4 Mental Health

Connecting with People

Self-harm Awareness

Participant Booklet




Version 3.4

EXERCISE 1:

Think of examples of challenging life events i.e. friend/family is ill, bullying at school/work, financial problems (a number of common life events happen at once)

You will work in small groups and think about what you do know to cope with these situations.

- Group 1 Who do you talk to?
- Group 2 What do you do now?
- Group 3 What gets you our bed in the morning?

All groups: What else works for you?

Definition of self-harm

"Intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent. Thus it includes suicide attempts as well as acts where little or no suicidal intent is involved."
(*Hawton et al 2007*)

Statistics on prevalence of self-harm

Most acts of self-harm do not result in presentation for medical attention as many people self-harm and choose not to go to hospital so self-harm is largely a community problem with real-term figures unknown:

- UK has one of the highest rates of self-harm in Europe with over 220,000 Emergency Department attendances per year following self-harm.
- Many people self-harm and choose not to go to hospital.
- Within the UK, between 1 in 12 and 1 in 15 of adolescents self-harm.
- This figure drops to 1 in 25 in the adult population.
- Of the over 220,000 attendances at hospital as a result of self-harm, it is understood that this represents 150,000 people who self-harm as some people will attend more than once..
- The highest rates of self-harm are amongst young Black and South Asian women.
- Self-harm is amongst the most common reason for women to be admitted to medical wards.
- Lifetime prevalence of self-harm in the UK is 4.8% in males, and 16.7% in females.
- Self-harm can also have a contagious effect, particularly with young people.
- There is emerging evidence that some vulnerable young people may be unduly influenced to engage in self-harm via the use of some social media platforms.

  BUT – there is also evidence that many young people significantly benefit from social media, and there are a range of resources designed to support them via websites such as:

  - http://www.docready.org/
  - http://mindful.org/

- Although most people do not usually self-harm to end their life, there is an important link between self-harm and suicide which is why every episode of self-harm needs to be taken seriously.

Exercise 2: Reasons why people self-harm

Think about and make notes of reasons why people may self-harm:

Multi centre study of self-harm report 2013 - Epidemiology and trends in self-harm

- Between 2000 and 2007 rates of self-harm declined in parallel with national suicide rates. This suggests that self-harm could be used as a sensitive measure of suicide prevention initiatives.
- Variation in rates of self-harm between the centres in the study (Derby, Manchester and Oxford) was related to socioeconomic deprivation.
- Young black women had higher levels of hospital presentation for self-harm than other ethnic groups in all three centres.
- Rates of self-harm in children and adolescents, especially girls, were higher than adults and appeared to have increased compared with earlier decades.
- In older people higher rates were found in males aged 75 years and over, in keeping with findings for suicide. These rates may relate to social isolation and physical disorders in older males.
- Rates of self-harm in Oxford university students were lower than rates of self-harm in other young people. However, levels of self-harm increased around the time of examinations. The characteristics of students presenting with self-harm owed some differences to those of other young self-harm patients, with a greater contribution of academic problems and eating disorders, lower prevalence of personality disorders and, in male students, higher suicidal intent.
- Self-cutting appears to have become more common in recent years.
- Levels of alcohol misuse in self-harm patients have increased in recent years, most noticeably in females. This is likely to reflect changes in drinking patterns across the general population, but is particularly worrying because of the higher rates of self-harm repetition and of suicide associated with alcohol misuse.
- Levels of drug misuse have also increased in self-harm patients, again, particularly in females.
- General hospital presentation following self-harm provides a particular opportunity for detection and intervention with alcohol and drug misuse.
- Levels of self-harm are higher in urban than rural areas and there are some differences in the characteristics of self-harm patients from urban and rural areas.
- Self-harm patients living alone are more likely to suffer from social isolation, and to have higher suicidal intent and repetition of self-harm.
- When assessing self-harm patients and planning aftercare, clinicians should consider both the patients' individual characteristics and the environment and circumstances in which they live.

Why is self-harm more common in women and in adolescents?

There is very little hard evidence of why this is the case, but there are a number of possible reasons why self-harm is a particular problem in adolescents:

Adolescence is an important time in our development characterised by major changes.

It is easy for young people to feel overwhelmed when upsetting things happen as they have not yet refined their coping skills. They may feel that some problems are outside of their control with no simple answer, or the pain may seem just too much to bear.

It is at times like this that people may consider self-harm as their only way to deal with unbearable emotional pain – they may even think that life is not worth living - and this is the time to get help.

Adolescents and adults who self-harm experience more frequent and more negative emotions such as anxiety, depression, and aggression versus those who do not self-harm. They may also have difficulties with expressing their emotions, problem solving, and low self-esteem. During adolescence self-harm is associated with symptoms of depression and anxiety, alcohol and cannabis use, antisocial behaviour and cigarette smoking.

Key messages

- Most self-harming behaviour in adolescents resolves on its own.
- Early intervention can prevent the escalation of self-harming behaviour and help to establish other, non-harmful, coping strategies for dealing with distress.

Reasons for self-harm

Self-harm is not an illness, it is an expression of personal distress.

Self-harm is a sign of emotional distress; an indication that something is wrong rather than a disorder itself. It is a way of coping with difficult or intolerable emotional situations. For each person, the underlying reasons are different.

Every contact with individuals who self-harm is a chance to address:

- Their unbearably intense emotional distress
- Trauma or abuse (often relating to childhood experiences)
- Their desperation
- Their guilt
- Their inability to cope with their pain any longer (emotional and/or physical)
- The 'bright red scream' of their pain; conversely, it may be a way of hiding distress – a 'private pain'
- A belief that they deserve to be punished (usually relating to abusive experiences/poor self-esteem/ self-hatred)
- Isolation and/or a lack of a sense of belonging
- The difficulties which can be related to being of a minority group
- The validation of their existence acquired through the sight of blood/flesh
- Their need to destroy their body and make it less attractive
- Their need for increased control
- The escalation of other concerning injuries/behaviours

- Their acting out the care they wish was shown to them, or 're-writing the script' of a childhood that was de-void of emotional comfort (e.g. the ritualistic and careful dressing of wounds created by self-harm)
- Other factors to consider:
    - Unattainable goals (exploring goal re-engagement and disengagement from the work of Prof. Rory O'Connor)
    - The theory of planned intent and the theory of planned behaviour in relation to the work of Prof. Rory O'Connor
    - The identification of poor problem-solving approaches, particularly in young people
    - Social perfectionism and social disconnection models

For some people who experience chronic suicidal thoughts, self-harming is the only mechanism they have to resist acting on those suicidal thoughts. After self-harming they often report that they experience a reduction in emotional pain and a reduced intensity of their suicidal thoughts.

Protective factors

Support from friends and family offers the most protection in preventing young people from thinking about self-harm or suicide. Adolescents who know they can talk to their parents about problems and know they have friends who care about them are less likely to consider self-harm or ending their lives.

It is never too late to take action to help a seemingly hopeless situation. Every contact with individuals who self-harm, is a chance to address the unbearable emotional distress that they are feeling.

Secrecy: How much does stigma affect people in opening up?

Self-harm and fear of discovery mean that people often keep their self-harm a secret. Unless medical treatment is required, self-harm is not usually reported. The reasons why people don't seek help following self-harm aren't known but it seems likely that stigma is an important factor. On the other hand, some may not disclose their self-harming behaviours because no one actually asks them if anything is wrong.

Only 1 in 5 young people aged between 16 and 24 with suicidal thoughts seek help from a GP. Young men are particularly unlikely to seek medical help unless severely distressed.

This may be because of the fear of stigma, preference for self-reliance, or even because young people have poor mental health literacy, not recognising that what they are experiencing is a mental health issue that they can be helped with.

Suicidal thoughts are far more common than people realise but we tend not to talk about them - it can be embarrassing or frightening to tell someone how we are feeling.

Young adults, especially men, are amongst those least likely to consult healthcare professionals when mentally distressed

- Adolescents and young adults frequently experience mental disorders, yet tend not to seek help.
- Young people perceive stigma and embarrassment, problems recognising symptoms (poor mental health literacy), and a preference for self-reliance as the most important barriers to help seeking.

Facilitators were comparatively under-researched. However, there was evidence that young people perceived positive past experiences, and social support and encouragement from others, as aids to the help-seeking process.

Key point:

Many people in extreme emotional pain do not know what to do or how to find help but it is never too late to take action to help a situation that seems hopeless; help is available if one knows what to do and where to go.

Biological, psychological and social theories underpinning the reasons why someone may self-harm as a coping mechanism – Health and social care professionals viewpoint

Psychoneuroimmunology (PNI)

PNI is the study of the interaction between psychological processes and the nervous and immune systems of the human body.

There is now sufficient data to conclude that psychosocial stressors and/or interventions can lead to actual health changes.

Theory of wound healing

When tissue is damaged (e.g. by cutting) chemicals called cytokines are released. They enter the bloodstream and travel to the brain, causing the release of endorphins – the body's 'feel good' hormone - which has a calming effect on emotions. This may partly explain why some people self-harm by cutting and why they may repeat this if they do not know how else to cope with their emotions.

Psychodynamic theories

Some people think that self-cutting is acting out the care that they wish was shown to them, or 'rewriting the script' of a childhood that was devoid of emotional comfort.

Problems with Emotional Regulation

Some people can find it difficult to regulate their emotions and can use self-harm as a way of managing distressing emotions. One factor, which might contribute to such negative emotions, includes social perfectionism.

Social perfectionism

It is often accompanied by overly critical self-evaluation and concerns regarding others' evaluations of them. If this drive stems from our view of what we think others think of us, these may not be either realistic or attainable goals. Then, when we fail to meet what we think others expect of us, the losses are magnified.

Social perfectionism is best conceptualized as a multi dimensional characteristic, as there are many positive and negative aspects.

In its maladaptive form, perfectionism drives people to attempt to achieve an unattainable ideal, and their adaptive perfectionism can sometimes motivate them to reach their goals. In the end, they derive pleasure from doing so. When perfectionists do not reach their goals, they often struggle to cope.

Disengagement and engagement

There is a need to start to understand the factors that may lead some with suicidal thoughts to progress to actions whilst others do not.

One of the strongest psychological predictors of self-harm and suicide is entrapment.

There is a need to understand more about disengagement and engagement aspects between people and how this may influence risk factors as well as developing coping resources and resilience.

Exercise 3: This is a quiz to test your understanding so far and also reinforce your learning

1. Which age group has the highest rates of self-harm?

2. Self-harm is the most common reason for which of the following to be admitted to a medical ward?
    a. Men
    b. Women
    c. Children

3. Can self-harm have a contagious effect?

4. What are two of the key findings from the 2013 Multi Centre study that should influence the way that we respond to self-harm?

5. Name two theories underpinning the reasons why someone might use self-harm as a coping mechanism.

6. What is the biggest barrier to people opening up about their self-harm?

7. Name one of the strongest psychological predictors of self-harm and suicide.

8. What are the key features of social perfectionism?

9. What is PNI?

10. Summarise the theory of wound healing in your own words

Exercise 4: What are and how do we overcome myths, stigmas barriers and attitudes?

Group 1: Overcoming myths and stigmas in society?

Group 2: Individual career (friends/acquaintance or relative) – what will they find difficult or challenging?

Group 3: Health and social care practitioners perspective – what may health and/or social (other professionals/ organisations) find difficult or challenging

Exercise 5: You will choose ONE case study to read and then discuss in small groups.

Having read the case study, identify things that might help this persons situation
Reading the case study start to think what makes a difference to people who are living with self-harm.

Case Study 1 – Jack

Jack appeared to have a happy life with his wife and two children, who were in their late teens. They lived in a comfortable semi-detached house in a popular part of the city. Jack had worked for the same company for 15 years, progressing into a middle management role and he got on well with his colleagues.

He had a range of hobbies, including model making, running and watching historical dramas. Jack's health had been generally good but he had always struggled to get a good night's sleep. He had the occasional drink at night to help him sleep.

Five years ago the company started to struggle as a result of the economic downturn. Targets were becoming more difficult to achieve and this put pressure on all of the staff. Any employees that left were no longer being replaced automatically. Jack found it even more difficult to get to sleep and he had increased his alcohol intake in the evenings to try to help him fall asleep. He increased the frequency and intensity of his runs, pushing himself harder than before. He was becoming more irritable at home, particularly with his wife.

The company had to make people redundant in order to stay afloat and Jack's team of staff was reduced. Jack was failing to meet his performance targets and his sleep deteriorated further. He was regularly consuming 3 or 4 bottles of beer per night to help him sleep. The lack of sleep started to affect his ability to concentrate during the day and it was taking him longer to complete routine tasks. Jack started driving more recklessly and often experienced road rage on his journeys to and from work. During this time, his relationship with his wife had deteriorated further, with most of their conversations ending in arguments.

A second round of redundancies was announced and Jack's role was put at risk. He started to become irritable with his colleagues at work and working longer hours to try to meet his targets and avoid losing his job. Jack felt on edge and generally unhappy. In order to sleep he started taking herbal night-time sedatives. He had also started having a large glass of whisky in the evening after three or four beers. He was gaining weight and constantly feeling tired during this period. He was also getting aches and pains and started taking paracetamol tablets as an analgesic.

Jack lost his job in this second round of redundancies and struggled with the social stigma of being unemployed. His relationship with his family had become strained and he barely spoke to his wife and children and when they did speak, it always resulted in an argument. After 18 months, finances became very difficult, as the redundancy payment and savings had run out. They were 3 months in arrears with their mortgage and the mortgage lender was putting pressure on Jack and threatened to repossess the house unless the arrears were paid. He was struggling to cope with the emotional and physical pain that he was experiencing. Jack was at this point, regularly taking between six and eight paracetamol tablets in the evening feeling slightly calmer afterwards.

Notes:

Case Study 2 – Anita

Anita is 25 years old and lives on her own in a deprived area of town. She has a small network of friends but generally keeps herself to herself. She works a few evenings a week in a local pub and finances are very tight.

Anita has struggled to cope with her thoughts and feelings for a long time. As a child, she found it difficult to talk about her feelings. This was made more difficult for her as she wasn't close to her parents and the relationship with her two older siblings was poor. She was not a very good student and was bullied as a result of having crooked teeth. When Anita was 12 years old, she started to self-harm, initially pulling her hair out and banging her hands against hard surfaces. She soon progressed to inflicting scratches which she hid under her clothing. Despite her wish not to, as her distress increased her self-harm progressed.

Every time she self-harmed, Anita felt guilty about what she had done to herself but was unable to share what was happening with others. Anita was embarrassed about her wounds although she ensured that they couldn't be seen by others.

Currently, Anita is struggling to pay her bills due to her low paid part-time work but she doesn't feel able to ask her boss for extra shifts; she lacks confidence around him because he reminds her of her father.

Anita feels that she had been coping reasonably well on her own for a number of years despite not sharing her difficulties with anyone else. However, her self-harm has been escalating recently. While she knows that this is something that she needs to deal with, she doesn't know how to go about it. Anita struggles most when she is criticised for something that has gone wrong and although she would like to be able to respond differently to such situations, she feels unable to do so. Her evening shifts at the pub are the most difficult for her and as a result she tends to self-harm most often after work. Immediately afterwards she feels much more in control although the feelings don't last long.

Anita feels ashamed by her self-harming behaviour and is stuck in a cycle with little hope of stopping.

Notes:

Strategies to help harm minimisation

Overview of Problem Solving Therapy

Problem-solving therapy (PST) is a form of psychotherapy that focuses on developing and improving a patient's coping skills and enhancing their ability to handle upsetting life experiences.

How PST Works

With PST, the therapist teaches the patient how to use a step-by-step process to solve life problems. The aim is for the therapist to assist the patient in:

- Identifying their problems;
- Coming up with several realistic solutions;
- Selecting the best solutions possible;
- Developing and implementing an action plan;
- Assessing the ongoing effectiveness of the action plan

- **Social problem-solving therapy.** This is a cognitive–behavioural process through which patients identify effective solutions for coping with stressful, everyday problems in social settings. Patients learn how to adapt, rather than employ a single coping strategy.

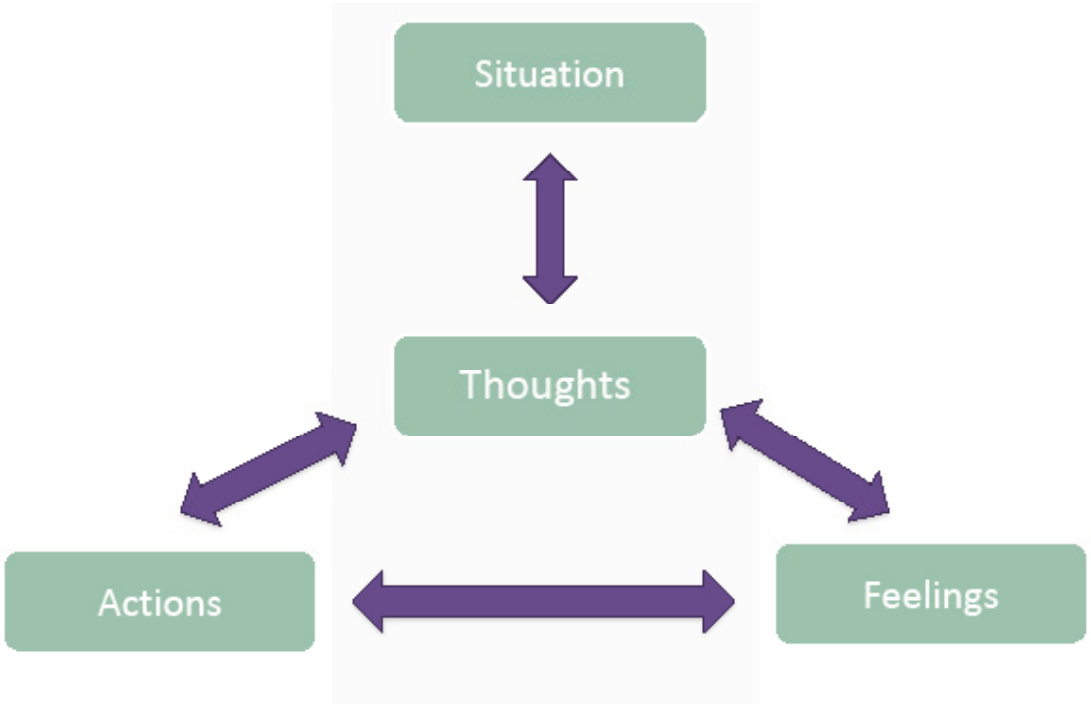
- **Problem-solving for Primary Care settings**. This therapy is provided by a Primary Care physician rather than in an analyst's office. Research into self-harm shows that PST is a brief, effective treatment for mild to moderate psychological disorders, including depression.

- **Self-examination problem-solving therapy**. This helps patients to determine their major goals, asses the problems that are getting in the way of reaching those goals, and apply problem-solving techniques as well as to accept uncontrollable situations.

Overview of Cognitive Behavioural Therapy

Cognitive behavioural therapy (CBT) is a type of talking therapy that's used to treat a wide range of mental health problems, from depression and eating disorders, to phobias and obsessive-compulsive disorder (OCD). It recommends looking at ourselves in a different way that might prove useful for us in everyday life.

CBT is based on the idea that problems aren't caused by situations themselves, but by how we interpret them in our own thoughts as our thoughts can affect our feelings and actions.



The way we think about a situation can affect how we feel and how we act.

How effective is cognitive behavioural therapy?

- Of all the talking therapies, CBT has the most clinical evidence to show that it works.
- Studies have shown that it is at least as effective as medication for many types of depression and anxiety disorders.
- But unlike many drugs, there are few side effects with CBT. After a relatively short course, people have often described long-lasting benefits.

Resources available

StayingSafe

www.StayingSafe.net
Free online resource supporting individuals to make their own Safety Plan

Wellbeing and Coping

www.WellbeingAndCoping.net

Free online resource supporting individuals to make their own Wellbeing Plan

Support organisations for people who are distressed, are experiencing suicidal thoughts or who self-harm and their families

Samaritans
Tel: 116 123 (24/7); email:jo@samaritans.org. www.samaritans.org

A 24/7 helpline service which gives you a safe space where you can talk about what is happening, how you are feeling, and how to find your own way forward. Samaritans volunteers are ordinary people from all walks of life who understand that there are sometimes things that you just cannot talk about to the people around you. They know that very often, with some time and space, people are able to find their own solution within themselves.

PAPYRUS HOPELineUK
Tel: 0800 068 41 41 (Mon to Fri 10am – 10pm & Weekends 2pm – 10pm).
www.papyrus-uk.org

PAPYRUS aims to prevent young people taking their own lives. A professionally staffed helpline provides support, practical advice and information both to young people worried about themselves, and to anyone concerned that a young person may harm themselves. PAPYRUS has a range of helpful resources including HOPELineUK contact cards or call 01925 572444 or Fax 01925 240502 for a sample pack.

Specialist help for people who self-harm

Get Connected
Tel: 080 8808 4994 (11am to 11pm).
www.themix.org.uk

Offers help by telephone and email for young people under 25 who self-harm.

Selfharm.co.uk
www.selfharm.co.uk

A project dedicated to supporting young people who are affected by self-harm.

RecoverYourLife
www.recoveryourlife.com

Internet Self-Harm Support Community. It also provides support for any emotional problems, in addition to selfharm.

togetherall
www.togetherall.com

A safe, online, anonymous service for people over the age of 16. Get the support of others who feel like you, 24/7, and learn ways to feel better and how to get on top of your own troubles.

CALL Helpline (Wales)
Tel: 0800 132 737
www.callhelpline.org.uk

A 24/7 service offering free emotional support and information/literature on mental health and related matters to people in Wales. Text 'help' to 81066.

CALM: Campaign Against Living Miserably
Tel: 0800 585858
www.thecalmzone.net

Offers help via the website and a helpline for men aged 15-35 who are feeling depressed or down. Callers are offered support and information. Calls are free, confidential and anonymous. The helpline is open from 5pm to midnight, Saturday to Tuesday, every week of the year. London callers may also call 0800 585858 or text 07537 404 717; begin your first text CALM1.

ChildLine
Tel: 08000 111
www.childline.org.uk

If you are worried about anything, it could be something big or something small, don't bottle it up. It can really help if you talk to someone. If there is something on your mind, ChildLine is here for you.

Step Change
www.stepchange.org

Free online support service providing anonymous and practical advice about money matters and debt.

National Debtline
www.nationaldebtline.org
Tel: 0808 808 4000

Free confidential and independent advice on how to deal with debt problems.

CRUSE Bereavement Care
Helpline: 0844 477 9400
www.cruse.org.uk

Email: helpline@cruse.org.uk.

Depression UK
www.depressionuk.org
Email: info@depressionuk.org

A national mutual support group for people suffering from depression.

SANE
SANEline: 0845 767 8000 (6pm – 11pm, 7 days a week)
www.sane.org.uk

Emotional support and specialist information to anyone affected by mental illness, including families, friends and carers. SANE offers 1:1 support via helpline and email services and peer support via an online support forum where people share their feelings and experiences of mental illness, as well as exchanging information about treatment and support options.

Survivors of Bereavement by Suicide (SOBS)
www.uksobs.org
Helpline: 0844 561 6855 (9am – 9pm, 7 days a week)

UK National Drugs helpline
Tel: 0800 77 66 00

A 24/7 service offering free and confidential telephone advice and information for anyone who is concerned, or has questions, about drugs.

Self Injury Support

www.selfinjurysupport.org.uk

Telephone, email, text and webchat support available
Their vision is that anyone who uses self-injury knows they are not alone

distrACT app - found on the NHS and at www.expertselfcare.com
Accessible on App Store and Google Play
the distrACT app give you easy, quick and discreet access to information and advice about self-harm and suicidal thoughts. Content created by doctors and experts in self-harming and suicide prevention.

Notes:

Connecting with People is the training delivered and owned by:

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A full list of Connecting with People training courses can be found at:
www.4mentalhealth.com/courses

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