



Adolescent Self-Harm and Suicide Ideation

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Terminology Varies

- Deliberate self-harm
- Self-injury
- Self-inflicted violence
- Self-injurious behavior
- Self-mutilation
- Non-suicidal self-injury
- Cutting

I use the term: self-harm

Self-Harm Definition

- Self-harm is defined as deliberate self-inflicted physical harm severe enough to cause tissue damage or markings that last for a minimum of several hours, done without suicidal intent or intent to attain sexual pleasure.
- Spiritual ritual, ornamentation body markings (tattoos), and/or modifications (body piercing) are not generally considered self-injury unless this is undertaken with the intention to harm the body.

Self-Harm Basic Information

- Cutting is most common form: knives, paperclips, razors, keys, glass, pins, etc.
- Over 16 documented forms.
- Any individual may use from 1 to over 10 forms.
- Any part of the body may be harmed - most often hands, wrists, stomach and thighs (hidden).
- Severity covers a broad continuum from superficial wounds to permanent disfigurement.
- Most people report little or no pain during the act - even pulling out teeth.

Other Forms of Self-Harm

- Using an eraser or friction to burn skin
- Burning with heat, chemicals or cigarettes
- Bruising oneself
- Pulling off fingernails and toenails
- Refusing to take needed medications
- Hitting self
- Banging one's head
- Ingesting sharp or toxic objects
- Picking scabs or keeping wounds from healing
- Deep scratching or pulling patches of skin
- Inserting objects into body openings
- Inserting needles or sharp objects under the skin
- Some forms of hair-pulling
- Tooth-pulling
- Bone-breaking
- "Carving" symbols, names or other images into the skin

Prevalence

- Approximately 1% of the population has, at one time, used self-inflicted physical injury as a means of coping with an overwhelming situation or feeling. (American Self-Harm Information Clearinghouse)
- Incidence is highest: teenage girls, borderline personality disorder, and dissociative disorders
- Recent studies of high school populations in the US and Canada consistently show a 13 to 24% prevalence rate.
- Prevalence = total number of cases at one time
- Incidence = rate of occurrence; new #s over time

Self-Harm

- Self-harming behavior **always** serves a function and purpose for the client.
- It is critical to understand what function/s and purposes the self-harming behavior serves each particular client.
- Begin with a stance of harm reduction rather than self-harm elimination.
- Honor that client's defense mechanisms and don't strip them too quickly. That's terrifying to the client.
- It is ultimately useful to help the client learn other ways to meet those needs.

Reasons Behind Self-Harming Behavior

- Distraction from emotional pain
- Distraction from painful thoughts or memories
- Distraction from other environmental problems
- Self-punishment (believe they deserve punishment for having good feelings or being an "evil" person or hope that self-punishment will avert worse punishment from some outside source)
- Reflection of self-hatred or guilt
- Maintaining control
- Feeling control over their minds and bodies

Reasons Behind Self-Harming Behavior

- Expression of things that can't be put into words (displaying anger, showing the depth of emotional pain, shocking others, seeking support and help)
- Expression of feelings of isolation and alienation
- Expression of feelings for which they have no label
- Affect modulation
- To relieve tension and anxiety
- To relieve anger and aggression
- To feel calm or numb
- To feel real by feeling pain or seeing the injury

Reasons Behind Self-Harming Behavior

- Coping with overwhelming psychophysiological arousal
- To reenact a trauma in an attempt to resolve it or to protect others from their emotional pain
- To create visible and noticeable wounds
- To communicate pain and anger to others
- To purify themselves
- To experience an increase in endorphins and the euphoria that goes with it
- To maintain a sense of uniqueness
- To nurture themselves or seek nurturing for injuries

Common Myths

- **Self-harm is usually a failed suicide attempt.**
- Self-injury is often a means of avoiding suicide
- Typically a suicide attempt is by completely different method than preferred form of self-harm
- Majority of persons with self-harm history (60%) report no suicide thoughts
- Non-suicidal self-injury best understood as a symptom of serious psychological distress
- Left untreated, self-harm could lead to suicide behavior
- Differentiate between a self-injurious act and a suicide attempt - require different treatments

Common Myths

- **People who self-injure are crazy and should be locked up.**
- People who deliberately self-harm are not psychotic.
- Self-harm is a coping mechanism like alcoholism, drug abuse, overeating, smoking cigarettes, etc.
- The vast majority of self-inflicted wounds are neither life threatening nor require medical treatment.
- Caution should be used when assessing a client's level of threat to self or others.

Common Myths

- **People who self-harm are trying to get attention.**
- Everyone needs attention; this is not bad.
- When distress is expressed by self-harm, something is definitely wrong. Help is needed, not judgment.
- Most people who self-injure go to great lengths to hide their wounds and scars.
- Many consider their self-harm to be a deeply shameful secret and dread discovery.

Common Myths

- **Only people with Borderline Personality Disorder self-harm.**
- Self-harm is a criterion for diagnosing BPD, but there are 8 other equally-important criteria for BPD.
- Not everyone with BPD self-harms, and not all people who self-harm have BPD.

Common Myths

- **If the wounds aren't "bad enough," self-harm isn't serious.**
- Severity has little to do with level of emotional distress.
- Different people use different methods.
- People have varying pain tolerances.
- To know a client's distress level - ask.
- Never assume; check it out with the person.

Common Myths

- **Only teen-aged girls self-injure.**
- All people and SES are represented.
- Male or female; gay, straight, or bi; Ph.D.s or high-school dropouts; rich or poor; and live in any country in the world.
- Some people manage to function effectively in demanding jobs: therapists, lawyers, engineers.
- Some are on disability. Some are highly achieving high-school students.
- Age typically ranges from early teens to early 60s, although may be older or younger.

Self-Harm

- Self-harm can begin early in life.
- Early onset is common around 7 years of age.
- Frequently, onset is middle adolescence (12-15) and can last for weeks, months, or years.
- Many times self-harm is cyclical rather than linear.
- Do not assume that self-harm is a fleeting adolescent phenomenon.
- Has some addictive qualities and may serve as a form of self-medication for some individuals.

Self-Harm Risk Factors

- High levels of perceived loneliness
- Less dense social networks
- Less affectionate relationships with their parents
- History of emotional and/or sexual abuse
- Suffer from diminished self-esteem
- Feelings of invisibility and shame
- Feelings of being unreal and inauthentic
- Never learned appropriate ways of expressing emotion
- Learned that emotions are bad and to be avoided

Self-Harm Risk Factors

- Histories of childhood sexual and physical abuse are highly significant predictors of self-cutting and suicide attempts.
- Evidence suggests that earlier, more severe abuse and abuse by a family member may lead to greater dissociation and thus greater self-injury.
- Also linked to eating disorders, substance abuse, post-traumatic stress disorder, borderline personality disorder, depression, and anxiety disorders.

Predisposing Factors

- Negative self-esteem
- Hypersensitivity to rejection
- Suppressed anger and sadness
- Chronic anxiety
- Relationship problems
- Poor functioning in school, home or work
- More common in females than males
- Typical onset is at puberty
- History of physical and/or sexual abuse

Predisposing Factors

- Average to high intelligence
- Middle to upper-class background
- Feels “empty” and isolated
- Drug or alcohol abuse
- Early history of medical illness or surgical procedures requiring hospitalization
- Imprisonment or institutionalization in drug treatment centers
- Inability to express or tolerate negative feelings
- Poor academic performance or truancy
- Has a background of emotional neglect

Self-Harm Indicators

- Repeatedly and deliberately cuts or harms self
- Displays tension immediately prior to the act
- Displays relaxation, gratification, pleasure or numbness during and immediately after the act
- Displays shame or fear of social stigma
- Attempts to hide scars, blood or other evidence
- Conversely, may display injuries in an attempt to gain attention or sympathy
- Typically uses multiple methods of harm
- Describes self-harm as addictive

Detection

- Detecting / intervening - difficult because of secrecy
- Unexplained burns, cuts, scars, clusters of similar markings
- Arms, fists, and forearms opposite dominant hand
- Inappropriate dress (long sleeves / pants in summer)
- Constant use of wrist bands / coverings
- Unwillingness to participate in events / activities requiring less body coverage (swimming, gym class)
- Frequent bandages
- Odd / unexplainable paraphernalia (razor blades, implements to cut or pound)
- Heightened signs of depression or anxiety
- Implausible stories to explain physical indicators

Additional Dangers of Self-Harm

- Even a single episode can correlate with a history of abuse and conditions such as suicidality and psychiatric distress.
- Relatively few seek medical or psychiatric assistance even following severe injuries.
- Potential link between self-harm and suicide.
- Always take self-harm seriously, particular if a person is injuring regularly or using methods that can cause a lot of damage to the body (like cutting with a knife, smashing glass with fists).
- Infection risks and HIV/AIDS.

Interventions

- Create a safe environment
- Form a relationship with structure, consistency, and predictability
- Treatment plans that emphasize:
 - Personal responsibility
 - Harm reduction
 - Identification of triggers and physical cues
 - Support systems
 - Eliminating self-harming objects (e.g., paper clips, staples, erasers, razors, pins, knives, sharp objects)

Interventions

- Assess the safety of self-injurious practices
 - Shared cutting implements - disease transmission
 - Dangerous objects in school - lead to detention
- Teach appropriate coping strategies
 - Identify, practice, use productive and positive coping
 - Enhance capacity to cope with adversity
- Enhance capacity to regulate emotional perceptions and impulses
 - Dialectical Behavior Therapy (DBT)
 - Build on existing strengths

Interventions

- Enhance social connectedness
 - Recognize and build on existing strengths
 - Reach out, connect with others in authentic, meaningful way
 - Participate in activities that feel meaningful
- Drug therapy (mood stabilizers, anxiolytics, antidepressants, and some newer neuroleptics)
- Exploring the underlying causes of self-injury
- Address sources of stress in external environment
- Promote and advertise positive norms related to help-seeking and communication about mental and emotional status and needs

Interventions

- Educate youth to understand the role media plays in influencing behavior
 - Images, songs, news articles on self-injurious behavior have increased significantly over past decade
 - Help adolescents become critical consumers of media to lessen vulnerability to glamorized self-harm behavior
- Avoid strategies aimed primarily at raising knowledge of forms and practices
 - Single-shot awareness raising strategies (e.g., school assemblies) are not effective but linked to increases in the behavior they intend to stop
 - Strategies which raise awareness about underlying **factors** (e.g., role of media) are more effective in positively raising awareness

Interventions

- Sometimes treated as an addiction: 12-Step
- Stress reduction and management skills
- Cognitive-behavioral therapy
- Family therapy
- Group therapy
- Hypnosis
- Eye Movement Desensitization and Reprocessing (EMDR)
- Hospitalization
- Set boundaries to keep yourself feeling safe while respecting the client's right to make his or her own decisions about how to deal with stress

Suicide Assessment

First, remember to do three things:

1. **Consult** - this allows for another opinion, better care, and protects you
2. **Document**, document, document!
Everything you do, everyone you talk to, every question you ask the client should be documented
3. **Evaluate** the client's risk

Suicide Risk Factors

James, R. (2011). *Crisis intervention strategies* (7th ed). Belmont, CA: Brooks/Cole.

- Exhibits the presence of suicidal or homicidal impulses and serious intent.
- Has a family history of suicide, threats of harm, and abuse of others.
- Has a history of previous attempts.
- Has formulated a specific plan.
- Has experienced recent loss of a loved one through death, divorce, or separation.
- Is part of a family that is destabilized as a result of loss, personal abuse, violence, and/or because the client has been sexually abused.

Suicide Risk Factors (continued)

James, R. (2011). *Crisis intervention strategies* (7th ed). Belmont, CA: Brooks/Cole.

- Is preoccupied with the anniversary of a particularly traumatic loss.
- Is psychotic (and may have discontinued medications).
- Has a history of drug and/or alcohol abuse.
- Has had recent physical and /or psychological trauma.
- Has a history of unsuccessful medical treatment, chronic pain, or terminal illness.
- Is living alone and is cut off from contact with others.

Suicide Risk Factors (continued)

James, R. (2011). *Crisis intervention strategies* (7th ed). Belmont, CA: Brooks/Cole.

- Is depressed, is recovering from depression, or has recently been hospitalized for depression.
- Is giving away prized possessions or putting personal affairs in order.
- Displays **radical shifts** in characteristic behaviors or moods, such as apathy, withdrawal, isolation, irritability, panic, or anxiety or changed social, sleeping, eating, study, dress, grooming, or work habits.
- Is experiencing a pervasive feeling of hopelessness and/or helplessness.

Suicide Risk Factors (continued)

James, R. (2011). *Crisis intervention strategies* (7th ed). Belmont, CA: Brooks/Cole.

- Is preoccupied and troubled by earlier episodes of experienced physical, emotional, or sexual abuse.
- Exhibits a **profound degree of one or more emotions** – such as anger, aggression, loneliness, guilt, hostility, grief, or disappointment – that are uncharacteristic of the individual's normal emotional behavior.
- Faces threatened financial loss.
- Exhibits ideas of persecution.
- Has difficulty in dealing with sexual orientation.

Suicide Risk Factors (continued)

James, R. (2011). *Crisis intervention strategies* (7th ed). Belmont, CA: Brooks/Cole.

- Has an unplanned pregnancy.
- Has a history of running away or of incarceration.
- Manifests ideas and themes of depression, death, and suicide in conversation, written essays, reading selections, art work, and drawings.
- Makes statements or suggestions that he or she would not be missed if gone.
- Experiences chronic or acute stressors.

Questions to Ask

1. Do you have thoughts of suicide?
2. Are they related to current stressors going on in your life, or have you had such thoughts before?
3. Do you have a plan? Tell me.
4. Do you have access to (components of the plan) a gun, pills, etc...

Signs of Depression

1. Loss of all pleasure in life
2. Sleep, energy, weight, or appetite changes
3. Decreased interest in sex and other pleasurable activities
4. Feelings of helplessness and hopelessness
5. Inability to think clearly & concentrate
6. Social isolation and withdrawal from others

Level of Risk

- **None** - no suicidal ideation
- **Mild** - some ideation, no plan
- **Moderate** - ideation, vague plan, low on lethality, wouldn't do it
- **Severe** - ideation, plan specific and lethal, wouldn't do it
- **Extreme** - ideation, plan specific and lethal, will do it

Level of Risk

Highest Risk Group has:

- **Suicidal ideation** (thoughts of killing self)
- **A plan** (any plan so long as it is definite and detailed is high risk)
- **High lethality** (guns and walking in front of busses are more serious than overdosing on Tylenol and slashing wrists)
- **Few inhibitors** (few reasons not to kill self)
- **Low self-control** (especially drinking or using drugs - can decide not to kill self but fail to act to reverse events and accidentally kill themselves)

Structure of Suicidal Client Interview

- **Listen** actively and **Engage** the client.
- **Normalize** feelings related to crisis and stress.
- **Validate** their experiencing of crisis and stress, hopelessness, and helplessness.
- **Exaggerate** the part of them that wants to live - even the smallest thing.
- **Support** client emotionally. You are with them.
- **Create a plan** with the client's involvement.
- **Define** the client's natural support system including spiritual/religious.
- **Provide** resources, options, and referrals.
- **Follow-up** with the client.

Make a No-Suicide Contract

- Best for client with support, low risk, and clear rationale for not killing themselves.
- Elements of No-Suicide Contract:
 - Client agrees not to hurt themselves
 - Teach and list coping strategies (ABCs)
 - If/when feel they can't stop themselves, they will call:
 - 911
 - Hospital emergency room (provide number)
 - Local crises line (Listening Ear - provide number)
 - Support person (make a list and write in numbers)
 - You, the therapist, or another designated professional
 - Return for help on next appointment
- Have client sign it and get a witness.

Family Intervention

- Best for client with high support and low impulsiveness.
- Client agrees to contact their family.
- Stay with the family member until suicidal thoughts are addressed in treatment
- Brief family on who to contact in an emergency.
- Family takes active role to remove drugs, guns, or other means of suicide from the home.
- Family promises 24-hour supervision.

Hospitalization

- Best for client with little family support, or mental illness, substance use or impulsiveness and high risk - plan with means.
- Always attempt a voluntary admission, but use involuntary if needed.

Suicidal Management

James, R. (2011). *Crisis intervention strategies* (7th ed). Belmont, CA: Brooks/Cole.

- Don't lecture, blame, give advice, judge, or preach to clients.
- Don't criticize clients or their choices or behaviors. Remember that as "crazy" as it seems, the lethal behavior makes perfect sense to the client.
- Don't debate the pros and cons of suicide. Philosophy has nothing to do with what is going on in a lethality case.

Suicidal Management (continued)

- Don't be misled by the client's telling you the crisis is past. Never just take the client's word that things are "settled" and "okay now."
- Don't deny the client's suicidal ideas. Ideation leads to action.
- Don't try to challenge for shock effects. This is not "Scared Straight" therapy. Challenges may be acted on to show you the client means business.
- Don't leave the client isolated, unobserved, and disconnected.

Suicidal Management (continued)

- Don't diagnose and analyze behavior or confront client with interpretations during acute phase.
- Don't be passive. Suicides are high on the triage scale. You must become active and directive.
- Don't overreact. Suicidal/homicidal behavior is scary, but it is behavior that can be handled.
- Don't keep the client's suicidal risk a secret or worry about snitching on them. This is life-threatening behavior. Tell someone who can keep the client safe.

Suicidal Management (continued)

- Don't get sidetracked on extraneous or external issues or persons. Deal with the lethality. The other stuff can and should be acknowledged as important to the person, but that's it.
- Don't glamorize, martyrize, glorify, heroize, or deify suicidal behavior in others, past or present.
- Don't become defensive or avoid strong feelings. The possibility for transference is great in lethal behavior. While lethal feelings are scary, they are exactly what need to be discussed and uncovered.

Suicidal Management (continued)

- Don't hide behind pseudo-professionalism and clinical objectivity as a way of distancing yourself from painful and scary material. You must get into the game and build the relationship.
- Don't fail to identify the precipitating event. Find what specifically caused the client to decide to become lethal. Identify the reason the client got here today so action plans can be generated to deal with it.

Suicidal Management (continued)

- Don't terminate the intervention without obtaining some level of positive commitment. Even if the person later goes ahead and kills him/herself or somebody else, try as hard as you can to get a commitment from them to do no harm.
- Don't forget to follow up. You must keep track of lethal people until the crisis has passed.
- Don't forget to document and report. Keep good records of your assessment of the client and when and what you did with your recommendations.

Suicidal Management (continued)

- Don't be so embarrassed or vain that you don't consult. Substantiation by another professional in a difficult case makes good therapeutic and legal sense.
- Don't fail to make yourself available and accessible. If you come in contact with a suicidal/homicidal client, you must stay the course, be available, and have backup support.

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