

*ABC of adolescence***Suicide and deliberate self harm in young people**

Keith Hawton, Anthony James

This is the 10th in a series of 12 articles

Deliberate self harm ranges from behaviours with no suicidal intent (but with the intent to communicate distress or relieve tension) through to suicide. Some 7%-14% of adolescents will self harm at some time in their life, and 20%-45% of older adolescents report having had suicidal thoughts at some time.

Suicide

Suicide occurs relatively rarely under the age of 15 years, although prevalence is likely to be underestimated because of reluctance of coroners to assign this verdict. A large proportion of open verdicts ("undetermined cause") are, in fact, suicides. Suicide rates are far higher in male than female adolescents. Until the past five or six years in England and Wales suicide rates were rising substantially in 15-19 year old and 20-24 year old young men, but then they began to fall somewhat in the older age group. The lack of change in female suicide rates may reflect differential effects of social change on gender roles.

Possible reasons for rise in male suicide rates in United Kingdom

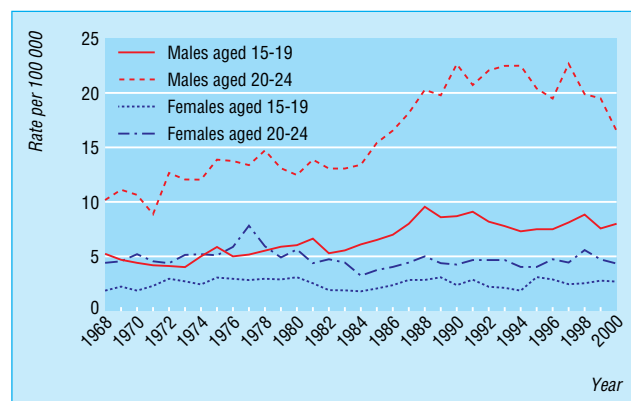
- Increased rates of family breakdown
- Increasing rates of substance misuse
- Increasing rates of depression
- Greater instability of employment
- Increased availability of means for suicide
- Media influences (thought to contribute to 5% of suicides in adolescents)
- Awareness of suicidal behaviour in other young people

Psychological postmortem studies of suicides show that a psychiatric disorder (usually depression, rarely psychosis) is present at the time of death in most adolescents who die by suicide. A history of behavioural disturbance, substance misuse, and family, social, and psychological problems is common. There are strong links between suicide and previous self harm: between a quarter and a half of those committing suicide have previously carried out a non-fatal act.

Deliberate self harm

The term deliberate self harm is preferred to "attempted suicide" or "parasuicide" because the range of motives or reasons for this behaviour includes several non-suicidal intentions. Although adolescents who self harm may claim they want to die, the motivation in many is more to do with an expression of distress and desire for escape from troubling situations. Even when death is the outcome of self harming behaviour, this may not have been intended.

Most self harm in adolescents inflicts little actual harm and does not come to the attention of medical services. Self cutting is involved in many such cases and appears to serve the purpose of reducing tension or of self punishment. By contrast, self poisoning makes up about 90% of cases referred to hospital. The substances involved are usually readily available in the home or can be bought over the counter and include non-opiate analgesics—such as paracetamol and aspirin—and



Suicide and undetermined deaths in England and Wales in 15-19 year olds and 20-24 year olds between 1968 and 2000. Data source: Office for National Statistics. *Twentieth century mortality: 100 years of mortality data in England and Wales by age, sex, year and underlying cause*. CD Rom. London: ONS, 2003.

Common characteristics of adolescents who die by suicide

- Broken homes (separation, divorce, or death of parents)
- Family psychiatric disorder or suicidal behaviour
- Psychiatric disorder or behavioural disturbance
- Substance misuse (alcohol or drugs)
- Previous self harm

Common expressions of parental grief after suicide by adolescents

- Refusal to accept that the death was a suicide
- Anger towards friends of the deceased, family members, medical staff, coroners, and even the deceased person
- Guilt
- Shame
- Constant search for explanation
- Fear of welfare of other children; overprotection
- Disruption of relationship with partner
- Stigmatisation
- Depression or suicidal ideation
- Alcohol misuse

General practitioners, bereavement counsellors, support organisations, and the clergy have important roles in providing support and facilitating grief

Possible motives or reasons underlying self harm

- To die
- To escape from unbearable anguish
- To change the behaviour of others
- To escape from a situation
- To show desperation to others
- To change the behaviour of others
- To "get back at" other people or make them feel guilty
- To gain relief of tension
- To seek help

psychotropic agents. Self harm by more dangerous methods, such as attempted hanging, may be associated with considerable suicidal intent.

Risk factors

Common characteristics of adolescents who self harm are similar to the characteristics of those who commit suicide. Physical or sexual abuse may also be a factor. Recently there has been increasing recognition of the importance of depression in non-fatal as well as fatal self harm by adolescents. Substance misuse is also common, although the degree of risk of self harm in adolescents attributable to alcohol or drug misuse is unclear. Knowing others who self harm may be an important factor.

Young South Asian females in the United Kingdom seem to have a raised risk of self harm. Intercultural stresses and consequent family conflicts may be relevant factors.

As many as 30% of adolescents who self harm report previous episodes, many of which have not come to medical attention. At least 10% repeat self harm during the following year, with repeats being especially likely in the first two or three months.

The risk of suicide after deliberate self harm varies between 0.24% and 4.30%. Our knowledge of risk factors is limited and can be used only as an adjunct to careful clinical assessment when making decisions about after care. However, the following factors seem to indicate a risk: being an older teenage male; violent method of self harm; multiple previous episodes of self harm; apathy, hopelessness, and insomnia; substance misuse; and previous admission to a psychiatric hospital.

Prevention

It can be difficult to identify young people at risk of self harm, even though many older adolescents who are at risk consult their general practitioners before they self harm. Suicidal ideation is relatively common among adolescents; precipitating events may be non-specific; acts of self harm are often impulsive; and secrecy and denial are common. Effective preventive care requires involvement of multiple agencies—for example, mental health services and social services. These agencies need to work in a coordinated way with adolescents thought to be at risk, including those with severe psychiatric disorders.

Assessment after self harm

All young people who have self harmed in a potentially serious way should be assessed in hospital by either a child and adolescent psychiatrist or a specialist mental health worker, psychologist, psychotherapist, or psychiatric nurse. This is necessary for the management of the medical issues and to ensure the young person receives a thorough psychosocial assessment.

The clinician can improve his or her examination by using a semistructured assessment. The natural starting point is inquiry about the events leading up to the act.

It is essential to establish whether the young person had a high degree of suicidal intent. As denial of intent is sometimes a problem, it is important to get as detailed an account of the circumstances as possible and compare these to factors known to be associated with high intent. Sometimes the reasons for self harm seem unclear because the act may seem highly impulsive. The clinician must therefore use all the information available to try to understand the motivation. This should involve exploring the adolescent's concept of death—asking, for example, what they expected to happen and whether they had thought they

Self harm is frequently a highly impulsive act—many individuals report that they had thought about the act for just minutes before doing it. Alcohol and drug consumption probably increases the likelihood of impulsive acts

Common problems preceding self harm

- Difficulties or disputes with parents
- School or work problems
- Difficulties with boyfriends or girlfriends
- Disputes with siblings
- Physical ill health
- Difficulties or disputes with peers
- Depression
- Bullying
- Low self esteem
- Sexual problems
- Alcohol and drug abuse
- Awareness of self harm by friends or family

Factors associated with repeated self harm

- Previous self harm
- Personality disturbance
- Depression
- Alcohol or drug misuse
- Chronic psychosocial problems and behaviour disturbance
- Disturbed family relationships
- Alcohol dependence in the family
- Social isolation
- Poor school record

Groups at risk who may benefit from preventive strategies

- Depressed adolescents (depression may be less easy to identify in adolescents than in adults because of atypical presentation, such as behavioural disturbance, poor school performance, and social withdrawal)
- Those with an interpersonal crisis, such as loss of a partner or running away from home
- Those who have previously self harmed, particularly if substance misuse and conduct disorder are present



would still be around afterwards to see the consequences of the act. Suicidal intent tends to be associated with depression and hopelessness.

The physical severity of the self harm is not a good indicator of suicidal intent because adolescents are often unaware of the relative toxicity of supposedly harmless substances such as paracetamol. Similar issues in the young person and their family can be usefully assessed in primary care in cases of less serious self harm.

Features of self harm that suggest high suicidal intent

- Conducted in isolation
- Timed so that intervention is unlikely (for example, after parents have gone to work)
- Precautions to avoid discovery
- Preparations made in anticipation of death (for example, leaving indication of how belongings to be distributed)
- Adolescent told other people beforehand about thoughts of suicide
- The act had been considered for hours or days beforehand
- Suicide note or message
- Adolescent did not alert others during or after the act

Treatment

Most adolescents who self harm do so in response to interpersonal crises and can be discharged for treatment as outpatients. Inpatient psychiatric treatment is usually reserved for those who have severe depressive or psychotic disorder, present an ongoing risk of suicide, or are in the middle of major psychosocial difficulties, such as disclosure of sexual abuse.

A crisis intervention model is often most appropriate. Compliance, however, can be a problem because the self harm may have had a positive effect by providing temporary relief from a difficult situation. Also the take-up of treatment depends largely on parental background and attitudes, which may include denial and negative views about psychological help. A home based treatment programme may overcome some of these problems.

Problem solving therapy is often used with adolescents and has the advantage of being direct and easily understood. Using problem solving techniques and rehearsing coping strategies can help the adolescent when he or she is confronted with future crises.

The problem solving approach can also be extended to involve the whole family. Family interventions are structured, usually last five or six sessions, and can be home based. Essential elements include the improvement of specific cognitive and social skills to promote the sharing of feelings, emotional control, and negotiation between family members. Role play can be a useful additional technique. It is wise to anticipate crises by making provision for appointments at short notice or giving telephone numbers for emergencies. Adolescents who self harm can also be treated in groups.

If depression is present, cognitive behaviour therapy is an effective treatment in adolescents. The selective serotonin reuptake inhibitor fluoxetine (Prozac) is effective in this age group. However, in view of the risk of further self harm by overdose, it is wise to limit supplies of this drug and get other family members to handle it, at least initially.

If school problems, particularly bullying, are prominent, liaison with the school is important. Further help may be provided by a school counsellor. In the case of learning difficulties, an assessment by an educational psychologist may be helpful in devising suitable educational options.

Important issues in assessment of adolescents who have self harmed

- Events surrounding the overdose or self harm
- Degree of suicidal intent and other reasons for the act
- The adolescent's current problems
- Possible psychiatric disorder
- Family and personal history
- History of psychiatric disorder or self harm
- The nature of the adolescent's resources and supports
- Risk of further self harm and of suicide
- Attitudes towards help

Assessment of families of young people who seriously self harm

Elements of assessment

- Family structure and relationships
- History of psychiatric disorder, including suicide attempts in the family
- Recent family life events, especially losses

Assessment of family's support and problem solving ability

- Inquire about the circumstances of the self harm, events leading up to it, and how it has affected the family
- Inquire about how the family has tackled serious problems in the past



Self poisoning is the second most common method (after self cutting) for deliberate self harm by adolescents

Treatment options for adolescent self harm

Individual

- Problem solving
- Cognitive behavioural therapy
- Treatment of underlying psychiatric disorder (such as antidepressants or cognitive behaviour therapy)
- Treatment of drug or alcohol abuse
- Anger management

Family

- Family therapy (such as problem solving or structural or systemic therapy)

Group

- Group therapy (including problem solving, cognitive behavioural therapy, and dealing with developmental concerns and emotions)

Others

- Environmental changes (such as temporary alternative accommodation)

Basics of problem solving therapy

- Identifying and deciding what problem(s) to tackle first
- Agreeing goals
- Working out steps to achieve goals
- Deciding how to tackle the first step
- Reviewing progress
- Dealing with psychological factors that obstruct progress
- Working through subsequent steps

When the self harm occurs alongside substance and alcohol misuse or violence, specific treatments for these conditions may be indicated. For older adolescents, referral to a self help agency or walk-in counselling service may be appropriate—and more readily accepted.

Further reading

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The ABC of adolescence is edited by Russell Viner, consultant in adolescent medicine at University College London Hospitals NHS Foundation Trust and Great Ormond Street Hospital NHS Trust (rviner@ich.ucl.ac.uk). The series will be published as a book in summer 2005.

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Information resources

For young people

- *Depression in children and young people*. Factsheet 21. From Royal College of Psychiatrists (RCPsych), tel 020 7235 2351; www.rcpsych.ac.uk

For parents and teachers

- *Suicide and self-harm in people*. Factsheet 15. From RCPsych (as above).
- Graham P, Hughes C. *So young, so sad, so listen*. London: Gaskell, 1995.
- www.youngminds.org.uk (YoungMinds is a national charity working to improve the mental health of all children and young people).
- www.euteach.com (for information on teaching about mental health issues in young people).

For parents and others bereaved by suicide

- Hill K, Hawton K, Malmberg A, Simkin S. *Bereavement information pack: for those bereaved by suicide or other sudden death*. London: Gaskell, 1997. Available via RCPsych (as above) and at www.rcpsych.ac.uk/publications/gaskell/bereav/index.htm
- Wertheimer A. *A special scar: the experiences of people bereaved by suicide*. 2nd ed. London: Brunner-Routledge, 2001.

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Keith Hawton is professor of psychiatry and director of the Centre for Suicide Research at the University of Oxford, and consultant psychiatrist at Oxfordshire Mental Healthcare Trust, Warneford Hospital, Oxford. Anthony James is consultant in adolescent psychiatry at the Highfield Adolescent Unit, Oxfordshire Mental Healthcare Trust, Warneford Hospital, Oxford.

An unusual interview

While working as a surgical registrar in Australia, I was applying for specialist registrar posts in the United Kingdom. I eventually received an email from a prestigious unit inviting me for interview, but, as I scrolled down the message, I was horrified to discover that the interviews were in six days' time. This would be a short time to arrange cover and transport had I been in the UK, but I was 10 500 miles away. Despite starting a week of leave on the day of the interview, I was on call for the preceding three days, and, with no cover available, it proved impossible for me to fly to the UK in time. I therefore asked for a telephone interview but was told that a telephone interview would not be possible because of the hospital's equal opportunities policy. I appealed to the postgraduate dean and waited.

I heard nothing more until I was checking my email at the airport before going on holiday. Having forgotten about the interviews, I was amazed to find an email telling me that I had been granted a telephone interview and that it would be that very evening. I realised that, at the time of the interview, I would be in the middle of a two hour bus transfer from the airport to our hotel, which we could not miss. I was told that the interview time could not be changed and I would be telephoned on my mobile phone for a conference call. Mobile reception can be patchy in Australia between metropolitan areas: the thought of what a conference call from overseas would be like was interesting.

I spent the flight reading anything useful that I could find saved on my laptop. I was trying to do the preparation work of several weeks in a few hours. At our destination I just took a seat at the back of a packed minibus and waited. Eventually my mobile rang:

I answered but could not hear anything. "Just great," I thought, "I can't even hear them." The phone rang again, and this time I was patched into the conference call.

I immediately forgot about the noisy, bumpy minibus journey. I could hear the interviewers perfectly, and the interview went well. When we arrived at our hotel my poor fiancée had to carry all our bags while I stalked around the car park answering questions about the research paper I was most proud of. The hotel staff must have thought me incredibly rude as I waltzed into the foyer with my wee Sherpa in tow, ignored them, and sat in the lounge to talk about laboratory research. When the interview ended the chairman of the interview panel said he would email the results of the interview the next day, and, other than a comment about the sound of a party in the background, I think he was unaware of my unconventional environment.

The next day, my fiancée and I were sitting in a café when a stranger came over and said, "Well, did you get the job, mate?" Apparently he had been a fellow passenger on the minibus.

I found out later in the day that I had been unsuccessful, but I received positive feedback. I was disappointed, but also grateful to the deanery for being bold enough to grant me their first telephone interview. The chairman of the committee told me that they were delighted with the telephone interview and would consider them in the future.

Grant D Stewart urology registrar, Canberra Hospital, Canberra, Australia (grantstewart@rcsed.ac.uk)