UNDERSTANDING SELF-HARM IN ADOLESCENCE

Professor Stephen Briggs
Director, Centre for Social Work Research
University of East London

Aims

- Provide an overview of our knowledge of self-harm by young people
- Discuss the relationship between self-harm and suicide
- Focus on identifying which young people self-harm, and why they self-harm
- Discuss principles for practice to prevent and reduce self-harm

What is self-harm?

- We need to start with definitions
  - Definitions and terminology are contested and can be confusing
- Some common terms include:
  - Self-harm, self-injury, non-suicidal self injury, suicidal self-injury, suicide attempt, self-cutting, self-poisoning, para-suicide

Definition of self-harm

self-harm is defined as:

- any act of intentional harm to the self, irrespective of method used or intended outcome; therefore including suicide attempts (NICE 2011; Hawton et al 2012a)
- methods commonly include self-cutting, self-poisoning, hanging, jumping, use of firearms
- Behaviours usually excluded are
  - 'risk taking behaviours' e.g. dangerous driving, unprotected sex, excessive drug use
  - other related psychiatric conditions e.g. anorexia

- I will be using this definition in this talk
- i.e. I will refer to 'self-harm' as above
- I will use the term 'self-cutting' to refer to self-injury caused by this method of self-harm

Why this definition?

- Self-harm is a complex behaviour, not a diagnosis
- There is a complex relationship between self-harm and suicide:
- Conscious intention and method of self-harm are poor predictors of outcome
  - Reported intention changes over time
  - Intention is often multiple, and ambivalent
    - the Golden Gate Bridge study: Hale (2008)
  - Individuals move between methods of self-harm
- Self-harm is a key risk factor for repetition and suicide completion

THE RELATIONSHIP BETWEEN SELF-HARM AND SUICIDE

The relationship between self-harm and suicide

- Self-harm is the key risk factor for suicide
  - An episode of self-harm increases the risk of repetition of self-harm and completed suicide by up to 100 fold (Kendall et al 2011)
- The method of self-harm does not indicate level of suicide risk
  - People who self-harm by cutting are just as likely to die by suicide as people using other methods
  - Self-harm by cutting is a strong independent predictor of suicide (Hawton et al 2012b)
- On the other hand, most people who self-harm do not complete suicide
  - Prediction of who will complete suicide is not possible
  - (i.e. prediction of suicide is an 'inexact science')
- There are no reliable scales or measures for predicting outcome (suicide):
  - in fact scales/measures are potentially dangerous and NICE (2011) warns against use of these for predicting outcomes

Principles of Care

Therefore, rather than sifting self-harm into ‘suicidal’ and ‘non-suicidal’ categories, clinical guidance recommends understanding each young person in order to make assessments:

“Offer an integrated and comprehensive psychosocial assessment of needs and risks to understand and engage people who self-harm and to initiate a therapeutic relationship”

NICE 2011 p207

Suicide rates/prevalence

- Suicide rates in recent years in UK are:
  - 8 per 100,000 for all ages (1 death every 2 hours; 4,200 deaths in 2010 (WHO 2014)
- Suicide rates are gender constructed
  - higher for males than females (11-12 male v 3 female per 100,000)
  - but females self-harm more than males (5:1)
- Changes in suicide rates are driven by social change
  - Current association between rise in male unemployment post 2008 and rise in male suicides (Barr et al 2012)
  - Current national suicide prevention strategy emphasises the importance of social factors:

    "Suicide prevention is most effective when it is combined as part of wider work addressing the social and other determinants of poor health, wellbeing or illness" (HMG/DH 2012)

Are suicide rates increasing in childhood/ adolescence?

- Comparing 1990-1999 with 2000-2009 in UK
  - Rates are rising slightly for 10-14 for females
  - Rates are falling for 10-14 for males
  - Rates falling 15-19 for males and females

(Kolves 2014)

World Health Organisation Report 2014 - Preventing Suicide: A global imperative

- Communities play a critical role in suicide prevention.
- Myths
- Key messages

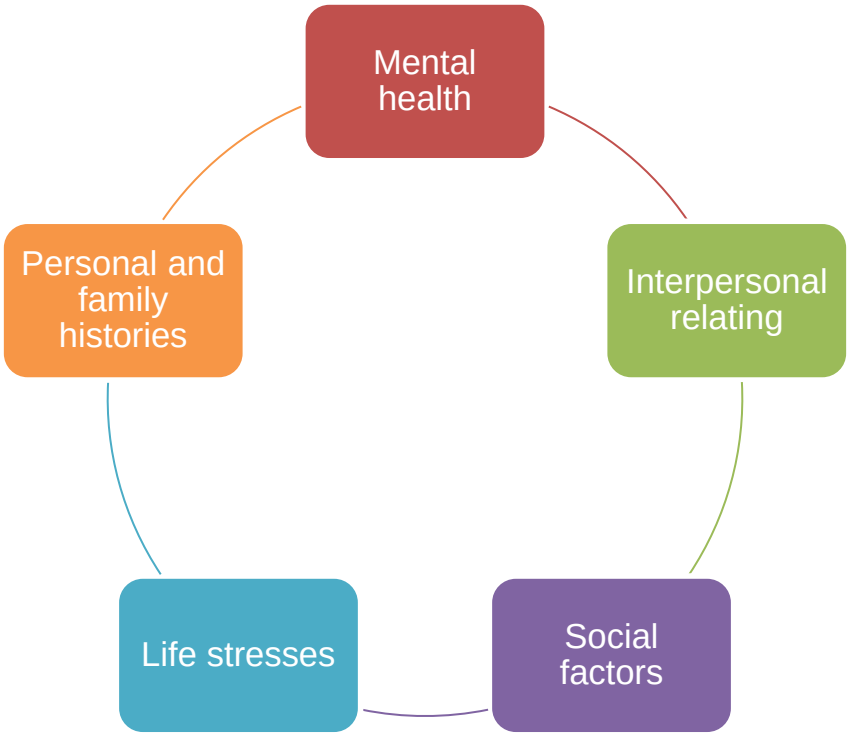
http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

UNDERSTANDING SELF-HARM

Understanding self-harm

- Which young people self-harm?
- Why do they self-harm?
- What are the best ways of intervening to prevent self-harm?

Young people who self-harm: factors



- Socio-demographic and educational status
- Individual negative life events and family adversity
- Psychiatric and psychological factors
- (Hawton et al 2012)

Prevalence of self-harm amongst young people

- There is concern that self-harm is increasing amongst young people, but we cannot be sure this is the case
  - Research on prevalence confuses terms and definitions, so it is difficult to know we are comparing similar findings
  - Estimates depend heavily on the tools being used
    - These can be: anonymised/self-reported/interview-administered
    - Questionnaires based on ‘yes/no’ answer to presence/absence of self-harm yield lower estimates than those which detail a list of possible self-harm behaviours (Ougrin 2014)
    - E.g. Madge et al 2008 – Child and Adolescent Self-harm in Europe (CASE) found 10% lifetime prevalence (used ‘yes/no’ answers)
    - Brunner et al (2014) – study in 11 European countries – found 28% lifetime prevalence (used list of possible behaviours)

Self-harm is under-reported

- A small minority of young people who self-harm access clinical services
  - NICE (2011) reports only 12% access health services
  - So, most self-harm is in the community

- Suicide prevention programmes, based on the known strong connection between self-harm and suicide risks, have aimed to reduce the taboo about self-harm;
- It is possible that more young people may be reaching services and professionals may be more aware and noticing/recognising young people who are harming themselves

The ‘natural history’ of adolescent self-harm

- Self-harm increases post-puberty
- Self-harm is often repeated (Hawton et al 2012a)
- Over 50% repeat (Madge et al 2008)
- But…most self-harm in adolescence resolves spontaneously in early adulthood (Moran et al 2012)
  - ‘Adolescence’ is a factor for self-harm: how this is responded to by responsible adults can make a difference
- It is difficult to predict which young people will continue to self-harm. Some indicators are:
  - Self-harm is associated with mental health difficulties (anxiety and depression), antisocial behaviour, alcohol and substance use
    - Mental health difficulties are more likely to persist into adulthood if there is a prolonged experience of these in adolescence (Patton et al 2014)
    - More intensive help in adolescence may reduce risks of mental health difficulties persisting into adulthood

Why do young people self-harm?

- Young people report their reasons for self-harm as:
  - an escape from intolerable distress or situations
  - a means of showing others how bad they feel
  - responding to feelings related to traumatic life events, childhood abuse, psychiatric illness or troubled relationships.
  - an important coping mechanism for dealing with feelings of frustration, loneliness or distress.
  - a cry for help, an escape, or as a means of gaining support.
  - a wish to die
  - to feel alive or relieve themselves of dissociation

- <u>The meaning and motivation behind each act may differ considerably from one incident to the next.</u>

(NICE 2011)

Self-harm is about….

- Dealing with intolerable situations and overwhelming feelings
- Responses to not feeling heard or understood
- Regulating emotions (in the absence of or inability of other means of doing this)
- Influencing others, e.g. others in close relationships

Peer influence

- Current concerns about peer influence on self-harm,
  - Some peer relations may ‘normalise’ self-harm behaviours
  - Peers may also provide support to reduce self-harm
- There is a lack of knowledge about how self-harm develops in groups:
  - “Further research to develop our understanding of the mechanisms involved is clearly required…. ” (Haw et al 2013)
  - Is it self-harm itself that triggers connections between individuals?
    - through contagion/imitation
  - Or is it from within a group – consisting of (vulnerable) people with similar characteristics in shared contexts – that self-harm behaviour develops from group relatedness?
  - Professionals can feel excluded from these young people’s ‘secret networks’
- <u>It is important to observe carefully in each case and not jump to conclusions: e.g. ‘explanations’ such as ‘contagion’</u>

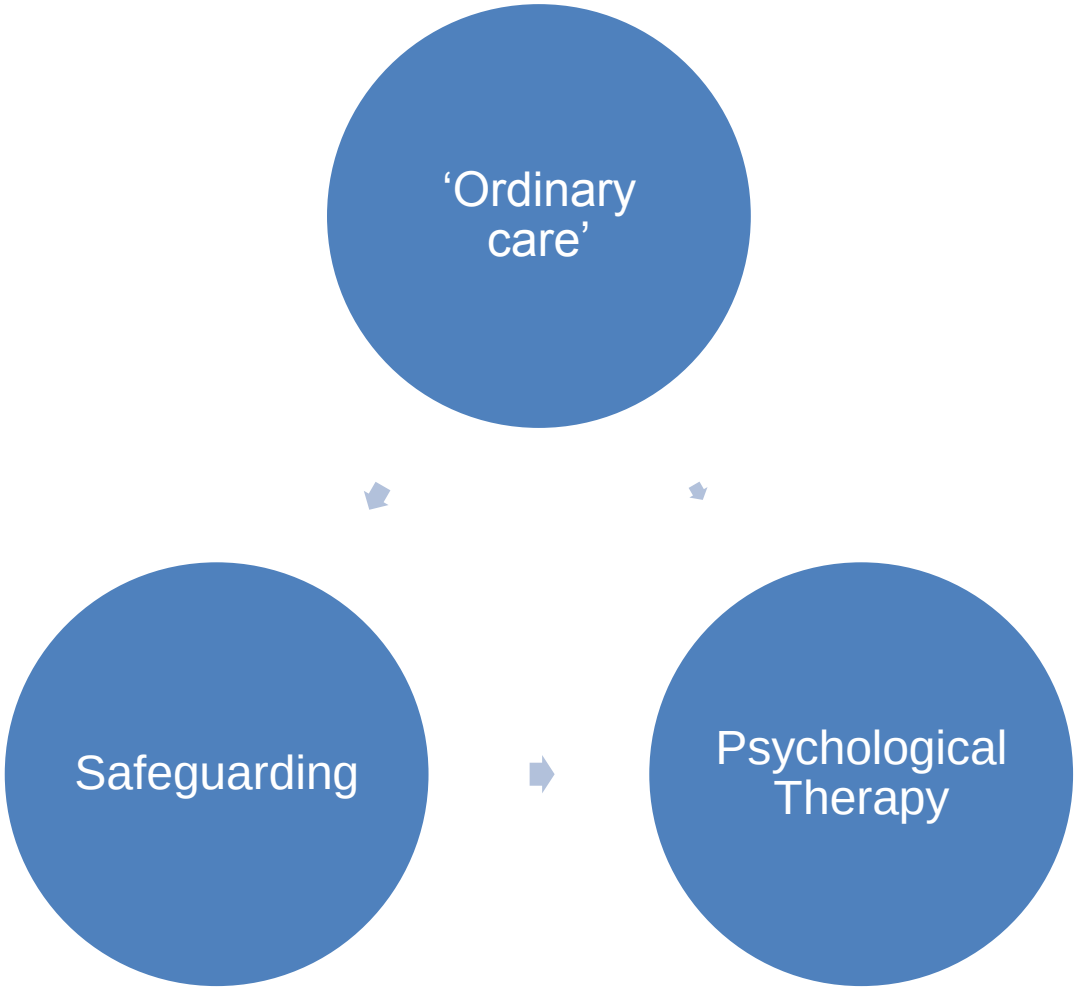
INTERVENTIONS

Every episode and every case is different….principles of care in NICE (2011)

- During assessment, explore the meaning of self-harm for the person and take into account that:
  - each person who self-harms does so for individual reasons, and
  - each episode of self-harm should be treated in its own right and a person's reasons for self-harm may vary from episode to episode (NICE 2011 p207)

- Exploration of self-harm thoughts, intentions and motivations is not dangerous
- There is evidence that talking about self-harm does not increase risks (Crawford et al 2011)
- A 'myth' of self-harm is that talking about it makes it happen (WHO 2014)
- Social stigma makes it difficult to access help
- "Given the widespread stigma around suicide/self-harm, most people do not know who to speak to" (WHO 2014)

Three key principles for intervention to prevent/reduce self-harm, and to attend to the factors involved for each young person



‘Ordinary care’

- All involved with a young person should empathically **explore meaning and motivation,** within the relationship to provide ‘sufficient containment’

- This can be difficult to achieve where:
  - The emotional impact of self-harm can be powerful
  - Professionals’ anxieties can be generated by ‘not knowing’
  - Adults/professionals can fear contact with self-harm
  - The stigma of self-harm affects professional responses

- Why can people who self-harm be treated badly in mainstream services?
  - Self-harm can elicit negative responses (wittingly and unwittingly) (Saunders et al 2011)

- So taking opportunities to link up with other professionals, and for reflective discussion is helpful

All professionals should:-

- aim to develop a **trusting, supportive and engaging relationship**
- be aware of the **stigma and discrimination** sometimes associated with self-harm, and adopt a non-judgemental approach
- ensure that **people are fully involved in decision-making** about their treatment and care
- maintain **continuity of therapeutic relationships** wherever possible
- Anticipate that the **ending of treatment, services or relationships**, as well as **transitions** from one service to another, can provoke strong feelings and increase the risk of self-harm (p118)

  NICE 2011

Safeguarding

- Professionals who work with children and young people who self-harm should consider whether the child's or young person's needs should be assessed according to local safeguarding procedures.
  - use a multi-agency approach, including social care and education, to ensure that different perspectives on the child's life are considered
  - if serious concerns are identified, develop a child protection plan.

- (NICE 2011 page 286)

Psychological therapies

- Psychological therapies are increasingly important for working with young people who self-harm
- Therapies are beginning to show evidence for improving outcomes for young people who self-harm compared with TAU
- NICE (2011) recommends providing therapy using one of a range of modalities:
  - psychodynamic,
  - CBT,
  - problem-solving

Key messages

- An episode of self-harm is a key risk factor for repetition and completed suicide
- Self-harm is often associated with mental health difficulties, alongside a wide range of factors (social, interpersonal, life events, background)
- There is no simple way of accurately predicting the outcome of self harm (i.e. suicide/long-term psychosocial disorders/long term self-harm/ cessation): a full assessment of needs and risks is necessary in each case
  - Understand individual motivation and the meaning of self-harm is vital: talking with young people about the reasons for self-harm
  - Develop trusting, supportive and engaging relationship
  - Take self-harm seriously, applying a sense of proportion
- All professionals have important roles in providing care for people who self-harm: it cannot be left to one group/discipline
- Key skills are:
  - understanding and working with our anxieties and fears
  - empathic exploration and relating to young people
  - relating to the experiences of ‘adolescence’ –changes, risks and opportunities
  - understanding the nuances and ambiguities of self-harm for young people

Resources

- National Suicide Prevention Strategy: Preventing suicide in England: A cross-government outcomes strategy to save lives, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf
- NICE Clinical Guideline: “Self-harm: longer term management” http://guidance.nice.org.uk/CG133
- Samaritans: www.samaritans.org
- Papyrus: https://www.papyrus-uk.org/

References

- Barr, B., Taylor-Robinson, D., Scott-Samuel, A. McKee, M. , Stuckler, D. (2012) Suicides associated with the 2008-10 economic recession in England: time trend analysis, BMJ 2012;345:e5142 doi: 10.1136/bmj.e5142,
- Brunner, R., Kaess, M., Parzer, P., Fischer, G. et al (2014) Life-time prevalence and psychosocial correlates of adolescent direct self-injurious behaviour, Journal of Child Psychology and Psychiatry, 55, 337-348
- Crawford M., Thana L., Methuen C (2011) Impact of screening for suicide: randomised control trial. *British Journal of Psychiatry*, 198, 379-84
- Hale, R. (2008) Psychoanalysis and Suicide; Process and Typology in Briggs, S. Lemma, A., Crouch, W. (eds.) *Relating to self-harm and suicide: psychoanalytic perspectives on theory, practice and prevention.* London, Routledge
- Haw C, Hawton K, Niedzwiedz C, Platt S (2013) Suicide clusters: a review of risk factors and mechanisms, *Suicide Life Threat Behaviour* 2013 Feb;43(1):97-108
- Kendall, T. Taylor, C, Bhatti, H. Chan, M., Kapur, N., On behalf of the Guideline Development Group (2011) Longer term management of self-harm: summary of NICE guidance, *BMJ* 2011;343:d7073 doi: 10.1136/bmj.d7073
- Kolves, K (2014) Global perspectives on child and adolescent suicide trends, Conference presentation ESSSB 15
- NICE (2011) *Self-harm: longer-term management*, (Clinical guideline CG133.) 2011. http://guidance.nice.org.uk/CG133

- Hawton, K., Saunders, K and O'Connor, Rl (2012a) Self-harm and suicide in adolescence, The Lancet, 379, 2373-82
- Hawton, K., Bergen, H., Kapur,N., Cooper, J. et al (2012b) Repetition of self-harm and suicide following self-harm in children and adolescents. Journal of Child Psychology and Psychiatry, 53, 1212-1219
- Madge, N., Hewitt, A. , Hawton, K. et al (2008) Deliberate self-harm within an international community of young people, Comparative findings from the Child and Adolescent self-harm in Europe study, Journal of Child Psychology and Psychiatry, 49, 667-677
- Moran, P. , Coffey, C., Roamiuk, H., Olsson, C. et al (2012) The natural history of self-harm from adolescence to young adulthood: a population –based cohort study, The Lancet, 379, 236-243
- Ougrin, D (2014) Commentary: Self-harm: a Global Priority – reflections on Brunner et al. Journal of Child Psychology and Psychiatry, 55, 4, 349-351
- Owens C et al (2011) Recognising and responding to suicidal crisis within family and social networks: qualitative study British Medical Journal, BMJ 2011;343:d5801
- Owens C et al (2011) Recognising and responding to suicidal crisis within family and social networks: qualitative study British Medical Journal, BMJ 2011;343:d5801
- Patton, G. Coffey, C., Romaniuk, H., Mackinnon A. Carlin, J. et al (2014) The prognosis of common mental disorders in adolescents: a 14-year prospective cohort study, *The Lancet*, Early Online Publication, 16 January 2014, doi:10.1016/S0140-6736(13)62116-9
- Saunders K, Hawton, K, Fortune S. et al (2011) Attitudes and knowledge of clinical staff regarding people who self-harm; systematic review, *Journal of Affective Disorders*, doi: 10.1016/j.jad.2011.08.024
- World Health Organisation (WHO) (2014) Preventing suicide; a global imperative http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

Thank you: for further information

Contact details

Email: s.briggs@uel.ac.uk

Websites:

www.stephenbriggsconsulting.co.uk

www.uel.ac.uk/cswr

Twitter:

@CSWR_UEL