Key Messages

- Self-harm is part of a continuum of behaviour that, at its most extreme, includes suicide, but much self-harm is not about intent to die. It represents a way of communicating distress and un-met need, and a way of providing a release of tension.
- The most common forms of self-harm behaviour are pain-killer overdose, and cutting.
- Self-harm is more frequent in groups of young people who are already vulnerable because of their life situation. Children in care, or in custody, or suffering life crises, are all at risk.
- Understanding the behaviour, and providing sympathy and support are important.
- Practitioners should be able to call on a range of interventions to help, although more evidence on effectiveness is needed. The evaluation and treatment of adolescent self-harm is still an under researched area of work. Additionally there needs to be a more robust platform for qualitative studies and personal testimony to be included in the evidence base
- High risk young people require long term multimodal interventions and there are unlikely to be quick fixes, as the behaviour is partly a response to the situation the young person finds themselves in.

References and Further Reading

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SCIE Research Briefing 17: *Therapies and approaches for helping children and adolescents who deliberately self-harm.* London: Social Care Institute of Excellence. Downloadable from: **http://www.scie.org.uk/publications/briefings/briefing16/index.asp**

Scottish Government (2008) *Effectiveness of Interventions to Prevent Suicide and Suicidal Behaviour: A Systematic Review* Leitner M, Barr W and Hobby L. Scottish Government Social Research. Useful overview of research on interventions. Available at **www.scotland.gov.uk/socialresearch**

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Useful Resources

TheSite.org, 'Young People and Self-Harm', recovery advice and support for young people:
http://www.thesite.org/healthandwellbeing/mentalhealth/selfharm,

National Self-Harm Network
http://www.nshn.co.uk/

Mental Health Foundation National Inquiry into self-harm. See MHF website at
http://www.mentalhealth.org.uk/campaigns/self-harm-inquiry/

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Adolescent Self Harm

Young people who self-harm in the UK are reaching epidemic proportions. Recent statistics from the Mental Health Foundation suggest that 1 in 15 young people will self-harm at some point. That equates to two teenagers in any classroom, although this may be an underestimate as it is a notoriously difficult topic to research. Lifetime estimates can be as high as 14% of young people (Hawton and James, 2005). Rates have been rising since the 1960's and the UK has the highest rates in Europe. Self-harming is predominantly an adolescent phenomena; however much of the literature is based on adult populations. There has been a very worrying trend amongst younger children with press reports of young people as young as 7 years old self-harming. This briefing will discuss some of the issues with a specific emphasis on the dilemmas for front line staff working in services to adolescents.

Describing Self-Harm

First, self-harm is not classified as a mental health disorder and most agree that it is a symptom and manifestation of significant un-met need; a way of showing distress. It can co-exist with or be a symptom of other disorders. There is no single universally agreed definition and self-harm is not limited by age, gender, race, sexual orientation, education, socio-economical status or religion. It is recognised and managed in various ways across the world.

It is easy to confuse self-harm with suicide attempts, but they are not the same. There is a general agreement that self-harm exists without necessarily intending to end one's life; whereas, in definitions of suicide, there needs to be a deliberate and direct intent to end life. More often than not, self-harm is about regulating emotions, survival and coping with stress. Still, one way of viewing self-harm is as part of a continuum with non-suicidal intent at one end moving through to suicidal ideation, self-harm/self injury, attempted suicide and completed suicide at the other end. Some young people may only ever experience suicidal thoughts and this may be fleeting and not acted upon. Others may act on the thought and self injure by for example "cutting". This type of self-harm may be of low lethality and have no suicidal intent; the majority of self-harming episodes are not about 'a wish to die'. However, other youngsters may enter at a later stage of the continuum and attempt suicide eg. overdosing/hanging. In this instance the intent would be greater and the act may be viewed as having higher lethality. What is known is that young people who enter this continuum in the first instance are at much higher risk of completing suicide.

Although there is general agreement that behaviour such as excessive drug and alcohol misuse, unsafe sex, body piercing and professional tattooing, and over-exercising are potentially damaging, they are not usually regarded as self-harm. Bulimia, Anorexia Nervosa, Obesity and other forms of eating disorders are viewed by some theorists as 'indirect' self-harm, where the damage is accumulative as opposed to immediate. This briefing is focused on 'direct' self-harm in young people, of which Paracetamol overdosing and cutting are the two most common forms. Below is a guide on the differences between indirect and direct types of self-harm. For the purpose of this article self-harm refers to "any intentional self injury irrespective of the apparent purpose of the act" (NICE 2004).

'Direct' Self-Harm	**'Indirect'** Self-Harm
Suicide attempts (e.g. overdose, hanging, jumping from a height, and use of a gun). ***Major self-injury*** (e.g. self-enucleation, autocastration). ***Atypical self-injury*** (e.g. mutilation of the face, eyes, breasts, or other injuries). ***Common forms of self-injury*** (e.g. wrist-, arm- and leg-cutting, self-burning and self-hitting).	***Substance abuse*** (e.g. alcohol, drugs, glue, IV drugs, etc.). ***Eating disordered behaviour*** (e.g. Anorexia Nervosa, Obesity). ***Physical risk-taking*** (e.g. walking in front of high-speed traffic). ***Situational risk-taking*** (e.g. getting in cars with strangers). ***Sexual risk-taking*** (e.g. unprotected sex with strangers). ***Misuse/abuse of prescribed medication***.

Mental health problems (such as anxiety, depression and feelings of hopelessness, which may or may not be a result of these stress factors), are significantly associated with self-harming behaviour; where we find one, we often find the other.

What Causes Self-Harm in Young People?

No single factor has been shown to predict or cause self-harm. However, there are many triggers including; low self-esteem, depression, anxiety, relationship difficulties, bullying, examination pressures and traumatic and/or abusive experiences. In fact, self-harm is not usually triggered by one isolated event, rather a set of circumstances or a combination of factors that have a type of accumulative effect over time. Young people often describe feelings of it being the 'last straw'. The origins of the event may lie much further back in time, and the young person is likely to be struggling with a variety of stresses and problems over time which have become unbearable. Because of events in their lives, young people feel increasingly under pressure and stressed, combined with inadequate support systems or a lack of skills in adopting healthier coping strategies. Research has shown that self-harm is also often not a singular occurrence but can go on for many years.

Bearing in mind that the true extent of self-harming in young people is difficult to ascertain, research has provided some valuable insight into what groups are likely to be the most vulnerable. Any groups more likely to experience mental health problems are more vulnerable to self-harm; this would include children and young people who have spent time in Local Authority Care and those held in custodial settings. The National Inquiry into Self-Harm undertaken by the Mental Health Foundation in the mid 2000s found that 65% of young women and 10% of young men in these settings reported self-harm and that females were more likely to harm repeatedly. Ethnicity may also play a role; Asian females aged between 15 and 35 are 2-3 times more likely to self-harm than their non-Asian counterparts. By targeting these priority groups, services can focus interventions where they are most likely to have an impact.

Course and outcome of young people who self-harm

Investigating course and outcomes presents difficulties for researchers and clinicians for many reasons, including a lack of agreement regarding the underlying problem and the fact that many young people do not receive medical treatment following their attempt. It is likely they will present in crisis and suicidal appeals for help are made closer to home eg. friends. Unlike some other conditions, there is no particular trajectory or definitive course post self-harm event, and the context in which it occurs is a key issue to assess in order to identify potential risk and protective factors prior to intervention. Many studies on outcomes fail to give an adequate age distribution and the samples often include older adolescents and the adult population and therefore results cannot be generalisable adequately to the adolescent population. However, research findings suggest that some adolescents who self-harm are at risk of a number of adverse outcomes. Some particular issues include:

...the chance of repetition after initial episode, with recent studies suggesting that this is greatest in the first few weeks, affecting between 10-25% of initial harmers. This may depend on young people's ability to mobilise social support and get help.

...the association with an increased risk of difficulties with social and psychological adjustment, which may relate to a higher number of environmental stresses experienced by people who are likely to self-harm.

...the risk of carrying on and completing suicide. It is widely recognised that official suicide rates conceal the real scale of fatalities particularly with younger people.

Working with self-harming young people

Working therapeutically and effectively with young people who engage in self-harming behaviour is perhaps one of the most complex and challenging issues facing front-line practitioners. The young people themselves often experience difficulty in rationalising their feelings and behaviours to others, and practitioners may struggle with negative and hostile reactions to the behaviour. "Attention seeking behaviour" has become inextricably linked to self-harm in the minds of some practitioners. Others may feel that "self-harmers are untreatable" and that people who do commit suicide do not disclose their intentions. Harbouring such misconceptions within the staff team can be counter-therapeutic.

Young people have stated that in some instances they have self-harmed to communicate to others that they are distressed and that they wanted to feel cared for and looked after, therefore responses should not be punitive and practitioners should respond as a friendly professional as opposed to a professional friend. Maintaining a healthy, optimistic, therapeutic alliance and healthy interpersonal boundary is imperative when the young person's life may appear incredibly bleak. Each act should be viewed as a unique experience to that young person and the communication should always be taken seriously.

Promising Treatments

For a lot of young people the behaviour can remit without any intervention and recovery, perhaps as a result of maturation and successful negotiation of adolescent transitions and challenges. However, many will require interventions. No single treatment has proven to be more effective than others. On the other hand, there are a number of promising avenues that can be considered as having sound clinical utility, although Randomised Control Trials in this area are rare.

(a) Individual Treatments

Individual therapy with young people who self-harm is often based at least initially on the principles of crisis intervention. Crisis or problem solving therapy is likely to be brief, intensive and focused on current difficulties. Individual therapies vary considerably depending on the support needed by that particular young person. Most practitioners tend to have their own framework of understanding the distress and a commitment to a particular kind of response/modality.

Such interventions range from counselling to more structured cognitive behavioural type strategies such as CBT (Cognitive Behavioural Therapy). CBT is a discrete, time limited, structured therapy which challenges aspects of the young person's core beliefs and negative thoughts. Problem solving therapy and techniques are helpful in encouraging the young person to re-establish a sense of autonomy. CBT therapists are likely to be more directive and prescriptive about reaching resolution.

Other individual therapies include psychotherapeutic interventions, which emphasises that the origins of the young person's current problems are related to their past. Another option is supportive counselling. Creative therapies such as art, drama and music may be used to enable the young person to use different mediums to communicate. All these have been subject to mixed evidence on effectiveness but may be useful in combination with other techniques. In addition, multi-systemic therapy (MST) is an evidence based treatment from the USA. It is an intensive home and family based treatment combining family and CBT strategies with a range of other family support services. Although it has been shown to be effective for a range of outcomes, it is a 24 hours commitment and therapists work with a small caseload in order for them to be available to respond to crisis.

Many young people have reported positive change when they have been able to make use of self management strategies. The debate continues about the pros and cons of harm minimisation in self-harm and certainly health education is a key factor for clinicians to implement. Some young people have been encouraged to draw up a security plan or care plan which includes triggers for episodes then a series of strategies to use instead of self-harming.

(b) Family Therapy

Family treatments or specific family therapies are an important component of therapy for young people who self-harm, however it is rarely used with older adolescents and as a sole treatment. A lot of practitioners tend to use a type of didactic intervention where parents receive a psycho-educational approach to help them understand the young person's dilemma.

(c) Group Treatment

Group therapy is based on the premise that children's difficulties develop within a network of relationships in the social context. Young people tend to function in groups and there is evidence that young people who self-harm identify with each other and often form covert groupings far away from adult scrutiny eg. virtual relationships, MSN/Facebook. Developmental Group Psychotherapy (Wood et al 2001) is a specific group programme for use with young people who repeatedly self-harm. Dialectical Behavioural Therapy (DBT) is also often used in the group situation, with a focus on changing behaviour and helping accept negative feelings. Studies have suggested it can be particularly effective, for example in reducing self-harm amongst women who have been diagnosed with Borderline Personality Disorder. As a combination of individual and group therapy, DBT it includes social skills training and access to crisis management by telephone. Self management is encouraged by developing self awareness reducing impulsivity through developing coping strategies and regulation of emotions. A 16 week programme of DBT has been adapted to use with young people particularly those who repeatedly self-harm, and group dialectical behavioural therapy has shown promise for suicidal adolescents (Miller et al 2007). Both treatments DGP and DBT involve the group programme being as an addition to other approaches.

(d) Psychopharmacological Interventions

Psychotropic drugs can be used in the treatment of self-harm particularly when there is evidence of co-morbidity such as anxiety states, psychosis or depressive symptomatology. Selective Serotonin Reuptake Inhibitors (SSRIs) such as Fluoxetine are often the drug of choice for adolescents because they have fewer side effects and are safer in overdose. However other SSRIs have been reported to increase young people's suicidality and impulsivity. Later research has refuted these claims. However use of medication with self-harming young people needs to be a cautious undertaking.

Conclusions

Self-harm poses a particular challenge for front-line practitioners providing services to young people, but it is a challenge that has to be anticipated and met. Any young people in a vulnerable situation experiencing stress are at more risk for self-harm. It is often a way of escaping from a situation or providing some release of anxiety and tension, or a way of demonstrating unmet need. Self-harm does not lead directly to suicide, and there are many different treatments that may be beneficial, including various kinds of behavioural therapy. Knowing how to access these would be useful. It often arises as a crisis response, and responding to it as such is helpful, but practitioners should be aware of the high overlap with other problems such as depression, which will also need attention. This is an area where more research is definitely needed, but in the meantime, practitioners should feel that self-harm is a way of communicating distress, and that there are things that can be done.