SELF-STUDY COURSE

Self-Destructive Behaviors
Updated January 2010
3.0 Training Hours

This self-study is based on the following sources:

Children and Adolescents with Mental Health Problems Alaska Center for Resource Families Self-study Course.


This self-study course was developed by Aileen M. McInnis, Training Coordinator for the Alaska Center for Resource Families, Southcentral Regional Office.

To receive training credit for reading this packet, please fill out the “CHECK YOUR UNDERSTANDING Questionnaire” at the back of this packet. Return the Questionnaire to the Alaska Center for Resource Families for 3.0 hours of training credit.

Alaska Center for Resource Families
815 Second Ave Suite 202
Fairbanks, AK 99701

1-800-478-7307 or 479-7307 (Fairbanks/North Pole)

www.acrf.org

The Alaska Center for Resource Families, a project of Northwest Resource Associates, is under contract with the State of Alaska Office of Children’s Services to provide training and information to resource families statewide.
Part One: Where Do Self-Destructive Behaviors Come From?

Resource families are dedicated to providing a safe place for children who are in need of care. So it is very saddening to care for a child who seems bent on hurting himself. Self-destructive behaviors include:

- head banging in a young child
- a 16-year-old who cuts on herself when under stress
- a suicidal teen who think life would be better off without him
- a child whose high risk activities puts him at constant physical danger

Why do children engage in self-destructive behaviors? What can a foster or adoptive parent do to help? This self-study will explore the question of why children harm themselves.

Self-destructive behaviors are difficult to deal with. Seeing a child act self-destructively once or twice may not mean you are facing a life-threatening problem. But if a child shows a pattern of such behavior, he or she is definitely in need of professional evaluation. Share your concerns with your social worker or mental health care provider. If a child is not in some kind of counseling, talk to the social worker. This self-study will give you information about why self-destructive behaviors happen and what a foster or adoptive parent might do. But you should not try to handle this situation all by yourself. You have a team of people including the social worker, guardian ad litem and possibly a therapist that are there for you and the child. Use them to make the best interventions and decisions for the child in your care.

An Introduction to Self-Destructive Behaviors

What is self-destructive behavior? The types of self-destructive behavior that will be discussed in this self-study tend to fall onto a continuum of behaviors from least to most potential for lethality.
High Risk Behavior: Children may engage in behavior that puts them at a very high risk of harm. This type of risk taking might cross into high-risk behavior that can cause irreparable harm to a child’s personable well being.

Self-Harming Behavior: A child may intentionally inflict some kind of harm to himself such as cutting, burning, rubbing skin raw, pulling out hair or picking off scabs.

Suicidal Behavior: May include attempts, threats or success to ending one’s own life.

A child or youth showing any of these signs may be at risk for also showing behavior that is typical of one of the other two categories. Each of these will be explored in greater detail in Parts Two and Three.

Why Do Children Show Self-destructive Behaviors?
This is a complicated question with many different answers. Just as there are different types of self-destructive behaviors, there are different causes to why children may show such behavior.

Guilt: Some children believe that they are basically bad. They think they deserve to be hurt because of their bad thoughts and behaviors. “I am so bad no one could possibly love me.” Children who feel guilty blame themselves for any problems or failure and often use negative terms to describe themselves. When these children are told something isn’t their fault, they don't believe it.

Early Deprivation and Abuse: Many children do not receive sufficient nurturance (affectionate care and attention) during their early years. These children have not received the basic care that enables them to feel wanted and psychologically safe and secure. They develop a sense of unworthiness. Therefore, they fall into a pattern of punishing themselves for being bad and unlovable. They feel that they don’t deserve to be happy. Depression becomes a natural way of life. It is almost as if they continue to abuse themselves because that is the pattern in their life. There is a high correlation between sexual abuse and self-harming behavior.

Anger Turned Inward: Children may become angry at themselves and try to hurt themselves. This is a straightforward way of punishing yourself for being bad. Even more typical is the situation where children become very angry at the unfairness or others. They see peers, teachers, parents, caregivers or siblings as mean, unfair and insensitive. Because of their dependence upon adults, direct expression of anger is unlikely. In frustration, children turn their anger against themselves.

Depression: Depression is very common in children who show self-destructive behaviors. Depression comes from helplessness, abusive or distorted relationships, a negative self image or abuse or neglect. Like adults, depression may have a physiological base in children. Depression can be an acute episode, such as after a death or a move, or can be chronic, such as a lingering gray, down mood that seems to be part of a child’s life.
**Feeling Helpless:** Prolonged helplessness and despair may lead to suicidal thoughts as a means of escaping a hopeless situation. Helplessness may be combated by some form of self-stimulation such as rocking, head banging, or self-injury. By raising their own arousal level, children who self-injure are able to combat the debilitating feeling of depression and helplessness by substituting a different kind of pain.

**Reaction To Deep Loss:** Young children are more vulnerable to loss of parents, while older children may be very attached to one friend, teacher or relative. Children experience the loss as a major trauma. They may become unable to carry on daily activities, dependent, disinterested, pessimistic, or suicidal. Unfortunately, foster care is filled with losses of parents, friends, pets, familiar places and possibly schools. Children in foster care are very vulnerable to depression. Adolescents experiencing the rejection or loss of a girlfriends or boyfriend are very at risk for developing depression and possible self-destructive behaviors.

**To Gain Attention, Love, Sympathy Or Revenge:** Children may hurt themselves or express feelings of sadness as a means of obtaining love and sympathy from others. This is especially true when attention cannot be gained by other means. For example, it is not unusual that a child may daydream about being dead and thinking about what people might say at his funeral or how sad they might be. But for a child to actually try to make this come true on some level can be very serious. Revenge may be obtained by self-destructive acts such as delinquency, drug consumption or poor school grades. Children may mistakenly think that they can “get back” at a parent or teacher by hurting or killing themselves. Or it may be that the only way they can think of to draw attention to themselves.

**Reaction To Tension:** Children who frequently experience negative feelings in interaction with others develop a need to relieve tension. During stress or fatigue, older children may pull their hair or scratch themselves. This is self-destructive behavior but may actually make an individual feel better when engaging in that behavior. It relieves stress or uncomfortable feelings on some level. For children who use self-destructive for this reason there is a danger of a pattern of addiction developing.

**Physiological:** Physical causes of depression must be considered when self-destructive behaviors occur in children. Medical causes must be ruled out. Hormonal imbalance might exist. Other causes of depression are iron deficiency anemia, thyroid dysfunction, viruses (especially mononucleosis in teenagers), food allergies, and blood sugar irregularities. Some physiological conditions may also be more likely to produce self-destructive behaviors such as a child with autism or mental retardation.

**Difficulty in Dealing With Other Feelings:** Some children have so many things happen to them that they seem to lose the resiliency to deal with it all. Their emotions may go numb. Or these feelings may be so overwhelming that a child feels only stress, hopelessness and lack of control. The self-destructive behaviors may be a way to get relief from the physical discomfort or psychic pain of the event.
When we think of self-destructive behavior, we often immediately think of suicide attempts. But there are two other categories of where children may try to hurt themselves. These include children with high-risk behaviors and with self-harming behaviors.

**High-Risk Behaviors in Children**

Many children will not show clear suicidal, but may engage in behavior that puts them at high risk of harm. This might include taking drugs, using large quantities of alcohol, driving at very fast speeds, darting out into traffic, climbing or crawling into dangerous places, playing with knives or guns or picking fights with older kids. In the extreme, this risk taking may cause irreparable harm to a child’s personable well being. For instance, there is the case of a person with severe insulin-dependent diabetes who fails to take insulin properly, even after having been carefully instructed about the importance of the procedure. Examples of self-destroying behavior include eating problems like anorexia nervosa or drinking lethal doses of alcohol or playing “Russian roulette” with a pistol.

Teenagers often engage in lots of high-risk behavior, feeling the rush of danger or experimentation, and the feeling of immortality. When this putting yourself in danger happens frequently or if this pattern happens in younger children, a resource family should be concerned that this child is exhibiting high risk behavior. Some “accident prone” children would fall into this category. Similarly, extreme risk taking often turns out to be self-destructive. These individuals may jump over a long drop, cross a street in heavy traffic, or drive at extremely high speeds. It may also include heavy alcohol and drug use and hanging out with violent people or in violent situations.

Some children need higher levels of stimulation than other. These are the kids that like snowboarding, skateboarding and other high speed “rush” sports. But sometimes a child’s infatuation with danger is based on the desire to flirt with death and injury. Sometimes these children will put themselves into dangerous situations, such as walking around alone downtown at 3 a.m. or picking fights with older bigger kids.

<table>
<thead>
<tr>
<th><strong>High Risk Behaviors</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Heavy alcohol and drug use</td>
</tr>
<tr>
<td>• Driving fast</td>
</tr>
<tr>
<td>• Climbing high and with long falls</td>
</tr>
<tr>
<td>• Darting into traffic</td>
</tr>
<tr>
<td>• Riding bike in dangerous places</td>
</tr>
<tr>
<td>• Refusing essential medication</td>
</tr>
<tr>
<td>• Picking fights with older kids</td>
</tr>
<tr>
<td>• Playing with guns or knives</td>
</tr>
<tr>
<td>• Hanging out with violent people</td>
</tr>
</tbody>
</table>
General Guidelines For Resource Families Working With High Risk Children

Provide a high level of safety and supervision. If children cannot provide their own safety, increase your level of supervision. Make sure your home is as safe as you can make them.

Look for underlying causes of depression or physical bases. We always must consider if there is an underlying physical reason for a child’s action. For many younger children, depression actually shows up in hyperactive behavior or high-risk activities.

Encourage an open communication and expression of feelings. To avoid falling into self-destructive behaviors, children need to feel adults take them seriously and can be turned to for guidance. Encourage open expression of all genuine feelings, including anger. In this kind of atmosphere, anger does not have to be expressed in others ways such as gaining revenge by self-destructive acts. There is no substitute for children being able to discuss angry, jealous, hopeless, sexual, and other feelings with caregivers.

Provide opportunities for lots of physical outlets. If you have a child who craves high arousal, channel it into areas that are more acceptable and less harmful. Sports, skating, skateboarding, hiking, climbing, wrestling, skiing, basketball, and karate are all high intensity activities that can help a child channel energy and get a “rush.”

Promote adequacy and effectiveness. Active problem solving and gaining personal satisfaction prevents helplessness. Children should be given choices and their sense of having good judgment continuously reinforced. The idea is to promote an active approach to facing everyday as well as unusual problems. These efforts are intended to immunize children against easily falling into a helpless depression when things go wrong.

Be alert to warning signs. There is no substitute to being sensitive to children’s feelings and behavior. Be aware of any signs of continued feelings of helplessness or depression. Take children’s complaints seriously and with respect. Pay attention to nonverbal behavior. Disruption of usual routines of eating, sleeping and studying may indicate depression. Loss of weight, irritability, and fatigue are significant. Be alert to the presence of any possible self-destructive objects in a child’s room such as a rope, pills, or a knife. In teenagers, alcohol or drug use may be early signs of depression.

Openly discuss sadness and hurting oneself. Children with high-risk behavior need to hear that you are concerned about their safety and well being. Point out consequences of their actions and ask them if they ever feel like hurting themselves. Many adults avoid confronting children for fear of intensifying their negative feelings or precipitating self-destructive behavior. Instead, taking children seriously and listening empathetically has a beneficial effect. Telling children that anger and depression are temporary is often a reassuring experience for younger children. They feel that adults can face strong feelings and that things will turn out better.
Self-Harming Behaviors in Children

Self-harming behaviors are called many things including self-mutilation, self-abuse, self-inflicted violence and self-injury. Broadly speaking, self-harming is the act of attempting to alter a mood state by inflicting physical harm serious enough to cause tissue damage to your body. This can include cutting (with knives, razors, glass, pins, any sharp object), burning, hitting your body with an object or your fist, picking at your skin until it bleeds, biting yourself, or pulling hair out, pulling out eyebrows.

Self-harming behaviors can have several origins. Self injury can be Psychotic (related to mental illness such as schizophrenia where injury is serious such as attempts to cut off limbs), Organic (related to behaviors such as head banging originating in organic disorders such as autism or Tourette’s Syndrome) and Typical (which is the intentional harming behavior toward oneself such as cutting, scratching or burning.)

The intention of this harming is not to kill oneself. This kind of behavior actually gives the person an emotional release from other tension, even though it may be causing pain to oneself. It is a quick way to relieve emotional discomfort to a level that can to be handled. Very often, there is a true denial of feelings in the person who self injures. They have difficulty sorting through and dealing with stress, anger, anxiety, loneliness and fear. They become deadened to these feelings. When they arise, these folks may result to self-injuring behaviors to feel back in control. There is also some theory that the role of serotonin in the brain may predispose some people to aggression and aggression toward self. Using self-injury to relieve tension and uncomfortable feelings can develop into an addicting pattern.

Groups at risk for using self harming include persons with psychiatric disorders such as borderline personality disorders or persons in psychotic states, emotionally disturbed children, mentally retarded and autistic children and person with a history of physical, emotional and sexual abuse. The behavior tends to begin in late childhood and early adolescence and is slightly more prevalent in girls. In recent years, cutting and self harm is seen in healthier individuals and seems to be more rooted in dealing with stress and tension. There has also been more attention given to self injury in movies such as Girl Interrupted and Thirteen and with celebrities talking openly about their self injury such as Johnny Depp and Princess Diana before she died.

Is self-harming behavior just another way of attempting suicide? Paradoxically, in many ways, self-injury is a way to stay alive. It’s a maladaptive coping mechanism that releases unbearable feelings and pressure through self-harm and ease their urge toward suicide. There is often a lot of shame and embarrassment in a child who self injures. There are also a lot of uncomfortable feelings on the part of the parent who works with them: revulsion,
anger, and distaste. A person who cuts herself intentionally does so primarily because of internal dynamics. She is not setting out to annoy or irritate her parents. A person who self injures often hides her injuries through long sleeves or jackets. Researchers and therapists are more frequently using the phrase Non Suicidal Self Injury (NSSI) to distinguish the self injury that is done to relieve tension or to feel sensation and an attempt to take one’s life. That being said, a repetitive pattern of Self Injury seems to put a youth more at risk of intentional or unintentional death since a youth may need to cut more often or deeper to get the same sense of relief. Studies have also shown that individuals who successfully complete suicide have had more episodes of self injury than those who do not attempt suicide.

Researchers have discovered that there seems to be a common pattern in self-injury in Non Suicidal Self Injury. This includes the occurrence of some kind of trigger. The trigger appears to be a threat of separation, rejection or disappointment. The person feels of overwhelming tension and isolation, and a fear of abandonment and apprehension. Anxiety increases and culminates in emotional numbness. Self-injury seems to cut through that numbness and relieves the person of this overwhelming discomfort and pain. It may seem a strange, foreign way to deal with our feelings, but for some children and young adults, it becomes a repetitive pattern.

It is sometime difficult to distinguish between ritual and culturally based self-injury and pathological self-injury. Some teens may engage in piercing, scarring or branding of their skin, imitating peers or music scars. While piercing your ear or tattooing a rose on your ankle may not be considered self-injury, excessive, unusual or compulsive acts of multiple piercings or branding along with depression or low self-esteem should cause concern. When teens hide behaviors, or are participating in self-harming rituals outside the norm of their peer group, or if there is an addictive, ritualistic quality in their desire for the practice, then a resource parent should be concerned.

“When I would cut, I would be so stressed, so agitated and feel so overwhelmed and helpless, though for years the only feeling I could identify was ANGER. I didn’t realize how detached I was from my other feelings.”

-- A recovering adult who showed self-destructive behaviors as a child.
**How Do You Help A Child Who Shows Self-Harming Behavior?**

**Seek professional assistance.** Involve social worker, psychologist, school nurse and other professionals to gain insight into the many variables involved. Seek medical attention when necessary. If the self-inflicted injury does not require medical attention, you should still seek medical advice to rule out organic or physical problems causing the injuries.

**Attempt to understand what is going on** with the child/youth in his or her environment to determine if it relates to the behavior. Do not shame a child, or ridicule her or show a distasteful reaction. Children are already embarrassed, don’t compound it.

**Show concern** for the injuries themselves. Whatever front they may put on, a person who has injured herself is usually deeply distress, ashamed and vulnerable. It is cruel to withhold needed medical attention. You have an opportunity to offer compassion and respect, and to model empathy and self-care.

**Help the youth find other appropriate activities to keep busy.** Make these activities as structured as necessary. When children and teens feel involved, useful and purposeful, feelings of loneliness and helplessness may lessen.

**Help the child think of alternate ways to express or obtain what they want.** Teach appropriate behavior and reward it each time it occurs. A person who self-injures can learn to detect the urge to hurt himself and stop them by yelling, “Stop!” or falling back on a different plan such as calling a friend, going for a run or writing in journal. A counselor can help a child set up a safety plan.

**Give children a creative outlet.** Using art, journals, writing, painting and poetry can all be ways to help a child express their feelings in a way that will lessen their anxiety.

**Try medication.** Some children and teens with depression, obsessive disorders and anxiety disorders may benefit from medication to relieve anxiety and physical discomfort.

**Help a child feel compassion and a care for self.** For example, a chronic head-banger is made to wash her hair, dry and brush it, and holds an ice pack on her head for five minutes after an episode of headbanging. A child who bites his hand could be made to wash his hand with an antiseptic solution, brush his teeth, and rub cream on his hand. Very young aggressive children may hit themselves out of frustration and anger. They might be made to pat and rub an area for two minutes.

**Teach children relaxation techniques.** Teach them how to take deep breaths. Have them pick out some soothing music to listen to. Rub their back (unless this arouses them more.) Teach them to squeeze a rubber ball or play with clay or do something else with their hands.
Suicidal behavior can be distinguished more easily than high risk or even self-injuring behavior. It is defined as any willful act designed to result in one's own death. People can injure and destroy parts of themselves without actually taking their own lives. Finality is present in suicide, which makes it the most serious form of self-destructive behaviors.

Suicides among young people nationwide have increased dramatically in recent years. Each year in the U.S., thousands of teenagers commit suicide. Suicide is the third leading cause of death for 15- to 24-year-olds, and the sixth leading cause of death for 5- to 14-year-olds. Teenagers experience strong feelings of stress, confusion, self-doubt, pressure to succeed, financial uncertainty, and other fears while growing up. In some cases, suicide appears to be a "solution." Often, the risk for suicide is increased by the presence of depression.

**Understanding Depression in Children**

Being depressed can mean anything from being in a funk to having a bad week to a persistent feeling of helplessness. Depression describes a normal emotion, but it can also refer to a psychiatric disorder. This is referred to as chronic depression or clinical depression. Children can get depressed as severely as adults can, but often hide depression behind behavior problems. It is common for children to be treated initially for hyperactivity, learning disabilities, laziness, drug abuse, or destructive behavior while the primary problem is actually depression. Children with untreated clinical depression are at higher risk for suicide attempts. How can you distinguish depression from normal sadness? You should suspect depression if a child has several of the following symptoms that linger for several weeks:

- depressed or irritable most of the time
- pleasure in all, or almost all, normal activities drops significantly
- has lost or gained more than 5 percent of his body weight
- has insomnia or sleeps too much
- is either very restless or very slowed down
- is tired most of the time
- has feelings of worthlessness or excessive guilt feelings
- finds it difficult to think, or concentrate or make a decision
- has recurrent thoughts of death or suicide

Very young children can show also signs of depression. These symptoms include not wanting to eat, not making expected weight gains, listlessness, hyperactive or frantic behavior, flat affect or little emotion. There is mounting evidence that many depressions have a physical basis and that there is a genetic pre-disposition to mood disorders that runs in families. Most clinical depression in children and teens is labeled major depression or a lingering, more chronic form of depression call *Dysthymic Disorder*. Another less common form of depression that is sometimes found in older teens and young adults is called Bi-Polar Affective Disorder (sometimes referred to as Bipolar Disorder).
to as manic depression.) This is a wild swing between an aroused state of energy and elevated, almost frantic mood to a state of extreme depression.

The goals of helping depressed children include: (1) to help them verbalize and identify the origins of the depression; (2) to help children elevate their mood so that they can return to normal functioning; and (3) to come up with a safety plan for children who may consider suicide. Some of the new psychotropic medicines can be quite effective in stabilizing brain function and antidepressants may be prescribed for depressive episodes. Psychotherapy is aimed at treating emotional problems a child might have as well as help a child learn how to manage his illness. Exercise, having fun and increasing social interaction are also important ways to regulate moods and are important additions to drug therapy.

**What are some warning signals that a child might be considering suicide?**
Depression is not an essential condition for a suicidal act, but it is highly correlated with life-threatening behavior. When teens feel overwhelmed by their problems and don’t see anyway out, their mood may spiral into such a pit of despair that they think about only ending the pain. They may see suicide as the only way out. If you are seeing several of the following behaviors in a child, you need to consider the possibility that the child may be at risk for suicide:

**Sudden change in behavior:** May include a personality change; running away; increase in violent or high risk behavior.

**Disturbances in sleep.** Early morning awakening; complains of insomnia; may display much tossing and turning; makes statements of not getting good rest when asleep.

**Loss of appetite:** Favorite foods are no longer appealing; picks at food; loses weight.

**Loss of interest in opposite sex or relationships:** A young person previously has shown interest in the opposite sex and it diminishes unexpectedly. Break up with girlfriend or boyfriend.

**Moodiness:** Especially if the child has not previously shown moodiness. The young person may change emotions and moods rapidly and without reason.

**Fatigue:** Especially when the youth’s activity level is not enough to account for the fatigue.

**Expression of helplessness and loss of hope**

**Verbal hints at suicide:** A teenager may complain of being "rotten inside"; give verbal hints with statements such as: "I won't be a problem for you much longer," "Nothing matters," "It's no use," "I won't see you again."

**Withdrawal and/or isolation from friends:** A young person becomes disinterested in his/her peer group; he become a loner; spends more time alone than before.

**Purchasing a rope, gun, pills or other lethal object.**

**Apathy:** Not caring about anything. Loss of interest in peers, school, sports, friends, future, possessions, clothes, etc.
Giving away prized possessions: May put his or her affairs in order—for example, give away favorite possessions, clean his or her room, throw away important belongings, etc. A young person giving away prized possessions is signaling they won’t need them anymore.

Sudden decline in school performance and general efficiency: This can occur during teen years for many reasons (i.e., drugs and alcohol, opposite sex relationships, bad peer group, etc.) but suicide must be considered as a factor along with the others.

Lift in depressed mood: Often when people are severely depressed, they don’t even have the energy to plan for suicide. But when the mood lightens or when the child decides to take his life and some energy returns, this becomes the critical time. If a child suddenly seems happy and cheery after a serious depression, observe the child and try not to leave him alone for very long.

Unusual neglect of personal appearance: Begins to neglect appearance; doesn’t take care of self physically; looks tired, unkempt; doesn’t seem to care what people think of them, especially after a pattern of taking care of themselves.

---

### What Is The Role Of Medication When Treating Children?

For persistent depression and condition such as anxiety disorders and obsessive/ compulsive disorders, medication can be immensely helpful. It is most helpful when used in conjunction with therapy that treats the causes and the roots of the disorder, while medication treats some of the physical symptoms. If your foster child is taking medication, you should know the following things:

1. Psychiatric drugs need a birth parent’s or guardian’s permission. Do not administer any drugs to a child before checking with the caseworker.

2. Ask the physician for problems you should watch for and who to call if something unusual happens that is linked to the medication. Make sure you understand all instructions including when it should be taken and how, and what foods or drinks should be avoided. Know the possible side effects to the medication.

3. A child under medication should have ongoing supervision by a medical professional and should be evaluated on a regular basis.

4. Children should be receiving other behavioral and emotional support while on medication. Medication is not a cure on its own. Be supportive and advocate if necessary if your foster child needs something he is not getting.
**When Does Self Injury Mean Possible Suicidal Intent?**

This is a tough question to answer. Look behind the behavior at the motivation. A person who participates in **Non Suicidal Self Injury** does not intend to kill themselves. In fact, many youth and adults who self injure want to feel and stay alive. *But…*

- A person may accidentally hurt themselves seriously, such as cutting to deep or too close to an artery
- Persons who have attempted or completed suicide usually have a more frequent history of self injury than those who don’t
- People who self injure may experience suicidal thoughts during the episode
- So it is important to pay attention and assess for potential threat of suicide. Self-injury is not suicidal behavior, but self injury may put a youth at risk for more severe injury whether intentionally or accidentally. As a parent, know the warning signs!

**When Assessing for Suicide, Remember S.L.A.P.!!**

In her book *When Your Child is Cutting: A Parent's Guide to Helping Children Overcome Self-Injury* Dr. Merry McVey-Noble offers parents an easy to remember guide for assessing potential for suicide. She calls it S.L.A.P. and asks parents to ask themselves these questions:

**S** -- **Specificity of suicide plan** Has he been thinking about suicide? Does he just wish he was dead or is he thinking about killing himself? Does he have a plan? How specific is it? (Does he know when, how, and where?)

**L** -- **Lethality of means** Some plans are more lethal than others. Ask how he is thinking of killing themselves. Is it lethal? Is it possible? It might be uncomfortable asking such questions but it is the best way to determine the level of risk. You can always preface your questions by expressing your concern and care about the seriousness of the situation.

**A** -- **Availability of means** Does the person have access to the means? If he says he will kill himself using a gun and you have a gun in the house, you need to get that gun out and get the youth to care.

**P** -- **Proximity of help.** Sometimes, a call to the therapist or arranging for a youth to talk to an on-call psychologist may be available to you. If none of those things are and you have nowhere else to turn, you might make the decision for hospitalization.

If after doing the SLAP assessment, you decide that your child is in danger of attempting suicide, be prepared to take him or her to the hospital. If a youth has self-injured but is not suicidal or in immediate danger, or does not need immediate medical attention, consult your social worker and the youth’s therapist first to determine your next step. Remember, use your team!
**Other thing to think about if you think your child is suicidal…**

What can a resource family do if these signs are present and you answer YES to many of the questions? It is very important that resource parent stay calm and act. First of all, reach out for help to a social worker or counselor. Following are some other ideas that might help you and your child get through this critical period.

**Prevent:** Remove a child’s access to dangerous objects. This includes firearms, medications, knives, alcohol, or drugs. Keep control over vehicle keys as well. This should be standard practice in your foster home, especially if you are caring for children or teens that are depressed.

**Ask and Listen:** Don’t be afraid to ask if someone is contemplating suicide. Always take these threats seriously. To help you gauge the severity of the threat, ask the person if they have a plan. If it is well thought out and the child has access to the means, this is a serious threat. Often the ability to talk about it with someone who is concerned offers a release for the child. *Listen*, don’t give advice. Don’t challenge or call the child’s bluff. Sometimes just being able to talk at length makes a child too tired to do anything to hurt himself.

**Persuade:** Offer hope. The next step is to offer hope in the form of help. With your words, let them know you care.

“I love you and I don’t want to see you hurt yourself.”

“I can tell you’re really hurting. Tell me what you are going through so I can understand.”

“I care too much to sit by and ignore what’s happening to you. Its time we found someone to give you’re the help you need.”

“I have heard you mentioning suicide lately. I am very concerned. Are you feeling so bad that you are thinking of killing yourself?”

Sometimes if you are able to talk to children at length, they talk so much that they get over the crisis point or sometimes they talk so much that they are just too tired to follow through. So stay with them and be supportive. Point out the good work the child has done. You may wish to get the child in touch with the therapist or crisis counselor during this time. For extremely suicidal children, there may need to be a regular “check-in” to monitor feelings.

**Refer:** You may need help with the child. Contact therapist or caseworker. If child is in immediate danger, he may need to be hospitalized. Call 911, or take the person to a hospital emergency room. **DO NOT LEAVE THE PERSON ALONE!** Some children will need to be hospitalized or place in a secure psychiatric facility in order to stabilize and protect them from harm.
We end this self-study in the way we began it. It is often difficult for resource families to work with a youth who shows self-destructive behavior. We want the best for them and it may be hard to understand why a youth or child might do this. We might even get frustrated and angry when a child persists in this behavior. For children and youth who are depressed or have established a pattern of self-harming, it will take time and healing to let go of those old destructive habits. Please be patient and understanding. In addition, you may wish to follow these general guidelines.

1. **Provide for the safety of a child or youth.** That means providing supervision and regular physical presence with a child. Make sure that guns, knives, broken glass, car keys, medications and tools are kept out of the reach of children or youth.

2. **Work with a therapist,** school counselor or social worker if you can. Do not do this work alone. Learn everything you can about a child’s condition so that you can be the most help you can.

3. **Be hopeful** and help a child find hope in his world. Talk about the future. Point out opportunities to affect how certain things will happen.

4. **Give the youth or child something to look forward to.** Plan something, no matter how small, that the youth will be able to carry out. Encourage a child in an area that interests him or help him explore some possible new hobbies. Plan enjoyable activities as a family.

5. **Promote social activities and interaction** with positive peers. Do not let a child watch too much television, play too many video games or spend too much time on the Internet. Increased time and energy spend on the Internet has been correlated to a slight increase in depression and decreased social time.

6. And most importantly, **don’t forget to get support for yourself.** Parents of children who attempt suicide or self-injure have their own feelings of confusion, guilt and self-blame. Children with depression and who self-injure may heal and change slowly. It is important that caregivers do not feel like they are failing when a child needs to take this time and may backtrack. Reach out for help and support for yourself.