

AN EFFECTIVE MANAGEMENT OF SUICIDAL IDEATION AND SELF-INJURIOUS BEHAVIORS IN YOUTH

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ABSTRACT

Depression is the most common yet ignored public health issues in Pakistan. The prevalence is uncommon among children but vastly evident during adolescence. Unhealthy parenting practices and childhood trauma directly contributes towards depressive disorders and suicidal ideation later in life if left unresolved. A similar case of 17 years old was referred with her presenting complaints of: sadness, irritability, crying spells, suicidal ideation, self-harm, negative thinking, loss of interest in pleasurable activities, sleeplessness, psychomotor agitation, fatigue, lack of concentration, feelings of rejection and worthlessness for a year. The formal assessment was done by using Beck Depression Inventory (BDI). Based upon the assessment, the client was provisionally diagnosed with Major Depressive Disorder 296.23. A management plan includes ABC model, Cognitive distortions, Double column technique, Triple column technique and Relapse prevention. For the management of the suicidal thoughts/ ideation, strengthening of familial support, creating supportive environment, ensuring protective environment, reducing access to objects, substance or any means that could be lethal danger to life, promoting connectedness. A total number of sessions conducted with the client were 12 and the change was 35%.

Keywords: Suicidal Ideation, Self-Injurious Behavior, Adolescence, Cognitive Behavior Therapy, Efficacy

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INTRODUCTION

A Clinically significant representation of depressive symptoms evidently usually appears in the adolescent age group from 12 to 20 years. These grown-up ages have various changes in their lifestyles, behaviors, attitudes, thinking pattern, social engagement, role models, idealism and adaptation according to societal standards. Such factors

predictably influence in the life of youth in this specific archetypal group ages. According to one of the studies it has been reported among adolescent age group around 50 to 80 percent has shown high prevalence of depressive symptoms along with suicidal ideation and tendency towards self-harm & self-destructive approaches (1). The risks of suicidal behavior among the teenagers were first scientifically studied and recorded from the years of 2005 to 2006 which led mental health practitioners alarmed and influenced them to raise awareness on mental health issues. At that time, it was reported more than 40,000 plus successful suicidal attempts and the age groups was significantly between 13 to 35 years (2). The individuals who are reportedly found to display self-injurious behaviors and suicidal attempts have

higher alarming predictors of psychosocial & psychological issues such as lack of parental support, societal or peer pressure, hopelessness, unhealthy eating problems, anhedonia, negative self-evaluations, low self-esteem. Such adolescence had history of neglected parents, traumatic childhood experiences and lack of acceptance and encouragement which highly contributed to the risky behaviors during their teens to adult age groups (3).

CASE STUDY

History of Present Illness & Treatment: The Client was experiencing symptoms of sad and irritable mood, crying spells, suicidal ideation, negative thinking, loss of interest in pleasurable activities (except painting), inability to sleep without sleeping pills, psychomotor agitation, fatigue, difficulty concentrating, feeling worthless and feeling rejected for 1 year. She lived with her parents and siblings in Multan. She described that her father was short tempered and her mother had less control over herself; hence, there were usual fights. She reported of not developing warm relationship with any of her parents since childhood but was mostly disturbed due to the conflicting environment of the house. Client also reported of frequent physical and verbal abuse from her parents.

Due to the environmental distress and conflicting parents', client began to remain scared, upset, sad, irritable, and later developed suicidal ideation and crying spells. Noticeable symptoms however, started 12 months ago due to a significant fight that took place between her parents on the second day of Eid. Client experienced frequent crying spells, negative thinking, and suicidal ideation, sad and irritable mood. Client reported of spending most of her time alone in the room and used to lock herself to escape the verbal arguments and fights of and with parents.

After prominent symptoms, client's parents took her to multiple doctors i.e. neurologists, psychiatrists and psychologists. Her parents also took her to traditional healers/ quacks as well to investigate, if any black magic or magical spell had been casted on her but, it did not help. Client also, took medication from a psychiatrist for her symptoms. She had therapy sessions with a psychologist as well. Client reported about some improvement after having sessions with her therapist however, she had to move abroad and terminate the sessions due to which client had an abrupt relapse and stopped taking her medicines. Thus, she moved to Lahore for treatment of her psychological distress staying at her aunt's place.

Background Information

Personal History: The client was born through a normal procedure. She achieved all her milestone at the appropriate age. The client's mother did not experience pre or post-natal depression. No significant injury, however, fever was reported at the time of birth. Client reported about her aim to

become a MBBS doctor as her dream. Perhaps, due to her psychological state she seemed like losing hope to keep working to achieve her goal. Moreover, client reported of never being involved in any romantic relationship with anyone nor has any sexual or substance abuse history. However, she reported that sometimes under stress she takes over dose of her sleeping pills and does non-suicidal self-harm by cutting her skin at arms or legs.

Educational History: Client started her schooling at age 4.6 years in a private school at Multan. But, she had to change her school as they moved to a nuclear family system from a joint one. The reason for the school switch was that the new school was close to home and was more convenient for the parents. Client reported of having a respectful relationship with her teachers. She had limited number of friends and did not participate much in extra-curricular activities at school. Client reported being bullied at school due to wearing glasses for her weak eye sight and being over-weight. She managed to achieve excellent grades in her matriculation, for which she received minimal appraisal from parents. After her matriculation, the client took admission in FSc in Multan however, due to increased psychological distress she decided to shift in Lahore with her aunt and got admitted in intermediate at a private college. The client did not have good friends as, she avoided talking to her class fellows and preferred staying alone. Moreover, client had no occupational background.

Family History: Client's father had his education till intermediate and worked in the Police Department as a sub-inspector. He had somewhat of a dominating personality since the beginning and used to get angry and fussy over little things. He took most of the decisions in the family. In contrast, client's mother reported of having a polite and easy temperament which later got destroyed after continuous conflicts with husband. Client's mother had received education till intermediate and worked as a teacher after marriage and took care of the family and household. She had recently let go of her job after client's symptoms got severe and decided to stay home look after her. Hence, the only bread winner of the house currently was her father. Also, the parents were not related by blood but had an arranged, out of the family marriage. Client had two twin brothers and a younger sister. All of her siblings were school going. The second born brother was in 9th grade and had an irritable temperament. He had seen his father hitting his mother and hence, developed the idea that he would also behave the same with his wife. Client did not have a coherent relationship with her brother and had minimal understanding and sharing with him. The other two siblings (a brother and a sister) were younger and twins. They both studied in grade 6 and had coherent relationship with the client. Client lived in a nuclear family system with her parents and three other siblings in Multan. Prior to living in a nuclear family system

client had lived in a joint family with her parents till 5 years after her birth. Her parents used to have frequent conflicts based on the idea of getting a separate house and living as a nuclear family. Her father did not want to leave his family; however, they got separated after long years of arguments and conflicts. Client's father did not receive any property of assets from his father due to getting separate. However, client's mother was happy taking nothing but peace of mind. The general environment of the family was strict and conflicting. Moreover, no genetically transmitted illness was reported from any of the parent's sides. The socio-economic status of her parents was middle class.

Premorbid Personality: Client had always been a hardworking student and a caring daughter. She used to write letters to her parents to resolve their fight as she was scared of them. She was reported as a sensitive child who used to over think about the conflicting environment and future outcomes. She desired of a cohesive and loving family and used to put efforts by helping parents resolve conflicts.

Case Formulation: The Client presented with the presenting complaints of sad and irritable mood, crying spells, suicidal ideation, negative thinking, loss of interest in pleasurable activities (except painting), inability to sleep without sleeping pills, psychomotor agitation, fatigue, difficulty concentrating, feeling worthless and feeling rejected for a year. Formal and informal assessment was done on the client and in the light of the conducted assessment case formulation of the client was done. The client was diagnosed with Major Depressive Disorder. According to Freud's Psychoanalytic theory, it was proposed that depression was resulted due to biological factors. However, he also claimed that depression usually takes place due to rejection from parents. He argued that depression is a silent cry over loss of an important relationship. In this case, client failed to develop a warm relationship with her parents despite being the first born. She was victim to her parent's aggression and marital conflicts; hence, she lost two significant relationships of her life (4). Freud also argues that due to the loss individual considers him/herself as a worthless person and as anger towards the lost person, client internalize the anger (inward expression) that takes form of depression. The inner-directed anger minimizes self-esteem, self-worth and makes the person feel even vulnerable to the situation (4).

Behaviorism stresses on the importance of environmental factors in shaping human behavior. It focuses on the observable behaviors that one gets exposed to and hence, learns from it. Hence, depression is perceived to be resulted by individual's unique interaction with the environment. Client's interaction with her immediate family members was found rough and insensitive under which negative emotions

were learned through observation, modeling and reinforcement. Also, using abusive language and having anger issues are also considered to be learned behaviors from her environment (5).

Cognitive theorist Aaron Beck who also developed the assessment tool BDI proposed theory for depression. He suggested that people who suffered depression often interpret their situation in a negative way. Beck identified three major reasons for depression: negative automatic thinking (cognitive triad), negative self-evaluation, and errors in logic (cognitive distortion). In this case, client was found making errors in all three steps proposed by Beck's theory. Hence, identification of cognitive distortions was done with the client. Also, double and triple column technique was used to restructure her cognitive errors (6).

The case can be well explained by the attachment theory proposed by Ainsworth in 1970. According to the theory children require and seek secure attachment, love and support from parents. If the child is neglected or maltreated by the parents, high probably is that the child would fail to establish secure attachment with the caregiver (7). Ainsworth has proposed three attachment styles out of which my client M.I falls into the category of "insecure avoidant attachment". Under this category, child is not provided enough love and secure thus, experience attachment dysfunctions. Child fails to relate to the parents or the caregiver and does not turn to them when are distressed or upset. This can happen when caregiver fails to provide comfort and neglect the child's needs (7). Client M.I has suffered anger and neglect from parents since a very young age due to which she could not develop love and safety with her parents that has contributed towards lack love and support and feeling alone and worthless

PSYCHOLOGICAL ASSESSMENTS PRE-INTERVENTION ASSESSMENTS:

Informal Assessment:

Clinical Interview: A clinical interview (8) was taken from both client and her mother to know in detail about family dynamics, client's temperament, life style, premorbid factor, environmental factors and the triggering event. Client was asked in depth about her feelings against the conflicting environment of the house. Client was asked about her strengths and weaknesses, about her aims and goals in life, about her desires and needs. Moreover, client's mother was interviewed to cross check the information client initially gave. Mother was asked about her relationship with client and other children, her relationship with husband and her role in family. Mother was also interviewed about their financial condition and strengths and weaknesses of the family. Mother was also investigated to find out if there is any pattern of psychological illness in extended family.

Subjective Rating of Symptoms

Table.3 Showing Subjective Ratings of the Client’s Symptoms on 1-10 Scale

Symptoms	Client’s Ratings
Sad and irritable mood	8
Crying spells	8
Suicidal ideation	7
Negative thinking	9
Difficulty in sleeping	8
Anger	7

FORMAL ASSESSMENT:

Beck Depression Inventory: Beck Depression Inventory BDI developed to assess symptoms of depression in an individual for previous week. BDI was used to check client’s score on Depression. Results show that client falls under the range of severe depression as her score was 39.

Table 4, The category Rating Score at Beck Depression Inventory BDI

Grand Total	Range	Severity
39	29-63	Severe Depression

QUALITATIVE ANALYSIS

BDI consists of 21 question items that comes with 4 likert points. The patient was instructed to pick 1 most relevant option describes her feelings or emotions. BDI covers 21 areas in the questionnaire that are; sadness, pessimism, past failure, loss of pleasure, guilty feelings, punishment feelings, self-dislike, self- criticism, suicidal thoughts or wishes, crying spells, agitation, loss of interest, indecisiveness, worthlessness, loss of energy, changes in sleep pattern, irritability, changes in appetite, difficulty concentration, tired or fatigue, loss of interest in sexual activity.

Client had extreme high scores on sadness, pessimism, loss of pleasure, self- criticism, loss of interest, and loss of interest in sexual activity. However, she had a minimal score on guilty feelings, punishment feelings, self-dislike, and tired or fatigue. Rests of the items were scored with the normal range.

THERAPEUTIC TREATMENT

Rapport Building: Rapport can be defined as a positive emotional connection. It is about building relationships through a sense of trust and confidence in each other, establishing good communication and identifying common beliefs and knowledge (9).

Rapport was built with the client in order to make her feel comfortable and engaged her in trustful relationship. The therapist explored client’s understanding of her illness and did a detailed discussion about her previous problems and episodes through probing and thoughtful questioning. The

therapist identified early warning signs and stressors associated with onset of previous episodes and over all relevant information. With the client, rapport building also consisted of reflective statements, acceptance and genuineness.

Supportive psychotherapy: Supportive therapy was done with the client by giving her unconditional positive regards, active and empathic listening. Rapport was built with the client by using the above-mentioned techniques along with nonverbal positive gestures i.e. head nodding, saying hmm, etc. Therapist provided the client with sufficient time to express herself and her problems. She was informed about the purpose of therapy sessions, their schedule and cooperation in the sessions was also discussed with the client.

Psycho education: Psycho education was done regarding the diagnosis, assessment findings, nature of problem and the contribution of environmental factor in her illness. Psycho education focused on mainly educating the patient regarding the stress vulnerability model of illness, the precipitating factors, maintaining, risk and protective factors in the development of disease or relapse. The patient was guided by therapist regarding depressive symptoms, its causes, course and treatment, as well as role of stress diagrammatically and with the examples of her own life. The whole therapeutic process was made clear in front of her. She was told about the self-monitoring. She was told about the effectiveness of medicines.

RELAXATION EXERCISES

Progressive Muscle Relaxation: The client was introduced by this exercise in the session given by the Jacobson (1929) (10) based on reciprocal inhibition and counter conditioning principles. The patient was given the rationale that the tension that is usually experienced is more a physical state than a mental state she was told that she could relax those muscles systematically so that she would feel calm rather than tense. The patient was given the demonstration how to relax or tense the eighteen muscles group and made to practice with feedback to correct any ambiguities then she was told to practice the procedure with the therapist giving instructions, which she followed. After completing the exercise, the brief imagery was done, then feedback was taken which was positive, and she felt relaxed. The client did this exercise and found it effective in improving sleep and to as a distraction from psychotic symptoms.

Deep breathing: Deep breathing was applied as a technique to help cope with stress, helpful as a distraction in stressful condition and as a focusing approach, keeping in view the rationale of reciprocal inhibition.

Activity Scheduling: For overcoming the avoidance different activities were planned for patient. From morning to night, the daily routine for patient was planned. In activity schedule the routine of waking, sleeping, exercise and other

activities was advised. This technique proved very helpful for reducing negative symptoms as well as decreased the intensity of positive symptoms.

Anger Management: According to Center for Integrated Health Anger (2013) is a complex and confusing emotion that you may experience in response to specific stressors. It is a feeling, an emotion, and is quite different than aggression, which is an action and intended to cause harm to others. In this case the client was showing aggressive behavior toward the family to manage this problematic behavior anger management techniques were taught to the client in which external and internal cues were identified to the client through a model along with the related thoughts and emotions, the client was also psych educated about the early warning signs of anger and alternative ways to deal with this behavior.

Cost and Benefit for self-harm: Client was asked to list down the benefits of self-harm or ending her life and think over them. Then she was asked to now write about the cost of harming herself and see across both columns and decide with idea is more suitable and beneficial.

COGNITIVE RESTRUCTURING

Therapeutic Agenda: This section contains feedback on prior techniques and applied agenda to talk about for the session. Session could be divided in 20-20-20 and each section could include a different topic for intervention.

Understanding Depression: She was explained how our thinking affects our feelings and hence, it maintains our positive or negative mood.

Daily Thought Record: The Daily Thought Record (DTR) is a fundamental strategy in cognitive therapy, which has been useful in the treatment of depression, anxiety, and other problematic mood states (11, 12). The standard DTR is a five-column form that is completed by the patient. Patient kept the record of his thought. In this technique patient realized and focused on the pattern of her thoughts and the coping strategies. It worked like self-evaluation.

ABC Model: The individual's interpretation of events determines how she feels and behaves (13). ABC model was explained to the client by therapist. The relationship between activating event, belief/thought and resulting emotions and consequences were explained to the client. It was also explained to the client to help her develop alternative ways of thinking and behaving which can reduce her psychological distress. ABC model was explained with the help of examples and also with events from her base line and A-B-C connection was build. It was made clear to client that our emotions, feelings are caused by our thoughts and not by any event or others. Client understood the connection after explanation and examples provided by therapist.

Cognitive Distortion: An introduction to 11 types of cognitive distortions was given to the client. Therapist explained the distortions that includes; All or None Thinking, Over

Generalization, Emotional Reasoning, Jumping into Conclusion, Mind Reading, Magnification and Minimization, Catastrophizing, Fortune Teller Error, Mental Filters, Disqualifying the Positives, and using Should Statements. Client was asked to analyze the common mistakes in her daily thinking and processing.

Verbal Reattribution: Negative self-appraisals, negative thoughts concerning the reaction and thoughts of others should be targeted for reattribution. The evidence typically stems from self-appraisal rather than from objective events, and this conclusion can be sought through guided discovery. However, in some cases tangible evidence does exist, and the 'goodness' of the evidence is then collaboratively reviewed with an aim of: (1) disputing its validity; (2) reframing it in more realistic terms (e.g., generating alternative explanations for evidence, and modifying any thinking errors in interpretation of it).

Double Column Technique (Identification): CBT based double column chart were provided to the client for a week. The aim was to write down the negative automatic thoughts in one column and then identify and write the cognitive distortions/errors in the other column. This would help the client gain awareness of her cognitive errors and identify them.

Triple Column Technique (Replacement): After double column chart, client was given a triple column CBT based chart. The triple column chart is a step ahead of the double column chart. Triple column consists of three columns in which first column is about writing the negative automatic thoughts, second is about identification of cognitive distortion/errors and third is replacement of the negative thoughts with positive ones. The aim of technique was to help client restructure her negative unhelpful thought patterns into positive helpful patterns.

Increasing Positive Thoughts & Decreasing the number of Negative Thoughts: Moving further in CBT client was further taught how to increase and focus on the positive thoughts. Client was asked to do this exercise when feel sad, nervous, irritable, and anxious and upset. The exercise was to stop everything that you are doing and relax your-self by using deep breathing and PMR exercises. She was told to make a list of positive thoughts that comes in her mind and was instructed to focus more on the positive and helpful thoughts. Next step in CBT was to stop or minimize the time spent on negative unhelpful thoughts. Thus, she was asked to interrupt the sequence of negative thoughts whenever she felt sad, worried, and worthless and rejected.

Understanding how Relationships affect one's mood :

One of the reasons for severe depression is when people give up on their social interaction and likes to be isolated from others. The exercise helps to foster healthy relationship and improve social interaction.

Problem Solving: It refers to symmetric process in which a person generates a variety of potentially effective solution to

problem judiciously chooses the best of these solutions and then implements and evaluates the solution (14).

Client was guided to follow the following steps:

- Define the problem
- Generate alternative solutions
- Evaluate and select an alternative
- Implement and follow up on the solution

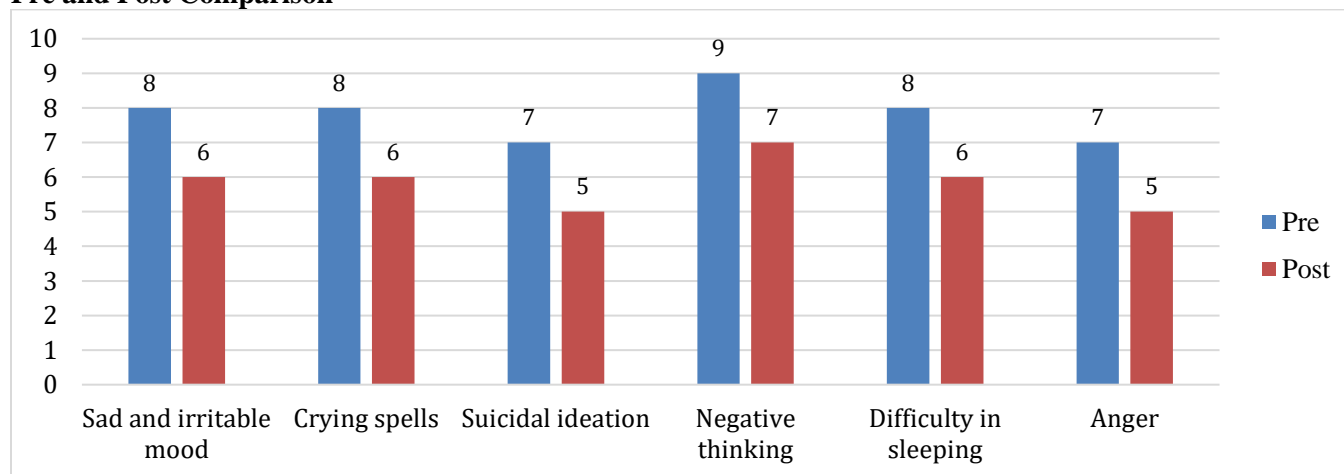
Social Skills Training: Social skills training consists of learning activities utilizing behavioral techniques that enable persons with schizophrenia and other disabling mental disorders to acquire interpersonal management and independent living skills for improved functioning in their

communities (15) The client was facilitated with different social skills i.e. take initiative to talk with the other patients in the ward, make and maintain eye contact while talking and different guidelines for social interaction through role playing and modeling.

RESULTS

The results showed that client improved over her sad and irritable mood, self-harm, crying spells and anger. The total change was 21% after the management.

Pre and Post Comparison



Post Assessment

Beck Depression Inventory BDI

BDI was used for post assessment of client’s score on Depression after therapy. Results show that client has improved as her post score was 24.

Client’s score on depression was reduced and significant improvement was seen after management.

Table.6, Table Showing Subjective Ratings of the Client’s Symptoms on 1-10 Scale

Symptoms	Client’s Ratings
Sad and irritable mood	6
Crying spells	6
Suicidal ideation	5
Negative thinking	7
Difficulty in sleeping	6
Anger	5

DISCUSSION

From the given case study, several factors were highlighted which identified psychological stress markers among youth group and the factors which influences on their mental health. According to the

study, client was being raised by avoidant parents who had less mutual understanding and knowhow of client’s physical, social and psychological needs. An environment in which she should feel safe and welcomed, she encountered unhealthy lifestyles, hatred, and destructive image of love between her parents, lack of parental love and support. It was during this time when she developed mistrust, fear, social abandonment and negative self-evaluations which led her to the path of depressive symptoms, suicidal ideation and self-harm. These unhealthy behaviors and psychological manifestation depicted that the client had traumatic past experiences from her childhood which was needed to be resolved by a mental health practitioner to help her cope from the situation and have alternative adaptations of healthy life styles and to reach to one of the goals from her therapy was self-healing and self-forgiveness.

LIMITATIONS

As therapist, I had no chance to work with the family to conduct parenting counseling which was much needed and to initiate some sessions on family therapy that would have worked the best to resolve conflicts. Also, client belong to another city which affected therapy outcomes favorably less than expected as she had to go

back to her home place hence; proper follow up sessions were not very feasible.

SUGGESTIONS

According to therapist's suggestions, the key role for this therapeutic management was client's parents who were the stakeholders and the ones who had greatly influenced in the client's mental health in a form of depression, suicidal ideation and self-injurious behaviors. Therefore, for this under therapeutic session's client's parents were considered to receive marriage counseling to better cope in spouse relationship and adopting healthy parenting styles which would aid in client's mental health treatment.

FUTURE IMPLICATIONS

The study will help to know about the importance of parenting styles which contribute in adolescence development and wellness in mental health. Also, adolescent age groups are being ignored in terms of seeking psychological services for resolving their personal conflicts and psychological issues. Unresolved conflicts later developed into alarming clinical manifestation. Our youth nowadays are facing anxiety, stress, depression, suicidal ideation, trauma related issues and many other psychological problems which are untreated and ignored by their caregivers, thinking that adolescence age group will cope by their selves or imposing as if they are faking the symptoms. So, it's a need to know about the early triggers and the inner issues from which adolescence are suffering. Better to seek psychologists, psychiatrist or mental health practitioners to deal with early signs before and not making it worse.

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