Seeking Solutions to Self-injury

A GUIDE FOR EMERGENCY STAFF

The University Of Queensland
AUSTRALIA

Centre for Suicide Prevention Studies

SEEKING SOLUTIONS TO SELF-INJURY: A GUIDE FOR EMERGENCY STAFF

The fourth in a series of four guides - 'Seeking Solutions to Self-Injury' (Young People, Parents and Families, School Staff and Emergency Staff).

ACKNOWLEDGEMENT

We would like to acknowledge the phenomenal assistance of Heather Valentine, in copy editing the first and second editions of the 4 guides in this series of 'Seeking Solutions to Self-injury', as well as managing the extensive distribution throughout Australia.

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Martin, G., Swannell, S., McAllister, M., & Hasking, P. (2014). *Seeking Solutions to Self-injury: A Guide for Emergency Staff.* Centre for Suicide Prevention Studies, The University of Queensland, Brisbane.

ISBN 978-0-9808207-6-8

Printed by Bluestar Group, Brisbane, Queensland.

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1. WHAT THIS BOOKLET IS ABOUT

This guide is about understanding self-injury and managing it in the emergency department context.

The guide is for you if:

- *You see patients who are seeking care for self-injury.*
- *You are confused about why someone would self-injure.*
- *You would like to know how emergency staff can best help people who self-injure.*

Self-injury can be a confusing behaviour. In an emergency context, even though treatment of the *physical* injury may be familiar and straight forward, knowing what to say and how to relate to the patient is often perplexing. This guide was developed specifically to help emergency staff (police, paramedics, nurses and doctors) feel more confident about responding in a helpful manner to patients who present with self-injury.

The guide is based on our best understanding of the current international literature, as well as a large number of our own research studies over many years. In addition, we consulted with many health care professionals, families and parents of young people who self-injure, as well as the people themselves.

This booklet explains self-injury and provides effective strategies for assessing, responding and referring patients. We hope you benefit from the information we provide.

2. WHAT IS SELF-INJURY?

We define self-injury as: **'Deliberate destruction or alteration of body tissue *without* suicidal intent'**. Other terms include: '*Non-suicidal self-injury' (NSSI), 'Self-mutilation', 'Auto-aggression', 'Self-wounding', and 'Cutting'. 'Deliberate self-harm' (DSH*) is commonly used to describe the phenomenon, but usually includes the wish to die (i.e. 'a suicide attempt'). Distinguishing between NSSI and DSH is important because **self-injury and suicide attempts require different management strategies**. Confusing self-injury with a suicide attempt can interfere with best practice management of self-injury.

This guide focuses on non-suicidal self-injury. We do **not** include drug use, alcohol abuse, anorexia or bulimia as self-injury - although we understand it can be argued they are forms of self-abuse. **Our focus is on those who damage the outside of the body to relieve painful feelings inside.** This may include cutting, scratching, burning, hitting a part of the body on a hard surface, or deliberately interfering with wound healing. We accept, and also include, swallowing of objects or chemicals to damage the body, as long as it can be clarified this was **not** a suicide attempt.

So this is **critical decision time**.

The majority of self-injurers presenting at emergency departments do not want to be there. Even when they attend willingly, it is only because they accept specialist medical care is required. Patients 'brought' against their will are often angry about being brought, and present as tearful

and upset. This may initially look like suicidal behaviour, but it is a mistake to automatically assume this. It is critical from everybody's perspective you clarify the issue at the outset.

Patients in this situation will have their guard up, expecting health professionals to judge or label them as attention seeking or manipulative. **The first step is to recognise and accept their internal experience as being valid**, and avoid rejecting, ignoring, or judging their experience. You don't have to agree with or support their feelings or thoughts - just recognise them as valid. Try something like: "I understand you have been feeling really awful."

Even in the middle of turmoil, the best way to distinguish between suicidal behaviour and self-injury is to ask questions: **"What were you trying to do?" "What did you want to happen as a result of hurting yourself?" "Did you think you might die?" "Did you really want to die?"** If they say they wanted to end their life, then they were most likely suicidal at the time of the act. They will require thorough mental health and suicide risk assessment, a possible admission for observation, and intensive follow up by mental health professionals.

If they deny wanting to end their life then, whatever the seriousness of the physical damage, you may have to accept their explanation; there is a high likelihood this is non-suicidal self-injury. We understand that many individuals have difficulty verbalising intentions, have mixed feelings about whether or not they wanted to die or, honestly, do not understand why they engaged in self-injury. This confusion may be frustrating for you as an emergency

worker, but it is important you do not immediately assume the individual is just trying to be difficult.

There is an issue in all of this about who is able, or allowed, to take the decision about whether a patient is suicidal or not. Whose responsibility is it? Best practice may be for a psychiatrist, psychologist or other mental health worker to decide. But in a rural or remote service, or after hours, they may not be available. However, there should always be a protocol available in your service to guide your decision-making. You should always follow the guidelines in this. We hope that the ideas we have suggested above make your decision-making easier, and allow you to feel more comfortable working with people who self-injure.

3. WHO IS LIKELY TO SELF-INJURE?

Self-injury is surprisingly common, and has been part of being human for centuries. Grief and contrition have been publicly demonstrated through self-injury (e.g. flagellation), and in many religions being devout has been shown through self-injury in the context of ritual.

Our recent research shows that about 8% of Australians claim to have self-injured at some time in their life, and 1% admit to hurting themselves at least once in the previous month (Martin et al., 2010).

Although there is no particular 'type' of person more likely to self-injure, international research indicates the common thread is **difficulty in emotion regulation**. This may include reacting more intensely than others to daily difficulties, as well as taking longer to recover from an emotional upset. These difficulties are often biologically based or the result of adverse life experiences (like early trauma or abuse). They are not simply addressed by telling the individual to 'toughen up' or 'think positive'. Be assured that individuals who self-injure repeatedly tell themselves to 'toughen up' and 'think positive', as they try to find ways to manage their emotions.

While people who self-injure tend to begin as an adolescent or young adult, our research shows adults *and* older people also self-injure. Males and females, rich and poor people, and people from different cultural backgrounds - all can self-injure.

A common misconception is that self-injury occurs almost exclusively among females. Research now suggests it occurs with similar prevalence across gender, and apparent differences relate to mostly to the report of methods used. Females are more likely to cut and scratch; males are more likely to hit a part of themselves against a wall, or kick something - more easily explained away as ‘an accident’.

Again, while many people assume self-injury occurs most commonly among adolescents, in fact prevalence is highest among 18 to 24 year olds.

An important fact is that **you don’t have to have a mental illness to need to self-injure**. Despite this, the Royal Australian and New Zealand College of Psychiatrists has produced guidelines that identify ***people and groups who may be at more risk***. The guidelines do use the term ‘self-harm’, but are still helpful to us. Those more at risk include:

- *Those under stress or in crisis and those who have self-harmed before.*
- *Those with mental disorders (e.g. anxiety, depression or schizophrenia).*
- *Those who misuse alcohol or other substances.*
- *Those who have experienced childhood trauma or abuse.*
- *Those who have a debilitating or chronic illness.*

Risks themselves ***do not cause*** the problem. Rather, each one contributes to an increased possibility of self-injury occurring in the first place, or of self-injury being repeated.

This leads us to the idea that if you are able to help someone sort out any problems that seem to be contributing to self-injury, then the self-injury may not need to occur, or will happen less often.

Perhaps what is more important is to discover ***what protects*** people from needing to self-injure in the first place, or ***what may reduce the likelihood*** of self-injury or perhaps reduce the likelihood of repetition or increasing severity. These **protective factors** include:

1. *Availability of opportunities at critical turning points or major life transitions (like 'leaving school', 'moving interstate', or 'losing a parent')*
2. *Supportive family and friends*
3. *Physical wellbeing, good nutrition, sleep and exercise*
4. *Secure, appropriate and safe accommodation*
5. *Financial security*
6. *Positive school (or work) climate*
7. *Prosocial peers*
8. *Problem-solving skills*
9. *Optimism*
10. *Meaningful daily activity*
11. *Sense of control and self-efficacy*
12. *Good coping skills*
13. *Effective use of medication (when required/prescribed).*

You may think that as an emergency worker there is nothing you can do to facilitate development of protective factors or reduce risks for patients. **However, do not underestimate your power to influence, or the authority of your role.** Young people have told us (and this is reflected in the

research literature) that those working at the front line of health-care, in crisis situations, are critical to modifying, or lessening risks for patients in the future.

Why? Because**:**

- *The problem of self-injury is just as real as cardiac arrhythmia and, sometimes, just as deadly.*
- *Experiencing a crisis may be the turning point the person needs to realise they have a problem. Most self-harm, contrary to popular opinion, is not seen by health professionals. When it is, you have the critical opportunity to demonstrate to the person that they have a serious problem and there is help available.*
- *Self-injury often involves a vicious cycle. Part of that cycle involves feelings that mount leading to the urge to self-injure. When patients seek emergency care for self-injury, they find it very easy to feel guilty for taking up your valuable time. You can minimise that guilt by conveying to them they have a right to care, and that you do not judge them.*
- *If you treat patients badly, you reduce the likelihood they will seek help in the future.*

4. WHY DO PEOPLE SELF-INJURE?

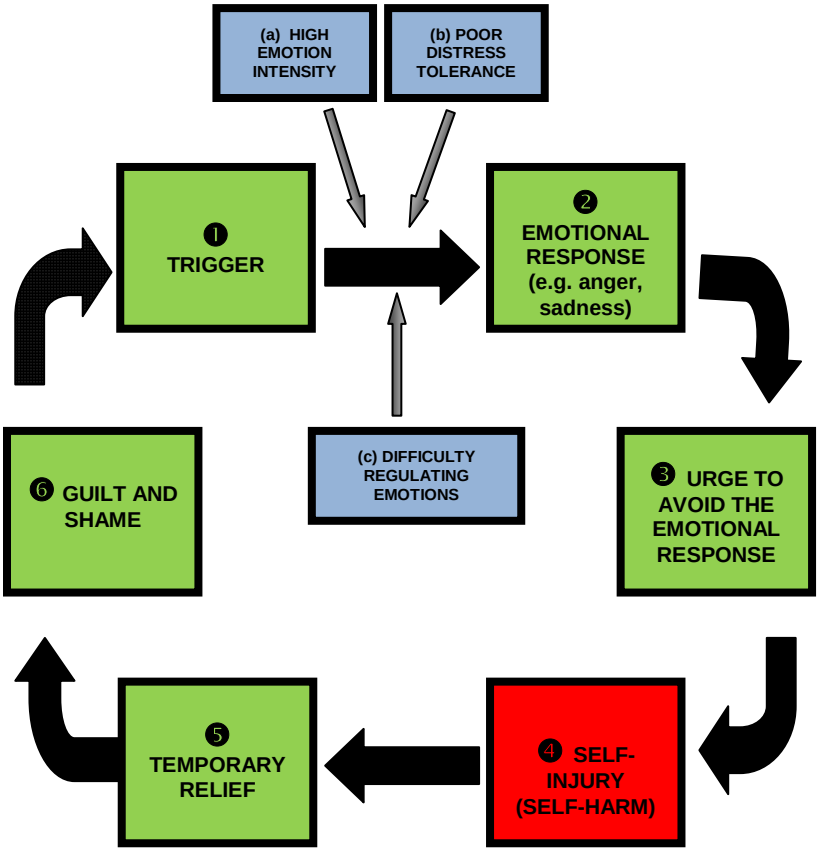
Our research shows there are many reasons someone may self-injure. These include:

- *Releasing unbearable mounting tension*
- *Relieving feelings of aloneness, alienation, hopelessness, or despair*
- *Combating desperate feelings or thoughts*
- *Discharging rage or anger*
- *Self-punishment – either because they feel bad inside and cannot change the feeling, or in some way to purify the inner self*
- *Attempting to feel alive again; the external injury accompanied by pain brings them back to reality*
- *Regaining a sense of control over inner feelings or some sense of having 'lost it'*
- *Self-soothing; after the damage they find ways to look after the wounds, and therefore themselves*
- *Reconfirming of personal boundaries and a sense of self*
- *Communicating with others; letting them know how bad they were feeling, but could not express in words*
- *Expressing conflict*
- *Bringing them 'back' from dissociative states: cutting or other actions can be grounding, bringing awareness to the physical body*

Do not jump to conclusions. Always ask the patient what best describes what they are going through.

We think this model is helpful. The diagram describes how a person can get into a cycle of self-injury.

Adapted from: Chapman, A.L., Gratz, K.L. & Brown, M.Z. (2006). Solving the puzzle of deliberate self-harm: The experiential avoidance model. *Behaviour Research and Therapy* 44, 371-394.



1. *The cycle begins with a stimulus or **TRIGGER**. This can be something stressful - like witnessing an accident, a*

conflict in a relationship, having an upsetting thought (no one likes you), or uncomfortable emotions (feeling you are about to have a panic attack). Often, the stimulus or trigger involves feelings of loss, rejection or abandonment.

2. *The trigger leads to an intense, unbearable **EMOTIONAL RESPONSE** (anger, sadness, anxiety, shame, fear), which increases over time, or leads to psychological numbness.*

   People who self-injure:
   a. *Are likely to have **HIGH EMOTION INTENSITY.***
   b. *Find it difficult to tolerate uncomfortable emotions (they have **POOR DISTRESS TOLERANCE)**.*
   c. *Don't know what to do about emotions (they have **DIFFICULTY REGULATING EMOTIONS).***

3. *This all leads to the **URGE TO AVOID THE EMOTIONAL RESPONSE**.*

4. *Other ways to reduce the emotional pain fail. Attempts may be made to avoid self-injuring, but once a critical level is reached the urge to **SELF-INJURE** becomes the 'only alternative'. If it has worked in the past, then it is likely the person will use it again.*

5. *Self-harming provides **TEMPORARY RELIEF** from intense and uncomfortable feelings. It is this relief that makes self-harming seemingly 'addictive', like a drug.*

6. *Relief does not last long, and within minutes or hours, feelings of **GUILT AND SHAME** usually appear. Other*

emotions may creep in, such as anger towards the self, or sadness about their situation. At this time the person may avoid others, or alternatively, may seek help. Sometimes the feelings of guilt and shame can even serve as the trigger or stimulus for another cycle of self-harm.

Why does self-injury emerge?

Self-injury occurs for a number of different reasons, and a number of different theories have been proposed to better understand and explain it. These include: biological influences or differences in how the brain works; internal and often unconscious conflicts; old patterns of behaviours that we have learned over time; and influences in our social and cultural environment.

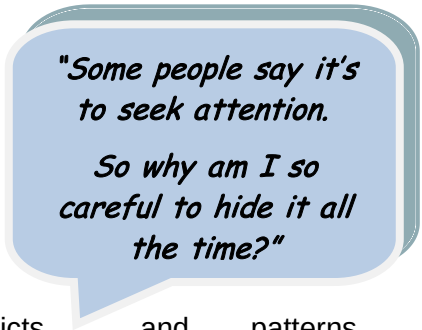
Biological: psychological trauma from prior abuse can affect the brain and the body in powerful, subtle and enduring ways. Research has shown that traumatic memories return to people vividly and with little warning, triggered by many unpredictable things. These memories can be just as frightening as the original event. Anxiety and inner tension are almost always the result. Like any anxiety, people feel a need to minimise it – ideally through relaxation, diversion or exercise, but sometimes through comfort eating, drinking, or smoking and, yes, through deliberate injury to the body. Self-injury triggers an endorphin surge that temporarily calms, or numbs feelings.

Traumatised people can also develop a sensitised biology – alert to even the slightest triggers in the environment, and

with a heightened response to stress. Because it occurs more frequently, understandably they find it difficult to keep finding ways to manage.

Change is possible by expanding anxiety reduction strategies, learning to avoid triggers, delaying urges to self-injure, and resolving earlier traumas.

Psychodynamic: Vulnerable individuals who have had rough times in their early days may experience a new situation according to an old family pattern or personal experience. They may tend to unconsciously seek to relive the original problem or relationship and react as they did in the past. Hidden old tensions in the mind and old patterns of behaviour can be difficult to identify, difficult to bear and difficult to sort out. They may use coping mechanisms that are not even fully understood, because they are sub-conscious. Turning anger inward (rather than expressing it appropriately outward) is an example.



These 'vulnerable' individuals may have an increased need for self-soothing to calm down. Sometimes (often initially by accident) self-injury can become a self-soothing mechanism. Change here is focused on raising awareness about these old internal conflicts and patterns, and finding relief and comfort in safer, less destructive ways.

Behavioural: self-injury can become a learned behaviour and sometimes a habit. This suggests possible methods leading to change - replacing self-injury with less destructive habits, and reinforcing healthier habits for coping both emotionally and practically. The changes are made slowly, bit by bit.

Social and Cultural: self-injury is more common in marginalised and oppressed people and cultural groups, those who may not have a voice, or who have difficulty making their voice heard. Change in this case is focused at a different level - on cultivating a more just society, facilitating release of anger and grief that may be associated with disempowerment, and trying to enable the person to find effective power strategies such as through social action. Matthew Nock, an accomplished researcher of self-injury, has developed an integrated theoretical model of the development and maintenance of self-injury which may help you gain a sense of what it is all about (Nock, 2009).

As emergency workers, you can help a person who self-injures by:

- *Appreciating there are reasons why self-injury has become part of this patient's life (even if you can't understand them);*
- *Accepting self-injury may have become the patient's only choice (at this time) to contain their emotion and avoid becoming overwhelmed;*
- *Accepting engrained habits cannot simply be told to go away, and they do not change overnight;*

- *Avoiding becoming resentful and frustrated to the point of ignoring them; and*
- *Dealing with your own irritation so that you do not further inflame the situation, increasing their irritation and anger, or sadness and feelings of alienation and rejection.*

It is vital in this context to understand that *the person is not the problem*. *The problem is the problem*. And the problem is *a behaviour* (in this case, self-injury) that is damaging, repetitious and distressing to everyone concerned - including the patient).

Perhaps the best way to understand the experience of people who self-injure is to listen to what *they* have told us:

- *They really don't know why they self-injure.*
- *They hide while self-injuring, doing it somewhere private or at a time of day where they feel they will be less likely to be discovered.*
- *Some say it is an impulsive act; some talk about having a ritualised way of doing it.*
- *They feel really bad in some way before the act of self-injury (e.g. depressed, stressed, angry, with memories of trauma), with 'everything building up'.*
- *Some talk about feeling no physical pain during the act of self-injury, while others tell us they need to feel the physical pain 'to make all the bad stuff go away'.*
- *Some feel good while cutting, some don't.*
- *Some say the sight of their own blood makes them 'feel real', where before they had felt like they were 'not part of life'.*

- *Some are not able to describe the experience, as if they have 'switched off' or dissociated during the act.*
- *Some feel immediate release or relief after self-injury, but many also talk about feeling ashamed, or even frightened.*
- *Most cover up their self-injury scars / wounds (e.g. long sleeves in summer, lots of bracelets) so as not to draw attention to the solution they feel they have to use.*

Every young person we have talked to agrees that self-injury is '***not about seeking attention***'.

"It was an accident that I started. There was this other girl, and she was hurting herself. Her problems and feelings seemed just like mine, and nothing else had worked. So…"

“Sometimes I get so angry, I just need to hit something; the pain over the next few days seems to help me focus on stuff…”

“I don’t want to keep on doing this, but so far I haven’t found anything else that works. I tried going to a group, but I got scared; I just couldn’t tell strangers… They wouldn’t understand.”

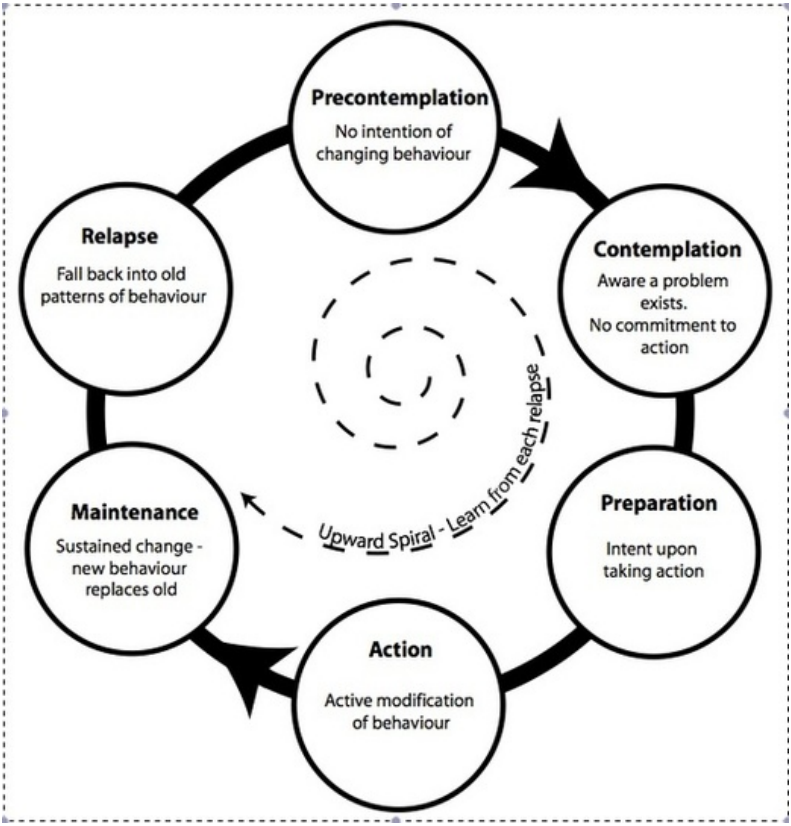
5. UNDERSTANDING CHANGE

We know that, as emergency workers, you tend to be action-oriented. This is what you have been trained to do – make an accurate diagnosis as quickly as possible, and then act to change the situation for the better. You are changing peoples' lives every time you provide care.

We accept it may be frustrating when you attempt to provide care for a patient who doesn't seem to share your need for rapid change, or your belief that change is easy – you *just do it*. People who self-injure may not yet be ready to take action to change their lives; they may be terrified of being left with no method of controlling or containing their emotions. And they may have some understanding that a 'quick fix' solution will only be temporary in the absence of deeper change in their coping with past trauma.

But if you take a few moments to reflect on the idea that change is a process, and may need to begin in tiny ways, you may find that there are still many things that you can do to help a patient – even in a busy emergency department.

A model of the change process looks like this.



From Prochaska et al.; 1992

Patients you see could be anywhere on this continuum. Your assessment of where they are at will help you to focus on the kind of support strategies you offer.

In the **Precontemplation** stage, the person does not consider the self-injurious behaviour problematic, so they

will not have even considered stopping, and may resent any suggestion to stop. The most helpful conversation you can have is about possible consequences of self-injury. One issue relates to using clean tools to cut, and cleansing the skin afterward. The patient may come up with other negative consequences which allow you to begin to discuss those. Remember to be validating and accepting as far as you can. It may also be helpful to provide written information (like our 'Guide for Young People') at this stage to 'plant the seeds of change'. If you come up with strategies for change at this point, they will become defensive and simply reject them (and you).

In the **Contemplation** stage, the patient is aware of the negative consequences of self-injury, but is yet to commit to change. Perhaps they wish to change, but don't feel strong enough or skilled enough. With gentle coaxing, they might be willing to accept a referral to a counsellor or psychologist who can strengthen their resolve and give them new skills.

In the **Preparation** stage, the patient has made a commitment to make changes. They may say: *"I've got to do something about this - this is serious. Something has to change. What can I do?"* They will be more receptive to information, suggestions and strategies you offer, including your making contact with family members, or a therapy service to set up counselling sessions.

In the **Action** stage the patient is actively involved in taking steps to change their behaviour, but lapsing and re-engaging in self-injury is common. Your words of motivation

and hope in the context of being ‘non-judgmental’, will be very important confirm their resolve.

In the **Maintenance** stage, the patient has spent some time successfully avoiding self-injury, through making significant changes in their lives, acquiring new skills, anticipating situations which could trigger a relapse, and preparing coping strategies in advance. If a patient presents at the emergency department after a period of time like this, your role is to help them see the episode as a temporary setback. How you respond to a patient in this stage could be the difference between them getting back on track, versus falling into a full relapse of continuing self-injurious behaviour.

Supporting your patient to maintain positive self-talk at this time is very important.

Relapse. Along the way to permanent behaviour change, most people experience relapse, sometimes more than once. In fact, it is much more common to have at least one relapse than not. There may be feelings of hopelessness and worthlessness, and your role is to remain optimistic for your patients and help to get them back on track.

So you see, at any stage in the process, (even in the chaos and pressure of an emergency department) there ***are*** things you can do to motivate, support, educate, and care for a patient without feeling helpless. But you *do* have to believe you can do this...

6. A B C PROVIDING EMERGENCY SUPPORT

No doubt you are fully trained in, and very familiar with, the ABC of physical life support (Maintain **A**irway, **B**reathing **C**irculation). It should be easy for you to step across into learning and using a very similar framework for mental health problems, in this context of self-injury (Kanel, 2007).

A **ATTEND** to the person, so they feel listened to

B **BREAK DOWN GOALS** into manageable parts

C Focus on possible **COPING** mechanisms

There are many ways that you can implement this, and they do not need to be lengthy or time-consuming, just part of your daily, respectful, high quality care.

Some of these ideas may depend on which stage of change your patient is in. Use your judgment.

ATTEND

- *Separate your professional role from any personal values you may hold, or adverse feelings in you brought on by the self-injury, so that you can care for this patient just as you might care for anyone else;*
- *Address the person by name, remembering they are already likely to feel 'undeserving' and of little worth (self-injury does not mean they are attention-seeking or stupid);*
- *Attend to the injuries respectfully, gently, and immediately (rather than leaving them on a barouche for*

hours in a corridor to attend to 'more important problems');

- *Demonstrate your regard for them by sitting with them in silence for a moment, offering them a drink or magazine, explaining the expected waiting time, and offering some privacy (ensuring they are still safe); and*
- *Let them express their story and their feelings in their own way.*

BREAK DOWN GOALS

- *Ask about the range of solutions they have tried so far (remembering that their current solution to problems may be the best they can manage at this time);*
- *Ask them how you can be most helpful to them right now. (This gives the person a little power in the situation, giving them voice); and*
- *Ask them about their plans for when they leave your care.*

COPING

- *Check out who is available to provide genuine support for them when their injuries have been dealt with;*
- *Think about the change process. Where do you think the patient is at? If you think they are ready, you could gently plant the seed of change, by asking if they were aware of support services for this issue, and if they would like you to provide a referral;*
- *Check out whether they have been attending a psychologist or counsellor, and how they have been helped so far; and*
- *Ask whether they have accessed online services or read any booklets to explain and help change self-injury.*

7. IF YOU HAVE ESTABLISHED RAPPORT, MOVE ON TO ASKING SOLUTION-FOCUSED QUESTIONS

When confronted by self-injury, it is easy to get overwhelmed and just want to focus on the problem and get rid of the patient as soon as possible. But the self-injury is not the whole person. Everyone may be obsessed by the problem at this point, but beginning to think about possible solutions 'down the track' *for the person with self-injury*, may be helpful (and may stop you from feeling 'helpless').

It may be that the patient you are caring for is not yet ready to talk about change, and that's ok. Simply by you conveying acceptance, you may have interrupted their cyclical pattern of guilt-urge-harm, and change actually may be occurring. At this point, you do not *have* to continue, you do not *have* to push for change.

But, if they are willing to talk, and you can manage the time (and your own feelings), don't be afraid to help them focus away from the present problem and on to the future by asking:

- *"When self-injury is not in the picture so much, what is your life like? Tell me about what you are able to do at work, school, with friends and family?"* Talking this way may begin to help the patient to imagine a brighter future.
- *"If you were to wake up tomorrow and the urge to self-injure was no longer there, what do you imagine you would be doing, thinking, feeling?"* Having a conversation about an imagined future can help to make it feel real and possible.

- *"Who do you think would be most pleased that you had been able to stop self-injury?"* This begins to look for people who may add *their* support to helping your patient cease self-injury.
- *"What is one thing that you could do differently from now on?"* Helping the person to plan just one little change in their life, could have a ripple effect to help this episode become a turning-point.
- *"What are you really good at? What makes you feel really good when you can manage to do it?"* These kinds of questions are often a surprise to someone who is in turmoil, and the answers can sometimes be just as surprising, reminding them they do have a place in life. Be prepared for the patient to say *'nothing'*, but continue to coax a response out of them – everyone has something they are good at or feel good doing!
- *"When you stop self-injury, what kinds of things will you be able to do? What plans do you have?"* It is common at this point to get very negative answers – *"I don't see any future." "I will never be able to get a job." "Can't see anyone ever loving me, with all these scars."* Just accept the answers, don't denigrate the responses, but you can say something like: *"The vast majority of people do actually stop self-injury. There is really good research supporting that."* (Rotolone & Martin, 2012; Andrews et al., 2013)

If their apparent lack of hope for the future continues, or you feel overwhelmed by it, trust your gut feeling and review their suicide risk assessment. If there is a need, call in a mental health professional to support this process.

8. ADVICE YOU CAN PROVIDE TO PARENTS AND CARERS

Self-injury can be difficult to understand when you are a parent, family member or friend, and emotionally attached to a person who is hurting themselves.

In advising family members the following strategies may help. Remember, during times of high pressure, people may not remember much of what you tell them. Keep information simple. Follow it up with a brochure or card, or a relevant booklet (see our guide for parents and families).

Friends and families should be advised to:

- Listen rather than talk. Say to the person, *"I am here to listen. Talking things through may help to release the tensions and stress that you could be holding inside."*
- Simply sit with the person, in silence if need be. Being there, showing you are prepared to give them time, space and concern is a way to demonstrate care.
- Let them express *their* feelings. Sometimes it is blowing off steam; sometimes there are serious things to be angry about. 'Getting it off their chest' will be helpful.
- Offer to talk openly and honestly. Don't hold back or pretend you have not noticed. Choose the right moment, when both the family member/friend and the patient are feeling calm.
- Explore why they have hurt themselves so you can ensure any problems are dealt with.
- Offer to go with them to talk to a counsellor; it just may help them to take that first step.
- Share the resources at the end of this book.

9. A NOTE ABOUT SELF-INJURY AND SUICIDE

Understanding the relationship between self-injury and suicidal behaviour is one of the most complex areas for anybody working with people who self-injure. While ***individual self-injurious episodes are usually not related to suicidal thoughts or feelings***, in many cases, people who self-injure do report feeling that life is not worth living, and some have had feelings of wanting to die.

In fact, research shows that people who attend emergency departments for self-harm are five times more likely to complete suicide within the subsequent 10 years compared with people who attend emergency departments for other complaints (Crandall et al., 2006). Despite the distinction we draw between self-injury and self-harm (ie including suicide attempt), it is possible the risk of subsequent suicide is higher among people who self-injure and require emergency medical care compared with people who self-injure but do not require emergency medical care. If this is the case, it is imperative emergency department staff at least consider suicide risk among all patients who present with self-injury. We refer you back to our discussion of 'Critical Decision Time' (page 2).

When we spoke to people who self-injure, what was really important to understand was that many of them talked about self-injury ***actually keeping them alive*** and reducing their wish to suicide; in other words self-injury became a sort of coping mechanism.

On the other hand, they talked about self-injury serving functions that had nothing to do with suicide or feeling suicidal. Many young people were really angry about responses from professionals who assumed they were suicidal when they were just self-injuring to release or manage feelings. Despite this, some people had been suicidal at some point, and they had self-injured with both suicidal and non-suicidal intent at different times (we said it was complicated). Self-injury is a *temporary* solution to managing overwhelming emotions, and if the underlying or background issues are not solved, the overwhelming emotions continue. As time passes and the emotional pain continues (despite the episodic and temporary relief gained from self-injury) people can lose hope, and when this occurs, they may become suicidal.

If your assessment reveals the patient is thinking about ending their life then, of course they will require urgent and focused mental health treatment.

10. GETTING ONGOING HELP

It is generally agreed that an important part of treatment is facing up to underlying or old issues and problems that relate to, or underpin, the self-injury. If our patients can do this, the old feelings stop returning, or stop returning with the same force, and they can cope better, and be far less likely to self-injure.

> "It is perfectly acceptable to shop around and eventually find someone who is the right person to help"

The people we interviewed had a range of experiences with professionals and others in regards to self-injury. The experiences ranged from positive and helpful to the negative (or even punitive) and unhelpful.

The following were considered the most helpful responses from professionals: (1) good listening skills; (2) a non-judgemental attitude; (3) effort to build rapport; (4) not forcing them to stop self-injury prematurely (i.e. before they were able to use alternative coping strategies); (5) assisting with coping skills; (6) working in a person-centred, solution focussed way; and (7) not 'freaking out.'

Although there are no empirically validated treatments for self-injurious behaviours *per se*, a number of treatments designed for other mental health problems have shown promise in reducing both frequency and severity of self-injury. – These include Cognitive Behavioural Therapy

(CBT), Dialectical Behavioural Therapy (DBT), Mindfulness (MBCT and ACT), and Problem Solving Therapy (PST). Other therapies may be helpful – such as expressive therapies like Voice and Movement Therapy (VMT; Martin et al., 2012) – but these have been less researched, and most professionals prefer therapies that have a strong evidence base for efficacy and effectiveness.

Cognitive Behaviour Therapy (CBT) is a psychological therapy that aims to address issues such as anxiety and depression, as well as a range of other mental health concerns. The focus is on changing the way individuals think, which impacts on the way they feel and the way they act. The approach often involves teaching effective problem solving skills, coping strategies, how to manage exposure to challenging situations, relaxation, identifying thoughts and feelings, and challenging individual beliefs.

Dialectical Behaviour Therapy (DBT) was specifically developed for the treatment of people who engage in self-injury and/or suicidal behaviours. The focus of DBT is both accepting the individual being treated (from the perspective of the therapist conveying acceptance and the patient learning acceptance), helping the person to change behaviours that may be self destructive (such as self-injury), and working towards a life that is fulfilling to them.

Learning **Mindfulness** is one of the many ideas that are part of DBT, and can in itself assist people who are anxious or depressed, or who engage in self-injury. Mindfulness is being aware, or paying attention to the present moment without judgement (the ‘unfolding of experience in the

present moment'). It includes being attentive to stimuli coming through your 5 senses (sight, hearing, smell, taste and touch) as well as to your thoughts and feelings. An essential element of mindfulness is cultivating a non-judgmental attitude, just accepting whatever comes to your mind, moment by moment.

Potential benefits of mindfulness include lowering stress levels and staying focused, particularly in times of high emotion when the many incoming thoughts or ideas or stimuli may cause one to feel 'scattered'. It helps people to act less impulsively by enhancing awareness of urges to action. For those who go over and over upsetting things ('ruminate') at length, it may help them to turn attention to other things or turn off the stream of images and thoughts. It increases the capacity to experience joy, and has been shown to reduce depression. Ultimately, (once you have got the idea and practice regularly), the awareness can help you experience an overall richer quality of life.

Problem Solving Therapy (PST) is a brief psychological intervention that focuses on identifying specific problems and generating alternative solutions for these problems. Individuals learn to clearly define a problem they face, brainstorm multiple solutions, and decide on the best course of action. A key element of PST is testing the chosen solution to see if it is effective, and refining the decision-making and problem solving strategy if necessary. Learning and practicing the process can provide you with the skills to help identify and effectively solve problems in the future.

11. IN SUMMARY

We understand the pressures that emergency staff are under, and that it may be difficult to cope with emergency problems in mental health for which you may have not received specific training. For many of you it may be problematic to get support or help in managing mental health problems - either because staff are not available for one reason or another, or they themselves are under pressure. It may also be stressful for you, or hard to remain positive, when so many patients are presenting with 'self-injury'.

We have tried to clarify the problem of self-injury for you, noting the differences to suicidal behaviour, and providing the steps you can take to provide best practice care of this surprisingly common behaviour. We accept that there will be formal protocols and practice rules developed locally for situations of possible suicidality, which you are obliged to follow. You may have to reject some of our advice, or adapt our ideas to the service or system practice in which you work. The critical issue at all times is whether you believe you can keep your patient safe, and whether your clinical practice is defensible to supervisors or senior managers.

We believe you are in a unique and pivotal position to assist patients who self-injure, using skills you may already have.

We hope that you have found this guide helpful.

12. USEFUL RESOURCES

National Services

- *Kids Help Line (instant telephone support – special expertise for young people) (1800 55 1800) www.kidshelp.com.au*
- *Lifeline (instant telephone support – special expertise in self-harm) (13 11 14) www.lifeline.org.au*
- *SANE Australia (complaints about services or media/support) (1800 187 263) www.sane.org*
- *Aboriginal and Islander Community Health Service www.aichs.org.au*
- *Australian Drug Information Network www.adin.com.au*
- *Headspace www.headspace.org.au*
- *Homelessness http://www.homelessnessaustralia.org.au*
- *Department of Human Services www.humanservices.gov.au/customer/subjects/domestic-and-family-violence*
- *The Salvation Army – Domestic Violence www.salvationarmy.org.au/find-help/domestic-violence/*
- *Reach Out! (by young people for young people - broad information) www.Reachout.com.au*

State-based Services

- *Child and Youth Mental Health Services www.health.qld.gov.au/*
- *Child and Adolescent Mental Health Services (State specific)*
- *www.health.vic.gov.au/mentalhealth/services/child/*

- *www.health.nsw.gov.au/mhdao/camhs.asp*
- *www.health.wa.gov.au/services/detail.cfm?Unit_ID=370 www.dhhs.tas.gov.au/mentalhealth/mhs_tas/gvt_mhs/child_and_adolescent_mental_health_serviceshealth.act.gov.au/c/health?a=sp&pid=1316133581&site=51103&servicecategory=23*
- *www.health.nt.gov.au/Mental_Health/index.aspx*

Additional Mental Health Websites

- *Beyondblue (information about depression) www.beyondblue.org.au*
- *Headroom (mental health info for young people) www.headroom.net.au*
- *LiFe (Commonwealth funded site with all info on suicidality) www.livingisforeveryone.com.au*
- *Mental Health Associations across Australia www.mentalhealth.asn.au*
- *The MoodGYM moodgym.anu.edu.au/welcome*
- *National Institute of Mental Health (US site – good info on mental health) www.nimh.nih.gov*
- *Psychcentral www.psychcentral.comReality Check/Media Check www.realitycheck.net.au*
- *Mobile Safety Services www.ruok.com.au*
- *Young Adult Health www.cyh.com/HealthTopics*

Websites – Self-Injury Specific

- ASHIC: American Self-Harm Information Clearinghouse www.selfinjury.org/
- LifeSIGNS: Self Injury Guidance and Network Support www.selfharm.org/
- RecoverYourLife.com www.recoveryourlife.com/
- S.A.F.E. Alternatives®: Self Abuse Finally Ends www.selfinjury.com/
- Self-Injury And Related Issues www.siari.co.uk/
- Self-injury guidance and network support www.lifesigns.org.uk
- Self-Injury Support www.sisupport.org/
- Self-injury.net www.self-injury.net/
- Self-injury: you are not the only one www.palace.net/~llama/psych/injury.html
- The International Self-Mutilation Awareness Group http://flmac.tripod.com/ismag/index.html
- The National Self-Harm Network http://www.nshn.co.uk
- Therapy for Self-Injury on Facebook http://www.facebook.com/groups/132968936724268/
- To Write Love on her Arms https://www.facebook.com/towriteloveonherarms
- Understanding Self-Harm http://harm.me.uk/ Young people and self-harm http://www.selfharm.org.uk/default.aspa

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ISBN 978-0-9808207-6-8