Addressing Self-Harm Disorders in Schools

Jim Raines, Ph.D., LCSW

Conference on Advancing School Mental Health

October, 2018

Conditions for Further Study

In the DSM-5, Section III: Emerging Measures and Models under Conditions for Further Study, two new disorders are proposed:

- *Suicidal behavior disorder*
- *Nonsuicidal self-injury*

Suicidal Behavior Disorder

- The individual has made a suicide attempt within the past 24 months.
- The act does *not* meet the criteria for nonsuicidal self-injury.
- The diagnosis does *not* apply to suicidal ideation or preparatory acts.
- The act was *not* initiated during a state of delirium or confusion.
- The act was *not* undertaken solely for a political or religious objective.

The *essential* feature of suicidal behavior disorder is that the individual had at least some intent to die.

Research on Risk

- Imminent risk is notoriously difficult to determine.
- More reliable markers include the degree of planning, a cognitive state that is extremely agitated, and recent discontinuation of a mood stabilizer (e.g., lithium).
- Less reliable markers include a willingness to talk about the future or signing a no-suicide contract

Rudd, Mandrusiak, & Joiner, 2006; Stanley & Brown, 2012

Proposed Specifiers

- Violence of the method of self-injury
  - Violent: Gunshot wounds, Hanging, or Jumping
  - Nonviolent: overdoses of legal or illegal substances
- Degree of remission
  - Current: <12 months since last attempt
  - Early remission: Last attempt 12-24 months

Nonsuicidal Self-Injury

A. The individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body
B. The individual engages in the self-injurious behavior with one or more of the following intentions:
   - To obtain relief from a negative feeling or cognitive state
   - To resolve an interpersonal difficulty
   - To induce a positive feeling state

Nonsuicidal Self-Injury (cont'd)

C. The intentional self-injury is associated with at least one of the following:
   - Interpersonal difficulties or negative moods or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring immediately prior to the act of self-injury.
   - Prior to engaging in the act, a period of preoccupation with the intended behavior that is difficult to control.
   - Thinking about self-injury that occurs frequently even if it is not acted upon.

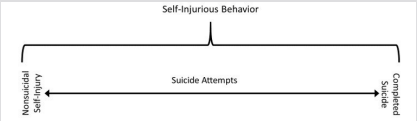
The *essential* feature of nonsuicidal self-harm is that the individual repeatedly inflicts superficial, yet painful injuries to the surface of the body

Exclusionary Criteria

- The behavior is *not* socially sanctioned (e.g., body piercing, tattooing) and not restricted to scab picking or nail biting.
- The behavior does *not* occur exclusively during delirium, intoxication, psychotic episodes, or substance withdrawal.
- The behavior is also *not* better explained by another mental disorder, such as excoriation, stereotypic movement disorder, or trichotillomania.

Why only Proposed Disorders?

- Both conditions have been recognized for decades (e.g., Graff & Mallin, 1967)
- Debate is whether the conditions are categorical or on a continuum?



Standard Terminology

- *Completed Suicide*: A self-injurious behavior that resulted in fatality and was associated with at least some intent to die as a result of the act.
- *Nonsuicidal Self-Injury* (NSSI): Self-injurious behavior associated with *no* intent to die. The behavior is intended *purely* for other reasons.
- *Self-Injurious Behavior*: Self-injurious behavior where associated intent to die is unknown and cannot be inferred.
- *Suicidal Ideation*: Passive thoughts about wanting to be dead or active thoughts about killing oneself.
- *Suicide Attempt*: A potentially self-injurious behavior, associated with at least some intent to die, as a result of the act.

Columbia Classification Algorithm of Suicide Assessment (Posner, Oquendo, Gould, Stanley, & Davies, 2007)

Prevalence Rates

- In 2015, adolescents and young adults aged 15 to 24 had a suicide rate of 12.5 per 100,000.
- Growing fastest in pre- and early adolescent girls, ages 10-14
- Increasing among African American children, ages 5-11
- Growing twice as quickly among rural youth.
- 80% of high schoolers who made a plan also made an attempt, 98% needed medical tx.
- Prevalence rates of NSSI are notoriously difficult to determine (~2.7% in the United States).

Bridge, et al., 2015; Fontanella, et al., 2015

Differential Diagnosis

	Suicidal Behavior	NSSI
Purpose	To escape pain or terminate consciousness	To reduce or communicate psychological distress
Methods	Usually one method	Usually multiple methods
Pain	Pain is persistent and unendurable.	Pain is intermittent and uncomfortable.
Hope	Client feels hopeless and helpless.	Client experiences periods of optimism and self-control
Restraint	Restriction of means is usually life-saving.	Restriction of means is often inadvertently provocative.
Repetition	Suicidal behavior is rarely repeated.	NSSI is often chronic.
Core Issue	Severe depression	Body alienation

Walsh, 2012

Differential Diagnosis (cont'd)

Borderline Personality Disorder:

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five or more of the following:

- Frantic efforts to avoid real or imagined abandonment.
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
- Identity disturbance: markedly and persistently unstable self-image or sense of self
- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
- ***Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.***
- Affective instability due to marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours or only rarely more than a few days).
- Chronic feelings of emptiness.
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- Transient, stress-related paranoid ideation or severe dissociative symptoms.

Screening

- ASQ:
  - Are you here because you tried to hurt yourself?
  - In the past week, have you been having thoughts about killing yourself?
  - Have you ever tried to hurt yourself in the past (other than this time)?
- Mini Suicide Scale:
  - In the past 6 months, did you:
    1. Think you would be better off dead (Yes = 1 point)
    2. Want to hurt or injure yourself? (Yes = 2 points)
    3. Think about suicide? (Yes = 6 points)
    4. Have a suicide plan? (Yes = 10 points)
    5. Attempt suicide? (Yes = 10 points)
  - In your lifetime, did you:
    6. Ever make a suicide attempt? (Yes = 4 points)

Crisis Team Composition

- School administrators have a duty to ensure a safe school environment.
- School resource officer can be help with:
  - Search warrant(s)
  - Weapons confiscation (esp. firearms)
  - Assistance with transportation to a hospital
- School-based mental health provider:
  - Skilled in suicide assessment,
  - De-escalation techniques,
  - Familiar with community mental health resources
- Teacher or Coach may be able to corroborate concerns from other students.
- Parents may be able to shed light on familial mental health issues, home stressors, and health insurance coverage.

Suicide Assessment Instruments

- Columbia-Suicide Severity Rating Scale (C-SSRS) has good content and predictive validity.
- A composite of the Suicide Ideation Questionnaire for young adolescents (SIQ-Jr), Alcohol Use Disorders Identification Test–Consumption subscale (AUDIT-C), and the Reynolds Adolescent Depression Scale (RADS-2) did best.
- Modular Assessment of Risk for Imminent Suicide (MARIS) has two parts (Galynker, 2017):
  - Client Scales:
    - Suicide Trigger Scale - Short Form (8 items)
    - Suicide Opinion Questionnaire - Short Form (7 items)
  - Clinician Scales:
    - Short Clinical Assessment of Risk for Suicide (7 items)
    - Therapist Response Questionnaire - Short Form (10 items)

Risk Assessment

1. Suicidal ideation or intent
2. Distinguish between risk factors & warning signs
3. Consider strengths and protective factors
   - Internal and External
4. Identify precipitating events or triggers
   - Acute or Chronic
5. Assess the degree of planning
6. Obtain collateral info from concerned others
   - Assess emotional regulation
   - Consider whether suicide contagion is a factor
7. Combine all facts into a summary and recommendation

Emotional Regulation

1. How emotionally aware is the student? Can they name their feelings?
2. How composed is the student during emotional stress?
3. How proportionate is the student's response to emotional stress?
4. How quickly does the student regain emotional control?
5. Can the student resist peer pressure?
6. Does the student abstain from drugs or alcohol?
7. Has the student attempted suicide within the past two years?

NSSI Assessment Instruments

- Self-Injurious Thoughts and Behaviours Interview (SITBI) uses an conversational format to distinguish between NSSI and generic self-harm.
- Non-Suicidal Self-Injury–Assessment Tool (NSSI-AT) Non-Suicidal Self-Injury–Assessment Tool (NSSI-AT) uses self-report to distinguish between NSSI and Suicidal Intent.

Bottom Line: Never assume a student is just "cutting" and not "rehearsing."

JCR SSWAA 19

Tier 1: Prevention

- NREPP recommends the Signs of Suicide program:
  - Two-day intensive program for youth 13-18 yrs. old.
  - Effective in reducing self-reported suicidal behavior;
  - BUT may produce little or no change in suicidal ideation or help-seeking.
- Gay-Straight Alliance (aka Genders & Sexualities Alliance) student club.

JCR SSWAA 20

Tier 2: Targeted Interventions

- Question, Persuade, & Refer (QPR) program for teachers or school staff
- Applied Suicide Intervention Skills Training (ASIST) for teachers or school staff
- Emotion Regulation Group Therapy (ERGT) for at-risk students

JCR SSWAA 21

Tier 3: Intensive Interventions

- Interpersonal Therapy for Adolescents (IPT-A)
  - Twice/week therapy to adolescents
  - 3 family sessions
  - Weekly phone consultation/availability
- CBT for suicide prevention (CBT-SP) + Pharmacotherapy
  1. Chain analysis of the events leading up to the suicide attempt,
  2. Safety planning to reduce subsequent suicide risk using both internal and external strategies,
  3. Addressing reasons for living and building hope,
  4. Case formulation of the youth's specific cognitive, behavioral, emotional, and contextual assets and problems, and
  5. Harnessing strengths and acquiring skills (e.g., problem-solving)

Tier 3: Intensive Interventions

- Dialectical Behavior Therapy +
  - Individual Therapy for youth
  - Multi-Family Skills Group
  - Phone-based "coaching" between sessions
  - Weekly consultation team meetings
- 4-week "Walking the Middle Path" module:
  - Reduce emotion dysregulation by enabling them to understand others' perspectives,
  - Find a middle ground when there are disagreements, and
  - Receive validation from their caregivers

Safety Plans

- Not the same as "No-suicide contracts"
- Focuses on *contingency planning*, not false promises:
  1. Warning signs (not risk factors)
  2. Internal coping strategies
  3. External coping strategies
  4. People who can help
  5. Professionals who can be called
  6. Making the environment safe (pills, guns)

Postvention Purposes

- Facilitate the healing of individuals from the grief and distress of suicide loss
- Mitigate other negative effects of exposure to suicide
- Prevent suicide among people who are at high risk after exposure to suicide

Postvention Dos & Don'ts

- Plan a meeting of the crisis team to review specific roles and responsibilities
- Provide psychoeducational information about suicide prevention to the public.
- Provide support to grieving peers or staff using scheduled appointments with qualified mental health professionals.
- Appoint a media spokesperson who will respond appropriately for requests for information about the student that follow FERPA confidentiality rules.
- Monitor social media channels to identify students who may be posting ideas or plans about joining or copying the decedent.
- Don't assume that the entire crisis team remembers their role or responsibility.
- Don't exaggerate or sensationalize the incidence or prevalence of youth suicide.
- Don't allow students to spend unlimited time in designated "grief rooms" at the school where they can ruminate about the death.
- Don't allow any school staff to provide private details to the media that are not considered public information or violate the decedent's confidentiality.
- Don't engage students on social media or blur professional and personal boundaries by "friending" students who seem to be grieving.

Dos & Don'ts (cont'd)

- Screen high-risk individuals who have suicidal thoughts or make suicidal gestures following the suicide of a peer.
- Encourage local media to practice responsible journalism and avoid sensationalizing the decedent's death.
- Identify key school staff who will represent the school at the decedent's funeral. Everyone should not go.
- Provide teachers with a script to share with classes and encourage them to share rumors heard from students.
- If parents or others want to memorialize the decedent, encourage them to support the school's suicide prevention program
- Don't assume that students with suicidal ideation or gestures are just seeking attention or sympathy from others.
- Don't ignore local media when they practice irresponsible journalism or neglect to send a letter to the editor about the coverage.
- Don't hold a school assembly to eulogize the student and characterize him/her as a tragic hero.
- Don't forget that teachers may also be affected by the loss or neglect to encourage them to engage in healthy self-care.
- Don't memorialize the student by making a plaque or planting a tree to glorify his or her memory.