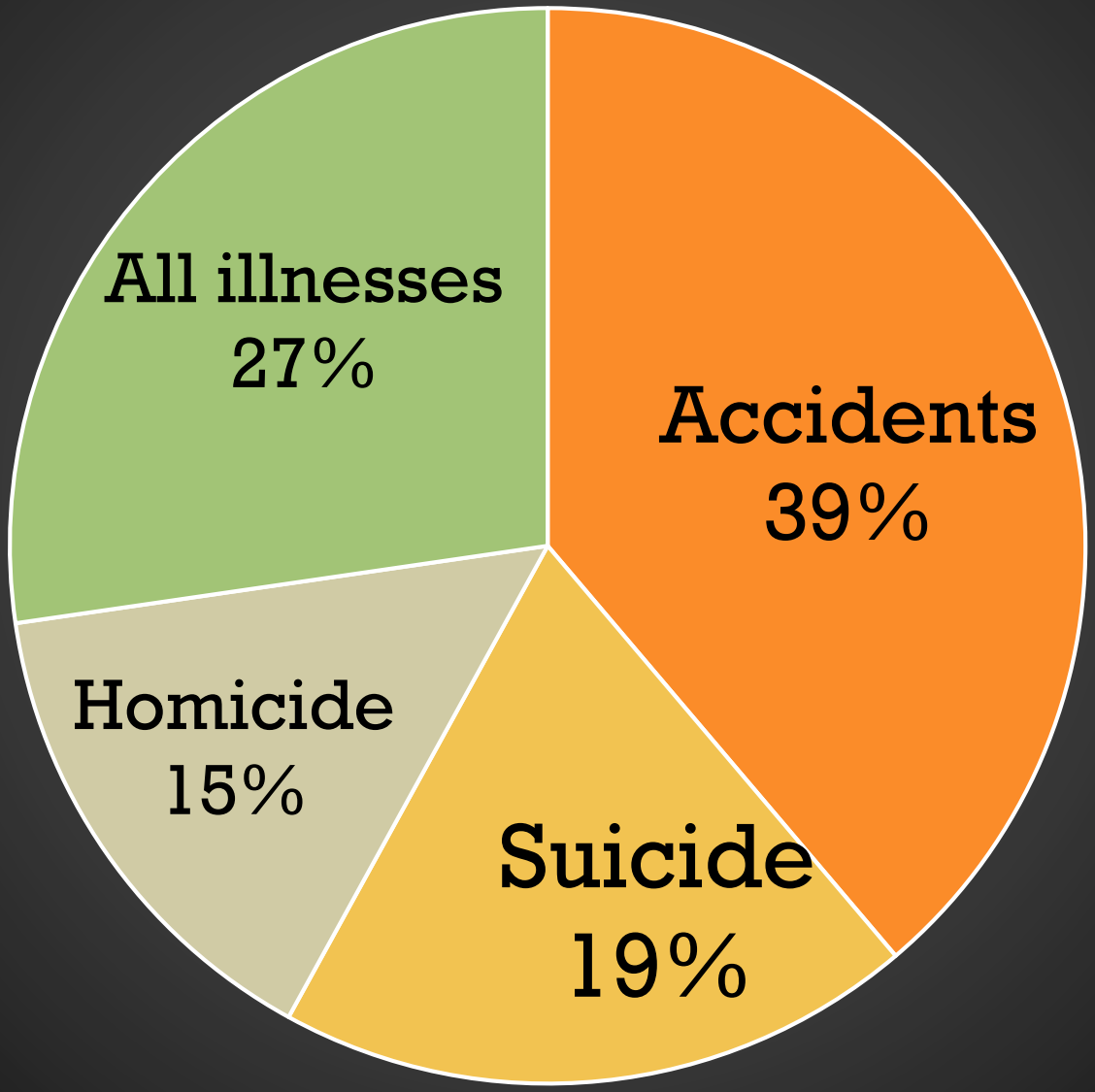
Stress/worry for clinician

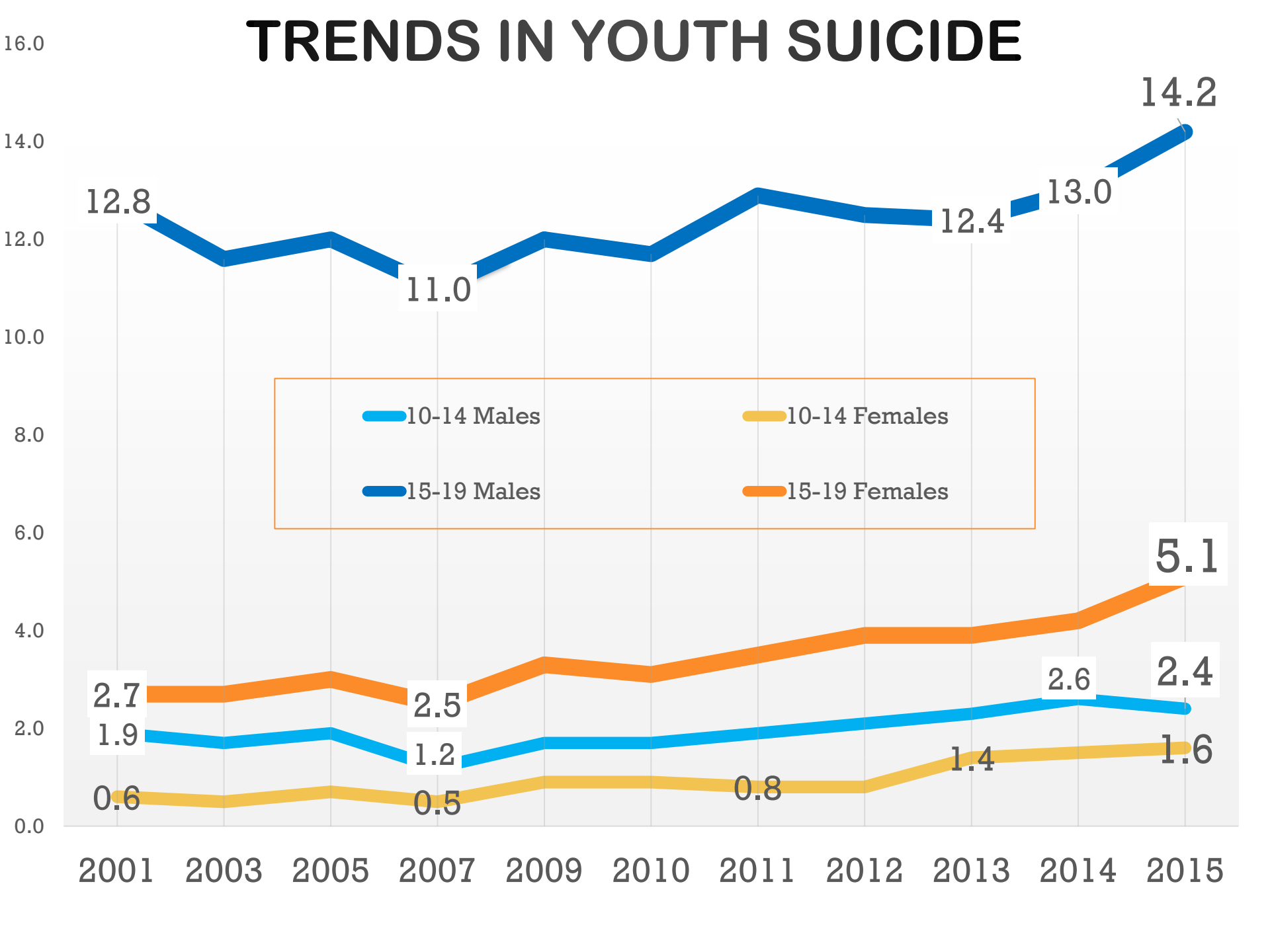
Trauma of losing a patient to suicide

Exposure to malpractice claims

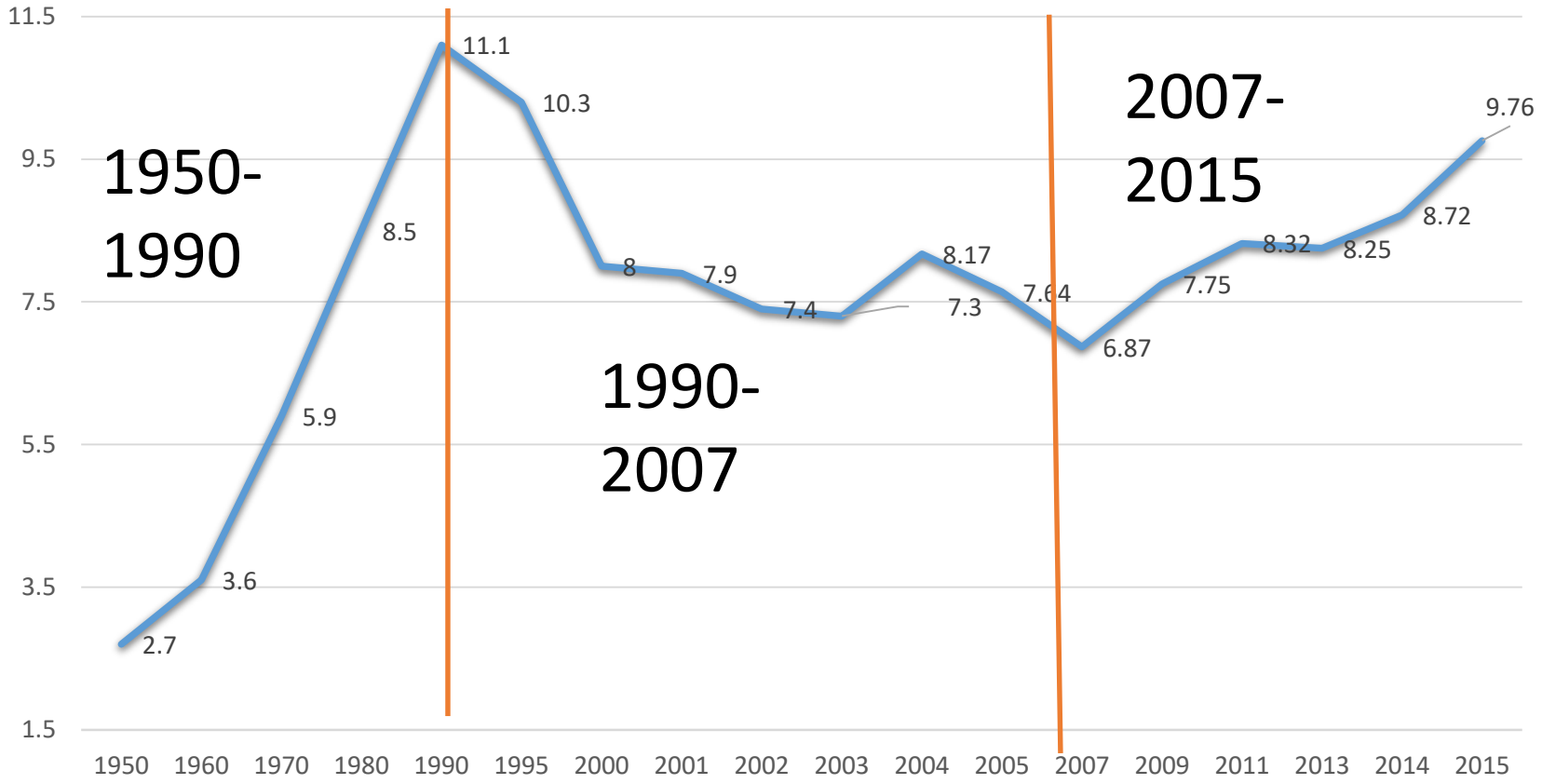
SUICIDE IS A LEADING CAUSE OF DEATH AMONG YOUTH.

LEADING CAUSES OF DEATH, AGE 15-19




TRENDS IN YOUTH SUICIDE
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
12.8
11.0
12.4
13.0
14.2
10-14 Males
10-14 Females
15-19 Males
15-19 Females
2.7
2.5
5.1
1.9
1.2
2.6
2.4
0.6
0.5
0.8
1.4
1.6
2001
2003
2005
2007
2009
2010
2011
2012
2013
2014
2015

Ages 15-19, suicide rates

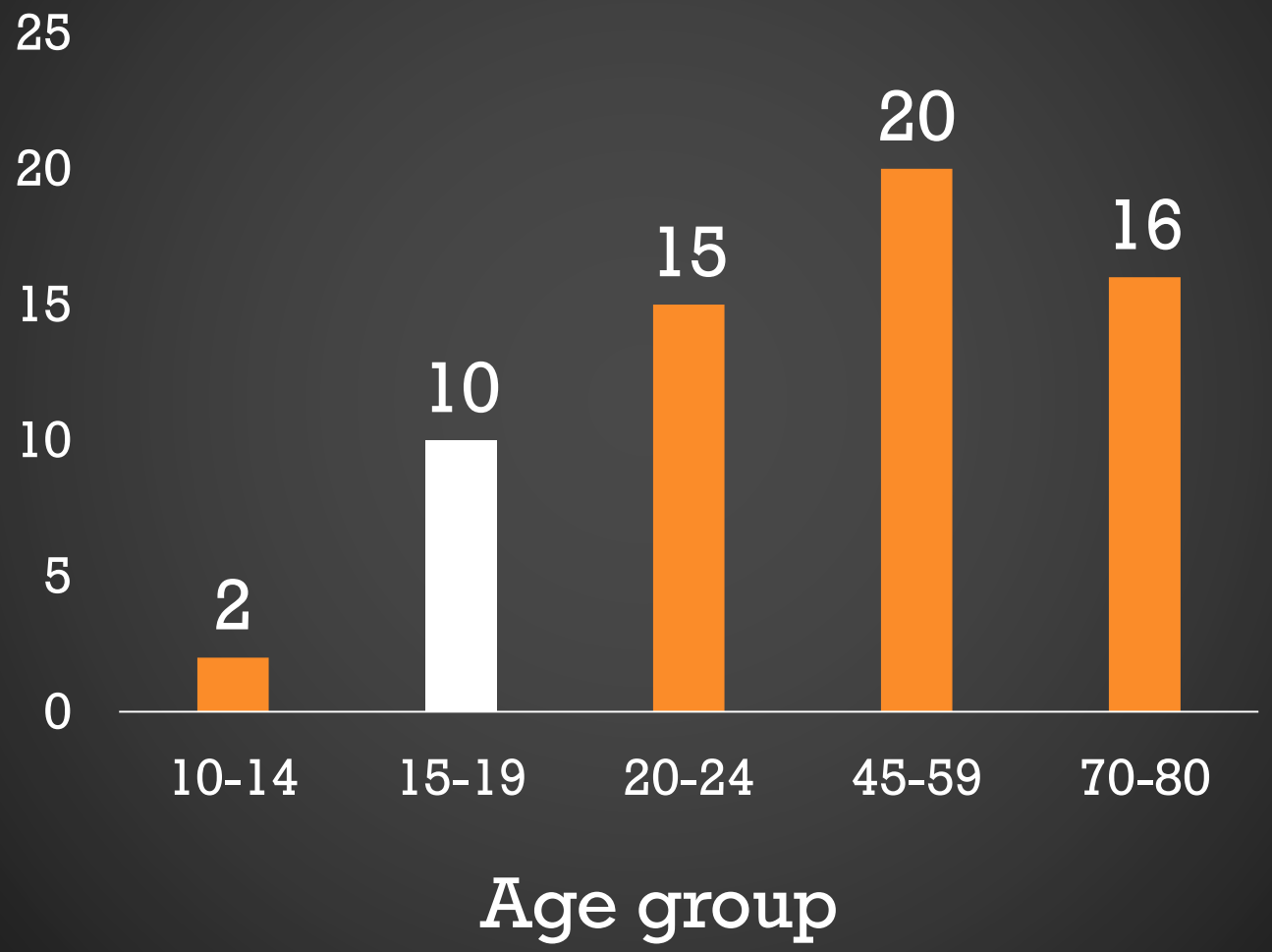


NOT JUST YOUTH

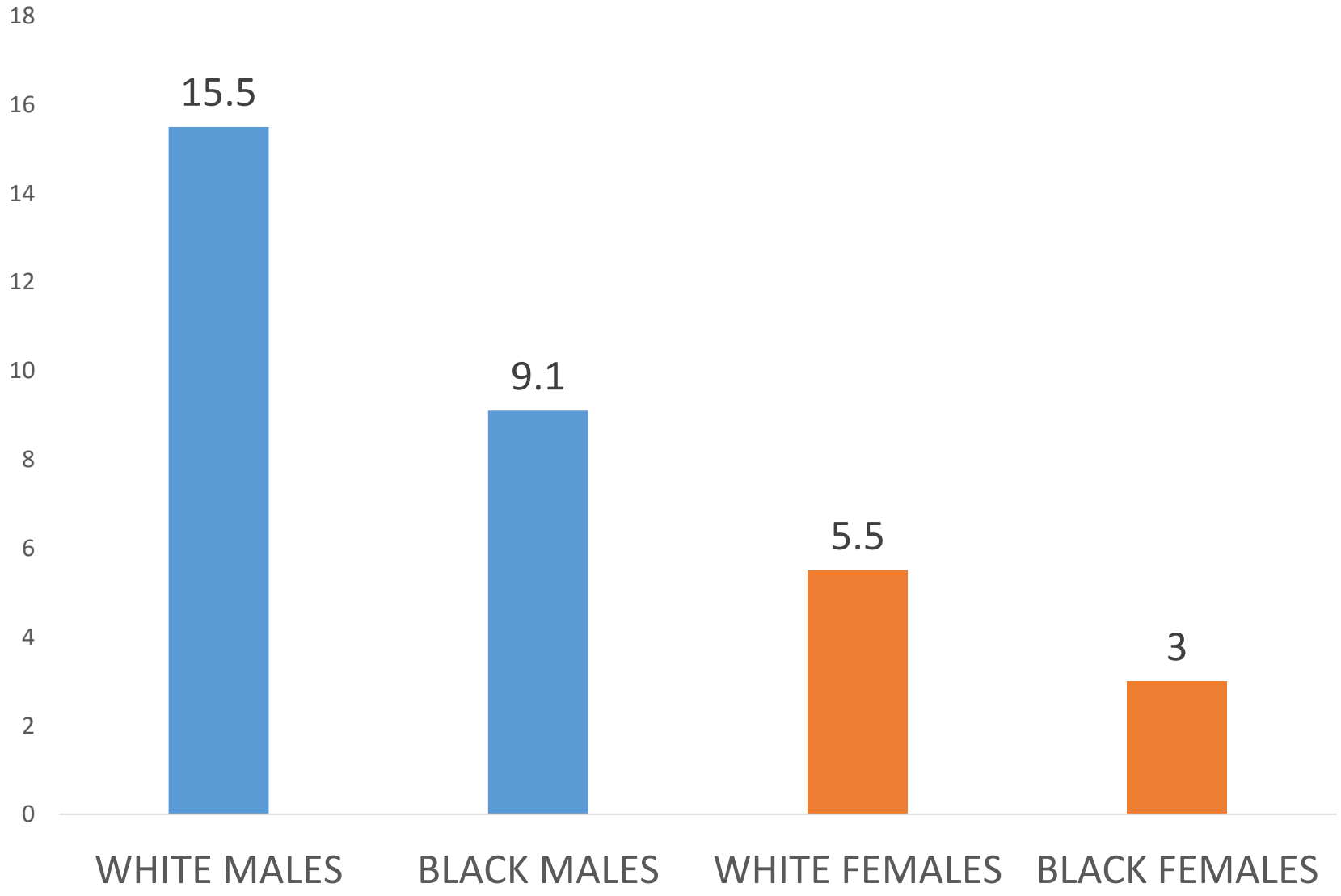
1999-2014: Suicide rates increased for all ages 10-74, with greatest increase since 2006.

Females 45-64, up from 6.0 to 9.8.

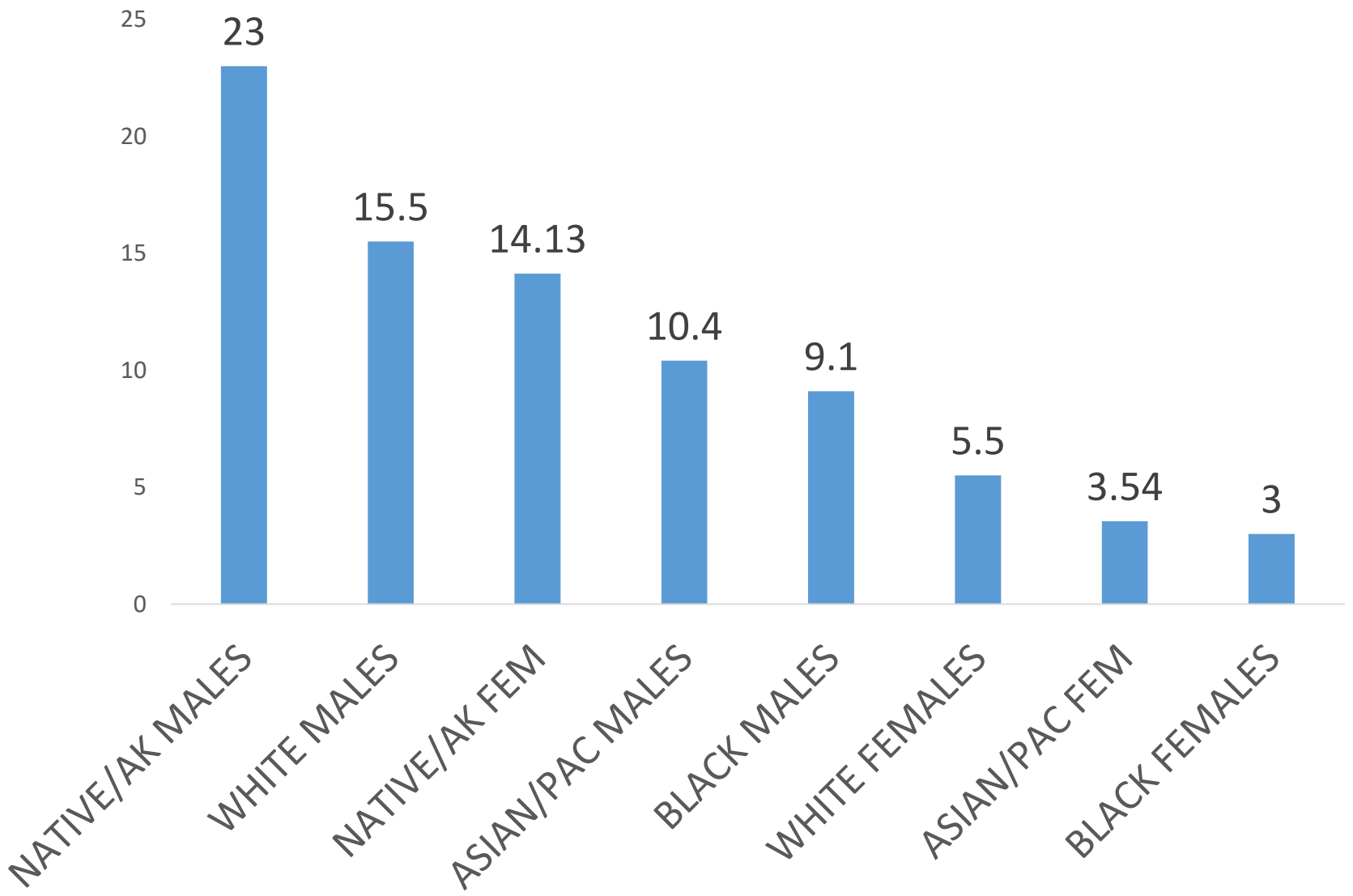
SUICIDE RATES BY SELECTED AGE GROUPS/100,000 (2015)



Gender/Ethnicity, 15-19



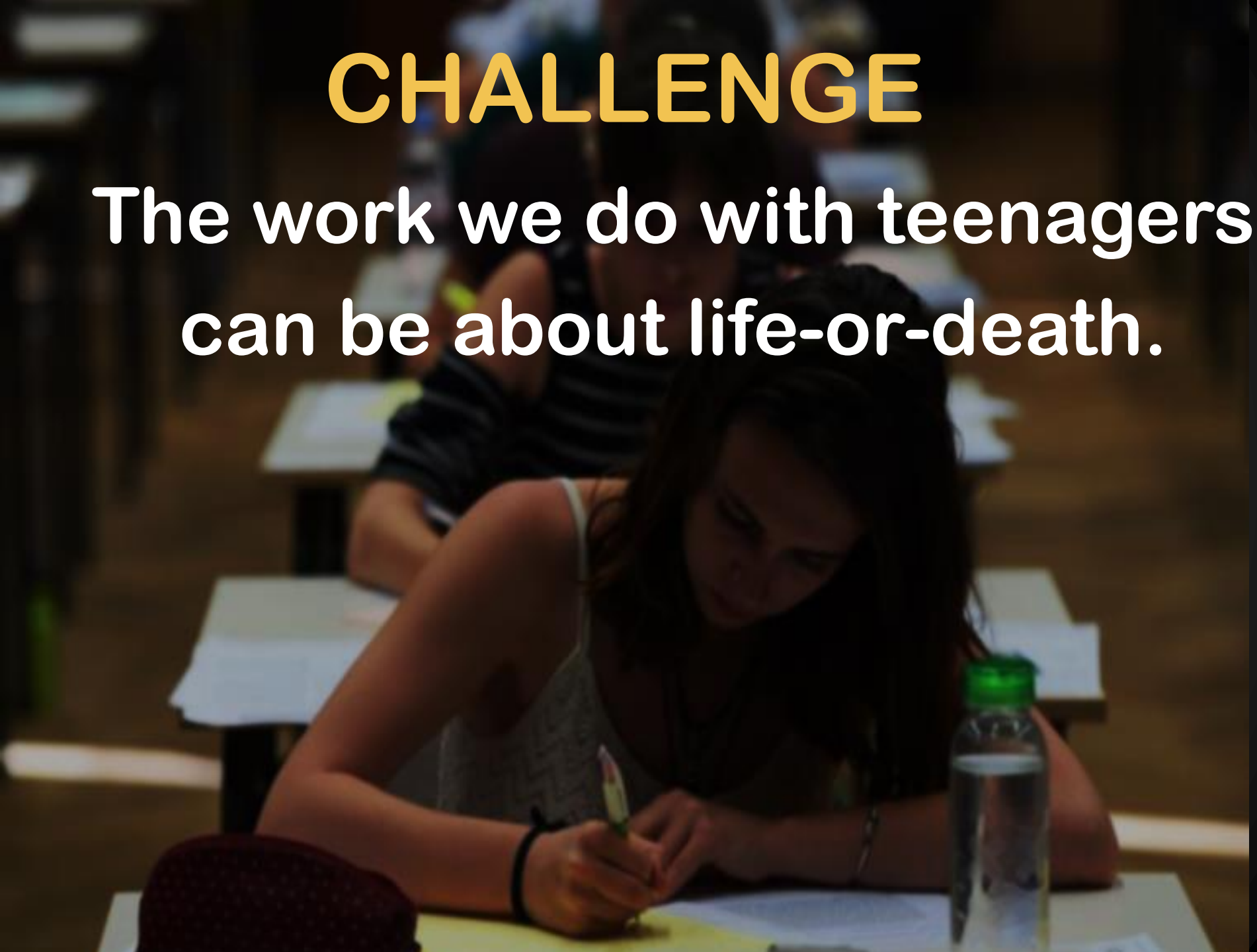
Gender/Ethnicity, 15-19



METHODS

Firearms 45%

Suffocation 40%



CHALLENGE

The work we do with teenagers can be about life-or-death.

THE BIG LIST OF CHALLENGES

A leading cause of death

Suicidality **is almost universal among teenagers**

Creates dilemmas and tensions in treatment

Inadequate treatment resources

Stress/worry for clinician

Exposure to malpractice claims

IDEATION

COMMUNICATION

PLANNING

ATTEMPTS

DEATHS

YOUTH RISK BEHAVIOR SURVEY 2015

TEENAGERS, DURING 12 MOS BEFORE SURVEY

- 30% feel sad or hopeless for 2 more weeks, enough to stop doing some usual activities during the year before the survey.
- 18% seriously considered suicide
- 15% made a plan

TEENAGERS, DURING 12 MOS BEFORE SURVEY

- 9% said they had attempted suicide
- 3% said attempted suicide & required treatment

DEATHS BY SUICIDE (TEENS) PER YEAR

- 10 in 100,000
- 1 in 10,000
- .011%

OUT OF 10,000 TEENS, IN ONE YEAR

1800 seriously considered suicide

1500 made a plan

850 attempted

300 attempted & required treatment

1 died by suicide

CHALLENGE

We have to address a LOT of suicidal behavior to help prevent an uncommon death.

THE BIG LIST OF CHALLENGES

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DO WE CONSCIOUSLY OR UNCONSCIOUSLY REJECT SUICIDAL PATIENTS?

THE RESPONSIBLE CHOICE TO DO OUR PART INCLUDES LIMITING HOW MUCH OF THE WORK WE DO.

CORE COMPETENCIES

- Suicide Prevention Resource Center/American Association of Suicidology
  - Lanny Bergman, Thomas Ellis, Marsha Linehan, & others.
- *Q: Do these constitute core competencies for dealing with adolescents, given the prevalence of suicidal behavior in the population?*

CORE COMPETENCIES

- Managing one's reactions to suicide & suicidal behavior.
- Able to address potential conflict: Clinician's goal to prevent suicide vs. patient's need to eliminate psychological pain.
- Able to collaborate & maintain non-adversarial stance.

CORE COMPETENCIES

- Assess suicide ideation, behavior, plans, intent.
- Collaboratively develop crisis plan.
- Develop a written treatment & services plan
- Develop policies/procedures for maintaining continuity of care, including reasonable steps to be proactive.

- ✓Challenges
- ✓Status & trends in youth suicide
- ✓Competencies
- Risk & protective factors

- Assessment
- Treatment/Safety Planning
- Therapeutic issues
  - Relationship & Rapport
  - Modalities

RISK FACTORS

RISK FACTORS

Demographic

Clinical

Family/Interpersonal

RISK FACTORS

Demographic

Clinical

Family/Interpersonal

Which of these is of LEAST practical value to the clinician?

DEMOGRAPHICS

Gender

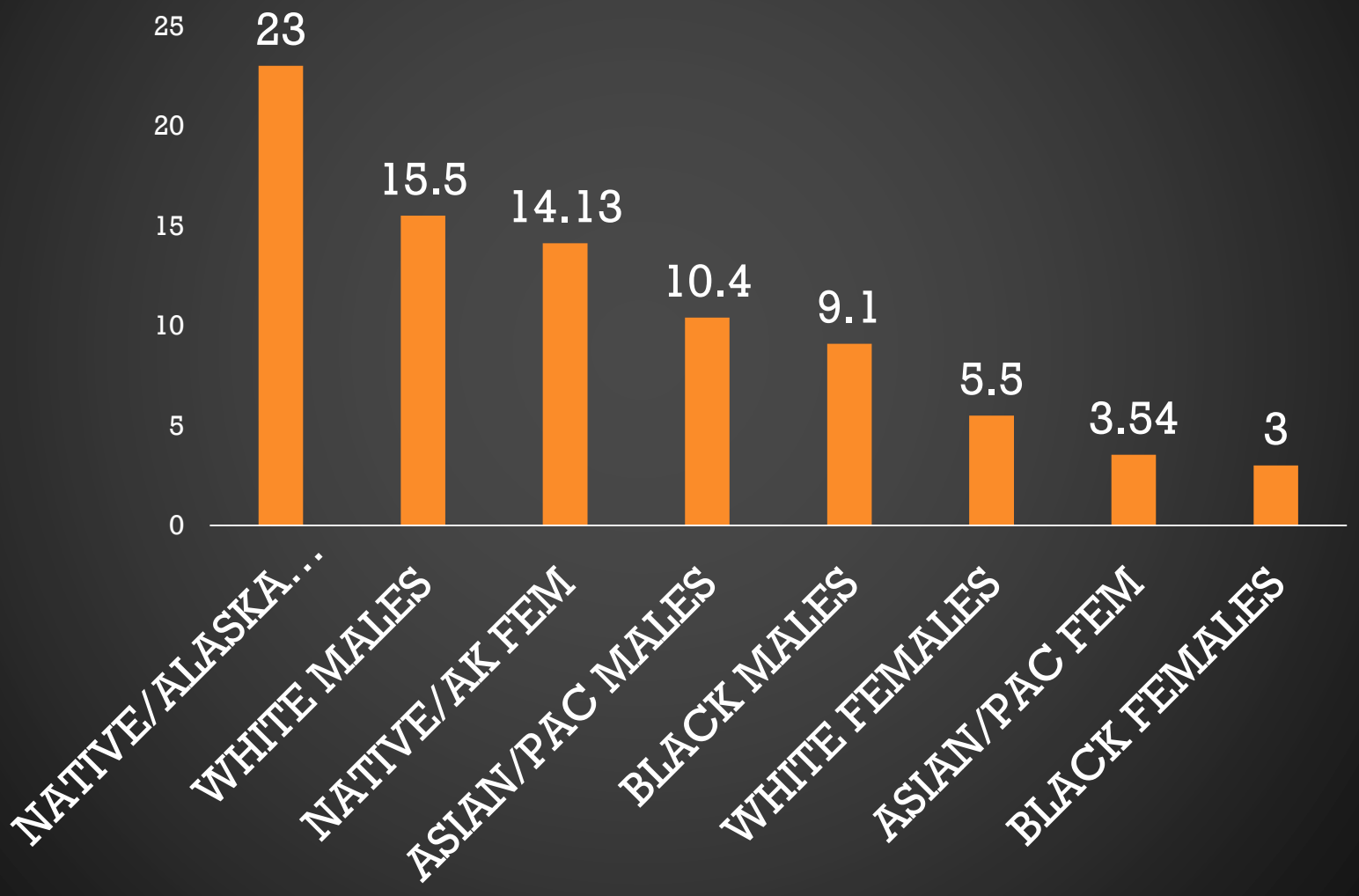
Males>Females

	13	15	17	19
Males	2.2	5.8	11.2	18.3
Females	1.0	2.5	2.9	3.4

DEMOGRAPHICS

Deaths by suicide increase with age, during & beyond adolescence.

ETHNICITY, 15-19



CLINICAL RISK FACTORS

- History of suicide attempt(s)
- Suicidal ideation & intent
- Psychiatric disorders
  - Depression / Bipolar
  - Alcohol / drug
  - Conduct disorders
  - PTSD
  - Others: Anxiety, eating disorder, schizophrenia)
- Nonsuicidal Self-Injury
- Emerging Personality Disorder
- Hopelessness
- Impulsivity
- Aggressive/Violence
- Sleep Disturbance
- Learning Disabilities
- Discharged from treatment

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  - Conduct disorders
  - PTSD
  - Others: Anxiety, eating disorder, schizophrenia)
- Nonsuicidal Self-Injury

CLINICAL RISK FACTORS

- Emerging Personality Disorder
- Hopelessness
- Aggressive/ Hx of Violence

IF YOU ARE WITH A PERSON EXPERIENCING GREAT PSYCHOLOGICAL PAIN, WHO FEELS TRULY HOPELESS, YOU ARE IN THE ROOM WITH A SUICIDAL PERSON.

FAMILY / INTERPERSONAL

- Family History of Psychiatric Illness and Suicide
  - Adolescent suicide 5 times more likely in offspring of mother swho died by suicide & twice as likely in offspring of fathers who died by suicide.

FAMILY / INTERPERSONAL

- Family History of Psychiatric Illness and Suicide
  - Family diagnoses associated with increased adolescent suicide: Antisocial PD, substance abuse, mood disorders

FAMILY / INTERPERSONAL

- Sexual abuse (5-fold increase)
- Abuse / neglect
- Bullying (bullies AND victims)
- Poor peer relationships (“thwarted belongingness”)
- Poor family support, increased family conflict

FAMILY / INTERPERSONAL

- Sexual orientation & identity
  - About 30% of LGBT youth attempt suicide at least once.
  - Males>Females
- Exposure to suicidal behavior
- Access to firearms & other means

THE PROTECTIVE FACTORS IN ONE WORD

belonging

- ✓Challenges
- ✓Status & trends in youth suicide
- ✓Competencies
- ✓Risk factors

- **Assessment**
- Treatment/Safety Planning
- **Therapeutic issues**
  - Relationship & Rapport
  - Modalities

SCREENING

- In counseling settings, all adolescents should be screened
- Ideally, all adolescents would be screened outside of counseling settings (schools, pediatricians)
- Psychometric instruments exist, but interview remains the standard
- Beware of NOT WANTING TO KNOW.

TIPS

- Screen early in session
- Calm, collaborative stance
- When screen suggests suicidality, be calm, collaborative. (Don’t freak!)
- Ask directly
- Ask more than one question!
- Encourage *parents* to ask directly

ASK QUESTIONS

Children / young adolescents

Sometimes children who get upset or feel bad wish they were dead or feel like they would be better off dead. Have you ever had these types of thoughts. When? Do you feel that way now?

ASK QUESTIONS

Children / young adolescents

Sometimes children who get upset or feel bad think about dying or even killing themselves. Have you ever had such thoughts? Did you think about how you would do it?

(Schedule for Affective Disorders & Schizophrenia for School-age Children – KSADS-PL)

FOR TEENAGERS
(CHILDREN'S INTERVIEW FOR PSYCHIATRIC SYNDROMES)

- Do you ever wish you were dead?
- Do you ever think life isn't worth living?
- Have you ever thought about suicide / killing yourself?

If YES:

- Have you thought about how you would hurt yourself?
- Have you ever tried to kill yourself?


Not
really.

RISK IS NOT STATIC.

IS ONE INITIAL SCREENING ENOUGH?

ONGOING ASSESSMENT OF AT-RISK ADOLESCENT

Establish understanding with patient that we have to assess and re-assess.

Establish understanding of keeping parents in the loop.

ONGOING ASSESSMENT OF AT-RISK ADOLESCENT

Consult with colleagues / supervisors.

Develop a system of documentation.

Sources of info: Questions to teen; parent reports; school reports

APPENDIX E

Teen Suicide Risk Assessment Worksheet

Evaluator _____ **Date** _____

Client _____

Gender: M F **Birthdate:** _____ **Age (years):** _____

Reason for Comprehensive Risk Assessment (e.g., recent suicide attempt, reported suicidal thoughts, hospital discharge/disposition, new client, other):

_____

_____

Sources of Information (Circle): **Teen** **Parent/Guardian** **Other**

Interview with _____

Interview with _____

Interview Form or Questionnaire (specify) _____

Other Source(s) of Information (specify) _____

Current or History of Suicidal Thoughts: **YES** **NO**

If yes:

What is content of thoughts?

_____

Time Course (today? past week? past month? lifetime?) _____

Frequency _____

Duration (How unrelenting?) _____

Has client considered a method? _____

Does client have a plan? _____

Any preparatory action(s) _____

Are there triggers that can be identified? _____

Recent or History of Suicide Attempt: **YES** **NO**

If yes:

How many suicide attempts? _____

APPENDIX F

Documentation of Teen Suicide Risk Assessment

Evaluator _____ Assessment Date/Time _____

Client _____

Risk factors (psychiatric disorders, active use of alcohol or drugs, history of trauma/abuse/family suicide, recent stress, hospital discharge/treatment change, contextual factor such as victimization/bullying):

_____

_____

Suicidal thoughts, impulses; history of suicide attempts (Thoughts: content, severity, frequency, controllability; Attempts: number, precipitants, method, functional analysis):

_____

_____

Mental status (current psychological functioning):

_____

_____

Protective Factors:

_____

RISK ASSESSMENT COMPONENTS

- Risk factors present / absent
- Suicidal thoughts, impulses, history of attempts
- Presence / absence of plan
- Protective factors in place
- Risk formulation (best judgement of current risk)
- Plan of action

COLLABORATIVE SAFETY PLAN

- What are my triggers?
- Agreement to speak to parents (or intermediary who will speak with parents)
- Call therapist and/or emergency numbers
  - 911
  - Crisis Center / Suicide Hotline
- Move away from method & means
- A couple of things that are important to me and worth living for.

NONSUICIDAL SELF-INJURY

NSSI

DEFINITION

deliberate, self-inflicted injury without suicidal intent and for purposes not socially sanctioned.

WHAT DOES SELF-INJURY *DO?*

- It relieves, at least partly and temporarily, overwhelming emotional pain.
- Or, in others, it ends numbness, depersonalization, derealization.
- NOT attention seeking, typically.
- NOT manipulative, typically.

J. of the American Academy of Child & Adolescent Psychiatry (Asarnow, et al, 2011)

NSSI "a clear marker for suicide risk"

(commentary: Wilkinson, 2011, p. 1.)

RECOMMENDATION

If NSSI is present, assess for suicidality.

If suicidality is present, assess for NSSI.

Re-assess over time. Monitor closely.

- ✓Challenges
- ✓Status & trends in youth suicide
- ✓Competencies
- ✓Risk factors

- ✓Assessment
- ✓Treatment/Safety Planning
- **Therapeutic issues**
  - Relationship & Rapport
  - Modalities

DILEMMA

Do I take on this teenager's care?

Do I participate in hospitalizing this person against her will?

Do I call the parents?

Do I focus on the self-injury behaviorally, or do I work on big picture issues?

How much / often do I assess suicide risk?

How much risk can I tolerate / manage?

A COMMON TENSION IN TREATING SUICIDAL TEENS

SELF-DETERMINATION

TEEN AND THE ADULTS IN HIS/HER LIFE WANT DIFFERENT THINGS

CONFLICTING INTERESTS IN HOW TO USE A SESSION

PRINCIPLES OF RELATIONSHIP-BUILDING

- Respect
- Avoidance of ageism
- Integrity
- Calm & concern
- Avoiding cool therapist stance
- Genuine collaboration

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WHAT'S KNOWN ABOUT TREATMENT?

- Outpatient therapies, targeting suicidality directly, are generally effective.
- CBT, generally, has best empirical support.
- Dialectical Behavior Therapy most supported.
- No data to support that inpatient treatment is effective in long-term for preventing suicide.

Dialectical Behavior Therapy with Suicidal Adolescents

Alec L. Miller, Jill H. Rathus, and Marsha M. Linehan

CHARACTERISTICS OF DBT

- **Support-oriented**: Help person ID strengths and build on them.
- **Cognitive-based:** ID problematic thoughts, beliefs and assumptions and work those.
- **Collaborative:** Addresses therapist-patient relationship matters, encourages homework, role-play, skills-practice.
- **Multimodal:** Individual, family, group, coaching, structured diaries

COMMON COMPONENTS (MODULES)

- Mindfulness
- Skills-building
- Distress tolerance
- Emotional regulation
- Interpersonal effectiveness

EXAMPLE: ACCEPTS

Distracting oneself from unpleasant emotions

Activities- Do stuff you enjoy

Contribute- Help someone

Comparisons- Life *could* suck more

Emotions- Get in touch positive emotions via humor, positive activities

Push away- Put the immediate problem on backburner

Thoughts- Force your mind to think about something else

Sensations- Sub other intense feelings (cold shower)