The Academy for Addiction Professionals

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 to we make a difference
- How to do a good assessment for suicide
- How to prevent suicide
- How to treat suicidality
- How to assess for self-harm
- How to treat self-harm
- 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 unremitting, 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 in not. On the other 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 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.

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."

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**
- 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, 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 (Vervaet 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. Counselors who see one or more of these signs should consider the 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, counselors 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” **

- 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.

Components of a good Suicide Assessment:

- *Ask directly about suicide, be specific in your inquiry*
- *Determine level of suicide risk; low, moderate or high*
- *Intensity and Frequency of thoughts, intent, active plan in place*
- *Determine 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*
- *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.

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.

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."

- **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
- 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
    - 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: C**ognitive **B**ehavior **T**herapy (CBT), **I**nter**p**ersonal **T**herapy (IPT), **D**ialectical **B**ehavior **T**herapy (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
  - 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*

    - ***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:*
        - *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 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***

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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 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. ********

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 inducingan 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.

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.

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 buggered up***"

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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-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
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 breakdown products (metabolites) of serotonin in spinal fluid. Seretonogenic deficits, determined by imipramine binding sites on platelets was linked to aggression and impulsiveness by Stoffetal (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 opiod 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***"

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.

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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 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.

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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)
- ✓ 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 pervious 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 opoids.

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.

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).***
>
> ***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.

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 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;

- **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.