Suicide and Bullying

Behavioral health Education Center of Nebraska (BHECN)
2015 Mental Health Nursing Training Series
Program 2: May 21, 2015

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Disclosures

• Dr. Catherine Jones-Hazledine does not have any conflicts of interest to disclose related to any aspect of this presentation.

• Heather Wilhelm is a speaker for the Otsuka Pharmaceutical Company. Ms. Wilhelm states that all information will be presented fairly and without bias and that she has not accepted a fee from a commercial company to do this presentation.
About BHECN

The Behavioral Health Education Center of Nebraska (BHECN, pronounced “beacon”) was created by the Legislature to address the shortage of behavioral health professionals in rural and underserved areas. BHECN recruits & educates students in behavioral health and trains & retains professionals in the workforce.

By increasing the number of behavioral health professionals, improving accessibility of behavioral health care, and building competence of the workforce, we are improving the health of all Nebraskans.

Learn more at unmc.edu/bhecn

Keep up with the latest events and trainings from BHECN: facebook.com/BHECN
Purpose

The purpose of this webinar series is to enable the learners to access and apply mental and behavioral health best practices for patient clinical care and support to promote recovery and reduce stigma.
About the Mental & Behavioral Health Care Webinar Series

Individual webinars will focus on common psychiatric disorders using a holistic approach to include cultural awareness, spirituality, interdisciplinary collaboration, psychopharmacology, and principles of recovery.
Acknowledgements

BHECN would like to acknowledge the collaboration with the American Psychiatric Nurses Association, NE Chapter (APNA-NE) in the development and implementation of this educational series.

Learn more at: www.apna.org
Mental illness prevalence

• 4.4% of Nebraskans are estimated to have a serious mental illness

<table>
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<th>Region</th>
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Note: Include both full- and part-time practitioners, 2012
Rate of Psychiatric Prescribers (MD/DO, APRN & PA) by Nebraska county, 2012
Child and Adolescent Bullying: Identifying and Intervening

CATHERINE JONES-HAZLEDINE, Ph.D.
Today we will talk about

• What bullying is, and what forms it takes
• Who bullies
• What contributes to this behavior (and how)
• Consequences of bullying
• What can be done to address the problem
  –for parents, schools, medical providers
What is “bullying”? 
• Bullying is a repeated aggressive behavior that is intentional and involves an imbalance of power.
• Power imbalance can be due to size or social status.
• Aggressive behavior can be physical, verbal or emotional.
  – Verbal is the most common.
Accepted Definition

- 3 Components
  - Intentional
  - Repeated
  - Power Imbalance
Is This Bullying?

Jo hates Kelsey. They used to be friends, but had a fight and stopped hanging out. Now every day in the hallway, Jo and her new friends make a point of staring and whispering under their breath and then giggling when Kelsey walks by. They aren’t really saying anything about her, but want her to think they are
Is This Bullying?

A group of 8th Graders always sit in the same seats on the bus, and like to suddenly stick out a foot to trip an unpopular 6th Grader as he walks past.
Is This Bullying?

Jen and Tara have an argument at school. Tara texts Jen afterward to say how angry she is, and that she doesn’t want to be friends any more.
Is This Bullying?

Sam and his friends play football at recess. Sam routinely tells John that he cannot play because he “is not fast enough”, so John is only allowed to play football with the group if Sam is absent.
Is This Bullying?

Pam has poor frustration tolerance and when she cannot understand something in class she tends to get very angry and verbally “lash out” at whoever is near – telling them to “shut up” or “drop dead”.

Forms of Bullying

- Physical Bullying
  - Hitting, kicking, poking, tripping
- Verbal Bullying
  - Calling names, insults, racist remarks
- Social Bullying
  - Not letting someone join a group, spreading rumors or lies, mimicking
- Psychological Bullying
  - Intimidating, stalking
- Cyber-bullying
  - Using technology to make someone feel bad
Some bullying behaviors

- Pushing, hitting, kicking
- Spreading a mean rumor
- Repeatedly calling names
- Repeatedly making fun of someone’s clothing, speech, appearance, etc
- Preventing someone from sitting at a certain table, being involved in an activity, associating with a group.
- Sending mean or threatening emails, texts, Facebook posts
More bullying behaviors

- Stealing or destroying another’s property
- Playing pranks on someone in front of their peer group
- Obscene gestures or language intended to harass or embarrass
- Repeated racial slurs
- Intentional, repeated annoyance of another
Identifying the Bullies

WHO BULLIES?
If Only It Were This Easy To Tell....
Who Bullies?

- There are bullies everywhere
  - All regions, all socioeconomic statuses, both genders, all ages
    - Problem peaks, though, in Middle School
    - Likely due to transitional nature of this time
      - Less supervision, hormonal changes, stress of transition, greater likelihood of depression and anxiety in this group, etc
- 30% of all kids in grade 6 – 10 have been involved in bullying (either being bullied or bullying someone) in any given semester
- Boys are more likely to be physically bullied
- Girls are more likely to be victims of rumor or sexual comments and are more likely to use social exclusion (not let people hang out with them)
Who Bullies?

• It is important to remember that there are not really stable categories of “bully” and “victim” – kids involved in bullying may cross back and forth over this line during their time in school.

• At the same time, research indicates that “80 percent of the problem is caused by 20% of the students”
Consequences of Bullying

THE HIGH COST OF BULLYING
Effects of Bullying

- Kids who are bullied are more likely to:
  - Be depressed
  - Be anxious
  - Be lonely
  - Have low self-esteem
  - Feel sick a lot
  - Have migraine headaches
  - Think about suicide
    - 15 – 25 kids per year commit suicide due to bullying
Effects of Bullying

- Kids who bully are more likely to:
  - Be unemployed later
  - Have substance abuse problems
  - Engage in dating or marital violence
  - Be convicted of a crime
  - Commit suicide
Why Does This Happen?

CAUSES OF BULLYING
What Causes Bullying?

- Not a simple question!
- Probably multiple factors
  - Individual Factors
  - Family Factors
  - Peer Group Factors
  - School Factors
  - Community Factors
Individual Factors

- Depression, Anxiety and other emotional issues
  - Misery loves company?
- Impulsiveness
  - Makes students prone to “act first, think later” types of behavior
- Poor social skills
  - Can lead to negative attention seeking
- Inadequate coping ability
  - Reduces student’s ability to more appropriately handle frustration, sadness, etc
Family Factors

- Abuse
- Neglect or just lack of parental involvement
- Inadequate supervision
- Aggressive behaviors modeled by family
Peer Group Factors

● Bullying is seen as acceptable
● “Mob Mentality”
  ○ People often willing to do or say things in a group that they wouldn’t 1:1
● Us versus Them (e.g. jocks versus nerds)
School Factors

● Inadequate staffing
  ○ Inadequate supervision in high-risk areas

● Adults are bullies
  ○ Students pay attention if staff model name-calling, teasing, mimicking of other students or staff

● Lack of adult intervention
  ○ Failure to see bullying as a problem
    • This is “normal kid behavior”
    • Kids need to “just deal”
  ○ Discouragement of “tattling”
School Factors

● Punishment versus intervention
  ○ Zero tolerance policies not necessarily effective

● Negative school climate
  ○ Where staff or students are unhappy
  ○ Prosocial behaviors are not encouraged/valued
Community Factors

- High levels of community aggression
- Few resources
- Lack of community-school cooperation
How do we stop this?

FINDING WORKABLE SOLUTIONS
Preventing and Intervening

● Simply having a no-tolerance policy is not enough
● Neither is a one time “bullying” presentation
● Teachers can’t do this alone
  ○ Change must include students, staff, parents, community members, and providers.
In Medical Settings

- Identifying at-risk children
- Helping families
- Screening for comorbid conditions
- Advocating for change
Identifying At-Risk Children

- Not necessarily a good screening measure
- Medical providers should ask about bullying if there are unexplained somatic symptoms
- Screen for bullying if there are dramatic changes in behavior
- Some students are at higher risk:
  - Students with academic differences often targets
  - Obese students, or students with physical disabilities
  - Gay/bi-sexual/transgendered students
Counseling Families

- Medical providers may need to help families understand the severity of the problem
- Teaching regarding the impact of the bullying and its effects
- Information about effective coping/interventions
- Guiding to resources to help
Screening for Comorbid Conditions

- If bullying continues, screening for behavioral health conditions may be necessary
  - Anxiety
  - Depression
    - Suicide risk
  - Conduct disorder
Advocating for Change

- As community members, consultants and providers we can often advocate for change in how families and schools address this issue.
  - at a school level
  - at a community level
  - at a family level
At a School-Wide Level

● Create an advisory team to study this issue in your school
  ○ Every school is different
  ○ Advisory team should include staff members, administration, parent members and students
● Involve EVERYONE
● Have a clear anti-bullying policy
  ○ Study policies from “model” districts
  ○ Policy should clearly define bullying
  ○ Reporting procedures, investigation, and consequences should be outlined
● Policy must be written AND clearly communicated to staff and students. Frequently.
At a School-Wide Level

● Prevention is important
  ○ It is never too early to start teaching tolerance, empathy and prosocial behavior

● Increased adult supervision will help
  ○ Certain areas and times are more “high risk”
  ○ These may vary school to school, but often include: hallways between classes, recess, bus rides, periods before and after school, bathrooms

● Train, train, train
  ○ Have trainings for all staff in how to respond consistently
  ○ Train students in how to respond to bullying
  ○ Train parents in how to identify and address these problems with their kids
At a School-Wide Level

● Don’t limit this discussion to seminars and assemblies
  ○ Set aside class time to address bullying topics
  ○ Include Bullying literature in reading classes, etc

● Provide individual and group resources to victims of, and perpetrators of, bullying
  ○ Remember long-term consequences for both groups?
At a School-Wide Level

- Changing the school “climate”
  - Have adults consistently model appropriate social behaviors
    - In their own behavior, and when they witness students exhibiting inappropriate behaviors
  - Encourage and reinforce prosocial behaviors and let students do the same
    - Coins for kindness
  - Recruit older students as models and mentors and identify them to the student population
    - Use peer pressure to your benefit!
In The Classroom and at Home

- Model prosocial behaviors
  - Be careful of your own use of teasing, etc
  - If you hear children being unkind or socially unskilled use it as a teaching moment

- Teach to this problem as often as possible
  - Consider including readings about this issue in your curriculum
  - Family Discussions

- Make sure that children understand the definition of bullying, and set a firm classroom/family policy
  - Have clear consequences
● Be careful about words such as “tattling”  
  ○ Tattling is telling an adult SOLELY to get someone else in trouble

● Don’t overestimate children’s coping abilities  
  ○ If children could “just ignore it” they wouldn’t be bringing it up to you in the first place

● Communicate  
  ○ Parents, teachers, medical professionals

● Use school and community resources  
  ○ Refer high risk kids to school or community counseling professionals
S.T.A.N.D

• Students Taking A New Direction Against Bullying
• A program that involved Gordon-Rushville Middle School, Gordon Elementary School and Gordon-Rushville High School
• Asked students to commit to:
  ○ Standing for something different than bullying
  ○ Standing up for themselves if they are bullied
  ○ Standing up for others if they see them being bullied
• Almost entire student populations (literally with 2 exceptions) signed a commitment sheet
• Used highly valued high school mentors
• Signed commitment of agreement to principles
• Highly identifiable visual element (tie-dyed shirt)

Smilebox Playback
References

- National Health Service Corps. www.stopbullyingnow.hrsa.gov
Suicide Across the Lifespan

Heather Wilhelm, MSN, PMHNP-BC
Just the Facts

• In 2013: 41,149 people in the United States died by suicide. About every 12.8 minutes someone in the country intentionally ends his/her life.

• Despite all of the new treatments, the suicide rate continues to fluctuate.
Just the Facts

• In 2013, the suicide rate was 12.6/100,000 deaths, making suicide the 10th leading cause of death in the United States.

• This greatly exceeds the homicide rate (5.3/100,000)

• From 1981-2010: 939,544 people died via suicide. 479,471 died from AIDS and HIV-related illnesses.
Just the Facts
(American Foundation on Suicide Prevention)

10 Leading Causes of Death, U.S., 2010

- Heart Disease: 595,444
- Malignant Neoplasms: 573,855
- Chronic Lower Respiratory Diseases: 137,789
- Cerebrovascular Diseases: 129,180
- Unintentional Injury: 118,043
- Alzheimer’s Disease: 83,308
- Diabetes Mellitus: 68,905
- Nephritis: 50,472
- Influenza & Pneumonia: 50,003
- Suicide: 37,793
Just the Facts
Just the Facts

Who is Most at Risk for Death by Suicide?

Suicide death rates vary considerably among different groups of people. The CDC reports suicide rates by four key demographic variables: age, sex, race/ethnicity, and geographic region/state.
Just the Facts

Suicide Rates By Age

• Midlife is the peak of suicidal behavior

• In 2013, the highest suicide rate (19.1) was among people 45 to 64 years old. The second highest rate (18.6) occurred in those 85 years and older. Younger groups have had consistently lower suicide rates than middle-aged and older adults. In 2013, adolescents and young adults aged 15 to 24 had a suicide rate of 10.9
Comparing Midlife to Late life

• Suicide rates (per 100,000) in 2013
  – 35 – 44 years: 16.00 (6,571 deaths)
  – 45 – 54 years: 19.55 (8,799 deaths)
  – 55 – 64 years: 17.50 (6,384 deaths)
  – 65 – 84 years: 14.45 (5,026 deaths)
    • Men 26.89
  – 85 + years: 17.62 (968 deaths)
    • Men 47.33
Just the Facts

• Suicide is the third leading cause of death for people ages 10-24.

• Suicide is the second leading cause of death for people ages 25-34.

• Suicide is the fourth leading cause of death for adults between the ages of 18-65.
Just the Facts

Question?

• Why do we hear so much about teen suicide when the teen suicide rate is below average?

• Is it warranted?
Just the Facts

Suicide Rates By Sex

• For many years, the suicide rate has been about 4 times higher among men than among women. In 2013, men had a suicide rate of 20.2, and women had a rate of 5.5. Of those who died by suicide in 2013, 77.9% were male and 22.1% were female.
Just the Facts
Just the Facts

Suicide Rates in Ethnicity

• White males accounted for 70% of all suicides in 2013.

• In 2013, the highest U.S. suicide rate (14.2) was among Whites and the second highest rate (11.7) was among American Indians and Alaska Natives. Much lower and roughly similar rates were found among Asians and Pacific Islanders (5.8), Blacks (5.4) and Hispanics (5.7).
Just the Facts

Suicide Methods

• In 2013, firearms were the most common method of death by suicide, accounting for a little more than half (51.4%) of all suicide deaths. The next most common methods were suffocation (including hangings) at 24.5% and poisoning at 16.1%
Risk Factors
Warning Signs of Suicide

- Risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss or change.
- Talking about wanting to die or to kill oneself.
- Looking for a way to kill oneself, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or in unbearable pain
Risk Factors

Warning signs (continued)

• Talking about being a burden to others.
• Increasing the use of alcohol or drugs.
• Acting anxious or agitated; behaving recklessly.
• Sleeping too little or too much.
• Withdrawn or feeling isolated.
• Showing rage or talking about seeking revenge.
• Displaying extreme mood swings.
Risk Factors

Additional Warning Signs of Suicide

• Preoccupation with death.
• Suddenly happier, calmer.
• Loss of interest in things one cares about.
• Visiting or calling people to say goodbye.
• Making arrangements; setting one's affairs in order.
• Giving things away, such as prized possessions.
Risk Factors

Warning Signs in Older Adults

- Unexplained or aggravated aches and pains
- Feelings of hopelessness or helplessness
- Anxiety and worries
- Memory problems
- Lack of motivation and energy
- Slowed movement and speech
- Irritability
- Loss of a loved one
- Loss of interest in socializing and hobbies
- Neglecting personal care (skipping meals, forgetting meds, neglecting personal hygiene)
Risk Factors

Psychiatric Diagnosis

• Major Depressive Disorder
• Bipolar Disorder, depressed phase
• Alcohol or Substance Abuse (primary diagnosis in youth suicides)
• Schizophrenia
• Personality Disorders
Risk Factors

Past Suicide Attempt
Risk Factors

Past suicide attempt

(See diagram on right)

After a suicide attempt that is seen in the ER about 1% per year take their own life, up to approximately 10% within 10 years.

More recent research followed attempters for 22 years and saw 7% die by suicide.
Risk Factors

Other psychiatric factors

- PTSD
- Eating Disorders
- Borderline Personality Disorder
- Antisocial Personality Disorder
Risk Factors

Other factors

• Major physical illness, especially recent
• Chronic physical pain
• History of childhood trauma
• Family history of death by suicide
Risk Factors

Suicide Rates by Region

• In 2013, nine U.S. states, all in the West, had age-adjusted suicide rates in excess of 18: Montana (23.7) and Alaska (23.1) being the highest with Massachusetts (8.2), and Connecticut (8.7) the lowest.
Risk Factors

Environmental

- Bullying
- Suicide “contagion”
- Access to lethal means
- Brain biology
- Socioeconomic status
Risk Factors

Sociodemographic

- Male
- Over age 45-64
- White
- Separated, Widowed, Divorced
- Living alone
- Unemployed or retired
- Occupation (health related occupations high, especially women physicians)
Prevention

Individual and Public Awareness

- Encourage help-seeking behaviors and continuation of treatment
- Destigmatize illness
- Destigmatize treatment
Prevention

Professional Awareness

• Healthcare professionals
  – Physicians, pediatricians, NPs, PAs, Nursing facility staff

• Mental Health professionals
  – Psychologists, social workers
Prevention

• College and University Staff
  – Counselors, Student Health, Student Residence, Resident Hall Directors, Advisors

• Other
  – Religious Leaders, Police, Fire, Armed Services
Prevention

Screening

• Must identify At-Risk individuals
Prevention

Prevention in Adolescence

• Ask the adolescent about it. Don't be afraid to say the word "suicide." Getting the word out in the open may help the child think someone has heard his/her cries for help. Pay attention to behaviors.
• Reassure him/her that he/she is important. Remind him/her that no matter how awful his/her problems seem, they can be worked out, and you are willing to help.
Prevention

Prevention in Adolescence

• Ask him/her to talk about his/her feelings. Listen carefully. Do not dismiss his/her problems as “typical teen behavior.”
• Make sure all lethal weapons are removed from the home, including guns, pills, kitchen utensils and ropes.
Prevention

Prevention in Midlife

- **Health**: Monitor for changes in health. Monitor for mood changes related to health
- **Aging**: Monitor for mood changes related to the perception of aging
- **Veterans**: Closely monitor for mood changes in recent war veterans
- **Caregivers**: Monitor those who have caregiver burdens
Prevention

Prevention in Older Adults

• **Intervention** — Acting on clues in changes in personality, behaviors and routines; talking honestly with the adult about their feelings of depression; ensuring the older adult sees a medical professional.

• **Maintaining** — Helping the at-risk individual maintain their medical intervention, whether by driving them to health appointments or ensuring they are adhering to prescribed treatments, whether in the form of prescription drugs, psychotherapy or other methods, that will enable them to combat their depression.
Prevention

• **Socializing** — Many older adults become isolated as their medical needs increase and their circle of friends grows smaller; it is vital to stave off general feelings of depression by ensuring that older adults are able to live their lives to the fullest extent, including being able to contribute to the community they live in. Take time to ensure they have an engaging social calendar and are able to indulge in interests they are passionate about.
Prevention

Treatment

- Medications
- Psychotherapy
Prevention

BOTTOM LINE!

• On-going screening is essential and professional help must be sought out!
Prevention
Resources


Practice Guideline For the Assessment and Treatment of Patients With Suicidal Behaviors
Resources

https://www.afsp.org/ American Foundation for Suicide Prevention
Mental & Behavioral Health Care Webinar Series 2015-2016

- March: Intro: Brain function, overview of Mental Illness
- May: Suicide/Bullying
- July: Diagnosis and Treatment of a Complex Psychiatry Patient
- Sept: Differentiating Depression & Bipolar Depression
- Nov: Schizophrenia & Associated Comorbidities
- Jan: Dementia in Long Term Care
Questions and Evaluation

• Questions?

• To receive your CNE certificate, complete the evaluation: http://bit.ly/MH-Webinar-Eval

• Slides and a recorded version of the webinar will be available soon.