

Understanding Self Harm



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Handbook

UNDERSTANDING SELF HARM

Handbook

*Feeling unreal and distant, disconnected with life,
I pick up my razor blades,
Relieved at the sight of them I cry,
Not totally aware I cut into the skin,
Jolted back into reality by the act,
Checking that I'm still alive that I'm still real,
For a short while I am in control, for a short while I am at peace.*

(Gardener, 2001 p3)

This training programme and hand book 'Understanding Self Harm' was developed by the HSE South Regional Suicide Resource Office.

- Richard Pacitti (Chief Executive of Mind in Croydon) undertook a key consultancy and advisory role.
- Steve Lamb (Project Nurse, Self Harm) and Agatha Lawless (Training and Development Officer) HSE South, undertook the key role of programme planning and development.

INDEX

FOREWORD	3
INTRODUCTION	4
PROGRAMME OUTLINE.....	5
DEFINING SELF HARM	7
HOW COMMON IS SELF HARM?	8
SELF HARM AND SPECIAL GROUPS.....	9
SELF HARM & SUICIDE	10
FUNCTIONS OF SELF INJURY	11
WHY DO PEOPLE SELF HARM?	12
CYCLE OF SELF INJURY	15
WHAT TREATMENT WORKS?	16
SELF HARM - WHAT HELPS?	17
'HARM MINIMISATION'	20
WHAT CAN FAMILY & FRIENDS DO TO HELP?	21
SUPPORT FOR STAFF	23
SELF HARM GUIDELINES	24
ACKNOWLEDGEMENTS.....	26
REFERENCES.....	27
SELF HARM INFORMATION / RESOURCES	29

Appendices

1. Self Injury Treatment Checklist
2. Self Injury Myths & Common Sense
3. Borderline Personality Disorder
4. Mental Health Act, 2001

FOREWORD

Self harm is a common occurrence in Ireland; each week our Accident & Emergency (A&E) departments care for people who have attended following overdose or self cutting. Each year there are 11,000 self harm presentations to our acute hospitals. The majority are less than 30 years old, with young people (aged 15-19 years) accounting for significant numbers of the attendees.

However, it is of note that self harm is typically a private act and as such many people rarely disclose their behaviour to others. Community studies indicate that the prevalence of self harming is far greater than is reflected by hospital figures. In Ireland, a recent survey indicated that as many as 1 in 10 young people will self harm at some point in their life.

The consequences of self harm acts may on occasions result in lasting physical, emotional and mental health harm for the individual. However, self harm behaviour not only affects those people who harm themselves; self harm also has a profound impact upon family, friends, peers and care agencies. Furthermore, the economic costs of self harm to the exchequer are significant, estimated at approximately €30 million per annum.

Despite the significant health, social and economic consequences, self harm is a phenomenon which is often poorly understood by both the general public and care providers. Individuals who self harm often suffer the stigma of mental illness and personality disorder, both within the community and the clinical environment. People who self harm are often seen as undeserving and distracting of the care needs of others who have not 'self-inflicted' their injury. Often these self harm attitudes and misconceptions are related to a belief that self harming individuals are intent on suicide or that their self harming is motivated by manipulative, attention seeking needs.

This programme 'Understanding Self Harm' provides help in addressing the challenges of self harm behaviours and meeting the needs of those affected by self harm. The programme offers participants an opportunity to explore pertinent issues on the motivation and meaning of self harm; the functions of self harm behaviour and reviews self harm treatments and responses that might help.

I would recommend this training programme to carers, community groups, primary health care workers, youth workers, acute hospital and mental health care practitioners and to all who are affected by or come into contact with those who self harm.

Additionally, I am encouraged that those involved in the development of this programme seek to evaluate the outcome of the programme and are intent upon the development of further self harm focussed training. Such energetic and innovative work is to be encouraged towards improving self harm understanding, treatments and care.

Through seeking to highlight the issues of 'hidden' self harm and delivering awareness training the programme is supportive of Reach Out – Irish National Strategy for Suicide Prevention 2005-2014.

Signed:



Geoff Day

Director of National Office for Suicide Prevention

INTRODUCTION

The existence of self harm and suicidal behaviours in Ireland is undisputed. The extent of the problem is evidenced daily in tragic events within our families, our communities and in our local/national media. Reach Out – The Irish Strategy for Action on Suicide 2005 -2014 acknowledges the prevalence of the problems and their impact upon individuals and the wider community.

This education programme is supportive of ‘Reach Out’ in aiming to reduce the stigma of self harm, improve individual and care agencies awareness and sensitivity to self harm issues and promotes effective care services for those who self harm. The programme seeks to promote the principles of Respect, Understanding and Choice:

Clinical and non clinical staff who have contact with people who self harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self harmed.

[NICE Guidelines 2004 p87]

The education programme was developed in the HSE South in consultation with Mind in Croydon. It is open to both agencies and individuals who seek to understand more about self harm, the reasons underlying self harm behaviours and to improve upon personnel/agency responses to the needs of those people who self harm. The Handbook looks at a wide a variety of self harm related issues, ranging from understanding and defining self harm; the functions, motivations and meanings of self harm and helpful responses in responding to those who self harm.

The programme is essentially informative in nature, but is designed to afford participants and agencies with a choice dependent upon their needs:

Option 1 – A half day (3 hour) programme. Teaching methods include presentations plus some participant involvement in debate is encouraged. All participants will be provided with a self harm handbook and slides.

Option 2 – A one day (6 hour) programme. Teaching methods reflect workshop/interactive style and utilise discussion groups and practical group exercises to promote learning and shared experiences. All participants will be provided with a self harm handbook and slides.

Individuals and agencies making their choice of training are encouraged to consider both the practical limitations and learning requirements prior to booking/attending an event.

The programmes will be facilitated and delivered by trainers from teaching, clinical health and social care backgrounds all of whom are highly competent and experienced in the suicide/self harm field.

The programme writers and facilitators are mindful that the complex nature of self harm demands the development of advanced courses beyond this awareness programme. As such, through evaluation and consultation with participants and training commissioners, the trainers would seek to develop further self harm focussed training programmes.

NB: This Handbook is considered a useful self harm information resource, however people working with those people who Self Harm are encouraged to undertake specific self harm training.

Understanding Self Harm Half Day Programme Outline*

Venue:	Time: 3Hrs	Date:
Part 1	Registration, Introductions and Ground Rules	
	<i>Aims of sessions</i>	
	<i>Self Harm</i> <ul style="list-style-type: none"> ● Defining self harm ● Self harm – Scale of the problem ● Self harm and suicide ● Methods of deliberate self harm 	
BREAK		
Part 2	<i>Understanding Self Harm Behaviour</i> <ul style="list-style-type: none"> ● Video – (Visible Memories) ● Why do people self harm? ● Functions of self harming ● Attitudes ● Who is affected by self harm? 	
	<i>Self Harm – What Helps?</i> <ul style="list-style-type: none"> ● Helpful responses ● What treatment works? ● Talking with a person about their self harm ● Self harm alternatives and substitute behaviours 	
	<i>Self Harm – The Key Messages</i>	

* The above outline refers to the half day (3 hour) programme. In delivering a one day programme the facilitators will spread out the programme utilising creative exercises' affording participants' greater opportunity for debate, discussion and skills practice.

Understanding Self Harm One Day Programme Outline*

Venue:	Time: 6Hrs	Date:
Part 1 (AM)	<p>Registration, Introductions and Ground Rules</p> <p>Aims of sessions</p> <p>Self Harm</p> <ul style="list-style-type: none"> ● Defining self harm ● Self harm – Scale of the problem ● Self harm and suicide ● Methods of deliberate self harm 	
BREAK		
Part 2 (AM)	<p>Understanding Self Harm Behaviour</p> <ul style="list-style-type: none"> ● Video – (Visible Memories) ● Why do people self harm? ● Functions of self harming ● Attitudes ● Who is affected by self harm? 	
Part 3 (PM)	<p>Self Harm – What Helps?</p> <ul style="list-style-type: none"> ● Helpful responses ● What Treatment Works? ● Talking with a person about their self harm ● Self harm alternatives and substitute behaviours 	
	<p>Working with Self Harm - Looking after yourself</p> <ul style="list-style-type: none"> ● Issues & challenges ● Policy & Procedures (Hawton) ● Support & Supervision <p>Exploring replacements to Self Harm behaviours</p> <ul style="list-style-type: none"> ● Substitutes ● Alternatives ● ‘Harm Minimisation’ ● Working with the underlying issues <p>Self Harm – The Key Messages</p>	

* The above outline refers to the (3 part) one day programme wherein facilitators utilise creative participatory exercises, affording participants’ the opportunity for debate, discuss and utilise taught skills amongst peers & colleagues. An alternative 3 hour (2 parts) programme is also available.

Defining Self Harm

Self-Harm

“Self-poisoning or self-injury, irrespective of the apparent purpose of the act”.

NICE Guidelines (2004)

Deliberate Self-Harm (*DSH):

The various methods by which people deliberately harm themselves, including self-cutting & taking overdoses. Varying degrees of suicide intent can be present & sometimes there may not be any suicidal intent, although an increased risk of further suicidal behaviour is associated with DSH.

(Reach Out 2005-2014)

**There is some debate about the definition & use of the terms ‘attempted suicide’, ‘parasuicide’, ‘deliberate self harm’ & ‘non-fatal suicidal behaviour’. These terms are sometimes used inter-changeably but deliberate self harm is the preferred definition of ‘Reach Out’*

Common Terms Used to Describe Self Harm

Synonyms

Self Harm
Deliberate Self Harm
Intentional Self Harm
Parasuicide
Attempted Suicide
Non-fatal Suicidal Attempt
Self Inflicted Violence

Sub Types

Self Poisoning
Self Injury
Self Mutilation

Favazza (1996) self-mutilation as “*the deliberate destruction or alteration of one’s body tissue without suicidal intent.*”

Babiker & Arnold (1997) define **self-injury** as “*an act which involves deliberately inflicting pain and/or injury to ones own body, but without suicidal intent*”. They distinguish self-injury from other apparently self-destructive behaviour:

Other Marginal Self-Injurious Behaviours e.g. reckless driving, overwork, smoking, drinking too much.

These are different from self-injury because they are socially acceptable and because the damage is not intended nor the primary purpose of the activity. It is akin to self-injury in that such activities may be used in order to cope, or as a way of exhibiting anger or frustration.

Self-Destructive Behaviours e.g. eating disorders, substance misuse, sexual risk-taking.

These are akin to self-injury because of its function as a distraction from immediate distress or as self-punishment. Self-injury is more direct, less socially acceptable and “madder”. The link between the activity and the consequences is more obvious and immediate. Self-injury often occurs in people who also have problems with substance misuse and/or eating.

Self-Harm e.g. overdosing, suicide, parasuicide.

In attempted suicide the person intends to kill themselves, in self-injury they do not. Self-injury can be the very reverse of self-destructiveness. People are seeking to preserve themselves. Their self-injury helps them with their struggle to stay alive. There is evidence however, that the risk of suicide in people who self-injure is between 50 and 100 times greater than in the general population.

Body “Enhancement” e.g. cosmetic surgery, piercing, hair straightening.

These activities tend to be socially acceptable but are akin to self-injury because they demonstrate an underlying belief that the person’s own body is not good enough. More extreme forms of body “enhancement” are more extreme piercing, head shaving, multiple tattooing may be intended to shock or identify with marginal groups. Such activities may be akin to self-injury because they communicate anger or the wish to belong to a group (e.g. Goths, modern primitives) the individual values.

Factitious Disorders i.e where someone causes injury or illness to themselves to achieve another desired end e.g. transfer to better living conditions. This involves self-injury not as an end in itself, but as a means to an end. It’s unlike self-injury because of the wish and need to make the injury public.

Somatic Expressions of Feeling i.e. where distress manifests as physical pain or symptoms.

Ranging from “psychosomatic” or “stress-related” illnesses to blindness or paralysis which has no apparent physical cause. Different from self-injury because the physical manifestations are not intentional nor under voluntary control. In self-injury the physical act follow the distress as a means of coping with it.

Self-Injury and psychosis

To the above list it might be useful to mention self-injury related to psychotic illnesses and episodes. In these cases the self-injury may be the result of delusions, hallucinations or thought disorder. Examples given by Favazza (1996) include people with a diagnosis of schizophrenia who either cut out their tongue with a razor or scratched out their eyes because “God told them to”.

How Common is Self Harm?

Self Harm can occur at any age but it is most common in adolescence and young people. Withing Ireland there are 11,000 Self Harm presentations annually (NSRF 2006). However hospital rates do not reflect the true scale of the problem:

Incidence of DSH in Ireland:

Figure 1

INCIDENCE OF DELIBERATE SELF HARM- IRELAND BY A&E ATTEENDANCE 2002 - 2005					
		2002	2003	2004	2005
Persons		8,400	8,800	8,600	8,600
Presentations		10,500	11,200	11,100	10,800 -3%
Rate*	- persons	202	209	201	198 -3%
	- men	167	177	170	167 -2%
	- women	237	241	233	229 -2%

*Age-standardised rate of person treated for DSH per 100,000

NICE Guidelines (2004)

“Since many acts of self-harm do not come to the attention of healthcare services, hospital attendance rates do not reflect the true scale of the problem” (NICE p20).

In Ireland: **The Young People’s Mental Health Report (2004)** surveyed 3830 school aged youths (age 15-17 years). 12.2% of those surveyed indicated a life time history of self harm and of these almost half (45.9%) had self harmed more than once. In respect of self harm thinking, 21.6% of those questioned indicated they had thought of harming themselves in the previous 12 months. On gender, girls are three times more likely to harm themselves than boys (13.5% v 4.9%).

The reliability of these figures as a reflective incidence of youth self harm is supported through similar international findings in surveys of school age youths (see figure 2).

Figure 2

INCIDENCE OF SELF HARM IN SCHOOL AGED YOUTHS Child & Adolescent Self Harm in Europe [CASE Study]				
Country	Self Harmed Previous year (%)		Lifetime (%)	
	Female	Male	Female	Male
Ireland	9.1	2.7	13.5	4.9
England	10.8	3.3	16.9	4.9
Belgium	10.4	4.4	15.6	6.8
Norway	10.8	2.5	15.3	4.3
Australia	11.8	1.8	17.1	3.3
The Netherlands	3.7	1.7	5.9	2.5

Adapted from Hawton and Rodman (2006)

Overall, women are more likely to self-harm than men. This is most pronounced in adolescence, where girls may be three times more likely to self-harm than boys (Hawton et al., 2002).

Self Harm and Special Groups: (see NICE Guidelines p23)

Diversity:

There is no good evidence to suggest that the incidence of self harm varies between different ethnic groups, with the exception of higher rates in young Asian women (Bhugra et al., 1999)

A recent survey of gay men, lesbians and bisexuals has suggested that this group of people may have an increased rate of self harm, which some groups reported was linked to their sexual orientation (King and McKeown, 2003). However, the report also identified higher rates of bullying and victimisation among these groups, factors also linked to self harm. It may be that these groups of people are bullied more often and that this may lead some to self harm.

Young People:

The rate of self harm is relatively low in early childhood, but increases rapidly with the onset of adolescence (Hawton et al., 2003). Most acts of self harm in young people never come to the attention of care services (Hawton et al., 2002) and it is also likely that many parents are unaware of the problem (Meltzer et al., 2002). Although clearly a manifestation of distress, self harm in young people is often a marker for the presence of other problems that might have an important bearing on outcome, such as substance misuse, poor school attendance, low academic achievement and unprotected sex (Kerfoot, 1998; King et al., 2001). Other issues relevant for young people include bullying, domestic violence, victimisation and child sexual and physical abuse.

Older People:

Although it appears that older people are less likely to self harm, the consequences are often more serious. It has been estimated that of every five older people who self harm, one will later die by suicide (Lawrence et al., 2000; McIntosh, 1992). Consistent with this, older people who have self harmed score highly on scales that measure suicidal intent (Merrill and Owens, 1990) and their profile resembles that of older people who die by suicide (Dennis and Lindsay, 1995). In particular, older people who self harm have high rates of physical ill health, social isolation and depression (Draper, 1996; Merrill and Owens, 1990; Pierce, 1977). Those with persistent depression are at particular risk of repetition of self harm or suicide (Hepple and Quinton, 1997)

People with a Learning Disability:

For those working with people with a learning disability, the term self harm usually refers to “self injurious behaviour” (SIB) which includes “head banging” and “nail biting”. The prevalence of SIB varies between 17% and 24% and is more common in women and girls, those with very low IQ, with communication difficulties and with certain genetic disorders (Deb, 1998; Deb et al., 2001). The management of SIB in people with a learning disability is outside the scope of this booklet.

Self Harm & Suicide

'Self Harm to Live / Suicide to Die'

"If I hadn't been injuring myself I would have topped myself".
(Angela from Visible Memories).

The evidence is that people who self-harm are at much greater risk of suicide than the general population (50 –100 times greater). It has been estimated that one-quarter of all people who die by suicide would have attended a general hospital following an act of self-harm in the previous year. However, this fact sometimes leads staff to interpret **all** acts of self-harm as a suicide attempt. The **National Self-Harm Network** has addressed this issue in some of their literature thus:

Is self-injury attempted suicide?

No, self-injury and suicide have an intimate relationship, but are different. Each individual has their own motivations and mix of self-injuring and suicidal feelings.

- Self-injury often represents the prevention of a suicidal period
- Self-injury is one way of averting suicide
- Self-injury may be a survival strategy
- Self-injury is frequently the least possible amount of damage and represents extreme self-restraint

The **NICE Self-Harm Guideline** recognises this point;

"Paradoxically, the purpose of some acts of self-harm is to preserve life. Professionals sometimes find this a difficult concept to understand".

(NICE Self Harm Guidelines, 2004)

. . . people who harm themselves as a way of relieving distress (through cutting, for example) might be compelled to do this as a coping and suicide prevention strategy. They are likely to continue to need to do this until they receive appropriate and sufficient psychotherapeutic interventions and support.

(NICE Self Harm Guidelines, 2004)



The Functions of Self – Injury for the Individual

Babiker and Arnold (1997, pp 73-85) identify the following functions:

1. Functions Concerned with Coping and Surviving

- **The Regulation of Distress and Anxiety** – For some people when feelings become intolerable, self-injury can serve a self-soothing or tension-reducing function. For some people, the **role of bleeding** is central in reducing distress and tension.
- **Dealing with Anger** – Many people who self-injure say this is the means by which they deal with what feels like intolerable anger. Many people are hard on themselves and turn their anger onto what they perceive to be their inadequacies or shortcomings. For people who self-injure, hurting themselves can serve as both a punishment for those “shortcomings” and a manifestation of this intense anger at the self.
- **Distraction** - Focussing the pain to make it manageable – another way in which self-injury seems to help people cope with unbearable feelings is avoidance. The injury takes the person’s attention away from their distress and anxiety onto something that feels more manageable. Physical pain may be very important in enabling the person to escape for a while from their emotional pain.

2. Functions Concerned with the Self

- **Increasing One's Sense of Autonomy and Control** – For many people, self-injury provides a sense of having control over something and being in charge of one’s own life. This is often the case in situations when control is taken from people, for example if they are in prison or hospital, or subject to abuse. The pain of self-injury may be an important part in the process of feeling in control, and perhaps proud of one’s autonomy and strength. Related to this function is a sense of a boundary being crossed, a risk taken, or a taboo broken.
- **Feeling Reality** – Sometimes people do not feel they are fully in the moment, actually living through their experiences. This phenomenon, in extremes referred to as dissociation or depersonalisation, may be experienced as feeling numb in the body, being not quite “there”, losing time or feeling dead or as though one is in a dream. This may originate as a protective function, but itself can be very distressing and scary. Self-injury can shock the system into a sharp return to reality and end these episodes of absence from full experience.
- **An Opportunity to Self-Nurture** – The period following self-injury may, for some people, provide their only opportunity to experience physical caring and comfort. The person feels they now “deserve” some special caring. It may be that some peoples’ experience of life is that, in the past, the only times they remember being physically cared for and “made a fuss of” is after they physically hurt themselves or were ill.

3. Functions Concerned with Dealing with One’s Experience

- **Demonstration or Expression to Oneself of Ones’ Experience** – For many people who self-injure horrible past experiences may have been minimised or ignored. Self-injury may act as a form of testimony; a way of honouring their experience. The injuries may provide evidence of their courage, endurance and/or suffering.
- **Re-enactment** – For some people, self-injury provides a replication of the circumstances of an abusive situation; the emotions, the fear and familiarity.
- **Self-punishment** – For some people who, as children, were made to feel bad, evil or contaminated, self-injury is a means of responding to these feelings. The person sees themselves as a bad or worthless person who “deserves” the injury and pain. The self-injury may function as punishment or atonement. Following the punishment the person feels absolved of the guilt and able to forgive themselves.

- **Cleansing and Excising** – Some people feel they rid themselves of “dirt”, “badness” or “contamination” and the associated feelings when they self-injure. For some people, the self-injury helps rid the person of some aspect of the abuser they feel has been left inside them.
- **Punishing the Abuser** – Some people, in moments of anger lash out at an abuser by punishing their own bodies.
- **Dealing with Confusion About Sexual Feelings** – For some people with a history of sexual trauma, sexual arousal may be confusing and may have become associated with distress, longing or pain. The effect of self-injury can be to deal with these feelings in an immediate physical way, which is seen as preferable to sexual release.

5. Functions Concerning Relationships with Others

- **Communication** – Self-injury may serve as an attempt to communicate with others. The individual feels unable to voice directly what they wish to communicate or that they are not being heard. Self-injury sends out a strong signal that something is wrong. A person may feel that speech is simply not powerful enough to convey the extreme emotions they are feeling.

Alexithymia is a clinical term coined by Peter Sifneos which describes people who appear to have limited abilities in the understanding, processing or describing their emotions (Bermond et al 2006). An increased level of Alexithymia, literally “a lack of words for emotions” and dissociative symptoms has been associated with some people who self-injure. Alexithymia does not equate to a deficiency of emotions, rather it means a disengagement from emotions and a difficulty in expressing those emotions through words.

- **Punishing Others** – Sometimes self-injury is carried out with the intention of upsetting others with whom the person feels angry. The message may be “It’s your fault”, or “You’ve let me down”.
- **Influencing Others’ Behaviour** – Self-injury may be a means of trying to influence one’s situation or others’ behaviour. The person may try to influence others to be nice to them or do things for them. Self-injury may be a way of seeking nurture from others. This behaviour sometimes leads to people being described as “manipulative” or “attention seeking”.

Self-injury may be a way of pushing people away, or trying to protect oneself, or discourage abuse. Self-injury may be an attempt to protect the body from unwanted sexual attention or molestation by making it “ugly” or “dangerous”.

Why Do People Self Harm?

When thinking about the motivations and meanings of self-injury Jan Sutton (2005, pp 137-150) describes **The eight Cs of Self-Injury**. These are:

Coping and crisis intervention – self-injury enables people to continue functioning when they feel psychologically threatened. Moreover, it serves as a suicide prevention strategy.

Calming and comforting – self-injury provides rapid relief from a build up of tension stress, anxiety depression and panic; it soothes emotional pain, and brings about a sense of calm and well-being.

Control - self-injury gives a sense of control, and sometimes a feeling of strength and empowerment. It provides control over a range of feelings and emotions, control over suicidal thoughts, control over flashbacks, control over the level of pain inflicted.

Cleansing – self-injury can be a symbolic attempt to cleanse one’s body from the pollution of abuse, to rid oneself of feelings of guilt and shame, or to literally “cut out” one’s abuser.

Confirmation of existence – self-injury ends episodes of depersonalisation and numbness – it “kick starts” the person back to “aliveness”. It provides proof that the person is alive and real and that one is capable of feeling something – even if it is pain. Seeing one’s own blood confirms one’s existence.

Creating comfortable numbness – self-injury may create a comfortable sense of numbness where one can escape psychological pain or escape reality.

Chastisement – for some people who feel they are bad and experience self-hate, self-injury can function as a form of self-punishment.

Communication – self-injury is a form of non-verbal communication, communicating to others what one is unable to communicate in words, or feelings and emotions that are beyond words.

Other considerations of motivations and meanings:

Observational:

Alderman (1997) suggests that occasionally, self-injury develops through observational learning i.e. learning how to perform a behaviour by watching someone else do it. She suggests that observed behaviour that is rewarded or that appears to be rewarding is more likely to be imitated than behaviour that is punished or has negative consequences. It is argued that people who engage in self-injury in institutional settings will receive secondary gains – benefits such as special treatment or attention.

Physiological Aspects of Self Injury

Alderman (1997 p15-16) explains that:

“Your body, including your particular genetics and the chemicals” in your body, affects your feelings, thoughts, physical sensations, and even your behaviour. Neurotransmitters, including endorphins, are chemicals that carry information through your brain and help you think, feel and act. Endorphins are natural opiates and are involved with helping you feel pleasure and control the sensation of pain. When your brain releases endorphins you generally feel a pleasurable sensation, similar to that produced by morphine, heroin, opium and codeine. Endorphins also protect you from experiencing pain. When you injure yourself, your brain is sent a signal that tells it to release endorphins so that you don’t feel much pain. Many people who engage in self-injury indicate that they feel little, if any, physical pain from their self-injuries. One theory is that some people engage in self-injury because their endorphins aren’t functioning properly – their endorphin level is too low and they use self-injury to generate additional endorphins. A second theory related to this is that people may become addicted to endorphins. It has been suggested that some people become so addicted to endorphins that they purposefully injure themselves in order to produce these chemicals.

Dissociation and Self Harm

(See p14; Dissociative Cycle)

Dissociation is a defense mechanism helping people to survive traumatic experiences. In this state certain thoughts, emotions, sensations, and/or memories are compartmentalized because they are too overwhelming for the conscious mind to integrate. There are studies showing that a history of trauma is almost universal for people who have moderate to severe dissociative symptoms. Usually, this is abuse in childhood. But some people may develop Post Traumatic Stress Disorder or more rarely dissociative amnesia or fugue, after a traumatic or extremely stressful experience in adulthood. Children generally have a greater natural ability to dissociate.

Research by Sutton (2005 p.127) re-enforces the view that that dissociative symptoms (trance-states, depersonalization and de-realization) play a significant part in motivating self-injury. Her study found that 56% of people reported being in a dissociative state prior to their most recent episode of self-injury.

Self-Injury: The Dissociative Cycle

(Source: Jan Sutton www.siari.org.uk)

Person experiences intense emotional pain

URGE TO SELF-INJURE (PERSON MAY EXPERIENCE CONFLICTING THOUGHTS)

Person may talk themselves through all the reasons why he/she shouldn't do it.



EMOTIONAL PAIN BECOMES UNBEARABLE – LIKENED TO:

A time bomb ticking away inside. Screaming inside.



URGE TO SELF-INJURE INCREASES

"The urge always wins—it's like I have stopped fighting against myself."



MENTAL DISSOCIATION (PREPARATION PHASE)

Likened to a form of spontaneous self-hypnosis — mind and body split — produces a feeling of numbness, depersonalization (feeling alienated from self), or derealization (feeling unreal/dead inside).

"It's as if I am looking in on myself. I know it's me but I feel detached from myself."



BEHAVIOURAL DISSOCIATION (ACTION PHASE)

Person self-injures (e.g., cutting or burning).

Person experiences no pain or the pain is minimal.

"I never feel the physical pain of cutting myself."



PERSON CEASES SELF-INJURING (TERMINATION PHASE)

"When I begin to feel faint that's my signal to stop."

"It makes me feel light-headed and I start shaking."

I have to stop and lay down for a while."



CONSEQUENCES

Person feels better (albeit temporarily).

May sleep deeply afterwards (which is a rare occurrence for many self-injurers).

"I needed to see physical evidence of my emotional pain."



DISSOCIATION DECREASES (PHYSICAL PAIN EXPERIENCED)

Reality of person's actions sink in.

"I feel very ashamed and it reinforces my self-hate."



PRESSURE STARTS TO BUILD AGAIN... THE CYCLE CONTINUES...

Recovery involves addressing the underlying emotional pain/traumatic experiences that triggered the need to self-injure and dissociate.

The Cycle of Self Injury

(Jan Sutton 2005)

Point A: Mental anguish

The individual may be plagued by intrusive or unacceptable thoughts, images, flashbacks, nightmares, or body memories of traumatic events; or burdened by negative self-beliefs, for example, "I'm bad, evil worthless, a waste of space, everything is my fault, I don't deserve." Trapped inside, the mental anguish begins to cause internal chaos.

A "fire" starts smouldering.



Point B: Emotional engulfment

The smouldering fire sparks powerful feelings and emotions, which trigger off "a raging inferno inside". These powerful feelings and emotions also remain trapped inside. The individual starts to feel frightened, desperate, about to explode, or dissociated (uncomfortable numb / feels nothing).



Point C: Panic stations

The raging inferno gathers momentum. The individual feels out of control, or too numb (detached, distant, disconnected), and experiences a compelling urge to self-injure.



Point D: Action stations

The individual self-injures, which extinguishes the raging inferno inside, or alleviates the feelings of alienation.

The act may be carried out in a state of:

- Awareness (the individual feels the pain).
- Partial awareness (the individual feels some pain).
- Non-awareness (the individual feels minimal or no pain (a dissociative state)).

The act may be motivated by:

- A need to release tension or anxiety.
- A need to communicate acute emotional distress (to self/others).
- A need to feel pain (self-punish).
- A need to escape from emotional pain (enter a dissociated state).
- A need to end a dissociated state (feeling disconnected from oneself; feeling numb, empty or dead inside; or experiencing oneself or one's surroundings as unreal).
- A need to exert a sense of control over one's body.
- A need to ward off suicidal thoughts.

Note: this list is by no means exhaustive



Point E: Feel better/different

With the raging inferno under control, the individual temporarily experiences:

- Relief from tension, anxiety, and pent-up emotions such as fear, anger, or frustration.
- A feeling of euphoria, numbness or detachment (dissociation).
- A sense of feeling more alive, more real, more grounded in reality – or, if the function was self-punishment – a degree of satisfaction.

Generally, the individual feels calmer, more in control, "comfortably numb" and can think more clearly. In other words, the shock from the self-injury appears to reduce the individual's level of emotional and physiological arousal to a tolerable level, and the internal chaos is temporarily soothed. Thus, the physical injuries may seem a small price to pay to escape from the "raging inferno inside". Furthermore, following an episode of self-injury, some individuals report sleeping soundly – this seems to be a rare occurrence for many.



Point F: The Grief reaction

The reality of the individual's actions starts to sink in. Shame, guilt, self-disgust or self-hate may rekindle the smouldering embers. Because the underlying issues (the internal chaos) remain locked up inside and unresolved, the cycle continues unless change is affected at point A.



Self Harm - What Treatments Works?

According to the NICE Guidelines (2004 pages 177-8):

The overriding conclusion from this review is that the evidence base for the treatments of self-harm is extremely limited. Most studies are small and tend to recruit fairly specific groups, making generalisation problematic. Moreover, as a group, people who self-harm are highly heterogeneous, and what works for one subgroup may be useless for another. With this important caveat in mind, the evidence, such as it is, can be summarised as follows.

There is limited evidence that:

- An intensive intervention plus outreach compared with standard aftercare reduces hospitalisation 12 months after treatment, and reduces hopelessness;
- Dialectical behaviour therapy compared with standard aftercare reduces repetition in people with borderline personality disorder [BPD* for Definition see Appendix 3]. Note Study limitations: numbers were small and this applied only to people who repeatedly self-harm
- Depot flupenthixol (intramuscular injection) compared with placebo reduces repetition rates in people who self-harm repeatedly. However, the absence of data on side-effects is an important omission.

For adolescents there is strong evidence suggesting that there is a clinically significant difference favouring group therapy over standard aftercare on reducing the likelihood of repetition, although the numbers were small.

The evidence reviewed here suggests that there are surprisingly few specific interventions for people who have self-harmed that have any positive effect. The Guideline Development Group came to the conclusion that, at the present time, there was insufficient evidence to support any recommendation for interventions specifically designed for people who self-harm. While there may be some evidence for the treatment of subgroups of service users, such as those diagnosed with borderline personality disorders, these studies were too small to make recommendations. However, the positive outcome for adolescents who have repeatedly self-harmed receiving group therapy is encouraging; although, because of the rather selective group this was applied to, this approach is in need of further investigation.

Moreover, the Guideline Development Group came to the conclusion that referral for further treatment after an act of self-harm should be determined by the overall needs of the service user, rather than the fact that they have self-harmed per se. This draws attention to the reliance on repetition as the primary outcome measure in many studies whereas outcomes relevant to service users such as depression status or quality of life may be more relevant.

Self Harm - What Helps?

(Source: Arnold 1995)

Unhelpful Responses:

Condemnatory, dismissive and punitive attitudes - Labelling people as attention seeking, wasting staff time, a nuisance, being refused treatment, being made to wait for treatment.

Ignorance and misunderstanding - Lack of knowledge in staff, crude and simplistic models of why people self-injure and what will help them stop.

Failure to listen or to address underlying issues - No opportunity to talk about feelings and problems and issues underlying the self-injury.

Inappropriate or inadequate treatment - Inappropriate treatment has the effect of making people feel worse, more “mad” and less able to be responsible for themselves. Medication and ECT does not seem to help. Talking therapies not often offered, or, if offered, too brief and superficial. Crude “behavioural” approaches such as ignoring people or threatening to withdraw help make it impossible to work usefully with staff. Such approaches fail to deal with practical problems such as housing, benefits and bullying.

Being subject to excessive or abusive power or control - Use of Mental Health Act and close observation often seem to be counter-productive. Also lack of privacy, dignity and respect in services.

Helpful Responses:

Sympathetic and supportive responses - Taking time to listen to someone, being non-judgemental, offering practical help.

Effective and appropriate treatment and support - Talking treatments with a supportive person about feelings and situations. Even one-off or short-term experiences of being listened to. Creative therapies. Help with practical problems. Crisis support.

Changes in life circumstances – for example getting away from an abusive relationship or ending bad relationships, getting better accommodation or starting a job or college course which improves one’s self-esteem.

Support – the support of friends and partners; having people who cared, accepted and valued them.

Self-expression and other strategies for avoiding self-injury – having non or less-harmful outlets for expressing feelings and emotions, e.g. writing, painting, sculpture, screaming, shouting, hitting something, driving, walking, relaxation.

Self-esteem and personal development – increase in self-esteem, belief in oneself and assertiveness, support and inspiration from friends, books, courses and counsellors.

Support Needs, Helpful Responses

After reviewing all the literature (particularly that from service users and the voluntary sector) the **NICE Guidelines** was able to highlight the most helpful responses for people who self-harm.

Positive staff attitudes

Service users’ experiences of services are much more positive when they encounter staff with non-judgemental attitudes who try to understand self-harm behaviour. For example, the focus group respondents reported that their experiences were greatly improved when healthcare professionals showed them respect and were calm, reassuring and considerate.

Being listened to and given time

Service users also point out the importance of being listened to by staff, even when the interaction is brief or only a single occasion. They also stress the importance of staff paying attention to, or talking about, the particular self-harm episode or suicide attempt, or about the service user's mental state. The focus group respondents said that simply being listened to was important, although in their experience many staff did not listen and appeared to ask questions only to protect themselves in case the service user went on to die by suicide.

Providing a safe environment

The importance of a safe environment is also highlighted: for example, those who had been admitted to a ward after an overdose, appreciated friendly non-judgemental staff and the chance to rest and think things through with pressures removed.

A safe environment and being listened to is especially important since service users may reveal information about their injuries that makes them feel vulnerable, fearing negative repercussions. This was highlighted by the focus group respondents, who reported feeling unable to be honest about the cause of their injury for fear of a staff member's reaction.

Being involved in treatment decisions

Focus group respondents reported being coerced into having treatment despite having full capacity to make informed decisions. They were critical of staff not respecting their right to be informed about treatment.

Focus group respondents reported that they want to be involved in discussions regarding treatment – for example, the method of suturing used – and reported more positive experiences of wound care when staff had involved them in decision-making. Those who were able to care for their own wounds appreciated being prescribed skin closure strips by their GP. Some reported that a lack of control surrounding their treatment and care resulted in their feeling anxious, panicked and more likely to injure themselves again.

Carer support

Focus group respondents who wanted to be accompanied while waiting for treatment and during treatment by a friend, relative or advocate reported negative reactions from staff to their request.

Staff knowledge of self-harm

Respondents find that staffs' lack of knowledge about self-harm can lead to their failing to listen to service users or address underlying issues. This can then lead to inappropriate or inadequate treatment. This was supported by focus respondents who also reported frequently encountering staff who presumed they had made a suicide attempt, when they had not. These service users felt that staff lacked knowledge and training about self-harm.

The research that is available about staff attitudes confirms the negative and often punitive attitudes of National Health Staff staff towards people who self-harm, and suggests that there are some fundamental emotional difficulties for staff when faced with such people.

"I want people to make informed opinions about me, not snap opinions based on misconceptions. I don't want to be treated with kid gloves either. I want to be accepted like anyone else and treated accordingly".
(Angela, from Visible Memories)

Helpful Responses to Self Injury

The **Bristol Crisis Service for Women** suggest the following helpful responses:

- Show that you see and care about the person in pain **behind** the self-injury
- Show concern for the injuries themselves. Whatever “front” they may put on, a person who has injured herself is usually deeply distressed, ashamed, frightened and vulnerable. It is cruel and counter-productive to “withhold attention”. You have an opportunity to offer compassion and respect; to show them something different from the way they have been treated by most people in their lives.
- Make it clear that self-injury is okay to talk about, and can be understood.
- Convey your respect for the person’s efforts to survive, even though this involves hurting herself.
- Help her make sense of her self-injury. For example: ask when the self-injury started, and what was happening then. Explore how self-injury has helped the person to survive (physically and emotionally), in the past and now. Ask how she feels before she hurts herself, and how she feels afterwards. Retrace with her the steps leading up to an incident of self-injury - the events, thoughts and feelings which led to it.
- Acknowledge how frightening it may be to think of living without self-injury.
- Encourage the person to use the urge to self-injure as signals of buried feelings, memories, needs. (These will be unfamiliar and frightening; go slowly and offer support.) Help her learn to express these in other ways, e.g. talking, writing, drawing, hitting something. Encourage her to ask for support and to care for herself.
- Help the person to break down isolation and shame and to build up support networks. (e.g. groups.)
- Don’t see stopping self-injury as the most important goal. A person may make great progress in many ways and still need self-injury as a coping method for some time. Self-injury may also worsen for a while when previously buried issues or feelings are being explored, or when old patterns and ways of living are being changed. This can be frightening but is understandable.
- It takes a long time for a person to be ready to give up self-injury. Encourage her and yourself by acknowledging each small step as a major achievement. Examples of very valuable steps might be: taking fewer risks (e.g. avoiding drinking if she thinks she is likely to self-injure); taking better care of the injuries; putting off hurting herself for a day or an hour; reducing the severity or frequency of the injuries even a little. In all cases, more choice is being exercised the “hold” of self-injury is being loosened.

Harm Minimisation

***“Most psychiatrists just want you to stop – but that’s unrealistic, it’s your coping mechanism and it’s been your coping mechanism for years”
(Clara – from Visible Memories).***

Both people who self-harm and services provided to them have recognised that harm minimisation rather than abstinence may be a more realistic and pragmatic aim for many people.

Experience has shown that self-harm is virtually impossible to extinguish through nursing observation or other interventions. It continues, albeit in secret, and therapeutic alliances are broken as individuals and staff struggle to determine who has control. The unit has developed an approach which whilst not condoning self-harm, tolerates it as a current means of coping whilst seeking for alternatives.

Two therapeutic strategies are central to this process:

- 1. Retention of responsibility:** In order for individuals to make the choice between further acts of self harm or developing alternatives, this choice needs to remain open to them, within limits
- 2. Therapeutic risk taking:** Staff and patients together contain the anxieties, which can result from self harm, through the process of sharing the risk taking between the resident and the staff team as a whole and negotiating behaviour within certain boundaries and limits.

(Source: Crisis Recovery Unit - Bethlem Hospital, London. www.slam.nhs.uk)

The NICE Guideline reflects these views.

“In attempting to prevent a person from hurting him- or herself, rather than looking at the underlying causes of such behaviour, or indeed the function such behaviour serves a particular individual, services can inadvertently either exacerbate the behaviour or ‘drive it underground’. Good practice guidelines developed by users recommend that stopping self-harm should not be a goal of treatment, nor should treatment or care be withheld as a condition of stopping self-harm”

And;

“As with any other treatment, the overarching aims are to reduce harm and improve survival while minimising the harm that may result from the treatment. The key aims and objectives in the treatment of self-harm should, therefore, include:

- *Effective engagement of service user (and carers where appropriate)*
- *Effective measures to minimise pain and discomfort.*

(NICE Guidelines, 2004).

What Can Family And Friends Do to Help?

Adapted from:

'Adolescent Self- Harm: An exploration of the nature & prevalence in Banyule / Nillumbik, Australia. (2004) p 54-56.

If you are a friend, parent, sibling, family member, teacher or a concerned other, it can be difficult to know how to help the individual in your life who is self harming.

What You May Feel

Upon learning that someone you care about self harms, it is typical to experience a range of conflicting emotions and feelings, i.e. shock, concern, denial, anger, frustration, empathy, sadness, guilt, confusion, vulnerability, curiosity, distress, anxiety, pain, powerlessness, protectiveness, sympathy. It is important to remember that the individual who self harms also experiences this mixed bag of emotions (Alderman, 1997; Anthony et al., 1997).

What You May Think

- It's all my fault
- I can fix this
- You're nuts
- This changes our whole relationship
- You're not who I thought you were
- You're doing this to manipulate me

These are some common thoughts that are associated with the knowledge that someone you care about is self harming. It is important that you are aware about your thoughts as they ultimately affect your feelings and how you relate with the person who is self harming (Alderman, 1997).

- *Don't panic.*
- *Talk about the self-harm:* it will not go away because you pretend it doesn't exist. Not talking about self-harm just reinforces the shame and secrecy associated with it.
- *Be honest about your thoughts and feelings;* many individuals who self-harm have trouble expressing their thoughts and feelings, so don't bottle yours up. Model the correct ways to express your feelings and emotions. Don't be afraid to laugh if it is appropriate.
- *Deal with the immediate medical concerns;* it is most helpful if wounds are addressed to in a calm and practical manner with minimal fuss.
- *Listen and find out what they need;* ask what they need but don't interrogate them. Acknowledge their pain without being intrusive.
- *Never make assumptions;* do not assume that they want to talk about it, or that it is attention seeking or suicidal in its nature. Some people who self harm have had bad experiences with medical or mental health professionals, so don't assume that's what they need.

- *Be available – within limits*; some people who self harm have difficulty with maintaining boundaries in interpersonal relationships. So, it is important to set clear and consistent guidelines, for example: if you cannot take crisis calls after 10pm, let them know.
- *Don't discourage self-harm*; telling someone not to harm themselves is both aversive and condescending. Most individuals who self harm would give it up if they could. It is a coping mechanism that they use to stay alive. Even casual comments encouraging your friend or relative to stop should be avoided because they run the risk of damaging your relationship and form a barrier to effective communication.
- *Understand the severity of their distress*; the fact that your friend or relative has chose physical pain over emotional pain indicates that they are experiencing intense inner turmoil. Provide a safe and open environment in which they can freely discuss their thoughts and feelings.
- *See the person, not the injuries*; self harm is merely a symptom of deeper underlying issues.
- *Get help with your own reactions*: the behaviours of others can have a profound effect on you, so it is important to take care of yourself emotionally, mentally and physically. It often helps to talk to a professional to get further information about self harm. Also it is useful to talk about your relationship with the person and discuss what thoughts and feelings their self harm raises for you.

What Not To Do

- Don't think you can stop them if they don't want to
- Don't tell other people without their consent
- Don't feel responsible
- Don't punish them
- Don't try to make them feel guilty



Self Harm Awareness – Support for Staff

Babiker and Arnold (1997) suggest some of the things that ought to be in place to provide support for staff working with people who self injure.

Training

To include:

- Information about self-injury.
- Attitudes and feelings about self-injury.
- Why people self-injure.
- Responding to people who self-injure.
- Agency policy and guidelines on self-injury.
- Resources.

Policies and Procedures

Such a policy might cover issues such as:

- The organisation's understanding and philosophy on self-injury.
- Its roles and responsibilities in respect of self-injury.
- Rules about admission by people who self-injure.
- Confidentiality.
- Responding to injuries and self-disclosure.
- Safety – including health and safety implications, access to first aid equipment, harm reduction techniques.
- Interventions.
- Training, information, supervision and support available to staff.
- Recording and reporting requirements.

Support

- Contact with other workers (especially important for lone workers and small staff teams).
- Offloading – opportunities to let off steam and talk about the issues raised by working with people who self-injure.
- Team working – multi-agency working with colleagues can benefit workers by helping to share ideas and approaches and provide support for each other.
- Supervision (not clinical) - time should be provided by a line-manager or other person (sometimes this is preferable) to allow workers to reflect on their work and their own feelings and responses to working with people who self-injure.
- Regular staff/team meetings – which give workers the opportunities to discuss ideas and issues. It can be helpful for such meetings to be facilitated, either formally or informally.
- Peer support groups - a variation on the previous idea this time based on people who share an interest/involvement in working with people who self-injure. They may be from a range of different teams or agencies.

Key Priorities for Implementation**Respect Understanding and Choice**

- People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm.

Staff Training

- Clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed.

Activated Charcoal

- Ambulance and emergency department services whose staff may be involved in the care of people who have self-harmed by poisoning should ensure that activated charcoal is immediately available to staff at all times.

Triage

- All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm. Assessment should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness.
- Consideration should be given to introducing the Australian Mental Health Triage Scale, as it is a comprehensive assessment scale that provides an effective process for rating clinical urgency so that patients are seen in a timely manner.
- If a person who has self-harmed has to wait for treatment, he or she should be offered an environment that is safe, supportive and minimises any distress. For many patients, this may be a separate, quiet room with supervision and regular contact with a named member of staff to ensure safety.

Treatment

- People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment.
- Adequate anaesthesia and/or analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments.
- Staff should provide full information about the treatment options, and make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent before any and each procedure (for example, taking the person to hospital by ambulance) or treatment is initiated.

Assessment of needs

- All people who have self-harmed should be offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment.

Assessment of Risk

- All people who have self-harmed should be assessed for risk: this assessment should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and the identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.

Psychological, psychosocial and pharmacological interventions

- Following psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment, including an assessment of risk, and should not be determined solely on the basis of having self-harmed.

Nearly all of the key recommendations in the guideline are at Good Practice Principles level, largely based on the expertise of the members of the group, particularly patients and carers. Also, the guideline recommended more research and made major recommendations about the on-going role of service users in the planning and commissioning of services, and in the future training of staff.



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Self Harm Information / Resources

Publications:

General:

- **Reach Out: National Strategy for Action on Suicide Prevention 2005-2014 (2005).** *Health Service Executive, National Suicide Review Group and Dept. of Health and Children.* A national strategy for action on suicide prevention which has been shaped by an extensive consultation process with all the key stake holders across the country. An underlying principle is that of shared responsibility. This document will inform suicide prevention initiatives for the next 10 years.
www.doh.ie/publications/reachout.htm
- **Suicide in Ireland; a National Study (2001) Departments of Public Health on behalf of the Chief Executive Officers of the Health Boards.** A large scale study of the factors associated with suicide in Ireland. Factors reported on include age, gender, marital status, employment status, contact with the health services and history of self-harm.
www.nosp.ie/publications
- **Supporting Life: Suicide Prevention for Mental Healthcare Service Users (2005).** *Schizophrenia Ireland*
The second discussion paper from this organisation, which aims to generate discussion around at-risk groups and suggest ways to assist in reducing their risk.
- **National Inquiry into Self-Harm among Young People: 'Truth Hurts'**
The national inquiry into self-harm is the UK's first major investigation into self-harm. It aims to collate information into self-harm and can provide information on additional support for those who self-harm, their family, friends and those who work with them.
Address: Camelot Foundation, University House, 13 Lower Grosvenor Place, London SW1W OEX
Tel: [020 7828 6085](tel:02078286085) Website: www.selfharmUK.org

Schools:

- **Health Promotion Guidelines for Health Professionals Visiting Schools (2003).** *Western Health Board*
Guidelines which aim to provide supportive information, advice and guidance on effective health promotion to health professionals who work with schools.
- **Suicide Awareness; An Information Pack for Post Primary Schools (2003).** *South Eastern Health Board.*
A practical resource for teachers which provides guidance regarding how to respond to students experiencing suicidal feelings, thoughts and behaviour. It follows the familiar three tiered approach of prevention, intervention and Postvention.
- **Mental Health Matters; A Mental Health Resource Pack (2001)** *Mental Health Ireland.* A resource pack for students engaging in the Transition Year programme in schools. Aims to promote personal, social, educational and vocational development. Materials include six modular-based units, which are supported by a video. Available from Mental Health Ireland
- **A Student Dies, A School Responds (2001).** *Mid Western Health Board.* A guide for post primary schools. Aims to enhance the capacity of schools to reduce the threat of suicide and provide an effective response in

the wake of a sudden traumatic death. The main sections include managing the immediate crisis, promoting emotional wellbeing in students, and maintaining good practice. The appendices include practical information and resources.

- ***Suicide Prevention in Schools; Best Practice Guidelines (2002). Irish Association of Suicidology.*** Provides an overview of suicide in Ireland along with guidelines for prevention, intervention and postvention in the school setting. It also provides a list of resources for schools including bereavement support groups and voluntary organisations. Common myths about suicide, points to consider when informing students of a death by suicide, and a list of common student reactions and recommended staff responses are also included. The guidelines are available from the IAS at a cost of €10.

Youth:

- ***Suicide Prevention: A Resource Handbook for Youth Organisations (2003). National Youth Federation, National Suicide Review Group and South Eastern Health Board.***

A comprehensive publication which provides information on suicide and parasuicide trends among adolescents, and on the multi factorial causes of suicide. The role of the youth worker is examined with regard to general prevention, crisis response and post suicide intervention strategies. The document also contains a list of services and resources available to youth organisations.

- ***The Youth Wise Guide (2002). Mid Western Health Board.*** Two publications have been produced under this heading. They are

1 *The Youth Wise Guide: Promoting Emotional Health in Youth People* – contains simple, practical advice and information for parents regarding the promotion of emotional health in young people. The reverse side contains a comprehensive list of services and resources for parents who require further advice and support.

2 *Youth Wise Guide: A Companion Pocket Book* – a smaller version of the main document which can easily be carried around by a parent to consult whenever he or she wishes.

- ***Good Habits of Mind (2005)*** – A mental health promotion initiative for those working with young people in out of school settings. Along with an exploration of the determinants of the health of young people, this resource documents good practice guidelines for organisations and workers who provide services for out of school youths. (www.youthhealth.ie)

Journals:

- ***Crisis: The Journal of Crisis Intervention and Suicide Prevention***

Editors in Chief: Ad Kerkhof and John F. Connolly

Published under the auspices of the International Association for Suicide Prevention

Publishes articles on crisis intervention and Suicidology from around the world.

- ***Suicide and Life – Threatening Behaviour***

Editor in Chief: Morton M. Silverman

Official Journal of American Association of Suicidology

Devoted to emergent theoretical, clinical and public health approaches related to violent, self destructive and life threatening behaviours. Multidisciplinary.

Websites:

www.nosp.ie	National Office for Suicide Prevention
www.doh.ie	Department of Health and Children
www.nsrp.ie	National Suicide Research Foundation
www.ias.ie	Irish Association of Suicidology
www.samaritans.org	Samaritans, UK and Ireland
www.mentalhealthireland.ie	Mental Health Ireland
www.console.ie	Console - Suicide Bereavement Support
www.aware.ie	Aware - Defeat Depression
www.barnardos.ie	Barnardos - Childrens Society
www.youthworkireland.ie	Youth Work Ireland
www.grow.ie	Grow - Mental Health
www.bodywhys.ie	Bodywhys - Eating Disorders Association of Ireland
www.ncb.org.uk/projects/selfharm	National Childrens Bureau
www.nshn.co.uk	National Self Harm Network
www.siari.co.uk	Self Injury and Related Issues
www.users.zetnet.co.uk/bcsw	Bristol Crisis Service for Women
www.basementproject.co.uk	The Basement Project - Training & Support Groups
www.mind.org.uk	Mental Health Charity, UK

Key Contacts:

Research and Education:

Irish Association of Suicidology

16 New Antrim Street, Castlebar, Co. Mayo
 Website: www.ias.ie
 Email: drjfc@iol.ie
 Tel: 094 9250858

National Office for Suicide Prevention

Room 2:35 Population Health
 Dr. Steeven's Hospital
 Dublin 8
 Web: www.nosp.ie
 Tel: 01 6352139

National Suicide Research Foundation

1 Perrott Avenue, College Road
 Cork
 Web: www.nsrp.ie
 Email: nsrf@iol.ie
 Tel: 021 4277499

Voluntary Groups:

Aware - Defeat Depression

72, Lower Leeson Street, Dublin 2
 Web: www.aware.ie
 Email: aware@iol.ie
 Tel: 01 6617211

Providing support and assistance to that section of society whose lives are affected by depression.

Barnardos - Childrens Society

Christchurch Square, Dublin 8

Web: www.barnardos.ie

Email: info@barnardos.ie

Tel: 01 4549699

Committed to the best interests of children and young people in Ireland, promoting and respecting their rights.

Console - Suicide Bereavement Support

All Hallows College, Drumcondra, Dublin 9

Tel: (helpline service) 1800 201 890

Tel: 01 8574300

Web: www.console.ie

Email: info@console.ie

Provides support to those bereaved by suicide.

Other Published Literature:

Bodies Under Siege - Self-mutilation and Body Modification in Culture and Psychiatry. (1996) Armando Favazza. ISBN 0-8018-5300-1

The Language of Injury - Comprehending Self-Mutilation. (1997) Gloria Babiker & Lois Arnold. ISBN 1 85433 234 1

Cutting the Risk – Self-harm, Self-care & Risk Reduction (2000) National Self-Harm Network ISBN 0 9534027 1 2

Healing the Hurt Within (2005) Jan Sutton How to Books www.howtobooks.co.uk

The Scarred Soul – Understanding & Ending Self-Inflicted Violence (1997) Tracy Alderman ISBN 157224 079 2

Treating Self-Injury – A Practical guide (2006) Barent W. Walsh ISBN 1-59385-216-9

Modern Primitives – An Investigation of Contemporary Adornment & Ritual (1989) ISBN 0-9650469-3-1

APPENDIX 1

Self Injury Treatment Checklist

About me _____

Name _____

Address _____

Postcode _____

Telephone _____

Date of Birth _____

I last ate at _____

I last drank at _____

I have a crisis card _____

I have been to this hospital before _____

My last tetanus injection was on _____

Known allergies _____

Current medication _____

Other current treatments _____

Other previous treatments _____

Name of GP _____

If possible, please contact the following person:

Name: _____

Telephone _____

My next of kin is _____

Telephone: _____

About my Injury

Cut injuries

I have cut myself Yes No _____

With a blade Yes No _____

With glass Yes No _____

Other _____

Burn injuries

I have burnt myself Yes No _____

With a flame Yes No _____

With a cigarette Yes No _____

Other _____

Overdose

I have overdosed Yes No _____

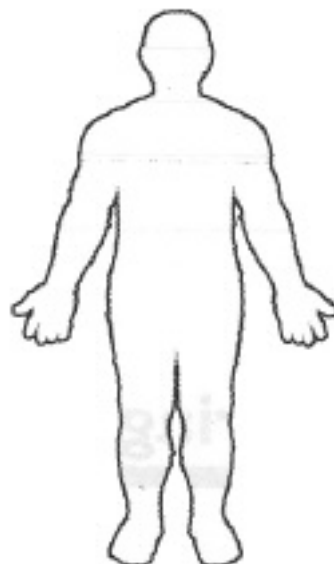
I have vomited since (time) _____

Name of drug _____

Quantity _____

Strength _____

Use this figure and a pen to show where you have injured



Self Injury Treatment Checklist

What you need to know to make my treatment as effective as possible;

- I need you to examine my injury in a private room
- I am distressed
- I need to sit alone
- I need someone to sit with me
- I am happy to sit in the main waiting area
- I need to wait somewhere quiet
- I am happy for students to observe or treat me
- I am able to discuss what has happened
- I prefer to be treated by a female doctor
- I prefer to be treated by a male doctor
- I would like to see a social worker
- I would like to see a psychiatric liaison nurse
- I would like to see a psychiatrist

Any Other Information

**National Self Harm Network, Campaigning for the rights and understanding of people who self harm
NSHN PO Box 16190 London WW**

APPENDIX 2

Self Injury: Myths and Common Sense

Is self injury attempted suicide?

No, self injury and suicide have an intimate relationship, but are different. Each individual has their own motivations and mix of self injuring and suicidal feelings:

- Self injury often represents the prevention of a suicidal period
- Self injury is one way of averting suicide
- Self injury may be a survival strategy
- Self injury is frequently the least possible amount of damage and represents extreme self restraint
- A diminishing sense of worth may culminate in suicide as its ultimate expression. People who self injure are statistically at a greater risk of going on to commit suicide.

Diagnostic Oversights

Accident and emergency staff may assume that the severity of the injury represents the severity of the condition. This leads to some misconceptions:

- If it's not an artery they don't mean it. It's acting out
- Minor injuries are attention seeking and aren't serious
- Serious injuries mean psychosis
- Its masochism

"If it was attention I wanted, I'd take off my clothes and walk into the street"

L.R. Pembroke
(Co-founder, NSHN)

"Whether others see the injury or not, a person who self injures is in extreme distress"

Smith
(Co-founder, NSHN)

APPENDIX 2 continued

Self Injury: Myths and Common Sense

Sound Familiar?	
Current treatment of people who self-injure is based on inaccurate stereotypes	The responses below are based on the real experiences of self - injurers
It's attention seeking	If attention was the motivation for self injury, it's not an efficient way of getting it. There are many easier, less painful and less degrading ways of attracting it.
It's a Borderline Personality Disorder	Self injury is not a diagnosis. What is true for one person is not necessarily true for another. Commonly, self injury is dialogue with yourself – an expression of inexpressible emotion or an absence of self value
They're manipulative	Self harm is a private activity. Accident and emergency departments will see only a few of the injuries before healing; it's not about its effect on others
Self harmers are usually hysterical women under 30 who grow out of it	Recent research shows the difference in rate of self injury between men and women is less marked. There is no evidence to show people “grow out” of it. It is not a behaviour or development “disorder”
It's self inflicted so it's not serious	How severe staff thinks the wound is won't tell them how bad the person feels. You may not witness all the forms of injury. Individuals have many ways of expressing their distress, often substituting one for another. Your perception of the seriousness of the injury may not indicate the extreme distress that injury represents
If you won't see a psychiatrist, you can't want to get better	Psychiatry has had little success in helping individuals who self injure; neither drug nor behavioural treatments can address the issue of self worth.
Either they enjoy pain or they can't feel it	Each person has a different pain threshold. Commonly the loss of sensation some people experience during injuring returns soon after. By the time a person is receiving treatment, it is common for the sense of pain to be amplified
Don't waste your time with her, we've been treating her for years	A long history of injury often results in being considered “a hopeless case” No attempt is made to offer support as it's assumed you're “incurable”
It's tension relieving	Tension is rarely the sole pressure on an individual to injure; each person has their own pressures and triggers to injure

APPENDIX 3

Borderline Personality Disorder

Borderline personality disorder is characterised by a “pervasive pattern of instability of interpersonal relationships, self image and affects and marked impulsivity that begins by early adulthood” (American Psychiatric Association, 1994¹). A person with the disorder often appears to be in a state of crisis, has unstable relationships, suffers from poor self image constantly feels empty and may be inappropriately angry. Seventy-five percent of people diagnosed with the disorder are women. The disorder has been associated with recurrent non-fatal suicidal behaviour, but recent research suggests that completed suicide is a real concern for people with borderline personality disorder (Linehan et al, 2000²). Both the impairment and suicide risk are greatest during the years of early adulthood (American Psychiatric Association, 1994).

For more information, check out BPD Central at www.bpdcentral.com or the National Institute of Mental Health at www.nimh.nih.gov/publicat/bpd.cfm.

¹American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders. 4th Edition. Washington D.C.: American Psychiatric Association.

²Linehan, M.Rizvi, S & Page, B. (2000). Psychiatric Aspects of Suicidal Behaviour: Personality Disorders. In K. Hawton & K. van Heeringen (Eds.) Suicide & Attempted Suicide. Chichester, England: John Wiley and Sons

APPENDIX 4

Mental Health Act 2001

For information and resources on Mental Health Act 2001 check out www.mhcirl.ie or contact info@mhcirl.ie

Mental Disorder (MHA 2001) means:

Mental illness, severe dementia or significant intellectual disability

WHERE

OR

A.

Because of the illness, dementia or disability; there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or other persons

B.

Because of the illness, dementia or disability:
The judgement of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration of his or her condition or would prevent the administration of appropriate treatment and reception, detention and treatment of the person would be likely to benefit or alleviate the condition of that person to a material effect.

Notes

Notes