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Aggression Management & Verbal De-Escalation

Overview and Objectives

The ability to effectively handle aggression is a crucial skill for someone working in Behavioral Health. Self-management and assertive communication are two key components to verbal deescalation.

This course will explore identifying, preventing and managing aggressive behavior through the use of verbal de-escalation interventions.

Introduction

Aggression

In psychology, the term aggression refers to “a range of behaviors that may result in both physical and psychological harm to oneself, others or objects in the environment.” The expression of aggression may occur in a variety of ways including verbally, mentally and physically. (Cherry, K. (n.d.) aboutpsychology.com)

Verbal De-escalation

Verbal de-escalation is a targeted, non-physical, intervention used with clients to diffuse, redirect, or de-escalate a conflict situation. The technique of verbal de-escalation uses calm language, along with other communication skills during a potentially threatening or dangerous situation in order to prevent an individual from causing harm to self, others, or the environment.

Aggression and Behavioral Health

As behavioral health workers, we interact closely with clients and their families. On many occasions, these interactions occur under difficult circumstances, possibly due to the client’s illness, personal issues, medication, or history of violent behavior. Violent and/or aggressive behavior from a client is common in the behavioral health field and staff members are often required to diffuse crisis situations. The ultimate goal is to provide an environment that is safe for both clients and staff members.



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It is important to remember that the client's interests and needs always come first. As behavioral health workers, we need to recognize that the aggressor is often feeling threatened, anxious, or fearful, and will respond even more aggressively if he/she feels threatened.

When the need to manage aggression arises, keep in mind it is beneficial to be genuine and authentic in order to build rapport with a client. The way we treat the client will influence how they respond to our de-escalation strategies. The majority of potentially violent situations can be diffused successfully through the use of effective communication techniques. Our goal as behavioral health workers is to remain calm and confident in our interactions with the escalated client, with hopes that he/she will respond positively to our respectful, assertive techniques.

Signs of Aggression

Possible signs of aggression to watch out for include:

- Easily or often angered
- Making threats of violence
- Intimidating others
- Drastic change in personality
- Red/flushed face/perspiring
- Standing tall
- Clenched fists
- Rapid breathing/pacing
- Direct, prolonged eye contact
- Exaggerated gestures
- Narrowing of the gaze
- Tight jaw/facial muscles
- Raised voice

Possible reasons clients become aggressive include:

- Frustration
- Immaturity
- Humiliation
- Excitement
- Learned Behavior



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- A means to an end
- To assert dominance
- To intimidate or threaten
- To express possession
- Unfairness (perceived or real)

When dealing with an aggressive client, consider the factors that may be contributing to the individual's aggression (risk factors) such as:

- Is the person facing a high level of stress? (e.g. recent bereavement, pending court issues)
- Is the person under the influence of substances or coming off substances?
- Does the person have a history of violence?
- Does the person have a history of psychiatric illness?
- Does the person have a history of violence or verbal abuse toward staff in the past?
- Has the person suffered a significant loss or frustration (e.g. losing a pass or parental rights)
- Has the person received a warning about their behavior?
- Does the person believe they have been treated disrespectfully?
- Has the person failed to receive a privilege they expected or counted on?
- Does the person have a hostile relationship with another client?

Effective Verbal De-Escalation

According to John Lundholm (2007), effective verbal de-escalation of aggression is built on five key strategies:

1. Self-management
2. Situational awareness (managing the stages of conflict)
3. Non-verbal communication
4. Listening (active and empathetic)
5. Assertive verbal communication

Self-management

In terms of managing our clients and their aggression, we need to first look at ourselves and the way we manage and express our emotions. Behavioral Health can be a very challenging and



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overwhelming environment to work in. At times, stressful situations arise in the workplace and how you choose to handle these situations is of the utmost importance. The choices we make in managing our emotions and responding to situations greatly influence the workplace environment. Most importantly, our choices and our behavior influence our relationships and rapport with clients.

“Everything can be taken from a man but the last of human freedoms – the ability to choose one's attitude in a given set of circumstances, to choose one's way.” – Viktor Frankl, "Man's Search for Meaning."

When working with our clients, we must strive to:

- Appear calm
- Be present
- Have relaxed muscles
- Look confident
- Be open and receptive
- Abstain from judgment
- Use a calm monotonous voice
- Be respectful and assertive

Situational Awareness

Situational awareness involves being aware of what is happening around you in order to understand how information, events, and one's own actions will impact goals and objectives, both immediately and in the near future. ("Situational awareness". (n.d.), para. 2, In Wikipedia) It is important to be aware of factors in the environment, in the client, and in the staff that can escalate the risk of violence. Awareness allows you to predict what is likely to happen next and what action you need to take. The more awareness you bring to a situation, the better equipped you will be to make smart and safe decisions. It is important to take responsibility for your own safety and security, as well as that of your peers. Listen to your gut and your intuition at all times, even when you are busy or distracted.

In a crisis situation, ask yourself the following questions to perform a quick self-assessment:

- Do I need to call for help from co-workers?
- Can I avoid criticizing and finding fault with the angry person?



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- Can I avoid being judgmental?
- Can I keep myself removed from conflict?
- Can I see the situation from the angry person's point of view or understand the need he/she is trying to satisfy?
- Can I remember that my job is to keep the peace and protect the client and staff?

Non-verbal Communication

It is important to recognize that a large part of communication is non-verbal; therefore, our facial

expressions, gestures, eye contact, posture, and tone of voice can speak the loudest. In order to be an effective communicator it is essential to be aware of your own non-verbal signals and body

language. Below are some descriptions and tips for non-verbal communication:

- **Space and Positioning**—It is important to remember that the amount of space required to feel comfortable differs based on gender, familiarity, culture, mood, etc. We all have our comfort level when it comes to personal space. Space can be used to communicate aggression or dominance. Standing too close to an angry individual can make him/her feel unsafe and, in turn, make YOU unsafe. Always position yourself to be at the same eye level as the client—if they are sitting, you sit—if they are standing, you stand. When standing, stand at angle from the individual—if you stand directly in front of a client they may feel more threatened and boxed in. Avoid standing too close to the person—a “kickdistance” is an appropriate gauge. Never turn your back to the client, as this can communicate that you don't care what the person has to say or you can get hurt because you will not be aware of your surroundings. Position yourself closer to the room entrance than the escalated client—do not physically back yourself into a corner.
- **Facial Expressions**—Be aware of your facial expressions. Your facial expressions and non-verbal signals can affect how a client will respond to you and their willingness to trust you. Be careful not to smile or laugh when re-directing a client as this will most likely escalate the client further.
- **Eye Contact**—The way we look at a person can communicate many different things such as anger, affection, and sadness. Staring at someone can cause them to feel anxious or uncomfortable. However, we need to use our eyes to express interest in what people are saying and communicating, so it is important to keep good eye contact without appearing confrontational. We must also keep in mind cultural differences when it comes to eye contact. Knowing a culture's norms can help you sharpen your non-verbal communication skills by teaching you to pick up on or use different facial or body



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language signals.

- Voice Tone—Certain voice tones can disturb some people and cause their aggression levels to rise. Pay attention to your tone and inflection—it's not what you say it's how you say it. Keep your voice calm and even, do not sneer, scowl, yell or sigh in exasperation.
- Body Movements and Gesture—Be aware of your own body language; keep an open stance, with your arms down at your side. Try to keep movements slow and calm. Be aware of your hand and arm movements as to not make gestures that could be perceived as threatening. Keep your hands out of your pockets and where they can be seen at all times—keep them in front of you, open and relaxed. Do not cross your arms or point your finger at the individual.

Listening

Active listening is the primary strategy for diffusing anger and aggression. Most people prefer to resolve conflict through communication and cooperation, rather than through aggression. People desperately need to be heard, and active listening keeps the lines of communication open. Active listening involves supporting positive conversation, acknowledging the other person's point of view, repeating back what they said in your own words, and showing empathy. Sometimes all an angry person needs is for someone to take the time to allow them to vent his/her anger and frustrations. Active listening is attempting to hear, acknowledge and understand what a person is saying (listening not only to words, but also to the underlying emotion as well as to body language). The objective of active listening is to build trust, collect relevant information, and diffuse any anger.

Steps to Active Listening

In order to actively listen to others take the following steps:

- Sit or stand with a receptive posture (do not slump your shoulders, be open with posture, do not cross arms in front of our chest as this will display a closed off approach).
- Look at the speaker—this will show that you are listening to them and not looking at your cell phone or distractions around you. Nod to let the client know you are acknowledging them.
- Let the speaker know you are listening (facial and verbal). Smile if appropriate to show them you are listening; be conscious of your facial expressions. Do not roll your eyes.



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- Paraphrase, summarize and repeat back what you've heard for accuracy—this will allow you to repeat what the client said and understand what they are telling you. This will help prevent miscommunication.
- Ask for more information if needed —ask questions as this can be encouraging to the client and you can get a clarification of their point of view and what happened.
- Allow the speaker to confirm accuracy—wait for the client to confirm that you understood what they stated.
- Allow silence —although you may find the silence unbearable, sometimes the escalated person may need time to reflect or think. We need to allow the other person silent time to reflect and collect their thoughts, and often they come up with their own solutions!
- Agree —frequently, when people are angry about something, there is at least some truth in what they are saying. When attempting to diffuse a client's anger, it is important to find that truth and validate their feelings.
- Apologize —sincerely apologizing for anything in the situation that was unjust or unfair allows for a client to feel heard and validated and can assist in de-escalation.
Invite criticism —simply ask the escalated person to voice his/her concerns of the listener (What am I doing wrong that makes you so angry at me? Tell me, I want to hear everything you are angry about.)

Assertive Verbal Communication

There are major differences between aggressive and assertive communication.

- Aggressive Communication is based on winning and initiating hostility. Aggression is acting without regard for the rights, needs, feelings, or desires of others. An individual with an aggressive style of communication may be perceived as a bully who disregards the needs, feelings, and opinions of others. Very aggressive people humiliate and intimidate others and can be physically threatening.
- Assertive Communication is based on balance and mutual respect. It requires being forthright about your wants and needs while still considering the rights, needs, and wants of others. Being assertive means being confident, direct and respectful. Guidelines for assertive communication include:
 - Use "I" statements—such as, "I feel", "I want", "I would like" – this shows that the speaker is taking responsibility for their own feelings.
 - Be empathetic—recognize what the person may be experiencing, "I



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understand you're having a tough time..."

- Give choices—give choices so the client still can feel they have control.
- Broken record technique—repeat the request if needed in the same way every time until they understand.
- Be clear and set reasonable limits.
- Describe to the client the nature of the interaction you are having in a non-positional way. For example: "I am noticing that we are both getting a little tired and frustrated. I am not sure how we can move on or resolve this. What do you think?"
- Be aware of your body language, tone of voice and words, as you don't want to sound confrontational. While it is important to communicate your viewpoint, it is important to do so in a way that refrains from personal attack. When we speak in a nonaggressive manner/tone, we encourage others to shift their behavior and do the same.

Staff Preparedness

All staff need to be prepared to manage aggression. Tips to remember include:

- Recognize early warning signs of aggressive behavior
- Take all threats seriously
- Report abnormal client behavior to other staff members
- Follow established rules and procedures
- Treat all clients equally—do not show favoritism
- Always treat clients with respect
- Do not speak in a loud or aggressive tone of voice
- Validate client requests, frustrations, and angry feelings

When faced with an aggressive situation seek to:

- Do a quick self-assessment and assessment of situation.
- Call other staff for assistance if needed.
- Appear confident and calm and don't take things personally.
- Create some space and check your surroundings for any potential objects that could be used as weapons.
- Avoid audiences when possible. When someone is acting up, ask the other clients to leave the area or, if possible, ask the agitated client to move to another location where they can express themselves without their peer involvement.



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- Show that you are listening.
- Be careful of your assumptions about the escalated client.
- Speak slowly, gently, and clearly—lower your voice tone.
- Avoid staring, arguing, or confrontation.
- Calm the person and assure he/she feels heard before trying to solve the problem.
- Keep both hands visible so the client doesn't misinterpret your actions.
- Avoid sudden movements that may startle or be perceived as an attack.
- Avoid threats and, instead, explain your purpose or intention.
- Move towards a safer place (avoid being trapped in a corner).
- Never touch the client as they may take this as an aggressive action.
- Be aware of transference and counter-transference reactions.

Have a plan ready for when you need it. Think about options and actions you could take before such a circumstance occurs. Decisions made before a crisis occurs are more likely to be effective than those thought of “on the fly”. There may be occasions, particularly with the mentally ill, when the listener is unsuccessful. Your safety and the safety of others should always be your primary concern.

De-escalation is a very difficult and humbling skill. You must maintain self-awareness. You must be able to control your own anger. You must be able to see the bigger picture. You must be willing to practice what you've learned.

Barriers to Effective Communication

In order to minimize communication problems:

- Use language appropriate to the person (use interpreter when necessary)
- Take time to communicate
- Confirm that you are understood
- Encourage and give feedback
- Communicate at an appropriate time and place (whenever possible)

There are many barriers to effective communication the most common of which include:

- Noise—it is hard to hold a conversation against a noisy background.
- Language—be careful of using jargon and avoid emotive language (words used



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deliberately to create an emotional impact or response). Express yourself in a direct manner. If there is a language barrier, seek assistance from other staff members or an interpreter.

- Perception and prejudice—everybody has a unique background and history with influences and experiences that form our way of looking at the world. Recognize your prejudices and work around prejudices of others. Maintain a professional attitude (do not allow our perceptions, personal opinions or prejudices to get in the way of duties and responsibilities to others).
- Intrusion of personal space—have you ever felt uncomfortable when someone stands a little too close? Remember that everyone has different preferences for personal space that a person needs to feel comfortable which can sometimes depend on one's culture and personal history. Be aware that being inappropriately far apart can also be uncomfortable.
- Power struggles—avoid getting into power struggles with clients. Work together with the person, not against them.
- Cultural Sensitivity—Culture can be defined as behaviors, beliefs, and values that are shared by a group of people. Each culture has its own unique rules, customs and ways of living life. Therefore, language is not always interpreted the same way for everyone. We need to be careful of our beliefs and personal assumptions when interacting with clients.
- Culture affects many aspects of a person's life. For example, the way conflict is dealt with can be determined by one's culture/belief system. Mental health providers need to be aware of the influence that culture has on mental illness and communication.
- According to Saldaña, D. (2001), The following issues are to be considered when working with a diverse group of people:
- Don't assume the individual is proficient in the English language. The individual may interpret your words or phrases differently.
- In the United States it is common for people to stand about 3 feet apart when having a personal conversation. In other cultures, people may typically stand closer, which may feel awkward to someone unfamiliar with this style.
- In the United States, individuals are encouraged to look each other directly in the eye. In other countries or cultures, people may show respect by not looking directly into someone's eyes when communicating.
- Most Americans expect a conversation to take turns, but in other cultures it may be typical for several people to talk at once.



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- Hand and arm gestures can be interpreted differently with various cultures.
- Facial Expressions – Can vary with different cultures so don't assume you know what someone is feeling based on their facial expressions.
- Silence – Some cultures may use silence often during a conversation.
- Touching – Varies from culture to culture, can be viewed as intrusive for one culture or viewed as aloof by another culture if you don't touch when speaking to someone. (Saldana, D., 2001)

Stages of Crisis Management

Danskin, E.(2013) defines the following as the four stages of Crisis Management:

1---Anxiety Level

During this stage you may notice a change in the client's behavior or energy. The recommended response to the client at this stage is one of support and empathy. It is important you demonstrate active listening and abstain from judgment.

2—Defensive Level

At the defensive stage the client experiences loss of rationality. The client will give cues both verbal and non-verbal indicating they are beginning to lose control and may challenge you and push buttons. They may not respond to words, but will be paying attention to your tone, posture and position.

The recommended response to an escalated client during this stage is "assertive and directive." You must set clear behavioral limits, be directive, professional and respectful at all times. The limits you set must be clear, simple and enforceable. Inform the client of the potential positive or negative consequences of his compliance/non-compliance with your direction and empower him/her to make a wise behavioral choice. It is important to remember you are there to enforce the consequences of the individual's choice, not to make the person choose one option or the other.

According to The Provincial Violence Prevention Curriculum, Effective Limits are:

- Specific
- Achievable



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- Realistic
- Enforceable

In order to effectively set limits:

- Validate the client's concerns
- Describe the behavior you want to change
- Explain why you want the behavior to change
- Describe the benefits of changing their behavior
- Describe the negative consequences of continuing their behavior
- Whatever they decide to do—your role is to follow-through on the benefits or negative consequences in a realistic timeframe.

Limit setting may not always work but you need to try it. This makes the client aware of the consequence before you enforce it and gives them the power to choose.

Example: "I know you are really upset right now, if you could lower your voice we can take a walk and talk about what happened." "If you continue to yell, and disrupt the clients in group therapy and I will have to call for help."

3—Acting Out

During the acting out stage the client loses control and verbal aggression turns into physical assault or damage to property. As the professional, it is important that you know your company's safety policy and procedure to be used when a client loses control.

4—Tension Reduction

At this stage, the client comes down from the peak of energy output, often going from explosive to withdrawn. The client may feel remorseful, fearful, or ashamed. This is the start of control or regaining rationality. The act of "going out of control" is even more frightening to the individual than to the staff. At this point the staff needs to use therapeutic skills, communicate and build rapport, assisting the client to gain equilibrium. (Danskin, E., 2013)

Summary

Verbal de-escalation is used when we need to calm a person down as we come face to face



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with someone who is frustrated and/or angry. The methods used are non-physical, instead we utilize effective communication skills. The goal is to prevent the situation from becoming worse or lead into aggressive/physical behavior. Effective communication will improve trust between clients and staff, increase safety and improve overall morale.

As a professional in Behavioral Health, know your limits. Sometimes the best thing for you and the client is for someone else to take over the intervention. Look out for your peers and be a supportive member of the team by assisting a co-worker in an intervention when necessary. Remember to debrief with co-workers and supervisors after an incident occurs. Discussing the incident that occurred, why it occurred and any improvements that could be made with the intervention, helps to plan for future incidents and improves staff communication and cohesion.

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Suicide and Self-Harm Training

What you will learn:

- The difference between suicide and self-harm
- The similarities between suicide and self-harm
- Are the risks increased for suicide when someone has a history of self-harm?
- The correlation between suicide and mental health diagnosis
- The correlation between self-harm and mental health diagnosis
- Suicide, Self-Harm and Eating Disorders
- Statistics about current suicide rates according to age, race, gender, etc.
- Correlation between self-harm and addiction
- Correlation between suicide and addiction
- How do we make a difference
- What time of the day do the most suicides occur?
- What month of the year do most suicides occur?

Introduction

“The beeper next to my bed went off at 1:30 a.m. When I called the number, my supervisor said that my client was trying to kill herself. She was on the Canadian side of the Niagara Falls where she deliberately climbed over a railing, walked down a few feet and stood there, 100 feet above the Niagara River. Police cars, firefighters, ambulances, and a crowd of people stood in the dark, watching to see what happens. Does somebody save her? Is she willing to jump? Will she climb back up? She was a librarian, intelligent, with a dark sense of humor colored by an unrelenting, depressive episode lasting over a decade. Before I started my car, I received a phone call that first line responders talked her off the ledge. She would attempt suicide two other times before I left the clinic and moved to another state. Every once in a while those of us who worked at the clinic run into each other and when her name is mentioned, there is agreement that she is probably dead.”

Nearly everyone at some time in his or her life thinks about suicide. Most everyone decides to live because they come to realize that the crisis is temporary, but death is not. On the other



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hand, people in the midst of a crisis often perceive their dilemma as inescapable and feel an utter loss of control.

Frequently, they:

- Can't stop the pain.
- Can't think clearly
- Can't make decisions.
- Can't see any way out.
- Can't sleep, eat, or work.
- Can't get out of the depression.
- Can't make the sadness go away.
- Can't see the possibility of change.
- Can't see themselves as worthwhile.
- Can't get someone's attention.
- Can't seem to get control.

Suicide is newsworthy because life is precious. In 1993, a 6-year old girl living in Florida stepped in front of a train. She left a note saying that she "wanted to be with her mother" who recently died from a terminal illness. This is the power of the human mind. A girl in Kindergarten thinks of the past and imagines a future that is so bleak, so devoid of meaningful moments without her mom, that she takes her own life. The same mental tools that distinguish us from other animals, the same mental tools that allow us to solve problems and produce creative works that give us symbolic immortality are the same tools that allow a 6-year old to contemplate a future that is terrible enough to physically leap into an oncoming train. If a 6-year old has the cognitive capacity to kill herself, then we need to step up our efforts to understand and prevent it from happening. **So, what do we do? What helps? What doesn't help?**

History teaches us that sometimes that it is the small things that make a big difference

In Great Britain Suicides were reduced rate dropped by one third after removing coal gas in favor of natural gas. How can this be? After all, if the impulse to suicide is primarily rooted in mental illness and that illness goes untreated, how does merely closing off one means of self-destruction have any lasting effect? At least a partial answer is that many of those who asphyxiated themselves did so impulsively. In a moment of deep despair or rage or sadness, they turned to what was easy and quick and deadly — "the execution chamber in everyone's



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kitchen,” as one psychologist described it — and that instrument allowed little time for second thoughts. Remove it, and the process slowed down; it allowed time for the dark passion to pass. **The British gas conversion proved that the incidence of suicide across an entire society could be radically reduced, upending the conventional wisdom about suicide in the process.**

In Northwest Washington stands a pretty neoclassical-style bridge named for one of the city’s most famous native sons, Duke Ellington, Running perpendicular to the Ellington, a stone’s throw away, is another bridge, the Taft. Both span Rock Creek, and even though they have virtually identical drops into the gorge below — about 125 feet — it is the Ellington that has always been notorious as Washington’s “suicide bridge.” By the 1980s, the four people who, on average, leapt from its stone balustrades each year accounted for half of all jumping suicides in the nation’s capital. The adjacent Taft, by contrast, averaged less than two.

After three people leapt from the Ellington in a single 10-day period in 1985, a consortium of civic groups lobbied for a suicide barrier to be erected on the span. Many argued that barriers really don’t work. In the Ellington’s case, opponents had the added ammunition of pointing to the equally lethal Taft standing just yards away: if a barrier were placed on the Ellington, it was not at all hard to see exactly where thwarted jumpers would head. Except that they were wrong. A study conducted five years after the Ellington barrier went up showed that while suicides at the Ellington were eliminated completely, the rate at the Taft barely changed, inching up from 1.7 to 2 deaths per year. What’s more, over the same five-year span, **the total number of jumping suicides in Washington had decreased by 50 percent**, or the precise percentage the Ellington once accounted for.

Impulsivity

What makes looking at jumping suicides potentially instructive is that it is a method associated with a very high degree of impulsivity, and its victims often display few of the classic warning signs associated with suicidal behavior. In fact, jumpers have a lower history of prior suicide attempts, diagnosed mental illness (with the exception of schizophrenia) or drug and alcohol abuse than is found among those who die by less lethal methods, like taking pills or poison. **Instead, many who choose this method seem to be drawn by a set of environmental cues that, together, offer three crucial ingredients: ease, speed and the certainty of death.** The difference between the two bridges was simple. The concrete railing the Taft Bridge stands chest-high while the pre-barrier on the Ellington Bridge came to just above the waist. Jumping from either would be lethal, but one required a few more seconds of thought a just a little bit more time and effort.



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Richard Seiden, a professor emeritus and clinical psychologist at the University of California at Berkeley School of Public Health, is probably best known for his pioneering work on the study of suicide. Seiden set out to test the notion of inevitability in jumping suicides. Obtaining a Police Department list of all would-be jumpers who were thwarted from leaping off the Golden Gate between 1937 and 1971 — an astonishing 515 individuals in all — he painstakingly culled death-certificate records to see how many had subsequently “completed.” His report, “Where Are They Now?” remains a landmark in the study of suicide, for what he found was that just 6 percent of those pulled off the bridge went on to kill themselves. Even allowing for suicides that might have been mislabeled as accidents only raised the total to 10 percent. “That’s still a lot higher than the general population, of course. **But, the more significant fact is that 90 percent of them got past it. They were having an acute temporary crisis, they passed through it and, coming out the other side, they got on with their lives.**”

A crucial factor in suicide is that it boils down to the issue of time. In the case of people who attempt suicide impulsively, cutting off or slowing down their means to act allows time for the impulse to pass — perhaps even blocks the impulse from being triggered to begin with. What is remarkable, though, is that it appears that the same holds true for the non-impulsive, with people who may have been contemplating the act for days or weeks.

What this means to us as Clinicians and Professionals in the field is that slowing down, limiting access to means, interrupting the process somehow, actually prevents suicide. If 90% of the people who were “interrupted” from their suicide attempt by jumping off of the Golden Gate Bridge and then did not make another attempt, then installing a couple of minutes maybe even hours or days between the thought and the attempt, can and does save lives.

“At the risk of stating the obvious,” Seiden said, “people who attempt suicide aren’t thinking clearly. They might have a Plan A, but there’s no Plan B. They get fixated. They don’t say, ‘Well, I can’t jump, so now I’m going to go shoot myself.’ And that fixation extends to whatever method they’ve chosen. They decide they’re going to jump off a particular spot on a particular bridge, or maybe they decide that when they get there, but if they discover the bridge is closed for renovations or the railing is higher than they thought, most of them don’t look around for another place to do it. They just retreat.” Seiden cited a particularly striking example of this, a young man he interviewed over the course of his Golden Gate research. The man was grabbed on the eastern promenade of the bridge after passers-by noticed him pacing and growing increasingly despondent. What was the reason? He had picked out a spot on the western promenade that he wanted to jump from, but separated by six lanes of traffic, he was afraid of getting hit by a car on his way there.”



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In a therapeutic setting, it is vital that we engage clients quickly, build a solid rapport, get to truly know them and evaluate for risk factors. We know that substance abuse has a high correlation with suicidality and that substance abuse is the ultimate in self-harm and is often suicidal in nature. We must use our treatment and medical team resources effectively and promptly whenever we have a client who has a prior history of suicide attempts or intent. This is also true for those who self-harm.

Despite our best efforts at suicide assessment and treatment, suicides can and do occur in clinical practice. Approximately 12,000-14,000 suicides occur per year while in treatment.

Facing the Facts

- In 2009, 36,909 people in the United States died by suicide. About every 14.2 minutes someone in this country intentionally ends his/her life.
- Although the suicide rate fell from 1992 (12 per 100,000) to 2000 (10.4 per 100,000), it has been fluctuating slightly since 2000 – despite all of our new treatments.
- Suicide is considered to be the second leading cause of death among college students.
- Suicide is the second leading cause of death for people aged 25-34.
- Suicide is the third leading cause of death for people aged 10-24.
- Suicide is the fourth leading cause of death for adults between the ages of 18 and 65.
- Suicide is highest in white males over 85.
- The suicide rate was 12.0/100,000 in 2009.
- It greatly exceeds the rate of homicide. (5.5/100,000)
- From 1981-2009, 901,180 people died by suicide, whereas 463,942 died from AIDS and HIV-related diseases.

Death by Suicide and Psychiatric Diagnosis Psychological autopsy studies done in various countries over almost 50 years report the same outcomes: 90% of people who die by suicide are suffering from one or more psychiatric disorders:

- Major Depressive Disorder
- Bipolar Disorder, Depressive phase
- **Eating Disorders**



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- Alcohol or Substance Abuse* *Primary diagnoses in youth suicides.
- Schizophrenia
- Personality Disorders such as Borderline BPD
- 42% had 2 or more Axis I Diagnosis
- 31% had Axis I and Axis II Diagnosis
- 50% had Axis I and at least one Axis III Diagnosis

Eating Disorders and Suicide

Suicide is one of the major causes of premature death in eating disordered (ED) patients (Berkman et al, 2007; Bulik et al, 2008; Foulon et al, 2007; Pompili et al, 2006) and the dominant cause of death among ED patients who die from non-natural causes (Møller-Madsen et al, 1996). Harris and Barraclough (1997) reported the suicide mortality rate among both anorexics and bulimics to be 23 times higher than that of the general population, placing the rate of suicide among ED patients among the highest of all psychiatric disorders.

Sullivan (1995) derived a crude rate of mortality (5.9%) due to all causes of death for individuals with Anorexia Nervosa (AN). This author analyzed 38 studies in which the cause of death was specified (N=164), and found that 89 (54%) of the deaths could be attributed to complications of the eating disorder, 44 (27%) to suicide, and 31 (19%) to unknown or other causes. The suicide mortality rate in people with AN is one of the highest of all psychiatric illnesses (Holm-Denoma et al, 2008; Kaye, 2008; Keel et al., 2003) with the risk of death by suicide in AN subjects calculated as high as 57 to 58 times the expected rate in similar age and gender populations (Herzog et al, 2000; Keel et al., 2003; Pompili et al, 2006). Because of this extremely high rate of suicide, suicide is a more likely cause of death in a current AN sufferer than are complications from the disorder.

Nonfatal suicidal behaviors (suicide attempts), as one might expect, also occur at significantly elevated rates among these patients, with the lifetime prevalence of suicide attempt found to be as high as 26% (3-20% of AN patients and 25-35% of Bulimia Nervosa [BN] patients: Franko et al, 2006; Milos et al,



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2004). In an earlier report Favaro et al (1997) found the rate of attempt to be lower, 13%. Bulik et al (2008) found that 16.9% of 432 AN patients (mean age = 30.4) had a history of suicide attempts with attempts being more common among purging AN patients (26.1%), binge eating patients (24.3%) and mixed AN/BN patients (21.2%) than among restricting subtypes (7.4%). Franko et al (2004) conducted a prospective study over 8.6 years and reported that 22% of AN and 11% of BN patients made a suicide attempt in this follow-up period. In a recent Belgian study (Vervaeke et al, 2008) of 342 AN patients, 38% were found to have suicide ideation and 10% to have histories of suicide attempt by the median age of 23 years, 7 months. The majority (62%) of patients reporting prior attempts reported making more than one. A history of suicide attempt is a significant risk factor for later completed suicide.

Domestic Violence and Suicide

Of the 34,000 Americans who lose their lives each year to suicide, all too often violence, including domestic violence, is woven through their lives. Women who experience intimate partner violence are 12 times more likely to end their lives by suicide than those who have not. And it is not just victims who are at risk; research indicates a two to five fold increase in suicidal behavior for children exposed to domestic violence. A growing body of research focuses on this link and offers us hope that better outcomes can be found.

Warning signs and implications; most people with thoughts of suicide are ambivalent about death; a part of them wants to die, but a part of them wants to live. Suicide is the means they identify to escape searing emotional pain and they see no other way out.

The American Association of Suicidology has developed a mnemonic to help identify the warning signs of suicide:

IS PATH WARM? The letters represent:

- Ideation • Substance abuse***
- Purposelessness • Anxiety • Trapped • Hopelessness***
- Withdrawal • Anger • Recklessness and • Mood change***

A history of trauma presents a significant risk factor for suicide, which may be evidenced by the above warning signs. Professionals who see one or more of these signs should consider the



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possibility that the person may be having thoughts of suicide. However, the only way to know for sure is to ask. Thus, when screening victims, professionals should be alert to suicidal risk and ask directly if the victim is having thoughts of suicide and assess for potential risk. If the person is having thoughts of suicide, there must be a full assessment and it must be taken seriously.

WHO [World Health Organization] reports that 1.5% of all deaths worldwide are due to suicide. Suicide is estimated to be the eighth leading cause of death in all age groups. The mean age for successfully completed suicide is reported to be 40 years. Although globally, more women attempt suicide, more men die from suicide by a factor of 4.5:1. Evidence is mounting that an increase in the number of suicides in some communities may represent only the tip of the iceberg of an epidemic of self-injurious behaviors and suicidal ideation.

The risk factors for suicide include female gender, low socioeconomic status, lack of education, unemployment, increasing age, being married, not working outside of the home, and domestic violence. As the literature reports, women known to be exposed to a violent intimate relationship were significantly more likely to be hospitalized with a psychiatric diagnosis, injury and poisoning diagnoses, and diagnoses of assault or attempted suicide. As WHO's recently released World Report on Violence and Health notes: "One of the most common forms of violence against women is that performed by a husband or male partner." The result is that half of humanity is vulnerable to a risk factor with profound implications for health, but one which is nevertheless often ignored.

Facts about Suicide

Suicide Is Not Predictable in Individuals

- In a study of 4,800 hospitalized vets, it was not possible to identify who would die by suicide — too many false-negatives, false-positives.
- Individuals of all races, creeds, incomes and educational levels die by suicide. There is no typical suicide victim.

Suicide Communications Are Often Not Made to Professionals

- In one psychological autopsy study, only 18% told professionals of intentions*
- In a study of suicidal deaths in hospitals: 77% denied intent on last communication
- 28% had “no suicide” contracts with their caregivers” **



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- Research does not support the use of no-harm contracts (NHC) as a method of preventing suicide, nor from protecting clinicians from malpractice litigation in the event of a client suicide***

Suicide Communications ARE Made to Others

- In adolescents, 50% communicated their intent to family members*
- In elderly, 58% communicated their intent to the primary care doctor**

Research shows that during our lifetime:

- 20% of us will have a suicide within our immediate family.
- 60% of us will personally know someone who dies by suicide.

Understanding Motivation

Some studies have made a dent into understanding suicide. **Researchers looked at 20 suicide notes by people who had attempted and successfully killed themselves. *The five dimensions included the sense of burden, the level of emotional pain and how much suffering there is their lives, escaping negative feelings and using death as an answer to ending pain, poor social relations and the belief that death is the answer to their troublesome relationships and most importantly a sense of hopelessness and the belief that life is not going to get any better.***

The most noted aspect of the notes of suicide completer's included a lot of detail about how much they were a burden on others and society at large. In fact, this sense of burden was the main dimension that distinguished suicide letters between attempts and successes. People do not commit suicide because they are in pain, they commit suicide because they don't believe there is a reason to live and the world would be better off without them.

Factors Affecting the Likelihood of Suicide

- *Intensity and Frequency of thoughts, intent, active plan in place*
- *Detail of plan and access to means*
- *Prior attempts, means used and prior hospitalizations or interventions for suicide prevention*
- *Prior attempts increase possibility of successful suicide*
- *Suicide attempts both actual and aborted (get detailed information and document)*
- *Intent – subjective expectation and desire for a self-destructive act to end in death*



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- *Medications, what they are currently taking, what they have taken in the past and what did or did not work*
- *Family history of suicide increases the risk exponentially*
- *Suicide attempters are usually more impulsive and aggressive regardless of psychiatric diagnosis.*
- *Protective Factors; family relations, positive therapeutic relation, religion/spirituality, belief system around taking of own life, employment, positive support system, pets, children, anything that connects them to life is relevant.*
- *Document EVERYTHING!*
- *Seek SUPERVISION*

What is it that enables a person to be strong enough to follow through and swallow an entire bottle of pills, ingest poison, or push the chair out so that they dangle from a rope tied to the ceiling? It might be controversial to use the word courage or strength in this context. Nevertheless, a suicidal person often must overcome intense emotional distress to commit the final act. Leading suicide researchers speculated that a sense of burden is necessary but insufficient to understand who kills themselves.

A person might also require the capacity to harm themselves. A person must be highly tolerant of pain and conflict to make room for the uncomfortable thoughts and feelings that arise when working toward the goal of ending life. This tolerance of distress must be acquired somewhere along the way. Researchers continue to find support for the notion that the greatest suicidal risk exists for people that believe they are a burden on society AND possess a history where they acquired the capacity to harm themselves.

If you remain unconvinced about the importance of an acquired capacity to tolerate pain and distress, consider these sobering figures. **One in 25 people who sought health care services at a hospital because of self-harm or self-injurious behavior will kill themselves in the next 5 years.**

Prevention may be a matter of a caring person with the right knowledge being available in the right place at the right time.

Because the two most prevalent risk factors associated with suicide are mental health disorders and substance abuse, it is vital to understand these risks and take steps to manage addictions in order to save lives.



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How are substance abuse and suicide linked?

Both substance use and addiction are associated with suicide attempts. One large study carried out across 12 states by the National Violent Death Reporting System showed that **alcohol was found in the bloodstreams of 33% of people who died from suicide, and opiates like heroin and prescription pain killers were present in the systems of almost 25% of people who committed suicide.**

Not all of these people were necessarily addicted to alcohol or opiates, although alcohol addiction is strongly associated with suicide. **According to the American Society for Addiction Medicine, 1 in 6 alcoholics will die from suicide, and 1 in 6 people who die from suicide have alcohol addiction. Experts estimate that 85% of the people who die from suicide suffer from major depressive disorder, alcohol addiction, or both.**

Intoxication itself puts people at a higher risk for suicide because it makes it more likely that individuals will engage in impulsive behaviors that can harm themselves or others, whether accidentally or intentionally. Alcohol and other sedatives alter a person's judgment, aggressiveness, and impulsivity. The crash that follows a cocaine or methamphetamine high can precipitate suicide attempts due to intense feelings of disappointment and self-loathing, as well as the neurochemical changes caused by cocaine and speed. Stimulants can also trigger manic episodes in people with latent bipolar disorder, and other drugs can sometimes cause psychotic episodes.

In addition, addictions can contribute to mental health disorders. The regular use of alcohol and other sedatives as well as habitual opioid-induced narcosis (unconsciousness) can lead to a form of depression called substance-induced mood disorder. The consequences of addiction in a person's life, including broken relationships, lost financial security, the potential for lost freedom through imprisonment, and poor health, can also contribute to situational depression and make it more likely that a person may attempt to take their own life.

Suicide by intentional overdose is yet another danger linked to addiction. Drugs of abuse should be considered to be potentially lethal means in the hands of a depressed person.

Do behavioral addictions increase a person's risk of suicide?

Yes, there is some evidence that indicates that a behavioral addiction like internet pornography, sexual addiction or compulsive gambling can increase a person's risk of attempting suicide. For example, people with the eating disorder anorexia are at a particularly high risk for suicide attempts.



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Myths versus Facts

- **MYTH:** People who talk about suicide don't complete suicide.
- **FACT:** Many people who die by suicide have given definite warnings to family and friends of their intentions. Always take any comment about suicide seriously.
- **MYTH:** Suicide happens without warning.
- **FACT:** Most suicidal people give clues and signs regarding their suicidal intentions.
- **MYTH:** Suicidal people are fully intent on dying.
- **FACT:** Most suicidal people are undecided about living or dying, which is called "suicidal ambivalence." A part of them wants to live; however, death seems like the only way out of their pain and suffering. They may allow themselves to "gamble with death," leaving it up to others to save them.
- **MYTH:** Men are more likely to be suicidal.
- **FACT:** Men are four times more likely to kill themselves than women. *Women attempt suicide three times more often than men do.*
- **MYTH:** Asking a depressed person about suicide will push him/her to complete suicide.
- **FACT:** Studies have shown that patients with depression have these ideas and talking about them does not increase the risk of them taking their own life.
- **MYTH:** Improvement following a suicide attempt or crisis means that the risk is over.
- **FACT:** Most suicides occur within days or weeks of "improvement," when the individual has the energy and motivation to actually follow through with his/her suicidal thoughts. **The highest suicide rates are immediately after a hospitalization for a suicide attempt.**
- **MYTH:** Once a person attempts suicide, the pain and shame they experience afterward will keep them from trying again.
- **FACT:** The most common psychiatric illness that ends in suicide is Major Depression, a recurring illness. Every time a patient gets depressed, the risk of suicide returns.
- **MYTH:** Sometimes a bad event can push a person to complete suicide.
- **FACT:** Suicide results from having a serious psychiatric disorder. A single event may just be "the last straw."



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- **MYTH:** Suicide occurs in great numbers around holidays in November and December.
- **FACT:** Highest rates of suicide are in May or June, while the lowest rates are in December.

Other psychiatric risk factors with potential to result in suicide (*account for significantly fewer suicides than Depression*):

- Post-Traumatic Stress Disorder (PTSD)
- Eating disorders
- Borderline personality disorder
- Antisocial personality disorder

Past suicide attempt

- 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.

Symptom Risk Factors during Depressive Episode:

- Desperation
- Hopelessness
- Anxiety and panic attacks
- Aggressive or impulsive personality
- Has made preparations for a potentially serious suicide attempt* or has rehearsed a plan during a previous episode
- Recent hospitalization for depression
- Psychotic symptoms (especially in hospitalized depression)
- Major physical illness, especially recent
- Chronic physical pain
- History of childhood trauma or abuse, or of being bullied
- Family history of death by suicide
- Drinking/Drug use
- Being a smoker

Socio-demographic Risk Factors

- Male
- Over age 65



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- White
- Separated, widowed or divorced
- Living alone
- Being unemployed or retired
- Occupation: health-related occupations higher (dentists, doctors, nurses, social workers) especially high in women physicians

Educational Tools

- Depression and suicide among college students: *The Truth About Suicide: Real Stories of Depression in College* (2004) Comes with accompanying facilitator's guide
- Depression and suicide among physicians and medical students:
 - *Struggling in Silence: Physician Depression and Suicide* (54 minutes)*
 - *Struggling in Silence: Community Resource Version* (16 minutes)
 - *Out of the Silence: Medical Student Depression and Suicide* (15 minutes)
 - Both shorter films are packaged together and include PPT presentations on the DVD's
 - Depression and suicide among teenagers:
 - *More Than Sad: Teen Depression* (2009)**
 - Comes with facilitator's guide and additional resources
 - Suicide Prevention Education for Teachers and Other School Personnel (2010)
 - Includes new film, *More Than Sad: Preventing Teen Suicide*, *More Than Sad: Teen Depression*, facilitator's guide, a curriculum manual and additional resources

The ISP is an anonymous, web-based, interactive screen for individuals (students, faculty, and employees) with depression and other mental disorders that put them at risk for suicide. ISP connects at-risk individuals to a counselor who provides personalized online support to get them engaged to come in for an evaluation. Based on evaluation findings, ISP was included in the Suicide Prevention Resource Center's Best Practice Registry in 2009. It is currently in place in 16 colleges, including four medical schools.

Preventing Suicide

Antidepressants and Adequate prescription treatment and monitoring. Only 20% of medicated depressed patients are adequately treated with antidepressants – possibly due to:

- Side effects or Lack of improvement



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- High anxiety not treated
- Fear of drug dependency
- Concomitant substance use
- Didn't combine with psychotherapy
- Dose not high enough
- Didn't add adjunct therapy such as lithium or other medication(s)
- Didn't explore all options including: ECT or other somatic treatment

Psychotherapy

- **Research shows that when it comes to treating depression, all therapy is NOT created equal.**
 - ***Study shows applying correct techniques reduce suicide attempts by 50% over 18 month period***
 - **To be effective, psychotherapy must be:**
 - Specifically designed to treat depression
 - Relatively short-term (10-16 weeks)
 - Structured (therapist should be able to give step-by-step treatment instructions that any other therapist can easily follow)
 - **Examples: Cognitive Behavior Therapy (CBT), Interpersonal Therapy (IPT), Dialectical Behavior Therapy (DBT)**
 - **Implement teaching of these techniques**

Means Restrictions

- Firearm safety
- Construction of barriers at jumping sites
- Detoxification of domestic gas
- Improvements in the use of catalytic converters in motor vehicles
- Restrictions on pesticides
- Reduce lethality or toxicity of prescriptions
 - Use of lower toxicity antidepressants
 - Change packaging of medications to blister packs
 - Restrict sales of lethal hypnotics

Media

- **Guidelines Media Considerations**
- **Consider how suicide is portrayed in the media**
 - TV
 - Movies



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- Advertisements
- **The Internet danger**
 - Suicide chat rooms
 - Instructions on methods
 - Solicitations for suicide pacts.

Warning Signs

- **Observable signs of serious depression**
 - Unrelenting low mood
 - Pessimism
 - Hopelessness
 - Desperation
 - Anxiety, psychic pain, inner tension
 - Withdrawal
 - Sleep problems
- **Increased alcohol and/or other drug use**
- **Recent impulsiveness and taking unnecessary risks**
- **Threatening suicide or expressing strong wish to die**
- **Making a plan**
 - Giving away prized possessions
 - Purchasing a firearm
 - Obtaining other means of killing oneself
- **Unexpected rage or anger**

Intervention

Three Basic Steps:

- **Show you care**
- **Ask about suicide**
- **Get help**
 - **Intervention: Step One**
 - *Show You Care*
 - *Be Genuine*



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- **Show you care**
- *Take ALL talk of suicide seriously*
 - *If you are concerned that someone may take their life, trust your judgment!*
- *Listen Carefully*
- *Reflect what you hear*
- *Use language appropriate for age of person involved*
 - *Do not worry about doing or saying exactly the "right" thing. Your genuine interest is what is most important.*
- *Be Genuine*
- *Let the person know you really care. Talk about your feelings and ask about his or hers.*
 - *"I'm concerned about you... how do you feel?"*
 - *"Tell me about your pain."*
 - *"You mean a lot to me and I want to help."*
 - *"I care about you, about how you're holding up."*
 - *"I'm on your side...we'll get through this."*
- **Intervention: Step Two**
 - *Ask About Suicide*
 - *Be direct but non-confrontational*
 - *Talking with people about suicide won't put the idea in their heads. Chances are, if you've observed any of the warning signs, they're already thinking about it. Be direct in a caring, non-confrontational way. Get the conversation started.*
- *You do not need to solve all of the person's problems – **just engage them.***
- *Questions to ask:*
 - *Are you thinking about suicide?*
 - *What thoughts or plans do you have?*
 - *Are you thinking about harming yourself, ending your life?*
 - *How long have you been thinking about suicide?*
 - *Have you thought about how you would do it?*
 - *Do you have ___? (Insert the lethal means they have mentioned)*
 - *Do you really want to die? Or do you want the pain to go away?*
- *Ask about treatment:*



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- *Are you taking your medications?*
- ***Intervention: Step Three***
 - *Get help, but do NOT leave the person alone*
 - *Communicate with your TEAM!*
 - *Contact Medical Staff*
 - *Know referral resources*
 - *Reassure the person*
 - *Encourage the person to participate in helping process*
 - *Outline safety plan*
- **Know Referral Resources**
- **Resource sheet**
- **Hotlines**
 - **Hotlines**
 - **National Suicide Prevention Lifeline**
 - **1-800-273-TALK**
 - **www.suicidepreventionlifeline.org**
 - **911 - In an acute crisis, call 911**
- **Reassure the person that help is available and that you will help them get help:**
 - *"Together I know we can figure something out to make you feel better."*
 - *"I know where we can get some help."*
 - *"I can go with you to where we can get help."*
 - *"Let's talk to someone who can help . . . Let's call the crisis line now."*

What to do

- ***Utilize Suicide Assessment Tools.***
- ***Follow Policy and Procedure of your Employer.***
- ***Ask your Supervisor for assistance.***
- ***Notify Medical Staff.***
- ***Many facilities Baker Act clients who present with moderate to high risk for suicide. A Baker Act is a 72 hour hold in a psychiatric hospital for evaluation and stabilization.***
- ***Increase monitoring of client with any suicidal ideation by placing them in a location where staff can observe more frequently. Contracting for safety is not believed to***



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reduce suicide attempts, but it certainly makes the client acutely aware that staff is now paying close attention.

- ***Reduce access to lethal means; i.e. remove all sharps from area in which the client is housed***

Self-Harm

*Self-Harm is an act in which people attempt to deal with deep distress and emotional pain by harming yourself with acts such as cutting, burning, sticking objects in your skin, or intentionally preventing wounds from healing, **you are becoming increasingly capable of suicide.***

One of the odd things about this line of research is that in any other context, high pain tolerance is strength, a gift, a form of emotional agility that allows a person to be more successful and satisfied with life. This is why we are bringing this research up. Look at the motives behind people's actions because what we might view as an admirable strength in another context is a fatal risk factor.

Clinical guidelines for the management of self-harm highlight the need for primary and secondary care services to provide a thorough assessment of mental health and social needs, precipitating factors and the risk of further self-harm or suicide among self-harming clients who we come into contact with. Appropriate treatment responses will be sensitive to differences between self-harm clients such as "diverse populations and diverse service needs".

Repetitive self-harm places a heavy burden on health and social services and society as a whole. **Up to half of hospital admissions following self-harm are repeat episodes, and a history of repetitive self-harm is a key risk factor for suicide. A single previous episode of self-harm is associated with high suicidal intent in a subsequent episode**

The experience of psychiatric illness emerged as a recurring theme with cutters. This was not based on any independent or third-party diagnosis of illness, but patients' own reports of **Depression, Borderline Personality Disorder and Bipolar Disorder, as well as Anxiety and Agoraphobia. There is also a significant correlation between Eating Disorders and Substance Abuse.**

Consistent with the well-documented relationship between psychiatric illness and repetitive self-harm it was not surprising that the experience of **psychiatric illness was interwoven with their accounts of self-harm**, and that their self-harm was seen as inextricably part, or



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symptomatic, of their illness. Self-harm is also highly correlated to substance abuse. As in the study by Sinclair and Green, they viewed their self-harm as a consequence of illness.

"When they told me I had depression, I could think, that's why I do it (self-harm). It sounds stupid, but that made me feel better" [female, aged 35 years].

"I've got this borderline personality disorder, and that's who I am, you know, it's my personality, so that's why it [self-harm] will never stop. What do they want me to do? Change my personality?"

A recent study showed that clients described their self-harm as a means to get support and attention, because of frustration about not receiving support for their illness, with self-harm a "sure thing" for being admitted to hospital. They also reported sometimes feeling a strong desire to be admitted, to escape the overwhelming and often uncontrollable emotions leading to self-harm.

Self-Harm and Suicidality

PTSD and Self-Harm

- Childhood abuse results in patterns of neglect in which the child's body, mind and emotions are available to be exploited by adults and it should therefore not surprise use that children who have been impacted in this way, might become adults who in turn abuse themselves and use their bodies to remove or relieve tension or act out impulses.
- Their experience is that a body is a vehicle for tension and has no other real value.
- To make matters worse, abused children are also deprived of the normal experiences of tension relief they don't have any way out except to self-harm.
- When distressed, children who have not been abused seek connections with others, preferably adults, to find soothing, reassurance, or comfort.
- Children who have experienced neglect or abuse have learned to avoid connection, rather than seek it, and to rely almost exclusively on their own resources.

********The most common mistake made by therapists is the assumption that self-harm and suicidality cause pain, rather than relieve it. If we assume that self-harm induces pain, then we will interpret it as masochism or self-punishment or a cry for help. ********



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And if we do that, we will miss the core issue in self-harm of mastery and relief-seeking. Because to interpret it as self-punishment usually leads the patient right into her feelings of shame and worthlessness, and she responds by thinking or saying, "But I am bad—I do deserve to be punished—and since I'll never feel anything but hate for myself, I'll never stop my self-harm." Or, "Since I will never be able to help myself, my only hope is to keep crying for help."

If, on the other hand, we go to the heart of the matter (to the fact that hurting the body, or planning to, brings welcome relief and is in fact an ingenious attempt to cope with overwhelming distress and tension), the patient will feel understood, and the therapist will be able to share the dilemma with her. If we acknowledge that self-harm and suicidality work in a paradoxical way and that the patient currently has no better way to soothe herself, we can begin to talk with her about why self-harm works and what other ways of achieving tension release could fulfill the same needs.

- Let us go back to the fact that the body has become the expected vehicle for tension relief and that accessing help or support is not an option because connection with others has always been more dangerous than helpful.
- Let us also remember what we know about the psychobiological effects of trauma: that the patient has become accustomed, perhaps even addicted, to adrenaline.
- She has learned that adrenaline is calming, that dissociation is calming, and that pain can increase the production of endorphins inducing an analgesic effect.
- And all of these ways of calming the body are completely under her control: she does not have to depend on anyone to achieve relief from distress through any of these avenues.
- Thus, self-harm of any sort "makes sense": all forms of self-harm either induce adrenaline responses, dissociation, or an increase in endorphin production.
- And the self-harm "doesn't matter" because the body doesn't matter.
- No wonder our patients are surprised and sometimes even annoyed that their self-harm and suicidality matter so much to us!
- In fact, they may even interpret our interventions to prevent or reduce suicidality as our not caring about how they feel.



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Childhood abuse can alter brain structure

Interestingly, research has reported that physical, emotional, and/or sexual abuse in childhood can actually alter neural structures that involve dopamine and serotonin. This is thought to happen indirectly through stress hormones released in the body due to the traumatic experience in childhood. These stress hormones are thought to interact with chemicals in the body to "trigger" different genes, such as the serotonin transporter gene, which then tells the body to develop its neurons in the brain a particular way.

Studies have shown that negligent parent-child interactions (including minimal touch, talk, and play) actually might alter neurons that process dopamine in the brain, leading to a condition known as "dopamine receptor supersensitivity" or "dopamine deficiency". Studies have shown that people who are super sensitive to dopamine are more prone to anxiety and impulsivity.

For example, numerous studies have recently shown that people with Parkinson's disease, who are known to have dopamine receptor supersensitivity, displayed impulsive behaviors such as gambling and shopping when given dopamine agonists (medications that increase dopamine in the brain). These individuals also reported high rates of anxiety when given these medications.

In the case of self-harm, studies have suggested that dopamine receptor supersensitivity may be involved in the expression of different forms of self-harm. Some studies using Positron Electron Tomography (PET) scans showed that individuals who self-injured showed dopamine receptor supersensitivity in their brains. This makes sense considering that anxiety and different forms of abuse have been associated with both self-harm and dopamine receptor supersensitivity.

Since research on stressful early parent-child relationships has demonstrated increased sensitivity to anxiety in adulthood by way of altered dopaminergic and serotonergic systems, it is questioned what type of effect caffeine might have on a person who has supersensitive dopamine receptors. This question arises because caffeine affects both dopamine and serotonin levels in the brain.



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Self-Harm and Alcohol/Drug Dependence

Patient accounts highlighted the significance of alcohol and drug use in their history of self-harm. One patient was presently abstinent, while alcohol had been involved in the most recent self-harm of the others. For some of these patients, self-harm was frequently the culmination of a binge drinking session which could last several days. Their drinking habit, which was often traced back to adolescence, served as an outlet for escaping problems and painful emotions. Cutting is another easily accessed outlet for escaping problems and painful emotions.

Feelings of hopelessness and low self-esteem associated with alcohol and drug dependency were common among these patients. Their chaotic lifestyles, as evidenced by difficulties in securing and keeping jobs and living in temporary accommodation, also contributed significantly to their self-harm. Several patients described losing contact with, or the support of, friends and family through their addiction or alcoholism. Relationships with their 'drinking and using buddies' were superficial and not mutually supportive.

All surveyed patients described the pressures of overcoming an alcohol and addiction as a factor contributing to their self-harm, yet viewed abstinence as the route to managing or prevailing over the behavior. In discussing the role of alcoholism and addiction on self-harm, some patients considered their excessive drinking and drug use as self-harming.

Responses to interventions included;

"It's pointless, there's nothing they can do, and you can't stop a self-harmer"

"Everything I've ever been given is useless, the whole thing's bugged up"

Borderline Personality Disorder and Self-Harm

What we do know is that there is a high correlation between self-harming behaviors and Borderline Personality Disorder. Borderline personality disorder is a disturbance in personality disorder which goes back and forth between self-blame and blame of others, and which almost always include both severe emotional highs and severe emotional lows. The jury is still out on how exactly this works and what's going on in the neural circuitry of people with BPD, but right now what we know is that they appear to have a lot of trouble regulating their emotions.

Of course, you might say. But it's not as simple as just telling someone to calm down. What appears to be going on in **Borderline Personality Disorder patients is that they have an over-**



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functioning of the limbic system of the brain, which is a group of brain areas associated with things like fear, emotion, and other behaviors. So if you have an over-functioning in these areas, you might expect greater emotional highs and lows.

But the limbic system is restrained in part by input from the prefrontal cortex, that big area in the front of your brain which is devoted to what we like to call "higher function" and which is often responsible for inhibiting impulsive behaviors and emotions.

The prefrontal cortex is the stop system or if you like, the brakes. People with BPD have a dysfunction in this area, in particular what appears to be a hypo-functional system. So this means they are getting too much emotion from the limbic system, and too little reigning in from the prefrontal cortex. The result is a very dysregulated emotional state, with really high highs, and very low lows. And one of the ways that people with BPD often attempt to deal with their excess emotion is through self-injurious behavior.

Why is that?

With Borderline Personality Disorder self-injury, it may not be a relief of the emotions, rather than just a distraction, which in turn decreases the activation in the brain and provides some relief. This doesn't mean that self-injury is a good thing, far from it. But it does mean that, if this hypothesis turns out to be true and distraction works very well to help people with BPD that we could come up with behavioral treatments to help combat their episodes of severe emotion. Things that they have to do which will distract them and then help them to deal with emotional surges, and possibly stop the cycle of self-and-other blame that can make them very difficult to identify and treat.

- **Intentional and often repetitive self-injurious behavior is exhibited by approximately 1-2 million people the in United States.**
- **The typical self-injurer is female (women are 1.5-3 times more likely than men to self-injure), adolescent or young adult, single, middle to upper-middle class, and intelligent.**

Though it is often conceptualized as a "derivation of suicide", the primary objective in approximately 85% of self-injurious events is tension relief opposed to suicide.

The nature of self-injurious events into four categories:

1) Stereotypic



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- 2) Major
- 3) Compulsive
- 4) Impulsive.

Stereotypic self-harm is primarily exhibited by individuals with developmental disabilities and occurs without regard for social context or without thought and feeling.

Major self-harm is very dramatic and occurs as an isolated event whereas compulsive self-harm occurs repetitively, sometimes multiple times a day.

Impulsive self-harm is episodic, buffered by periods where no self-harm occurs. Generally, self-harm is accomplished in the absence of pain due to disassociation the individual achieves and is followed by a **feeling of relief or normalcy which continues until the cycle begins again..**

According to the current definition of self-harm in which it is described as "the destruction or alteration of body tissue that occurs in the absence of conscious suicidal intent" , an exhaustive list of self-harm includes tattooing, piercing, surgical implants, scarification, pigmentation changes, radical dieting, hunger striking, fasting, cutting, and burning.

Because self-harm varies etiologically over a continuum, it is impossible to assign a definitive causal argument which becomes problematic in attempting treatment.

An important question that arises in the treatment of self-harm is whether the behavior is in response to neurochemical stimuli or whether there is something that is being communicated by the individual who is exhibiting self-injurious behavior. If there is something that the self-harming client is nonverbally articulating, what follows is whether the individual is aware of this and how they themselves interpret their behavior.

To address these nuances, motivating factors behind self-harm have been categorized as either interpersonal, in which attempts are made to effect change in the interpersonal environment, or intrapersonal, in which attempts are made to "quell intra-physic distress"

Neurochemistry and Self-Harm

At the biological level, self-harm is attributed to abnormal neurochemistry involving the neurotransmission of serotonin, dopamine, and endorphins. Serotonergic deficits, or decreased serotonin levels, have been observed in self-harming individuals by analyzing the



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breakdown products (metabolites) of serotonin in spinal fluid. Serotonergic deficits, determined by imipramine binding sites on platelets was linked to aggression and impulsiveness by Stoffet al (1987) and Birmaher et al (1990) **which suggests that self-harm is akin to impulse disorders like kleptomania and trichotillomania and also correlates to theory that self-harm is yet another impulse control disorder.**

Another neurochemical explanation of self-harm is that the body becomes addicted to endorphins, pain-relieving neurotransmitters derived from opium, released by self-mutilation. Individuals with self-harming behaviors have abnormal endogenous opioid systems which may be congenital or a result of neurochemical responses to events in early childhood. **This correlates further with high self-harm rate and PTSD.**

Those who were unwilling to engage with services were more likely to have been harming themselves over a long period. In line with this, patients spoke of feeling they were "beyond help" or "defeated"

The unwillingness to seek support for self-harm was most strongly expressed by patients whose accounts were characterized by traumatic life events (especially in childhood) or chronic life problems (including coping with the consequences of childhood trauma, a series of traumatic events), although not exclusively.

Some patients voiced a greater degree of willingness to engage with a variety of services, sharing an aspiration to minimize their self-harming behavior, and were more likely to remain in long-term contact with services.

"I badly want to ... stop ... I've been asking for help, I'm willing to try anything"

Clients who reported a longer commitment to a particular intervention tended to recount feeling satisfied with this service. In contrast, experience of a large number of different interventions was associated with less commitment to, or perseverance with, any particular intervention.

Some patients (all female) felt that they were not in a position to feel or demonstrate any dissatisfaction, and dwelled on feelings of guilt, linked to the self-inflicted nature of their injuries:

"You feel like a fraud ... [there are] wards full of people who are not well, and you want to punish yourself even more because ... there is other people who need the space more than you"



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When looking at self-harm and suicide we assume some similarities due to the methods involved. This is both true and not true at the same time. Some of what needs to be understood is the patterns of repetition, to look at the correlation between self-harm and suicide as well as past traumatic experiences.

Signs of self-harm include;

- **many cuts/burns on the wrists, arms, legs, back, hips or stomach,**
- **wearing baggy or loose clothing such as wearing hoodies or long sleeves during hot days to conceal the wounds,**
- **always making excuses for having cuts, marks, or wounds on the body,**
- **finding razors, scissors, lighters or knives in strange places,**
- **spending long periods locked in the bedroom or in the bathroom, isolation and avoiding social situations.**

Why do people self-harm?

- *They do it to escape their feelings, to cope with stressors, to express their pain and to punish themselves.*
- *Some mutilate their bodies for what is happening in their lives, they lack the appropriate coping skills, suffer from low self-esteem and they feel that they deserve what they are doing to themselves, to feel euphoria (it's true that when we get hurt endorphins are released into the blood stream resulting in a natural high or feeling of euphoria).*

Self-harm is addictive and habit forming.

Self-injury, self-inflicted violence, self-injurious behavior or self-mutilation is defined as a deliberate, intentional injury to one's own body that causes tissue damage or leaves marks for more than a few minutes which is done to cope with an overwhelming or distressing situation. Statistics show that self-harm is more common amongst girls who begin this addiction in their early teens and may continue into their adulthood. But there are guys that have been known to inflict self-injury.

Common Ways of Self-injury

Cutting this type of self-injury involves making cuts or scratches on your body with any sharp object including knives, needles, razor blades or even fingernails. The arms, legs and front of



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the torso are most commonly cut because they are easily reached and easily hidden under clothing.

Cutting can be habit forming. It can become a compulsive behavior — *meaning that the more a person does it, the more he or she feels the need to do it.*

The brain starts to connect the false sense of relief from bad feelings to the act of cutting, and it craves this relief the next time tension builds.

When cutting becomes a compulsive behavior, it can seem impossible to stop.

It's easy to see how cutting can become an addiction, where the urge to cut can seem too hard to resist.

A behavior that starts as an attempt to feel more in control can end up controlling you.

Hair-pulling (trichotillomania) this is an impulse control disorder which at times seems to resemble a habit, an addiction, or an obsessive-compulsive disorder. The person has an irresistible urge to pull out hair from any part of their body. Hair pulling from the scalp often leaves patchy bald spots on their head which they hide by wearing hats, scarves and wigs. Abnormal levels of serotonin or dopamine may play a role in this disorder.

The combined treatment of using an anti-depressant such as Anafranil and cognitive behavioral therapy (CBT) has been effective in treating this disorder. CBT teaches you to become more aware of when you're pulling, helps you identify your pulling habits, and teaches you about what emotions and triggers are involved in hair pulling. When you gain awareness of pulling, you can learn to substitute healthier behaviors instead.

Other Forms

- Branding – burning self with a hot object
- Friction burn – rubbing a pencil eraser on your skin
- Picking at skin or re-opening wounds (dermatillomania) – an impulse control disorder characterized by the repeated urge to pick at one's own skin, often to the extent that damage is caused which relieves stress or is gratifying
- Many compulsive skin picking causes are emotional or mental. Emotional trauma can lead to feelings of helplessness and insecurity. When a child is being traumatized and bullied, he or she loses the feeling of being in control of their environment.
- Hitting (with hammer or other object)



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- Bone breaking
- Punching
- Head-banging (more often seen with autism or severe mental retardation)
- Multiple piercing or tattooing – may also be a type of self-injury, especially if pain or stress relief is a factor
- Drinking harmful chemicals
- *From a study which was conducted with 60 clients who were receiving drug treatment it was revealed that 65% of the clients had a history of self-harm.*
- *Cutting is the most common method of self-harm with 72% utilizing this method.*
- *The other forms of self-harm include head banging 15% and picking 13% which other unnamed methods being 10%.*
- The most common feeling experienced before these acts of deliberate self-harm is emotional pain which was described by 64% of the sample.
- The most common feeling afterward is regret fullness with 41% endorsing this emotion. Alcohol and drugs were frequently implicated in the episodes and were perceived to have aggravated the self-mutilation.
- Almost half of the sample had made a previous suicide attempt and 82% of the sample had a history of traumatic experiences.

As unlikely as it seems, deliberate self-harm has been reported to be an addiction and falls under the realm of addictive behavior (process addictions include a variety of behaviors such as gambling, sex addiction, food, internet, gaming, etc.)

The neurotransmitters of addictive behaviors (process addictions) utilize similar neuropathways as substance use does. With self-harm there is said to be an alleged addiction to endogenous opioids.

Self-harm is actually a “coping mechanism” and as destructive as it is, it is still a mechanism that works and this is part of the addictive quality of this behavior.

There is a significant amount of repetition with deliberate self-harm.

- Risk factors include prior episodes, psychiatric history, and alcohol and drug use.
- Antisocial Personality Disorder and Borderline Personality Disorder are also highly correlated to self-harm.
- Major self-harm such as castration of limbs and enucleating of eyes is usually associated with psychosis.



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Superficial or moderate self-harm, which is the most common form, including cutting, burning, scratching, skin-picking, hair-pulling, bone-breaking, hitting, interference with wound injuries and deliberate overdosing.

Deliberate Self-Harm and Suicide Deliberate Self-Harm is distinct from suicide; the basic understanding is that a person who truly attempts suicide seeks to end all feelings where as a person self-harm seeks to feel better.

- In fact self-harm can actually be a life saver. Suicide is not reported to provide relieve as self-harm does and it is repeated less frequently.
- Although self-harm is not the same as suicidal behavior, there is a strong association between the two.
- Suicide risk with self-harm is increased a hundred times than the general population.
- Completed suicide is associated with major depressive disorder, severe bipolar disorder, alcohol/drug abuse and a past history of suicidal acts.
- Although the two may blur, the meaning does not and this is focused on whether or not the person intends to die.
- The mean age of first self-harm is 23.2 years with a standard deviation of 6.5.
- Common places where self-harm occurs includes; wrist, abdomen, anterior left chest in the region of the heart, arm and thigh. Other methods include hanging, inhaling car fumes and drinking fuel.
- Beyond regret, other emotions include feeling stupid, selfish and desperate. Other categories include family problems and thinking of past trauma and difficulties.
- More than 50% of those who carry out self-harm were under the influence of alcohol and drugs.
- Science sheds new light into self-injurious behavior, the brain, and early childhood experiences.

Self-harm or self-injury has generally been defined as self-destructive behavior without the intention to die. Although the behaviors that are classified under this definition have not yet been clearly defined, it has been generally accepted that the different and dynamic forms of self-harm lie along a continuum. This continuum ranges from mild forms of self-harm such as nail biting to more severe forms such as cutting and head banging. In between this spectrum lie impulse control disorders such as obsessive hair pulling (Trichotillomania) and obsessive skin picking (Dermatillomania).



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Anxiety and physical and emotional abuse have been shown to be prevalent among people who self-harm (including skin-picking and hair-pulling). People who self-harm are often found to have higher rates of anxiety than those who do not and research has reported that most people who self-injure have a diagnosable anxiety disorder. Research has also reported that people who self-injure have reported higher rates of physical and emotional abuse in childhood than those who do not.

Caffeine is known to raise dopamine levels and produce stress and anxiety in certain individuals logically suggesting that individuals who have dopaminergic receptor sensitivity might be more vulnerable to anxiety and increase risk for self-injuring.

As strange as it may sound, some individuals hurt themselves to obtain relief from emotional stress. Actions such as cutting or burning oneself are behaviors displayed by people who compulsively hurt themselves.

This behavior is sometimes evident among individuals with borderline personality disorder (BPD). BPD is a condition that often leads to intense emotions among individuals who have difficulty regulating their emotions.

Accordingly, this group of people displays high prevalence rates of self-injurious behavior, which may help them to reduce negative emotional states.

Researchers have studied the effects of emotional stimuli and a thermal stimulus in people either with or without borderline personality disorder.

They conducted a brain imaging study using picture stimuli to induce negative, positive, or neutral affect and thermal stimuli to induce heat pain or warmth perception. The painful heat stimuli were administered at an individually-set temperature threshold for each subject.

In patients with Borderline Personality Disorder, they found evidence of heightened activation of limbic circuitry in response to pictures evocative of positive and negative emotions, consistent with their reported emotion regulation problems. Amygdala activation also correlated with self-reported deficits in emotion regulation. However, the thermal stimuli inhibited the activation of the amygdala in these patients and also in healthy controls, presumably suppressing emotional reactivity.



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Dr. John Krystal, editor of *Biological Psychiatry*, commented, “These data are consistent with the hypothesis that physically painful stimuli provide some relief from emotional distress for some patients with Borderline Personality Disorder because they paradoxically inhibit brain regions involved in emotion. This process may help them to compensate for deficient emotional regulation mechanisms.

Most of the clients did not seek any medical treatment after the self-harm and 64.1% of the clients had never been referred to psychiatrist and 74.4% had never been followed up by general psychiatrist or any other medical professional.

When asked if they wanted to stop harming 92% reported that they needed to stop self-harming and gave different reasons such as to live, it is mad to keep hurting myself, it leads to scars and it doesn't look good, for the sake of the children, it can lead to infection and it is stupid..

Things that prevented and reduced the feeling or need to self-harm included being drug free and having family support were the main reasons.

How do they know when to stop self-harm? Some said they did not know, when it hurts, realizing that I did it when I was mad, when my heart pumps fast, and when getting consciousness back.

The feelings prior to self-harm are emptiness, frustration, fear, agitation, anger and emotional pain. The feelings reported after self-harm are relaxed, euphoria, angry, and regretful.

Interventions should include;

- Self-Harm Safety Contract which can include an agreement not to harm for a certain amount of time or they can contract to speak with staff before they self-harm. Any interruption in the process can slow the client down enough, perhaps engage the prefrontal lobe and improve the client's chances of refraining from further self-harm.
- Utilize tools such as a Body Map of Cuts, Burns, Picking upon admission and when seen by medical staff. This can be done with photos as well as an outline of the human body on which staff records all current scars, cuts, etc. This provides a baseline of all self-injuries and will therefore assist with identifying if further cutting/self-harm occurs.
- Have client's journal about their feelings throughout the day and indicate when there are urges or cravings to cut. This may provide insight into particular moods or events



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that trigger self-harm and there is now a therapeutic opportunity to address these feelings and situations.

- A simple tool is to ask them to write one page of feelings or thoughts in their journal each time that they have a craving to cut.
- Another method is to provide them with a red marker and ask them to write with the red marker on their body whenever they have a craving/urge to cut. After the urge has passed ask them to wash the red marker off with soap and water.
- Another intervention is to ask them to paint/draw/make a collage of their pain. After they have completed the assignment ask them if you can hold it for them for a day. At the end of the day ask them if they would like it back and ask them to explain why. Ask them why they need their pain, how it serves them and what would happen if they let it go. After about 5 days of this, ask them to create a similar art assignment in which they create their life without pain and/or freedom and joy. After this is completed, ask them to keep them both for a few days and then ask them which one they would like to give away. This changes the way that the brain interacts with self-harm and increases their ability to ask for help and deeply consider their choices. .
- For pickers and people who pull their hair, sometimes simply asking them to wear gloves for the day. Don't tell them that they cannot pick, simply ask them to wear the gloves. Again, this provides a "pause" button in between the obsession and the compulsion and sometimes this is enough to see great improvement.

Although there are limited medications that have been specifically identified to reduce urges for self-harm, there are medications that assist with impulsivity and obsessive compulsive disorders.

Medications that work with Obsessive Compulsive Disorder may be helpful with Self-Harm

- Clomipramine (Anafranil)
- Fluvoxamine (Luvox CR)
- **Fluoxetine (Prozac)**
- Paroxetine (Paxil, Pexeva)
- **Sertraline (Zoloft)**

Medications that work with Impulse Control Disorders and could assist with Self-Harm;



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- **Antidepressants.** Selective serotonin reuptake inhibitors (SSRIs) are commonly used to treat kleptomania. These include fluoxetine (**Prozac**, Prozac Weekly), paroxetine (Paxil, Paxil CR), fluvoxamine (Luvox, Luvox CR) and others.
- **Mood stabilizers.** These medications are meant to even out your mood so that you don't have rapid or uneven changes that may trigger urges to self-harm. One mood stabilizer used to treat impulse control disorders is lithium (Lithobid) and **Risperdal (Risperidone)** has also been found to be helpful.
- **Anti-seizure medications.** Although originally intended for seizure disorders, these medications have shown benefits in certain mental health disorders, possibly including impulse control disorders. Examples include topiramate (Topamax) and valproic acid (Depakene, Stavzor).
- **Addiction medications.** **Naltrexone** (Revia, Vivitrol), known technically as an opioid antagonist, blocks the part of your brain that feels pleasure with certain addictive behaviors. It may reduce the urges and pleasure associated with self-harm.

Again, follow your employer's policy regarding self-harm behavior, communicate with your supervisor, notify appropriate staff, and speak with medical/psychiatric staff and DOCUMENT.



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Understanding Domestic Violence

Course Description

This course is designed to assist the behavioral healthcare worker in understanding domestic violence and the mandates that involve behavioral healthcare workers. In addition to defining domestic violence, this course will review the effects of domestic violence, the cycle of violence, associated risk factors, safety planning, confidentiality and the legalities of domestic violence.

Course Objectives

Upon completion of this course the participant will:

- Be able to define domestic violence.
- Be able to discuss the statistics related to domestic violence.
- Develop an understanding of the impact and consequences of domestic violence on the victim from a health, psychological, and emotional perspective.
- Be able to identify national and local domestic violence resources.

Introduction

Every year, on average, more than four people a day are murdered by their romantic partners in the United States. Men and women of all ages are at risk for domestic and sexual violence and its effects, which include: long-lasting pain, increased risk of substance abuse, depression, poor academic performance, suicidal ideation, and future violence. In addition, sexual and domestic violence are linked to a wide range of reproductive health issues including sexually transmitted disease and HIV transmission.

Defining the Problem

Domestic violence is a broad term that indicates violence in close or intimate interpersonal relationships. This violence is known by many names: intimate partner violence, wife abuse, wife battering, spousal abuse, woman abuse, etc. Some define the term domestic violence even broader to include child abuse, elder abuse, or any close interpersonal relationship. Put simply, domestic violence occurs when one person purposely causes either physical or mental harm to another when they are in a close personal relationship. These crimes occur in both heterosexual and same-sex relationships.



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Because the definition of domestic violence varies from agency to agency and state to state, obtaining accurate statistics is difficult. It is also important to remember that abuse rarely occurs in just one form; more frequently forms of abuse occur in combinations. A man who is physically abused is also likely isolated and controlled by his partner; a woman who is abused sexually may also be stalked and emotionally abused. Domestic violence is a serious, preventable public health problem affecting more than 32 million Americans (Tjaden & Thoennes, 2000a). It occurs on a continuum, ranging from one assault that may or may not significantly impact the victim, to chronic, repeated abuse which is also known as battering (CDC, 2008).

Definitions and Types of Abuse

Definitions

Domestic violence (also known as domestic abuse, spousal abuse, or intimate partner violence) occurs when a family member, partner or ex-partner attempts to physically or psychologically dominate another. Domestic violence often refers to violence between spouses, or spousal abuse but can also include cohabitants and non-married intimate partners. Domestic violence occurs in all cultures; people of all race, ethnicity, religion, sex and class can be perpetrators of domestic violence.

The following definition and examples are provided by domesticviolence.org –

Domestic violence and emotional abuse are behaviors used by one person in a relationship to control the other. Partners may be married or not married; heterosexual, gay, or lesbian; living together, separated or dating. Examples of abuse include:

- Name-calling or putdowns.
- Keeping a partner from contacting their family or friends.
- Withholding money.
- Stopping a partner from getting or keeping a job.
- Actual or threatened physical harm.
- Sexual assault.
- Stalking.
- Intimidation.

Violence can be criminal and may include physical assault (hitting, pushing, shoving, etc.), sexual abuse (unwanted or forced sexual activity), and stalking. Although emotional,



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psychological and financial abuses are not criminal behaviors, they are forms of abuse and can lead to criminal violence. The violence takes many forms and can happen all the time or once in a while.

"Family or household member" means spouse, former spouse; persons related by blood or marriage, persons who are presently residing together as if they are a family or who have resided together in the past as if they are a family, and persons who are parents of a child in common regardless of whether they have been married. With the exception of persons who have a child in common, the family or household members must be currently residing or have in the past resided together in the same single dwelling unit.

The U.S. Office on Violence Against Women (OVW) defines domestic violence as a "pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner". The definition adds that domestic violence "can happen to anyone regardless of race, age, sexual orientation, religion, or gender", and that it can take many forms, including physical abuse, sexual abuse, emotional, economic, and psychological abuse.

The Florida Coalition Against Domestic Violence defines domestic violence as:

"A pattern of controlling behaviors – violence or threats of violence – that one person uses to establish power over an intimate partner in order to control that partner's actions and activities. Domestic violence is not a disagreement, a marital spat, or an anger management problem. Domestic violence is abusive, disrespectful, and hurtful behavior that one intimate partner chooses to use against the other partner."

Florida's legal definition of domestic violence is as follows:

"741.28 Domestic violence; definitions. --As used in ss. 741.28-741.31: "Department" means the Florida Department of Law Enforcement. "Domestic violence" means any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member.

"Law enforcement officer" means any person who is elected, appointed, or employed by any municipality or the state or any political subdivision thereof who meets the minimum qualifications established in s. 943.13 and is certified as a law enforcement officer under s. 943.1395."



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Types Of Abuse

Physical Violence

Physical violence is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to, scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; slapping; punching; burning; use of a weapon; and use of restraints or one's body, size, or strength against another person.

Sexual Violence

Sexual violence is divided into three categories: 1) use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; 2) attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure; and 3) abusive sexual contact.

Threats of physical or sexual violence

Using words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm constitutes "threats of physical or sexual violence."

Psychological/Emotional Violence

Psychological/Emotional Violence involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources. It is considered psychological/emotional violence when there has been prior physical or sexual violence or prior threat of physical or sexual violence. In addition, stalking is often included among the types of domestic violence. Stalking generally refers to "harassing or threatening behavior that an individual engages in repeatedly, such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person's property" (Tjaden & Thoennes 1998). Stalking is the unwanted pursuit of another person. By its nature, stalking is not a one-time



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event. The individual's actions must be considered in connection with other actions to determine if someone is being stalked.

Statistics and Costs

Statistics

Approximately, 29% of women and 10% of men in the U.S. have experienced rape, physical violence, and/or stalking by an intimate partner and reported at least one measured impact related to these or other forms of violence in that relationship (Black et al., 2011). In general, victims of repeated violence over time experience more serious consequences than victims of one-time incidents (Johnson and Leone, 2005).

1 in 4 women (24.3%) and 1 in 7 men (13.8%) aged 18 and older in the United States have been the victim of severe physical violence by an intimate partner in their lifetime (Black et al., 2011).

Nearly, 15% of women (14.8%) and 4% of men have been injured as a result of domestic violence that included rape, physical violence, and/or stalking by an intimate partner in their lifetime (Black et al., 2011).

In 2010, 241 males and 1095 females were murdered by an intimate partner (U.S. Department of Justice, FBI, 2011).

More than one in three women and more than one in four men in the United States have experienced rape, physical violence and/or stalking by an intimate partner in their lifetime.

74% of all murder-suicides involved an intimate partner (spouse, common-law spouse, ex-spouse or boyfriend/girlfriend). Of these, 96 percent were women killed by their partners.

1 in 5 female high school students reports being physically and/or sexually abused by a dating partner.

Interpersonal violence is the leading cause of female homicides and injury-related deaths during pregnancy.

The percentage of women who consider their mental health to be poor is almost three times higher among women with a history of violence than among those without.



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Women with disabilities have a 40 percent greater risk of domestic violence, especially severe violence, than women without disabilities.

Nearly half of all women in the United States have experienced at least one form of psychological aggression by an intimate partner.

On average, more than 3 women are murdered by their husbands or boyfriends every day. 1 out of 3 women around the world has been beaten, coerced into sex or otherwise abused during her lifetime.

These statistics come from The American Psychological Association

Costs to Society

Costs of domestic violence against women alone in 1995 exceeded an estimated \$5.8 billion. These costs included nearly \$4.1 billion in the direct costs of medical and mental health care and nearly \$1.8 billion in the indirect costs of lost productivity (CDC 2003). This is generally considered an underestimate because the costs associated with the criminal justice system were not included.

In 2003 domestic violence costs exceeded \$8.3 billion, which included \$460 million for rape, \$6.2 billion for physical assault, \$461 million for stalking, and \$1.2 billion in the value of lost lives (Max et al. 2004).

The increased annual health care costs for victims of domestic violence can persist as much as 15 years after the cessation of abuse (Rivara et al., 2007).

Victims of severe domestic violence lose nearly 8 million days of paid work-the equivalent of more than 32,000 full-time jobs-and almost 5.6 million days of household productivity each year (CDC 2003).

Women who experience severe aggression by men (e.g., not being allowed to go to work or school, or having their lives or their children's lives threatened) are more likely to have been unemployed in the past, have health problems, and be receiving public assistance (Lloyd and Taluc 1999).



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Risk and Protective Factors

Risk factors are associated with a greater likelihood of domestic victimization or perpetration. They are contributing factors and may or may not be direct causes. Not everyone who is identified as "at risk" becomes involved in violence.

Some risk factors for domestic violence victimization and perpetration are the same. In addition, some risk factors for victimization and perpetration are associated with one another; for example, childhood physical or sexual victimization is a risk factor for future domestic violence perpetration and victimization.

A combination of individual, relational, community and societal factors contribute to the risk of becoming a victim or perpetrator of domestic violence. Understanding these multilevel factors can help identify various opportunities for prevention.

Children in a Violent Home

Most children in violent homes know about the violence. Parents may think children do not know about the violence, but most of the time they do. They can feel helpless, scared and upset. They may also feel like the violence is their fault.

Violence in the home is dangerous for children. They are afraid for their parents and themselves. Children feel bad that they cannot stop the abuse. If they try to stop the fight, they can be hurt.

They can also be hurt by things that are thrown or weapons that are used. Children live with scary noises, yelling and hitting. They are harmed just by seeing and hearing the violence. Children in violent homes may not get the care they need. A parent who is being abused may be in too much pain to take good care of their child. Children who live in violent homes can have many problems. They can have trouble sleeping. They can have trouble in school and getting along with others. They often feel sad and scared all the time. They may grow up feeling bad about themselves.

Victims, Abusers and the Cycle of Violence

Before establishing who the victims of abuse are and who the perpetrators are, let's look at what abuse is and define some examples of abuse.



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Caution: As we look at what is known about those who perpetrate domestic violence it is essential to remain mindful of the dangers of generalizing. Here are some things to consider:

- How dangerous a particular batterer is cannot be determined on the basis of generalizations but must be determined by the survivor in the context of her or his actual knowledge and experience of the perpetrator.
- An individual survivor's decisions about what to do or not do about the violence is very much a function of what that survivor knows about the perpetrator and not what studies tell us about perpetrators in general.
- The empowerment model does not explicitly or implicitly point survivors toward leaving a violent partner. Instead, it points toward supporting each survivor to become clear about the safest and best path for her or him.

About Abuse

Many people who are being abused do not see themselves as victims. Also, abusers do not see themselves as being abusive. People often think of domestic violence as physical violence, such as hitting. However, domestic violence takes other forms, such as psychological, emotional, or sexual abuse.

The following is a brief list of patterns of controlling behavior:

- Pushing, hitting, slapping, choking, kicking, or biting.
- Threatening victim, their children, other family members or pets.
- Threatening suicide to get the victim to do something.
- Using or threatening to use a weapon.
- Keeping or taking the victims paychecks.
- Making statements with the intent of making the victim feel bad.
- Forcing sex or sexual acts the victim does not want or like.
- Keeping the victim from seeing friends, family or going to work.

Who Are The Victims?

Victims can be of any age, sex, race, culture, religion, education, employment or marital status. Although both men and women can be abused, most victims are women. Children in homes where there is domestic violence are more likely to be abused and/or neglected. Most children



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in these homes know about the violence. Even if a child is not physically harmed, they may have emotional and behavior problems. Anyone can be a victim—a lesbian, gay, or transgendered person; people of color; a physically or mentally challenged individual; the elderly; a male or female; children, adolescents, etc.

A person can be a victim of abuse or at risk if they are dating someone who:

- Is very jealous and/or spies on you
- Will not let you break off the relations
- Hurts you in any way, is violent, or brags about hurting other people
- Puts you down or makes you feel bad
- Forces you to have sex or makes you afraid to say no to sex
- Abuses drugs or alcohol or pressures you to use drugs or alcohol
- Has a history of bad relationships and blames it on others

Who Are The Abusers?

Abusers are not easy to spot. There is no 'typical' abuser. In public, they may appear friendly and loving to their partner and family. They often only abuse behind closed doors. They also try to hide the abuse by causing injuries that can be hidden and do not need a doctor.

Abuse is not an accident. It does not happen because someone was stressed-out, drinking, or using drugs. Abuse is an intentional act that one person uses in a relationship to control the other. Abusers have learned to abuse so that they can get what they want. The abuse may be physical, sexual, emotional, and psychological. Abusers often have low self-esteem. They do not take responsibility for their actions. They may even blame the victim for causing the violence. In most cases, men abuse female victims. It is important to remember that women can also be abusers and men can be victims.

Risk Factors for Becoming an Abusive Partner

Why Don't People Leave Abusive Relationships?

Some of the many reasons people don't leave abusive relationships are listed below:

- Fear of retaliation against the victim, children, friends and/or family members.
- Partner may threaten to kill her or other family members if she leaves, threaten to kill himself or escalate his violence in an attempt to hold her in the relationship.
- Fear of losing children or placing the children in danger, either in a custody battle or because of partner's threats.



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- Fear of an inadequate or harmful response by the criminal justice system and other institutions.
- Fear that no one will believe her. Batterers are often respected and popular members of the community who keep their violence and controlling behaviors secret from the public. The battered woman knows this and it increases her fear that no one will believe her. Because she believes many people will not understand the seriousness of the violence, they will not support her disruption of the family.
- Fear of being deported for undocumented persons who are victims of domestic violence.
- Fear of being blackmailed; partner may have threatened to reveal to the authorities any wrongdoing such as alcohol or drug abuse. In same sex relationships, the fear of job loss or losing one's children if the victim's sexual orientation is revealed.
- Fear of losing her support systems. In order to escape their partner's threats of retaliation, many battered women have to leave the community which provided them with support. This is especially difficult for women whose ethnic, racial and/or cultural heritage, language and experiences are affirmed by her community (i.e. Asian, African-American, Jewish, Latina and Native American).
- The batterer has literally isolated her. For example, a batterer may prohibit the battered woman from using the phone, may insist on transporting her to work, may read her mail, and may forbid her from seeing family and friends.
- Hope for change and that the batterer's treatment is successful. Battered Women are reluctant to leave when their partners are in treatment. They believe the treatment will motivate them to change and stop battering. Therefore, it is very important that battered women are referred by law enforcement to domestic violence programs so that they can be informed about treatment programs for batterers and evaluate whether these programs are likely to effect the change that will make life safe for them.

The Role of the Behavioral Healthcare Professional

Early Intervention

Behavioral Healthcare providers can help by screening for domestic violence. You can do this by documenting abuse in the medical record, safeguarding evidence, providing medical advice, referrals, safety planning, and showing empathy and compassion.

Early identification and intervention with victims of domestic violence can help prevent injuries and save lives (Nelson, et al, 2012; Decker, et al, 2012). Many victims of domestic violence seek assistance in healthcare settings, often repeatedly, but are only treated for symptoms and



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injuries. Unfortunately, healthcare professionals often fail to identify victims. Missed cases of domestic violence may be due to the screening method: depending on the screening tool that is being used, the rate of detection has been reported to range from 9.2% to 30.5% (Sprague, Madden, Dosanjh, et al, 2012). Missed cases may also be due to healthcare professionals simply not screening (Sprague, Madden, Simonovic, et al, 2012), and many nurses are not prepared to provide care to a woman who is a victim of violence from her partner (Sundborg, et al, 2012). There are many reasons nurses, physicians, and other healthcare professionals may not screen for domestic violence including:

- Lack of time.
- Lack of training.
- Lack of resource.
- Language barriers.
- Cultural barriers.
- Emotional discomfort.
- Behavior of the victim, e.g. uncooperative, unwilling to accept help. (Beynon, et al, 2012)

Behavioral healthcare providers see victims of domestic violence for suicide attempts, anxiety, and depression. Practitioners who specialize in chronic pain, such as headache or stomach disorders, also treat victims of abuse. Pediatricians who see abused children may also see abused women because child abuse and spousal abuse frequently co-exist (Harding, et al, 2013).

Screening

Screening questions should always be asked in a private room, away from the batterer and preceded by assurances of strict confidentiality. The spouse or partner should be separated from the patient if they demand to accompany the patient into the examining room (Hancock, 2011). Victims of domestic violence may not discuss the violence unless they are asked directly (Beynon, et al, 2012; Morse, et al, 2012). However, many victims of domestic violence will talk about the abuse if they are asked in a direct, caring, and non-judgmental manner (Decker, et al, 2012;)

By acknowledging and addressing potential client barriers, behavioral healthcare staff may become effective advocates for their clients experiencing domestic violence. Client barriers include, but are not limited to, the following:



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- Fear of disclosure—a client experiencing domestic violence may be reluctant to disclose her abuse fearing she or her children will be further harmed. A typical tactic of a batterer is to threaten harm, including murder, if a victim discloses. A client may also fear disclosure because she is humiliated by her experience, feels she is worthless, etc.
- Lack of trust in Behavioral Health staff—a client may not fully disclose or may minimize her abuse because she doesn't trust her counselor to understand her experience, to respect her autonomy, and / or to protect her confidentiality. Perpetrators typically will not disclose their abuse of partners.
- Lack of awareness—some patients, even those encountering extreme abuse, may believe that their experience is "normal". Many perpetrators don't acknowledge their behaviors as being violent, abusive or harmful to their partners.

Documentation

Documentation is critical, both for the protection of the patient and of the healthcare provider. When interacting with a client document all relevant history, including:

- Chief complaint or history of present illness.
- Record details of the abuse and its relationship to the presenting problem.
- Document any concurrent medical problems that may be related to the abuse.

For current victims, document a summary of past and current abuse including:

Social history, including relationship to abuser and abusers name if possible.

Patient's statement about what happened, not what lead up to the abuse—e.g. "boyfriend John Smith hit me in the face" not "we were arguing over money."

- The date, time, and location of incidents where possible.
- Patients appearance and demeanor—e.g. "tearful, shirt ripped" not "distraught."
- Any objects or weapons used in an assault—e.g. knife, iron, closed or open fist.
- Patients account of any threats made or other psychological abuse.
- Names or descriptions of any witnesses to the abuse.

Document results of physical examination:

- Findings related neurological, gynecological, mental status exam if indicated.
- If there are injuries, (present or past) describe type, color, texture, size, and location
- Use a body map and/or photographs to supplement written description;
- Obtain a consent form prior to photographing patient. Include a label and date.



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Document laboratory and other diagnostic procedures:

- Record the results of any lab tests, x-rays, or other diagnostic procedures and their relationship to current or past abuse

Document results of assessment, intervention and referral:

- Record information pertaining to the patient's health and safety assessment including your assessment of potential for serious harm, suicide and health impact of domestic violence.
- Document referrals made and options discussed.
- Document follow-up arrangements.
- If patient does not disclose domestic violence victimization document that assessment was conducted and the patient did not disclose abuse.
- If you suspect abuse, document your reasons for concerns i.e. "physical findings are not congruent with history or description," "patient presents with indications of abuse".
- Offer at least one follow-up appointment (or referral) with a healthcare provider, social worker or domestic violence advocate after disclosure of current or past abuse.

Safety Planning

Whenever social workers interact with families experiencing domestic violence, the worker's first concern should be the safety of both the children and the adult victims. To help increase safety for children and adult victims, social workers should partner with adult victims and children (if appropriate) to develop domestic violence safety plans. To help increase safety for children and adult victims:

- Behavioral Health professionals should partner with adult domestic violence victims and children (if appropriate) to develop safety plans.
- Safety plans address risk to both the child and the adult victim.
- A safety plan should reflect the specific information the behavioral healthcare provider has gathered from the assessment.
- Behavioral healthcare providers should do safety planning whenever domestic violence is identified as an issue or when circumstances affecting safety have changed.
- Age-appropriate safety plans for children can increase their safety and support their resilience.

Domestic Violence safety planning typically covers:



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- Immediate safety, as well as safety during assaults, stalking, or abuser attempting contact.
- Escape.
- Long-term safety.
- Safety for children.

Domestic Violence safety planning addresses a wide variety of issues, including:

- Increasing victim safety at home, commuting, at work, at school, and other public spaces.
- Identifying who should know about the danger that a perpetrator poses in these places.
- Identifying who can be a source of support or protection in each of these places.
- Identifying risks from the perpetrator, as well as other risks such as homelessness.

Typical Elements of a Safety Plan for immediate safety and safety during assaults include:

- Identifying a relatively safe room in the house to run to when abuse starts, such as a room with a locking door, a telephone, and access to the outside; moving away from the kitchen, the bathroom, or areas where weapons are stored during fights.
- Establishing a code or agreement with neighbors or children about when to call 911.
- If the perpetrator has guns, hiding or disposing of the ammunition and, whenever possible, making sure that the guns in the house or car are not loaded Planning for escape.
- Making copies of critical documents or moving the originals of those documents to a safe place, such as a friend's or family member's home or the victim's workplace. Critical documents include: - social security cards - school records, bank records - insurance, passports - medical information.
- Packing a small bag with clothes, a couple of toys, and any medicines taken regularly by the adult victim or the children and keeping it in a safe place outside the house, in the trunk, or with a trusted friend.
- Changing the locks on the house, getting an unlisted number, getting caller ID, and blocking caller ID on calls from the victim's house.
- Asking neighbors, co-workers, and/or family to call 911 if they see the perpetrator.
- Finding out how to use technology (cell phones, email, and internet) safely and ensure the perpetrator cannot track movements via the victim's cell phone (information on this can be found at www.getmoneygetsafe.org/privacyandtechnology.cfm).



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- Identifying who to talk to at work about the situation, what is necessary to increase safety at work (such as security, escort to and from car, locking office door), and how to arrive at and leave work safely.
- Knowing what to do and where to go if the perpetrator is following the victim (identify police stations close to routes to and from home/work/ school, don't stop, and call 911 on a cell phone).
- Plan for safety with children.
- Plan for emotional support.

Important Phone Numbers

- If you are in immediate danger, call 911
- National Domestic Violence Hotline at 1-800-799-SAFE (7233)
- National Sexual Assault Hotline at 1-800-656-4673

Documentation Reporting and Legal Requirements

Calling the police is not always in the best interest of a victim of domestic abuse. Some victims of domestic violence have learned to distrust the police or believe that law enforcement intervention will further endanger them. Immigrant victims may fear that calling the police will lead to deportation. Others are unwilling to use law enforcement intervention until a safety plan is in place. Each victim should be informed of their legal options and encouraged to make their own choices (Burnett, 2011; Hancock, 2011). The requirements for reporting incidents of domestic violence - what must be reported, how it must be reported and to whom, and who is responsible for the reporting – vary from state to state (Family Violence Prevention Fund, 2010).

Florida statute 790.24 requires healthcare providers to report gunshot or life-threatening wounds or injuries. This does not cover the majority of injuries sustained in domestic violence. Reports are to be made to the sheriff's department or the police department. Failing to report is a 1st degree misdemeanor and is punishable by up to a \$1,000 fine and up to one year in prison. Florida law also mandates the reporting of child abuse or neglect and elder abuse or abuse of the disabled.

In Florida, a 24-hour domestic violence hotline is available for toll-free counseling and information. The number is 800-500-1119. The counselors answering the toll-free line may refer the victim to his or her local domestic violence center. A list of Florida certified domestic violence centers organized by county and city may also be found on the Florida Coalition



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Against Domestic Violence website at <http://www.fcadv.org/centers>. As of 2014, Florida had 42 certified domestic violence centers that provide information and referral services, counseling and case management services, a 24-hour hotline, temporary emergency shelter for more than 24 hours, educational services for community awareness relative to domestic violence, assessment and appropriate referral of resident children, and training for law enforcement personnel.

The Florida Domestic Violence Confidentiality and Privilege Laws—90.5036 Domestic violence advocate-victim privilege states:

“(1) for purposes of this section:

- A “domestic violence center” is any public or private agency that offers assistance to victims of domestic violence, as defined in s. 741.28, and their families.
- A “domestic violence advocate” means any employee or volunteer who has 30 hours of training in assisting victims of domestic violence and is an employee of or volunteer for a program for victims of domestic violence whose primary purpose is the rendering of advice, counseling, or assistance to victims of domestic violence.
- A “victim” is a person who consults a domestic violence advocate for the purpose of securing advice, counseling, or assistance concerning a mental, physical, or emotional condition caused by an act of domestic violence, an alleged act of domestic violence, or an attempted act of domestic violence.
- A communication between a domestic violence advocate and a victim is “confidential” if it relates to the incident of domestic violence for which the victim is seeking assistance and if it is not intended to be disclosed to third persons other than:
 - Those persons present to further the interest of the victim in the consultation, assessment, or interview.
 - Those persons to whom disclosure is reasonably necessary to accomplish the purpose for which the domestic violence advocate is consulted.
- A victim has a privilege to refuse to disclose, and to prevent any other person from disclosing, a confidential communication made by the victim to a domestic violence advocate or any record made in the course of advising, counseling, or assisting the victim. The privilege applies to confidential communications made between the victim and the domestic violence advocate and to records of those communications only if the advocate is registered under s. 39.905 at the time the communication is made. This privilege includes any advice given by the domestic violence advocate in the course of that relationship.



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The privilege may be claimed by:

- The victim or the victim's attorney on behalf of the victim.
- A guardian or conservator of the victim.
- The personal representative of a deceased victim.
- The domestic violence advocate, but only on behalf of the victim. The authority of a domestic violence advocate to claim the privilege is presumed in the absence of evidence to the contrary."

Vulnerable Adult Abuse

Report suspected abuse of vulnerable adults to the Florida Abuse Hotline. All reports are confidential, including the name of the reporter. Abuse means any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant impairment to a vulnerable adult's physical, mental, or emotional health. Abuse includes acts and omissions (415.102(1), F.S.)

If the abuse was perpetrated by the spouse/partner or other person known to the victim, it constitutes domestic violence. The National Center on Elder Abuse (2006) encourages health professionals not to try to answer, "Is this domestic violence?" or "Is this elder abuse?" Instead, efforts should be made to maximize both the domestic violence and aging networks services by partnering to meet the unique needs of older victims.

To be admissible in a court of law, medical documentation should include the following:

- Photographs of the injuries.
- Body maps, which document the extent and location of the injuries.
- Description of the patient's demeanor.
- A record of the patient's comments about how the injuries occurred. The patient's own words should be set off in quotation marks or identified by such phrases as "the patient states" or "the patient reports."

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