

# Lesson 3: Understanding Deliberate Self-Harm\*

1

AS A RESULT OF THIS LESSON, YOU WILL BE BETTER ABLE TO:

- Differentiate deliberate self-harm from suicide attempts
- Explain why survivors of domestic violence might deliberately harm themselves

\*Parts of this lesson were adapted from materials created by Sue Eastgard, MSW of The Youth Suicide Prevention Program of Washington State and are used with permission. [www.yspp.org](http://www.yspp.org)

# Deliberate Self-Harm and Domestic Violence

2



Research on deliberate self-harm (DSH) is limited. Research on the intersection of DSH and domestic violence is almost nonexistent.

However, a few studies do indicate that DSH may be significantly more common among people who have experienced domestic violence. Because of this and since many advocates do not feel prepared to respond to DSH, we are covering DSH in this course.

# What is Deliberate Self-Harm?

3

Deliberate self-harm (DSH) is inflicting intentional damage to one's own body. This is also known as non-suicidal self-injury, self-inflicted violence, self-mutilation, or self-abuse.

Behaviors that are socially acceptable (to most) are not typically considered to be DSH (e.g., ear piercing, tattooing, etc.)

Substance abuse and eating disorders are usually not considered self-harm because the resulting tissue damage is ordinarily an unintentional side effect. However, they are risk factors for self-harm.

# Suicide vs. Self Harm

4

*“A person who truly attempts suicide seeks to end all feelings whereas a person who self-mutilates seeks to feel better.”*

Armando R. Favazza, MD

Department of Psychiatry, University of Missouri

# Increased Risk for Suicide

5

While the intention of deliberate self-harm (DSH) is not to kill oneself, self-harm may unintentionally result in suicide.

Those who engage in DSH may be at an increased risk for suicide.



# Examples of Deliberate Self-Harm

6

Common types of deliberate self-harm include:

- Burning
- Cutting
- Hair Pulling
- Head Banging
- Hitting
- Ingesting Poisons or Objects
- Scratching
- Skin Picking



The type of self-harm used may vary depending on cultural identity. For example, ingesting poison may be more common for people who are rural and have easy access to pesticides.

# Theories on Deliberate Self-Harm

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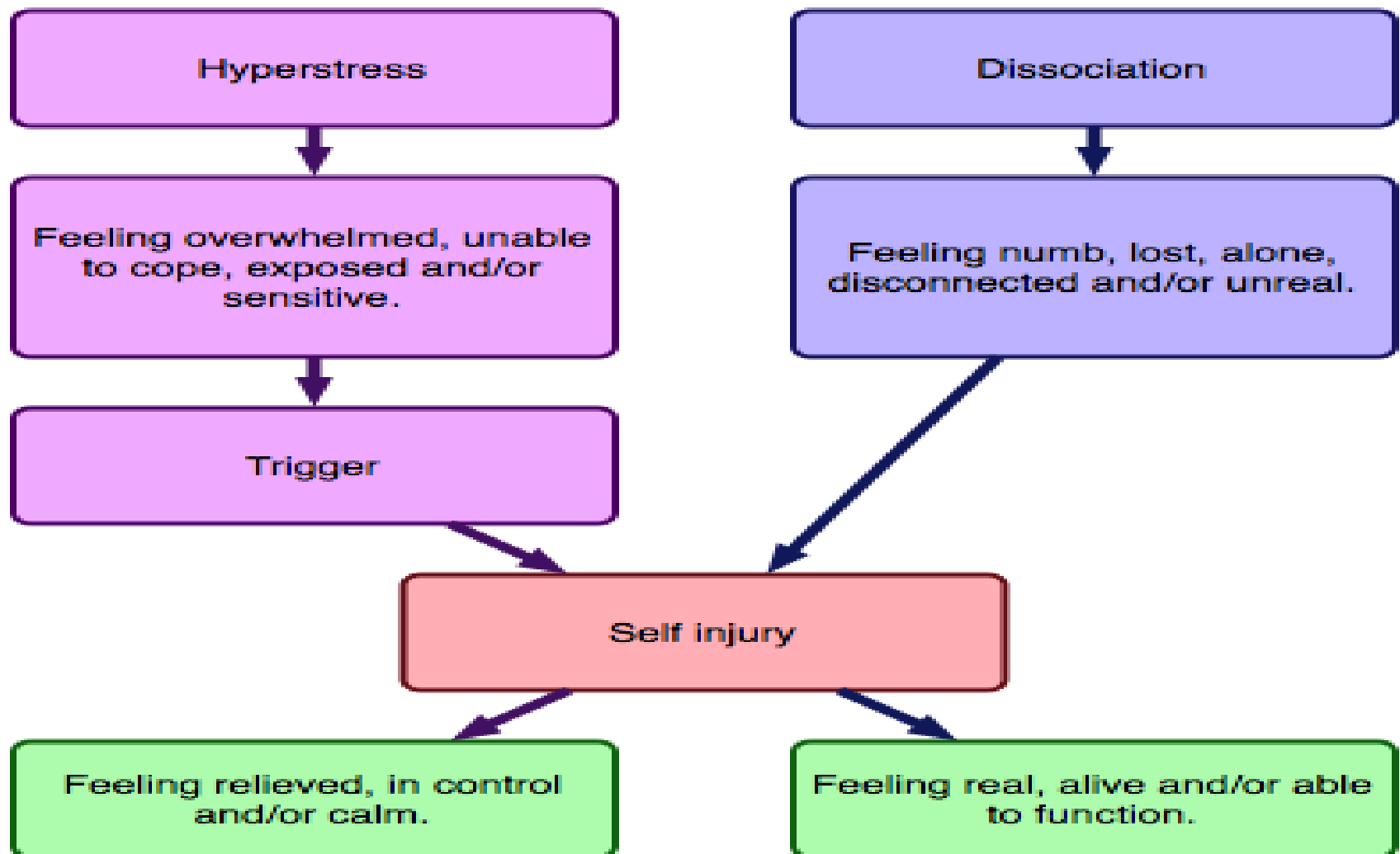
People may engage in deliberate self-harm in order to regulate their emotions.

One theory is that people harm themselves in order to decrease negative or uncomfortable emotions. ↓

Another theory is that people harm themselves in order to feel *something*. ↑

The next slide visually depicts these theories.

## Precursors to Self Injury





# Why Deliberate Self-Harm?

9

*Why don't people who engage in deliberate self-harm do something else to regulate their emotions?*

Many who harm themselves have histories of childhood abuse, neglect, and trauma.

As a result of their experiences, they may:

- Feel self-loathing
- Lack the capacity to self-soothe
- Experience boundary confusion
- Have difficulty coping with being alone
- Have difficulty managing feelings of anger, sadness and fear



# Consequences for Negative Emotions

10

People who self-harm may come from families where they are punished for feeling sadness or anger, or where they are told they are not feeling what they are feeling.

*“You shouldn’t be mad.”*

*“You should smile.”*

*“That shouldn’t bother you. You’re fine.”*

*“Stop crying or I will give you a reason to cry.”*



Similarly, DV survivors may suffer consequences for expressing anger or sadness or focusing on their own needs.

# Deliberate Self-Harm as Communication

11

On the surface deliberate self-harm (DSH) may look like attention seeking or manipulative behavior. However, this is a problematic oversimplification.

People who engage in DSH may be trying to communicate their needs. DSH can be help-seeking behavior. However, many who self-harm do so in secret.



Trauma experiences can interfere with a person's ability to articulate what has happened to them and what they need.

# Trauma and Memory

12



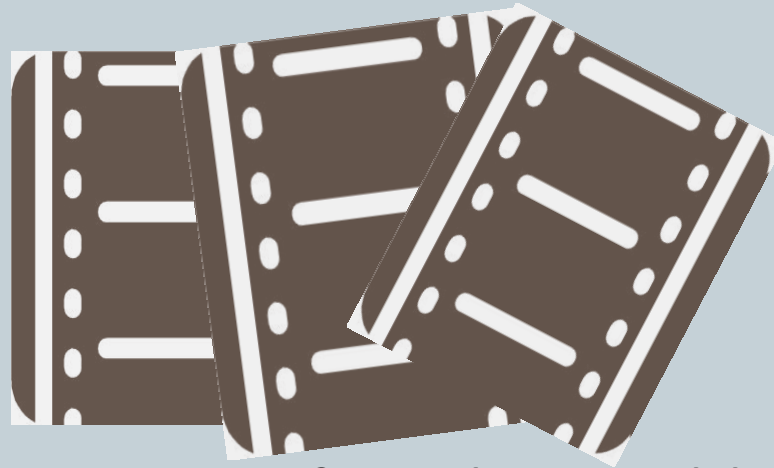
Traumatic stress can over stimulate the central nervous system. This can put the body in a state of hyper-arousal and can result in changes in how memories are stored and retrieved.

Words and emotions related to memories are stored in different parts of the brain. Sustained or excessive stress can damage the part of the brain that stores language related to memory.

# Trauma and Memory continued

13

Traumatic memories are therefore stored primarily as emotions, sensations or visual images.



This can prevent survivors from being able to put their experiences into words. Instead they may feel flooded by images and feelings without the language to make sense of them.

# Coping with Trauma

14

Physical hyper-arousal (e.g., elevated heart rate and blood pressure) combined with overwhelming emotions can make it difficult to cope. When you add to this a childhood where coping skills were not modeled or taught, stress can be too much to bear.



Some survivors may cope with this by dissociating or becoming emotionally numb. Dissociating is like daydreaming or zoning out. It can be a defense against extremely difficult emotions. In more extreme cases, people who dissociate may lose time.

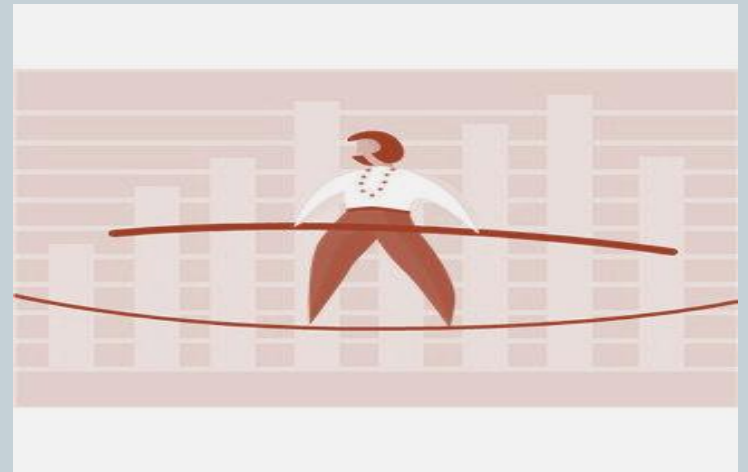
# Coping with Trauma continued

15

Some may seek ways to release the tension or to feel in control of their emotional pain.

As the theories suggested, deliberate self-harm can be an attempt to cope with the lack of feeling or the excess of feeling.

Harming one's body may create the sensation of emotional release or balance or normalcy.



# Deliberate Self-Harm and Control

16

We know that DV survivors are in situations where they may have very little control over their own lives and bodies.

It is possible that deliberate self-harm (DSH) may give them a sense of being able to control when and how they are harmed.

It may also be an expression of their belief that they deserve the harm that has been inflicted upon them or that they do not deserve to soothe themselves in non-harmful ways.

Abuse survivors may feel that their bodies have betrayed them and may seek to punish themselves.

Unfortunately, engaging in DSH may exacerbate feelings of self-loathing and shame and may lead to more DSH.



# But Doesn't It Hurt?

17

Some who self-harm may tolerate the physical pain in order to reduce the emotional pain. Keep in mind that many survivors report that emotional abuse is more difficult to take than physical abuse.

Some who self-harm do feel pain and may prefer to feel that rather than to feel nothing or empty inside.

Others who self-harm may experience little or no physical pain from their actions. Self-harm can result in the release of endorphins (a naturally occurring substance in the brain.) They are released in response to physical injury and may eliminate the pain and produce pleasant feelings. This sensation can be addictive.

# Goals of DSH Response

18

- I. Harm reduction
- II. Increase healthy self-soothing
- III. Increase emotional regulation skills
- IV. Increase interpersonal effectiveness
- V. Address underlying trauma issues

# Step I - Harm Reduction

19

Upon learning that a survivor is engaging in deliberate self-harm (DSH) or following an incident of DSH take the following steps:

1. Remain calm. Overreacting to DSH can exacerbate the problem and overwhelm the survivor.
2. Obtain medical help, if needed.
3. Put the DSH in perspective. Explain that people who have experienced trauma may harm themselves as a way to cope with their experiences. Let the survivor know that this can be dangerous and there is help available.

# Harm Reduction continued

20

4. Ask if the survivor is already receiving services from a MH provider and if the provider is aware of this issue. Depending on the circumstances, you may want to make a referral for MH services or ask for a release of information to discuss the situation with the therapist.
5. Ask the survivor how you can be helpful. Are there situations that trigger the self-harm? Can you help the survivor avoid these situations or identify alternatives to self-harm?

# Step II - Increase Healthy Self-Soothing

21

What has worked for the survivor in the past? Do they have other ways to self-soothe?

Suggest alternatives such as:

- Journaling
- Exercising
- Gardening
- Self-Expression through art, music, or dance



# Step II continued

22

Offer resources such as:

- Diaphragmatic breathing exercises (an example of this is available at the end of the course)
- Progressive muscle relaxation

Many self-soothing activities can be done in groups which can be beneficial for building social skills and support, and decreasing isolation.






# Step III - Emotional Regulation Skill Building

23

Building emotion regulation skills can help reduce DSH.

You can help survivors strengthen their emotion regulation skills by:

- Helping them increase positive emotions by providing opportunities for fun
- Decreasing emotional suffering by reducing self-blame and increasing self-care
- Assisting them in identifying and describing emotions (e.g., help them recognize when they are feeling sad or angry)   

# Distress Tolerance

24

Talking about how to increase their tolerance for distress can also be helpful.

Discuss how to:

- Improve the moment; make a bad situation better
- Identify pros and cons of situations
- Be open and willing to engage positively in life



# Step IV – Increase Interpersonal Effectiveness

25

Increasing the interpersonal effectiveness of someone who engages in deliberate self-harm (DSH) can decrease their stress and increase their ability to get their needs met. This can enable them to decrease DSH.

You can help them:

- Understand the factors that reduce interpersonal effectiveness (e.g., not knowing how to interact appropriately and not being able to self-filter)
- Say “no” to unwanted requests and demands
- Build social support



No

# Interpersonal Effectiveness Scenario

26



Angela comes from a large family that generally eats dinner together. In Angela's family, it is normal for multiple conversations to occur simultaneously and interruptions are commonplace.

Angela is accustomed to this style of communication and finds herself chastised among friends while lunching with them for being "rude and inconsiderate." While Angela's interpersonal skills are acceptable with her family at home, it is important that she note it is not acceptable in most social situations.

# Scenario Questions

27

- *What could you do to help Angela improve her interpersonal effectiveness?*
- *How could you help her read cues about when it is okay to interrupt?*

# Possible Scenario Answers

28

- Angela could watch how other people in the group interact.
- Observing other people's reactions can help her know if her actions are appropriate.
- Cues could be verbal, tonal, facial, body language.
- Practice with her – role play.



# Step V - Address Underlying Trauma Issues

29

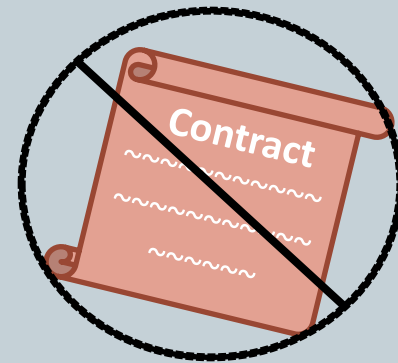
Harm reduction and self-soothing are important, but ultimately, the wellbeing of the survivor requires addressing the trauma they are experiencing or have experienced.

DV advocacy and support groups can be helpful. It can also be helpful for the survivor to receive assistance from a therapist who has experience with deliberate self-harm and trauma.

# Treatment

30

- You can instill hope that survivors can really feel better. Let them know that there are effective treatments for deliberate self-harm and trauma.



- Contracts are not recommended. Trying to control the behavior without providing alternatives and addressing the underlying issues can result in an escalation of the deliberate self-harm. It can feel more like a power struggle than support.

# Treatment continued

31

- Cognitive behavioral therapies designed to treat trauma, as well as medication, can be helpful.
- Dialectical behavioral therapy, while designed for people with Borderline Personality Disorder (BPD), can be helpful for people who self-harm even if they do not have BPD.
- Inpatient psychiatric treatment may be necessary for some who engage in deliberate self-harm.

# Next Steps

32

In addition to assisting the survivor with harm reduction, self-soothing, emotion regulation, and interpersonal effectiveness, be sure to follow the steps of the flow chart regarding:

- Referring the survivor for MH services,
- Obtaining consultation, and
- Collaborating.

The next few slides give you a chance to apply what you have learned.



# Case Example

33

Maria is a resident at your shelter. Her roommate Sally woke up and saw Maria cutting herself, and thinks she might seriously hurt herself or that she might be suicidal.

Maria usually keeps her cuts bandaged, but now that Sally has seen her cutting herself, she no longer tries to hide it from her.

Sally has asked for a new room, and she has told all of the other residents about Maria's cutting. Staff members are also concerned and nervous about Maria's cutting.

# Case Example Question # 1

34



*How can staff best support Maria?*

Take a couple of minutes and think about what staff can do.



# Case Example Answer # 1

35

It's helpful to be calm when you speak with Maria about this and not to overreact to the situation.

Talk with her and let her know that you are concerned about her. Let her know that sometimes survivors cut themselves as a way to cope with the trauma and stress they have experienced. Let her know you can help her find healthier ways to cope with her stress throughout her stay at the shelter. You could talk to her about diaphragmatic breathing, progressive muscle relaxation, and other coping methods.

Offer to refer her to a therapist to talk about this more.

If Maria would like, offer to help her talk to her roommate about what happened.

## Case Example Question # 2

36

*How can you help Maria's roommate and other shelter residents respond to Maria's cutting in a way that is healthy for them and her?*



# Case Example Answer # 2

37

You can talk to Maria's roommate about deliberate self harm and invite her to ask questions.

Offer her a referral to speak with a therapist.

Encourage her to talk to Maria.

If other residents express concern, go through the same steps with them.

Be sure to seek consultation for yourself and collaborate, if Maria is getting MH services.

# Lesson 4: Suicide Prevention\*

38

**AS A RESULT OF THIS LESSON, YOU WILL BE BETTER ABLE TO:**

- **Explain why survivors of domestic violence might feel suicidal**
- **Talk to a survivor about suicidal thoughts and feelings**

**\*Parts of this lesson were adapted from materials created by Sue Eastgard, MSW of The Youth Suicide Prevention Program of Washington State and are used with permission.**

**[www.yspp.org](http://www.yspp.org)**

# Info from the 2006 WA Fatality Review

39

Several studies indicate that DV increases women's risk of suicide attempts and of death by suicide.

Whether or not survivors have any of the common risk factors before being abused, abusers' tactics of control systematically exacerbate suicide risk factors by increasing victims' social **isolation**, undermining their sense of **self-worth**, and creating barriers to accessing **support and resources**.

Institutional barriers to accessing support—such as lack of language interpretation or childcare resources—can reinforce survivors' sense that they have little **hope** of regaining **control** over their own lives.

# Advocates and Suicide Prevention

40

As a domestic violence advocate you are ideally suited to prevent suicide because you have both the opportunity to talk to survivors about their thoughts about killing themselves and because your skill set is well suited for suicide prevention.

While talking to someone about feeling suicidal is not easy, this training segment will better prepare you to talk to survivors about suicide and to utilize the skills you already have to respond effectively in the moment.



# Writing Exercise

41

Before we start addressing suicide prevention, it can be helpful to first take some time to think about your own attitudes and beliefs about suicide and about people who consider taking their own lives.

Please do the brief writing exercise on the next slide.

You will not be asked to share this information with anyone else and there are no right or wrong answers.



# Writing Exercise continued

42

Please take out a blank piece of paper and spend a few minutes completing these sentences:

1. People who commit suicide are \_\_\_\_\_.
2. To think about killing yourself is to \_\_\_\_\_.
3. When someone tells me they are suicidal I feel \_\_\_\_\_.
4. When we die this is what happens: \_\_\_\_\_.
5. My culture feels that suicide is \_\_\_\_\_.
6. Completing these sentences made me feel \_\_\_\_\_.

# Beliefs and Attitudes about Suicide

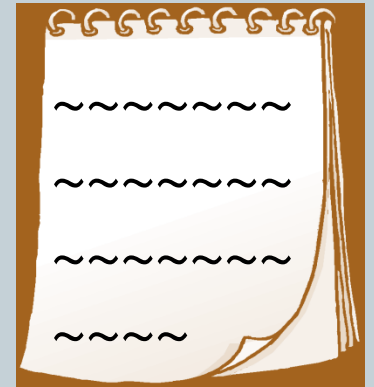
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Review your answers to the writing exercise.

*How would you describe your beliefs and attitudes about suicide?*

*In what ways might your beliefs and attitudes help you assist someone who is feeling suicidal?*

*In what ways might your beliefs and attitudes make it harder for you to assist someone who is feeling suicidal?*



# Beliefs and Attitudes continued

44

It is important to be aware of our feelings because they can get in our way if we are not conscious of them and they can either undermine or support our ability or our willingness to intervene.

Similarly, a survivor's beliefs and attitudes about suicide can influence their decision to seek help or to commit suicide.

# Advocate Reactions

45

Some advocates may feel anxious about talking to a survivor about suicide and may even avoid doing so because of their fears about it.

You might be wondering, *“What if I screw this up?”* or *“Will it be my fault if she kills herself?”*

It can be helpful to keep in mind that you are very capable of having conversations about many other difficult topics (e.g., emotional, physical, and sexual abuse, stalking, risk of being killed by the abuser, etc.)

# Advocate Reactions continued

46

Just as we do safety planning with survivors to decrease their chances of being physically harmed by their abusive partners, we can do suicide prevention planning to help survivors decrease their chances of harming themselves.

Similarly, while we do everything we can to avoid it, we must accept that there may be times when people who have experienced DV take their own lives. Hopefully, as a result of this training, we can reduce the chance of that happening and increase our effectiveness at talking with survivors who may be suicidal. We will start by looking at general risk factors and warning signs.

# General Risk Factors for Suicide

47

## Biological

- Personal/family history of mental illness, depression
- Chronic pain or Disabilities

## Sociological

- External reasons why someone is unhappy (e.g., DV)
- Isolation

## Psychological

- How one interprets their problems (e.g., self-blame)
- Stigma related to obtaining MH care

## Existential

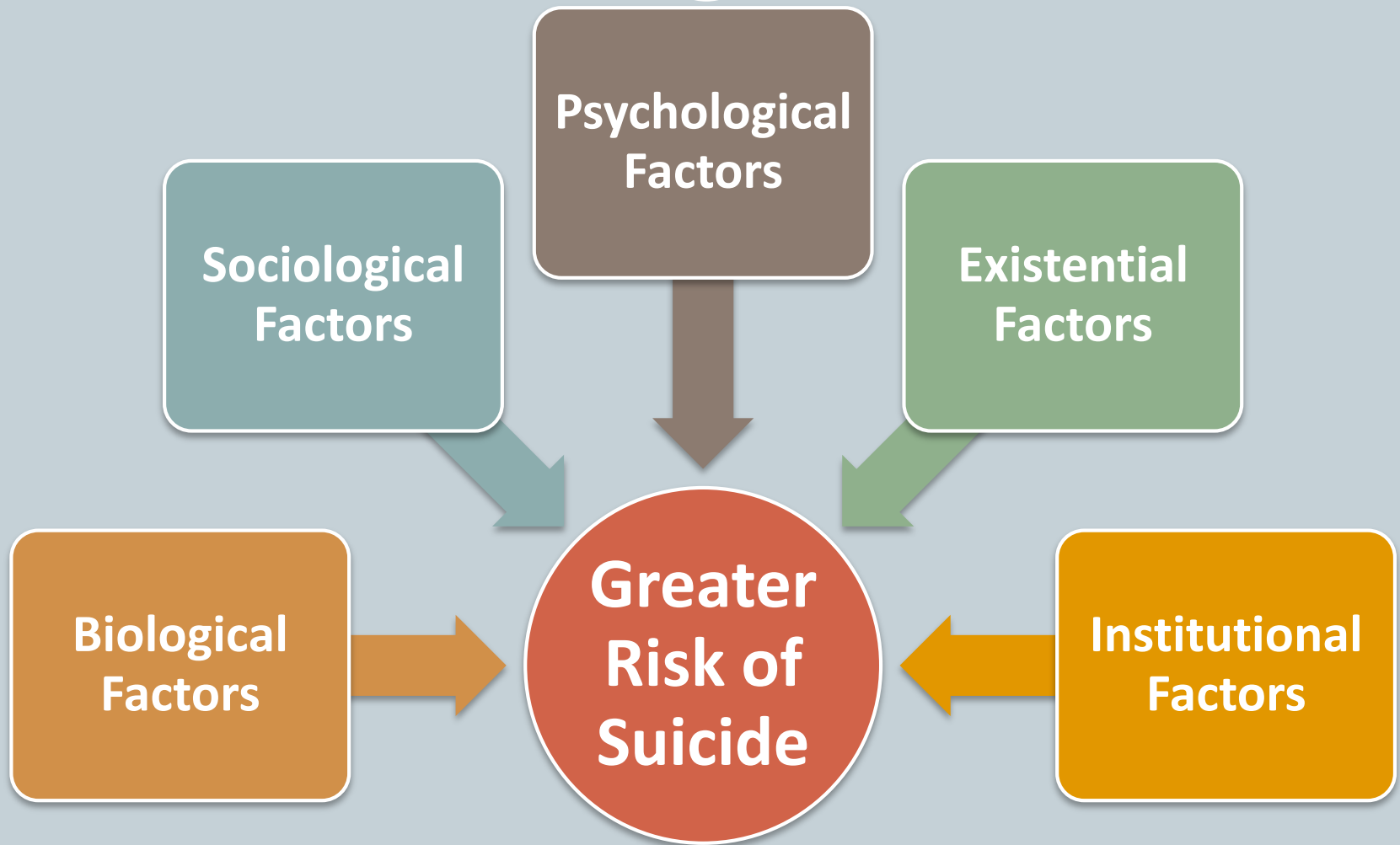
- *Is the world a safe and good place? Is anything going to change or is it always going to be like this?*

## Institutional

- Barriers to obtaining MH care (e.g., not qualifying for free services, lack of childcare or transportation)

# More Types of Factors = Greater Risk

48





# Warning Signs

49

The presence of risk factors, even without warning signs, is still significant. Warning signs might not be present until a person is very close to deciding to commit suicide. Signs include:

- Current talk of suicide or making a plan
- Strong wish to die, preoccupation with death, giving away prized possessions
- Signs of serious depression and anxiety
- Increased alcohol and/or drug use

# Suicide Prevention Steps

50

1. Ask about thoughts of suicide and risk factors
2. Use your judgment to determine risk level
3. Use flowchart to determine intervention steps
4. Do suicide prevention planning
5. Refer or reconnect to MH services
6. Obtain consultation
7. Collaborate

# Ask about Suicide

51

In lesson 2 we talked about asking about suicidality. Since this is important, we will cover asking in more depth here.

Do not hesitate to raise the subject of suicide. You do not have to be a therapist to talk about suicide and talking about it will not put the idea in survivors' heads.

You will be more likely to receive an honest answer when asking about suicide if you are direct in a caring and nonjudgmental way.

# What to Say

52

Ask:

*Do you ever think about suicide?*

*Do you ever think about hurting or killing yourself?*



It is helpful to phrase the question both ways.

If the survivor has been contemplating suicide, it is important to obtain more information to get a sense of whether the survivor is at imminent, moderate, or low risk of committing suicide. This will help you determine the appropriate response and will make consultation more productive.

# Getting More Info

53

Say something like...

*I appreciate your courage in sharing with me your thoughts about suicide. In order to best assist you, I'd like to ask you some more questions.*

## Questions to Determine Risk Level

History

*Have you ever tried to kill yourself?*

Plan

*Have you thought about how you would kill yourself?*

Means

*Do you have the means? (e.g., if they are planning to shoot themselves, ask if they have access to a gun)*

Imminence

*When are you planning to do this?*

Help Seeking

*Have you talked to anyone about this?*

# Suicide Prevention over the Phone

54

- If you are talking to the survivor over the phone or via a TTY or a relay service and the survivor appears to be at **imminent** risk for committing suicide, then you need to ask the survivor to tell you where they are located. 911 will need this information if you need to call them. You may also be able to determine their location via caller ID or by dialing \*69 if they hang up on you.
- If it is not an emergency situation, but the risk is moderate, ask if the survivor is okay with you connecting yourself and the caller to the Crisis Clinic via conference call. Proceed with referrals and prevention planning.

# Imminent versus Moderate Risk

55

To determine risk level use your judgment and consider the following:

	<b>Imminent Risk</b>	<b>Moderate Risk</b>
Risk Factors	The more risk factors, the greater the risk	
Warning Signs	The more warning signs, the greater the risk	
History	Recent, serious attempts	Older, less lethal attempts
Plan	Has clear plan	Has less developed plan
Means	Has means available (e.g. gun, pills, etc.)	Does not have the means or easy access
Imminence	Plans to kill self in the next day or two	Does not intend to implement the plan soon

# No Clear Risk

56

The survivor may have some concerning behavior, but not be suicidal. Use your own judgment or instincts about what constitutes concerning behavior.

For example, the survivor is not eating, is sleeping a lot, or appears to be very sad, confused, or angry. Survivors who are not engaging at all with staff or who are isolating themselves may also be of concern.

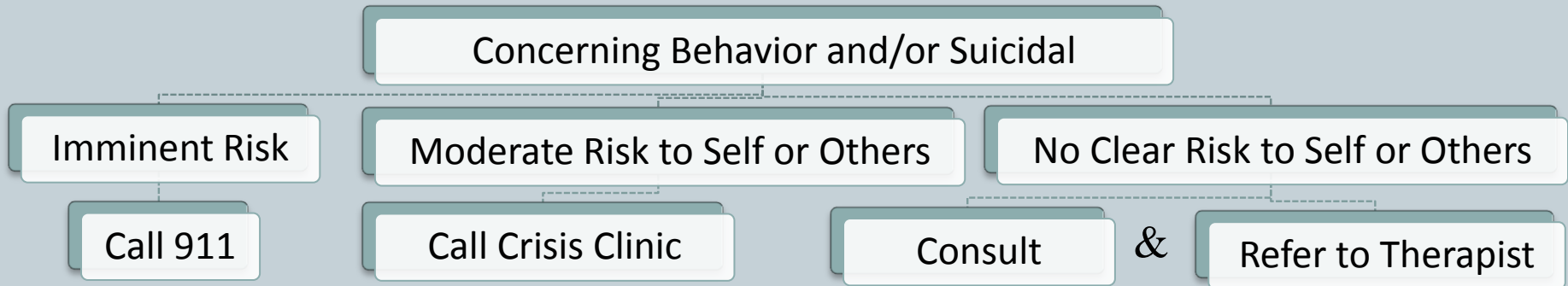
The survivor may have thoughts of suicide, but have expressed clear reasons why they would not commit suicide (e.g., children need them.)

It is important to take survivors' mental health needs seriously even if they are not at imminent or moderate risk.



# Follow the Flowchart Steps

57



What have you learned from the survivor's prior help seeking actions? Is the survivor already working with a therapist? Is there already a prevention plan?

If so, the next logical step may be to reconnect the survivor with the therapist and to review their plan. If not, it may be necessary to call 911 or the Crisis Clinic depending on their risk level.

# Tips for Responding

58

## DO

- Remain calm
- Instill hope
- Let the survivor know you care
- Ask about their feelings
- Use your active listening skills (listen carefully and paraphrase what you have heard)

## *DO NOT*

- Jump into problem solving
- Share your personal experiences
- Let your own anxiety interfere with your ability to listen

# Suicide Prevention Plan

59

After accessing emergency assistance from 911 or getting assistance from the Crisis Clinic, if needed, work with the survivor on a suicide prevention plan.

Ask the survivor, *What has motivated you to keep going?*  
Help the survivor reflect on what brings meaning or joy to his/her life.

You can acknowledge that they are in pain and ask them if they are willing to create a suicide prevention plan with you. This is more advisable than doing a contract.

# Suicide Prevention Plan - Today

60

- *What are your plans for tonight?* Help them make plans if they do not have any (keep it simple like eating dinner or connecting with a friend or watching television.)
- *What helps you feel better when you feel upset? Who can you call? Where can you get support?*
- You can give them the Crisis Clinic number and a DV help line number and let them know they can share that they have been encouraged to call for support around feeling suicidal.
- If possible, you can encourage them to call back at a particular time.

# Suicide Prevention Plan - Tomorrow

61

- If the survivor is already connected with a mental health provider, then they can contact the provider directly or the after hours number for the provider (if applicable.) The Crisis Clinic can figure out who their provider is, if they are enrolled in a community mental health program.
- If the survivor is not connected with a community mental health organization, then you can call the Crisis Clinic and they can determine if a Next Day Appointment is appropriate and available for them.