

# Parasuicide

Module 2, Chapter 4

**Parasuicide** is a word used to describe behavior in which a person hurts himself/herself by cutting, burning etc., but does not intend to carry out suicide and in most cases, does not want to die. These behaviors are referred to as SI's (self injuries), SIB's (self injurious behavior) or self mutilation.

People who engage in parasuicide behavior often indicate that their self injury is a mechanism to cope with overwhelming emotions that they do not know how to regulate or express effectively. These individuals are often diagnosed as having Borderline Personality Disorder (BPD).

**The goal in assisting individuals who are thinking of or threatening to cut or injure themselves is to:**

1. Help the person to identify feelings or events that led up to the urge to harm themselves and express feelings about these. This requires listening carefully and asking questions to assist person in expressing feelings of distress, anger, sadness etc. and validating those feelings.
2. Assisting the person in identifying alternatives to self injury to manage the distress.

**If self injury has already occurred**, the crisis responder should assess the seriousness of the injury and initiate appropriate care (from having person clean a minor scratch or cut and apply a bandage if needed to referring person to immediate medical care).

## Borderline Personality Disorder (BPD)

### Definition and Prevalence

BPD is personality disorder characterized by a pervasive inability to regulate emotions and control behaviors linked to emotions. Intense negative emotions commonly include depression, anger, self-hatred and hopelessness.

BPD occurs in 0.2 to 1.8 % of the general population, in 8 to 11% of psychiatric outpatients and 14 to 20 % of inpatients. (Linehan, 2005)

People with BPD are among the highest utilizers of inpatient psychiatric services.

Follow up studies consistently indicate the diagnosis of BPD is a chronic condition, although the number of individuals who continue to meet diagnostic criteria slowly decreases over the life span.

An average of 15 years after the initial assessment, 25 to 44% continue to meet the criteria (Linehan, 2005)

### Treatment Outcomes (Linehan, 2005)

BPD has been associated with worse outcomes in treatments of Axis I disorders including Major Depression, OCD, Bulimia and Substance Abuse.

Follow up studies of BPD individuals who have received standard community-based inpatient and outpatient treatment demonstrate that traditional approaches are marginally effective at best when outcomes are measured two to three years following treatment.

In studies investigating pharmacotherapy for BPD, drop out rates are commonly very high and medication adherence has been problematic, with upwards of 50% of clients and 87% of therapists reporting medication misuse, including overdose as a method of attempting suicide.

## **Borderline Personality Disorder (BPD)**

### **Features/Feelings**

It is useful to try and understand how it feels for the individual with BPD.

In a word – **Chaotic**.

Individuals experience:

- Incredible internal conflict and struggle.
- No sense of own personality –may feel like “separate parts”.
- No sense of self – boundaries never developed (most likely due to physical or sexual abuse in childhood).
- Intense floods of emotion.
- High levels of shame.
- Emotionally frozen at 2 -4 years of age (teddy bears, imaginary friends, etc.).
- May spend a lot of time in “trance,” “split off,” “drowned”.
- Strong fears of abandonment.
- High potential for self abuse or suicide (those around them often come to believe that the self abuse and suicide attempts are “for attention” and, therefore, the behavior is minimized).

There certainly is some of that in some individuals; however, clients describe the self abuse or suicide attempts in two ways:

1. It's a means of managing extreme emotional pain – “It hurts so much inside, I can't stand it and when I cut myself, it releases **some** of the pain”.
- or –
2. Means of managing fear and feeling real – “I feel numb – like I don't exist – at least physical pain is something”.

It's extremely frightening for these individuals to feel nothing, like they don't exist. The abuse is a way of pulling people in and gaining attention, but it may be for either of these reasons so, ignoring it and passing it off as “attention seeking” is not useful.

It's useful to talk about the feelings leading to the cutting, recognize how uncomfortable they are and help the person figure out other ways of managing those feelings.

(From: Jerome Kroll, “The Challenge of the Borderline Patient”)

## **Borderline Personality Disorder (BPD)**

## Crisis Intervention with Individuals with BPD

The features that make these clients difficult to work with are:

1. The emotional intensity, and
2. Interpersonal demands for engagement.

On-going therapy and, when needed, crisis therapy needs to help the patient move toward greater competency in life. Most individuals with BPD are locked into maladaptive and self destructive patterns in key areas of their lives.

Realization of these patterns and the move toward improved functioning in relation to self and others are the criteria by which the effectiveness of therapy is to be judged. (Kroll)

Dr. Kroll talks about **two modalities of treatment**:

1. Supportive—advice giving, problem solving and fairly open encouragement.
2. Exploratory—more austere procedure devoted to the pursuit of insight.

Marcia Linehan's Dialectic Behavioral Therapy (DBT) addresses these as well: "A validating environment must be created that allows the therapist to extinguish maladaptive behaviors while at the same time soothing, comforting and cajoling the patient through the experience".

(Both Kroll and Linehan address the dialectic of caring and support on one hand, while **at the same time** decreasing maladaptive behaviors.)

## **Borderline Personality Disorder (BPD)**

### **Key Points in Crisis Intervention**

1. Need to be extremely careful in "unraveling" these individuals - There is very little sense of self so confrontation, especially by an unknown crisis worker, can be too frightening. Looking at and changing behaviors is best done in long term therapy. Role of crisis worker is to listen to the client and help the individual identify feelings about the crisis and then move toward helping the individual make an adaptive plan.
2. Shame is so deep, if you care about them too directly, they can experience more shame and act out (even suicide).
3. **The issue** – over and over is – **Are you going to abandon me?** Making a decision to work with a client with BPD is a commitment. They do best with one, consistent, long term therapist. Plugging them in and out of programs is a disservice, better to refer to one on-going person.
4. As a staff, you need to be very consistent. These clients often present as articulate, warm, insightful and they form intense relationships whom they initially idealize and later devalue.

These extremes in relating to people, as well as severe dependency and fear of rejection, are very common symptoms. This is what leads to “splitting” and “polarizing”. One useful thing to look at diagnostically is, if a client brings up strong feelings of disagreement among staff, you may want to look for undiagnosed BPD; e.g., one staff or group of staff will feel feelings of anger, frustration, feel helpless and manipulated and another staff or group will feel very supportive of the client and begin to feel some of the same chaotic feelings the client feels regarding the rest of the staff or the program. It’s important that staff share their feelings and discuss at Case Conferences.

5. **Counter transference** – Because boundaries are such a problem for people with borderlines personality disorder,, they do have the ability to find the therapist or staff’s weaknesses. They will get at your issues so stay aware and alert for signs that you are reacting from your own feelings and issues rather than therapeutically (i.e. if you know that a person’s “victim role” triggers something in you – either a need to care take or fix or a feeling of rejection and blaming the victim, you need to work on these issues with your clinical supervisor and develop a therapeutic approach based on the client’s needs, not your feelings. If you get overly involved emotionally, it will lead to burnout which leads to rejection of the client which is counterproductive. Less is better!

## **Borderline Personality Disorder (BPD)**

### **Keep Goals in Mind:**

1. Establish stable relationship that is not abusive so client can experience such a relationship. Relationship with staff may be the only non-abusive relationship the client has ever experienced.
2. Decrease hospitalizations by helping client regulate emotions and behaviors.
3. Support group that offers both support and firm limits.

### **Suggested Reading:**

Kroll, Jerome; The Challenge of the Borderline Patient; 1988

## **Dialectical Behavioral Therapy (DBT)**

Individuals with BPD are often in a state of crisis and are, therefore, often unable to use adaptive coping skills. Emotional arousal interferes with cognitive processing, thereby limiting the person’s ability to focus on anything other than the present crisis.

**Dialectical Behavioral Therapy** is a comprehensive cognitive–behavioral treatment. “In a nutshell, DBT is very simple. The therapist creates a context of validation rather than blaming the patient, and within that context, the therapist blocks or extinguishes bad behaviors, and drags good behaviors out of the patient,

and figures out a way to make the good behaviors so reinforcing that the patient continues the good ones and stops the bad ones.”<sup>1</sup>

In standard outpatient DBT, the responsibility for assisting a client belongs to the individual therapist, but there are times when other team members intervene in crisis situations.

The following **strategies** are useful for all people in crisis. Some of the words and definitions, however, are utilized and understood in the context of DBT therapy and may need to be altered to assist people who are not in a formal DBT program.

**1. Paying Attention to the Affect Rather Than the Content**

Crisis worker should help the client identify their feelings, communicate to the client the validity of the feelings, provide an opportunity for emotional ventilation and offer reflective statement.

**2. Exploring the Problem**

Crisis worker should concentrate on helping the client focus on the here and now issues of the crisis and avoid being drawn into a discussion of all the negative events of the client’s life.

Identify precipitants and the feelings being expressed i.e. “that sounds overwhelming right now”.

**3. Focus on Problem Solving**

The crisis worker functions as a consultant to the client, helping the client break the problem down into pieces that can be dealt with and offering a solution based on the client’s skills.

**4. Obtain a Commitment to a Plan of Action**

The crisis worker, together with the client, agrees on a plan.

**5. Always Reassess the Suicide Risk.**

If the client initially presented with suicidal ideation, always reassess that at the end of the intervention to determine if it persists and needs further intervention.

## **DBT Coaching in Crisis Intervention**

When in crisis, DBT skills can be very useful for individuals who have mastered the concepts of the skill areas and can verbalize and focus on the skills.

**It is not possible to teach the concepts of the skills during a crisis so the following suggestions are useful in working with people who already have a grasp of the skills and have had some practice in group and with individual therapist.**

**If you know the individual is in DBT:**

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<sup>1</sup> Marsha Linehan, *Cognitive Behavioral Treatment of Borderline Personality Disorder* (The Guilford Press, New York London 1993) pg.97

1. Assess the crisis as you would with any client in crisis and attend to safety issues first.
2. Identify the contributing factors and feelings of the individual in crisis. Allow time for ventilation and support.
3. Prior to moving into planning phase, ask the client what they have tried and if their efforts have helped. **Ask what DBT skills they have learned and if they feel able to utilize them.**
4. Offer to talk about the use of the skills the individual has identified. **Don't decide for the individual what skills they should be using.**
5. **If the individual is open to your assistance with using the skills, the following points may be helpful in coaching the individual.**

## Use of DBT Skills in Crisis Intervention Coaching

### 1. Core Mindfulness

If the client identifies this as a skill they are using, help the person remember that **wise mind is a balance between the emotional mind and the reasonable mind**. Ask the person to **observe the following** without getting reactive to the experience:

- to **describe** feelings and thoughts;
- to be **non-judgmental** (no "good," "bad," "should," "should not");
- to **stay in the moment** – do one thing at a time;
- to **focus on what works to get needs met**.

### 2. Interpersonal Effectiveness

Help the individual stay mindful. reinforce efforts and negotiate. Be gentle, act interested, validate and be confident. Be fair, stick to values and be truthful.

### 3. Emotion Regulation

Remind individual to **reduce vulnerabilities** (treat physical illness, eating, exercise and sleep and avoid mood altering drugs).

- **Build Mastery** - encourage individual to do one thing each day to make self feel competent and in control.
- **Build Positive Experiences** – engage in pleasant activity as possible and think about longer term changes so more positive experiences will occur.
- **Opposite-to-Emotion Action** - Changing emotion by acting opposite to the current emotion.

### 4. Distress Tolerance

- **Distract** - Wise Mind accepts emotions, actions of others, etc.
- **Self-Soothe** - Use senses – vision, hearing, smell, taste and touch to soothe self (i.e. petting one's animal, cooking, relaxation, breathing etc.)
- **Improve the Moment** - Imagery, "vacation" from focusing on issue, encouragement, etc.
- **List out Pros and Cons of actions.**

- **Radical Acceptance** - Freedom from suffering requires **acceptance** from deep within of **what is**. Let yourself go completely with what is. Let go of fighting reality. **Just Be.**

**Key Point:**

While these techniques can be useful to all people, it is, again, not possible to introduce the concepts in time of crisis.

It is possible, however, to use some of these concepts oneself in working with people while being careful not to use specific DBT terminology, i.e., instead of using term **self-soothe** may ask individual, "**what can you do to help you relax or comfort self right now?**". Instead of **Radical Acceptance** terminology, may ask individual "**do you think you can control or change the other person you are in conflict with?**

**Suggested Reading:**

Linehan, Marsha M.; Cognitive-Behavioral Treatment of Borderline Personality Disorder; 1993.