Assessing Client Risk for Self Harm

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Presented by CEUSchool
Course Summary

This course will help mental health professionals recognize behavior patterns and warning signs that a person may be at risk for suicide. It will define and standardize a continuum of behaviors and terminology. It will teach mental health professional to recognize risk factors as well as to identify protective factors. The professional should learn to actively intervene in ways that explore the level of risk without increasing it; while ensuring that those at risk can access the services necessary to reduce the risk.

Course Objectives

Upon completing this course students will:

1. Define and standardize a continuum of behaviors and terminology
2. Recognize risk factors
3. Recognize behavior patterns and warning signs that a person may be at risk for suicide
4. Be able to identify protective factors
5. Be able to actively intervene, usually by talking to a person in ways that explore the level of risk without increasing it
6. Ensure that those at risk can access services necessary to reduce the risk

Brief Bio:

Jamie Berman, LCSW-R, CASAC is the Admissions Director at a leading enhanced substance abuse treatment agency in Manhattan. She is a licensed social worker in the states of New York and New Jersey and a licensed psychotherapist in New York. Jamie received her Master of Social Work from Adelphi University and SIFI Certification from New York University. She is an adjunct professor of graduate studies at Touro College and a mentor to Social Work graduate students. Jamie has conducted trainings on topics such as Signs and Symptoms of Withdrawal – Detoxification Process, Interview Skill for Chemical Dependency Counseling and Assessing Client Risk for Self Harm. Jamie is a member of the National Association of Social Workers and an active member of a planning committee to provide annual state conferences for criminal justice system and treatment providers.
Introduction

Fifty percent more people die by suicide than homicide each year in the United States. In the United States, one person commits suicide every 16 minutes averaging 89 suicides per day. More than 5 million people in the United States have been affected by suicide. Fifty two percent of all suicides are carried out with a fire arm kept in the home. Over 90% of all suicide victims have a significant psychiatric illness at the time of their death. Mood disorders and substance abuse disorders are the most common.


Suicide is the 11th leading cause of death, with a ratio of 11.1 per 100,000 people. Males complete suicide at a rate of four times that of females, however females attempt suicide three times as often as males. The risk for suicide is increased in depressed alcoholic individuals. Feelings of hopelessness are found to be more predictive of suicide than depression. The vast majority of individuals who are suicidal often display clues and warning signs.

http://www.sprc/suicide prev basics/data.asp. Many suicides are preventable. Most people who commit suicide do not want to die; they want to stop the pain.

Challenges for assessing client risk for self-harm:

- Fear
- Professionals own unresolved issues
- Lack of trust
- Being judgmental
- Lack of awareness
• Cultural bias
• Technical and practical skills
• Stigma

Who is at risk?

Biological Factors:
• Substance Abusers
• Individuals suffering from depression
• Individuals suffering from other mental illnesses
• Those inflicted with physical illness
• Participants in high risk behaviors
• Familial history of suicide
• Someone who is disable or disfigured
• Someone who is fatigued
• An individual in the life stage of adolescence/elderly

Psychological Factors:
• Those suffering from depression or other mental illnesses
• Someone suffering with an addiction
• Inflicted with low self esteem
• Someone with poor coping skills
• An individual who is easily frustrated or angered
• Someone who feels hopeless, in a state of despair, or fear
• An individual who is impulsive
Someone who is anxious

Social Factors:

- An individual living in isolation
- Someone who has non existent or unstable support systems
- A trauma survivor
- Diminished/changed socio-economic circumstance
- The experience of a relational loss

Suicide or self harm is not a normal response to life stressors or crisis. Although some people go through crisis everyday and endure unbearable pain, the vast majority of the population does not respond to such by inflicting injury to themselves or making a decision to end their life.

When assessing client risk for self harm the mental health professional must become aware of the clients protective factors.

These factors include:

- Strong connections to family and/or community support systems
- Cultural and religious beliefs that discourage suicide and support self preservation
- Effective coping mechanisms, problems solving and conflict resolution skills
- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Ongoing support through all types of therapeutic alliance
- Restricted access to lethal means

http://www.surgeongeneral.gov/library/caltoaction
A trauma is an objective event that damages a person’s sense of well being and creates anxiety. (Herman, Lewis MD., 1997). For a trauma to set off a crisis, the person has to perceive the event as very threatening. Crisis caused by trauma is characterized by mental and emotional confusion caused by the perception of a threat. It involves a sense of urgency and lasts a few hours to a few weeks. (Herman, Lewis MD., 1997). There are four types of traumas that set off crises. These include situational traumas, developmental traumas, intra-psychic traumas, and existential traumas. A situational trauma is one that is caused by a circumstance. Examples of this consist of the death of a loved one, the dissolution of an important relationship, serious illness, serious financial problems, arrest, relapse and family violence. A developmental trauma occurs while an individual is in the process of growing through life stages and an upset is caused. Examples of this may be peer pressure, marriage, children leaving home or retirement. Intra-psychic trauma is when thoughts and feelings create upset. Identity confusion may create this. Thoughts and feelings created by interpersonal friction and mental illness causing perceptual distortions can also create this sort of trauma. Existential trauma is caused by a feeling of emptiness and a lack of purpose in life. This is when an individual recognizes that his/her daily activities do not provide meaning and satisfaction in everyday life. Different individuals exhibit different reactions to crises. These reactions vary from shock, anxiety, depression, anger, and intellectualization. The goals of crisis intervention are to stabilize the individual so no further deterioration in functioning occurs; to relieve the individual of as much pressure as possible; to convert the emergency to a solvable problem and resolve it; and to
There are three primary tasks involved when assessing a client risk for self harm. The mental health professional must gather all relevant information related to risk factors for suicide. All information must be gathered related to the client’s suicidal ideation and planning. Finally, a sound clinical judgment based on this information must be made.

It is crucial that a professional knows what to look for when assessing for self harm. Some signs of crises are more obvious than others. Some clients actually verbalize distress. Other client’s may exhibit “acting out” behavior. Client relapses, reports from third party, a significant event, radical changes in behavior, psychotic behavior and an inability to contain/control emotions are all signs of crisis. Some behavior is less subtle. Mood changes, social withdrawal, vague complaints, appearing pre-occupied, and protracted events are all examples of this. Ten to fourteen days is the average length of time people struggle with crisis before seeking help. The sooner a person requests help after a breaking point the better the prognosis or outcome because there has been less time for maladaptive behaviors to set in.

When assessing client risk for self harm it is important to know your client’s history. Static factors such as alcohol and others drugs of abuse, smoking, unprotected sex, known medical/mental health conditions, driving while intoxicated, criminal justice involvement and involvement with weapons or gun play should be considered. Static factors such as self-mutilating behavior, impulsivity or violent traits by history and history of previous suicide attempts
should also be considered when assessing client risk for self harm. Behavior predicts behavior. Previous engagement in high risk activities, significant mental/medical illness, access to lethal means, impulsiveness, violent history and previous suicide attempts are all indicative of increased possibility of self harm. All behaviors should be evaluated on a continuum. All behavioral changes should be either observed or reported by either the client or a third party. Behaviors to evaluate are as follows:

- Reporting or appearing to be using drugs/alcohol
- Depressed
- Anxious
- Despondent
- Remorseful
- Agitated
- Angry
- Experiencing sleeplessness or lethargy
- Appetite change

Once these observations have been made the mental health professional must establish rapport with the client rapidly. The client should feel that he or she has a knowledgeable ally who will see him/her through the crisis. In order to establish rapport the professional needs to obtain facts. As much information as possible should be obtained. Questions regarding the precipitating events need to be asked. In order to do so, paraphrasing techniques should be used to clarify what the client is stating. Active listening skills should also be utilized. It is important that the client is allowed to speak; probe as needed; re-direct as needed. If substance use is involved find out what the client took, how much and when. Ask the client how and what the feelings are about the event and in the current moment. You should demonstrate compassion. For example, “Things seem really difficult for you right
now.” “How can I help?” Remind your client that crises do pass and that help is available. Do not be judgmental. Try to view the crisis from your client’s perspective. What may seem incidental to you, may be overwhelming to the client.

A professional needs to know the difference between an ideation, plan and means. If the client is experiencing or having any thoughts about hurting or killing him/herself, that is an ideation. When the answer to this question is yes, the following needs to be explored:

- Is the client talking about it, stating intent, making threats or gestures?
- Expressing innuendos – the world would be better off without me, I just want to die.. or making other statements that convey they may be suicidal.
- Are they pre-occupied with death and dying?
- Fantasizing about the act and possible repercussions (adolescents).
- Seeking access to means.
- Is the thought recurrent?
- Are they having command hallucinations?

A plan is whether or not a client considered or has thought out a concrete means to end his/her life. Some possible methods include overdose, car crash, jumping off or in front of something, slashing or cutting themselves, shooting self. The lethality and immediacy of the plan must be assessed. Is the client currently in possession of a weapon or are other means readily available to carry out is a question that needs to be asked. Have they decided on a method, time and place is another question that needs to be asked. The question of means is the next question to be asked.
Whether or not the client has access or the actual ability to carry out their intent is what needs to be answered. When speaking with the client, the following questions should be asked:

- Has the client harmed him/herself or made previous attempts/gestures in the past? If so, how and when? Did this result in ER treatment or medical/psychiatric hospital admission?
- Is the client unable to contain or losing control of his/her emotions?
- Is the client especially labile?
- Is the client angry? Is he/she threatening violence?
- Is the client psychotic?
- Is the client hearing voices?
- Does the client have the means to injure himself or others?
- Is the emotional change extreme?
- Is the client under the influence of drugs or alcohol?

An affirmative response to any of those questions means that the situation must be handled with immediacy and may require an emergency responder. Any client in this situation should not be left alone. When managing the crisis do not attempt to talk the client out of it. It may be perceived as a challenge that may result in the client shutting down. Do not attempt to cheer the client up by minimizing his/her losses. This will likely result in him/her feeling misunderstood. Remember to remain objective. Do not interrupt the client to relieve your own feelings about suicide; take care of your own feelings later with a colleague. Do not become anxious. Your anxiety and discomfort will only agitate the client. Be prepared for the flood of emotion and confusion that the client may pour out. Work to
reframe the crisis into a solvable problem and potential growth situation whenever possible. This relieves some of the pressure that the client feels. Help the clients to identify both his/her strengths and viable support systems. Formulate a protective plan with support from your supervisor and input from the client. Be realistic with the client about their problems. This can build trust. If appropriate, let the client know if he/she is in some way (s) contributing to the problem. Help the client to explore ways that he/she might otherwise work through his/her crisis.

It is important to remember that most people are ambivalent about taking their lives, someone indicating that they are considering such is in all likelihood consciously or not looking for help and possibly and alternative means of relief.

It is important to remember that people in crisis frequently cannot stop the pain; cannot think clearly; make a decision; see any way out, sleep eat or drink, get out the depression, see the possibility of change, see themselves as worthwhile, get someone’s attention or seem to get control. Not all depressed people are suicidal, however most suicidal people are depressed.

In 2004 suicide was the 3rd leading cause of death for young adult ages 15-24. Suicide accounts for over 12% of all deaths among 15-24 years old. Caucasian males have the highest rate of suicide. Those with the presence of a psychiatric disorder communicating feelings of boredom and listlessness have a high rate of suicide. Impulsive and aggressive behavior, increased use of drugs/alcohol, recent severe stressors, family instability, any history of deliberate self harming are all cause for concern.

Most adolescent suicide attempts are precipitated by interpersonal
The elderly make up to 12.4% of the population, but account for almost 16.0% of the suicides. The rate of suicide for the elderly in 2004 was 14.3 per 100,000. Statistically, elderly white males are highest risk. 84.6% of elderly suicides were male-suicides in late life time were 7.7x greater than for female suicides. Female suicides peak in middle age, but decline at age 60. Older adults have fewer suicide attempts, but a higher completion rate than the rest of the population. Depression is a leading cause of suicide amongst the elderly. Alcohol and substance abuse play a diminished role. Common risk factors include: the recent death of a loved one, physical illness, perceived poor health, social isolation, loneliness and loss of employment or other significant changes.

About 90% of all suicides meet the DSM IV diagnostic criteria for an Axis I mental illness disorder at the time of death. Substance abuse and mood disorders; depression the most prevalent one, account for the majority of these diagnosis.

Depression has a fairly consistent set of symptoms that last for at least two weeks in duration. The following is a list of symptoms that may present themselves during this two week period:

- Feeling sad
- Crying
- Loss of interest in pleasurable activity
- Listlessness, lethargy and lack of energy
• Disruptions to sleeping and eating patterns
• Difficulty concentrating
• Feelings of hopelessness
• Pessimism
• Despair
• Preoccupation with problems
• Suicidal thoughts

Bi-Polar Disorder was formerly referred to as Manic Depressive Disorder. This differs from depression in that there are periods of depression that are punctuated by periods of mania or hyper activity. The client’s mood fluctuates from high to low hence the terminology “mood swings”. Episodes of mania include abnormally elevated mood, sometimes irritability, grandiosity, distractibility, agitation and decreased need for sleep. Excessive and impulsive behaviors are more likely to occur in a manic phase.

Sometimes depression is caused by a malfunction in brain chemistry.

When an acute crisis is over, it is important that the mental health professional debrief. Take care of your needs with a colleague or supervisor. A study done by the US Prevention Services Task Force concluded that there is insufficient evidence that the use of standardized risk assessment screening instruments is either harmful or helpful in reducing risk of self harm and therefore has refrained from making a recommendation for or against their use.

The common link amongst people that kill themselves is the belief that suicide is the only solution to a set of overwhelming feelings. The attraction of suicide is that it
will finally end the unbearable feelings. The tragedy of suicide is that intense emotional distress often blinds people to alternative solutions that are almost always available.

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