Reducing Youth Self-Harm: Insights from Current Clinical Research

By Gordon R. Hodas, M.D.

Introduction

This article considers the results of recent research on the reduction of youth self-harm. Self-harm encompasses both suicide attempts and what is referred to as nonsuicidal self-injury (NSSI), which includes cutting. Our primary source of reference is a recent review article by Brent and colleagues, “Protecting Adolescents from Self-Harm: A Critical Review of Intervention Studies” (2013). We consider the key findings of this article with recognition of the challenges entailed by adolescence in general, and how additional risk factors may predispose some youth toward suicidality and self-harm.

In delineating the tasks of adolescence, most developmental experts through the years have, in my opinion, missed the boat. Certainly, developing a stable personal identity and stable peer relationships, along with other commonly identified tasks, are all important. However, in my view the most important task of adolescence involves simply surviving it and staying alive. There are many risks that youth face that can potentially be life-threatening. These include poverty, unsafe neighborhoods and various forms of trauma. Other risks involve drug and alcohol use, unsafe driving, excessive risk-taking, uncontrolled impulsivity, negative peer pressure, family stress, and depression. For vulnerable youth, outcomes may involve the risk or the reality of self-harm – suicidal thinking, overt suicidal behavior, or NSSI.

We now know that, while direct suicidality may be a more immediate concern, NSSI is also a strong predictor of both attempted and completed (e.g., successful) suicide. We also know that many distressed youth do not disclose their emotional pain, making the identification of suicidality at school and in the community particularly challenging.

The need to support youth and preserve life has been a priority within Pennsylvania for many years, and has led the Department of Public Welfare (DPW), in collaboration with other systems, to seek and obtain federal suicide prevention grants (see PA CASSP Newsletter, 2012). Thus far, these have involved a growing number of counties, with intervention based on identification of at-risk youth followed by treatment collaboration between local mental health agencies and primary care practices. There has been concurrent education of the local workforce on youth suicide, including both identification and intervention.

Relevant Information on Youth Suicidality and Self-Harm

It is worthwhile to review the following information on youth suicidality and self-harm:

- Suicide remains the third leading cause of death in youth aged 15-24 years in the U.S.
- The peak incidence of suicidal behavior is during adolescence.
- Suicidal behavior is often recurrent, with 15-30 percent of adolescent attempters making a repeat attempt within a year.
- The risk for completed suicide is significantly elevated in youth who have previously made a suicide attempt. This risk is also increased in youth who have engaged in nonsuicidal self-injury.
- Adolescent females make more attempts, while adolescent males have a higher completion rate.

- The medical severity (lethality) of a suicide attempt may not reflect the seriousness of an individual’s suicidal intent and desire to die, so each event needs to be assessed carefully. For example, with suicide attempts via pill ingestion, some severely suicidal youth may choose pills (e.g., an SSRI antidepressant) that have relatively low lethality. In contrast, some youth with low suicidal intent may ingest pills (lithium carbonate) with greater lethality.

- Depression is the most common risk factor for adolescent suicide.

- The highest risk period for a repeat suicidal event is approximately 1-4 weeks following a youth suicide attempt. In addition, for depressed youth in general and for depressed youth suicide attempters entering into mental health treatment, the median time to a suicidal event is 3-5 weeks. Thus, the greatest risk for a suicide attempt is shortly after an attempt and early in treatment.

- Based on existing data, there is no perfect suicide treatment—e.g., there is no treatment that can necessarily prevent repeat youth suicide attempts. However, there are interventions that can lower the risk, and these are relevant to us.

**Treatments that Can Make a Difference**

The authors identify specific clinical treatments for adolescent self-harm that have evidence of some meaningful outcomes. These include multisystemic therapy (MST) and Attachment-Based Family Therapy (ABFT), both of which are available in Pennsylvania and both of which work with the family and not just the youth. Other cited interventions include variations of cognitive behavioral therapy (CBT), which may address suicidality directly and/or the underlying depression.

**Core Elements of Interventions that Help Reduce Suicide Risk**

Given the difficulty of implementing specific treatment models in their entirety in some settings, there have been increasing efforts in mental health to identify what appear to be the core elements of successful interventions within many evidence-based models. The authors’ elucidation of these elements is their greatest contribution.

Core elements that reduce suicide risk are identified as involving the following:

- A strengths-based approach and interventions that support protective factors. The authors state, “A purely deficit-focused orientation many not be appropriate...” While suicidality and self-harm are serious and must be addressed, there is also a need to be strengths-based.

- Promoting motivation to change, particularly through use of motivational interviewing.

- Working with the family, and increasing family support and family relationships.

- Promoting positive affect within therapy and within the family.

- Promoting youth sobriety, since substance use is disinhibiting and increases the risk of suicidality.

- Promoting healthy sleep patterns, since insomnia can exacerbate mood lability, negative affect, and impulsivity, “all of which can increase suicidal risk.”

**Discussion**

While there is a clear need for additional clinical research on the treatment of youth suicide and the reduction of self-harm, it is also useful to pause for a moment and consider what we already know. There is benefit in embracing the insights we now have and allowing them to guide our ongoing clinical and research efforts.

Interestingly, the identified core elements of effective treatments to reduce youth self-harm encompass both fundamental concepts of effective psychotherapy and also very specific, pragmatic targets for clinical attention. For example:

- We know that mental health treatment works by promoting trusting relationships and re-establishing hope (Frank, 1973; Davidson, 2014). There is no better way to achieve this than by being strengths-based, meeting individuals where they are (as through motivational interviewing), and promoting the shared experience of positive affect.

- Mental health treatment also works by recognizing and supporting an individual’s social
context. No contextual elements are more important, especially in addressing youth suicide, than the family and the youth’s relationships with his or her caregivers (Hodas, 2008). While supporting the family in general is important, in my opinion the emphasis on promoting positive family relationships is especially important.

• The identification of both substance use and impaired sleep as appropriate targets of intervention is practical and consistent with an enlightened public health approach. The deleterious effects of substances and, to a lesser extent, sleep impairment, have been known for some time, but these elements need to be more systemically addressed as part of youth suicide treatment.

Finally, based on my own clinical experience over many years in working with youth who are suicidal and their families, I now offer three additional comments, to further guide support for the youth in crisis and his or her family:

• Avoid youth blaming: The youth’s distress needs to be recognized as genuine, not seen as “attention-seeking” or “manipulative.” The latter statements are not only inaccurate, but are likely to increase the danger of overt self-harm by the youth.
• Avoid family blaming: The family did not “cause” the youth’s depression or suicide attempt, and the caregivers want to do the best they can for the youth. They need both support and guidance. If, for example, a frustrated parent tells the youth to “go ahead and kill yourself, if that’s what you want to do,” the therapist needs to reframe the situation and redirect the family member in a firm, supportive, and non-blaming manner.
• Promote attachment and hopefulness, and extend the use of a safety contract to include the family as a whole: It is not just the youth who needs to make a safety contract, but the youth and family together. To be sure, the youth should be encouraged to make a non-suicide commitment to the family and agree to seek help when needed. In addition, however, the parents/caregivers can be supported in making a safety contract with the youth. The nature of the family’s safety contract is as follows: “We love and care about you, and we want to support you. We will never give up.” In this way, reciprocity between youth and family is highlighted, as both embrace a renewed commitment to the youth’s wellbeing and to life.

References


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