



Suicide and Non Suicidal Self Injury

Understanding the Difference and How to Assess Them





Part One



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- Leader of Clinical Services at St. Louis Center for Family Development
- Team Leader of STLCFD DBT program for adolescents and adults
- 12 years experience working with children, adolescents, families, and adults through evidence based treatments including: Prolonged Exposure, Family Systems, Cognitive Behavior Therapy, and Dialectical Behavior Therapy.

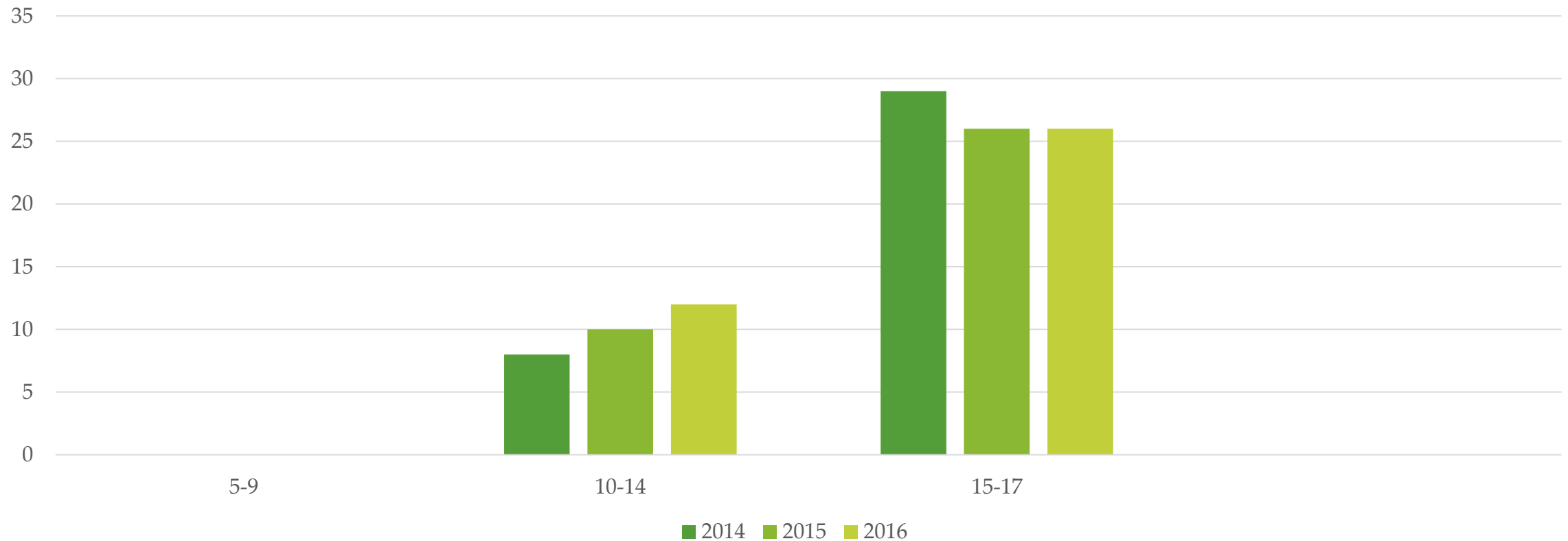
Learning Objectives

What do you want to walk away knowing?

- Understand the difference between Non Suicidal Self Injury, Suicidal Ideation, and Suicidal Behavior
- Know the prevalence of suicide in Missouri and the rate it affects different populations
- Understand how to formulate risk for suicide when considering different factors
- How to talk with someone expressing suicidal ideation to assess risk and create a safety plan

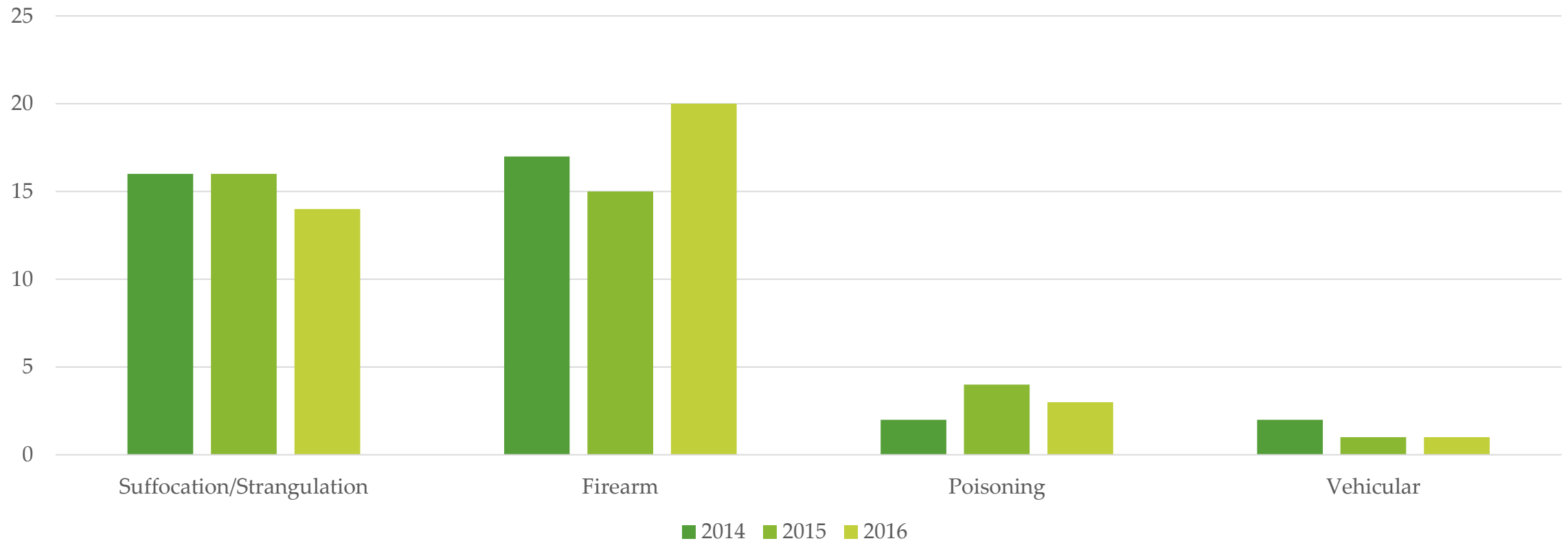
Missouri Suicidal Rates in Children

Suicides By Age



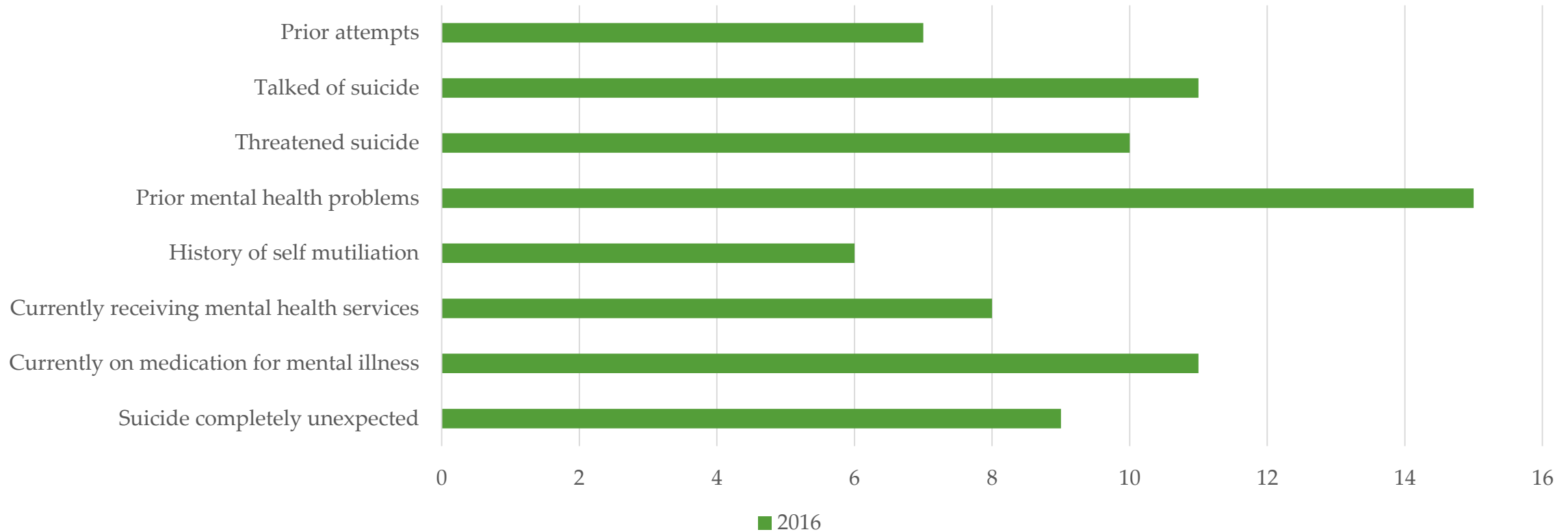
Missouri Suicidal Rates in Children

Suicide By Mechanism



Missouri Suicidal Rates in Children

Warning Signs of Suicide



Missouri Suicidal Rates in Children

- Missouri has a higher rate of suicide than the national average (18.3 per 100,000 vs. 13.26 per 100,00)
- The 2015 Missouri Student Survey found that 16.2% of all Missouri high school students and 18.9% of female high school students reported they seriously considered suicide.
- 13.4% of all students actually made a suicide plan
- 9.8% of students surveyed stated they had attempted suicide
- Suicide attempt rate for females was higher but more males succeeded than females.

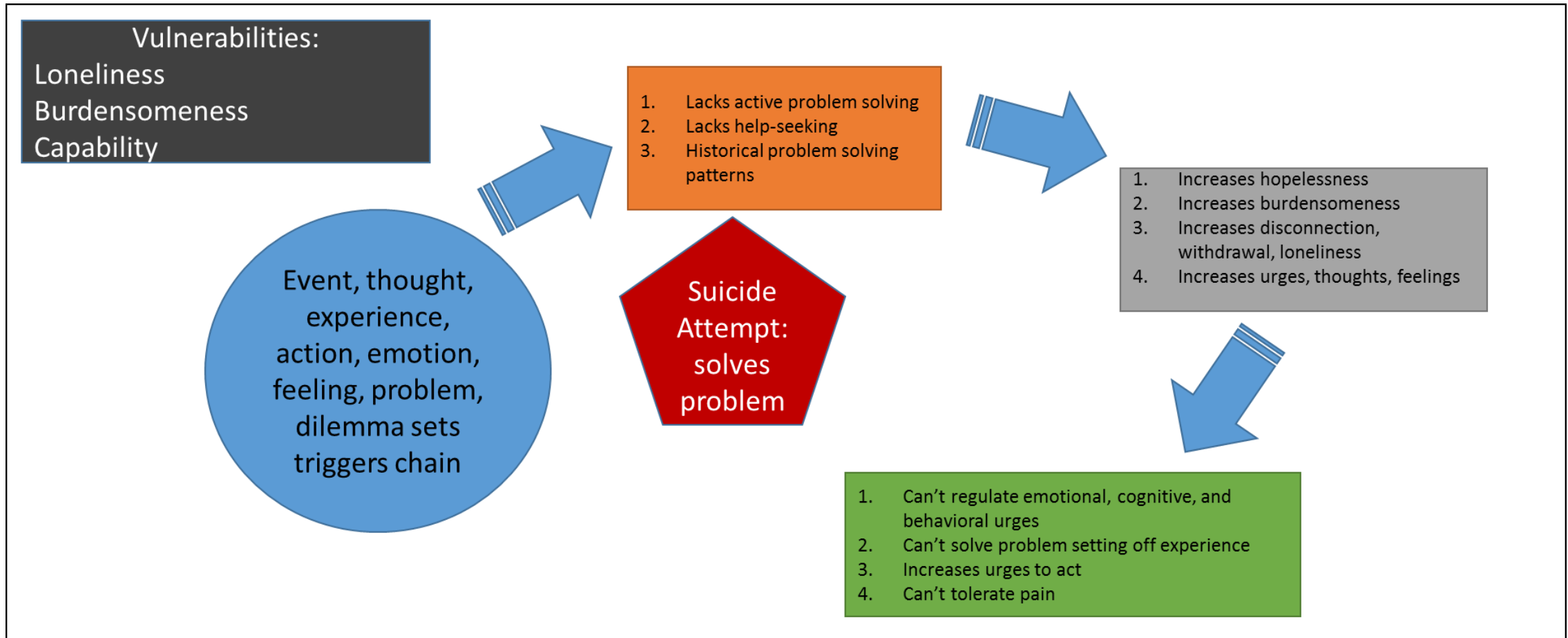
Defining Suicidal Behavior

- Suicide related behavior: “All self inflicted life threatening behaviors in which a person intended to harm or kill him or herself, and which could, whether intentional or not, result in the person’s death.” – McLaughlin p.1
- Does this include the following?
 - Suicidal thoughts
 - Suicidal images
 - Suicidal urges
 - Suicidal planning
 - Suicidal intent
 - Suicidal attempt

Defining Non-Suicidal Self-Injury

- "the intentional destruction of one's own body tissue without suicidal intent and for purposes not socially sanctioned" – Nock, 2009
- NSSI is
 - Intentional
 - Physical
 - Differentiated from repetitive behaviors such as those seen in autism
 - Suicide attempts- definitional distinction based on lack of intention to die
 - Functional differences from suicidal behavior

Suicide Theories: Problem Solving



Long Term Risk
Factors

Any Factor that is associated
with the long term risk for

Short-Term Risk
Factors

Behaviors or Situations that are
indicative of Imminent Risk. Part of
the Short-Term Risk Assessment

Imminent Indicators

Behaviors or contexts that are highly
associated with Imminent Risk. Part of
the Short-Term Risk Assessment

Individual Factors

What you know about the particular
person, their patterns, their triggers,
their vulnerabilities, their past

Individual
Protective Factors

Factors associated with prevention or
decreased likelihood of acting on
suicidal thoughts or urges

Clinical Algorithm

The synthesis of all your knowledge,
data, experiences, understanding,
perceptions that define clinical
judgment

Suicide Risk

Types of Assessment of Suicidal Behavior

Long-Term Risk of Suicidal Behavior

Understanding the long-term risk factors that increase the likelihood of suicidal behavior. This provides an overall picture of how a person, in the long-term, falls into a group at high risk for suicide.

Short-Term Risk of Suicidal Behavior

The direct and indirect behavioral indicators or circumstances that increase the immediacy and predictability of suicidal behavior.

Note. Adapted from Linehan, M.M. (1993). *Cognitive Behavioral Treatment of Borderline Personality Disorder*. New York, NY: Guilford Press.

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Long-Term Risk Factors

- Prior Attempt
- History of medically serious attempt
- Recent psychiatric hospital discharge
- Diagnosis of Depression, BiPolar Disorder, Schizophrenia, Borderline Personality Disorder
- Multiple Diagnoses (3+ in high risk category)
- Cognitive impairment, decreased concentration/indecision
- History of impulsivity
- Family member died by suicide
- History of childhood sexual abuse
- Unemployed
- Financial Strain
- Physical Illness

Note. Adapted from Linehan, M.M. (1993). Cognitive Behavioral Treatment of Borderline Personality Disorder. New York, NY: Guilford Press.

Short-Term Risk Factors

- ❑ Current Attempt
- ❑ Recent psychiatric hospital discharge
- ❑ Extreme cognitive rigidity- no flexibility in thinking and problem solving
- ❑ Current sleep problems
 - ❑ Early morning awakening
- ❑ Current hopelessness
- ❑ Current helplessness
- ❑ Panic and significant anxiety
- ❑ Current psychotic symptoms
- ❑ Current drug or alcohol use
- ❑ Intense levels of Agitation
- ❑ Actively making death arrangements
- ❑ Lethal methods available
- ❑ Likely to be alone; currently socially isolated
- ❑ Recent unemployment
- ❑ Newly diagnosed physical illness

Note. Adapted from Linehan, M.M. (1993). Cognitive Behavioral Treatment of Borderline Personality Disorder. New York, NY: Guilford Press.

Suicide Protective Factors

- Actively making plans for the future
- Verbalizes hope for the future
- Displays self-efficacy in problem area
- Shows attachment to life
- Has responsibilities to kids, family, or others
- Embedded in protective social network/family
- Attached to therapy and at least one therapist
- Belief that suicide is immoral or will be punished
- Hopeful that the current treatment direction will be effective
- Hopefulness in general
- Taking steps to engage in treatment or seeking help

Note. Adapted from Linehan, M.M. (1993). *Cognitive Behavioral Treatment of Borderline Personality Disorder*. New York, NY: Guilford Press.

Getting from Long-Term Risk to Imminent Threats of Suicide

The Presence of One or More of the following Long-Term Risk Factors

- Past Suicide Attempt
- Past Non-Suicidal Self-Injury
- History of Mental Health Diagnosis (BPD, BiPolar, Depression, Schizophrenia)
- History of Multiple Mental Health Diagnoses
- Ongoing Sleep Difficulties
- Loss of Loved One
- Marginalized Community
- Low Social Support/Rejection from Family
- Unemployment
- Chronic Physical Pain



The Presence One or More of the Following Short-term Indicators

- Current Suicidal Intent
- Means/Method Available
- Lethal Means Available
- Vague Plan
- Very Specific Plan
- Precaution against discovery
- Current Substance Use
- Currently alone or will be alone
- Anhedonia
- Concentration difficulties
- Prompting event for previous attempt
- Sudden Loss or Negative Life Event
- Abrupt clinical change (pos/neg)
- Hopelessness
- Current Major Depressive Episode
- Turmoil/Anxiety/Panic
- Global Insomnia
- Current psychosis
- Impulsivity



Absence of the Following Protective Factors

- Hope for the Future
- Attachment to Life
- Attachment to Therapy or Therapist or Helper
- Health and Supportive Social Support Network
- Belief in ability to solve the problem setting off suicidal crisis
- Responsibility and attachment to children, family, pets or others/community
- Imbedded in protective community
- Strong faith beliefs
- Fear of attempting suicide
- Believes suicide is immoral and possesses high spiritual affinity
- Willing to follow a plan
- Expression of wanting to live
- Access to helping relationship

Suicide Risk Formulation Profiles

Low Risk

Moderate Risk

High Risk

- ✓ No prior SI/SH
- ✓ Low intensity or absent thoughts
- ✓ No access to suicidal means
- ✓ Wants to live
- ✓ Strong Support
- ✓ Religious Conviction
- ✓ No family hx
- ✓ Baseline Social Support

- ✓ Can regulate emotions
- ✓ Can tolerate Reality Testing
- ✓ No active psychosis
- ✓ Future Focused
- ✓ No high risk diagnoses
- ✓ No alcohol or drugs
- ✓ Low levels of mood and anxiety sx's

- ✓ Previous hx low lethality, more than 6 mths ago
- ✓ SH detectable/minor first aid
- ✓ Plan is vague, sub-lethal, less feasible
- ✓ Some access to means
- ✓ Vacillation of intent
- ✓ One diagnosis

- ✓ Ambivalence
- ✓ Provisions for discovery
- ✓ Modest support system
- ✓ Social withdrawal
- ✓ Sleep diminished
- ✓ Impulsivity
- ✓ Hope diminished
- ✓ Some coping ability

- ✓ Several attempts w/high lethality
- ✓ NSSI
- ✓ Active/Persistent SI
- ✓ Intrusive intensity
- ✓ Clear plan, lethal, feasible
- ✓ Access to means
- ✓ Wishes to die

- ✓ Suicide in family
- ✓ Isolating
- ✓ Severe insomnia
- ✓ Deliberate self-harm
- ✓ Command hallucinations
- ✓ No reasons to live
- ✓ No coping
- ✓ Multiple DX
- ✓ Panic/Despair
- ✓ No pleasure

General Guidelines for Talking with Someone About Suicide

1. Talk about suicide openly
2. Present suicidal behavior as a response to a problem
3. Maintain stance that suicide is an ineffective solution to problem solving
4. Involve others, including other therapists and staff
5. Schedule sessions frequently if needed
6. Stay aware of the complexities
7. Maintain professional consultation

What to Assess

Suicidal Thoughts and Urges

Assess the presence of suicidal ideation:

“are you having thoughts of killing yourself?”

Assess intensity of suicidal ideation:

“on a scale of 0-10, how intense are your current thoughts to kill yourself?”

Assess duration of suicidal ideation:

“when thoughts of suicidal pop into your mind, how long to they typically stick around?”

Assess intensity of suicidal urges:

“on a scale of 0-10, how intense are your current urges to kill yourself?”

Plan and Intent

Assess the presence of a plan:

“have you thought of a plan to kill yourself?”

Assess specificity of plan:

“When would you plan to kill yourself?”

“Where would you plan to kill yourself?”

“How would you plan to kill yourself?”

“are you taking precautions so that if you act, no one can stop you or interfere or save you?”

Assess intensity of intent:

“how intent are you in carrying out your plan to kill yourself?”

“on a scale of 0-10, how intent are you in acting on this plan?”

Access to Means

Assess the presence of means:

“do you have access to a gun? Do you have access to lethal dosages of medications? Do you have access to poisons?”

Assess for presence of means for any previous suicide attempts:

“in the past, what means did you utilize to attempt to kill yourself?”

REMOVE ACCESS TO MEANS!

Always remove/restrict access to the means

Never leave a person or isolated who is at high risk

Suicidal Behavior likely in **next several hours**

- Suicide Note Written or in progress
- Methods are available or easily obtained
- Alcohol consumption; current overuse of medications
- Isolation
- Precautions against discovery; deception or concealment of timing
- 1st 24 hours of Imprisonment/Jail

Note. Adapted from Linehan, M.M. (1993). Cognitive Behavioral Treatment of Borderline Personality Disorder. New York, NY: Guilford Press.

Guide to Establishing Safety

1. Gain Commitment to Staying Safe
2. Remove ANY Lethal Means
3. Create Safety Plan
4. Gain Commitment to Safety Plan
5. Troubleshoot

Note. Adapted from Linehan, M.M. (1993). *Cognitive Behavioral Treatment of Borderline Personality Disorder*. New York, NY: Guilford Press.

Guidelines for Suicide Intervention

- Guide the person in defining the problem
- Focus on the MAIN issue
- Emphasize temporary nature of problem
- Explore possible solutions
- Aim at reducing pain, pressure, agitation
- Aim to resolve immediate crisis and Refer

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Learning Objectives

What do you want to walk away knowing?

- What behaviors constitute self harm and how this differs from suicidal ideation or behaviors
- Prevalence of self harm behaviors in children and adolescents
- Learning the function of self harm behaviors
- Assessing safety with self harm behaviors
- Responding to self harm behaviors

Rates of Self Harm in Missouri

	Male	Female	Total
Cut, scratched or hit myself on purpose to hurt myself	7.8%	22.9%	15.5%
Pulled my hair or eyelashes	2.5%	7.0%	4.7%
Swallowed more medicine than a doctor told me to take to hurt myself	0.9%	7.1%	3.9%
Burned myself	0.9%	5.9%	3.3%
Used drugs or alcohol to hurt myself	0.7%	4.7%	2.6%
Other	3.0%	3.3%	3.1%
Swallowed something on purpose that was not food, drink or medicine in order to hurt myself	0.1%	0.9%	0.5%

About 18% of Missouri students reported self harm behaviors, with females much more likely to engage in this behavior than males (25.3% vs. 10.5%)

What is Non Suicidal Self Injury (NSSI)?

- "the intentional destruction of one's own body tissue without suicidal intent and for purposes not socially sanctioned" – Nock, 2009
- NSSI is
 - Intentional
 - Physical
 - Differentiated from repetitive behaviors such as those seen in autism
 - Suicide attempts- definitional distinction based on lack of intention to die
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NSSI and Emotion Dysregulation

- “Suicidal and other impulsive, dysfunctional behaviors are usually maladaptive solution behaviors to the problem of overwhelming, uncontrollable, intensely painful negative affect.” – Marsha Linehan
- The act of physically injuring oneself can be very effective in relieving intense emotional pain
- Sometimes can be effective in eliciting helping behaviors from the environment
- Often becomes strongly reinforced method of coping

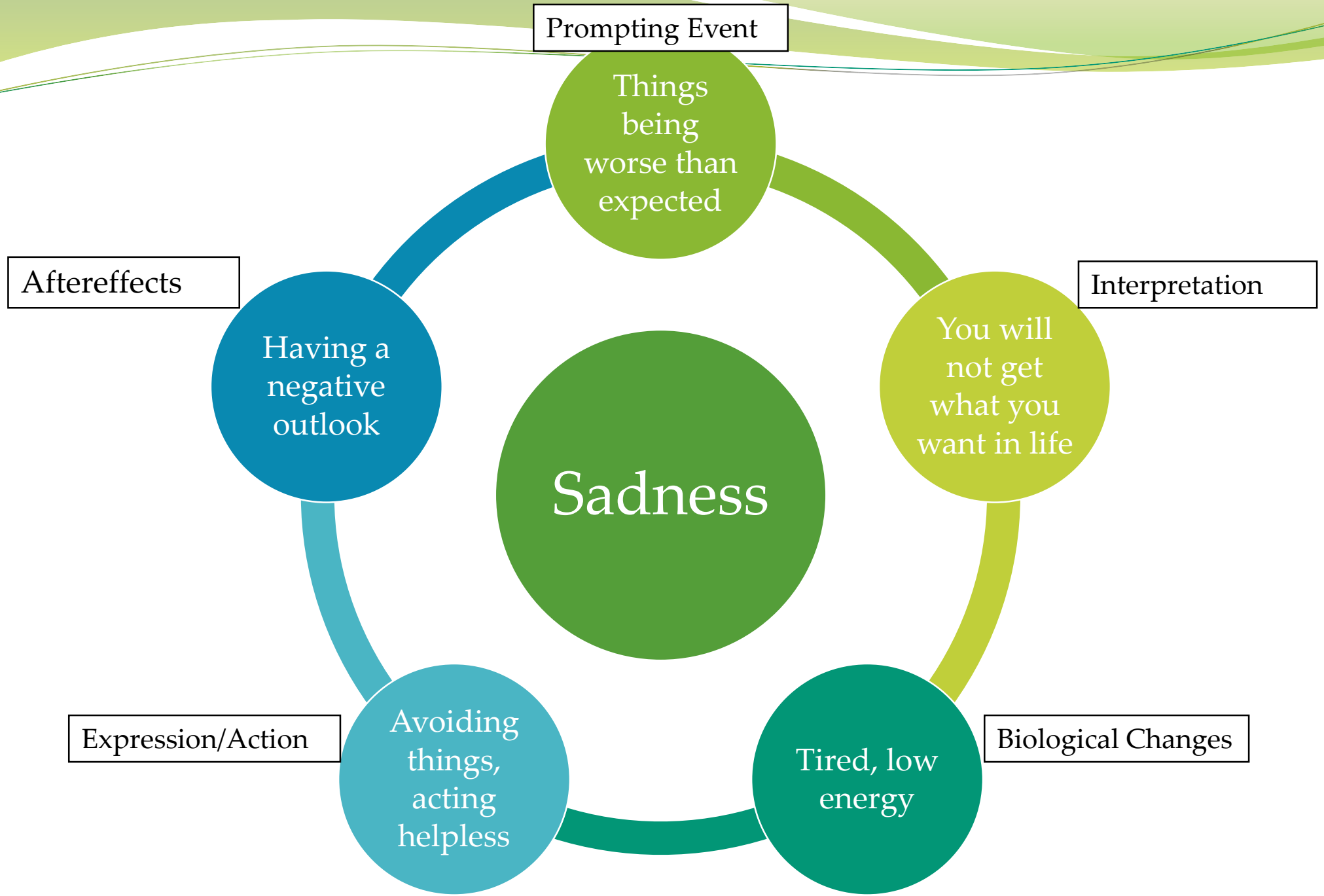
Factors influencing NSSI

Respondent

- The behavior is an automatic response to a situation or specific stimulus
 - External triggers – something happening outside the client, in the environment (example: bad grade on a test)
 - Internal triggers – occurring in the client's mind (example: thoughts, feelings, judgments, flashbacks)

Operant

- The behavior is under the control of the consequences.
 - Functions to affect the environment
 - When behaviors function to get others involved
 - Avoid the trap of labeling the behavior as “manipulative”





Responding to NSSI

Affect

- Pay attention to the affect a client is expressing.
- Communicate the validity of their feelings and provide opportunity for emotional ventilation.

Explore

- Help focus them on what exactly happened and reduce discussion of all negative events.
- Identifying key prompting events of current crisis.
- Formulate and summarize the problem situation.

Responding to NSSI

Focus

- Focus on problem solving.
- Model breaking a problem down into small parts.
- Highlight more than one way to address a problem.
- Highlight long term consequences to options.
- Ask the question “What’s getting in the way?”.

Tolerance

- While validating a client’s pain you can also express the necessity to tolerate the negative emotion experience.
- “If I could take away your pain I would, but I can’t. Sometimes pain has to be tolerated”

Responding to NSSI

Commitment

- Make effort to persuade the client to agree to a plan of action.
- Time limited and explicit on tasks/skills to be completed.

Assess Suicide

- Especially if suicidal ideation is discussed in the context of self harm urges.
- Reassess their suicide risk at the end of the interaction and use risk assessment procedures.

Involving Parents/Caregivers

- The context of your setting will influence this decision
- If your setting does not have strong policy regarding reporting self harm behaviors...
 - Adolescents may be less likely to disclose these behaviors if parents are alerted, there can be a strong shame response
 - Validate parents concerns about self harm and
 - Encourage adolescent to discuss the behavior with their family and individual psychotherapist (if present)

Involving Parents/Caregivers

- The context of your setting will influence this decision
- If your setting does have strong policy regarding reporting self harm behaviors to administration or family
 - Provide ample validation to adolescent that this is upsetting to them and you understand their point of view.
 - Highlight the option to reach out to you for help problem solving and tolerating emotions even if they feel they choose to not disclose their self harm to you



Questions?

