

Understanding self-harm and suicidal ideation and behaviour

This section describes our current understanding of factors that can lead to self-harm and suicidal ideation and behaviour.

For clarity, models of self-harm and suicide are described separately, but it is important to hold in mind that there are both continuities and discontinuities between these areas, and that in some people there will be close links between them.

Interventions to help people who self-harm or are suicidal are based on the principles set out in this section; as such, these guide the practice set out in other areas of this framework.

Frameworks for understanding self-harm

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| An ability to draw on knowledge that while there are many motivations for self-harm, the goal is not usually death (and it is this that distinguishes it from suicidal behaviour) |
| An ability to draw on knowledge that it can be hard to ascribe motivation, and that this can change within and across acts |
| An ability to draw on knowledge that (whatever the motivation) self-harm is associated with a greater probability of suicide |
| An ability to draw on knowledge that it is unhelpful to view self-harm as 'attention seeking' or manipulative, and so dismiss its potential significance and its meaning to the person |
| An ability to draw on knowledge that the function of self-harm is best determined by looking at specific incidents that led up to and followed the self-harm |
| An ability to draw on knowledge that people who engage in self-harm may experience: |
| higher levels of negative affect in general (e.g. depression, anxiety, hostility, anger, negative self-esteem) than their peers who do not self-harm |
| emotions more strongly than their peers who do not self-harm and be less comfortable expressing their emotions to others verbally |
| An ability to draw on knowledge that self-harm is thought to develop through the interaction of both long-term (predisposing) factors and more immediate factors |
| An ability to draw on knowledge of factors that may predispose people to self-harm, such as: |
| a genetic predisposition for strong emotional reactivity |
| high levels of familial criticism and hostility |
| experiencing abuse and/or maltreatment during childhood |
| intrapersonal and interpersonal risk factors, such as acute relationship crises and loss |
| high aversive emotions |
| difficulty tolerating high levels of distress |
| discomfort with strong feelings |
| difficulty expressing feelings verbally |
| An ability to draw on interpersonal risk factors for self-harm: |
| poor communication skills |
| poor social problem-solving skills |

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| An ability to draw on knowledge that before self-harm, a person commonly experiences: |
| feelings of rejection |
| overwhelming negative feelings directed to the self (such as anger, shame, disgust or guilt) |
| feeling numb |
| strong negative feelings directed toward others |
| An ability to draw on knowledge of the ways that self-harm can function to help manage intense emotional states, for example: |
| releasing a sense of unbearable tension |
| stopping bad feelings |
| regulating affect |
| reducing the experience of emotional pain |
| communicating the level of distress being experienced (and so drawing attention to its presence) |
| relieving a sense of frustration |
| relieving the experience of emotional numbness (e.g. feeling something, even if it is pain) |
| An ability to draw on knowledge of the ways that self-harm can function to help manage intense cognitions, for example, as a way of: |
| controlling racing thoughts |
| suppressing unwelcome thoughts |
| An ability to draw on knowledge that while immediately after self-harm there can be a sense of relief, this is often followed by negative feelings such as guilt and shame |
| An ability to draw on knowledge that self-harm may become a habitual response to feeling overwhelmed or stressed, reinforced by the experience of: |
| increased positive feeling (immediate but short-lived) |
| decreased negative emotions (immediate but short-lived) |
| increased attention to distress from others |

Frameworks for understanding suicide

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| An ability to draw on an awareness of models that identify factors associated with the emergence of suicidal ideation and intent |
| an ability to draw on knowledge that because these models draw attention to factors which are <i>generally</i> relevant they should not be used as indicators of risk in any one person (because of the challenge of predicting self-harm and suicide) |
| an ability to draw on knowledge that these are not competing models, but are best seen as complementary and overlapping, with each focusing on different aspects of a person's experience |
| An ability to draw on knowledge of models that help understand the factors that lead a person to move from a 'motivational' phase (in which suicidal ideation develops) to a 'volitional' phase (in which a decision to act on this ideation is made) |
| An ability to draw on knowledge of psychological models that emphasise the role of overwhelming thoughts and feelings of hopelessness about oneself, the future and one's capacity to change one's circumstances for the better, a state of mind that has a number of potential determinants: |
| long-standing 'dispositional' factors that become more problematic in the presence of stress, such as: |
| a sense that others set a high standard for the self, and that fulfilling these standards is a condition for being accepted by others |
| a restricted ability to apply problem-solving strategies that might ameliorate difficulties |

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| a tendency to employ unhelpful ways of thinking (such as overgeneralisation, jumping to conclusions or 'all-or-nothing' thinking) that in turn exacerbates distress |
| impulsivity, particularly when combined with a tendency to respond to difficulties with aggression |
| processes associated with mental health problems |
| long-standing and unhelpful ways of making sense of the world that become activated when trying to manage challenges, and which: |
| tend to shape unhelpful ways of thinking |
| increase the salience (and presence) of negative thoughts |
| processes associated with suicidal acts in which a person intends to die |
| entrapment combined with a long-standing sense of hopelessness about the future (a sense that the current situation cannot be changed and is intolerable), leading in turn to: |
| 'cognitive disengagement' in which 'rational' decision making is impaired by extreme distress, restlessness, racing thoughts and agitation |
| 'attentional narrowing' – a narrow focus on the present that precludes 'rational' thought and problem solving |
| 'attentional fixation' in which suicide appears to be the only option, which in turn reinforces a sense of hopelessness |
| a downward spiral in which hopelessness and attentional fixation interact, and which further promotes suicidal intent |
| An ability to draw on knowledge of psychological models in which suicidal behaviour emerges from an interaction between suicidal ideation and circumstances that increase the likelihood that a person will act on their suicidal thoughts, in particular: |
| a sense of defeat, humiliation and/or entrapment |
| the absence of attainable positive expectations for the future, combined with low levels of resilience |
| a sense that a need for connectedness has not been met, and so the possibility of social belonging has been 'thwarted' (characterised by feelings of loneliness and the absence of a reciprocal caring relationship) |
| experiencing oneself as a burden on, together with a sense of hopelessness that this is an unchanging state of affairs, made worse by factors such as: |
| adverse childhood experiences, family conflict, unemployment or physical illness |
| an affective state of self-hate, characterised by low self-esteem, self-blame and shame, and a mental state of agitation |
| an acquired capability for suicide in combination with factors that increase the likelihood of a person moving from the motivational to the volitional phase, such as: |
| a history of impulsive and aggressive behaviour |
| having access to the means for suicide and plans for acting |
| a lowered fear of death |
| imagining oneself as dying or dead |
| elevated physical pain tolerance |
| cognitive appraisal that the pain involved in the chosen method of suicide is tolerable |
| a diminished fear of pain and death acquired through habituation to painful and fear-inducing life events such as: |
| previous self-harm and suicide attempts (both attempted and aborted) |
| practising or preparing for suicidal behaviour |
| An ability to draw on knowledge of models that emphasise the centrality of emotional dysregulation, a state of mind characterised by |
| affective vulnerability, exemplified by: |
| emotional reactivity |

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| emotional lability |
| experiencing intense unbearable negative emotions |
| a history of responding impulsively in response to acute negative affective states |
| difficulty in tolerating and regulating emotions (and difficulty experiencing the emotions themselves) |
| difficulty accessing appropriate self-regulatory strategies |
| the experience of hopelessness about being able to effect a change in circumstances |
| a perception that relief will only come through self-harm or suicide |