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SUICIDE

AND BRAIN INJURY

Acquired brain injury (ABI), including traumatic brain injury (TBI), can cause a lasting change in a person's thinking, how they react to certain situations, and how they relate to others. The intersection between suicide and brain injury is complex and overlapping. Suicide attempts may result in a brain injury (from falls, lack of oxygen, substance use, etc.). On the other hand, sustaining a brain injury might lead to an increased risk of suicidality due to additional stressors, medication, and impulsivity. Common influences might be:

- increased stress, helplessness, and isolation
- greater difficulty with relationships
- depression, and other mental health conditions
- difficulty controlling emotions, decision-making, planning, and problem solving
- loss of support system, job, and/or income

COMMON DEFINITIONS

Suicidal ideation - self-reported thoughts of engaging in suicide-related behavior.

Suicidal behavior - a spectrum of activities related to thoughts and behaviors such as suicidal thinking, attempts, and completed suicide.

Self-harm/Injury - the methods by which individuals injure themselves of suicidal or non-suicidal intent, such as self-laceration, battering, or recklessness.

DID YOU KNOW?

a person with brain injury is at an increased risk of suicide.

Mackelprang et al. (2014) found that 25% of participants experiencing hospitalization reported suicidal ideation at some time during the first year after TBI, a rate that exceeds the general population by almost 7 times. Screening and assessment is crucial at all stages following injury because there is not a specific window of risk for suicidality after TBI.

SUICIDE WARNING SIGNS

Talk or comments may be passive or directly related to suicide.

If a person talks about:

- Killing themselves
- Feeling hopeless
- Having no reason to live
- Being a burden to others
- Feeling trapped
- Unbearable pain

Behaviors that may signal risk, especially if related to a event, loss or change:

- Increased use of alcohol/ drugs
- Looking for a way to end their lives, such as searching for methods
- Withdrawing from activities
- Isolating from others
- Sleeping too much/ little
- Visiting or calling people to say goodbye
- Giving away prized possessions

Moods may be persistent or fluctuating, but often are all-consuming:

- Extreme sadness or stress
- Loss of interest
- Irritability or aggression
- Humiliation/Shame
- Agitation/Anger
- Relief/Sudden Improvement

Offer Support

Every person, brain injury, and struggle is different. Together we can all help to prevent suicide. As a supporter, be sure to keep in mind follow-up strategies within 48 hours after a suicidal crisis or hospital discharge: make a phone call, send a short text message, write a letter/email, or visit their residence. Here are strategies & resources to help change the internal narrative that there is no way out to one of hope and community.

Promote Prevention

FOR INDIVIDUALS & FAMILIES

- Talk to someone with psychotherapy, counseling, & support groups.
- Medication and management can be helpful for regulating emotions.
- Encourage connecting to providers, transportation, and group activities.
- Provide or seek a positive environment and support.
- Take time to evaluate a sense of purpose & of self, spirituality, or meaning.
- Responsibility such as a pet, chores, or job can help with purpose and feeling valued.
- Distractions & self-care can help to reduce stress.
- Helping others (volunteer work, acts of kindness, donating, etc.) can feel rewarding.

FOR PROVIDERS

- Take more time, be patient, and promote independence at all opportunities.
- Repeat or cue the person many times and provide written handouts for memory.
- Involve support, family, or friends whenever possible to avoid misinformation or confusion.
- Coordination of care should be communicated between all providers.
- Recommend family and couples counseling or positive group interactions with other people.
- Provide consistent monitoring and follow-up because memory and organization may be a barrier.
- Communicate that there is a possibility of suicide and the resources available.
- Medication may help, but pay attention to potential misuse or negative side-effects or ones that may be awkward to talk about.
- Written communication (i.e. emails) are often not enough to fully assess needs.
- Educate and support caregivers on expectations, coping skills, burnout, and connection to respite services.

Encourage Connection

RESOURCES & REFERENCES

National Suicide Prevention Lifeline:
- 1-800-273-TALK (8255)
- TTY: 1-800-779-4889
- suicidepreventionlifeline.org

Veterans Crisis Line:
- 1-800-273-8255 and Press 1
- www.veteranscrisisline.net

Suicide Resource Prevention Center:
- 877-(438-7772)
- www.sprc.org

Substance Abuse and Mental Health Services Administration (SAMSHA):
- www.samhsa.gov

Defense and Veterans Brain Injury Center (DVBIC):
- 1-800-870-9244
- dvbic.dcoe.mil

North Carolina Resources:
- crisissolutionsnc.org
- hopeline-nc.org
- LME/MCO Crisis Centers

HOPE is available.

BRAIN INJURY ASSOCIATION OF NORTH CAROLINA

in partnership with NCDHHS

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