Suicide Prevention & Intervention: mind the gap
assessing, managing, and treating self-harm and suicidality

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PLEASE DO NOT FORGET:
- Visit [evaluation link] to evaluate this training
- Contact Denise Beagley for content-related questions denise.beagley@asu.edu
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learning objectives
• discuss the prevalence of suicide nationally and locally
• increase awareness of the definition of suicide and self-harm
• increase comfort in screening for depression, suicidal ideation, and non-suicidal self-injury
• differentiate between potentially lethal suicidal ideation and non-suicidal self-injury
• identify evidence-based practices to address self-harm and suicidal ideation
• identify community resources that are appropriate and relevant to patient needs

the material covered during the presentation may be difficult to listen to, please remember to:
• show sensitivity to those who have lost someone or who are suicide survivors
• create a judgment free space so people may talk about personal & clinical experiences related to self-harm and suicide
• be mindful of self-care
• step out if needed
• other requests?
• a note about self-care

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A PDF of the presentation, and all handouts will be made available after the presentation.

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I am good just taking a break

I could use some support and someone to talk with

part I: prevalence of suicide

40,200 17,250 44,965

homicide  suicide  motor vehicle accidents

match the number with the type of death

there are an average of 123 suicides per day in the U.S.

on average, a suicide occurs every seven hours in Arizona
AZ Suicide Data 2017

2016: **1271**

Who is dying by suicide?
49% were younger than age 50

Arizona has the 17th highest suicide rate in the country

(AHCCCS, 2017)

2nd
leading cause of death for 15-34 year olds

3rd
leading cause of death for 10-14 year olds

(CDC, 2015)

25
attempts occur for every 1 completed suicide

(SAMHSA, 2016)

10th
leading cause of death for general US population

8th
leading cause of death for American Indians/Alaskan Natives

(CDC, 2015)

34.2
suicides per 100,000 youths for Native American adolescents ages 15-24 compared to 9.7/100,000 for all US races

37.5
suicides per 100,000 youths for Native American individuals ages 25-34 compared to 9.7/100,000 for all US races

(Bostwick et al., 2014)

2
3 times greater prevalence of suicidal ideation and attempts among Native American/Alaska Native youths compared to other youths

(Wexler et al., 2005)

50
percent greater suicide deaths among Native American/Alaskan Native people compared to Caucasian people

(Weiser et al., 2009)
77.7% of suicides occur amongst men (ADHS, 2016)

36.7 completed suicides by AI/AN men per 100,000

11.9 completed suicides by AI/AN women per 100,000 (ADHS, 2016)

Firearms are the leading method of choice for men,

Poisoning is the leading method of choice for women (e.g. prescription overdose)

Suffocation is the leading method of choice for suicide for AI/AN young adults

Firearms is the second leading method of choice

Part II: Defining self-harm versus suicide

Agenda:
- Defining self-harm
- Self-harm prevalence
- Risk factors
- Warning signs
- Self-harm myths
- Assessment
- Interventions
- Resources
deliberate self-harm: nonfatal self-poisoning or self-injury with or without suicidal intent

(Olfson et al., 2018)

non-suicidal self-injury (NSSI): direct, deliberate destruction of body tissue without lethal intention

(Muehlenkamp et al., 2012)

suicide attempt: intentional self-injury with intent to die

(Bartlow et al., 2012)

shallow, yet painful injuries to surface of his/her body

absence of suicidal intent has either been stated or inferred

difference between self-harm and attempted suicide: intent to end life

common types of self-harm

- scraping or scratching skin
- cutting skin
- self-hitting or banging (to break or bruise)
- burning
- pinching
- interfering with a healing wound
- self-biting
- picking or ripping skin

DSM 5 criteria: nonsuicidal self-injury (NSSI)

- can occur outside of the context of borderline personality disorder
- seeking relief from negative feelings
- interpersonal problems & negative feelings
- not a socially-sanctioned behavior (e.g. body piercing, tattooing)

suicide continuum

Adapted from Brent et al., 1988

25

26

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Part III: Prevalence Rates for Self-Harm

5% of population has engaged in self-harm

(US News & World Report, 2014)

5-10% of adolescents report having self-harmed

(Hawton et al., 2012)

Self-harm is common among young people

7.3% of adolescents in the US engaged in non-suicidal self-injury over a 12-month span

(Muehlenkamp et al., 2012)

Part IV: Risk & Protective Factors Against Self-Harm

Risk factors:

- History of previous self-harm (self & family)
- History of mental illness
- A violent method of self-harm
- Comorbid substance use disorder
- Intimate partner violence
- Trauma
prior episode of self-harm and previous psychiatric treatment **strongly** associated with repetition of self-harm

risk of self-harm repetition varied based on **initial method** of self-harm

repetition more likely for those who used **cutting** or other forms of self-injury versus self-poisoning

(Hawton et al., 2012)

risk of suicide after self-harm especially high for:

- men
- AI/AN populations
- those with violent self-harm behaviors (e.g. hanging)

(Olfson et al., 2018)

**protective factors**

- cultivating culture
- forming links to the community
- a sense of responsibility
- spirituality
- positive coping skills
- problem solving skills

Olfson et al., 2018

individuals with a history of self-harm, but who had not self-harmed within the past year reported having higher family support and satisfaction with life

Olfson et al., 2015

role of self-esteem

higher self-esteem and resilience reported by individuals who had stopped self-harming within the past year compared to those who had self-harmed within the past year

(Wexler et al., 2015)

(Whitlock et al., 2015)

**enculturation**: the process of learning about one's own culture

→ protective factor against suicidal & self-harm behaviors

Olfson et al., 2018

communities with greater community member engagement, functional community institutions, and cultural continuity had lower suicide rates

(Wexler et al., 2015)

(Wexler et al., 2015)

(forming links to the community)
qualities associated with cessation of self-harming included a sense of spirituality

commitment to spirituality and high endorsement of cultural spiritual orientations associated with a decrease in the number of reported suicide attempts

(Whitlock et al., 2015)

problem solving skills

conflict resolution and communal mastery at the individual level shown to be a protective factor against suicidal behaviors

(Whitlock et al., 2015)

part V: warning signs for self-harm

personal strength

positively reframe events

self-understanding

hopefulness

reduction in self-harm

acceptance of one’s life and limitations

sense of belonging

positive coping skills

general protective factors

life satisfaction

positive problem skills

connectedness

responsibility

positive coping skills

spirituality

access to care

warning signs vs risk factors

warning signs: observable; usually indicate imminent risk of self-harm

risk factors: provide an estimate of the likelihood of someone being at risk for self-harm or suicide

(Rudd, 2018)
negative feelings & cognitions
- depression
- anxiety
- tension
- anger
- generalized distress
- self-criticism

behavioral warning signs:
isolating, change in body language, negative self-talk, how they're dressed (long sleeves/pants when it's hot out)

physical warning signs:
cuts, bruising on neck, change in physical appearance or hygiene

family warning signs:
reporting concerns or changes in the individual

part VI: self-harm myths

myth: self-harm isn’t common
5% of the population has engaged in self-harm

myth: if you self-harm, you’re suicidal

myth: people who self-harm are manipulative or looking for attention
myth: it’s not self-harm if you don’t cut yourself

myth: self-harm is untreatable

Cognitive behavioral therapy and dialectical behavior therapy have been shown to be effective in treating self-harm.

part VII: assessment

Mind: for better mental health

Note about self-care

WARNING: GRAPHIC CONTENT AHEAD

Images of non-suicidal self injury forthcoming. Please feel free to avert your eyes or step out if needed.
What does self-harm look like?

Comorbidities:
- anxiety
- depression
- borderline personality disorder
- substance use disorders
- eating disorders

Part VIII: Interventions

Intervention strategies that are culturally congruent and that can have more sustainable impacts

What we need...

Steps for working with self-injury

- screen & assess
- teach coping skills
- connect clients to correct level of care
- consult
- educate & collaborate

Screen for self-harm/suicide risk with evaluations

Understand self-harm as a coping strategy for clients

Teach coping skills for emotion management besides self-harm
steps for working with self-injury

connect clients
To correct level of care to stabilize/develop coping strategies

consult
With supervisors and team members about best practice guidelines & for case consultation

educate
Client about what impacts self-harm and how to develop a safety plan

communication

useful strategies for raising topic of suicide/self-harm with clients:

• normalization: gentle lead-in to a discussion of any sensitive topic
• shame attenuation: a way to inquire about behaviors that may have shame and guilt attached

listen actively
• can be the most effective tool in creating a strong working alliance
• occurs when you try to understand what the speaker believes and feels
• involves giving your full attention to the individual; shows you are interested
• respond by paraphrasing and summarizing the main issue

purpose of active listening

• identifies and validates feelings
• communicates that we care and understand
• reduces defensiveness
• promotes change
• is an effective emotion regulation strategy
• helps people: ‘talk it out rather than act out’

evidence-based treatments for self-harm

• cognitive behavioral therapy (CBT)
• dialectical behavioral therapy (DBT)
• psychodynamic therapy (particularly in cases of trauma)
• mindfulness techniques
• medications to treat underlying or comorbid conditions (e.g. antidepressants)
• anything that assists that particular client in emotion regulation and stress reduction (e.g. meditation, cardiovascular exercise, etc.)

alternatives to safety contracts

safety planning
• conversation between client and clinician when client has urge to self-harm
• aim: explore client feelings, reduce impulsive urge to self-harm, and consider alternatives to self-harm for coping strategies
safety cards/plan

physical card for client to carry at all times

may include:
• your contact information
• counselor’s contact information
• 24-hour crisis number to call in emergency
• contact information for supports (family/friends)
• number for emergency medical services

safety plan practice

open discussion

How do you differentiate between self-harm and suicidality with your clients?

What do you do if you are unsure if your client is self-harming or suicidal?

How do you currently manage self-harm in your clients versus suicidality?

agenda

prevalence
risk factors
warning signs
suicide myths
assessment
interventions
additional resources
**part II: risk & protective factors**

**risk factors**
- mental illness
- past attempts
- family history of suicide
- history of trauma
- recent loss
- chronic health condition/pain
- incarceration
- access to a firearm
- chronic substance abuse
- ongoing adversity
- poor coping skills
- intergenerational trauma

**vulnerable populations**
- white males in midlife
- elderly men
- American Indians/Alaskan Natives
- veterans
- LGBTQ (youth who identify)
- individuals bereaved by suicide
- individuals with traumatic brain injury
- individuals who have attempted suicide in the past

**untreated depression is the leading cause of suicide**

**adult men** are the highest risk population for suicide

**young women** are at the highest risk of self-harm
suicide and substance use

75.7% of individuals were “drunk or high” at the time of suicide attempt

32.1% used substance overdose as their method of attempted suicide

part III: suicide myths and facts

myth: those who commit suicide are weak

myth: suicides are an impulsive act

myth: suicide is selfish

protective factors

• mental health treatment
• adequate coping skills
• social support
• religious beliefs
• therapeutic alliance
myth: suicidal people want to die

myth: if someone is determined to commit suicide, they will

myth: talking about suicide is going to give someone the idea

Do antidepressants cause suicide...?

- Depression usually results in:
  - anhedonia (def): a lack of pleasurable feelings
  - hypersomnia (def): excessive sleep

- Hypothesis: Antidepressants may cause relief of anhedonia and hypersomnia, providing the individual with enough energy and motivation to suicide.
  - An FDA review found only 4% of those taking SSRIs report an increase in suicidal thoughts
  - Difficult to determine, as depression causes an increased risk of suicide; individuals with SI are usually removed from controlled trials

(part IV: differentiating between self-harm & suicidality)

Suicide continuum

Adapted from Brent et al., 1998
suicide vs self-harm: why they do it

**suicide**
- pain and problems seem insurmountable
- suicide seems like the only way out
- lack of felt belongingness
- feeling like a burden
- lethal intent stated or inferred

**self-harm**
- obtain relief from negative feelings or cognitive state
- resolve interpersonal difficulty
- gain sense of control
- induce a positive feeling state
- absence of lethal intent

suicide vs self-harm: what to look for

**suicide**
- how they talk (voicing hopelessness)
- how they behave (especially if there are new/dramatically different behaviors)
- what their mood is like (depressed, irritable, etc.)

**self-harm**
- how they appear (injuries on body, difference in hygiene)
- how they behave (isolating, what they are wearing)
- what others have noticed (reported concerns or changes)

suicide vs self-harm: how to respond

**suicide**
- complete an assessment
- use attentive listening
- medication
- safety planning
- therapy
- peer support
- hospitalization (if necessary)

**self-harm**
- complete an assessment
- use attentive listening
- CBT/DBT/mindfulness
- coping skills
- support groups
- family support
- safety planning

part V: screening & assessment

progression of suicide

precipitating events/factors

vague suicidal thoughts

suicide behaviors/self-harm

death

warning signs

depression
social withdrawal
lack of interest in activities they used to enjoy
physical agitation/restlessness
vague references to suicide or death
calling people to say goodbye
self-harm behaviors
Thomas Joiner

- perceived burdensomeness
  - the view that one's existence burdens others
  - "my death will be worth more than my life to family, friends, society, etc."
  - this idea represents a potentially fatal misperception

- thwarted belongingness
  - low sense of belongingness
  - one is alienated from others

- acquired capacity
  - theory suggests that suicide entails a fight with self-preservation motives
  - continued hardships impact the self-preservation instinct
  - Thomas Joiner hypothesized that the capability for suicide is acquired largely through repeated exposure to painful or fearsome experiences.

Pink flags

- unusual risk taking
- feeling overwhelmed
- acting anxious, agitated, reckless
- changes in mood
- sleeping too little or too much
- poor impulse control
- change in work/school performance
- talking about being a burden to others

Thwarted belongingness

- "I am alone."

Acquired capability for suicide

- "I am not afraid to die."

Desire for suicide

- "I am a burden."

When people hold two specific psychological states in their minds simultaneously, and for a long enough period of time, they develop desire for death.
a note about lethality

those vocalizing suicidality most **loudly** may be less lethal, those being more **subtle** may be more lethal

a word of caution

**a sudden, unexplained** improvement in mood could indicate **the decision to suicide**

a word of caution

**declining assistance** could indicate **a decision to suicide**

the Kevin Hines story

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**a word of caution**

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**assessing for ideation**

key questions:

- how often do they have these thoughts? (frequency)
- how intense are the thoughts? (intensity)
- how long do the thoughts/feelings last? (duration)
- do they have a plan? (intent)
- do they have the means/access? (e.g., firearm)

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**depression screening tool**

**Patient Health Questionnaire-9 (PHQ-9)**

- screening for depression and suicidal thoughts
- widely used in primary care, behavioral health settings and internationally
- validated across a variety of cultural groups
- inquires about energy level, sleeping difficulties, appetite, suicidal thoughts
- provides a range of depression scores from mild to severe
- can be used to track improvement

PHQ-9 practice

https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/218

Columbia-Suicide Severity Rating Scale (C-SSRS)
- assesses: suicide risk, severity/immediacy of risk, and level of support needed
- inquires about: suicidal ideation, intensity of ideation, and suicidal behavior
- includes assessment of the potential lethality from 0-2
- consider following positive screen on the PHQ-9 (particularly answer in the affirmative on SI item)

part VI: interventions

if you determine a client is suicidal…
- ask them about their intent to suicide
- key questions: do they have a plan? means?
- if confirmed (or strongly suspected), DO NOT leave them alone
- utilize empathetic/reflective listening
- ask if they have access to hanging material
- ask if they have access to a firearm and/or drugs/alcohol/medication
- take them to the hospital or crisis center, only if necessary

interventions
- medication
- safety plan
- therapy
- peer support
- hospitalization

take away: ensure treatment response matches severity of demonstrated client need
**tips & hints**

- consult with a supervisor or your team
- if making a referral, follow-up with the referral source to ensure the client arrives/seeks treatment
- solicit the help of the client's significant other/s (if possible)
- eradicate possible means (e.g., weapons, medications)
- use the least intensive/intrusive intervention that is required for client safety

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**Do safety contracts work?**

- sometimes called a “no-suicide contract” (NSC)
- typically a written, signed contract between client and provider
- can provide a false sense of security for provider and the agency/organization
- limited evidence that they prevent suicide

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**safety contracts: helpful or hurtful?**

- typically a written, signed contract between client and provider
- can provide a false sense of security for provider and the agency/organization
- no credible evidence that they are effective in preventing suicide attempts
- ethical issues around “controlling” the client
- Incidence of self-harm 5x greater in clients with no-suicide contracts

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**alternatives to safety contracts**

**safety planning**

- conversation between client and clinician when client has urge to self-harm
- aim: explore client feelings, reduce impulsive urge to self-harm, and consider alternatives to self-harm for coping strategies

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**safety cards/plan**

- physical card for client to carry at all times
- may include:
  - your contact information
  - counselor’s contact information
  - 24-hour crisis number to call in emergency
  - contact information for supports (family/friends)
  - number for emergency medical services

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**part VII: wrap-up**
open discussion:

1. What do you intend to implement from today’s training and discussion?

2. In what ways are you feeling better prepared to address suicidal ideation?

3. How might your clients benefit from our training/discussion today?

resources

- American Foundation for Suicide Prevention: www.afsp.org
- National Suicide Prevention Lifeline 1-800-273-TALK (8255)
- Native American Youth Crisis Hotline 1-877-209-1266
- EMPACT – suicide prevention hotline (480) 784-1500