Safety Planning with Self-Injurious Youth in a Clinical Setting: Best Practice Recommendations and Cautions

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Workshop Objectives

1. Identify and explain the components of a safety plan for suicidal and self-injurious youth.
2. Clarify when to apply a safety plan for self-injurious youth.
3. Describe how to collaborate with parents and caregivers in the implementation of the safety plan.
Distinction Between Self-Harm and Suicidality

- Self-injurious behavior involves tissue damage with NO intention of dying.
- The terms Self-Injurious Behavior (SIB) and Non-Suicidal Self-Injury (NSSI) are often used interchangeably.
- Suicidality includes thoughts and behaviors with the intention of death.
Suicide Continuum

- Passive death wish
- Suicidal ideation no method
- Suicidal ideation with plan

Suicidal Ideation

Non-suicidal self-injury

Suicide Attempt
Completed Suicide

Brent et al., 1988
Risk Factors For Adolescent Suicide

- Depression or bipolar disorders
- Hopelessness
- Drug or alcohol use
- Availability of firearms
- High suicidal intent
- Previous attempt
- Co-existing condition
- Exposure to suicide
- Suicidal behaviors
- Self-harm behavior
- Behavior problems
- Current or past abuse
- Legal or disciplinary crisis
- Engaging in bullying behavior - target or bully
- Lack of treatment
- Family history of suicidal behavior
Five Critical Domains to Assess For Suicidal Teen

- Characteristics of the suicidal behavior
- Current and lifetime psychopathology
- Psychological characteristics
- Family and environmental factors
- Availability of lethal agents (e.g. firearms, medications)
Details Of Most Recent Suicidal Episode

- What was immediately happening prior?
- What thoughts were going through his/her head?
- How “close” did s/he come?
- If an attempt, what did s/he use?
- Did s/he tell anyone?
- Did anything stop him or her?
NSSI (Non Suicidal Self Injury) and Suicidal Behavior

- NSSI and suicidal behavior commonly co-occur in teens
  - 70% of teens who engage in NSSI report lifetime history of suicidal behavior

- NSSI is a risk factor for suicidal behavior
  - longer history of NSSI
  - more methods
  - absence of physical pain during NSSI

(Nock et al., 2006)
A Word Of Caution...

The prediction of future suicidal behavior is NOT measurable; however, research does identify risk factors and “favorable” conditions for a completed suicide.
Statistics and Research

• A reported 13% to 23% lifetime prevalence of self-injury. Often beginning between ages 13 and 15 (Muehlenkamp & Gutierrez, 2004).

• One in five youth suffer from a diagnosable emotional disorder and yet only 20% of these youth get appropriate treatment (Kaffengerber & Seligman, 2007).

• Nearly 1/5 teens reported suicidal thoughts & about 1/10 attempted suicide (National Center for Health Statistics, 2006)

• No sex or SEC differences identified in NSSI (Nock, 2006)
Summary

- Self-injury is distinct from suicidal behavior and also a risk factor for suicidal behavior
- NSSI serves a function for the teen
- Use of chain analysis to understand self-injury
  - Triggers
  - Vulnerability factors
  - Emotional needs
  - Consequences/outcomes

(Goldstein and Poling, 2011)
Protective Factors Identified for Reducing Suicidal Behavior; None Identified for Self-injury

- Family and school connectedness (Kaminski et al., *J Youth Adol*, 2010)
- Reduced access to firearms (Grossman et al., *JAMA*, 2005)
- Safe schools (Eisenberg et al., *J Ped*, 2007)
- Self-esteem (Sharaf et al., *JCAPN*, 2009)
- Academic achievement (Borowsky et al., *Pediatrics*, 2001)

(Refer to Youth Suicidal Behavior Fact Sheet, National Center for the Prevention of Youth Suicide)
Implications for Mental Health Professionals

- Suicidal intent *must* be assessed with any client who engages in self-harming behavior.

- If there is a bleeding or seeping wound the nurse/medical staff should evaluate and treat.

- The media, internet, videos and music are mediums for parents to monitor.
Approaching Parents

- Voice concerns and observations
- Educate parents about self-injurious behaviors
- Address concerns of parents
- Assist with referrals for evaluation, higher level of care, and crisis intervention
- Collaboratively plan with teen, family, and referral
Research on Safety Planning

- Although many clinicians still rely on no-harm contracts there is no evidence they are effective (Lewis, 2007).

- American Psychiatric Association (APA) recommends against no-harm contracts with patients who are new, using substances, agitated, psychotic, or impulsive (2003).

- Instead, the APA (2003) recommends a collaborative plan created by teen, family, and clinician to enhance safety by using external and internal resources and minimizing triggers.
Purpose of Safety Plan

- A way to start a dialogue and open up barriers
- Give the teen a set of skills to use in crisis
- Convey an understanding of the seriousness of teen’s distress
- A collaborative effort
- No guarantees
Why Do Teens Self-Harm?

Top 3 reasons we see in the clinic:

1. To feel something vs. nothing
2. To feel physical pain rather than emotional pain
3. To punish oneself
Other reasons may include:

- Punish someone else
- Gain focus
- Not kill themselves
- Experiment
- Imitate others who self-injure
Why is the “why” important?

So the safety plan can address triggering situations and alternative/healthier ways to meet the teen’s underlying needs.
Common Characteristics of Self-Injurious Youth

These teens display a pattern of difficulty:

- Labeling or identifying their emotions
- Effectively regulating their emotions
- Trusting that their emotional experiences are valid
- Tolerating distress
- Effectively solving problems

(Miller, 1999)
What We (STAR Clinic) See in the Teen

• Critical, hostile statements toward self and feelings of guilt, shame, and anger when experiencing strong emotions.

• These reactions intensify the pain of the original emotion and further support the downward mood spiral.

• FAST, intense mood swings downward and SLOW return to baseline (regular) mood.
Characteristics of Families Whose Teens Self-Injure: An Invalidating Environment (Goldstein and Poling, 2011)

- Often reject the teen indiscriminately
- Punish emotional displays of teen and inconsistently reinforce emotional escalation
- Over-simplify and underestimate problem-solving and goal-setting
- Indulge the teen without inconsistency
Helping Families Understand Role of an Invalidating Environment

- Help both parents and teen to understand how their reactions to each other may be invalidating.
- "Kernel of Truth"
- Coaching parents to become more aware of the ways in which their communication is overly negative and critical.
Strategies to Help Parents Respond Calmly & Non-reactively to Teen’s Provocations

• Exit and wait

• Staying short and to the point

• Call a “truce”
Thoughts From Dialectal Behavior Therapy To Consider...

- People are doing the best they can and they must improve.
- Empathy for the client and the clinician are necessary.
- Skill development is essential.
- Individuals are responsible for their actions.
From A Behavior Modification Perspective...

- There is a pay-off in self-injurious behavior or teens wouldn’t do it.
- There is also a price to pay for engaging in self-injurious behavior; however, clients don’t always see it.
- The self-injurious behavior often becomes a habit unless it is replaced with another more appropriate behavior.
Although replacing the self-injurious behavior with a more benign behavior may be a helpful tool...

The goal is to help teens address their underlying reasons for self-harming.
Creating a Validating Environment

- Therapist must non-judgmentally acknowledge destructiveness of teen’s behavior.
- “You’re doing the best you can, AND you can do better.”
- Therapist refrains from criticizing the individual but instead focuses on negative consequences of specific behaviors.
Creating a Validating Environment (cont’d)

• Important to evaluate possible reinforcements for the teen to continue self-injurious behaviors (what does s/he gain/get from the behavior).

• ESSENTIAL to remain non-judgmental.

• Important not to advise teen to stop the behavior. Essential to collaborate.
Skills to Help Teens Decrease Self Injury: Refer to STAR Manuals

- Emotion education
- The Freeze Frame Technique
- Emotion Regulation Skills
  - Distress Tolerance
  - Sensory Soothing
- Communication Skills

- Download “Emotional Regulation, Distress Tolerance and Interpersonal Skill Development” manual at www.starcenter.pitt.edu
CAUTION

Constant monitoring of suicidal ideation should be conducted both clinically and by self reported levels of hopelessness and depression.
Formulating the Safety Plan

- Teen’s ability to problem-solve decreases in the intensity of an acute episode
- Written list of coping strategies; hierarchically arranged
- Developed collaboratively
- Results in a “promise” between teen, parent, and therapist that if teen has suicidal or self-injurious impulses, teen will inform a responsible adult
Formulating the Safety Plan (cont’d)

- At minimum the safety plan should include the telephone numbers of:
  - Social supports
  - Therapist
  - On-call therapist (if available)
  - Local 24 hour emergency psychiatric services
  - Other local support services that handle emergency calls
Formulating the Safety Plan (cont’d)

• Work collaboratively to develop specific coping strategies:
  • Development and use of coping cards - self coaching
  • Relaxation skills
  • Utilizing social supports
  • Construction of “Hope Kit”
Steps In A Safety Plan

- **ASK** the child if s/he can agree to not hurt him/herself while you arrange for help.

- **REHEARSE** strategies to help her/him cope with suicidal thoughts and feelings s/he may be having.

- **IDENTIFY** with the teen, trusted adults s/he can turn to if these feelings come back or get worse. When possible notify the identified person with how to help the teen.

- **INFORM** the child of which hospital s/he should call or go to if the situation gets worse and none of these adults can be reached.

- **AVOID** situations that make the teen want to self-harm or worsen suicidal feelings.
Thoughts vs. Acts

- Ask the teen to promise to remain “safe” and not to engage in further suicidal or self-injurious behavior between this session and next.

- Essential to distinguish that by agreeing to the “promise” the teen is NOT promising s/he will never experience another suicidal or self-injurious urge or thought.
Professionals who I can ask for help:
My therapist: ________________________________ Phone #: __________________________
Hospital ER: ________________________________ Phone #: __________________________
Crisis hotline/Other: __________________________
Setting the Stage: Making the Environment Safe

- Remove all weapons and means at least while teen is seeking and/or in treatment.

- At a minimum secure ammunition separate from weapon and keep medications under adult supervision and delivery.
Recognizing the Warning Signs

- When is my temperature getting “hot?”
- Have teen identify at least three thoughts, behaviors, moods, situations, feelings that may indicate self-injury or suicide ideation may occur
  - Withdraw, isolate, turn friends down
  - More irritable, get into arguments with friends
  - Don’t want to talk with anyone
Applying CBT to Address the Warning Signs

- If the warning sign is “I become easily annoyed” then help teen to identify the accompanying thoughts, feelings and behaviors:
  - What are you feeling?
    - Frustrated
    - Mad
  - What is the behavior?
    - I lash out
    - I withdraw
  - What are your thoughts?
    - “Nobody gets me”
    - “I am alone”
Help Teen to Identify Vulnerability Factors in the Environment

- How will you know when to use your safety plan?
  - Identify social situations, web sites, events, songs, substances that may trigger thoughts and urges to self-injure
  - Negotiate with teen to avoid activities that increase likelihood of self-injury
  - Use chain analysis to identify warning signs from prior instances of self-injury

(Goldstein and Poling, 2011)
Inserting Skills

• Collaborate with teen to develop skills to practice when urges to self-injure are low and high

• Identify more than one skill to try - include distraction as at least one skill

• Help the teen prioritize and practice if possible
Internal Strategies: Things I can do by myself for myself

• Write down all options - screen later - offer “suggestion lists” as needed

• Don’t be directive - Ask open ended questions:
  • “What could safely bring you—pleasure, relief, and/or distraction?”
    • Teen may answer something unrealistic like, “Not being around people.” Still write it down to validate teen.

• Troubleshoot options after brainstorming - “On a scale of 1-10 how likely are you to use your skill if you have the urge to self-injure?”
Helping Teen “Vet” their Options

- *Listen to music* - Clarify which music and the likely feelings generated by it. Find another song beside “our song” especially following a break up.

- *Go for a walk* - Be sure the time and place are safe and parents/adult knows where you are and when you are to return.

- *Take a nap* - Revisit sleep hygiene and time of day.
It helps to remember that although the safety plan is often developed within a context of therapy it is not meant to be therapy, but rather a “jumping off point.”

Knowing “why” a teen wants to self-injure or has suicidal ideation helps us to address their underlying needs.
Revisiting Reasons for Self-Injury & Generating New Ways to Cope: More Open Ended Questions

- Wanting to feel physical pain as opposed to emotional pain
- Wanting to punish self
- Wanting others to feel bad and notice pain

- Is there something else you can do physically?
- Is there some other way to reconcile the thing you did wrong or to make amends?
- Is there another way to communicate that you are upset with them?
Remember to discuss all barriers to the teen keeping his/her safety plan...including how and where they will keep it.

Problem-solve with the teen, parents and other caregivers to address the barriers.
If Teen can think of nothing

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Revisit teen’s motivation to keep him/herself safe. Hospitalization may be necessary. In Allegheny County we also have the re:solve walk in center as an option - 1-888-796-8226
External Strategies: People Who Can Help Distract Me in a Non-Crisis

- Other teens and adults whom you could contact
- Might involve sports, recreational centers, religious/spiritual centers, hobbies
- Generate people for different times of day and places
- Consider offering support to peers who are identified by teen
External Strategies: Adults I Can Ask for Help in a Crisis

- Help teen to identify adults s/he could reach in and out of home, school, and community
- When possible, notify the adult the teen has identified to be sure they would know what to do if the teen came to them in crisis
- Explore texting and online supports
- Have teen enter crisis number into their phone
- Role play with teen what they would say
Another strategy to play into teen development...

• When role-playing with teen have them consider what/how they would respond if a friend came to them.

• Remind all teens they can use re:solve for crisis consultations related to themselves and for others they are concerned about.
Reaffirming the safety plan should be a part of every treatment session.

When possible the safety plan should be shared with key adults such as parents, caregivers and school personnel.
Problems in Monitoring Suicidality

- Barriers
  - Lack of trust
  - Fear of hospitalization
  - Concern over removal of freedoms
  - Desire to please family or therapist
Assessing Current Safety with the Teen and Family

- Assess for the presence or absence of suicidal ideation and intent and the degree of severity (frequency, intensity, duration) of past 48 hours or since last visit
- Develop and negotiate safety plan with teen
- Collaborate and review the safety plan with family
- If family conflict is a likely precipitant to suicidality or self-injury, work with teen and family to negotiate a “truce”

(Goldstein and Poling, 2011)
Remaining Out of the Hospital

• No current suicidal thoughts/plans
• No need for stabilization
• Triggering conflicts have been minimized or addressed
• A supportive adult can be identified in the home by teen
• Teen and family know how to communicate about unsafe feelings i.e. a rating scale or check in times

(Current Psychiatry, 2010)
Remaining Out of the Hospital (con’t)

• Teen willing to begin and or continue treatment

• Teen and family educated on and understand risk drug and alcohol use plays in disinhibition and impulsivity

• Teen and family agree on safety plan and to follow up with services

• Teen and family can identify crisis resources
  (Current Psychiatry, 2010)
When Suicidality Continues... What Then?

- Chain analysis
  - Explore precipitants and motivations
- Discuss function of thoughts/attempt
  - What are the needs of the teen?
  - How does s/he get those needs addressed?
  - What are alternative ways to get needs met?
When Suicidality Continues...
What Then? (*cont’d*)

- Skill deficits
- Examine environmental response
- Continue to re-conceptualize collaboratively with the teen
Knowing When To Go To The Hospital

- Current plan or thoughts
- Need for more intensive evaluation
- Therapeutic alliance not established
- Can’t/unwilling to evaluate safety risks
- Risk Factors - significant conflicts, increase in drug or alcohol use
- Emotional liability/presence of severe mental health symptoms (psychosis, mood disorder)
- Significant impulsivity and unpredictable behavior

*Instinct*

(Current Psychiatry, 2010)
Summary

- Establish no-harm safety plan with teen and family. If conflict has been a precipitant, work with family to call a “truce”.

- Evaluate possible reinforcements for the teen to continue self-injurious behaviors (what does s/he get or gain).

- Remain non-judgmental.
Summary (cont.)

• Teach and enhance skills of teen and parent around communication, conflict management, emotion regulation, distress tolerance and need identification (“freeze frame” technique) - See STAR manuals.

• Work with school to re-enforce treatment strategies.

• Continue to update safety plan and revisit any safety issues - review and rehearse crisis resources.
References


• Goldstein TR and Poling KD (2011). SIB Institute, STAR Conference, Pgh., PA
References (con’t)


References (con’t)


References (con’t)


Selected Resources

- National Suicide Prevention Lifeline
  - http://www.suicidepreventionlifeline.org/
  - 1-800-273-TALK

- Suicide Prevention Resource Center - www.sprc.org
  - Safety Planning Guide for Clinicians and Template

Selected Resources (cont.)

- Cornell Research Program on Self-Injurious Behavior in Adolescents and Young Adults
  - [http://crpsib.com/factsheet_aboutsi.asp](http://crpsib.com/factsheet_aboutsi.asp)

- National Institutes of Mental Health

- National Center for the Prevention of Youth Suicide
  - [http://www.suicidology.org](http://www.suicidology.org)
STAR-Center Resources

• STAR-Center website
  • [http://www.starcenter.pitt.edu](http://www.starcenter.pitt.edu)
  • Manuals include:
    Dialectical Behavior Therapy with Teenagers
    Managing Anxiety
    Living with Depression
    Teenage Depression
    Postvention
Life isn’t the way it is supposed to be. Life is the way it is. It is how we cope that makes the difference.

Anonymous Adolescent
We acknowledge with gratitude the Pennsylvania Legislature for its support of STAR-Center and our outreach efforts.

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