Self-Injurious Behaviour / Deliberate Self-Harm

Evidence Based Intervention

Practitioner Expertise | Best Available Evidence | Lived Experience Expertise

Fast facts

- Intentional self-injury is known by several different phrases in clinical settings and in the research literature, including deliberate self-harm, self-injurious behaviour, non-suicidal self-injury and parasuicide.
- True prevalence of deliberate self-harm is difficult to establish, as many young people do not present to hospital or community services.
- The evidence-base for effective interventions for children and adolescents is extremely limited, and therefore recommendations are only tentatively provided.

Interventions that work – at a glance

This table represents a compilation of information from several different sources (Fonagy et al. (2015), The Matrix (2015), and Carter et al. (2016) and is designed to provide an overview only. Directly consulting these sources will provide considerable additional information.

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<th>Gold</th>
<th>Silver</th>
<th>Bronze</th>
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It is essential to first establish the risk of further self-injurious behaviour, and/or suicidality, and to take steps to reduce this risk. Self-harm and suicidal behaviour are not necessarily independent of each other, and careful assessment is essential to determine a young person's intent at the time of inflicting harm, and their broader psychosocial needs and strengths. The following interventions are recommended for situations where a young person's risk of further self-harm is consistently and carefully assessed and managed in conjunction with the specific intervention.

<table>
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<th>Self-injurious behaviour</th>
<th>Mentalisation-based therapy or Dialectical Behaviour Therapy</th>
<th>CBT or psychodynamic interpersonal therapy</th>
<th>Assertive outreach approaches</th>
<th>Rapid response treatment while in emergency department</th>
<th>Group-based CBT</th>
<th>Medication</th>
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The fine print

1. Overall, evidence from randomised controlled trials has suggested that pharmacological treatment does not reduce the risk of further deliberate self-harm (Carter et al., 2016). Unless intervention with medication would otherwise be indicated (e.g. for treating a mood or anxiety disorder), initiating pharmacological intervention is not advised (Carter et al., 2016). Particular mental health problems may increase the likelihood of deliberate self-harm, and may be usefully treated with medication (Fonagy et al., 2016).

2. There is a little (poor quality) evidence to suggest that overall, psychosocial and/or psychological therapies reduce the likelihood of deliberate self-harm (Carter et al., 2016). These include CBT and brief psychodynamic interpersonal therapy. CBT approaches featuring problem-solving seem particularly useful (Fonagy et al., 2015). However, there is not enough good quality evidence to say with certainty which specific approaches are best (Carter et al., 2016).

3. Studies have shown that group-based CBT approaches are no more effective than treatment as usual, and they are more expensive (Fonagy et al., 2015).

4. Assertive outreach with psychological therapy (solution-focussed approaches, motivational interventions to enhance engagement, clinician-initiated contacts, and rapid crisis response) may reduce the likelihood of future deliberate self-harm (Carter et al., 2016). Other approaches that have some evidence of usefulness include telephone follow-up after presenting to hospital with self-harm, “green cards” to facilitate hospital admission if required, negotiating treatment contracts, and manualised “therapeutic assessment” (Fonagy et al., 2015). However the evidence-base for effective interventions for child and adolescent deliberate self-harm is overall extremely limited (The Matrix, 2015).

5. While further research is needed, Dialectical Behaviour Therapy (DBT; originally developed for adults with borderline personality disorder) shows promise for the treatment of deliberate self-harm in adolescents (Fonagy et al., 2015; Carter et al., 2016). Mentalisation-based approaches, which involve both individual and family treatment may be an effective approach, particularly for those young people who are at risk of progression to borderline personality disorder (Fonagy et al., 2015). The Royal Australian and New Zealand College of Psychiatrists guidelines recommend that either CBT, MBT or DBT ought to be offered to children and adolescents who self-harm (Carter et al., 2016).

6. Based on limited evidence, rapid response treatment in emergency department settings seems to be useful to improve the likelihood the child or young person will engage with later interventions, and to decrease the risk of further self-harm (NICE, 2013; The Matrix, 2015). The limited available research suggests that several characteristics of emergency department support are useful – assessment, formulation, and intervention. Specific recommended interventions include identifying strengths and weaknesses of the young person’s support system, triggers or precipitants, and addressing any misperceptions or maladaptive behaviours or communication patterns that contributed to the young person’s distress (The Matrix, 2015).

Description and demographics

In New Zealand, “deliberate self-harm” (often abbreviated to DSH) is a phrase commonly used to describe an individual intentionally inflicting harm on themselves in a way that is not socially sanctioned (e.g. piercing or tattoos). Most commonly, this behaviour involves inflicting injury with a knife, needle, or razor to the dorsal forearm or front of the thighs (American Psychiatric Association, 2013). It can also include intentional ingestion of substances in excess of prescribed or therapeutic dose, ingestion of recreational or illicit drugs with the intention of harming oneself, or ingesting a non-ingestible object or substance (Hawton, Rodham, Evans & Weathall, 2002; cited in Fonagy et al., 2015). Other terms used to describe this behaviour include “parasuicide” or simply “self-harm” (Fonagy et al., 2015). Fonagy and his colleagues (2015) cite NICE advice suggesting that “self-injurious behaviour” is a phrase that carries fewer pejorative overtones and better encapsulates the complexity of the psychosocial and relational aspects involved.

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) introduces the new category of Non-suicidal Self-Injury, in the ‘Conditions for further study’ section. This diagnosis describes an individual who inflicts intentional self-inflicted damage to themselves, without suicidal intent, for one of several reasons - gaining relief from a negative emotional state, resolving interpersonal difficulties, or inducing a positive emotional state (American Psychiatric Association, 2013). The intentional self-injury is associated with interpersonal difficulties or negative feelings or thoughts which occur immediately prior to the intentional injury, and with rumination or pre-occupation with self-injury.

A recent survey of students attending a selection of New Zealand secondary schools explored the prevalence of deliberate self-harm. Around 29% of female students, and 18% of male students reported having harmed themselves intentionally in the last 12 months (Clark et al., 2013). This may be an under-estimate of actual prevalence, as the survey did not include those young people in alternative education, or those completely disengaged from education. And it is also known that published rates of intentional self-injury tend to underestimate the true proportion generally (Carter et al., 2016). Māori individuals are twice as likely as non-Māori to require hospitalisation as a result of deliberate self-harm (Ministry of Health, 2015). The hospitalisation rates for women are twice as high as men, and young people have the highest rates of hospitalisation following deliberate self-harm (Ministry of Health, 2015).

The recent Australian and New Zealand College of Psychiatrists practice guidelines for the management of deliberate self-harm (Carter et al., 2016) includes comprehensive material around considerations when working in partnership with Māori clients, and ought to be consulted for further information.

References


National Institute for Clinical Excellence (NICE) (2013). Quality standard for self-harm. NICE; Quality Standard QS34