Deliberate Self Harm Transcript.
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0.01 **Chair:** Good afternoon everybody and welcome to our live webinar on deliberate self-harm. So, without any further ado I'd like to introduce Dr Ian Collings who is doing the second of two talks that he's done on mental health issues for us during this lockdown period. He is a Consultant Psychiatrist and Honorary Clinical Lecturer at the Swansea Bay University Health Board and today he's talking on deliberate self-harm. Thank you, Ian.

0.37 **Speaker:** Thank you very much Nicola. Hopefully you can all hear me okay. I'm absolutely delighted to be speaking to you all today. I know how busy you all must be at the moment. But hopefully during the course of this next hour we can have a good discussion about deliberate self-harm, that you often see presenting in primary care. This is a sort of follow-on talk to the one I gave not that long before Christmas about suicide and suicide risk, so hopefully it will help you or support you in managing and supporting these patients. I'm very much looking forward to some conversations and interaction during the course of my presentation today.

And in the spirit of a conversation and some interaction, I'm going to start with a typical case that you might see actually with deliberate self-harm and this is where you'll have the opportunity of maybe typing some thoughts into the chat box. I will be really keen to hear what you think. So, let's have a look at this case, shall we?

This is a 17-year-old female who presents to your clinic with repeated episodes of self-harm. The self-harming occurs at times of stress. She cuts herself using a pencil sharpener blade. She usually self-harms by cutting her upper thighs. The majority of episodes don't result in help seeking. Following taking a sort of psychiatric history and doing a mental state examination and reassuring yourself that there aren't any acute concerns or any acute risk issues, what might be your first steps in the management of this young woman?

So, working on the on the premise that she doesn't appear to be acutely mentally ill, and you're satisfied there aren't any acute risk history issues or risk issues that would warrant escalation at that point, what might be some of the first steps you might take in the management of this lady?

I can see someone has scribbled in blue on my slide perhaps if you could write in the chat box what your next steps might be with regards to this lady, and I'll give it a minute or two for people to start perhaps putting some things in to that chat box. I would be keen to hear what you do currently.

Okay Asma - I refer for counselling.

Okay and that would be a practice counsellor, I presume. But there's also a range of voluntary agencies that would provide support for people with deliberate self-harm.

Kalindi - Assess risk for suicide. Yes - let's say you've done that, and you think that suicide risk is low?

A CAMHS safety plan. So that is about safety planning. Thanks for that Laura. That's about safety planning around deliberate self-harm. I guess a form of harm minimisation really there, thinking about that. Excellent. Thank you.

Signposts for self-awareness re stressors. It's really important that you understand what could be triggering these self-harms and if it is sort of psychosocial stressors that are the particular trigger

then obviously having a kind of an approach to deal with some of those things would be really useful.

Ayla – You ask - What distraction techniques have been used before? That is a really useful tool/ strategy to use with people that recurrently self-harm and do it in a way that doesn't often present to healthcare settings.

Deb - Give alternatives. Hairband on wrist/ice. Excellent. That's a really good strategy Deb to manage people who are engaged in recurrent acts of self-harm because it's a sort of safe non-destructive type of pain that you can get the individual to replace the kind of more destructive type of self-harming with. So that's a really good strategy that people can use at home along with Ayla's strategy about distraction. There are many forms of distraction.

I like that Neeraj. I like that a lot. Using ketchup to mimic blood. People might think that's a bit of an odd thing an odd thing to say, but actually I think that's really useful strategy that people can use. Because it does mimic blood and it gives the impression to that person in the moment, who are self-harming, and that they're perhaps they are bleeding and that can be enough in some people to prevent acts of deliberate self-harm.

So wonderful. Thank you all. There are some really good strategies in terms of supporting that person who clearly doesn't present very often around her self-harm, but really good strategies to use. A lot of them low level but very effective strategies to use to provide support and help that person to support themselves who are self-harming.

So, you don't need me to talk about self-harm. You've got it covered. You are aware of all the strategies. Okay so thank you everyone for your thoughts about that. There will be more opportunities for interaction as we go through the presentation.

7.08 **Speaker:** So, what are we going to talk about today? First, we're going to talk about well what is deliberate self-harm. You know what's the definition of deliberate self-harm, as opposed if you like to harm that is sustained in a failed suicide attempt perhaps. There are very different drivers in in the case of someone who tries to end their life and is harmed as a consequence and somebody who self-harms. There are many quite complex aetiologies and reasons why people self-harm. So, we're going to talk about that. We're going to briefly talk about the epidemiology of self-harm. How common is it? What are the high-risk groups that you need to be concerned about when you're doing your day-to-day practice? We're going to talk about some of the risk factors and triggers and some of the things you need to be on the lookout for in terms of red flags which might mean you need to escalate the situation further, perhaps to mental health services. And then I'm going to spend a bit of time talking about models of self-harm. There are many models of self-harm that have been postulated as to why people may self-harm and I'm going to just talk about sort of those higher the main models for self-harming. And then talk about how you might elicit disclosure. What kinds of questions you might want to ask, particularly if that person is in front of you. Also, as well if you're doing tele-consultations or telephone consultations, which I know you're doing more and more of at the moment. And then we'll talk about the management of self-harm in terms of self-help if you like. Strategies to improve and reduce self-harming but also ways to refer on, signposting escalating etc, etc. And hopefully there'll be time at the end if you have any questions if you want to ask or any cases you want to share perhaps that you can hear from me in terms of how I might manage or even probably more helpful your colleagues, in terms of how they might manage those cases as well.

So, I commend that plan to you. I hope that kind of meets your kind of learning needs or anticipated learning needs you're expecting to get from this session.

9.49 **Speaker:** So, what is deliberate self-harm? Well, it's different from somebody who tries to end their life and is harmed as a consequence of a failed suicide attempt. You know that ultimately is related to the person's wish to end their life and to die. With deliberate self-harm, that is an intentional act of self-injurious behaviour. It can be planned, or it can be impulsive. And deliberate self-harm can include many different types of harm. Most often it's through cutting or through overdose, but it can be through doing things like burning yourself and banging yourself. So, banging parts of your body against hard things or banging your head against hard things. It could be punching doors or walls or that kind of thing. Inserting objects and that could include inserting objects into sort of orifices that you already have anatomically, or it could include inserting things like pins or needles into yourself. I remember many years ago when I was a registrar having a patient with an emotionally unstable personality disorder in Whitchurch Hospital, where I was training at the time. And I remember she was a very interesting form of self-harm. She would insert sewing needles mostly into her hands actually. And she would insert them fully into her hands. So, by looking at it, examining her hand you would see that it had a few small sorts of punctures on it. You wouldn't see any needles, but her hand is very swollen. And I remember sending her for an x-ray and there were about 20 or 30 sewing needles that she'd inserted into the flesh of her hands. It was really vivid. You could see all of these needles on the x-ray. So, you can insert objects both sharp objects into your skin and object into your mouth or objects into other orifices. You often see people inserting, as a form of self-harm, inserting things into the anal canal or the vaginal canal as well. Swallowing is another form of self-harm as well. I run a high dependency rehabilitation unit or I'm the consultant for a high dependency rehabilitation unit in Swansea and we currently have a patient with a mild learning intellectual disability but also a schizoaffective disorder and he frequently swallows all kinds of things, which is a real problem. Because you know, they've often required surgical removal. So, he's had numerous endoscopic procedures and laparoscopic procedures actually, where things have had to be removed from various parts of his gastrointestinal tract. So that's a particularly concerning type of self-harm, because it can have quite severe consequences.

That is not the limit of what self-harm can include. There are other types of ways you can self-harm but they're the most common ways. Driving fast with an intention perhaps to come off the road. Engaging in high-risk sexual behaviours are forms of self-harm that you need to be aware of actually and not sort of exclude if people mention it to you in part of their conversation. You know, limiting food is also a form of self-harm. Limiting food and water. Obviously, it depends on the rest of the psychopathology as to whether it could be a formal eating disorder, but you know all of these are potential ways that people can self-harm. So be aware of that and I suppose think about perhaps asking about some of these things if someone presents to you with cutting or overdosing. Be aware or be aware to ask them perhaps about other methodologies they may use to self-harm.

14.30 **Speaker:** Self-harm is very prevalent. However, studies underestimate the prevalence because the vast majority of individuals that engage in regular self-harm or even just one-off self-harm or infrequent self-harm. will not present. The vast majority will not present unless it's serious, unless it causes them an injury that has other consequences. So, remember that prevalent studies often underestimate the prevalence of self-harm. But we reckon that (and being a younger person is a particular risk factor for self-harm) that one in ten young people will self-harm and it's more common in younger people as well. It's more common in younger women particularly. And as I've said a lot of types of self-harm do not result in help seeking behaviours, like in our typical case at the beginning. The majority of deliberate self-harm and I'm not talking about people trying to kill themselves by taking an overdose, I'm talking about people overdosing as a form of self-harm deliberately wanting to cause harm to themselves rather than deliberately want to try and kill themselves - eighty percent of deliberate self-harm is through overdose. Fifteen percent is through

cutting and this is rough. I mean from one prevalence study to the next, these figures may alternate slightly. And then the remaining five percent then are through those other methods that I mentioned before.

16.10 **Speaker:** A bit more audience participation now I'm afraid. You're probably all thinking it would it be nice just to sit and eat my lunch and have a webinar on deliberate self-harm without me having to ask you questions. So, apologies for that but be interested to hear what you think.

What do you believe are the high-risk demographic groups for deliberate self-harm? And I've given you a couple already but what might the other high-risk demographic groups for self-harm be? We've spoken about young people. We've spoken about women.

Yes, thanks Nicola – female. Absolutely very important demographic risk factor.

High achievers - that's an interesting one, Deb.

There's something there about perfectionism actually I'll come back to that.

Childhood trauma - Ayla - Yes definitely.

Children of people with a family history of mental health problems. Absolutely. Yes.

And then there's the increased risk of self-harm in people who are suffering a lot of poverty/ overcrowding. Obviously, a lot more critical to think about this now with the consequences the socioeconomic consequences of the pandemic.

Sexual abuse – absolutely.

Any other potential high-risk demographic groups that you might want to be aware of?

Students – okay.

Fractured upbringing - which would feed into that childhood trauma. Absolutely. Definitely.

Yes, these are all really good thoughts.

Alcoholism. Excellent.

Thank you.

17.55 **Speaker:** So, these are the particular high-risk groups that you may find a higher prevalence of deliberate self-harm in. I'm not discounting these other ones. These are all risky groups for increased risk of self-harm. But if you like, these are the highest risk. So, we mentioned young women. Deliberate self-harm is also more common in prisoners and that can sometimes be related Ayla to a personality disorder, yes. That is definitely a reason for increased prevalence of deliberate self-harm. Asylum seekers we see more with self-harm and veterans, particularly veterans that may suffer from post-traumatic stress disorder because actually one of the models of self-harm is almost like an anti-dissociative way of trying to get out of those dissociative phenomena that you get in PTSD, those flashbacks that really disable people with PTSD. Self-harm is higher in the LGBTQ plus community. Related to sort of social adversity. Related to childhood experiences. Related to you know the trauma that is that is coming that is you know faced by LGBTQ plus when they're coming out. Also, marginalization in society. It still happens a lot particularly in the trans community, so that is something that we see a higher rate of both self-harm and suicide. And there's this group of young people that self-harm together as well. This is really interesting. So, you know there are groups of young people that will often self-harm. So, you get this sort of peer thing going on. This peer group

pressure going on in groups of young people. You get perhaps young people maybe who are sort of following that sort of Goth tradition perhaps, that will self-harm. Also fuelled by the pro self-harm websites which I'm going to talk about a bit more in a minute. And also, people have experienced physical, emotional or sexual abuse during childhood. There's an increased risk of those individuals self-harming later on in life. As is also, an increased risk of being diagnosed with personality disorders particularly what I would refer to as those cluster B personality disorders. So, you know, emotionally unstable personality disorders and anti-social personality disorders. You can get people in those groups that will self-harm. But not discounting these other high-risk groups that have been mentioned in the chat box. Yes, there's increased risk of self-harm in people who have suffered/who are currently suffering social adversity – poverty, overcrowding, job loss, all the rest of it. But there's also that risk and there's also that tie in there with those social adversity triggers to mental illness as well.

These are the high risks. So, these are the people that perhaps you're seeing in your clinics who you may want to screen perhaps for deliberate self-harm if they fall into these particular high-risk groups.

21.25 **Speaker:** And just a note to mention about pro-self-harm websites. They are ubiquitous and they're hard to get away from. And young people particularly are drawn to these pro self-harm websites. And I mean they're not particularly healthy things to be drawn to, I have to say. And when I was originally preparing for this presentation when I originally gave it as in the old days as a face-to-face presentation to a crowd of you, it was very easy for me to find a whole host of pro-self-harm websites, kind of in the mould of these Pro Ana websites as well. And these pro anorexia websites that are becoming more and more ubiquitous. These websites are communities of often young people who are telling each other and inciting each other and advising each other on the best ways to self-harm. And so, it's really important and sort of fits in with all the kind of triggers for self-harm. You know bullying online bullying all the rest of it. It's really important as part of and perhaps an assessment that you're screening or asking about whether the individual is using these kinds of websites. You just read the little passage there. The person who's writing this (and I wanted to choose one of the passages that wasn't too difficult to read about) is complaining that this particular self-harm discussion forum is too inactive but is the only one that they can find. It's very easy to find a whole range of self-harm websites, I have to say.

23.19 **Speaker:** So, what are the kinds of triggers for the act of self-harm in people?

Well people not listening can often be a trigger for self-harm, as are the feelings of hopelessness that people will often get if they suffer from self-harm. Feeling isolated, feeling out of control, feeling powerless. All of these kinds of things are the triggers to most people who will experience self-harm. I mean it's a lot more complex in terms of the aetiologies if you like, of why people self-harm and the models that lead people to self-harm, but these are often those immediate triggers that people will talk about as the immediate forerunner to an act of self-harm. And it's important to understand perhaps in the people that do present to you that you ask about some of these triggers. What particular triggers are there for those particular people that are self-harming?

Lovely designs appearing on my slides. Thank you for that.

Okay. Next question now. You have a person Infront of you who is presenting with acts or an act of deliberate self-harm. What factors would increase your concern about the episode of deliberate self-harm in the person? What if you like, would be your red flag signs related to that act of deliberate self-harm that you may have more concern about or may want to escalate?

Yes, it's all coming in.

Severity and repeated nature.
If they find it useful or satisfying.
Lack of remorse.
Planned.
Level of secrecy.
Escalating severity.
Concealing event - yes.
Escalating in the context of deterring mental state at assessment.

Excellent. Yes, these are really important red flags. So, repetitiveness, severity.

I think often, if they find it useful or satisfying, that not is not necessarily a red flag. Because remember the majority of people who self-harm aren't actually presenting. That may not necessarily be a red flag. It actually may be quite protective, particularly if they're self-harming in a way that's not overly destructive.

A lack of remorse - again it would depend on the dynamics and what the thinking patterns are going on at the time, Kim, I guess as to whether that would be a red flag.

Planned versus unplanned - potentially yes.

Escalating severity. Definitely. Of course, Farah, if someone is talking about/or someone has acted in a way to harm themselves and are talking about suicide and ending their life that would be something that I would be concerned about too. That would be a red flag for me.

26.35 **Speaker:** So yes, these are the main kinds of red flags that I would identify. So, you know dangerous or increasingly dangerous or violent methods. So, you know, if someone starts off perhaps like our first case that of unscrewing the blade out of a pencil sharpener or using a razor but that escalates into something sharper or a bigger knife or what have you then you'd be concerned about that. I remember once seeing a patient - and this was a really good example of increasingly dangerous violent methods of self-harm - he would continue to use a knife, a carving knife to self-harm but as things escalated, he would start to put that knife on the gas ring. So, it would literally heat up to red hot and in a way, I suppose that would cauterize the wound as it did it, but actually it would be cutting deeper, and it would be causing more damage potentially to sort of arteries and tendons and all the rest of it. So that was would be an increasingly dangerous or violent method. If the self-harm is becoming more regular and if it's being done in isolation more frequently these would be red flags for me. And of course - now this is an important take home message here: self-harm doesn't always need to happen in the context of mental disorder. It can often happen not in the context of mental disorder. But if there is a presence of a mental disorder, and I suppose this where suicidality comes in as well, if there is the presence of mental disorder then that is a red flag symptom for me. And I'm not saying of imminent harm but obviously something you might want to consider escalating and either if the self-harm hasn't helped deal with the emotion, feelings are still intense – yes, yes. Hopefully some of you came to my suicide talk a few months ago and yeah absolutely you know I think if the self-harm attempt isn't dealing with the thing that they're harming for, or they're harming because of, then they're likely to increase their violence or increase their dangerous methods. So that's why it would be a red flag. And also, obviously protective factors you know. That is part of your ongoing dynamic risk assessment. And remember we spoke about the importance of individualised and dynamic risk assessments when I talked about suicide. It's not a one-size-fits-all when it comes to suicide risk assessment. It has to be individualised. It has to be

based on the risk factors, the protective factors etc. And that also applies to risk assessment for people who are self-harming.

29.38 **Speaker:** So here are some of the models of self-harm that I just wanted to briefly discuss and as I said before, self-harm doesn't always have to occur in the context of a mental disorder, and you need to be I guess aware of that and be screening for the presence or absence of a mental disorder when you are assessing patients.

So, the first model of self-harm I wanted to talk about is this thing referred to as affect regulation. So often people will have intense emotions, or we will hear people talk about it as intense emotional pain. And often perhaps people won't be able to express this intense emotional pain through sort of speaking about it or through other means e.g. writing about it and they will often respond to this intense emotional pain by harming themselves. And that almost gives them a relief or a release. This is often a model that we see perhaps in people who have emotionally unstable personalities that will be characterised by quite extreme fluctuations in their mood ranging from elation to very low hopelessness. And often people with those emotionally unstable personalities will self-harm because of this to get a release to get a sort of numbing if you like of that emotional pain.

And then there's the anti-suicide. So, there's a group of people perhaps who will self-harm almost as a protective factor against suicide. So, they will self-harm in a way by sort of channelling perhaps those impulses to end their life into a more protective or constructive way. You know I mean better than killing yourself if you think about it by channelling those impulses into harming themselves. So, in a sense it's kind of a protective factor for suicide, by them self-harming.

And then there's this method around anti-dissociation. So again, people with emotionally unstable personality disorders, people with post-traumatic stress disorder, will often have this dissociation, won't they? And that dissociation could be related to intense emotions in people with a personality disorder or it could be related to some kind of stimulus related to the trauma in people with post-traumatic stress disorder. It's the kind of thing that makes them go into a flash back. So, people will self-harm to try and help them not dissociate. To help them feel in the here and now. It's almost a kind of grounding, in a kind of destructive way. There are more much more constructive ways of doing grounding work. It's almost a way of grounding yourself, so you don't dissociate, by self-harming.

And then there's the whole issue around interpersonal boundaries. This is kind of difficult one to explain in a way that in some individuals they will self-harm to affirm if you like their own boundaries and protect themselves against the loss of identity by trying to create that distinction between the self and others. So, I suppose you could get that in someone e.g. it's not common that people with schizophrenia will self-harm, but people may with schizophrenia, particularly in the acute stages of schizophrenia, may self-harm because there's often a blurring of those boundaries where you end and your environment begins if you like.

And then the next model of deliberate self-harm around interpersonal influence and be careful about this because this is often used, I think lazily, when trying to explain why people might self-harm. It's all too easy to say people are doing this to manipulate the environment. I hate that word manipulate. Often you know people that self-harm to exert influence on their situation sounds so much better than manipulate their environment. Those people have learned the way of doing that from a very early age and aren't able to do it in any other way but to self-harm. So, there are those individuals that want to influence their situation by self-harming.

And then as those people that might punish themselves by self-harming. So, they may feel intense guilt or pain or shame about something and they self-harm to relieve that guilt or shame.

And then there are those people that self-harm to get sensations. To generate exciting sensations or stimulate themselves and they will self-harm to do that. We're starting to verge now into a whole host of different mental disorders related to sort of psychosexual functioning. I'm not going to go into that in detail but there's that sort of that sort of sadism component there perhaps.

So, these are all types of models that explain why people might self-harm. It's never as clear-cut as someone will fit into one category and another person will fit into another category. Sometimes people may have more than one underlying psychodynamic reason that they may self-harm. You know it may be to affect regulation, anti-suicide, and anti-dissociation. It will be a combination of different ones. It's never as simple as just one model underpinning their self-harm. But these are the kinds of reasons or the kinds of psychodynamic or psychological models that people self-harm for.

36.47 **Speaker:** And in terms of sort of moving on now from understanding the definition and epidemiology and the models etc. to the assessment of somebody who self-harms. And I've just put up some questions there. You don't need me to tell you to ask these questions. I mean these questions you no doubt and ask day in day out of your patients. And these are the kinds of questions that you may want to ask as an assessment or through the sort of telemedicine. You know - start off with nice open questions: How have you been feeling? Have you ever felt so low that you've considered harming yourself? Of course, it may not be because they feel low that they may harm themselves, but it's a better way than any to ask about that. And then you ask about the triggers, the precipitants. How they're feeling when they or just before they self-harm? How they're feeling afterwards? What the consequences for them of the self-harm? How often it happens? What means do they use? And then that has to collate as part of your assessment to asking about the relationship between self-harm and suicide and whether they've ever done anything about these plans. So, these are typical questions. You don't need a psychiatrist to tell you about questions you ask a person who is self-harming, or who is feeling an urge to self-harm. These are questions you ask in your daily practice.

38.08 **Speaker:** Moving on now to talk about the management of self-harm. And I wanted to start by talking about that initial assessment of a person who comes into your practice and self-harms. You obviously want to take into account a number of dynamic factors in this particular situation, such as, the risk to their physical health of the episode of self-harm you're seeing them for or the multiple episodes of self-harm that they've done in the past, but you're only just seeing them now. You want to try and understand what is the physical risk? So, if someone is cutting superficially with a fairly blunt instrument on their thighs, the physical risk of that is going to be significantly lot lower than somebody perhaps who's swallowing things like batteries or inserting pins or needles into their skin or inserting things into various orifices. Okay so you want to satisfy yourself as to the physical risk. I mean if the physical risk means that there's some form of immediate physical danger then obviously, you're going to have to escalate that appropriately to general hospitals. You need to assess the emotional state of that person who's presenting to you. That's not the same as the mental state. It's - what is happening? What emotions are going on at this moment in time when that person's sitting in front of you. But also, perhaps, at the time that they're self-harming. And also, that prodromal period. What's going on immediately before self-harming and how that impacts those emotions right after self-harming. Clearly you know as part of your assessment you're going to want to rule out any mental disorder or at least any acute mental disorder and that's why you're going to do a mental state. You're going to ask about mood, you're going to ask about alcohol and drug misuse, you're going to elicit psychotic symptoms. And then there's the ongoing risk. You know we talked

about those red flag symptoms before. What is the ongoing risk to that person if they continue to self-harm? Is there a suicide risk and clearly if someone is self-poisoned and is presenting to you you're going to have to refer to emergency medicine (or obviously after speaking to Drug Line about the medication that they've ingested). You're going to refer to emergency medicine for treatment of that overdose or assessment. You know a range of blood tests, ECG and the rest of it. But particularly if you're in a rural setting you're going to have to consider the welfare during transfer and what the best way of transferring that person would be. You know with a loved one, by an ambulance, etc. These are the things you're going to have to think about. And rural communities, particularly if it may take, I don't know an hour perhaps to get to the local hospital, then you may want to think about taking, for example, paracetamol levels or LFTs or clotting at the time of presentation and send that sample with the patient to the to the emergency medicine department particularly if it's going to take a while for them to get to that emergency medicine department. So, these are things that you might want to consider doing as part of that referral.

41.47 **Speaker:** But what if referral to A&E isn't necessary which in the vast majority of cases will be the case? If referral to A&E isn't necessary, then you need to think about their mental state and whether there's any evidence of acute mental disorder and you need to decide whether they require referral to mental health services and whether that referral based on the risk and the presentation needs to be routine or the same day. And you all know about how that would work in your local area and the last presentation I gave just before Christmas we gave all the contacts for those sorts of crisis team/home treatment team services right across Wales.

And it will depend very much on whether there's a severe mental disorder present. The acuity of that mental disorder. Because you know they could have had schizophrenia for a long time but it's not particularly acute, in which case it probably doesn't need assessment that day. And it also depends on whether there's ongoing thoughts or plans of self-harm and also suicide and also those red flags that I mentioned before. If that necessarily isn't warranted, an urgent referral to mental health services that day or that week, perhaps you feel that on balance, referral could be more of a routine referral to mental health services. Of course, this is all in the caveat that they are suffering from mental disorder. You may want to consider how you're going to prescribe for that person particularly if they engage in self-harming behaviour by taking overdoses. And just simple measures like weekly scripts in those cases, would be beneficial.

43.28 **Speaker:** Quick clinical scenario that I'm not going to ask you to answer but I may answer it myself, just in the interests of time. A 20-year-old man presents to you with one episode of self-harm. He superficially cuts his wrists with a Stanley knife the wound is superficial and only requires a simple dressing. You have no concerns about any symptoms of mental illness and he's not expressing any suicidal ideas. The episode seems to have been triggered by the man failing his driving test. The man frequently has urges to self-harm. He asks for advice on how to manage these impulses.

Well, the first bit of advice I would give is to be calm and validate the emotions that he may be having. You can't be sort of telling him off and this applies to parents as well in kids who self-harm you know there's no good punishing kids who self-harm because it will drive the behaviour underground and it's really important to give that information to parents. Focus on the underlying struggles. Focus on helping them to problem-solve. In this case well you can always take another driving test. The best drivers are those who've passed second time round, people keep telling me. And you can refer to a number of organisations that support people with self-harm. There are many other ways that if people continue to self-harm, you can help them to manage their own self-harming behaviour as well.

45.01 **Speaker:** And here are some of those ways that you can support people, to support themselves. Really important to help that person identify a support network. And that could be yourself as the GP. It could be friends or family that they may want to disclose this to. Or it could be somebody impartial like a support group or a support line. That is a fundamental important thing to do in terms of helping people help themselves.

And then there's these kinds of things that you do around distraction and that could be in a kind of self-soothing way the person could do other activities that help to distract them in a positive way you know – exercise, listen to music, those kinds of things in a self-soothing type of distraction. Sometimes actually, particularly if it may be causing the self-harm or triggering the self-harm, having time out from other people might be helpful. You know people in some relationships might self-harm because of inter-personal difficulties, relationship difficulties. We talked about this group of young people that self-harm before. Taking time out can help reduce the frequency of self-harm in these individuals.

Obviously, relaxation technique or using things to help them relax. And this is a really good one this. It goes back to what our colleagues said before about using tomato ketchup. Some people find making some ice cubes with some red dye in and squeezing these in their hands and seeing that red liquid trickle down their hands and over their wrist, can be a really good way of preventing episodes of self-harm. It seems very simplistic, but actually until people can be effective. As is the harmless pain and this was mentioned before. Holding onto an ice cube, having a hair band or elastic band on their wrist and pinging it when they're feeling an urge to self-harm. It's a form of distraction. Causes harmless pain and can help in some people. And in a sub-group of people, writing about their experiences or about their feelings about their emotions, getting it out is quite cathartic. And if the person doesn't have someone to talk, to this can be a good way to help them manage or reduce their frequencies of self-harm.

47.26 **Speaker:** And then there's the more specific types of management. And this tends to be thinking about voluntary sector organisations. But also, formal forms of psychotherapy interventions that may be used for specific mental disorders. Just as a caveat there's not a medication that can be prescribed that will reduce self-harm. There's a very old study, many years ago I think, that Clopixol Depot could reduce self-harm and emotionally unstable personality disorders. I wouldn't really go down the medication route at all. These are the treatments. It has to be social. It has to be psychological.

Self-help lines - we've spoken about. Self-help groups. Relationship therapy - if it's an individual in a in a toxic relationship that may be triggering self-harm. Problem-solving therapy - that's simple you know helping a person to solve their problems by doing self-soothing, by looking at trying to find practical solutions to the problems that may be causing them to self-harm, and also by developing a support network. That could be enough to prevent people self-harming.

If it's a mood disorder or a psychotic illness - CBT. And then you've got psychodynamic therapy, group therapy. We're talking more as an addressing self-harm in the context of personality disorder here. Family therapy - again for younger people children/adolescents who may be self-harming. Particularly if there's unusual dynamics going on in the family. You know, control issues going on in the family. Family therapy may be helpful in these groups.

49.10 **Speaker:** So that's it. I hope you found that really helpful. Self-harm is a deliberate self-injurious behaviour distinct from the harm caused by suicide. It's common and it's under-reported. It's complex in terms of all of those models of self-harm. Management obviously includes assessment and a dynamic and individualised approach to risk, and assessment of the presence of

mental disorder. And there are many useful self-management techniques that can be used that can really nip self-harm in the bud.

There are a number of helplines and that I would commend to you. I will go back to that slide if that's okay. These are some of the helplines that I would recommend. Papyrus particularly useful for young people who self-harm as is Childline. It's no longer called Get Connected - it's now called Connected. And that's an organisation set up by a Catholic group originally, but actually they're non-denominational and non-religious these days. And they support young people and the parents and the schools and provide education to schools, to support people with self-harm.

I would also recommend these two self-help books. Self-help is a really important way of supporting people and with self-harm and these are the two books that I would recommend. These are books that people can go away with and read and hire in the library or buy off Amazon. They are relatively cheap. These are good books that I would recommend as a starter in terms of helping the person help themselves with self-harm.

So just going back for me to the take-home messages. Really, from my perspective, people who self-harm aren't necessarily suffering from mental disorder. We've seen there is a complex aetiology at play. But remember, and I said this last time, self-harming does increase the risk of completed suicide - up to 60, 70 or 80 times in people. So, remember that is important and that's why you need to make sure you are assessing suicide risk. And in young people who self-harm, always consider the impact of social media, bullying and pro-self-harm websites.

And in answer to Paul - Do I use any particular risk assessment tool? No, I don't think they're helpful generally. In fact, I think some risk assessment tools are unhelpful because they lead you into a sense of sort of false sense of security because many of the risk assessment tools are very focused on those static risk factors and actually risk assessment should be dynamic and individualised to the person. So, when I'm assessing risk, I think about the risk factors in the individual. I think about the means they're using to self-harm. I think about the protective factors on that individual, the social support structures, all of those kinds of things, before I would ever use a fixed risk assessment tool, if you know what I mean, Paul.

So, thank you very much. I hope you find that helpful and I'm more than happy to answer any quick questions you may have thank you.

52.38 **Chair:** Thank you very much, Ian. Are there any questions that people would like to post in the comment box? There don't appear to be any questions, Ian. Oh, hang on! Any advice to family of self-harmers?

53.10 **Speaker:** So yes, Neeraj. Thank you for that. Any advice to a family of self-harmers as they can also have post-traumatic stress? Well, that's an interesting thing going on there. Now what's going on there I wonder? And is this the parents who are self-harming regularly and then the children are sort of modelling behaviour on children by direct observation? Or what's going on in the whole dynamic of that family? Oh, I'd like to know a lot more information about that family to understand what is going on. I suppose you know you'd want to know what the reasons are for the self-harm, whether there are any underlying mental disorders in the individual, what's going on with everyone else. You know, why the whole family is self-harming? It's difficult to give you some suggestions other than to get a lot more information about what's going on and be really interested in what the dynamics are. And if you've got one identified person that may be the main person in terms of mental illness then they need to be referred to mental health services I would say, and perhaps that could then access family therapy.

Are there any other questions?

54.28 **Chair:** Somebody asked: What are pro-self-harm websites?

54.34 **Speaker:** Basically, websites that advocate and encourage self-harm and advocate ways to do it. A bit like pro-Ana websites you may have seen or heard of these. They are anorexia websites where people give tips on how to reduce their calories or to exercise, all the rest of it. Unhelpful. Really unhelpful. But this is what the internet has given us I suppose. All the positive things and a few negative things as well, I believe.

55.02 **Chair:** There certainly don't seem to be any further questions there. So thank you very much Ian for again a lovely, informative talk with lots of practical advice for how we might deal with our patients who deliberately self-harm.

Thank you, Nicola. I've really enjoyed it.