

# Understanding self-harm in young people

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# Overview

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- Myths about self harm
- What is self harm?
- Epidemiology
- Aetiology and risk factors
- Self –harm and suicide
- Evidence based treatment



# Myths about self-harm



- It's a Serious mental illness
- Attention seeking/manipulative behaviour
- “a teenage girl thing”
- Not harmful/always risk of attempted suicide
- MC reason for self-harm- Suicide
- Risk assessments tools- most important

# What is self-harm?

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Various terminologies used:

- Self-harm
- Self injurious behavior (SIB)
- Non suicidal self injury (NSSI)- (DSM-5)
- Self mutilation
- Deliberate self harm(DSH) (RANZCP CPG)



# Is Self-harm a mental illness?

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- Self-harm is a symptom of multiple mental disorders, not a disorder in its own.
- “Self-harm is not an illness, but is more or less dangerous behaviour that should alert us to an underlying problem or difficulty .” (***National Collaborating Centre for Mental Health, 2004***)

# **(DSM-5; American Psychiatric Association, 2013) for NSSI**

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## **DSM-5 proposed criteria for NSSI**

### **Criteria A**

- Engagement in intentional self-inflicted damage to the body (e.g., cutting, burning, stabbing, hitting, excessive rubbing)- 5 or >5 in last 1 year only minor or moderate physical harm (i.e., there is no suicidal intent)

# DSM-5 ( Cont.)

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## Criteria B

### ***Expectations of SIB***

- To obtain relief from a negative feeling or cognitive state.
- To resolve an interpersonal difficulty.
- To induce a positive feeling state.

# DSM-5 (Cont.)

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## Criteria C

***associated with at least one of the following:***

- Interpersonal difficulties or negative feelings or thoughts,- depression, anxiety, tension, anger, generalized distress, or self-criticism,
- Preoccupation with the intended behaviour
- Frequent Thinking about self-injury.



## DSM-5 (Cont.)

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### Criteria D:

- The behaviour is not socially sanctioned.

### Criteria E:

- Clinically significant distress in interpersonal, academic, or other important areas of functioning.

## DSM-5 (Cont.)

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### Criteria F:

The behaviour does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal.

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**The National Institute for Health and  
Care Excellence (NICE) guidelines  
(National Collaborating Centre for  
Mental Health, 2004)**

‘Self-harm’ is -

*‘Self-poisoning or injury, irrespective of the  
apparent purpose of the act’.*

# Epidemiology:

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## Do we have the right information?

- 7/8 episodes of self-harm do not lead to a hospital presentation (Hawton et al., 2002).
- Systematic review- up to half of adolescents who self-harm do not seek help (Rowe et al., 2014).

## Epidemiology :A large ( $n = 12,006$ )

### Australian study of community self-injury (Martin et al., 2010)

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- Mean age of onset -17 years
- Males earlier(10–19 yrs): females (15–24yrs).
- Lifetime prevalence- 17% of Australian
- F: 12% M (15-19 years)
- **Self-harm/attempted suicide – F>M**
- **Death by suicide –MC- males M:F 3:1**

*(Hamza et al. 2012)*

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**UK study of nearly 200,000 medical records ([Morgan et al, 2017](#)). mortality risk between self-harming and non-self-harming adolescents:**

## (Morgan et al, 2017).

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- Self-harm rates Girls 3 times > boys
- 68% increase in self-harm rates in girls- 2011 and 2015
- Death from unnatural causes- 9 times
- Death from suicide -17 times more
- Death from fatal alcohol or drug poisoning - 34 times

# Epidemiology Source

(RANZCP 2016)

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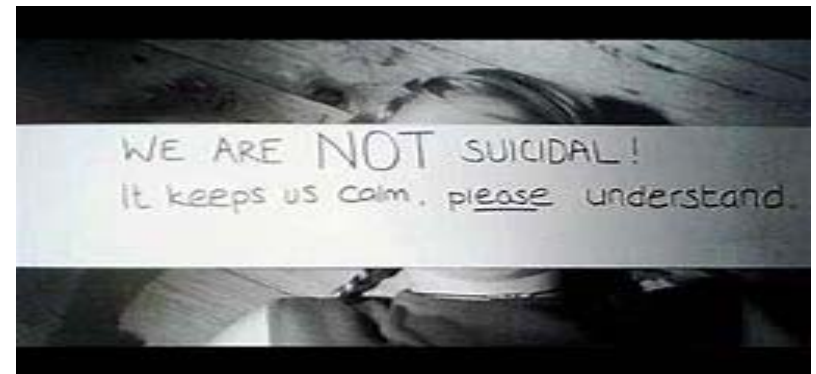
- A study of adolescents in 11 European countries- life-time prevalence of 27.6% for NSSI: 19.7% occasionally and 7.8% repetitively. *(Brunner2013)*
- The estimated risk of repetition of DSH - 5% and 25% per year.
- The risk of repetition - highest in the first year remains high for many years after DSH.



# Self-harm recurrence and suicide (Hospital presentations)

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- Hospital presentation with DSH- 1/6 further DSH in the following year.
- 1/25 - Expected to die by suicide in the next 5 years (Carroll et al., 2014).



# Suicide - Leading cause of death (2015-18)

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- Suicide was the leading cause of death among people aged 15–24 (35%), followed by land transport accidents (22%).
- For people aged 25–44, it was also suicide (21%), followed by accidental poisoning (12%).

Source: Australian Institute of Health and Welfare.

# Number of deaths by suicide

## 2009-2018 (Australian Bureau of statistics-ABA)

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.
NSW	623	674	617	727	718	832	839	818	880	899
Vic(d)	576	558	526	514	533	658	678	639	621	593
Qld	525	588	578	631	676	658	761	689	804	786
SA	185	197	212	198	203	243	234	225	224	212
WA	279	313	309	367	336	367	402	370	409	383
Tas.	79	64	74	71	74	69	84	94	80	78
NT	37	45	44	48	33	56	48	47	51	47
ACT	32	41	33	24	37	38	46	28	58	47
<b>Australia</b>	<b>2,337</b>	<b>2,480</b>	<b>2,393</b>	<b>2,580</b>	<b>2,610</b>	<b>2,922</b>	<b>3,093</b>	<b>2,911</b>	<b>3,128</b>	<b>3,046</b>

(f)



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# Death by suicide in children 2014-2018 (ABA)

Age group (years)	2014	2014	2015	2015	2016	2016	2017	2017	2018	2018
	No./proportion	Rate(d)	No./proportion	Rate(d)	No./proportion	Rate(d)	No./proportion	Rate(d)	No./proportion	Rate(d)
<b>5-17 years</b>										
<b>Males</b>										
Suicide	51	2.6	49	2.5	63	3.2	63	3.1	61	3.0
All causes	244	12.7	298	15.2	280	14.1	270	13.4	262	12.8
Proportion(f)	20.9	na	16.4	na	22.5	na	23.3	na	23.3	na
<b>Females</b>										
Suicide	38	2.1	40	2.2	28	1.5	35	1.8	39	2.0
All causes	195	10.7	217	11.7	161	8.6	197	10.3	166	9.6
Proportion(f)	19.5	na	16.4	na	17.4	na	17.8	na	21.0	na
<b>Persons</b>										
Suicide	89	2.4	89	2.3	91	2.4	98	2.5	100	2.5
All causes	439	11.7	515	13.5	441	11.4	467	11.9	448	11.2
Proportion(f)	20.3	na	17.3	na	20.6	na	21.0	na	22.3	na
<b>All ages(e)</b>	<b>2,922</b>	<b>12.3</b>	<b>3,093</b>	<b>12.9</b>	<b>2,911</b>	<b>11.9</b>	<b>3,128</b>	<b>12.6</b>	<b>3,046</b>	<b>12.1</b>



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# What causes self-harm

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Adolescent self-harm is the result of complex interactions between biological, interpersonal, social and psychiatric factors.

# Self-harm-Biological factors

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- Serotonin imbalance (Evans et al,2004)
- Low dopamine- needs more stimulant/risks
- Change in sleep pattern
- Frontal lobe- not fully developed – absence forward thinking, increase risk taking behavior,
- Poor understanding- potential lethality of methods(Fortune and Hawton, 2005).

# Risk-factors

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- Developmental trauma –Poor attachment, childhood sexual/physical/emotional abuse (*Evans and Hawton, 2005*)
- Family factors- Disruptions of care, family relationships breakdown
- Family conflict and low parental monitoring (9-10 yrs). *Deville et al 2020*

# Risk-factors

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- Older adolescent- Bullying, peer pressure
- F/H of depression, suicide (38-55%) and substance use
- Higher in indigenous population (ABS)-10.1 deaths per 100,000 persons, compared to 2.0 per 100,000 for non-Indigenous persons.



## Risk-factors

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- Kids under care of local authorities(OHC,foster)
- Anniversaries –increased risk
- Psychiatric comorbidity – 81.2%- depression, anxiety, alcohol misuse ( Hawton et al., 2013b). ADHD/Autism,BPD
- Conflict or loss following the break-up of a relationship, disciplinary crises or legal crises (Hawton et al., 2003)

# (Hawton *et al*, 2006) Motive for self-injury by young people

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<b>Motive</b>	<b>Self-cutting, % (n/N)</b>	<b>Self-poisoning, % (n/N)</b>
<b>Escape from a terrible state of mind</b>	<b>73.3 (140/191)</b>	<b>72.6 (53/73)</b>
<b>Punishment</b>	<b>45.0 (85/189)</b>	<b>38.5 (25/65)</b>
<b>Intention to die</b>	<b>40.2 (74/184)</b>	<b>66.7 (50/75)</b>
<b>Demonstration of desperation</b>	<b>37.6 (71/189)</b>	<b>43.9 (29/66)</b>
<b>To find out if someone loved them</b>	<b>7.8 (52/188)</b>	<b>41.2 (28/66)</b>
<b>Attention seeking</b>	<b>21.7 (39/180)</b>	<b>28.8 (19/66)</b>
<b>Wanted to frighten someone</b>	<b>18.6 (35/188)</b>	<b>24.6 (16/65)</b>
<b>Wanted to get back at someone</b>	<b>12.5 (23/184)</b>	<b>17.2 (11/64)</b>

# Risk assessment tools

## Myths/facts (RANZCP 2016)

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- No widely accepted tools for clinically assessing a patient's risk of subsequent DSH or suicide.
- Risk assessments tools-not demonstrated to reduce repetition of DSH.
- Categorising patients low risk / high risk of future fatal or non-fatal self-harm – No reduction in overall rates.

# DSH/suicide predictability (RANZCP2016)

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- Majority of people categorised as high risk for DSH or suicide (based on a risk assessment) do not go on to have these outcomes;
- A large proportion of adverse events such as DSH and suicide- people who were categorised to be at 'low risk'.
- Still need to follow local health policy for risk assessment- comprehensive assessment



# Outcomes due to self-harm (RANZCP-2016)

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- Key clinical outcomes for hospital treated DSH- Suicide and repetition of DSH
- Impaired quality of life -Impairment of functioning in physical, psychological and social domains
- Mental health morbidity (e.g. anxiety, depression, substance use)

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The UK NICE guideline for the short-term management self-harm (National Collaborating Centre for Mental Health, 2004) recommends a integrated needs and risk assessment approach

# Assessment and management (RANZCP-2016)

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- Comprehensive biopsychosocial and cultural assessment by trained clinicians involving patient and young family CAMHS team <18 years, taking care of consent/confidentiality
- Aim for out patient management if safe.

# Assessment and management (RANZCP-2016) -Cont.

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- Admission; Mental disorder that cant be treated safely in a community setting.
- High risk and lack of engagement from the young person warranting Mental Health Act assessment.



# Evidence for Pharmacological Treatment (RANZCP CPG)

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- Pharmacological treatment doesn't reduce the risk of repetition of DSH. Level 1
- Antidepressants and lithium; ineffective in preventing repetition of DSH (level 2)
- Beneficial for suicidal behaviour (thoughts, attempts, suicide mortality) - major depression or bipolar disorder.

# Psychological intervention (RANZCP CPG)

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- Psychological interventions – not more effective than treatment as usual for hospital-treated DSH in children and adolescents.
- Some evidence from a small number of RCTs suggests that CBT, MBT or DBT might help reduce repetition of DSH among children and adolescents. level 2

## Additional factors

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- Negative attitudes of general hospital staff-repeatedly self-harmers.
- Active training - consistent improvements in staff knowledge and attitudes (Saunders et al., 2012).

# Additional factors

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- Aim to develop a trusting, supportive and engaging relationship
- be aware of the stigma and discrimination
- Suicide prevention strategies –indigenous

# Timeline of intervention

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- Timeliness of intervention - important
- DSH repetition mostly within 1–4weeks of an index DSH event.
- Interventions might not commence within 4 weeks, or too few sessions may be delivered within 4 weeks (Brent et al., 2013).

# Objectives of intervention (RANZCP 2016)

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- Realistic
- Reduction in the number of DSH events or
- Cessation of DSH after a period of time
- More achievable goal than immediate cessation of DSH.

# Fortune et al. (2008) adolescent survey-what is helpful

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- Main support-friends(40%),family(11%), school
- Enhancing the provision of school-based mental health
- Anti-bullying campaign, Peer support



# Fortune et al. (2008) adolescent survey-what is helpful

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- Promoting good mental health and emotional well being
- Healthy diet and exercise
- Increased youth-orientation



# Borderline Personality Disorder (RANZCP 2016)

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- Suicide threats/attempts very common, Completed suicide 8%-10% (DSM 5-664)
- DBT is effective in reducing repeat DSH
- MBT and CBT- needs further evaluation

# Borderline Personality Disorder (RANZCP 2016) Cont.

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- Group therapy alone is not effective in reducing DSH in people with borderline personality disorder.
- Pharmacotherapy is not effective for reducing repetition of DSH in BPT.

# Staff burn out and self care

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- Staff- emotional response- Anger, guilt, frustration, self-blame
- Pressure to prevent self harm
- Lead to staff burn out
- Staff self care- Supervision, debriefing, holidays, meditation, hobbies
- Be kind to yourself

# Summary

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- Self-harm is not a mental disorder, it's a behaviour
- Response to psychosocial issues, method of coping and regulating emotions.
- Early intervention- can prevent fatal outcome

# Summary

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- Not just risk assessment
- Biopsychosocial assessment -Young person/family
- Screen and treat underlying serious mental illness.

# Myths about self-harm-review

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- It's a serious mental illness
- Attention seeking/manipulative behaviour
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- Not harmful/always risk of attempted suicide
- MC reason for self-harm- Suicide
- Risk assessments tools- most important

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