CASE 8

Self-Harm and Suicidality

IDENTIFICATION: The patient is a 16-year-old Hispanic female referred to the emergency department for evaluation by her school guidance counselor and subsequently referred for inpatient hospitalization.

CHIEF COMPLAINT: "I told my friend I was hurting myself."

HISTORY OF CHIEF COMPLAINT: The patient told her friend at school that she had been self-harming by making cuts on her left forearm and that she wanted to die. She states she cuts herself after arguments with her mother because it helps her to feel better. Her mother would not let her go out with her friends and expects her to help take care of the house and her younger siblings. Patient started to have suicidal thoughts about a month ago, and the thoughts have been increasing in intensity since then. She currently has a plan to overdose on over-the-counter sleep medication that her mother keeps at home. Patient reports difficulty focusing in school and recent loss of energy. She reports crying daily at home and denies history of symptoms of mania or hypomania.

PAST PSYCHIATRIC HISTORY: No previous psychiatric hospitalizations. Patient was in outpatient therapy about 6 months ago because of depression and anxiety. She stated that she had stopped going because insurance did not cover it anymore and her family could not afford to pay for it. No previous psychiatric medication trials.

MEDICAL HISTORY: No known allergies. No acute or chronic medication problems. Regular menses. Not using any birth control. Patient reports poor sleep and reduced appetite for the past month. Not intentionally restricting her diet. Height and weight are within normal limits. Superficial healing lacerations noted on left forearm.

HISTORY OF DRUG OR ALCOHOL ABUSE: Patient denied use of alcohol, marijuana, or other illicit substances.

FAMILY HISTORY: Patient's mother is from Ecuador and her father is from Puerto Rico. The patient was born in the United States. She lives at home with her mother and three younger siblings. The patient's father returned to Puerto Rico about 4 years ago, and she has minimal contact with him. Her mother works for a catering company. Patient's mother has a history of depression treated with fluoxetine. Maternal aunt and grandmother too may have depression. No reported psychiatric hospitalizations or family history of bipolar disorder.

PERSONAL HISTORY

Perinatal: Normal full-term vaginal birth. No known complications.

Childhood: No developmental delays or learning disorders.

Adolescence: The patient states she gets mostly As and Bs in her classes at school and does not require any special educational accommodations; however, her

grades have declined significantly in the past month. She identifies as bisexual and denies any current intimate relationship. History of sexual activity with both male and female peers.

TRAUMA/ABUSE HISTORY: Patient denied.

MENTAL STATUS EXAMINATION

Appearance: Casual dress, adequate grooming and hygiene, bangs dyed blue.

Behavior and psychomotor activity: Normal gait, moderate eye contact.

Consciousness:	Alert.
Orientation:	Oriented to person, place, and time.
Memory:	Not formally tested but appeared intact during the assessment.
Concentration and attention:	Attention was intact during the assessment.
Visuospatial ability:	Not assessed.
Abstract thought:	Not formally assessed.
Intellectual functioning:	Good intellectual functioning and vocabulary.
Speech and language:	Quiet volume, low pressure, underproductive.
Perceptions:	No evidence of perceptual disturbance. Patient denied hallucinations.
Thought processes:	Logical, coherent.
Thought content:	Preoccupied with anger about having to take care of her siblings.
Suicidality or homicidality:	Suicidal ideation with plan to overdose on over-the-counter sleep medication, which she has access to at home. Patient reports uncertain intent to act on this plan.
Mood:	Depressed.
Affect:	Congruent with mood, constricted.
Impulse control:	Poor.
Judgment/Insight/Reliability:	Poor/Poor/Fair.

FORMULATING THE DIAGNOSIS

Which diagnosis (or diagnoses) should be considered?

296.23 (F32.2) Major Depressive Disorder, Single Episode, Severe

Diagnostic Criteria

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

- **Note:** Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (eg, feels sad, empty, hopeless) or observation made by others (eg, appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (eg, a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiologic effects of a substance or another medical condition.

Note: Criteria A–C represent a major depressive episode (MDE).

Note: Responses to a significant loss (eg, bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of the MDE in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

In distinguishing grief from an MDE, it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, whereas in an MDE, it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of an MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of an MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in an MDE. In grief, self-esteem is generally preserved, whereas in an MDE, feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (eg, not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in an MDE, such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

D. The occurrence of the MDE is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

- **Note:** This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance induced or are attributable to the physiologic effects of another medical condition.

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What is the rationale for the diagnosis?

The patient's symptoms include depressed mood, loss of appetite, insomnia, loss of energy, diminished ability to concentrate, and recurrent thoughts of suicide. Therefore, she reports more than five symptoms required for diagnosis of a major depressive disorder. They have contributed to clinically significant distress and impairment of her academic functioning. Her symptoms are not attributable to physiologic effects of a substance or to another medical condition. In addition, the symptoms are not caused by other schizophrenic or psychotic disorders. Her symptoms have never included a manic or hypomanic episode.

Which condition should be considered?

There is no current *Diagnostic and Statistical Manual of Mental Disorders,* 5th *ed.* (*DSM-5*) code for Nonsuicidal Self-Injury (NSSI). It is listed in the section for Conditions for Further Studys: Nonsuicidal Self-Injury in *DSM-5*.

Proposed Criteria

A. In the last year, the individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body of a sort likely to induce bleeding, bruising, or pain (eg, cutting, burning, stabbing, hitting, excessive rubbing), with the expectation that the injury will lead to only minor or moderate physical harm (ie, there is no suicidal intent).
   - **Note:** The absence of suicidal intent has either been stated by the individual or can be inferred by the individual's repeated engagement in a behavior that the individual knows, or has learned, is not likely to result in death.

B. The individual engages in the self-injurious behavior with one or more of the following expectations:
   1. To obtain relief from a negative feeling or cognitive state.
   2. To resolve an interpersonal difficulty.
   3. To induce a positive feeling state.
      - **Note:** The desired relief or response is experienced during or shortly after the self-injury, and the individual may display patterns of behavior suggesting a dependence on repeatedly engaging in it.

C. The intentional self-injury is associated with at least one of the following:
   1. Interpersonal difficulties or negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately before the self-injurious act.
   2. Before engaging in the act, a period of preoccupation with the intended behavior that is difficult to control.
   3. Thinking about self-injury that occurs frequently, even when it is not acted upon.

D. The behavior is not socially sanctioned (eg, body piercing, tattooing, part of a religious or cultural ritual) and is not restricted to picking a scab or nail biting.

E. The behavior or its consequences cause clinically significant distress or interference in interpersonal, academic, or other important areas of functioning.

F. The behavior does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal. In individuals with a neurodevelopmental disorder, the behavior is not part of a pattern of repetitive stereotypies. The behavior is not better explained by another mental disorder or medical condition (eg, psychotic disorder, autism spectrum disorder, intellectual disability, Lesch–Nyhan syndrome, stereotypic

movement disorder with self-injury, trichotillomania [hair-pulling disorder], excoriation [skin-picking] disorder).

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What is the rationale for the diagnosis?

The patient meets the proposed criteria of engaging in intentional self-inflicted harm to her body (cutting) of a sort that may induce pain with the expectation that the injury will lead to only minor physical harm. She is engaged in the self-injurious behavior with the intent to resolve interpersonal difficulty (with her mother). The self-injury is associated with depressive and angry thoughts before the behavior. The cutting is not a socially sanctioned behavior. It does not seem to cause clinically significant distress at this time. It is not associated with substance intoxication, psychosis, or neurodevelopmental disorder. Therefore, if NSSI were a diagnostic category in the next edition of the *DSM*, she would likely meet the criteria.

What test or tools should be considered to help identify the correct diagnosis?

Patient interview will be used to assess the extent of suicidality. The therapeutic alliance and detailed interviewing are the best means to evaluate symptoms in an inpatient setting. However, using a Hamilton Depression Scale is another option. The Self-Injurious Thoughts and Behaviors Interview (SITBI) could be used to assess self-injurious behaviors.

Gathering collateral information from the family and prior hospital records would be integral to assessing the patient. Because of the short stay in inpatient units, it may not be practical to obtain school records and records from previous outpatient providers, even though these would be useful sources of information in formulating the diagnosis and subsequent treatment.

What differential diagnosis (or diagnoses) should be considered?

None.

FORMULATING THE TREATMENT STRATEGY

What treatment would you prescribe and what is the rationale?

Psychopharmacology: Fluoxetine 10 mg daily. This medication is FDA approved to treat major depressive disorder for ages 8 to 18.

Consider Naltrexone 25 mg daily for self-injurious behaviors. Naltrexone is used off-label for self-injurious behaviors. The patient should be monitored for increase or decrease in self-injurious behavior.

Diagnostic Tests: All routine blood work and pregnancy test. If any symptoms of sexually transmitted infections (STIs) become apparent, then appropriate testing and referrals can be made.

Referrals: Because the patient is currently hospitalized on an inpatient unit, a family meeting with the social worker will address psychodynamic stressors. Patient will be referred for continued medication management and psychotherapy following discharge from the psychiatric hospital.

Type of Psychotherapy: Group therapy with peers on the inpatient unit.

Psychoeducation: There is an FDA warning on all selective serotonin reuptake inhibitor (SSRI) medications regarding risk of increased suicidality when prescribing antidepressant medications for people up to age 25.

Educate the patient and the family about the medication and psychotherapy to improve treatment adherence and to address any concerns they may have.

What standard guidelines would you use to treat or assess this patient?

AACAP Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. *J Am Acad Child Adolesc Psychiatry. 2007*;46(11):1503–1526.

CLINICAL NOTE

- Cultural influences, including gendered expectations, may contribute to additional stressors in certain ethnic populations. This should be evaluated on a case-by-case basis. Cultural awareness is vital in treating patients and families who are members of minority populations.

REFERENCES/RECOMMENDED READINGS

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington, VA: American Psychiatric Publishing; 2013.

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