Deliberate self-harm in young people

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Introduction

In this study the author will attempt to explore the question “ What factors can be used as the most effective predictors for completedsuicidein young people who self-harm within theeducationsystem”. Only articles and research which have been written by experts in the area of parasuicide and self-harm will be explored.

The beginning of the study will define exactly what is meant by the term deliberate self harm, at present there is no single diagnosis for the symptoms and are often labelled as Depersonalisation Disorder, BorderlinePersonalityDisorder or Post TraumaticStressDisorder among many.

The National Institute for Clinical Excellence (2004, p2) state that the rates of deliberate self-harm have been steadily rising during the past 10 years to the point where it has now become a major publichealthproblem which accounts for roughly 150, 000 accident and emergency attendances each year. NICE (2004, pp2-3) continue to say that the highest number of reported

cases of deliberate self harm in Europe is in the U. K, with those young people who self harm being 100 times more likely to continue to commit suicide in the year subsequent to their incident of self harm, due to this it is often thought that young people who carry out acts of deliberate self harm intend to follow through and commit suicide, however, this is not often the case.

Favazza and Conterio in 1988(1988, pp 22-30) co authored the largest study conducted on cutting, their sample was of 240 chronic self-harmers, of all studies that have been carried out previously this was a larger sample of them all combined, a profile was drew up from he study of what they described as a “ typical” self-harmer, they stated that this would be a white female which will have begun self injurious behaviour at the age of fourteen years old. Throughout her adolescents would have carried out acts of self injurious behaviour at least 50 times, this would usually be through cutting but also using other self injurious behaviour methods, including hitting or burning herself. Today however a “ typical” self harmer could equally be a male but they would have started carrying out acts of self injurious behaviour at the age of twelve years old, this indicates that the pattern of self harm is changing, this could possibly be due to social circumstances, where the self injurious behaviour starts earlier but continues later into adult life, nevertheless Stone & Sias (2003, pp112-113) argue that it is difficult to really know what the typical characteristics of young people who carry out acts of self-harm are.

The study will focus around repetition of self harm and how this could effect the later risk of completed suicide regardless of recent guidance from NICE

(2004) it still remains uncertain how best to manage young people who self-harm when they present to professionals and how to recognise young people who will later carry out completed suicide. The study will focus on several research papers including those on the suicide risk in young people who carry out acts of self harm and on suicide after self harm.

It will then be concluded by researching further strategies which professionals could employ to try and reduce the prevalence of completed suicide in young people who carry out acts of self harm. It will also try to identify if any predictors are present which may indicate which young people are more at risk in order to allow teaching staff to refer them to the relevant multi professional team to help manage their treatment accordingly to reduce this risk.

Literature Review

The National Institute for Clinical Excellence (NICE, 2004 p38) describes self harm as " An act that individuals carry out in order to hurt themselves when they are feeling desperate, confused, angry or sad." However this definition does not give any indication as to what self harm actually is. Spandler et al (2007 p9) however provides a much clearer definition stating that " self harm is an impulsive or compulsive act in which individuals carry out in order to inflict physical wounds upon themselves. Motivationbehind this act being their need to cope with unbearable emotions and/or psychological distress, carrying out this act may help the individual to regulate and control their sense of emotional balance."

There are various definitions used by researchers to describe the term “ self harm” this may cause confusion and misunderstanding as to what exactly constitutes an act of self harm. Sharman (2007 p3) also defines self harm as “ a means of expressing one’s feeling” and as a way of communicating when feelings and thoughts may not be able to be expressed. After self harm has been carried out children feel better for a while and also feel that they are able to carry on with life.

Soomro (2007 p1) argues that self harm is not just a response to an emotional or psychological need in which an individual carries out a non fatal act. When carrying out the act to a variable degree, an intention to end their lives may be present. Due to this the phenomenon is often described as “ parasuicide” or “ attempted suicide”.

According to a study carried out by Hawton et al (2007 p441) there is an increasing number of children who are carrying out acts of deliberate self harm. This increase is particularly in girls. However, a study carried out by Anderson et al (2007 p470) states that the number of boys who self harm has raised since the 1970’s. Young children who carry out acts of self harm are causing major concerns to the educational, health and social services. In several countries the third most common cause of death in boys aged 15-18 is suicide. Due to the characteristically high suicide intent held by some children demonstrating self injurious behaviour, which is carried out with particular planning to ensure that they are not discovered or found out, and also in the fatal methods which are often used in these circumstances, self harm is also viewed as parasuicide.

The terms “ self-harm” and “ attempted suicide” (Simpson 2006 p429) are sometimes used interchangeably as though they are one and the same problem. Despite the fact that it has been recognised that to the individual carrying out the act there is a significant difference and conflicting meaning between self harm and suicide, self harm is essentially used by individuals with the intention of being able to carry on with their lives.

In this context (McDougall et al 2010, pp 11-16) the two most common forms of self harm are termed as “ cutting” and “ poisoning”. Cutting is performed on both arms and legs, consisting of shallow cuts made to the skin. Cutting is also carried out on other parts of the body including sexual organs and breasts these forms of cutting are less frequent. However, it must never be assumed that self harm is restricted to the individual cutting themselves, as individuals who carry out acts of self harm can often be quite resourceful in finding ways and resources they can use when harming themselves.

Examples of self-harm include the following-:

Cutting

Swallowing harmful substances or objects

Skin pulling/ scratching/ biting

Head banging

Breaking bones

Throwing themselves against objects

Pulling out hair

It is seen by many people that those who self harm are attention seekers, (Spandler et al 2007 p17 McDougall et al 2010 p39) however this could not

be further from the truth as many children who demonstrate acts of self harm are extremely self conscious of the wounds and scars which they have inflicted on themselves, and often go to extreme lengths to conceal them and their behaviour from others most often by wearing clothing which cover and hide their wounds or scars.

Whilst trying to define self harm it must be remembered that it is extremely important to appreciate that it may be divided into two major groups. It is argued by Favazza (1996 pp225-260) that the first of these groups may be described as culturally sanctioned self-mutilation, this then being sub-divided into practices and rituals. The second group is described as deviant self-mutilation, which is then sub-divided into stereotypical self-mutilation, major-mutilation and moderate/superficial self-mutilation. Favazza (1996 pp225-260) then carries on to say stereotypical self-mutilation is seen as being repetitive in nature with the behaviour being carried out in a rhythmic pattern by the child. This is most commonly seen in head banging. Major acts of self-mutilation (Favazza 1996 pp225-260) lead to profuse bleeding and major tissue damage. This often occurs suddenly, and at the time of the incident may be a result of the child being in a psychotic state. He then continues to say that moderate/superficial self-mutilation is the most widely performed act of self harm. This type of behaviour holding prevalence in the range of 750 to 1, 400 cases per 100, 000 people. If asked to describe self harm, the majority of people would recognise moderate/superficial self-mutilation as a form of injury including burning, skin picking and cutting. However, in a study carried out by Hawton, Rodham, Evans, & Harris (2009

p26), the overall prevalence of children who perform deliberate self harm is 6729 per 100, 000.

Favazza's description of self harm (1996 pp225-260) provides a much more complete definition and gives a much clearer description of the act. However it still can be seen how difficult it is to effectively describe what self harm consists of as the terms " self-harm", " deliberate self-harm" and " parasuicide", cause misunderstanding and confusion, thus resulting in people holding their own opinions and ideas of what self harm actually is.

In several studies carried out by Gratz et al (2002); Van der Kolk, Perry, & Herman, (1991; Zlotnick et al, (1996) which concluded that many children who demonstrate acts of self harm may have experienced a history of emotional neglect, prolonged separation from parents/caregivers, physical and/or sexual abuse which may have led to the onset of self-destructive behaviour. This behaviour then may be maintained through their lack of secure attachment. It was found in a study of 28 participants by Van der Kolk, Perry, & Herman, (1991 pp1665-1671) that only one of the participants had not reported any form of trauma nor had their care needs been disrupted in any way. From the 28 participants 89% had experienced some form of disruption to the care needs they received from their parents/caregivers. They also found that 79% had suffered significant trauma, many suffering some form of abuse at the hands of theirfamilyand friends. These conclusions by Van der Kolk, Perry, & Herman, (1991 pp1665-1671) were also confirmed by Freeman (2010 pp58-60), where studies showed that there are numerous life factors such as sexual abuse, emotional

and physical abuse/neglect, and parental addiction or illness, all of which may contribute to the onset of children carrying out acts of self harm.

The studies would indicate (Sutton 2005 pp53-54) that there are a range of factors which may trigger the onset of children demonstrating acts of self injurious behaviour. However major traumatic experiences such as neglect, emotional, physical and sexual abuse or a combination of all events appear to be the most common trigger factors.

This is also argued to be the main reasons for children demonstrating self-harming behaviour by Martin and Gillies (2004) cited in Garisch &Wilson (2010 p152). They state that more than 20% of children reported having to deal with forms ofbullyingand victimisation. Also, in a study carried out over a six month period by Strong (2000 p64) of children in an adolescent psychiatry unit in 1988, 83% reported were actively involved in performing some form of deliberate self harm due to being victims of abuse.

It is argued by The Mental Health Foundation (2006) that the rates of self injurious behaviour are much higher amongst children aged 11 and 25 years, with the average age being 12 when children are beginning to demonstrate self injurious behaviour. McDougall et al (2010 p34) agrees with this aphorism that the number of children between 10 and 24 years demonstrating self injurious behaviour has dramatically increased. They also continue to say that numerous numbers of children are also demonstrating other forms of self-destructive behaviour such aseating disorders, unprotected sex and substance abuse. They also feel that children carrying out this self injurious behaviour are desperately trying to discover a way to

cope with their overwhelming thoughts and feelings which demonstrating acts of self harm is intended to ease. This is a similar view that is held by Sutton (2005 p117), who argues that children who demonstrate acts of self harm find release in hurting themselves at a time in their lives when they are experiencing periods of immense emotional distress in which they feel that their ability to cope and function has failed. When carrying out the act of self injury it provides the child with a real focus to their lives, enabling them to think clearly and often provides a clear mind, creating a space where the child feels that they have total control over some aspects of their life. Spandler et al (2007 p10) also argue that the act of self injurious behaviour may serve a purpose of helping children to regulate their emotions due to this being the area with which they hold a great deal of difficulty. They also go on to say that when the child carries out the act of self harm it restores a sense of emotional equilibrium as well as reducing their internal state of tension and turmoil. Gerson and Stanley (2003 p2) agrees with Sutton (2005 p117) that the act of self injurious behaviour provides focus, as often physical pain is absent or, conversely, it is welcomed and experienced by the child as a way for them to feel alive again and reverse a sense of deadness. They report that after carrying out an act of self harm, children’s emotional state is improved and often feel less upset, even though carrying out the actual act is borne out of a sense of distress and hopelessness.

Hawton and James (2005) as cited in British Journal of SchoolNursing(2009 p36) state “ At sometime during adolescence between 7-14% of children will have carried out some form of self injurious behaviour, and 20 – 45% would have had suicidal thoughts.” The NHS Centre for Review and Dissemination

(1998 p2) also state that demonstrating acts of self injurious behaviour peak within teenage years. This also was confirmed by Sutton (2005 p42) who determined that between the ages of 13 -18 years 35% of children had carried out acts of self harm, with 30% reported to have an average frequency of every 2/3 weeks.

It is estimated by Burningham (2006) that 2 -3% of teenage girls make serious attempts to carry out some form of self injurious behaviour to harm themselves in some way. However this is not to say that although girls are reported to perform self harm acts on more occasions than boys (NHS Centre for Review and Dissemination 1998) the behaviour is confined to girls, as between 1980 and 1998 the rate of self harm being demonstrated by teenage boys has almost doubled.

It is believed by Gowers (2005) as cited in British Journal of School Nursing (2009 p35) that deprivation may be an indicator to the prevalence of self injurious behaviour within children. The Office of National Statistics (2005) agrees with this aphorism that the social class in which a child belongs has an impact on the number of children who demonstrate self injurious behaviour. McAllister (2003 pp179-183) argue that children who carry out acts of self injurious behaviour have been subject to vulnerability due to social factors they encounter. However Webb (2005) as cited in The British Journal of School Nursing (2009 p37), comments no particular social class has an impact on the number of children who carry out acts of self harm.

The Mental Health Foundation (2006) acknowledges that although there are 142, 000 children attending accident and emergency each year, the actual

number of children who carryout acts of self injurious behaviour may not be estimated due to them not presenting the injury or keeping the act to themselves.

Burningham (2006 p1) estimates the rate of self injurious behaviour among girls continues to rise faster than that of boys. However, in a study carried out by Van Heeringen & De Volder (2002, p136) found that the number of boys who committed suicide through carrying out acts of self injurious behaviour was significantly higher than that of girls. The Samaritans (2008) as cited in McDougall et al (2010 p33) agrees with Van Heeringen & De Volder stating that children aged over 14 years suicide in boys is three times more likely than it is in girls.

It is stated by Hawton and James (2005 p892) that the risk of suicide following a self injurious incident varies between 0. 24% and 4. 30%, though understanding the risk factors leading to a suicide attempt are limited and what is recognised can only be used in conjunction with careful assessment of the child, which would enable correct decisions about their care it be made. However, there are some known factors which indicate a higher risk of completed suicide following self injurious behaviour. These may include: feelings of hopelessness or apathy, substance misuse, previous episodes of self-harm and violent methods of self harm. However, it is important to recognise that children who carry out acts of self injurious behaviour, (McDougall et al 2010 p133) commit suicide as a miscalculated or accidental result of harming behaviour which has gone too far.

To support research into suicide and self harm (Spandler et al 2007 p12) the Government have introduced policy and practice to help support and cater for young children who carry out these acts. Whole school approaches and Anti-bullying strategies (The Mental Health Foundation 2006) have been implemented into Education providing a clearer awareness for teaching staff and pupils into the impact that self injurious behaviour holds. A report by The British Journal of School Nursing (2009 p98) stated that in a class size of 30 there may be 2/3 girls and 1 boy demonstrating acts of self injurious behaviour. The Department for Education and Skills (DFES) (2006) stressed the importance that school nurses need to accept that self harm is to be acknowledged as a public health problem. Ofsted (2005) identified that self harm is an issue that needs addressing in schools and issued " Healthy Minds: Promoting Emotional Health and Wellbeing in Schools", expressing that promoting pupils' emotional wellbeing plays a vital role in their education. Two documents issued by The Department for Education and Skills (2006) " Youth Matters: Next Steps" and " Looking for a school nurse" also identify the importance of the role of the school nurse in tackling the emotional and mental wellbeing of the pupils. It stresses the importance of bridging the gap between education and health as children could be performing self injurious behaviour within the school setting. Clark (2003 pp353-356) found that school nurses feel more able to hear and understand children who carry out acts of self injurious behaviour and feel confident in referring them to the multi agency team when they have been provided with appropriate training.

Having appropriate training may help teaching staff and school nurses become knowledgeable in accurate and early identification of self injurious behaviour and suicide. (Horowitz et al 2001 as cited in McDougall 2010 p209)

It is stated by Warm (2002 p122) that the primary goal in supporting children who carry out acts of self injurious behaviour is providing them with a safe and secureenvironmentpromoting them to feel like they have control over their lives and a sense of identity. The secondary goal is to support the child in developing their verbalisation skills, allowing them to build their confidence in identifying their feelings and building on ways to develop alterative coping mechanisms. It is the role of the teaching staff and school nurses to be supportive, encouraging but most of all non-judgmental.

It is apparent that self injurious behaviour cannot be ignored or referred to as a " stage" in which children go through during their adolescent years or treated as an insignificant event. Studies which have been carried out on attempted suicide have revealed that over half the children who have sadly taken their own lives have used some form of laceration in the index episode of self injurious behaviour. Fagin (2006 p194)

Methodology

The following study was conducted using only secondary research, however, if the author had used primary research ethical consideration must be respected at all times. The focus of research into self-harm (Best, 2006, p10) is itself directed towards young people who are both emotional and vulnerably disturbed, where carrying interviews may raiseanxietyand

emotional levels for the young person who is describing their past or even present experiences. Before the study commences the young person should be given a full explanation of what the study entitles and its implications (Informed consent), after this information is given the young person is required to sign a written consent form.

A search was carried out to construct this study (Fink, 2005, pp3-5) utilising numerous books, computer databases both which provided comprehensive search strategies. Early searches were conducted using a concise list of final key words. At this stage the words identified were as follows-: Self-Harm, Self-Injurious Behaviour, Non-Fatal, Suicide, Adolescent, and Mental Health.

All electronic data bases available and their respective depth of the search dates were carried out utilised within the ExLibris Metalib data base search engine. The electronic journals which where searched in this way comprised the following-:

Journals CINAHL with Full text up to 14th March 2011 (30 in total)

JSTOR – Arts andScienceI up to 14th March 2011 (30 in total)

Science Direct (subscribed content) up to 14th March 2011(30 in total)

ACM Digital library up to 14th March 2011 (28 in total)

SocINDex with Full text (EBSCO) up to 14th March 2011 (23 in total)

Professional Development collection (EBSCO) up to 14th March 2011 (17 in total)

JSTOR – Ireland Collection up to 14th March 2011 (17 in total)

Psysc Articles (EBSCO) up to 14th March 2011 (4 in total)

Business source Elite (EBSCO) up to 14th March 2011 (2 in total)

The search strategy was carried out on several occasions throughout a 4 month period, November 2010 to March 2011. The search was finalised on Monday 14th March 2011 where five papers were identified which were later used in the final analysis. The main purpose of the search was for the author to gain an understanding of the limitations and capabilities of the search engine and also to become familiar with the topic of Self harm. Background reading was selected by a range of books and from the papers identified at this stage, also from the reference lists which were attached to the papers that were identified as topical.

A methodical review was also commenced utilising the ExLibris Metalib data base using shortened key words such as Suicide, Self-Harm, School Nurse, and Self injurious behaviour. At this time there were no methodical reviews appropriate to this study.

In order to carry out these searches it is important to select journals which are appropriate and provide papers which are suitable as well as papers which would not was highlighted, along with the need to assess the initial search terms as the search term “ suicide” was making the search to broad causing a negative impact and also takes the search for self harm in a wider direction, once papers had been identified that may possibly fit the search criteria the word ‘ suicide’ was omitted from further searches. Suitable

papers were being identified with the omission of the word ‘ suicide’ identifying self-harm resulting in non-fatal suicide attempts.

As a result of this the author revised a list of terms to search:-

Young people who self–harm(adolescence, female, male, Abused)

Multi-professional policy(Teachers, School Nurse, Doctors, Primary Carer)

ObservationLevel(Self Injurious Behaviour, Risk Assessment, Health Assessment, physical Health)

Non-Fatal Suicide

The revised list of keywords (Fink, 2005, pp22-26) was then entered into the ExLibris Metalib database of methodical reviews to determine if any similar or identical reviews had previously been carried out. On March 14th 2011 the final search was carried out producing negative results. The author carried the search out as a multi-dimensional strategy this was done by entering the keywords in their individual groupings before combining the groups together to undergo further searches, this allowed for each topic to be analysed both as separate topics and in depth. However, the results obtained proved to be poor with the keywords “ adolescence who self-harm” producing only 12 papers and observation level producing only 8 papers, the remaining topics producing no further papers. Finally all of the 17 topics were combined together and put in a search, also providing a negative result. Before the list of keywords (Fink, 2005, pp22-26) were put together to carry out a search of various databases, appropriate databases available via the ExLibris Metalib search engine were reviewed and selected.

The author initially chose the selected databases due to their relevance to the topic area. Also as a result of the key word search strategy that verified which journals proved more productive at identifying relevant papers on the areas of risk and non fatal suicide, self injurious behaviour and adolescents who self harm. When identifying papers which are relevant to the area some databases provided the author with an in depth search ability to view journals that stretched back several years. To allow for seminal work which may have been carried out years earlier and not replicated to be included in the study, the author searched each journal from the earliest date possible.

The databases selected and used at this point were as follows:-

Journals CINAHL with Full text up to 14th March 2011

JSTOR – Arts and Science I up to 14th March 2011

ACM Digital library up to 14th March 2011

SocINDex with Full text (EBSCO) up to 14th March 2011

Professional Development collection (EBSCO) up to 14th March 2011

Psysc Articles (EBSCO) up to 14th March 2011

Business source Elite (EBSCO) up to 14th March 2011

Using the same multi-dimensional strategy which had been used previously the revised list was entered into the databases listed above. The results of this search identified 57064 papers on young people who self harm, 41645

multi-professional policy, 406 papers on observations levels and 143 papers on non fatal suicide.

Inclusion and Exclusion criteria

At this stage of the search a list of suitable criteria was developed in order to assist in the selection of relevant papers. This criterion was as follows:-

Inclusion Criteria

Under 20 Abused MaleFemale

Drug use. Alcohol use. Physical illness. Suicidal intent.

School nurse Papers relevant to UK Europe.

Papers relevant to Australia. Papers relevant to New Zealand.

Papers less than 10 years old. Teenagers

Exclusion Criteria

Over 20’sPharmacological.

General hospital settings. Presentations to A+E.

Papers over 10 years old.

The author now carried out a search of papers using other options which are available and an online search of sites concerned with self-harm, however, although this search produced some interesting background information, nothing that fitted into the inclusion criteria was produced. The author then

carried out an online search of specialist journals using bothGoogleScholar and ExLibris Metalib data base search engines producing 148 papers in total, 86 in ExLibris Metalib data base and 62 in Goggle Scholar, where one or more of the keywords were contained (Fink, 2005, pp22-26) Young people who self-harm, multi-profession policy, Observation policy and Non-fatal suicide. However, although these papers were produced many of them were only abstracts of the full text. At this time the journals that were accessed included the following-:

British Journal of Psychiatry

British Journal of School Nursing

Journal of ChildPsychology& Psychiatry

Journal of Psychology & Psychiatry Child Health Nursing

Brown University Child and Adolescent Behaviour

The New School Psychology Bulletin

Child and Adolescent Mental Health

British Journal of Clinical Psychology

Counselling Psychology Quarterly

Archives of suicide Research

To locate suitable papers the author carried out the searches using a randomised pattern of the keywords in the journal index. The author used

the University of Sunderland St Peters library to carry out similar searches of any journals that featured papers on self-harm. Due to the relevance of the subject a total of 11 papers were selected.

In total of all the searches that were carried out 179 papers were produced, which the author identified as being useful or possibly relevant for this review as each one contained one or more of the four basic keywords in their title.

Once the papers had been identified the author read the abstracts of all the papers to distinguish how relevant the keywords in the titles were to the actual topic of the review. This narrowed the number of papers down to 21 which the author selected for inclusion in the review at this point. The author then made three piles and reread all of the 21 journals again, all papers which were suitable were placed in one pile, ones that were possible were placed in another pile and ones that were rejected were placed in the final pile. At this point the author reread the journals using the keywords as marking criteria to ascertain the relevance to the review. In order to make use of the best available appropriate evidence the papers that were deemed to be the most recent work on the subject were selected. At the end of the search the author has 5 definite papers for inclusion in this study.

Data Analysis

Paper 1 by Hawton (2005, pp1-3) indicates that there is a strong relationship between young people who carry out acts of deliberate self harm and those who carry on to commit suicide, with between 40% and 60% of young people

losing their lives through suicide, having had at least one incident of self harm. In this case self harm being the main risk factor for completed suicide.

The aim of the study was to carryout a long-term follow-up of a large consecutive group of young people who self-harmed in order to access the risk of suicide according to gender, suicidal intent, age, length of follow up and repetition. Also the study was designed to access the risk of death from other causes not just that of suicide, for this study young people were identified through the Oxford Monitoring System, data was collected on all young people who were present at hospital through carrying out acts of self harm.

The study was carried out in Oxford, the main cohort of the study, was identified over a 20 year period starting January 1st 1978 and ending December 31st 1997 with a follow up at the end of 2000 giving a mean follow up period of 11. 3 years. The part of the study which was concerned with suicidal intent of young people, those who presented during a period of 5 years between January 1st 1993 and December 31st 1997 were also included and assessed in the study using the Beck Suicide Intent Scale.

Young people included in this study were aged 15 years or over, with information being collected through national mortality registers on survival rates and estimated deaths being calculated from the national mortality statistics. The sample included 12, 666 young people where follow up was possible 11, 583. In the region of two-thirds (N = 6961) were female with a following two-thirds aged 15–24 years old. Self-poisoning was the main method of self harm in 85% of young people

Paper 2 by Hawton and Harriss (2008, pp441-448) studied a large, consecutive sample of under 15 year olds who presented to a general hospital following an act of deliberate self harm and went on to investigate their characteristics, problems, methods of deliberate self harm, if they repeated acts of deliberate self harm, and what the long-term outcome was in terms of risk of death. This is in contrast to previous studies of deliberate self harm in children and young adolescents which have tended to be based on small samples and have not usually included any type of long – term follow up of the participants (Kosky, 1983, pp457-468). 710 young people during a 26-year period between 1st January 1978 to 3rd December 2003 and who were under 15 years of age at the time of their first presentation, were included in the study, with deliberate self harm being defined as intentional self-injury or self-poisoning, irrespective of what the motivation for the act was, with the first episode of self-harm occurring during the study period being classed as the index episode.

Subjects for the study were identified through the Oxford Monitoring System for Attempted Suicide (Hawton et al., 2003, pp987-996) as it collects information on all deliberate self-harm patients which are assessed by the general hospital psychiatric service. Whereas non-assessed young people were identified through the regular searching of records detailing presentations to the hospital emergency department. However, this resulted in more limited information being collected, which included gender, age and method of deliberate self-harm employed. This use of a two pronged approach ensured that all patients presenting to the hospital following an act of deliberate self-harm were identified.

During the study, from 1st January 1993 until 31st December 1997, wherever possible the Suicide Intent Scale (Beck, Schuyler, & Herman, 1974, pp45-46) was completed at the time of assessment. The scale was used in order to assess the extent to which an individual appeared to want death to be the result of their deliberate self harm and is scored on the basis of the responses the patient gives to questions concerning the circumstances surrounding their act of deliberate self-harm and their thoughts and feelings at the time they committed the act.

During the 26 year study period 710 patients under the age of 15 years (N = 99 males and 611 females) presented to the hospital, all following a total of 831 acts of deliberate self harm (N = 118 males and 713 females) with the youngest patient being only 8 years of age. From 12 years of age the number of patients presenting to hospital showed a substantial increase, with a female to male ratio of 6. 5: 1 amongst those aged between 12-14 years. Following the index episode most of the participants in the study were admitted to a general medical bed (86. 1%, 611 females/710 both sexes) and most were followed up with an assessment from the hospital psychiatric service (82. 7%, 587 females/710 both sexes), with no major differences being identified between the genders in the proportion of those admitted or assessed. Compared to those children who had self-injured those who had taken overdoses (92. 4%, N = 58 males/446 females) were more likely to be admitted to hospital and to be assessed. Nearly three-quarters of these overdoses involved the use of analgesics (74. 1%, N = 49 males/328 females), with over half of these patients taking paracetamol as the drug of choice. There being a similar proportion of male (54. 4%) and female (55.

6%) children taking this type of overdose with most of the self-injuries, including those which were combined with self-poisoning, involving self-cutting (85. 2%), and this being usually the young persons' wrist or arm (74. 1%).

It was found that relatively few of the female children in the study were actually in current psychiatric treatment at the time of the deliberate self-harm episodes, with both current and previous treatment being found to be more common in the male children. A quarter of the young people (26. 8%, N = 150/559) had a history of deliberate self-harm, with a similar proportion (25. 7%, N = 151/587) repeating episodes of deliberate self-harm and re-presenting to the same hospital during the study period. There was found to be no difference between males or females in history of deliberate self-harm or subsequent repetition, with high Suicide Intent Scale Scores (13+) being recorded in only 16% of cases, again the proportions were similar in both genders.

By far the most common type of problem for young people prior to an act of deliberate self-harm involved difficulties in relationships with other family members (77. 3%, N = 320), the next most common problem being relationships with friends which was significantly more common in girls (40. 7%, N = 147) than in boys (26. 4%, N = 14). Problems relating to schoolwork were recorded in more than two-thirds of patients (37. 9%, N = 16/141), with relationship problems between girlfriends or boyfriends being relatively uncommon during the study.

Follow-up information was available for a total of 464 patients (93. 9%, N = 66 males/398 females) out of 494 young people who presented to hospital during the first 20 years of the study period. Of these patients almost all (98. 1%, N = 455/464) had taken an overdose, some in combination with self-injury. During the follow-up six young people (1. 3%, N = 2males/4females) died with only one death being due to natural causes. All of the deaths occurred several years after the initial presentation for deliberate self-harm, the shortest interval being 3 years 9 months and the longest 19 years 3 months.

Paper 3 by Hackney (2009, pp34-40) argues that it is during adolescence that self-harming behaviour typically begins and that such behaviours are indicative of some form of serious psychological distress and it is suggested that any people who carry out acts of deliberate self-harm may also be at greater risk of suicide. The paper goes on to highlight deprivation as having a possible impact on the prevalence of self-harm while identifying the school nurse as being a key professional in tackling these health inequalities and empowering children in the promotion of their own mental wellbeing. The study also stresses how important it is for multi-agency professionals to work together in order to bridge the gap between health and education, as self-harm may present within the school setting at any time.

The study estimates that 7-14% of adolescents will carry out deliberate self-harm at some time in their lives with 20-45% of older adolescents having had suicidal thoughts at some time. The Office for National Statistics (2005) shows that 10% of adolescents between the age of 5 and 16 years have a clinically diagnosed mental health disorder with more than 24, 000

teenagers in the UK requiring hospitalization after deliberately self-harming themselves, this equates to 1 out of 10 teenagers who self-harm by either taking an overdose or cutting themselves. Interestingly it was found that boys (aged 5-10 years) were twice as likely to have a mental health disorder as girls of the same age.

Statistics acquired through A and E admissions show that 54% (N = 81 male/188 female) of young people who come into contact with the services do so as a direct result of self-poisoning. However, this accounts for only a small portion of those young people who carry out acts of self-harm, 10% (N = 13/32) carry out acts of deliberate self-injury, 11% (N = 35/19) suffer from acts of illicit drug poisoning with 25% (N = 72/53) who suffering from alcohol poisoning. These statistics are collated by identifying how many young people are actually seen by acute mental health services. However, these statistics are representative of only a very small proportion of the true incidence of self-harm in young people. It was found in a study of adolescent mental health by CAMHS that only 2. 6% of young people aged between 5-16 years had a clinically diagnosed mental disorder, a figure which was considerably lower than the national average. However, it was also found that up to 6. 5% of all referrals involved young people who had attempted deliberate self-harm.

Data from the Office for National Statistics (2005) indicates that it is also social class which has an important impact on the number of young people who carry out acts of self-harm, arguing that children and young people who present to services following an act of self-harm are already vulnerable owing to a number of social factors which includes

repeatedchildhoodtrauma, unemployment, isolation and living in a noxious environment. However, it was also pointed out that those children and young people who carry out acts of self-harm are not restricted to only one social class but rather are found across all social classes. It has been identified that adolescents who suffer from self-harm may in actual fact present with different types of behaviour such as cutting, overdoses, and burning themselves as it is acknowledged that in most cases the self-harming behaviours are an attempt to either control or contain distressing feelings which are normally the result of emotional, physical or sexual abuse.

Paper 4 by Anderson and Standen (2007, pp470-477) details a study carried out amongst doctors and nurses (N = 230) in clinical areas in which children were most likely to be seen on admission following an act of deliberate self-harm; accident and emergency; paediatric medicine; inpatient child and adolescent mental health services. Domino’s Suicide Opinion Questionnaire (Domino et al. 1982) was used in the study to both collect information and assess attitudes towards suicide among children and adolescents. The questionnaire consists of 100 items which are scored on a five-option Likert Scale with the possible responses of ‘ Strongly Agree’, ‘ Agree’, ‘ Undecided’, ‘ Disagree’ or ‘ Strongly Disagree’. These items then contribute to eight clinical scales and their associated themes. The Suicide Opinion Questionnaire scores for each clinical scale were then submitted to a series of analysis of variance and two-way analyses of variance. Post hoc comparisons were then made with the Scheffe test in order to identify differences not only according to participant’s profession but also their area of specialty. Subsequent analysis of variance was then conducted in order to

examine any difference in attitudes that resulted from the participant's gender, age or length of experience in their current post. During the study period the Suicide Opinion Questionnaire was responded to by 179 nurses and doctors practicing in the research setting with a further 51 participant's failing to respond to the questionnaire.

The findings of the study suggest that the individuals taking part perceived suicide among children and adolescents as being a reflection of mental illness (N = 36. 3 nuses/39. 7 doctors, p <0. 006) and that such behaviour often represents a cry for help (N = 36. 5/37. 5, p <0. 840) from the person committing the act. There was also a general agreement amongst participant's that individuals do have the right to take their own lives (N = 22. 9/22. 2, p <0. 135), however, they also felt that this behaviour was often committed as an impulsive act (N = 23. 0/23. 1, p <0. 312). Furthermore, there was agreement with the view that every child or adolescent could potentially commit suicidal behaviour, and that this type of behaviour was considered to be an aggressive act (N = 23. 0/23. 1, p <0. 505) on behalf of the individual. On the other hand, both nurses and doctors obtained lower mean scores, which suggests a greater disagreement between participant's, on the themes of religion (N = 17. 9/18. 7, p <0. 896) and moral evil (N = 8. 3/8. 5, p <0. 375). This in fact highlights that participant's are less likely to accept the idea that a lack of religion is an influencing factor in suicide and are less likely to see it as a morally bad action.

This study found that both nurses and doctors were in overall agreement with the notion that suicidal behaviour among children and adolescents reflected some form of mental illness, although doctors indicated

significantly more agreement (N = 134 nurses, 10%/45 doctors, 31%). This fact may have implications on practitioner’s decisions regarding referral of individuals to appropriate mental health care. The attitudes in this study reflect a contemporary view of suicide and to some extent a more understanding approach to the behaviour through the recognition that individuals have the right to take their own life, and not seeing it as puzzling behaviour in young people. This also suggests more recognition of both the psychological and social problems being faced by the children and adolescents of today and when faced by such problems it is not surprising that they react by engaging in acts of deliberate self-harm that often lead to suicide.

Paper 5 by Madge et al. (2008, pp667-677) has as it’s main focus the Child & Adolescent Self-harm in Europe (CASE) Study, a seven-country investigation of deliberate self-harm which takes the Schools Survey as it’s area of research. A total of 30, 477 children and adolescents were included in the Schools Survey dataset. Overall, 51. 3% of the sample was male and 48. 7% female. A standard questionnaire was developed for the study which included items on; self-harm behaviour; health and lifestyle; life events and problems; personal and psychological characteristics (including personal problems requiring professional help, anxiety anddepression, self-esteem, impulsivity, and coping behaviour); and attitudes towards self-harm among children and adolescents. Strict criteria were developed for the classification of deliberate self-harm, which was classified as an act with a non-fatal outcome in which an individual deliberately did one or more of the following; Initiated behaviour (for example, self-cutting, jumping from a height), which

they intended to cause self-harm; Ingested a substance in excess of the prescribed or generally recognised therapeutic dose; Ingested a recreational or illicit drug that was an act that the person regarded as self-harm; or Ingested a non-ingestible substance or object. The study criteria for self-harm was met if it appeared that at least one of these acts had occurred.

Datasets were weighted by age for 14 and 15 year olds (N = 13, 512), and for 16 and 17 year olds (N = 16, 963) in order to take account of differing age profiles in national samples. Percentages of males and females were similar within each age group and therefore gender was not taken into account in age standardisation.

During the study Chi-square tests were carried out to assess the vicariate associations between pairs of the following variables; gender, methods of self-harm, reasons for self-harm, premeditation, whether the act took place at home, hospital presentation, someone knowing of the act, involvement of alcohol and/or drugs, and previous history of self-harm.

Overall during the study period 8. 9% of females and 2. 6% of males reported as having had an episode meeting the study criteria within the past year and 13. 5% and 4. 3% respectively reported an episode sometime during their lifetime. Not surprisingly it was found that in both genders, the prevalence of self-harm increased as the time period became greater, with children and adolescents being roughly four times more likely to report an episode of deliberate self-harm within their lifetime as an episode during the past month. Overall it was twice as likely of females as males to report episodes of deliberate self-harm within the last month, and over three times

more likely for them to report episodes during the last year or during their lifetime. However, these rates may in fact underestimate the true prevalence of self-harm among children and adolescents as self-harmers may only show as having more absences from school than non self-harmers and may be less likely to respond to direct questions concerning self-harm.

Overall, well over half (55. 9%) of self-harm episodes involved self-cutting only, with 22. 3% involving overdose only. 11. 7% involved another single method and the remaining 10. 7% involving multiple methods. However there were marked gender differences (Chi square = 115. 82, df = 3, p < . 001). Females were much more likely to report self-cutting than males (59. 5% compared to 44. 3%), and overdose only (23. 1% compared to 19. 5%) but were less likely to have used another single method of self-harm such as self-battery, jumping, and hanging (6. 4% compared to 26. 0%). Reasons chosen by participant's to explain episodes of self-harm during the previous year included; 'I wanted to get relief from a terrible state of mind' (70. 9%), 'I wanted to die' (59%), and 'I wanted to punish myself' (43. 6%). Generally speaking those who self-harm were least likely to state that the aim of harming themselves was in order to frighten someone, get their own back, or get attention.

Conclusion

Following analysis of the data it is clear that adolescents between the ages of 5 – 17 years of age, approximately 19, 000-20, 000, who are admitted annually to hospital following acts of deliberate self-harm using a range of different methods, have an increased risk of progressing on to committing completed suicide (Powell et al, 2000, p267) and those adolescents who

present to hospital on subsequent occasions may be at a far higher risk of completed suicide as the prevalence of self-harm increases rapidly during adolescence with the Samaritans (2008) stating that following road traffic accidents, suicide is the biggest cause of death among 10-24 year olds, with 184 deaths in young people aged 10-19 years of age reported annually.

However, no definite answer has been provided through the analysis of the data, of which young people are most at risk, although it does appear that a crucial factor could be the length of time between the last act of deliberate self injurious behaviour and the attempt of carrying out suicide, this being particularly so in the 12 month period following the initial act of deliberate self injurious behaviour. (Hawton et al, 2003, p540; Cooper et al, 2005, p298; Carter et al, 2005, p254), Therefore within the education system it is vital that any young person assessed as having risk factors associated with deliberate self harm are identified and given adequate care in order to maintain their well being and safety. Nevertheless, it must be acknowledged that when young people who carry out acts of deliberate self harm are being assessed they may not admit to experiencing suicidal feelings or thoughts. (Pierce, 1981, p393; Hjelmeland et al, 1998, p224).

The prognostic value of the Suicide Intent Scale (Beck, Schuyler & Herman, 1974, pp45-46) which was used by Hawton (2005, pp1-5) and Hawton and Harriss (2008, pp441-448) in order to determine the extent to which an young person wanted death to be the result of their deliberate self injurious behaviour is moderately low argues Kapur et al (2005, p395) particularly in young people who repeatedly carry out acts of deliberate self harm do not receive further follow up or deny experiencing suicidal feelings or thoughts.

It is clear from the data analysis that more young females (74. 1%) take non-fatal overdoses with a female to male ratio of 6. 5: 1. However, young males tend to use more violent methods of self-harm, such as hanging, which is often associated with greater suicidal intent (McDougall, Armstrong and Trainor, 2010, p32). It was seen that nearly three-quarters of overdoses were through the use of some form of analgesic with paracetamol being the drug of choice in over half the cases, this could possibly be due to the widespread knowledge of the affects of large amounts of paracetamol on the internal organs or could simply be the result of the ease with which paracetamol can be obtained. However, despite this high percentage Hawton and Harriss (2008, pp441-448) found that relatively few female adolescents were actually receiving any form of psychiatric treatment at the time of the deliberate self-harm episodes, with both current and previous treatment being found to be more common in male adolescents. This was also reflected in the study by Anderson and Standen (2007, pp470-477) which found that both doctors and nurses felt that suicidal behaviour amongst children and adolescents was a reflection of some form of mental illness. However, Webb (2002, pp235-244) argues that whist self-harm is not in itself classified as a mental disorder, most professionals agree that it is often both a symptom and a manifestation of significant unmet needs. Self-harm can either exist together with other problems or be a symptom of other disorders, though some adolescents who carry out acts of deliberate self-harm may have more serious underlying mental health problems, such as depression, psychosis or eating disorders.

The data analysis has brought to light the necessity for further in-depth research, especially in relation to identifying the signs and factors which may be used to determine which young people who repeatedly carrying out acts of self harm are at a higher risk of completed suicide, with research also identifying how to make the assessment of young people more reliably and accurate.

It is evident that there is a significant need for randomised controlled trails to be carried out, in particular the ones where interventions are compared against each other. When evaluating these trails it is essential that the numerous different elements involved in what may be complex interventions are taken into account, the use of both qualitative and quantitative methods used to carry out these studies could prove beneficial in providing rich and in depth data on the topic of self harm.

It has been suggested that the families of adolescents who carry out acts of deliberate self-harm are also included in further studies (Freeman, 2010, p69) and that such studies are carried out on a much larger and meticulous scale.

It is important that teaching staff present an understanding of alternative strategies that they can use in order to maintain the emotional and physical safety of the young people in their care that carry out acts of deliberate self harm and who may be at risk of completed suicide. It is important that teachers take particular care when working with children/adolescents who carry out acts of deliberate self-harm in order to regulate overwhelming stress or a dissociated state as Hackney (2009, pp34-40) states in his paper

that a great many adolescents who self-harm have suffered some form of neglect which has resulted in a physiological stress response that is easily triggered, but not easily regulated which in turn leads to the act of self-harm.

One radical alternative strategy for the reduction of deliberate self-harm is harm minimisation, which concerns accepting the individuals need to self-harm as being a valid method of survival until survival by other means becomes possible (Spandler and Warner (eds), 2007, pp166-167). Harm minimisation neither condones nor encourages self-harm but rather is about facing the reality of maximising safety should an episode occur. If adolescents are determined to harm themselves in some way then it is better for them to do so with information on basic anatomy, physiology, first aid, wound care, correct usage of dressings and safer ways to harm. 'Safer' self-harming refers to how to injure, what to injure with, and where to carry out the injury as the risks of carrying out harming behaviour with no information are far greater than the risks of harming with information. If children and adolescents have no information then they have no choices. The act of making injury as safe as possible can in itself result in a reduction of not only the severity or frequency of the harm but can also help to prevent life or limb threatening damage.

Therefore, can harm minimisation be carried out with both children and adolescents, Spandler and Warner (eds), (2007, p171) believe that it can be by adapting the principles to the age group, they also believe that it is an essential treatment for teenagers and young adults as it can reduce the severe scarring or reduced mobility caused by the lack of correct wound

care. It can also help to reduce damage to internal organs resulting from medication overdoses.

It is also recommended that within schools where pupils carry out acts of deliberate self-harm there are implemented self-harm programs (Crowe and Bunclark, 2000, pp48-53) these are aimed to encourage the young people who carry out acts of deliberate self harm to try to find different ways to express their feelings, this could include drama therapy and creative writing and arts, as well as classes which are aimed at teaching the young people ways at improving their coping skills, improving assertiveness and changing their restrictive thinking patterns. These strategies could prove a way forward in the education system, using interactions that are not only put in place to help prevent young people committing suicide but also to help reduce the number of young people and adolescents who carry out acts of deliberate self-harm.

Personal Reflection

When I first started to study research into self-harm as a predictor of completed suicide in children and young people I was aware that deliberate self-harm occurred in children and adolescents but was unaware of the actual scale of the problem (Gibbs, 1988). Since carrying out the study I now feel that both children and adolescents who are admitted to hospital following a deliberate act of self-harm through the use of various methods constitute a population who have a greatly increased risk of going on to carry out completed suicide (Powell et al, 2000, p267).

I also feel that those young people who present to hospital on subsequent occasions with an increasing severity in their self-harmingbehaviour couldactually be at a far higher risk of completed suicide. However, an analysis of the data used in the study has not provided me with a definite answer as to which young people are most at risk, though it does appear that the time from the last incident to a suicide attempt may be a crucial factor in the identification of these individuals, this is especially so in the first 12 months following an act of deliberate self-harm (Gibbs, 1988; Hawton et al, 2003, p540; Cooper et al, 2005, p298; Carter et al, 2005, p254).

Throughout the study it has become clear to me that the process of teachers and teaching assistants discovering that a young person in their care is self-harming is gradual. Theteachermay initially feel that something is not quite right if they spot injuries on the child but they are often reluctant to press the issue when the child either refuses to engage with them in conversation or offered them a viable excuse in which case they took a " wait and see" approach (Gibbs, 1988; Owens, Horrocks and House, 2002, pp139-199).

Following analysis of study data I feel that deliberate self-harm among young people is a serious challenge to teaching staff, a challenge for which there is a need for much better data about its prevalence. There is also a clear need for teaching staff to have both a better awareness and a better understanding about what constitutes self-harm and what its underlying causes are within the younger population. Teaching staff must also be trained to intervene with effective responses to young people who carry out acts of deliberate self-harm in order to prevent the act from occurring or limit the harm done if this is not possible as it is estimated that in a class of

30 two or three girls and one boy will be involved in acts of deliberate self-harm (Gibbs, 1988; Strong, 2000, pp249-252). For this to happen there may need to be a change in restrictive thinking patterns and practices and the learning of new interactive skills within teaching in order to allow teaching staff to better use interactions which are designed to both reduce the repetition and prevent suicide among young people who carry out acts of self-harm.

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