

Assessing for Suicidal & Non-Suicidal Self-Injurious Behavior: A Clinical Approach

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Points to Ponder!

- “Any therapist, regardless of how competent, successful, and skilled, may lose a client through suicide. What will distinguish this therapist from another who was clearly negligent, careless, and indifferent to her/his client’s suicidal state is the presence of a well-documented, thorough client record” (Freemouw, Perczel, & Ellis., 1990, p. 10).

Telling Questions

- How would you define self-injurious behavior?
- What are your feelings/reactions/ attitude towards self- injurious behavior?
- What are your reactions/ feelings towards people who self- injure or who have previously engaged in self-injurious behavior?

Definitions

- **Non-Suicidal Self Injury (NSSI)**- Episodic self-injurious behavior (SIB) (e.g. cutting, burning, choking game) is observed among normally developing children and adolescents.
- Chronic and severe SIB is more common among people with developmental or psychiatric disabilities or other special populations such as prisoners.
- NSSI may be related to specific biological conditions or syndromes.
- NSSI can be used for attention-seeking, self-stimulation, or for communication (to either get or avoid something).
- Self-injurious behavior occur without suicidal intent
- NSSI is primarily conceptualized as a tool for emotion regulation (Nock & Prinstein, 2004)
- Effective intervention programs identify and remedy the cause, and teach replacement behaviors.

Telling Questions

- What is suicide?
- What are your feelings/ reactions towards suicide?
- What are your reactions/ feelings towards people who are suicidal?
- What are your reactions/ feelings towards people who have attempted suicide?

Suicide Defined

- According to **Butterworth's Concise Australian Dictionary**: *Suicide can be defined as the deliberate act of taking one's life.*
- **Kosky et al.** further observes that *suicidal behavior can be interpreted as a manifestation of distress associated with loss or abandonment, a release from despair, an expression of hostility or revenge, an appeal for help, a wish to test fate or to be reunited with a loved one, or a response to the disordered thinking of a psychotic illness or drug intoxication.*
- **David Lester** argues that *death caused by one's own voluntary act is not necessarily a sufficient criterion to use when judging whether the psychological process of suicide has occurred. There are examples of cases where people have died accidentally by suicide and other examples of cases where a person intended to die but who lived because they were accidentally found.*

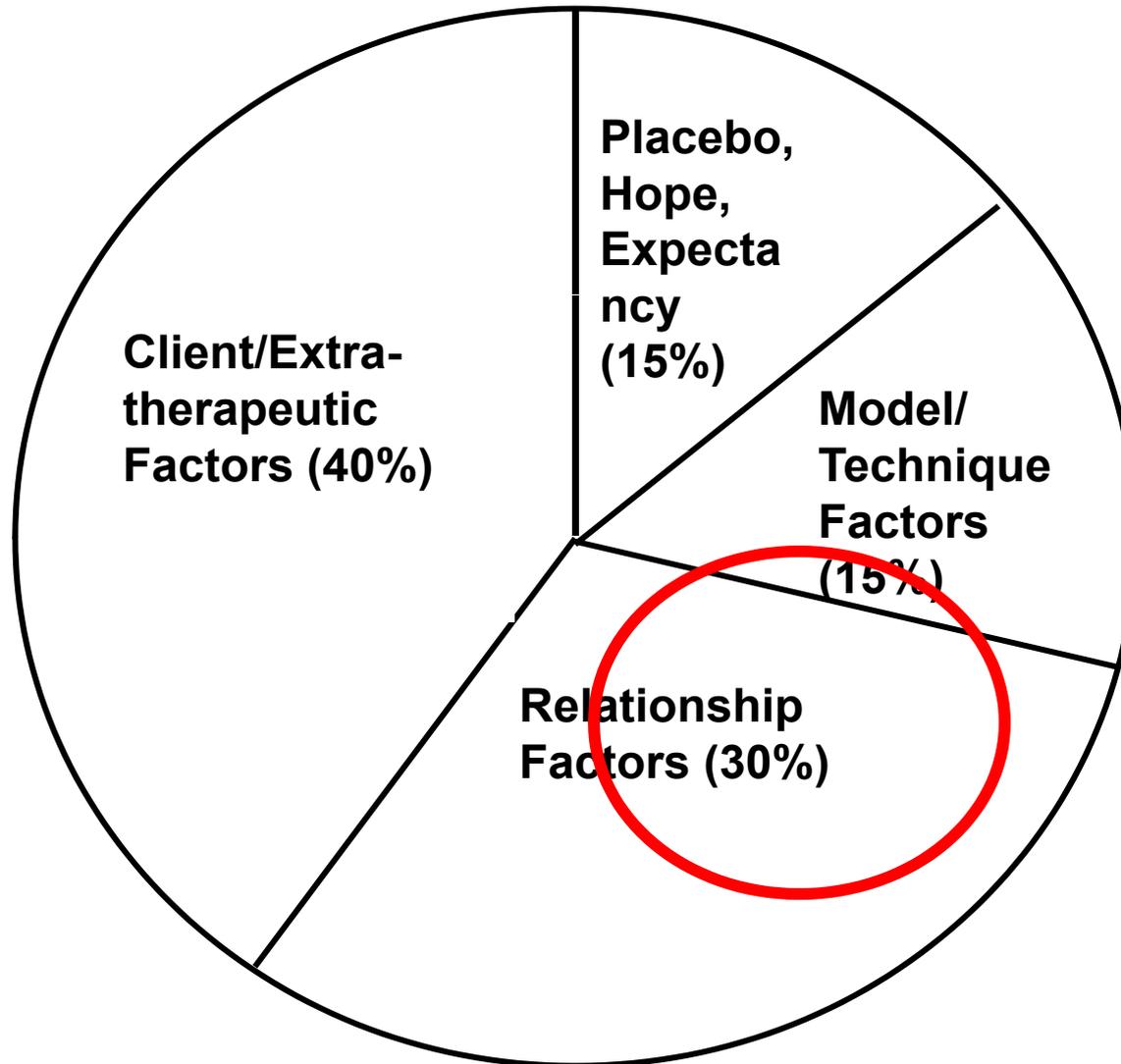
The Use of Assessment Instruments

- Various instruments have also been used assessing for suicide risk. These include assessments such as the :
 - ✓ Hopelessness Scale (Beck, Weissman, Lester, & Trexler, 1974)
 - ✓ The Beck Depression Inventory (Beck & Steer, 1987)
 - ✓ The BDI-II (Beck, Steer, & Brown, 1996) that were not specifically designed to measure suicide ideation, but what is measured correlates with suicide ideation.
- In addition, there have been instruments developed specifically to assess for suicide ideation. These instruments include:
 - ✓ Beck Scale for Suicide Ideation (BSSI) (Beck, Kovacs, & Weissman, 1979)
 - ✓ Suicidal Ideation Scale (SIS) (Rudd, 1989)
 - ✓ Suicide Behaviors Questionnaire (SBQ) (Cole, 1988)
 - ✓ Reasons for Living Inventory (Linehan, Goodstein, Nielsen, & Chiles, 1983)
 - ✓ Suicidal Ideation Questionnaire (Reynolds, 1987)
 - ✓ MMPI-A

Assessments for Adolescents/ College Populations

- Some of the above instruments have also been validated for use with **adolescent** or **college populations**. In addition, there are instruments that have been specifically developed for these populations.
 - ✓ **College Student** Reason for Living Inventory (Westefeld, Cardin, & Deaton, 1992)
 - ✓ Suicidal Ideation Questionnaire – **Junior High version**
 - ✓ Multiattitude Suicide Tendency Scale – **for adolescents** (Orbach, Milstein, Har-Even, Apter, Tiano, & Elizure, 1991)
 - ✓ Fairy Tales Test (Life and Death Attitude Scale for the Suicidal Tendencies Test (**for children 10 and younger**)) (Orbach, Feshbach, Carlson, Glaubman, & Gross, 1983)

Common Factors Model of Counseling Outcomes (Hubble, Duncan, & Miller, 1999)



Questions to Guide Suicide Assessment

- Either as part of an intake assessment, or based on information you have gathered indicating that a suicide assessment is in order, the starting point is (Frierson et al , 2002):
 - ✓ Ask directly if the client has thoughts of suicide.
“Have you thought of committing suicide?”
 - ✓ “Are you thinking of killing yourself?” In this case, subtlety is counterproductive.
 - ✓ If the response is **YES** “How often have you had these thoughts?”
 - ✓ “ Do you have a plan on how you are going to kill yourself?”

To continue or not to continue with assessment!

- If the answer is anything but a confident “NO”, then assessment should proceed.
- Even in cases when a client answers by saying “NO”, continued exploration and discussion of what the client has said or presented that may be related to suicidal ideation is warranted.

(Frierson et al , 2002).

Cont...Assessment

- ✓ Have there been previous attempts? (When, surrounding circumstances, rescuer?)
- ✓ For example: “When?” “How often?” “What happened?” “What was going on in your life at the time?”
- ✓ *If attempts were made, then exploration of method and rescuer should be explored.
- ✓ *If the client indicates having thoughts or having made attempts in the past, even if there is no current ideation, past experiences should be thoroughly explored.

(Frierson et al , 2002).

Cont...Assessment

- *If the client does not answer questions about suicide, the answers are vague, or if the client conveys that he/she has entertained thoughts of suicide then...
 - ✓ Are the thoughts pervasive or intermittent?
 - ✓ When was the last time the thought occurred to the client?
 - ✓ Do these thoughts typically occur in times of crisis?
 - ✓ Is there a specific precipitating event?
- *Even if answers to these questions continue to be vague or seem to be more intermittent, ideas of how the person might commit suicide need to be explored.

Explore the plan.....

- Is there a plan? What are the details of the plan? How extensive is the plan?
- Examples: “How have you thought of killing yourself?” “When would you carry out the plan?” “Do you have a date and time?” “Where would you be?” “Who would you want to find you?”
- What is the lethality of the means/method?
- Is there access to the identified means?
- Examples: “If you were to commit suicide, how would you do it?” “Do you have the pills?” “Where are they?” “What type of pills would you take?” “What type of gun?” “Where would you get the gun?” “Do you have bullets?” “Where is the gun? The bullets?” “Do you have a rope/cord?”

Interventions!

- The previous questions have related specifically to suicide ideation. In addition, questions that **assess for risk** and **protective factors** are explored. All of this information aids in determining risk and subsequent interventions.
 - ✓ *Is the client using drugs or alcohol?*
 - ✓ *What are the client's social supports?*
 - ✓ *Does the client have a religious or spiritual affiliation?*
 - ✓ *How is the client discussing suicide and potential aftermath?*
 - ✓ *Do fantasies seem to be positive or painful?*
 - ✓ *Is the client able to see any alternatives to suicide?*
 - ✓ *How does the client respond to challenges to distorted thinking?*

Counselor Skills & Behaviors

- There are Important skills, attitudes, knowledge and behaviors when working with clients in crisis or with suicidal ideation:
 - ✓ Remain calm and controlled
 - ✓ Exhibit respect for the client
 - ✓ Problem-solving skills
 - ✓ Active listening
 - ✓ Trustworthiness
 - ✓ Restatements/ paraphrases
 - ✓ Sincere
 - ✓ Directive
 - ✓ Reflections of feelings
 - ✓ Empathic
 - ✓ Cognitive disputation
 - ✓ Be able to Challenge and confront client
 - ✓ Ability to develop a Contract
 - ✓ Ability to involve client in making decisions and contributing to problem-solving

Potential Actions/ Interventions

- Make psychological contract
- Conduct an assessment
- Identify the message! What will committing suicide do for you? What problem will it solve/
- Identify reasons for living! What purpose would it serve to live? How would he/others benefit?
- Define and impose goals
- Expand client's view of the problem
- Build on client's strengths
- Support of client/ availability to client

Potential Actions/ Interventions

- Develop a safety contract also known as/ no-harm contract/ suicide prevention contract/ no-suicide decision agreement
- Remove means-suicide weapons/ substance etc
- Engage social/ family support/ increase sessions/ contacts with client
- Voluntary hospitalization
- Involuntary hospitalization

Negligence

- Brems (2000) summarized the following questions related to negligence:
 - ① Was the counselor aware or should have been aware of the risk?
 - ② Was the counselor thorough in assessment of the client's suicide risk?
 - ③ Did the counselor make "reasonable and prudent efforts" to collect sufficient and necessary data to assess risk?
 - ④ Were the assessment data misused, thus leading to a misdiagnosis where the same data would have resulted in appropriate diagnosis by another mental health professional?
 - ⑤ Did the counselor mismanage the case, being either "unavailable or unresponsive to the client's emergency situation?"
 - ⑥ Was the counselor negligent in the way she/he designed her/his intervention with the client after assessing risk?
 - ⑦ Did the counselor make adequate attempts to keep the client safe (i.e., set up a plan of contingencies with appropriate resources, phone numbers, etc)? Did the counselor remove the means to be used by the client in the suicide attempt?
 - ⑧ In cases of minors, were parents or caretakers informed of the client's potential risk?

Counselor Duty

- The following are considered reasonable duty for counselors in terms of suicide prevention (Remley & Herlihy, 2001):
 - ✓ Counselors must know how to make assessments of a client's risk for suicide and must be able to defend their decisions
 - ✓ When a decision is made that the client is a danger to self, counselors must take whatever steps are necessary to prevent the harm
 - ✓ Actions to prevent harm must be the least intrusive to accomplish that result

How to protect yourself and your clients

Counselors should:

- ① Inform clients of the limitations of confidentiality through standard “informed consent” procedures.
 - ② Begin their study of suicide assessment prevention early and continue to stay current through professional development activities regarding suicide and crisis intervention and ethical/legal issues in counseling (Laux, 2002)
 - ③ Be familiar with suicide risk factors , procedures for suicide assessment, and guidelines for intervention (Brem, 2000)
 - ④ Abide by the standard of practice to consult with other mental health professionals (Remley & Herlihy, 2001)
 - ⑤ Must properly document the process of suicide assessment and intervention through case notes and reports (Brem, 2000)
- As reported by Brems (2000), *“as long as mental health and health professionals have been able to show prudent and responsible care (through assessment of risk and tailored intervention planning), the courts have tended to rule in favor of the practitioner”* (p. 166).

***SAD PERSONS**

(a mnemonic for assessing suicide risk)

- **Sex** (male)
- **Age** (elderly or adolescent)
- **Depression**
- **Previous suicide attempts**
- **Ethanol abuse**
- **Rational thinking loss** (psychosis)
- **Social support lacking**
- **Organized plan to commit suicide**
- **No spouse** (divorced /widowed/single)
- **Sickness** (physical illness)

Adapted from Patterson et al (1983).

Cognitive Behavioral Therapies for NSSI-B

- Problem Solving Therapy (PST; D’Zurilla & Goldfried, 1971)
 - PST assumes that dysfunctional coping behaviors result from a cognitive or behavioral breakdown in the problem solving process (D’Zurilla & Nezu, 2001)
- Dialectical Behavior Therapy (DBT; Linehan, 1993)
 - DBT is based upon a conglomeration of Zen Buddhism, cognitive-behavioral interventions, problem solving, and skills training
 - The core dialectical principle underlying DBT is a balance between encouraging the client to change and accept him or herself simultaneously
- These treatments share common features:
 - *Time limited*
 - *Structured therapies with immediate targeting of NSSI*
 - *Focus on remedying skill deficits*

Problem Solving Therapy (PST; D’Zurilla & Goldfried, 1971)

- “The goal of PST is to help clients identify and resolve the problems they encounter in their lives, as well as teach clients general coping and problem solving skills that they can utilize in the future to deal more effectively with the problems they encounter” (Muehlenkamp, 2006).
- Steps of problem solving:
 - Problem identification
 - Goal setting (utilizing behavioral analysis of the problem)
 - Brainstorming & assessing potential solutions
 - Selecting & implementing a solution
 - Evaluating the success of a chosen solution
- * Teaching these skills is critical in the therapy process since people who engage in NSSIB have been found to exhibit poor problem solving skills and tend to have rigid thinking styles

1993)

- Pre-treatment phase:
 - Orienting client to the therapy
 - Obtaining a commitment agreement for therapy
 - Stage one focus is on reducing NSSI or suicidal behavior
 - Validations of clients experience
 - Problem solving techniques/ teaching of adaptive techniques
 - Behavioral skills training in mindfulness, emotion regulation, interpersonal effectiveness, distress tolerance etc
 - Maintaining therapy compliance as well as reducing distress associated with Axis 1 disorder
 - Stage two addresses ways of dealing with traumatic experiences and invalidating environments
 - Stage three emphasizes developing and maintaining self-respect while synthesizing skills learned

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