## CHAPTER 1  
**YOUNG PEOPLE AND SELF-HARM**

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**Exploring issues – worksheets and activities**

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Self-harm and Young People is Volume 338 in the ‘Issues in Society’ series of educational resource books. The aim of this series is to offer current, diverse information about important issues in our world, from an Australian perspective.

KEY ISSUES IN THIS TOPIC
There are many types of behaviours that are considered to be deliberate self-harm (or self-injury), and young people harm themselves for different reasons. Non-fatal, self-injuring behaviours such as self-cutting, self-poisoning, self-burning and even attempted suicide are common but often hidden responses to emotional pain, and are attempts to relieve, control or express distressing feelings.

This book explores the prevalence of self-harm, identifies the warning signs, and addresses the many myths and misconceptions. Advice is also presented on how to deal with these behaviours for people who self-harm and their concerned friends and families.

What are the causes of self-harm, who is at risk, and what are the ways in which young people in distress can find support in order to cope with their feelings? What are the possible links with mental illness or thoughts of suicide? How do you keep out of self-harm’s way?

SOURCES OF INFORMATION
Titles in the ‘Issues in Society’ series are individual resource books which provide an overview on a specific subject comprised of facts and opinions.

The information in this resource book is not from any single author, publication or organisation. The unique value of the ‘Issues in Society’ series lies in its diversity of content and perspectives.

The content comes from a wide variety of sources and includes:
- Newspaper reports and opinion pieces
- Website fact sheets
- Magazine and journal articles
- Statistics and surveys
- Government reports
- Literature from special interest groups

CRITICAL EVALUATION
As the information reproduced in this book is from a number of different sources, readers should always be aware of the origin of the text and whether or not the source is likely to be expressing a particular bias or agenda.

It is hoped that, as you read about the many aspects of the issues explored in this book, you will critically evaluate the information presented. In some cases, it is important that you decide whether you are being presented with facts or opinions. Does the writer give a biased or an unbiased report? If an opinion is being expressed, do you agree with the writer?

EXPLORING ISSUES
The ‘Exploring issues’ section at the back of this book features a range of ready-to-use worksheets relating to the articles and issues raised in this book. The activities and exercises in these worksheets are suitable for use by students at middle secondary school level and beyond.

FURTHER RESEARCH
This title offers a useful starting point for those who need convenient access to information about the issues involved. However, it is only a starting point. The ‘Web links’ section at the back of this book contains a list of useful websites which you can access for more reading on the topic.
SELF-HARM AND YOUNG PEOPLE

Self-harming is a behaviour and not a mental illness and there are many reasons why someone may self-harm. Orygen Youth Health provides some facts and advice

WHAT IS SELF-HARM?
➤ Self-harming is a behaviour and not a mental illness
➤ Self-harm is when someone deliberately hurts or mutilates their body without meaning to die (although death may still occur)
➤ Self-harm often begins in teenage years and can be a way of communicating or coping with distress
➤ Not all people who self-harm are suicidal
➤ There are many reasons why someone may self-harm including a cry for help, a way of coping with stress, a symptom of a mental illness like depression, and/or it may show someone is thinking of suicide.

WHAT TO LOOK FOR
There are many different types of behaviours that can be considered self-harming. These include:
➤ Self-cutting: e.g. cutting of upper arms/wrists/thighs
➤ Self-poisoning: e.g. swallowing excessive amounts of prescribed or illegal drugs
➤ Self-burning: e.g. using cigarettes or lighters to burn the skin.

The best way to help someone you know that is self-harming is to encourage and support them to seek professional help.

There are other behaviours that are not formally considered to be self-harming behaviours but are ‘risk-taking’ behaviours that can lead to personal harm. Some examples are train surfing, driving cars at high speed, illegal drug use, or repetitive unsafe sexual practices whilst knowing of safe sex practices.

WHAT CAUSES SELF-HARM?
In most instances when someone self-harms it is an attempt to relieve, control or express distressing feelings. People self-harm for different reasons and sometimes it can be difficult to put the reasons into words.
Some people who self-harm may not know other ways of telling people about their emotional pain, and some may feel a sense of control over pain when they self-harm.
Research suggests some people are more at risk of self-harming and they include people who have experienced emotional, physical or sexual abuse, or stressful and highly critical family environments, and young people who suffer from a mental illness, such as depression.

WHAT CAN YOU DO IF YOU SELF-HARM?
Try to talk to someone about it. Telling a trusted adult can help to make sure you are safe and that you get medical assistance if you need it. If you repeatedly self-harm it is best to get some psychological treatment (counselling). One aim of counselling is to help you to feel better and find safer and more helpful ways of coping.
If you are having suicidal thoughts you should see a professional or call your local hospital or a helpline (such as Kids Helpline on 1800 55 1800 or Lifeline on 13 11 14). Counselling usually involves helping to increase problem solving, communication and coping skills.
Sometimes this can take time so it’s best to keep at
counselling even if you think it’s not helping the first couple of times. Sometimes it can be difficult to accept counselling after self-harming because you might be feeling guilty, angry, and/or ashamed. Trying to be open to counselling or support can assist you to feeling less overwhelmed and stressed in the long run. If you are not finding counselling helpful it is important to let your counsellor know, that way you may decide to change the goals or approach or even arrange to see a different counsellor.

Supporting someone who self-harms can be a stressful experience so getting support for yourself is also recommended.

HOW CAN YOU HELP A YOUNG PERSON WHO SELF-HARMS?

Some people just stop self-harming, others can continue in a fairly safe way and others can place themselves at risk of dying. The best way to help someone you know that is self-harming is to encourage and support them to seek professional help. Try to help the young person feel safe to discuss the self-harm. Try to remain calm and maintain an open attitude recognising the young person may feel ashamed of their actions.

It is important not to be critical or get angry when discussing these issues.

It is important that you ask the young person whether he/she feels suicidal.

Call your local hospital or mental health service if you think the young person is suicidal, to get professional help. Initial treatment involves dealing with any immediate medical complications of self-harm, if present. Call an ambulance (000) or take the person to the accident and emergency department of the local hospital if the person needs urgent medical attention.

Supporting someone who self-harms can be a stressful experience so getting support for yourself is also recommended.

SERVICES AT ORYGEN YOUTH HEALTH – CLINICAL PROGRAM (OYH-CP)

Orygen Youth Health Clinical Program is able to assist some young people (15-24) with anxiety disorders who live in western or north-western metropolitan Melbourne.

To make a referral or get some advice contact the OYH-CP Triage worker on 1800 888 320 or via the paging service on 03 9483 4556.

For children and teenagers under 15 years of age living in western or north-western metropolitan Melbourne contact RCH Mental Health Service on 1800 445 511.

For further information regarding mental health and information in other languages visit:

➤➤ www.betterhealth.vic.gov.au
➤➤ www.sane.org.au
➤➤ www.healthinsite.gov.au
➤➤ www.ybblue.com.au
➤➤ www.beyondblue.org.au
➤➤ www.reachout.com.au

It is important that you ask the young person whether he/she feels suicidal.

Call your local hospital or mental health service if you think the young person is suicidal, to get professional help. Initial treatment involves dealing with any immediate medical complications of self-harm, if present. Call an ambulance (000) or take the person to the accident and emergency department of the local hospital if the person needs urgent medical attention.

Supporting someone who self-harms can be a stressful experience so getting support for yourself is also recommended.
The term ‘self-harm’ refers to a range of behaviours that range from mild to moderate self-injury as a response to emotional pain to more extreme behaviours such as attempted suicide (Skegg 2005). In many cases, self-harm is not intended to be fatal (Skegg 2005).

Self-harm frequently involves cutting and poisoning (typically overdosing on medication), but may also involve behaviours such as self-battery or hanging (De Leo & Heller 2004; Skegg 2005).

The number of young people who commit suicide is relatively low compared with the number who commit self-harm. A range of interacting factors – related to individual, family and social circumstances – are associated with increased risk of suicide among young people.

These include:
➤ Mental illness combined with harmful drug use
➤ Previous suicide attempts or intentional self-harm
➤ Family history of suicide or suicidal behaviour
➤ Socioeconomic disadvantage, including low educational achievement, unemployment, imprisonment
➤ Experience of abuse in childhood
➤ Easy access to firearms (Beautrais 2000; Goldney 1998).

There is a distinction to be made between intentional self-harm where the intent is to commit suicide, and where the intent is to only commit self-harm, but death results. In this section, hospitalisations for intentional self-harm will be referred to as such (this includes attempted suicide), while deaths due to intentional self-harm will be referred to as suicides, but it is acknowledged that not all of these deaths occurred with that intention.

**Hospitalisations**

Almost one-third of all intentional self-harm hospitalisations were for young people in 2005-06, although this represented only 2% of all hospitalisations of young people.

➤ In 2005-06, there were 7,299 hospitalisations of young people due to intentional self-harm – a rate of 197 per 100,000 young people
➤ Between 1996-97 and 2005-06, the hospitalisation rate for intentional self-harm among young people increased by 43%, from 138 per 100,000 young people to 197. The percentage increase was greater among females than males (51% compared with 27%), and the female rate was consistently at least twice as high as for males over this period (2.5 times in 2005-06) (Table 5)
➤ In 2005-06, the hospitalisation rate for young females was highest among those aged 15-17 years (426 per 100,000 young females, which was 3.5 and 1.5 times that for 12-14 year old and 18-24 year old females, respectively) (Figure 13). Among young males, the rate increased with age (from 21 to 163 per 100,000 12-14 year old and 18-24 year old males, respectively)
➤ The majority (79%) of intentional self-harm hospitalisations were for young people in 2005-06, although this represented only 2% of all hospitalisations of young people.
The prevalence of self-injury in Australia is substantial and self-injury may begin at older ages than previously reported, according to an article in the *Medical Journal of Australia*

Self-injury is deliberate damage to the body without suicidal intent. Graham Martin, Professor and Director of Child and Adolescent Psychiatry at the University of Queensland, and co-authors conducted a cross-sectional study to gain an accurate understanding of self-injury and its correlates in the Australian population. A sample of 12,006 Australians, from randomly selected households, participated in the study.

In the four weeks before the survey, 1.1 per cent of the sample self-injured. Six-month prevalence was 1.8 per cent. Lifetime prevalence was 8.1 per cent. For females, self-injury peaked between 15 and 24 years of age. For males, it peaked between 10 and 19 years of age. The average age of onset was 17 years, but the oldest was 44 for males and 60 for females.

Prof Martin said that most of the self-injurers in the study reported discussing the problem with someone, but only a third had sought help.

“Self-injurers are more likely to have mental health problems and are at higher risk of suicidal thoughts and behaviour than non-self-injurers, and many self-injurers do not seek help.

“The rate of self-injury in Australia in the four weeks before the survey was substantial, and onset of self-injury may occur at older ages than previously thought,” Prof Martin said.

“The rate in males across the age range challenges previously held beliefs that self-injury is predominantly a problem for women; clearly it is not.

“The personal and financial costs are likely to be high, and further research is needed to determine the most appropriate and cost-effective strategies for prevention.”

*The Medical Journal of Australia* is a publication of the Australian Medical Association. The statements or opinions that are expressed in the MJA reflect the views of the authors and do not represent the official policy of the AMA unless that is so stated.

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hospitalisations among young people were due to intentional self-poisoning (5,769 hospitalisations), followed by intentional self-harm by sharp object (15% or 1,122 hospitalisations).

Population groups

The intentional self-harm hospitalisation rate was almost twice as high among Aboriginal and Torres Strait Islander young people compared with other young Australians in 2005-06 (332 hospitalisations per 100,000 young people aged 12-24 years compared with 188), after adjusting for differences in age structure (data do not include Tasmania, the Australian Capital Territory and private hospitals in the Northern Territory, see Technical notes in Bulletin 60 – *Injury among young Australians*).

Young people aged 15-24 years living in Very Remote areas were hospitalised for intentional self-harm at twice the rate of young people living in Major Cities in 2005-06 (age-standardised rates of 438 compared with 222 per 100,000 young people). Similarly, the age-standardised hospitalisation rate was higher for those young people living in the most socioeconomically disadvantaged areas than those living in the least socioeconomically disadvantaged areas (260 compared with 203 per 100,000 young people).

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Extract from Bulletin 60 – *Injury among young Australians*’

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Queensland psychiatrist Professor Graham Martin is a very determined man. So when he stepped towards the room of an angry, uncommunicative, self-injuring 16-year-old and heard one of the nurses say, “I bet you don’t get anything out of her”, he had all the incentive he needed.

He put his head down and strode forward boldly.

“This young girl looked more like a 13-year-old, not anorexic, but certainly very thin. She had scars all the way down her leg and her arm where she had been cutting herself,” he says.

“For the first 20 minutes or so, I could not get her to recognise my presence or respond to any of my questions. She didn’t even react when I started making provocative statements.

“I watched as she looked down at her hands, then at the photograph album, look back at me and then hand it over.

“It was the first time she actually acknowledged me.”

Inside the album were photos of her mother, who had died of cancer when she was six. Her father blamed her for her mother’s death and had repeatedly abused her both verbally and sexually.

Her older brothers had treated her in a similar way.

“Because she was treated so badly by her family, she had come to truly believe she was to blame for her mother’s death,” explains Professor Martin, the director of child and adolescent psychiatry at the University of Queensland.

“So every time something awful happened in the family, she would cut herself because it was the only thing that brought her relief.”

At 13 and then again at 15, she found herself pregnant after being raped by a number of young men at parties where she had used drugs and too much alcohol. Both pregnancies were terminated.

“Listening to this young woman share her terrible story, knowing she has experienced more emotional pain than many of us could ever imagine, I felt compelled to ask: ‘Why are you still alive? Why would you want to go on living?’

“And very quietly she responded with: ‘My violin’.”

Self-injury exists across the age groups, not just in young people, and is just as prevalent in males as in females.

Admitting he found it difficult to believe “this damaged little girl” played the violin, Professor Martin pursued the subject further and soon discovered she had actually passed her grade seven exam.

“For the first time she became really animated and she said to me: ‘I would really, really love to become a violin teacher.’

“So we spent some time exploring how she could achieve that goal, and within just that one session, her whole demeanour, her whole attitude changed, and we decided she wasn’t suicidal.

“Eventually she moved to a group home and she went back to school to finish her education. She still uses self-injury occasionally, but she is living a much better life and she is on track to accomplish her dreams.”

Common behaviours

Deliberate self-harm and self-injury are common behaviours in Australia. While recent figures from the Royal Australian and New Zealand College of Psychiatrists (RANZCP) show more than 25,000 people in any year are admitted to hospital as a result of self-harm, worrying new study results suggest an estimated 200,000 Australians, or 11 per 1,000 people per month, self-injure.

The study also showed the 12-month prevalence of self-injury is 2.6 per cent, corresponding to an estimated 520,000 Australians or a rate of 26 per 1,000 people per year.

“This can be compared to recent Australian 12-month prevalence figures for panic disorder, obsessive compulsive disorder, generalised anxiety disorder and agoraphobia,” say the authors of the Australian National Epidemiological Study of Self-Injury (ANESSI).

“Such a high prevalence is reason for us to take self-injury as seriously as we would take other mental health problems.”

Furthermore, the study shows self-injury exists across the age groups, not just in young people, and is just as prevalent in males as in females.
“Somehow seeing the blood on the arm, the leg, the stomach or wherever, allows these people to feel real, to feel that they are human and not so isolated.”

While many worry these figures reflect a significant increase in the number of people self-harming in the community, the University of Sydney’s Professor Philip Boyce says it may be because we are more conscious of it now than and as a result more people are seeking help. Or, says the former chair of the RANZCP Clinical Practice Guidelines Team for Deliberate Self-Harm, it may be that we are classifying self-harming behaviour differently.

Professor Martin, who is lead author of ANESSI and director of the Centre for Suicide Prevention Studies in Young People, agrees a true picture of the prevalence and nature of self-harm and self-injury has been difficult, but he believes rates are rising.

He says international studies of school children show that between 2000 and 2003, rates were about 5-6 per cent. More recent studies show they are now more likely to be 8 per cent.

He attributes the rise to changes in society.

“Generally speaking, we live in a faster, more stressful environment. We are also living in a less kind society,” he says.

Other reasons, he surmises, are bullying and changes in parenting practices.

“Parentshavelesstime,aregenerally less skilled and the relationships between parents to children are much more problematic and difficult.

“It is also clear that violence in the family is more of an issue.”

**Predicting problems**

While mental health problems are also associated with self-harm – problems including general psychological distress, certain mental health conditions such as anxiety, and psychological issues such as dissociation – none of these factors alone will necessarily predict the presence of self-injury, Professor Martin says.

Furthermore, self-injury can be a major risk factor for suicide, but it is not a suicide attempt.

“There is some international evidence showing the longer people go on, and the less therapy they get in the long term, the more likely they are to get into suicidal behaviours. But in the early stages, it is not about suicide.”

Instead, Professor Martin says people use self-injury for several reasons, including to control or contain emotion; to punish the self; or to cure a feeling of emptiness.

“Somehow seeing the blood on the arm, the leg, the stomach or wherever, allows these people to feel real, to feel that they are human and not so isolated.”

And many, he says, do rely on their GPs for help.

Evidence from Western Australia shows that more than a third of people hospitalised after an episode of deliberate self-harm visited their GP in the previous week, while almost two-thirds visited their GP in the previous month.1

That is why Dr Phill Brock, chair of the RANZCP’s Faculty of Child and Adolescent Psychiatry, reminds GPs with patients that may be self-injuring, to take the time to “do a quick inventory”.

“Ask about school, how they are going with their studies, how things are at home or work, with their friends, how they spend their leisure time and so forth.

“If there is any indication of poor coping in any area, that’s then a time to inquire a little further.”

Dr Brock says it is also useful to remember that only a “very, very small minority” of disturbed patients use self-harm repetitively as a coping strategy.

In these cases, he suggests it may be beneficial to ensure a child is placed in a supportive environment where alternative coping strategies can be taught.

“The job of the doctor is to listen and see if they can help the young person find the meaning and find some alternative coping strategies.”

“But for the vast majority of cases, the best help a GP can provide is to listen, be respectful and take the
complaint seriously. If there is an indication mental health is being compromised, provide some mental-health first aid or arrange an extended session in the near future.”

So far, it’s believed that dialectical behaviour therapy – a skill-based, cognitive behavioural approach that emphasises acceptance of the person as they are, combined with an expectation that current behaviours need to change – has consistently shown efficacy in self-injuring clients.

“Every single act of self-harm has meaning,” Dr Brock says.

“The job of the doctor is to listen and see if they can help the young person find the meaning and find some alternative coping strategies.”

REFERENCES

STUDY FINDS ONE IN TWELVE TEENAGERS SELF-HARM

A study by the Murdoch Childrens Research Institute and Kings College, London found that one in twelve teens self-harm during their adolescent years

• It is the first population-based study to examine incidence and prevalence of self-harm during transition from late adolescence to adulthood
• 15 years was the most likely age for self-harm, however, it was found that most young people gave up self-harming behaviour as they became adults. This trend was attributed to them developing different ways of dealing with difficult emotions
• 10% of females reported self-harm at least once during adolescence, compared with 6% of males – a 60% increased risk of self-harm in girls compared with boys
• 1,943 Victorian students in their early adolescence were included in the study and were asked about recent self-harming on four occasions during their teenage years, and were then followed up through to their late 20’s
• The majority of students questioned only reported self-harm in adolescence; 90% of those who self-harmed as teenagers had ceased by their twenties
• All forms of self-harm, such as cutting and overdosing, became less common in their late teens and twenties
• During adolescence, self-harm was associated with symptoms of depression and anxiety (3.7 times increased risk compared with no depression or anxiety), anti-social behaviour (doubling the risk), high risk alcohol use (doubling the risk) and cigarette smoking (2.4 times the increased risk)

Adolescent symptoms of depression and anxiety also predicted later self-harm in young adulthood, even in those who had not harmed themselves in their teens.

Alison Dower scratches her arms. She doesn’t have an itch, not even a tickle, but still she can’t fight the urge to scratch. And not just a little – Alison scratches to cause pain, to draw blood and escape the emotional burden of her depression.

“I get a thrill when I go deep enough to bleed,” she says. “Even in the days after I’ve cut or scratched, the pain of pushing on the wounds gives me an overwhelming sense of satisfaction.”

Alison traces the roots of her psychological struggle to bullying and family troubles in her high school years. She found that scratching helped to escape her stress. Later, she turned to occasionally cutting herself to achieve the same effect. By the age of 16, she was hooked.

While her peers obsessed over their social diaries, Alison hid behind closed doors, mutilating her body with scissors and blunt knives. She experimented with different objects, and over time, figured just how deeply she could penetrate her skin without being admitted to hospital.

The term ‘self-harm’, which has evolved from older phrases such as ‘self-mutilation’ or ‘self-injury’, is broadly defined as the intentional injuring of body tissue without suicidal intent. It can take a variety of forms, including cutting, burning, hair-pulling, biting and piercing.

According to the Australian National Epidemiology Study of Self-Injury (2008), about 230,000 Australians deliberately self-harm in a four-week period – mostly, but not only, girls – and about 24,000 cases each year result in hospitalisation. In a separate survey of 12,000 people, researchers from the University of Queensland found that 8 per cent of 15- to 24-year-olds had self-harmed at some point in their life.

Lead researcher of that study, Professor Graham Martin, director of child and adolescent psychiatry at the University of Queensland, says the survey may only show the tip of the iceberg.

“For Alison, self-harming makes perfect sense. “It calms me down by replacing intense emotional pain with a more intense sensation,” she says. In fact, after nine hospital admissions, she says self-harm is often the only thing standing in the way of a suicide attempt.

“It takes my mind off my emotional distress, and is an immediate relief from the other problems that I know won’t go away.”

Most people who self-harm have stories similar to Alison’s, says Associate Professor Michael Baigent, clinical adviser at beyondblue.

“Self-harm is a very secretive behaviour, and it is very possible that half a million Australians self-harm each year,” he says.

Evidence is also mounting that the prevalence of self-harm is increasing, he says: “It is very likely we may have an epidemic on our hands.”

Dr Janis Whitlock (PhD), a prominent researcher in the field, also holds this view. She and colleagues at Cornell University in the US surveyed college mental health providers, secondary school counsellors, nurses and social workers. Almost all respondents indicated that self-injurious behaviour has become increasingly prevalent in the past few years.

For Alison, self-harming makes perfect sense. “It calms me down by replacing intense emotional pain with a more intense sensation,” she says.

Could mental health professionals themselves have been implicated in...

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driving this self-harm epidemic?

Professor Baigent thinks so. He is concerned about the effect of a recent push to acknowledge self-harming behaviour as a mental illness.

“The language around self-harm has entered our common day conversations,” he says. “We are describing the symptoms and conditions more than ever before, which actually normalises the behaviour to some extent.”

In fact, Professor Baigent says the increased dialogue may actually encourage people to start self-harming.

“Labelling it as a symptom of mental illness may actually push people to inadvertently adopt the behaviour,” he says. “There is a chance that we are creating this culture of self-harm, and perpetuating the very illness we are trying to cure.”

But even if this is true, it’s far from the only reason more people are hurting themselves in this way. The internet and social networking portals are also thought to be major culprits.

“The sheer magnitude of uncensored sites that discuss self-harm is worrying,” Professor Baigent says. “What’s worse is that many promote self-harm as a fashionable behaviour, which is poisonous to young adolescents who are searching for an identity.”

Last year, Dr Whitlock noted that several studies have shown self-harm has a ‘contagious’ capacity to spread in a population. She and her group found that since 1980, references to self-injury have dramatically increased in the media, and they continue to skyrocket.

“Self-injury in print news media prior to 1990 was extremely rare, while researchers found 1,750 related news stories in the 2000-2005 period alone,” she says. “This increase is even more pronounced on the internet.”

“There’s also the chance they could accidentally commit suicide by misjudging their self-harming act.”

Even a rudimentary Google search confirms the truth of this: thousands of chat rooms and forums – many littered with graphic details about self-harming methods and techniques.

Thirteen-year-olds seek advice on how to cut without their parents finding out, and others divulge details of their hospital admissions and suicide attempts. While some of the content touches on recovery efforts and counselling, about 30 per cent would be considered harmful by most psychiatrists.

Professor Baigent fears the ‘vicious’ chat rooms and social networking sites are encouraging some adolescents to experiment with self-harming behaviour without realising the consequences.

“If kids pick up this behaviour, and it is reinforced, there is potential for it to become a life-long habit that’s hard to escape,” he says.

“There’s also the chance they could accidentally commit suicide by misjudging their self-harming act.”

UNDER THE CARPET

The University of Queensland’s Professor Martin disagrees that too much discussion about self-harm could be damaging. He says the focus should turn towards ‘sensibly’ dealing with self-harmers, rather than speculating why the trend is increasing.

“For too long the negative stigma around self-harm has brushed it under the carpet ... but it’s critical that it’s taken seriously … people are dying from this illness.”

At first, most self-harmers experience depression or anxiety because of some form of trauma, Professor Martin explains.

As a coping mechanism, they then turn to mild forms of destructive behaviour, such as cutting, hitting, or even starving themselves. This then forms a habit, and before long, many patients find themselves in hospital because they’ve gone too far.

Alison is living proof. After just over four years of self-harming, her arms and legs are covered in scars. Her wardrobe is now dominated by long-sleeved shirts and heavy trousers.

“I didn’t realise how self-harming would take over my life, but there seemed to be no way to escape it,” she says.

Alison’s family recognised her behaviour as a cry for help, and admitted her to intensive therapy in 2008. She used meditation and breathing techniques to distract her from self-harming, and tried mindfulness techniques to train her mind to disregard negative thoughts.
After 12 months of therapy, Alison found herself fighting the same demons.

“The more I was told I couldn’t self-harm, the more I wanted to do it, and the more I just wanted to say, ‘Fuck it’ and take my life,” she recalls. But almost three years on, she is finally on the road to recovery.

“Self-harm still plagues my mind ... it’s like my best friend and worst enemy,” she says. “I feel invigorated after scratching, and I miss it when I know I can’t do it ... but I’m also more aware of the downward spiral that follows.”

‘SILLY LITTLE GIRLS’

Professor Martin says most self-harmers share the same frustration as Alison.

“They know there are other ways to deal with their stress, but keep turning to the same techniques they know will work because they’re scared of seeking help,” he says.

He tells of patients who have been left to wait hours in hospital corridors, or sent home without stitches for their self-inflicted scars.

“Most self-harmers are treated abominably,” he says. “But disregarding them is only perpetuating the problem, and potentially increasing their risk of suicide.”

While self-harm and suicide don’t always occur together, Professor Martin says research suggests up to 40 per cent of self-harmers have thought about, or attempted, suicide.

While self-harm and suicide don’t always occur together, Professor Martin says research suggests up to 40 per cent of self-harmers have thought about, or attempted, suicide.

“This highlights the severity of self-harm and the need to take it seriously,” he says. “But that’s hard with a culture that believes self-harm is littered with ‘silly little girls’ who are crying for attention.”

He argues that it is ‘dangerous’ to trivialise self-harm because people in need may not get the help they need.

Alison is a prime example. She’s struggled to conceal her illness for years, and admits she’s been close to death as a result of self-harm.

“I don’t know why I have the feelings I do,” she says. “Sometimes I know I need help, but don’t realise I’m ill until I’m covered in cuts and scratches, and struggling to get out of bed because of my depression.”

But all is not lost. Alison is adamant her support network has made a big difference – often swaying her from suicide attempts.

“Mindful and meditation techniques have helped me get along with my daily life, and knowing I can talk to someone about my thoughts gives me peace of mind,” she says. “I know I’m far from recovered, but every bit of help makes a difference.”

The evidence for what works in treating self-harm is sparse. In a systematic review of 23 trials, UK researchers concluded that the most promising approaches include problem-solving therapy, providing emergency service contact information, long-term psychological therapy, and depot flupenthixol for those with repeat self-harm experience. But they cautioned that current knowledge was insufficient and more trials were sorely needed.

Now 22, Alison is juggling full-time work and a university degree with the help of her family, GP and psychiatrist.

“I don’t even want to think about where I’d be without their help ... but I’m doing okay, even if it is just with a few glitches.”

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**Australian Doctor, 10 February 2011**

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WHAT IS SELF-HARM?

Self-harm occurs when people deliberately hurt their bodies. The most common type of self-harm among young people is cutting. Other types include burning the skin until it marks or bleeds, picking at wounds or scars, self-hitting and pulling hair out by the roots. At the more extreme end of the spectrum, self-harm can include breaking bones, hanging and deliberately overdosing on medication.

There are other deliberate behaviours that can be harmful to one’s health that are not normally included in the definition of self-harm. These include self-starving, binge drinking, smoking or other drug use and dangerous driving.

Self-harm is more common than people may think. About 12% of young people in Australia report having self-harmed at some point in their life.

How many young people self-harm?

Research suggests that 6-7% of young Australians (aged 15-24) have self-harmed in any 12-month period, while over 12% report having done so at some point in their life. Self-harm is more common after the onset of puberty. The average age at which self-harm first occurs is 12-14 years and, in adolescents, it is more common among girls than boys. However, self-harm can occur in anyone, regardless of their age, gender, socio-economic status or culture/ethnicity.

Self-harm often goes unnoticed. It is commonly done in private and most young people who self-harm don’t seek help or come to the attention of health services.

Why do people self-harm?

Most self-harm is in response to intense pain, distress, or overwhelming negative feelings, thoughts or memories. Although young people who self-harm might say that they want to die, the driving force behind their behaviour is often more to do with expressing their distress and desire to escape from troubling situations. It is usually a build up of negative experiences/stresses rather than any one single event or experience that triggers self-harm in young people.

Young people who self-harm may feel that it helps to relieve their distress and bring some sense of relief in the short term. However this feeling of relief typically doesn’t last because the problems causing the distress are not being addressed. For some young people self-harm is a ‘once off’ event, but for others (over 50% who self-harm) it can become repetitive. Most young people who repeatedly self-harm say they never thought they would come to rely on it as a way to cope with their feelings.

Many realise that, in the long term, self-harm is not an effective coping mechanism, but find it hard to give up. Often, they are not able to find other ways to cope with their distress (e.g. talking with somebody they can trust).

Some young people who repeatedly self-harm may experience the behaviour as being ‘addictive’. It is important to respect this viewpoint, and understand that, for these young people, recovery is not as simple as ‘just stopping’. Often a person can stop self-harming only when they have developed more effective ways of coping with their distress. This process usually takes time. Initially the focus may need to be on helping the young person to reduce their level of self-harm rather than asking them to give it up immediately. However, with time and appropriate support, many young people do recover and stop self-harming.

What are the most common myths surrounding self-harm?

There are many myths surrounding self-harm, which
makes it hard to separate fact from fiction. It can be very confusing and difficult to understand, both to the person who is self-harming and to their friends and family. Raising the topic of self-harm can bring up uncomfortable feelings including fear, guilt, and shame. Some of the most common myths around self-harm are:

- **“Self-harm is an attempt at suicide”**
- **“It’s just attention seeking”**
- **“It’s an ‘emo’/’goth’ thing”**
- **“If you self-harm it means you’re mentally ill”**
- **“People who self-harm have borderline personality disorder”**

These are myths, not fact. But even as myths, they can be very powerful and impact not only on young people who self-harm, but also on those around them.

**MYTH: “Self-harm is an attempt at suicide”**

Often what frightens people most about self-harm is the assumption that the person is trying to kill themselves. **This is not true. In the vast majority of cases, self-harm is a coping mechanism, not a suicide attempt.** It may seem counter-intuitive, but in many cases, people use self-harm as a way to stay alive rather than end their life. 

It is important to understand that self-harm is mostly an attempt to hurt, not to kill oneself. However there is a relationship between self-harm and suicide that does need to be considered. Sometimes people injure themselves more seriously than they intend to, and this can put their life at risk. Young people who self-harm are also at a much higher risk of attempting suicide at some time in the future than those who don’t self-harm, even if they’re not suicidal at the time. This doesn’t mean they will attempt suicide, but rather that their risk is higher. It is important to encourage anyone who is self-harming to seek help from a health professional to address any underlying emotional problems (e.g. depression or anxiety).

**MYTH: “It’s just attention seeking”**

Self-harm is not about attention seeking. Most young people who self-harm go to great lengths to draw as little attention as possible to their behaviour by self-harming in private and by harming parts of the body that are not visible to others. 

The term ‘emo’ was originally used to describe a style of music known as ‘emotive rock’, which used expressive and often confessional lyrics. Today the term is used more broadly to describe a fashion style and personality traits such as being emotional, sensitive, shy, introverted, or angst-ridden.

Even those closest to the young person are often unaware of it. One study found that the rates of self-harm reported by young people were three times higher than their parents estimated. Concealing self-harm can be a big burden for young people and can affect their day-to-day life. For example, it can determine what clothes they can wear (to cover up cuts or scars), limit their activities (e.g. not going to the beach or swimming) or cause them to avoid physical or intimate relationships in which someone might become aware of their self-harm.

Rarely, threats of self-harm or actual self-harm might be used to achieve a certain aim. This is often called ‘manipulative behaviour’. **Most of the time people self-harm in an attempt to change how they are feeling, rather than trying to get attention from, or manipulate, other people.**

**MYTH: “It’s a fashion, a trend or an ‘emo’ thing”**

Self-harm is not a new behaviour that arrived with a certain subculture or ‘trend’ amongst young people. Mental health professionals have been studying and treating self-harm for decades. Despite this, self-harm has been and continues to be associated with certain subcultures resulting in stereotyped beliefs that only ‘certain kinds of people’ self-harm. Recently the ‘emo’ trend has received attention as being associated with depression, self-harm and suicide. A national inquiry into self-harm among young people in the UK found no evidence to suggest it was associated with any particular youth subculture.

**MYTH: “If someone self-harms, they must have a mental illness or a personality disorder”**
**Self-harm is a behaviour or symptom, not a disorder or an illness.** Self-harming behaviour is strongly suggestive of an underlying psychological or emotional problem, but many young people who self-harm do not meet the criteria for any specific mental illness diagnosis.

Parents often experience intense emotional responses when learning that their child is self-harming, including shock, embarrassment, shame, guilt and confusion.

Borderline Personality Disorder (BPD) is the only mental health disorder for which self-harm is a diagnostic feature. As a result, young people are sometimes labeled as having BPD simply because they self-harm. In fact, only a small minority of young people who self-harm meet the diagnostic criteria. **Self-harming behaviour alone should never result in the assumption that a person has BPD.** BPD should only be diagnosed following a comprehensive assessment.

**Other unhelpful ways of talking about self-harm**

As well as being influenced by common myths, people’s understanding of self-harm is influenced by the way it is talked about in the media and in day-to-day conversation. Self-harm is often talked about in unhelpful ways, such as ‘a trend’ or ‘an epidemic’. These sorts of sweeping statements should be avoided – they are inaccurate and potentially harmful.

**What effect do these myths have on young people who are self-harming and their families?**

The myths that surround self-harm contribute to the guilt, shame and fear experienced by most young people who self-harm. They are very aware of the labels that might be placed on them if anyone finds out about their self-harm and often fear being labelled (e.g. as an ‘attention-seeker’, ‘crazy’, ‘stupid’) by others. These fears can drive their efforts to keep their self-harm a secret.

Young people also feel a tremendous amount of guilt and shame about their self-harm. This can make it very hard for them to find the information and support they need to find better ways to cope with their emotional distress and problems.

**Young people who do seek support for their self-harm are most likely to turn to friends or family first.** If the person they turn to believes the myths about self-harm, they are more likely to respond in a negative or unhelpful way. This might include not taking the self-harm seriously (e.g. it’s just ‘a phase’ or ‘attention seeking’), getting angry with the person, or panicking and jumping to the conclusion that the person is suicidal when this may not be the case. **If a young person’s initial attempts to seek support are negative or unhelpful this might add to their distress and their self-harm might become more frequent or serious.**

Parents often experience intense emotional responses when learning that their child is self-harming, including shock, embarrassment, shame, guilt and confusion. Many report feeling that they have ‘failed’ their child in some way, or fear how other people might react to learning of the self-harm (e.g. ‘you’re bad parents’ or ‘your child is crazy’). As a result, some parents are reluctant to confide in friends or family about what they are going through. This adds to their sense of isolation and can leave them feeling overwhelmed. Because of these sorts of experiences, parents often only seek help for their child when the self-harm escalates and a crisis occurs. Delays in seeking help can have serious consequences for the young person and their family. If there are psychological problems underlying the self-harm, it is best to seek help early so that appropriate support and treatment can be provided.

**Beyond the myths – how can young people who self-harm be helped and supported?**

It can be difficult to know what to do if you are worried about someone who is, or may be, self-harming. It is perfectly natural to feel overwhelmed. Try to acknowledge your feelings, whatever they may be, and deal with them (e.g. talk to somebody about how you’re feeling, take some time out to clear your head). One of the most helpful things that you can do is to remain calm. To do this you need to get your own emotions under control first.

If you are self-harming it’s important to remember that there is a lot of support out there. If you’re not ready to talk to someone you know about your self-harm, you can talk to a doctor (GP) or call a confidential helpline (e.g. Lifeline 13 11 14). It can also help to look up websites that are designed for young people – such as headspace.org.au and reachout.com.au – for reliable information, advice and support. You may also be interested in some of the tips listed below.

**Tips for supporting somebody who is self-harming:**

- Don’t ignore or dismiss your concerns
- Do educate yourself about self-harm: see below for a list of helpful resources
- Do try to manage your own emotions. This will help you

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**UNHELPFUL LANGUAGE: “SELF-HARM IS ...”**

<table>
<thead>
<tr>
<th>THE FACTS</th>
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<tbody>
<tr>
<td>“... an epidemic”</td>
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<tr>
<td>There is no evidence to support the idea that the rates of self-harm among young people warrant it being described as ‘an epidemic’. Using such language only creates widespread panic and alarm that can be very frightening, particularly for parents.</td>
</tr>
<tr>
<td>“... a trend”</td>
</tr>
<tr>
<td>Self-harm is not ‘a trend’. It is a serious problem that often indicates serious emotional distress.</td>
</tr>
</tbody>
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to approach the person in a calm and non-threatening manner

➤ Don’t panic and jump to conclusions about why the person is self-harming. Don’t assume you know the reason – instead ask about the feelings that are driving their self-harm

➤ Do ask the person directly if they are feeling suicidal (see accompanying mythbuster: ‘MYTH: Asking young people about suicidal thoughts or behaviours will only put ideas in their heads’30)

➤ Do encourage the person to get support from a health professional: getting help earlier means any underlying problems that do exist can be detected and the person can get appropriate support

➤ Do recognise that their self-harm may be one of their only coping tools and that asking them to give it up can be very frightening. Reassure the person that you don’t expect them to stop today

➤ Don’t make ultimatums or try to force the person to stop: this is likely to make things worse

➤ Don’t agree to keep secrets: it is possible that the person’s safety is at risk from their self-harm. This means you may have to tell somebody else to keep them safe. If this happens only tell the people who need to know (e.g. a counsellor/teacher/parent)

➤ Do try and be as open with the person as possible: If you need to tell somebody else about their self-harm to keep them safe, try to speak to them about this first. It is important that they don’t feel that things are being taken out of their control and that everyone will suddenly know about their self-harm

➤ Do look after yourself: consider whether you need to get some advice and support for yourself (e.g. from a helpline/counsellor or a friend).

It’s good to learn some things that you can do to help yourself, but it’s important to remember that helping yourself doesn’t mean you have to go it alone.

Tips – some self-help techniques that may be helpful

Young people who self-harm say that finding ways to distract themselves when they get the urge to self-harm is very important to their recovery57. These may not work for everyone but it can be helpful to give them a try to see if you can find one that might work for you:

➤ Using a red pen to mark the skin instead of cutting

➤ Hitting a punch bag to vent anger or frustration

➤ Exercising

➤ Making lots of noise (e.g. with an instrument, banging pots and pans)

➤ Writing your negative feelings on a piece of paper and then ripping it up

➤ Scribbling on a large piece of paper with a red pen

➤ Writing a diary or a journal

➤ Talking to a friend (not necessarily about self-harm)

➤ Doing a collage/artwork

➤ Going online and looking at self-help websites.

Using ‘substitute forms of self-harm’ can also be helpful, e.g.:

➤ Rubbing ice on the skin instead of cutting

➤ Putting elastic bands on the wrists and flicking them instead of cutting

➤ Eating a chilli.

It’s good to learn some things that you can do to help yourself, but it’s important to remember that helping yourself doesn’t mean you have to go it alone. Talking to someone you trust about what you’re going through can make things a lot easier. This might be a friend, family member, teacher, youth worker, counsellor or GP. You can also call a confidential helpline.

REFERENCES


WANT TO KNOW MORE?

For more reliable information about self-harm including fact sheets, young people’s stories of their experiences of self-harming and recovery, and information on how and where to get help check out the following websites: headspace.org.au and reachout.com.au

The Royal Australian and New Zealand College of Psychiatrists Guidelines on Self-harm are also helpful to young people and their carers (www.ranzcp.org/resources/clinical-practice-guidelines.html)

For practical tips on how to approach somebody who may be self-harming read the Mental Health First Aid Guidelines for Non-Suicidal Self-Injury (www.mhfa.com.au)

For more reliable information about self-harm including fact sheets, young people’s stories of their experiences of self-harm, and adolescents in Great Britain in 1999 and adolescents who try to harm, hurt or kill themselves: A report of further analysis of the national survey of the mental health of children and adolescents in Great Britain in 1999. London: Office for National Statistics.


30. Centre of Excellence in Youth Mental Health (2009) ‘Mythbuster-Suicidal Ideation: Myth “Asking young people about suicidal thoughts or behaviours will only put ideas in their heads”’. Oxygen Youth Health Research Centre.

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Self-harm is the deliberate injuring of oneself in an attempt to cope with strong feelings such as anger, despair or self-hatred. Someone who self-harms may inflict physical injuries in a variety of ways such as cutting, piercing, burning or biting themselves. This is known as direct self-harm.

Generally speaking, someone who self-harms isn’t trying to commit suicide. A person who is suicidal is desperate to never feel anything again, whereas the person who self-harms is only trying to make themselves feel better. In some cases, a person may self-harm in an attempt to drive away suicidal feelings. Research is scarce, but it seems that between 1986 and 1991, about five per cent of public hospital injury-related admissions in Victoria were self-inflicted. (However, this estimate includes cases of failed suicide attempts.) Other terms for self-harm include self-injury and self-mutilation.

**Reasons for Self-harming Behaviour**

Some of the many reasons why a person might self-harm could include:

- Low self-esteem
- Poor body image
- Self-hatred
- Post traumatic stress disorder
- The belief that punishment is deserved
- Strong feelings of anxiety or depression
- Emotional numbness (feeling physical pain is ‘better’ than feeling nothing)
- A response to physical, sexual or emotional abuse.

**Other Forms of Self-harm**

Indirect self-harm involves inflicting physical injury in a more roundabout way, such as neglecting to manage an illness or failing to seek help for a disorder or alcoholism. Direct and indirect self-harm is generally different from socially acceptable forms of ‘self-harm’, such as tattooing and body piercing, because the reason for doing it is different. Tattoos and body piercing may be done for spiritual, aesthetic or cultural reasons, whereas self-harm is a destructive coping mechanism for dealing with psychological problems, such as severe anxiety.

**Severity of Self-harm**

Direct self-harm can be categorised by the severity of the injuries, for example:

- **Moderate self-harm** – such as cutting, burning, piercing, biting and hairpulling
- **Stereotypic self-harm** – such as headbanging. Stereotypic self-harm may be associated with other disabilities
- **Major self-harm** – such as amputation and castration. Major self-harm is often associated with some form of psychosis.

**Regularity of the Self-harming Behaviour**

Direct and moderate self-harm can also be categorised by the amount of times the behaviour is repeated, for example:

- **Compulsive** – this type of self-harm is thought to be
linked to obsessive-compulsive disorder. The person may be overwhelmed by anxiety, and so self-harms to relieve the tension

- **Impulsive** – the person may occasionally self-harm, but injuring themselves isn’t used on a regular basis as a means of coping. The person may not even consider themselves to be a self-harmer.

### THE RESPONSE FROM THE MEDICAL PROFESSION

Anecdotal evidence from people who self-harm suggests that many workers in the medical and health professions don’t understand and often react in negative ways.

This may include:

- Showing horror or revulsion
- ‘Talking down’ to the person, ridiculing them or trying to shame them
- Resentment that the person is ‘wasting’ hospital time and resources that could be given to people who are in ‘genuine’ need
- The mistaken belief that the person has a form of Munchausen syndrome (the desire to inflict injuries or induce symptoms to get medical attention)
- Deliberately delaying treatment or giving them inadequate treatment, such as little or no pain medication
- Instructing the person on where to cut their wrist (for example) so that their next ‘suicide attempt’ will be successful.

### TREATMENT OPTIONS

Treatment could include:

- Psychological intervention and/or counselling
- Psychiatric treatment
- Learning other forms of effective coping techniques
- Understanding and support from family members, friends and doctors
- Medical treatment for the physical injuries
- Until the self-harming behaviour is under control, advice on harm minimisation techniques; for example, how to keep piercing and cutting implements sterile.
- Until the self-harming behaviour is under control, first aid training and adequate supplies of first aid equipment in the home (such as bandages and antiseptic solution).

### OTHER FORMS OF COPING

Self-harming behaviour may be destructive, but it seems to help the person to manage their strong feelings. This is why it is so important to introduce other, more positive coping strategies before attempting to stop. Otherwise, the self-harming will continue, despite the person’s best intentions or their promises to loved ones.

Different coping strategies that could be helpful include:

- Regular exercise
- Stress management
- Counselling
- Forms of personal expression, such as writing or painting

### HOW TO HELP DURING AN INCIDENT

If you witness a loved one self-harming, try hard to control your emotional response. Yelling, crying or becoming hysterical will only make your loved one more stressed, which can reinforce their self-harming behaviour.

Suggestions include:

- Try to act in a neutral way
- If necessary, take them to a more private place
- Help them to administer first aid to their injuries
- If their injuries are severe, take them to the nearest hospital emergency department for treatment
- If this is the first time you discovered their self-harming behaviour, ask your doctor for referral to appropriate mental health services.

### WHERE TO GET HELP

- Your doctor
- Psychologist
- Lifeline Tel. 131 114
- Suicide Helpline Tel. 1300 651 251
- Kids Helpline Tel. 1800 551 800
- Mental Health Foundation of Australia (Victoria) Tel. (03) 9427 0406.

### THINGS TO REMEMBER

- Self-harm is the deliberate injuring of oneself in an attempt to cope with strong feelings such as anger, despair or self-hatred
- Many workers in the medical and health professions don’t understand self-harm and often react in negative ways
- Self-harm is not a type of suicidal behaviour – in some cases, a person may self-harm in an attempt to drive away suicidal feelings.

This page has been produced in consultation with, and approved by Monash Alfred Psychiatry Research Centre, School of Psychiatry and Psychology.

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What is deliberate self-harm?

Deliberate self-harm (also known as self-injury) is when you deliberately inflict physical harm on yourself, usually in secret and often without anyone else knowing. Some examples are cutting, burning, biting or hitting your body, pulling out hair or scratching and picking at sores on your skin.

Deliberate self-harm is not necessarily a suicide attempt and engaging in self-harm may not mean that someone wants to die. Most commonly deliberate self-harm is a behaviour that is used to cope with difficult or painful feelings.

Why do people deliberately harm themselves?

People who deliberately harm themselves have often had tough experiences or relationships in their lives.

You may have:
➢ Been bullied or discriminated against
➢ Lost someone close to you, such as a parent, brother, sister or friend
➢ Broken up with a boyfriend or girlfriend
➢ Been physically or sexually abused
➢ Experienced a serious illness or disability that affects the way you feel about yourself
➢ Experienced problems with family, school or peer groups.

Deliberate self-harm may be used as a way to cope with experiences and the strong feelings associated with it.

Self-harm may:
Provide a way to express difficult or hidden feelings
It is not uncommon to feel numb or empty as a result of overwhelming feelings you may be experiencing and engaging in deliberate self-harm may provide you with a temporary sense of feeling again. It may also provide a way to express anger, sadness, grief or hurt.

Be a way of communicating to people that you need some support
When you feel unable to use words or any other way to do so, you may feel that the only way you have left is to harm yourself.

Be a way of proving to yourself that you are not invisible
Feeling the pain when you harm yourself can make you feel real – like you are not invisible – that you do have feelings and that you aren’t numb.

It is only a temporary ‘solution’ though, a ‘band-aid fix’, because your real feelings of hurt and distress have not been dealt with.

Provide you with a feeling of control
You might feel that self-harm is one way you can have a sense of control over your life, feelings, or body, especially if you feel as if other things in your life are out of control.

Bring an immediate sense of relief
It is only a temporary ‘solution’ though, a ‘band-aid fix’, because your real feelings of hurt and distress have not been dealt with. It can also cause permanent damage to your body if you injure nerves.
Psychologically, it may be associated with a sense of guilt, depression, low self-esteem or self-hatred along with a tendency to isolate yourself from others.
Finding help

Lifeline is now online. If you are experiencing a personal crisis, Lifeline can help.

Although it may seem hard, it’s important that you can reach out to someone who can help you work through some of the reasons for harming yourself and find healthier, more positive alternatives for alleviating the pain you feel inside. It may take time, but it’s important to remember that you can move to a happier and healthier outlook.

Speaking to someone about your self-harm may be hard and it is particularly important to trust the person you are speaking with. Try a counsellor or a counsellor at Kids Helpline.

If you are having difficulty speaking about what you’re going through, you might start with sentences such as ‘Right now, I’m feeling…’, ‘I think it started when…’, ‘I’ve been feeling this for…’, ‘My sleep has been…’, ‘Lately school/work/uni has been…’.

Or write them down to give to someone you trust.

It may be necessary to talk to someone like a counsellor, psychologist, or psychiatrist to help you to work through some of the reasons why you are harming yourself and to find alternative strategies for alleviating the pain you feel inside.

Like any relationship, building trust with your counsellor, psychologist, or psychiatrist may take time and it is important you find someone you feel comfortable with. This may mean seeing several people before finding the one that you ‘click’ with.

If there is a family member you feel comfortable telling, it may be helpful for you to have their support in finding a counsellor that is right for you.

It’s likely that the person you feel comfortable telling will already be worried about you and will be relieved at having the opportunity to listen and help.

If you don’t get a positive response, try to remember that it is not because you have done something wrong, but because the person you have told may not know how to respond to what you have told them or may not understand much about deliberate self-harm.

Don’t give up! Either try again or maybe speak to someone else who you think you might receive a more supportive response from.

If talking about it with someone is too overwhelming, an alternative is to email or write down what you want to say.

Otherwise, a first step might be to talk to Lifeline (131 114) – cost of a local call from a landline or Kids Helpline (1800 55 1800) – free from a landline. Both are anonymous and open 24 hours/7 days a week.


Coping without harming yourself

As well as support from a friend, family member and/or health professional, it may also be necessary to create a list of alternative strategies to self-harm for managing your emotions.

If you are feeling like you want to harm yourself there are a number of things that you might try to distract yourself with until the feelings become more manageable. If you can, make sure that you are around other people and remove any sharp objects from the area.

Some ideas for releasing energy or feelings include:

➤ Choose to put off harming yourself until you’ve spoken to someone else or waited for 15 minutes (and see if you can extend it for another 15 minutes beyond that, continue to do it again and so on until the feeling passes)

➤ Write in a journal – you might like to use an online journal. Reach Out plans on having the journals up and
Running soon!

➢ Exercise – go for a run or walk in the park to use up excess energy
➢ Play video games – this may be a good way to distract yourself and help until the anxiety passes
➢ Yell or sing at the top of your lungs on your own or to music. You might do this into a pillow if you don’t want other people in the house to hear
➢ Relaxation techniques – activities like yoga or meditation are often helpful in reducing anxiety
➢ Cry – crying is a healthy and normal way (i.e. not weak or dumb) to express your sadness or frustrations
➢ Talk to someone – talk with a trusted friends or call a helpline.

**Alternatives to deliberate self-harm**

There are some more suggestions below that some people have tried in an emergency if none of the above suggestions have helped.

However, these suggestions will **not help** in the long run as they keep you from addressing the thoughts and feelings that result in this self-harming behaviour.

**If you are finding that you are often using these suggestions below, or similar ones, please find help and talk with someone.**

These suggestions are alternatives to self-harm but they are not a solution to the problem.

➢ Punching a pillow or punching bag
➢ Squeeze ice cubes till your fingers go numb
➢ Eat a chilli, or something really hot
➢ Have a cold shower
➢ Put vapour rub or deep heat under your nose (it stings and makes you cry)
➢ Waxing your legs (or getting them waxed)
➢ Draw or write in red over your body (instead of cutting).

**Take care of yourself**

It’s important to eat well, exercise and be kind to yourself. While not a solution in itself, doing all these things contribute to a higher sense of self-worth, increased stability of moods, and a general better sense of wellbeing – making you feel more happy, on the outside and the inside.
An issue that has been of increasing concern to Kids Helpline counsellors over the past 10 years has been the number of young people who disclose self-injuring behaviours, during counselling sessions about other problems. People use different words to describe this behaviour. In this paper we will be using ‘self-injury’.

**WHAT IS SELF-INJURY?**

Kids Helpline defines self-injury as deliberate, non-life threatening self-effected bodily harm or disfigurement of a socially unacceptable nature. Those who engage in self-injury are deliberately doing physical harm to themselves in ways that are not intended to end their lives.¹

The predominant forms of self-harm disclosed to Kids Helpline counsellors are cutting the skin of arms or legs and/or deliberate overdoses of both prescription and over-the-counter medications not designed to be fatal. Other behaviours such as burning or picking the skin or pulling out hair can also be termed self-injury, but are not nearly as common as the first two. Kids Helpline recognises that self-injury is different from suicidal behaviour, but some young people who self-injure are also suicidal or can become suicidal.

**WHY DO PEOPLE SELF-INJURE?**

Self-injury can be understood as a means of coping with overwhelming and inexpressible emotions. Self-injury often becomes a compulsive behaviour that perpetuates deep shame, guilt and self-hatred. It is a deeply addictive experience and the dangerous nature of the activities means that death can occur even when the young person is not intending to kill themself.

Research suggests that 5-6% of the general population of young people deliberately self-injure each year in Australia.

**HOW OFTEN IS IT HAPPENING?**

As self-injury has no consistent definition in the general community (the term self-harm is often also used, but with slightly wider meaning), it is difficult to estimate how often it is happening. At Kids Helpline, the rate of young people reporting self-injuring behaviours is increasing. In 2008, self-injury was reported 7,710 times. In 2009, this had risen to 8,166 reports, with 15% of all counselling type contacts reporting these behaviours.

Research suggests that 5-6% of the general population of young people deliberately self-injure each year in Australia. Although we don’t know exactly how many young people are engaging in this behaviour, it is clear that self-injury is being spoken about more frequently these days throughout youth communities such as schools and universities. It is also evident that many more research studies are being carried out in order to better understand what helps and what doesn’t.²

**HOW CAN YOU KNOW IF IT IS HAPPENING?**

Sometimes a parent or carer is the last person to know when their child is self-injuring. Young people tend to confide in a close friend first, whom they commit to secrecy. This often leaves ‘the friend’ fearful for the safety of the person engaging in self-injury, but anxious about losing their friendship if they tell an adult who could help.

A small number of young people publicly display their self-injury, either by discussing it generally, showing their scars or by self-injuring in public.³ However, most young people who finally disclose this behaviour to a Kids Helpline counsellor say they have been keeping it a secret from those in their immediate environment. They may cover their cuts or scars by wearing long sleeved shirts or jumpers and long pants even in warm weather. Or, if they regularly take overdoses of medications such as paracetamol, they may hide from their parents in their bedroom, ‘sleeping it off’. This particular form of self-injury is very dangerous as unlike other self-injuring behaviours like cutting, there are no outward scars to communicate the young person’s
distress until serious damage has occurred to the liver and kidneys. If parents find a packet of Panadol pills in a schoolbag, young people tell Kids Helpline they can easily pass them off as being for legitimate headache or period pain.

Below, a Kids Helpline caller relates their experience of self-injuring with over-the-counter medication:

“I don’t know how many I really take. But every day when I feel not so good... Normally just Panadol I guess and sometimes other stuff like Nurofen, whatever is in the cupboard I guess, or my schoolbag.” (Kids Helpline caller, age 13)

WHY DO YOUNG PEOPLE SELF-INJURE?

Self-injury is different for everyone who does it. Some young people tell Kids Helpline they do it to:

➤ Get relief from overwhelming negative emotions such as anger, frustration, sadness or loneliness
➤ Help them to feel ‘something’, when they would normally feel numb or ‘not really alive’
➤ Punish themselves – some young people carry a belief from past trauma or abuse that they are essentially ‘bad’ and need to be punished.

Various mental health disorders can also include self-injuring behaviour. It is important that your child is screened for such disorders when seeking assistance.

WHAT IS THE IMPACT ON YOUNG PEOPLE AND THEIR FAMILIES?

Young people who self-injure

These days, self-injury is more commonly spoken about amongst young people; however, this has not necessarily reduced the stigma attached to it in the wider community. The conflicted nature of the emotions driving the behaviour causes enormous ambivalence in the young person. This frequently aborts attempts to get help and may subconsciously sabotage relationships with those who are trying to help.

Families

When parents are finally ‘let in’ to their child’s secret, they often have feelings similar to grief and loss reactions, including:

➤ Disbelief
➤ Denial
➤ Anger
➤ Fear and anxiety
➤ Helplessness
➤ Guilt.

These feelings often occur along with other strong emotions such as:

➤ Embarrassment
➤ Failure
➤ Shame
➤ Powerlessness
➤ Disgust.

If you are in this situation, it is important to give yourself permission to feel any emotion that comes up as no emotion is ‘wrong’. Also, accepting your emotions is a good way to model healthy reactions for your child. However, it is also important not to act based on these first reactions, but to take time to process strong emotions (away from your child) and then come back and build a collaborative plan of action with your child. It is also important to understand that no one is to ‘blame’ in this situation.

You may benefit from seeking professional help and support to deal with your own feelings, and how best to manage what is going on for you and your family.

WHAT CAN PARENTS DO?

An issue as complex as self-injury cannot be adequately covered in an article such as this.

The most important messages we want to give you here is:

➤ DON’T IGNORE the behaviour, and
➤ DON’T PANIC – self-injury CAN be treated.

Self-injury is commonly spoken about amongst young people; however, this has not necessarily reduced the stigma attached to it in the wider community.

Other things you can do are:

Seek professional help

Because of the complexity of self-injuring behaviour, it can be very helpful to seek professional assistance to work out why your child is self-injuring and how you can support them. You may also need help coming to terms with what’s happening prior to or while you are supporting your child. Speaking with a professional can help you understand your own emotions as well as develop a plan of action for supporting the young person.

Current research indicates that Dialectical Behaviour Therapy (DBT) is an effective way of treating self-injuring behaviour. It teaches how to identify and challenge faulty and rigid thinking, and change the resulting unhealthy behaviours.

There are also many books about self-injury written for parents or carers that can provide further information on seeking help for your child, you and your family. See the listings at the end of this article to find out where you can go for further help and information.

Offer support to your child

Let your child know that you want to help them in the best way you can. Tell them you have trust that, with professional assistance, they will be able to find better ways to cope with the overwhelming emotions driving their behaviour. Avoid telling your child to ‘just stop it’, as self-injury can be addictive and research tells us that
people with addictive behaviours are unable to stop without extended periods of support.

**Show belief and understanding**

Tell your child that you believe in their capacity to work towards finding alternative healthy coping strategies. This will help give them the space to feel some control in the short-term – that their coping mechanism will not be ‘taken from them before they are ready’ – while at the same time assisting them to feel reassured by your confidence that hope lies ahead.

It is critical that you persist in letting your child know that you trust and support them to find a way through this experience, no matter how long it takes and no matter how many setbacks there are along the way.

It is also important for your child to know that you understand and validate the emotions driving their behaviours but that you also know there are more constructive and helpful ways to process those feelings.

It is critical that you persist in letting them know that you trust and support them to find a way through this experience, no matter how long it takes and no matter how many setbacks there are along the way. If your child believes that you trust in them, they will more readily trust in themselves to find a way through.

**WHO CAN I CONTACT FOR MORE INFORMATION?**

If you have any concerns about your child and the issue of self-injury, call Parentline in your state on the phone number below.

- Parentline Queensland and Northern Territory – 1300 30 1300
- Parentline Victoria – 13 22 89
- Parent Helpline South Australia – 1300 364 100
- Parent Line New South Wales – 13 20 55
- Parent Help Centre Western Australia – (08) 9272 1466
- ParentHelpline South Australia – 1300 364 100
- Parentline New South Wales – 13 20 55
- Parent Helpline – 1300 364 100
- Parentline National Helpline – 1300 364 100
- Parentline Tasmania – 1300 364 100
- Parentline Western Australia – (08) 9272 1466
- ParentLine ACT – (02) 6205 8800
- Parentline Tasmania – 1300 808 178.

Counselling is also available from Lifeline on 13 11 14 or speak with your GP to access face-to-face services in your local area.

**USEFUL WEBSITES, ARTICLES AND BOOKS ABOUT SELF-INJURY:**

- Sane – [www.sane.org/information/factsheets/suicidal_behaviour_and_self-harm.html](http://www.sane.org/information/factsheets/suicidal_behaviour_and_self-harm.html)

**REFERENCES**

Deliberate self-harm, also known as self-injury, refers to people intentionally inflicting physical harm on their bodies in an attempt to cope with distressing feelings. This is most often done in secret and without other people knowing.

People who self-harm may not necessarily want to die.

Self-harm often begins in the teenage years and is more common in young people aged between 11 and 25 years.

Types of behaviour suggestive of self-harm

The most common forms of direct self-harm include:

- Cutting areas of the body, such as the stomach, arms and thighs
- Burning the skin with cigarettes or a lighter
- Overdosing on prescription or illegal drugs. For example, taking more medication than prescribed
- Other forms of direct self-harm include piercing, hitting, biting, pulling out hair, scratching, and picking at sores.

Indirect self-harm occurs when the person’s behaviours result in physical damage to the body in a more ‘roundabout’ way. Such as:

- Neglecting to manage an illness as advised or not seeking help for a disorder
- Binge eating or starvation
- Abuse of alcohol or drugs.

Self-harm is distinguished from risk-taking behaviour, which involves repeatedly putting oneself in dangerous situations. For example, driving at high speeds or train surfing. There is a high risk of severe harm occurring to the person, or even death as a result of such behaviours.

Why do people self-harm?

Self-harm is usually a response to distress. People self-harm as a way of coping with the distress and emotional pain connected with difficult life events or circumstances. That is, the person is trying to relieve, control or express distressing feelings.

These distressing feelings include: hopelessness, anxiety, rejection, anger, despair, and guilt.

For some people, self-harm is a means of trying to make themselves feel better. It provides relief from psychological distress, as it decreases tension or pressure, releases intense, overwhelming negative emotions, and therefore provides brief escape. Although it brings immediate relief, it is a temporary solution.

Some people view self-harm as giving them a sense of control over the pain and their lives. It may help them to cope with emotional numbness, as when they self-harm they can feel something; it proves they are not invisible. Some people also report using self-harm to control or drive away suicidal thoughts.

Others use self-harm as a form of self-punishment – to deal with strong feelings of guilt, shame or self-hatred.

Sometimes people who self-harm find it hard to explain their feelings to others or to communicate to others that they are struggling. Self-harm provides a way for the person to express difficult or hidden feelings such as emptiness, anger, sadness, grief and hurt. Self-harm becomes a way of telling other people about his or her emotional pain and letting people know he or she needs support.

The frequency of self-harm varies with the individual. Some people use self-harm regularly; others do it 1-2 times and then stop. It can become a coping mechanism that the person uses in response to all difficult life circumstances or it may be related to a specific problem.

Factors contributing to self-harm

- Experience of abuse in childhood or adolescence – emotional, physical, or sexual
- Loss of a parent in childhood due to death or separation
- Significant losses as an adolescent. For example, the death of someone close to the person
- High impulsiveness
Poor body image and low self-esteem, eating disorders and body disconnection
Serious illness or major surgery in childhood
Serious illness or disability – this may have an adverse effect on the person’s self-esteem
Peer isolation and alienation in adolescence, including being bullied or discriminated against
Relationship break-up
A stressful or critical family environment; family violence or severe family conflict; witnessing impulsive, self destructive behaviours within the family as a child
Distressing symptoms of an underlying mental illness such as depression, PTSD, or anxiety disorder.

Suicide and deliberate self-harm
Self-harm should always be taken seriously. One of the risk factors for suicide is previous self-harm or a prior suicide attempt.

Whilst engaging in self-harm sometimes suggests the person is thinking of suicide, not everyone who self-harms is suicidal. In general, someone who self-harms isn’t trying to suicide. With suicide, the person is desperate never to feel anything again, whereas with self-harm, the person usually wants to feel better. In fact, sometimes a person who self-harms is actually trying to drive away suicidal thoughts. Nonetheless sometimes people accidentally die as a result of their self-harming behaviour.

The table below may be used as a general guide to understand the differences between suicidal behaviour and self-harm.

Although people who self-harm do not necessarily want to die:

- Common feelings underlying both self-harm and suicide attempts could be feeling overwhelmed or loss of control, and hopelessness. If self-injury fails to ‘work’ to cope with these feelings, the person may increase the severity of harm, or start to believe that he/she cannot control pain and contemplate or attempt suicide
- Repeated self-injury could lead a person to believe he/she cannot stop, which might lead to feelings of hopelessness and possibly suicidal thoughts.

Response from health professionals to self-harm
Anecdotal evidence from people who self-harm suggests that many health workers do not understand self-harm. Some may have formed a mistaken belief that the person is engaging in self-injury ‘just to get medical attention’. Others may feel resentful, as they believe that the person is wasting valuable time and resources that could be given to others in ‘genuine need’. As a result, many health workers often react in negative ways to the person.

This may include:

- Outwardly showing horror or revulsion in response to seeing the person’s injuries
- Treating the person in a demeaning manner
- Deliberately delaying treatment or giving insufficient treatment, such as administering very little or no pain medication
- Showing the person where he/she should cut the wrist next time in order to ‘successfully suicide’.

If you or someone you know feels at risk, contact the SuicideLine on 1300 651 251.
Understanding self-harm

Understanding self-harm can be the first step toward recovery. This fact sheet from Somazone presents brief advice on the key issues.

WHAT IS SELF-HARM?

Self-harm is when a person deliberately hurts themselves. People can hurt themselves in a lot of different ways, including burning, biting, cutting, hitting, scratching or poisoning.

There is some debate about whether or not unhealthy eating behaviours (restricting food, excessive dieting, using laxatives or bingeing) and body piercing are types of self-harm. This fact sheet takes a general view, so you can choose to include or not include those things in your definition of self-harm.

WHY DO SOME PEOPLE HARM THemselves?

➤ To relieve pain
➤ To feel something other than emotional pain
➤ Because they are feeling overwhelmed with problems
➤ Because they are feeling confused or exhausted by all of their feelings
➤ Because they don’t know how else to communicate or control their thoughts or feelings.

While each person’s story is different, the most important thing to remember is that a person usually harms themselves to try to manage something they are finding difficult or overwhelming.

WHAT CAN TRIGGER SELF-HARM?

➤ Thinking about past abuse
➤ Stressful situations
➤ Conflict
➤ Depression
➤ Self-hatred.

WHAT ARE SOME CONSEQUENCES OF SELF-HARM?

➤ Feeling embarrassed or ashamed
➤ People staring at injuries or asking questions
➤ People judging or labelling
➤ Sometimes having to wear certain clothing to hide injuries
➤ Getting infections or scarring from injuries
➤ Being hospitalised
➤ Trying to explain things to family and friends.

Some people think that self-harm can help a person to feel better, at least a bit. However, any help self-harm may seem to give is only temporary. After self-harming, the problems are still there and the person’s thoughts and feelings are still basically the same.

HOW CAN I STOP SELF-HARMING?

You may find that you can stop self-harming by yourself. If so, here are some ideas to help you stay on track and feel better:

➤ Distract yourself by concentrating on other things
➤ Hang out with people you feel comfortable and safe with
➤ Do nice, fun or caring things for yourself
➤ Find new ways to deal with your thoughts and feelings, such as through art, writing, music, exercise, or meditation.

You may find that you need some help to stop self-harming. If so, here are some ideas of people and services to try:

➤ Call a helpline or try online counselling
➤ Talk to a qualified doctor or counsellor
➤ Join a group that will help you manage your thoughts and feelings better
➤ Talk about your feelings, thoughts and actions with someone who is trustworthy, understanding and supportive
➤ Try some of the ideas on the websites under More information.

WHAT CAN I DO IF I KNOW SOMEONE IS SELF-HARMING?

➤ Try not to overreact; it does not necessarily mean they are suicidal
➤ Take their behaviour seriously; don’t label them as ‘attention seeking’ because self-harm is a genuine cry for help
➤ Be there, be kind, and be sensitive
➤ Listen carefully and try to understand
➤ Don’t judge, lecture, or blame them
➤ Ask someone else to help if you’re not sure what to do
➤ Encourage them to get help from a helpline, or a qualified doctor or counsellor
➤ If a person has hurt themselves seriously, respond with first aid. For example, if a person has cut themselves deeply, wrap the cut firmly with a bandage or cloth and get medical help immediately. For this and other serious emergencies, call triple zero (000)
➤ Get support for yourself because you are more help to others if you feel okay.

MORE INFORMATION

➤ headspace www.headspace.org.au
➤ Lifeline www.lifeline.org.au, tel. 13 11 14
➤ Reach Out au.reachout.com
➤ Somazone www.somazone.com.au
➤ TheSite.org www.thesite.org

This fact sheet was developed for Somazone by Susan Hunt at eCounselling. Last updated in 2011 by Louise McCutcheon at Orygen Youth Health.
HOW CAN I HELP SOMEONE WHO SELF HARM?

It is a myth that self-harm is done ‘just for attention’, advises the Suicide Call Back Service

**DURING AN INCIDENT**

- Try to control your emotional reaction and respond in a neutral way to the person. Yelling or panicking may increase the person’s distress and could reinforce self-harm.
- If there are other people around, take the person to a more private place, so as not to attract unnecessary attention.
- Help the person to administer first aid to his/her injuries. If the injuries are severe, call an ambulance or take the person to the hospital. Try to take the person to a facility where he/she will be treated sensitively.
- Ask the person if he/she is suicidal – it is important to either rule this out, or get the person appropriate mental health support if he/she is suicidal.

It is a myth that self-harm is done ‘just for attention’. Most people do it in private and hide their scars, as they feel ashamed and fear being thought of as ‘freaks’. The need for attention is a normal human motivation. The question to ask is: if the person is using self-harm as a way to communicate their distress, why is the person going to such desperate lengths to get attention?

It is helpful for the person to understand the reasons underlying his/her self-harm, as well as learning other ways of coping with self-harm thoughts and feelings.

**DO**

- Listen to the person so he/she feels heard and supported, and take the person’s problems seriously.
- Encourage the person to talk about his/her feelings rather than self-harming. Explore with the person what other strategies he/she could use to cope, rather than self-harming.
- Find ways to enhance the person’s self-esteem and acknowledge his/her positive qualities.
- Encourage the person to seek professional help. It is vital that the person receives appropriate health care that is sensitive, skilful and non-judgmental. Ongoing support delivered in this manner could reduce the person’s self-harming behaviour and therefore also reduce the likelihood of accidental death.
- Assist the person to access professional support. Suggest options for support and offer to accompany the person to an appointment. Your local GP can advise about specialist mental health professionals who can help.
- Ask if the person is suicidal. It is important to check this out.
- Call an ambulance or take the person to the local hospital emergency department if they need urgent medical attention.
- Get support for yourself as well – caring for someone who self-harms can be emotionally demanding and stressful.

**DON’T**

- Panic, become angry, reject the person, or take the person’s self-harming behaviour personally. Such reactions may create feelings of guilt and shame for the person.
- Condone self-injury. At the same time, try to be non-judgmental and let the person know you will support him or her to find alternatives to self-harm.
- Remove self-harm as a coping strategy without first replacing it, as this increases the person’s vulnerability to life difficulties.
- Give ultimatums. This could increase feelings of rejection for the person and decrease trust between you, as the person may feel unheard. This could result in the person feeling unsupported and withdrawing from you. The motivation for change must come from within the person.
- Pressure the person into undertaking any treatment he/she feels uncomfortable with.

If you or someone you know feels at risk, contact the Suicide Call Back Service on 1300 659 467.

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www.suicidecallbackservice.org.au
Self-harm is one of the most distressing issues that parents may have to face. This info sheet provides an overview of self-harm and some tips for parents of adolescents from Parent Line.

**What is self-harm?**
- Self-harm is generally considered to be a coping strategy in response to mental distress.
- It is a deliberate (rather than an accidental) act that involves harm to the body.
- It is often done in secret.
- Some self-harming behaviours include cutting, picking, burning, scratching, hitting, and swallowing substances or objects.
- The extent of self-harming is hard to research because it is often done in secret and may be hidden under clothes.
- Behaviours such as tattooing and body piercing are not generally considered to be self-harming behaviours in our culture.

In some adolescent subcultures, self-harm is more prevalent. It is important to remember that self-harm is a complex problem that requires professional treatment. For some people it is a single event that is never repeated. For others it can become a pattern of repeated behaviour that occurs throughout their lives.

A young person who self-harms has not ‘gone crazy’ but is likely to be very distressed. Self-injury is nearly always a way for them to cope.

**Why do young people self-harm?**
It is difficult for many people to understand why someone would want to hurt or injure themselves.
Those who resort to self-harm often have poorly developed problem solving or coping skills, and difficulties in expressing or regulating their emotions.

There are many reasons why people self-harm. Below are listed some of the more common ones:
- To provide relief from psychological pain.
- To interrupt traumatic memories.
- To express depression, anxiety, or anger.
- To relieve emotional numbness and to feel ‘real’ again.
- To gain a sense of control over their lives and emotional experiences.
- To experiment with a new behaviour.
- To belong to a group.

**IS THERE A LINK BETWEEN SELF-HARM AND SUICIDE?**
People who self-harm usually do so without any intention of killing themselves. It is usually a survival strategy for coping with painful feelings. It may be destructive but it is not intended to be lethal. When questioned, the majority of young people who self-harm will state that they have no intention of killing themselves.

Self-harm and suicidal thinking can go together, and self-harming behaviour can precede a suicide attempt although there is not necessarily a link between the two.

Any young person engaging in self-harming behaviour needs to receive a thorough assessment by a mental health professional to assess their level of risk. This is not something that parents should undertake themselves.
As an act of self punishment in response to self-blame
As a cry for help.

A young person who self-harms has not ‘gone crazy’ but is likely to be very distressed. Self-injury is nearly always a way for them to cope. It is clearly not a healthy or productive way of coping, but to some adolescents it is the only strategy they can think of at the time.

It is not helpful to think of self-harm as attention seeking. Most self-injury is hidden and a source of shame for all concerned.

Frequently parents are unaware it is happening. It is not something the young person is proud of or wants to draw attention to.

Concluding that it is just attention seeking behaviour can minimise the serious emotional pain of a young person, and may prevent them from receiving the help that they need.

What should parents do?

Parents frequently feel a variety of strong emotions when they discover that their child is self-harming. These include anxiety, powerlessness, alarm, repulsion and anger. It is easy to feel frustrated by what looks like irrational and destructive behaviour and simply want it to stop immediately.

Try to stay calm. Express your concern and love for the child. Self-injury must be taken seriously, but at the same time try not to overreact or express a strong emotional response of anger, fear, revulsion or frustration.

It is not helpful to think of self-harm as attention seeking. Most self-injury is hidden and a source of shame for all concerned.

Your most important response as a parent should be to seek out a mental health service with expertise in dealing with this area. Your general practitioner is a good starting point to find this type of help. Alternatively you can contact the child and adolescent team within your local area health service.

Self-harm is usually a complex issue. Frequently adolescents do not want high levels of parental involvement in their life – which they might view as intrusive. At the same time most parents desperately want to help their son or daughter.

It can be very unpleasant to be stuck in the middle of these two forces – your adolescent keeping you at a distance and your concern as a parent, wanting to do everything you can to help.

In extreme situations where a serious injury has occurred dialling for an ambulance or attending the Emergency Department of your local hospital will be necessary.

Keep life balanced

Don’t let this symptom of your child’s distress become your focus, or let your family life become centred on this issue. Try and keep your routines and relationships as normal as possible.

Focus on providing emotional support

Focus on expressing your love and support.

Try to remain engaged with your adolescent when things are going well, not only at times when they are self-harming.

Showing understanding is not
encouraging the behaviour. Being judgemental and angry will make the situation worse, as will punishing them for this behaviour.

Ensure you do not give them the impression that you think they are crazy.

**Manage your emotions**

Try to avoid expressing your anger and frustration about the self-harm as it is far more likely to cause further self-harm than to stop it.

Your anger will cause further distress that may mean that they are more likely to use the coping method of self-injury.

**Avoid power struggles**

No matter how strongly you feel you cannot control an adolescent’s personal behaviour.

Getting your son or daughter to promise that they will not do it again is unlikely to be effective and may create further pressure and secretiveness about the behaviour.

**Respect their privacy**

It can be difficult to balance the need to monitor self-harming behaviour and respecting your child’s privacy. Don’t try to force them to reveal their most private thoughts because they might not be ready or able to do so.

It will probably not be helpful to try to get them to explain their reasons for self-harm; there is a good chance that they might not be able to explain why.

If they don’t want to talk, don’t try to force them. Just be there for them and let them know that you are there when they want to talk.

**Don’t minimise**

If they discuss their source of grief or upset, don’t minimise it. A fight with a peer might be a big issue for an adolescent.

It is important for parents to listen, let the child know they have been heard and not make them feel criticised or judged about the issues that concern them.

**Look for patterns**

It might be helpful to keep a brief diary of the young person’s self-harm. You may be able to work out times or events that increase the risk of it happening.

No matter how strongly you feel you cannot control an adolescent’s personal behaviour.

Look for themes as this may give you some clues as to what might be happening for them and when they are at their most vulnerable.

**Maintain wellbeing**

Encourage any activity or hobby that your child enjoys. Try and help them maintain their regular interests.

Reducing stress can reduce the drive towards self-harm. Exercise, social contact, and hobbies are generally effective stress reduction strategies.

**Support their recovery**

If your adolescent has a Crisis Plan to implement during periods of severe stress, gently support its use.
Key points about self-harm
An extract from a treatment guide for consumers and carers from The Royal Australian and New Zealand College of Psychiatrists

KEY POINTS ABOUT SELF-HARM

1. Self-harm is a behaviour that can occur in many different disorders and situations.
2. Self-harm may be an attempt at suicide, although not necessarily so.
3. All self-harm deserves serious assessment. If you are concerned that you, or a member of your family, are at risk of self-harm, or have self-harmed in the past, then seek help from your family doctor or local mental health services.
4. If an underlying mental illness is present, it should be appropriately treated in the expectation of reducing the risk of further self-harm.
5. Sometimes self-harm is a reflection of a person’s distress, independent of mental illness. In such situations, social, behavioural and psychotherapeutic approaches are advised.

Self-harm is a behaviour and not an illness. People self-harm to cope with distress or to communicate that they are distressed. Self-harm includes self-poisoning, overdoses and minor injury, as well as potentially dangerous and life-threatening forms of injury. It does not mean body piercing, getting a tattoo, unusual sex or the recreational use of drugs and alcohol. Some people who self-harm are suicidal at the time. Others report never feeling suicidal.

This guide is for people who have engaged in self-harm, and their families and carers. It aims to inform them of the best possible assessment, treatment and support and what to expect of services intended to reduce self-harm and its related suffering.

Self-harm is more common among younger people. In any year, more than 24,000 people are admitted to hospitals in Australia as a result of self-harm, and thousands more are treated in emergency departments and not admitted. Usually, more women than men self-harm. Women more commonly take overdoses than men. Overdose is the most common form of self-harm in Australia.

What causes self-harm?
There is no single cause for self-harm. However, research suggests that some people seem to be more at risk than others.

People at greater risk include:
- Those under stress or in crisis, and those who have self-harmed before
- Those with mental disorders (e.g. anxiety, depression or schizophrenia)
- Those who are in treatment for a mental disorder
- Those who misuse alcohol or other substances or have these addictions
- Those who have experienced childhood trauma or abuse
- Those who have a debilitating or chronic illness.

Is it just attention seeking?
Some people think that self-harm is ‘just attention seeking’. This attitude is unhelpful and it trivialises self-harm and the distress the person is feeling at the time.

People who self-harm have genuine difficulties coping with aspects of their lives. Research shows that people who self-harm often struggle with problem-solving, and they find it particularly hard to ask for help. They tend to forget how they solved a similar problem in the past, and they get stuck when trying to solve a current problem. This can lead to frustration and to feeling out of control.

For other people, self-harm may indicate that they are...
Warning signs of self-harm

For many people who self-harm, the act of harming themselves is something they try to keep secret. Adolescents hide their self-harming from teachers, friends and family, while adults may have partners, friends and workmates, and in some cases their children, from whom they hide their self-harm. Some people may have one or two close friends who know that they self-harm, but in many cases family and friends might only suspect that something is going on with their family member or friend or be completely unaware.

While there are obvious signs that someone is self-harming, such as exposed cuts and burns, and overdoses that require intervention, there are some less obvious signs that someone may be self-harming.

Psychological signs

➤ Dramatic changes in mood, especially in adolescence, or in adults with previous history of self-harm
➤ Changes in eating and sleeping patterns
➤ Losing interest in friends and social activities
➤ Breakdown in regular communications with family or friends
➤ Hiding clothes or washing own clothes separately
➤ No longer interested in favourite things or activities
➤ Problems with relationships
➤ Low self-esteem
➤ Being secretive about feelings
➤ Avoiding situations where they have to expose arms or legs, e.g. swimming
➤ Strange excuses for injuries
➤ Dramatic drop in performance and interactions at school, work or home
➤ Withdrawing from usual life.

Physical signs

➤ Unexplained injuries, such as scratches or burn marks
➤ Unexplained recurrent medical complaints such as stomach pains and headaches
➤ Wearing clothes inappropriate to conditions, e.g. long sleeves and pants in the middle of summer
➤ Pulling hair or picking at fingers or skin when upset or stressed
➤ Hiding matches, tablets, razors or other sharp objects in unusual places, such as back of drawers, under the bed, in back of cupboard
➤ Use of drugs.

What can lead to self-harm?

Some factors that can predispose people to self-harm include:

➤ Neglect and abandonment in early life
➤ Bullying in or out of school
➤ Lack of basic problem-solving skills
➤ Dysfunctional family life
➤ Drug and alcohol use in parents

How to approach someone who has self-harmed

Firstly you should assess if the person needs immediate first aid, apply if necessary and call an ambulance if the injury is life threatening.

For those who have self-harmed, talking about their self-harming behaviour with a family member or friend can be a frightening and overwhelming experience. The most important way to approach someone who has self-harmed is to remain calm and create an open discussion as to why they feel they need to self-harm. Let them talk freely – the most valuable thing you can do is listen. It is natural for you to feel angry, scared and frustrated. You may even blame yourself, especially if you are a parent. Keep in mind that usually a person who self-harms does so because they have poor or no coping skills.

Self-harm is always serious. It can cause disability or death. It is also serious because it means that a person is distressed at the time of the injury.

It is best to approach a person who self-harms with a non-judgemental attitude, as approaching with aggression or criticism will only inflame the situation. Gently assure them that no matter what their actions, you will provide the love and support needed to help them.

Explain to them that their behaviour is ‘unhealthy’ and that they need to seek help.

Arrange an appointment with the person’s doctor and contact other organisations that can help. Research self-harm to find out more information for yourself and the person who is self-harming. Arrange counselling for yourself, to help with your behaviour and emotions.

Remember, you can help someone who is self-harming but you cannot stop someone from self-harming.

GETTING PROFESSIONAL HELP

Why should I get help for self-harm?

Of those who present to a hospital after self-harm, about half will never again attend with the problem. Others have multiple hospital visits after repeating self-harm. This increases the chance of the behaviour becoming a habit as a response to distress.

Research shows that 1 per cent of those who self-harm die by suicide within the first year of going to hospital with the problem. Some people die by accident after self-harm because of the seriousness of their injuries or the toxicity of substance they took.

How do I get professional help?

It is important to get help whenever you have thoughts of self-harm. Except in a medical emergency, a general practitioner (GP) is often the first place to get help. It is
best to make an extended appointment so that you can
discuss your situation without feeling rushed.
You do not have to be physically sick to see a GP. It is
okay to talk to a GP about your feelings, problems, your
lifestyle and your overall wellbeing. You can ask the GP to
arrange for you to meet with a mental health professional
trained in providing treatments to reduce self-harm. Your
GP can also work jointly with you and a mental health
professional in the longer term.

It is okay to ask for help before you hurt
yourself! About half of all people who attend
hospital after self-harm do not attend hospital
again with the problem. Treatment can
Teach you new coping skills.

You may also contact mental health services directly –
free public mental health services are listed in the
front pages of the phone book. Mental health services
have ‘crisis teams’ or ‘crisis and assessment teams’ (CAT
teams). Many also have workers who specialise in helping
young people. Often, they will come to you, and some are
contactable 24 hours a day, at least by telephone. They can
arrange assessment and professional counselling with a
psychiatrist, psychologist, social worker, occupational
therapist or a mental health nurse.

You can also call a helpline. These are listed in the
phone book and in many public phone boxes. They can’t
provide ‘therapy’ over the phone, but can help you over
the initial crisis of feeling out of control, alone and unsafe.
Their purpose is support and referral.

What will happen if I go to the emergency
department?
If you have already injured yourself, it is likely you will
end up in the hospital emergency department. Medical
and nursing staff will first treat your injuries.
➤ They will assess you mentally and physically
➤ Typically you will have your blood pressure and pulse
monitored, and you may have blood tests and an
electrocardiogram (ECG)
➤ If you have taken an overdose, you may be asked to drink
charcoal in water. Sometimes a tube is put into your
nose to your stomach and sometimes it is necessary to
have your stomach pumped out to remove the overdose.
Sometimes, you may be given other medication (either
orally or via a drip into your blood vessel) to counteract
the overdose
➤ Other medical or surgical procedures may be required
for your injuries.

Due to the nature of hospital emergency departments,
there may be a long wait if you do not need urgent medical
intervention.

Can the hospital help me find mental health care?
It is an important part of the emergency department’s
job to link you with a mental health worker for psychological
assessment and treatment after self-harm, or to offer other
forms of support.

Staff may:
➤ Talk to a member of your family or a friend to decide
whether or not you will be safe to go home, and to
ensure that you have support if you leave hospital
➤ Contact your GP to discuss the possibility of the GP
providing you with counselling after you leave hospital
➤ Introduce you to, or give you the name of, a mental
health professional who can work through the problems
that led you to harm yourself.

A minority of people are admitted to hospital after
self-harm. Usually this is to treat a psychiatric illness
where the person cannot be treated at home. However,
most mental health care is provided on an outpatient basis
in your local area.

TREATMENTS FOR SELF-HARM

The main purpose of treatment is to first deal with
underlying mental health problems so that people are more
able to cope when distressed and are less likely to self-
harm. While research to date has proven that treatment
for underlying mental health problems is effective, it
has not yet proven that treatments specifically reduce
self-harm. This may be due to limitations in study design
and evaluation.

Treatment goals
➤ Treat associated mental illness
Prevent future self-harm
Improve coping skills
Reduce distress
Prevent suicide
Extend the time between self-harm
Reduce injury severity
Help your family to help you.

Psychological therapies
Cognitive behavioural therapy (CBT), problem-solving therapy (PST) and interpersonal therapy (IPT) are short-term forms of psychological treatments, whilst dialectical behavioural therapy (DBT) and psychotherapy are therapies carried out over a longer period. These treatments must be provided by health professionals with special training, and have proven effectiveness for helping people with depression, anxiety disorders and other mental health problems. There is some promising research to show they may help people to reduce the risk of self-harm.

Medication
Anti-depressant medications have been shown to be effective in treating depressive illness and, if indicated, may be prescribed by your doctor.
For the treatment of bipolar disorder, mood stabilisers or antipsychotics may be indicated.
If you have one of these disorders and are prescribed such medication, you may find the relevant RANZCP guides helpful.

Treatments that are not recommended
Recovered memory treatment is a form of in-depth psychological treatment that is used to recall past trauma. One small study showed its potential to increase self-harm in some people who are vulnerable, in particular, those who may have survived past trauma. It is NOT recommended.

Cultural needs
Health professionals should always respect and cater for the wide diversity of cultural groups in our community. Depending on your cultural background or religious beliefs, when you are seeking treatment, or helping a person you care for get treatment, you may have special requirements that you need to communicate to the health professionals you encounter.

There are very effective treatments available for most mental illnesses. Thorough assessment is recommended.

You may need to request:
- Translator if your first language or that of the person you care for is not English
- Explanations of medical or other terms that may not be clear
- Respect for your religious practices and understanding of the roles of males and females in your culture
- Treatment provided in a particular setting (you may have a cultural preference for home or hospital treatment)
- Special food or access to a prayer room if you need to go to hospital
- Understanding of your family’s expectations of treatment.

It is very important to discuss cultural issues with your health care provider, to enable them to better understand you and so that your religious beliefs and cultural practices can be incorporated into your treatment plan.

What does treatment cost?
It is important to discuss all potential costs involved in your treatment with your health professional.
In Australia, some GPs bulk bill, which means that Medicare will cover the full cost of any visit. If your GP does not bulk bill, partial rebates are available through Medicare and you will need to pay any difference. There will also be an additional cost for any medication that
may be prescribed.

Your GP may refer you to appropriate services, such as for psychological services provided by a psychologist or an appropriately trained social worker or occupational therapist. Any treatment provided by these health professionals will only be rebated by Medicare if you have previously claimed a rebate for a GP Mental Health Treatment Plan. A GP Mental Health Treatment Plan will be developed by your GP and tailored to your needs to find the treatment that is right for you, monitor your progress and assist you in achieving your goals for recovery.

Medicare rebates are also available for assessment and treatment by a psychiatrist. A psychiatrist may also refer you for Medicare-subsidised treatment with a psychologist, an appropriately trained social worker or occupational therapist. You may receive up to 12 individual/and or group therapy sessions in a year. An additional six individual sessions may be available in exceptional circumstances.

Your GP may also refer you to other government funded providers of psychological services depending on what is available in your local area.

GETTING SUPPORT AND HELPING YOURSELF

The role of the family and friends

Family and friends are often the first to notice that a person has been self-harming or intends to self-harm and therefore have an important role to play in protecting that person. They should discuss self-harm openly and in a non-judgemental manner with their family member or the person they care for and also with relevant health professionals such as a doctor, nurse or psychologist.

If provided with treatment and social support, the majority of those who carry out self-harm will recover and lead full and productive lives.

Family and friends have a role to play in providing that much needed social support and in encouraging the person they care for to engage in treatment.

A family member or friend can offer to accompany the person they care for to an appointment. This will enable them to feel supported as well as ensuring that they obtain professional help.

By looking after yourself and your relationships, and by thinking positively about the future, most agree it is possible to overcome self-harm in time.

Even though it is desirable for family and friends to encourage the person they care for to seek help, care should be taken not to put pressure on them to obtain treatment they are not comfortable with. Those who self-harm need to understand the reasons for their behaviour and learn different ways of coping. Family and friends can help by attending and participating in any treatment and assisting the person they care for in carrying out new coping strategies.

Often family and friends are overwhelmed and distressed by their friend or family member’s self-harming behaviour and may also require support. A local GP should be able to link them to an appropriate carer organisation. By seeking the appropriate support for themselves, family and friends are helping to improve the social environment of the person they care for.

Self-harm may be minimised if family and friends show acceptance, understanding, trust, kindness and support to a family member or friend that does, or may, self-harm. Such love and support are often sought by those who self-harm.

How can I help myself?

Evidence shows that those who attend their appointments with health professionals are more likely to improve their coping mechanisms and have a better outcome.

You can help yourself by:

➤ Attending appointments
➤ Finding a skilled professional who you can trust and work with, and who is specially trained to work with people who self-harm (usually a psychiatrist or psychologist) so that you have the greatest chance of overcoming the problem
➤ Devising an emergency care plan, with the help of your health professional
➤ Always reminding yourself of the positive skills you have and building on them.

Lifeline Australia: 13 11 14
Keeping the first appointment is a step toward helping yourself.

By looking after yourself and your relationships, and by thinking positively about the future, most agree it is possible to overcome self-harm in time. It is recommended that you use research-based treatments for any mental disorder you might be experiencing and get help to cope with stress.

Some people who have overcome self-harm have found the following to be helpful:
Reading information on websites which advise on how to get the most out of mental health care

Attending support groups for people with similar problems

Reading books of interest

Continuing activities that are positive and being hopeful about the future

Fostering and developing new interests

Balancing work or school and leisure

- Continuing positive relationships and observing the coping styles of other people.

It is also helpful to find someone you can confide in.

**Self-harm in rural areas**

Self-harm has increased in rural areas due to the enormous suffering arising from frequent droughts and the associated socioeconomic hardship. Many people living in rural areas live in isolation, and when encountering emotional difficulties often have to deal with their problems alone. This is often because they have little opportunity to access professional help as there are fewer mental health professionals working in rural areas.

Family and friends have a major role to play in providing help to those who self-harm. This is particularly so for those living in isolated rural areas.

Help can also be obtained from local GPs and school counsellors. GPs can arrange for a review by visiting mental health professionals or through teleconferencing with metropolitan mental health professionals. Lifeline and Kids Helpline provide telephone counselling and are alternate sources of support and referral information for those in rural areas who self-harm or have the intention of doing so. Self-help strategies, such as those listed above, may help delay a person acting on the urge to self-harm or increase the interval between self-harm episodes and thereby allow time for appropriate professional help to be sought.
All self-harm deserves serious assessment. If you are concerned that a member of your family is self-harming, then seek help from your family doctor or local mental health service. This fact sheet will help you to understand deliberate self-harm and how it relates to suicide and suicide prevention.

What is deliberate self-harm?

Deliberate self-harm (also known as self-injury) refers to the attempt to inflict physical harm to one’s self and is often done in secret. Cutting, burning and ingesting toxic substances are the most common methods of deliberate self-harm, but other methods are also commonly used. It is more common among young people aged 11-25 years.

Deliberate self-harm varies with the individual. Some people deliberately self-harm regularly, while others may do it only once or twice and then stop. They may injure themselves in response to a specific problem and stop once the problem is resolved. Others may self-injure over a much longer period, whenever they feel pressured or distressed, and use it as a way of coping, particularly where they have not learned or cannot use more positive ways of coping.

Why people deliberately self-harm

People who deliberately harm themselves typically report feeling hopeless, anxious and rejected, having low self-esteem and finding it difficult to cope with the events in their lives. They often find it difficult to explain their feelings to others. They say that they do it to release tension or pressure, to reduce emotional pain, to punish themselves due to feelings of guilt and shame, to avoid letting others know how they are feeling, or to give themselves a sense of control over their lives. Deliberate self-harm may also be a symptom of an underlying mental illness requiring treatment by a health professional.

Links between suicide and deliberate self-harm

Deliberate self-harm should always be taken seriously:

➤ One of the major predictors of suicide is a previous episode of deliberate self-harm, including previous suicide attempts
➤ Some research suggests people who self-harm are at increased risk of suicide, but other evidence indicates that they have no intention of dying and that harming themselves is their way of coping with life. However, even if there is no suicidal intent accompanying the deliberate self-harm, the risk of accidental death is very real
➤ People who repeatedly injure themselves may come to feel that they cannot stop, and this may lead to feelings of hopelessness and possibly suicidal thoughts
➤ People who self-injure and those who attempt suicide have similar feelings of hopelessness, often believing that things will never improve or that they have lost all control over their life. Additionally, if self-injury does not relieve tension or control negative thoughts and feelings, the person may injure themself more severely, or may start to believe they can no longer control their pain and may consider suicide.

Responding to people who deliberately self-harm

Self-injury should always be treated seriously, no matter what its cause or motivation. It is important that the person receives immediate and appropriate health care that is skilful and non-judgemental, and continues to receive adequate support throughout treatment and recovery. Ongoing sensitive care and support for people who self-injure may reduce this behaviour and reduce the likelihood of accidental death resulting from self-injury.

Many suicide prevention activities, such as those that aim to build individual resilience may also help to reduce self-harming behaviours and prevent someone who self-injures from considering suicide in the future.
Dos and don’ts for friends and families

People who deliberately injure themselves are often very distressed, and require support and care from family, friends, and the community and health professionals.

Here are some tips on how to best support and care for someone who self-injures:

1. Seek medical help. This is an important first step. Some health professionals may dismiss it as attention-seeking, so it is crucial to go with the person to the hospital or medical office to ensure that he or she is treated sensitively and receives the care that is needed.

2. Ask the person if they have considered suicide. The person may not have suicidal thoughts so they may become uncomfortable or upset. However, it is important to rule it out, or to seek support. Always take self-injury seriously and pay particular attention if the person talks of feeling depressed, hopeless or anxious, as these may also be associated with suicidal thinking.

3. Take care how you react. It can be distressing to find that someone is self-injuring, or to see their injuries.
   - Try not to panic, become angry, reject the person or ignore the problem. Don’t take the self-injury personally by thinking that the person is doing it to hurt you. These reactions may increase the person’s feelings of guilt and shame. Remain calm and focus on supporting the person and helping him or her to find better ways to cope.
   - Don’t condone the self-injury. Be non-judgemental, and let the person know that you will continue to support them throughout their recovery and that you will be there for them no matter what they do.
   - Don’t give an ultimatum. It can be tempting to demand that the person stop their self-injury immediately. This may drive the person away, make them feel more rejected, decrease their trust in you, and make them believe you are not listening.
   - Listen to the person so they feel heard and supported and reassure them that the conversation will be treated confidentially.

4. Provide the support the person needs. Self-injury is more likely to stop if the person can learn other ways to cope with their feelings and emotions:
   - Help the person to find other coping strategies.
   - Encourage the person to seek further help. There are many people and organisations that can help the person find better ways of coping and dealing with the issues underlying their self-injury.
   - Suggest options for support (e.g. seeing their local doctor or another health professional) and offer to accompany the person to their appointment.
   - Do not pressure the person into any treatment they are not comfortable with.

   If you or someone you know feels at risk, contact the Suicide Call Back Service on 1300 659 467 or SuicideLine on 1300 651 251.

MORE INFORMATION

- Mental health and wellbeing – information on the Australian Government’s role and contributions to mental health reform activities in Australia: www.mentalhealth.gov.au
- Mental Health Foundation of New Zealand – Self-harm: An information booklet for young people who self-harm and those who care for them: www.mentalhealth.org.nz
- Nillumbik Community Health Service – self-harm information packs available at: www.nchs.org.au
- SANE (7236).
- The Royal Australian and New Zealand College of Psychiatrists (RANZCP) – offers a self-harm treatment guide for consumers and carers: www.ranzcp.org
- Royal College of Psychiatrists (UK) – offers a range of resources: www.rcpsych.ac.uk
- Salvo Care Line (Salvation Army) – offers a crisis counselling service available throughout Australia: visit www.salvos.org.au for the number in your state.
- Samaritans (UK) – offers information about self-harm: www.samaritans.org
- SANE Helpline – offers a wide range of information about self-harm: Ph: 1800 18

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In Victoria alone more than 500 deaths per year are caused by suicide. The highest number of suicides occurs among males aged 25 to 34 years. Suicide occurs across all socioeconomic levels. Suicide can be an impulsive act or a well thought out plan. All people – not just mental health professionals – can help young people experiencing suicidal thoughts by providing emotional and practical support.

**Warning signs of suicide**

Predicting suicide is difficult. Changes in behaviour outside the person’s normal range of behaviour and which do not make sense to those close to them may be a warning sign.

Other warning signs may include:
- Loss of interest in previously pleasurable activities
- Giving away prized possessions
- Problem behaviour and substance misuse
- Apathy in dress and appearance, or a sudden change in weight
- Sudden and striking personality changes
- Withdrawal from friends and social activities
- Increased ‘accident proneness’ and self-harming behaviours.

**Most young people who complete suicide told someone of their plans**

About 80 per cent of young people who complete suicide told someone they intended to kill themselves.

**Triggers of suicide**

Stress can contribute to suicide. A young person may experience an overwhelming and immediate stress, or stress that builds up over a long time.

People who have attempted suicide before are very likely to try again. Those who have a history of harming themselves deliberately are also at higher risk of suicide.

Stressful episodes can trigger suicide. These include:
- Loss of an important person through death or divorce
- Incest or child abuse
- A sense of failure at school
- A sense of failure in relationships
- Breaking up with a girlfriend or boyfriend
- Experiencing discrimination, isolation and relationship conflicts with family, friends and others because the young person is gay or lesbian
- The recent suicide of a friend or relative, or an anniversary of a suicide or the death of someone close to them.

People who have attempted suicide before are very likely to try again. Those who have a history of harming themselves deliberately are also at higher risk of suicide.
### SUICIDE MYTHS

Incorrect beliefs concerning suicide include:

<table>
<thead>
<tr>
<th>MYTH</th>
<th>FACT</th>
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<tr>
<td><strong>Young people who talk about suicide never attempt or complete it. They are just seeking attention.</strong></td>
<td>It is more likely a cry for help and should always be taken seriously.</td>
</tr>
<tr>
<td><strong>Once a person is intent on suicide, there is no way to stop them. They will be suicidal forever.</strong></td>
<td>Suicide can be preventable. If they receive the help they seek, they are less likely to attempt suicide.</td>
</tr>
<tr>
<td><strong>Suicide is hereditary.</strong></td>
<td>Whilst suicide tends to run in families, it is not hereditary. It is important for suicidal people to know there are options other than ending their life.</td>
</tr>
<tr>
<td><strong>All suicidal young people are depressed.</strong></td>
<td>Whilst depressed mood is common, this is not true for everyone who suicidies.</td>
</tr>
<tr>
<td><strong>A marked and sudden improvement in mental state following a crisis indicates the suicide risk is over.</strong></td>
<td>When there have been signs of a possible suicide attempt, a sudden improvement in mood may in fact indicate that the person has finally decided to take their own life.</td>
</tr>
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#### Helping a young person experiencing suicidal thoughts

You may be able to help a young person if you:

- Listen and encourage them to talk, show that you are taking their concern seriously
- Tell the person you care
- Acknowledge their fears, despair or sadness
- Provide reassurance, but do not dismiss the problem
- Ask if they are thinking of hurting or killing themselves, and if they have a plan
- Point out the consequences of suicide for the person and those they leave behind
- Ensure they do not have access to lethal weapons or medications

- Stay with the person if they are at high risk
- Immediately tell someone else, preferably an adult
- Get help from professionals, offer to go with them to provide support
- Let them know where they can get other help
- Provide contact numbers and assist them to ring if necessary.

#### What is not helpful

Try to avoid:

- Interrupting with stories of your own
- Panicking or becoming angry
- Being judgmental
- Offering too much advice.

#### Where to get help

- Your local community health centre
- A doctor (not necessarily the family doctor)
- Suicide Helpline Tel. 1300 651 251
- Kids Helpline free call Tel. 1800 551 800
- Other telephone counselling, information and referral services, such as Lifeline Tel. 131 114
- Mental Health Advice Line Tel. 1300 280 737.

#### Things to remember

- You don’t have to be a trained professional to help a young person experiencing suicidal thoughts
- Take all suicide threats seriously
- You can help by offering emotional and practical support, by listening and by helping to link the person with professional help.
Despite some concerns about its accuracy, the main source of Australian data on suicides is the Australian Bureau of Statistics. They release new data on an annual basis. Unless otherwise stated, the statistics provided in this document are from ABS publications.1 Compiled by the Mindframe national media initiative

How many people die by suicide in Australia?
➤ Suicide is a prominent public health concern in Australia. For the past five years, around 2,100 people have taken their life each year, with 2,132 deaths recorded in 2009
➤ For the past decade suicide represented 1-2% of all deaths registered in Australia
➤ Although suicide attempts are more common in women than men, generally men take their own lives at a rate four times that of women.

Is the problem getting worse?
➤ Suicide rates for both males and females have generally decreased since the mid-90s, with the overall suicide rate decreasing by 23% between 1999 and 2009. This can be seen in the figure below, which is sourced from the Australian Bureau of Statistics2
➤ Despite the common belief that there is a 'youth suicide epidemic', suicide rates among young people, the age group 15-19 years has the lowest rate of suicide for both males and females. The rate of suicide deaths in males has fallen by 29% in the last decade and the rate for females has dropped by 46%
➤ Despite these decreases, suicide remains a major external cause of death, accounting for more deaths than transport accidents between 1995 and 2009

Suicide is a prominent public health concern in Australia.
For the past five years, around 2,100 people have taken their life each year.

➤ Although accurate suicide statistics are difficult to obtain for Aboriginal and Torres Strait Islander people, figures reveal that the percentage of all deaths attributable to suicide is generally much higher for these populations and may be increasing.

Do rates vary between states and territories?
➤ Combining suicide data over a five-year period provides a more reliable picture of differences across the states and territories due to the relatively small number of suicides in some states and territories in any one year
➤ In recent years (2004-2009) the Northern Territory and Tasmania had the highest rate of suicide, followed by South Australia. In contrast, New South Wales and Victoria had the lowest rates of suicide and the ACT and Queensland had fluctuating rates.

Are the rates different for males and females?
➤ Suicide rates for males are higher than those for females and have been higher since at least the 1920’s.
More women than men, however, attempt suicide. The ratio of male to female suicides rose from 2:1 in the 1960s to over 4:1 in the mid 1990s. In recent years, the suicide rate for males has reduced slightly to 3.3 times that of females in 2008, and is consistent across most age groups.

Between 2000 and 2009, the suicide rate fell by 21%, with this rate of change different for males (24%) and females (13%).

Do rates vary across age groups?

The peak age-group for suicide in men is 85 years and over (28.2 per 100,000 in 2009). Over the last 10 years, this group has consistently had generally higher rates than other age groups of men. Nevertheless it is important to note that rate of suicide in this age group has declined 46.4 per 100,000 in 2000.

In other age groups, there has been a trend towards men in their middle years having the highest rates of suicide.

From 1990 onwards, there has not been any one age group of females that has consistently had a higher rate of suicide than other age groups.

For men, the largest drop in suicide rates between 2000 and 2009 is observed for 20-24 year olds and 25-29 year olds, with a fall of 42% in suicide rates for each of these groups. In contrast, the suicide rate for those men aged 60-65 years has increased by 10% over this period.

One quarter of suicides in Australia occur among people who have migrated to Australia with 60% of these being from non-English speaking countries.

For women, the largest drop in suicide rates between 2000 and 2009 is observed for 15-19 year olds, with a fall of 46% in suicide rates for this group. In contrast, there was a 66% increase in suicide rates from 2000 to 2009 for women in the 50-54 years age group.

Further facts and statistics, including rates of death by age, sex and state can be found here.

Do the patterns the same for Aboriginal and Torres Strait Islander people?

For women the largest drop in suicide rates between 2000 and 2009 is observed for 15-19 year olds, with a fall of 46% in suicide rates for this group. In contrast, there was a 66% increase in suicide rates from 2000 to 2009 for women in the 50-54 years age group.

Further facts and statistics, including rates of death by age, sex and state can be found here.

Do rates vary among people from culturally and linguistically diverse backgrounds?

One quarter of suicides in Australia occur among people who have migrated to Australia, with 60% of these being from non-English speaking countries. However, rates vary according to country of origin, gender and age.

First generation migrants in Australia show similar suicide rates to those in their country of origin.

Rates are generally higher among people born in English-speaking countries, and those from western, northern and eastern Europe, and lower among people from southern Europe, the Middle East and Asia.

Overall, males born outside of Australia have a lower suicide rate than Australian-born males, while the rate is higher for females born overseas than for Australian-born females. The rate is also higher for people of both genders aged over 65.

Do rates vary between urban and rural areas?

There is some evidence that suicide rates in rural and remote areas are significantly greater than in urban populations. This may be especially true among young men in remote regions.

Possible factors contributing to low coverage in some areas of Australia, the ABS only publishes data for NSW, QLD, SA and NT. Thus data on suicide rates are likely to be, at best, minimum figures and the information must be interpreted cautiously.

The percentage of deaths attributable to suicide is much higher among Aboriginal and Torres Strait Islander people (about 4.0%) than non-Indigenous Australians (about 1.4%).

Suicide is more concentrated in the earlier adult years for Aboriginal and Torres Strait Islander people than for the general Australian population, with recent data indicating the highest rates for both males and females in the 15-24 year age group.
higher rates in these areas include isolation, rural poverty, increased risk-taking behaviour and access to lethal means (e.g. firearms). It has also been suggested that a culture of self-reliance, that does not encourage help-seeking behaviour, may be one of the most important contributing factors to youth suicide in rural areas.8

What are the most common methods of suicide?

➤ Since the late 90s, more than 40% of suicide deaths have been from hanging, making this the most common method.

➤ Males who die by suicide are more likely to do so via hanging than females, with approximately 50% of male suicide deaths due to this method since 2001, compared with 40% of female suicide deaths.

➤ Females who take their own lives do so via drug poisoning in more than a quarter of cases, whereas for males, this method constitutes less than 10% of suicide deaths.

➤ Suicides by firearms were far more common among males in the mid 1990s, but the numbers per year are now less than half. This is most likely due to restrictions on firearm ownership in place since 1997.

Are people in custody more at risk?

➤ People in any form of custody have suicide rates more than three times higher than the general population.

➤ The Royal Commission into Aboriginal Deaths in Custody found that Aboriginal and Torres Strait Islander people were not more likely to die in custody than non-Indigenous people.9 High numbers of Aboriginal and Torres Strait Islander deaths in custody were related to the high rates of incarceration in this population group.

What are some of the impacts of suicide?

➤ A death by suicide can have devastating impacts on family, friends, colleagues, health professionals, emergency services, and potentially the whole community. People who have been directly affected by suicide may themselves experience mental health problems, and are at increased risk of taking their own lives.

➤ People who identify with the person who has taken their own life (as someone in a similar life stage or circumstance to themselves) may be adversely affected by their death and consider suicide themselves as a result.

More than half of the individuals who self-harm do not have suicidal thoughts at the time of self-harm and self-harm has been described as a way to avoid suicide.

What is the relationship between self-harm and suicide?

➤ The relationship between self-harm and suicide is complex. Most commonly the motivation for self-harming behaviour is to cope with, or to gain a sense of relief from painful emotions and distressing personal experiences, not to result in death.10

➤ Any action that is deliberately intended to cause death is best regarded as a suicide attempt.11 Any deliberate attempt on one’s life that results in death is best understood to be a suicide.

➤ According to published research, more than half of the individuals who self-harm do not have suicidal thoughts at the time of self-harm and self-harm has been described as a way to avoid suicide.12

➤ This being said, acts of self-harm need to be taken seriously. Individuals who self-harm may be considered at higher risk of further, more severe self-harm and later suicide.13 Self-harm and suicide attempts can be performed by the same individual – and in some cases the intent may not be completely clear.

REFERENCES


2. Ibid.


11. Ibid.


Data on this webpage has been updated to reflect the Australian Bureau of Statistics (ABS) Catalogue 3303.0 ‘Causes of Death Australia, 2009’, released Tuesday 3 May 2011.
## WHAT WE KNOW

<table>
<thead>
<tr>
<th>WHAT WE KNOW</th>
<th>WHAT WE DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many people who attempt/contemplate suicide may have been thinking about suicide for some time.</td>
<td>The actual number of suicide deaths in Australia. But, we do know more people die through suicide than through road accidents or skin cancer and it is many times more common than homicide.</td>
</tr>
<tr>
<td>The predisposing risk factors, warning signs and precipitating events associated with suicide and self-harm.</td>
<td>The constellations of risk factors that are most likely to lead to suicide and how we use our understanding of risk and protective factors to actually identify those at risk and prevent suicide.</td>
</tr>
<tr>
<td>The vast majority of people who attempt or complete suicide either have contact with health services or tell someone about their intentions prior to their attempt (warning signs).</td>
<td>The economic cost of suicide and self-harm – in terms of health care and lost productivity for the individual concerned. An estimate based on recent modeling would be $17.5b per annum.</td>
</tr>
<tr>
<td>Prevalence of mental illness in the community.</td>
<td></td>
</tr>
<tr>
<td>The level of direct funding for national suicide prevention is less than $1 per person per annum.</td>
<td>The role stigma plays in discouraging help-seeking behaviour and problem solving for those at risk of suicide and self-harm.</td>
</tr>
<tr>
<td>Substance abuse (including alcohol consumption) can be both a risk factor and a precipitant of suicide – i.e. gives an individual the courage to attempt suicide and/or may be seen to reduce the potential pain that might be caused by the attempt.</td>
<td>The economic cost of grief resulting from suicide and self-harm – in terms of health care and lost productivity.</td>
</tr>
<tr>
<td>The number of Australians with mental illness not accessing any service or care.</td>
<td>The personal (health and wellbeing) and social cost of suicide and self-harm on those bereaved.</td>
</tr>
<tr>
<td>“Gatekeeper training” for front line workers in suicide prevention and assistance e.g. Police, Emergency Services, GPs.</td>
<td>The role that mental illness plays in the high rates of suicide among Indigenous Australians.</td>
</tr>
<tr>
<td>Reducing access to lethal means is an effective prevention strategy.</td>
<td>What effect, if any, has resulted from the NSPS over the past decade on suicide and self-harm rates/patterns.</td>
</tr>
<tr>
<td>Access to evidence-based pharmacological (SSRIs, SSNRIs et al) and psychological treatments (CBT, DBT, life skills etc).</td>
<td>The extent to which media reporting, internet promotion of suicide and cyberbullying impact on suicidal behaviour.</td>
</tr>
<tr>
<td>Follow up contact with people who are in crisis or previously attempted suicide or have been in-patients at an acute MH service is effective.</td>
<td>The quality of care – including continuity of care – provided by acute care mental health units. This is highly variable across Australia.</td>
</tr>
<tr>
<td>Suicide risk may be greatest following discharge from acute psychiatric care.</td>
<td></td>
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</tbody>
</table>

Suicide Prevention Australia is the national peak body and advocate for suicide prevention. We aim to increase public awareness around suicide prevention and to destroy the stigma associated with help seeking and suicide. Our mission is to make suicide prevention everybody’s business.

From ‘Suicide and Suicide Prevention in Australia; Breaking the Silence’.

Source: Suicide and Suicide Prevention in Australia: Breaking the silence
Executive summary, page 16. Lifeline Australia | www.lifeline.org.au
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It is distressing to realise that someone close to you may be considering suicide. This tool kit will help you identify signs to look for, decide what to do, and where you can go for help. Most people who consider suicide get through the crisis. Family, friends and professionals can make a big difference in helping people stay safe and re-establish reasons for living.

**ARE YOU THINKING OF SUICIDE?**

You are not alone. Thoughts of suicide occur for many people for a range of reasons. The most important thing to remember is that help is available. Talking to someone is a good place to start, even though it may seem difficult. Approach someone you trust or call one of the helpline numbers listed at the end of this tool kit. Tell someone today if you are thinking about suicide.

**WHY DOES SOMEONE CONSIDER SUICIDE?**

People considering suicide often feel very isolated and alone. They may feel that nobody can help them or understand them. They believe that suicide is the only way out of the difficulties that they are experiencing.

Having a mental health problem does not mean a person will have thoughts of suicide – many don’t. However, mental health problems can affect the way people view situations. They affect motivation and openness to seek help, therefore we need to be part-icularly aware of the vulnerability to suicide that people experiencing mental illness can have.

**WHAT DO I DO NOW?**

The following tips will help you know what to do

1. **DO SOMETHING NOW**

   If you are concerned that someone you know is considering suicide, act immediately. Don’t assume that they will get better without help or that they will seek help on their own. It’s easy to avoid being part of that help or to hope that someone else will step in. Reaching out now could save a life.

2. **ACKNOWLEDGE YOUR REACTION**

   When you realise that you need to take action to help someone who is considering suicide, your natural reaction may be to:
   - Panic
   - Ignore the situation and hope it will go away
   - Look for quick-fix solutions to make the person feel better
   - Criticise or blame the person for their feelings
   - Tell the person they are being silly and trivialise the issue or dismiss them.

   These reactions are common but not helpful. It’s natural to feel panic and shock, but take time to listen and think before you act. If you find you’re really struggling, enlist the help of a trusted friend or helpline.
3. BE THERE FOR THEM

Spend time with the person and express your care and concern. Ask them how they are feeling, hear their pain and listen to what’s on their mind. Let them do most of the talking.

4. ASK IF THEY ARE THINKING OF SUICIDE

Unless someone tells you, the only way to know if a person is thinking of suicide is to ask. Asking can sometimes be very hard but it shows that you have noticed things, been listening, that you care and that they’re not alone. Talking about suicide will not put the idea into their head but will encourage them to talk about their feelings. They will often feel a great sense of relief that someone is prepared to talk with them about their darkest thoughts.

5. CHECK OUT THEIR SAFETY

If a person is considering suicide it is important to know how much they have thought about it, so ask them about the following:

➤ Have they thought about how and when they plan to kill themselves?
➤ Are they able to carry out their plan?
➤ Have they ever deliberately harmed themselves?
➤ What support can they access to stay safe and get help?
➤ How can you help them draw on connections with family, friends, pets, religious convictions, personal coping strengths and strategies?

Use this information to decide what to do. If you are really worried, don’t leave the person alone. Seek immediate help – see contact numbers listed on Lifeline’s website [www.lifeline.org.au](http://www.lifeline.org.au) or phone Lifeline on 13 11 14.

Remove any means of suicide available, including weapons, medications, alcohol and other drugs, even access to a car. Be aware of your own safety.

For immediate crisis intervention when life may be in danger ring the ambulance or police on 000 or go to your local hospital emergency department.

6. DECIDE WHAT TO DO

Now that you have this information you need to discuss together what steps you are going to take. What you decide to do needs to take into account the safety concerns that you have. Don’t agree to keep it a secret.

You may need the help of others to persuade the person to get professional help – or at least take the first steps to stay safe. These may include their partner, parents, or close friends. Only by sharing this information can you make sure that the person gets the help and support they need.

Thoughts of suicide often return and when they do it is important for the person to again reach out and tell someone.

7. TAKE ACTION

The person can get help from a range of professional and supportive people:

➤ GP
➤ Counsellor, psychologist, social worker
➤ School counsellor, youth group leader, sports coach
➤ Emergency services – police and ambulance
➤ Mental health services
➤ Community health centres
➤ Priest, minister, religious leader
➤ Telephone crisis support services such as Lifeline and Kids Helpline.

When the person has decided who they are most willing to tell, help them prepare what they will say. Many people find it difficult to express their suicidal thoughts.

Offer to accompany the person to the appointment. After the appointment, check that they raised the issue of suicide and ask what help they were offered. Help them follow through with the recommendations.

In some situations the person may refuse to get help.
While it’s important that you find them the help they need, you can’t force them to accept it. You need to ensure that the appropriate people are aware of the situation. Don’t shoulder this responsibility alone.

8. ASK FOR A PROMISE

Thoughts of suicide often return and when they do it is important for the person to again reach out and tell someone. Asking them to promise to do this makes it more likely that it will happen. Encourage the person to promise to call you, a GP or Lifeline on 13 11 14 if suicidal thoughts return, and to do this before they harm themselves.

People who have recently been discharged from hospital for treatment of mental health problems may also be at higher risk of suicide.

9. LOOK AFTER YOURSELF

If you’re helping someone who is considering suicide, make sure you also take care of yourself. It is difficult and emotionally draining to support someone who is suicidal, especially over an extended period.

➤ Don’t do it on your own. Find someone to talk to – friends, family or a professional
➤ Recruit other people to help support the person you are worried about
➤ Get in touch with carer organisations or support groups. Contact Lifeline on 13 11 14 to find what’s available in your area
➤ Try not to let your concerns about the other person dominate your life. Make sure you continue to enjoy your usual activities, take time out to have fun and keep a sense of perspective.

10. STAY INVOLVED

Thoughts of suicide don’t easily disappear without the person at risk experiencing some change. Their situation or feelings may change, or they may feel more supported and able to deal with it. In either situation, the continued involvement of family and friends is very important.

Below are some tips to ensure the person at risk continues to get the best help possible:

➤ Ensure the person has 24-hour access to some form of support. This may be you, other family members and friends, or Lifeline
➤ Accompany the person to appointments if possible. Your support can be a great encouragement
➤ If you are the primary carer, try to establish a good relationship with the health professionals responsible for the person’s treatment. Your opinion and input is valid and may be very valuable
➤ Advocate for the person. Sometimes a service or health professional may not be capable of meeting all the person’s needs. You can advocate for appropriate services

➤ Discuss with the person what issues or situations might trigger further suicidal thoughts. Plan how to reduce this stress and what coping strategies can be used
➤ Continue to be supportive but not overprotective
➤ Encourage the person to write out a plan for how they are going to stay safe, the steps they will take and other people to get involved if things start to get rough. A clearly documented stepped plan is a useful tool to keep a person safe.

MENTAL HEALTH

People who have recently been discharged from hospital for treatment of mental health problems may also be at higher risk of suicide. It is important that they receive ongoing support in the community.

You may be able to help, by supporting them to attend any follow-up visits with their GP or mental health specialists. If the person has not sought help for a
suspected mental health problem, you should encourage them to do so.

**WHAT TO LOOK OUT FOR**

**Situations** – what's happening in the person's life?

**Have they experienced any life changes recently?**
- Recent loss (a loved one, a job, an income/livelihood, a relationship, a pet)
- Major disappointment (failed exams, missed job promotions)
- Change in circumstances (separation/divorce, retirement, redundancy, children leaving home)
- Mental disorder or physical illness/injury
- Suicide of a family member, friend or a public figure
- Financial and/or legal problems.

**Feelings** – how does the person feel about their life?

Events and life changes can be difficult and sometimes devastating. Most people who experience them don’t consider suicide, but some do.

- Be aware of:
  - How the person feels about what’s happened
  - What it means to them
  - Whether the pain feels bearable.

**Behaviours** – what are they doing?

People at risk of suicide usually give clues by the way they behave.

- These may include:
  - Previous suicide attempts
  - Being moody, sad and withdrawn
  - Talking of feeling hopeless, helpless or worthless
  - Taking less care of themselves and their appearance
  - Losing interest in things they previously enjoyed
  - Difficulty concentrating and/or sleeping
  - Being more irritable or agitated
  - Talking or joking about suicide/death
  - Expressing thoughts about death through drawings, stories, songs etc
  - Saying goodbye to others and/or giving away possessions
  - Engaging in risky or self-destructive behaviour
  - Increasing alcohol/drug use.

**PLACES TO GO FOR HELP NOW**

For immediate crisis intervention when life may be in danger call the ambulance or police on 000 or go to your local hospital emergency department.

For further information about places to go for help when someone is at risk of suicide, visit the Lifeline website: www.lifeline.org.au.

**National Helpline Support**

- Lifeline 13 11 14
- Kids Helpline 1800 55 1800
- Mensline Australia 1300 78 99 78
- Salvation Army Hope Line for suicide bereavement support 1300 467 354
- The Suicide Call Back Service 1300 659 467.

**ACKNOWLEDGEMENTS**

Prime Super is the proud sponsor of the Lifeline Information Service — your mental health and self-help resource. Prime Super is Australia’s only nationally operating super fund dedicated to rural and regional Australia. For more information on Prime Super, please ring 1800 675 839 or visit their website www.primesuper.com.au. Lifeline and Prime Super are working in partnership to promote mental health awareness, help-seeking and suicide prevention.

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Last revised June 2010
EXPLORING ISSUES

ABOUT THIS SECTION

‘Exploring issues’ features a range of ready-to-use worksheets relating to the articles and issues raised in this book.

The activities and exercises in these worksheets are suitable for use by students at middle secondary school level and beyond.

As the information in this book is gathered from a number of different sources, readers are prompted to consider the origin of the text and to critically evaluate the questions presented.

Does the source have a particular bias or agenda? Are you being presented with facts or opinions? Do you agree with the writer?

The types of ‘Exploring issues’ questions posed in each *Issues in Society* title differ according to their relevance to the topic at hand.

‘Exploring issues’ sections in each *Issues in Society* title may include any combination of the following worksheets: Brainstorm, Research activities, Written activities, Discussion activities, Quotes of note, Ethical dilemmas, Cartoon comments, Pros and cons, Case studies, Design activities, Statistics and spin, and Multiple choice.

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WORKSHEETS AND ACTIVITIES
BRAINSTORM

Brainstorm, individually or as a group, to find out what you know about self-harm.

1. What is self-harm?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________

2. In what ways do people self-harm?

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________________________________________________________________________
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3. Why do some people choose to harm themselves? Provide a list of common triggers for self-harming.

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________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________
________________________________________________________________________
What help is available to people who want to stop self-harming? Make a list of organisations which offer help and advice, summarise who they are and what they do, and include their contact details.

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________________________________________________________________________
Provide your own definitions for the following terms relating to self-harm:

- **Self-cutting:**

- **Self-poisoning:**

- **Self-burning:**

- **Risk-taking behaviours:**

- **Suicide:**
1. Role play a conversation between a young man who has been cutting himself and a healthcare professional who is treating his injuries. What could the healthcare provider say to encourage the young man to seek help?

2. A friend has recently been through a difficult time at home after her parents separated. You notice some marks on her arm and are concerned she has been injuring herself. You confide your concerns in someone you know, but she says your friend is just trying to get attention and the best thing to do is to ignore the self-harm. In pairs or as a group, role play what you would do.
After reading each of the following statements, consider their meaning in pairs, or use them as starting points for group discussions.

1. There are many reasons why someone may self-harm including a cry for help, a way of coping with stress, a symptom of a mental illness like depression, and/or it may show someone is thinking of suicide. (Orygen Youth Health, p.1)

2. Sometimes it can be difficult to accept counselling after self-harming because you might be feeling guilty, angry, and/or ashamed. (Orygen Youth Health, p.2)

3. “Self-injurers are more likely to have mental health problems and are at higher risk of suicidal thoughts and behaviour than non-self-injurers, and many self-injurers do not seek help.” (Medical Journal of Australia, p.4)

4. “Somehow seeing the blood on the arm, the leg, the stomach or wherever, allows these people to feel real, to feel that they are human and not so isolated.” (Prof. Graham Martin, p.6)

5. “For too long the negative stigma around self-harm has brushed it under the carpet ... but it’s critical that it’s taken seriously ... people are dying from this illness.” (Prof. Graham Martin, p.9)

6. “Self-harm still plagues my mind ... it’s like my best friend and worst enemy. I feel invigorated after scratching, and I miss it when I know I can’t do it ... but I’m also more aware of the downward spiral that follows.” (Alison Dower, p.10)

7. Young people who self-harm may feel that it helps to relieve their distress and bring some sense of relief in the short term. However this feeling of relief typically doesn’t last because the problems causing the distress are not being addressed. (headspace, p.11)

8. Self-harm is not about attention seeking. Most young people who self-harm go to great lengths to draw as little attention as possible to their behaviour by self-harming in private and by harming parts of the body that are not visible to others. (headspace, p.12)

9. Self-harming behaviour may be destructive, but it seems to help the person to manage their strong feelings. This is why it is so important to introduce other, more positive coping strategies before attempting to stop. Otherwise, the self-harming will continue, despite the person’s best intentions or their promises to loved ones. (Better Health Channel, p.17)

10. Sometimes a parent or carer is the last person to know when their child is self-injuring. Young people tend to confide in a close friend first, whom they commit to secrecy. This often leaves ‘the friend’ fearful for the safety of the person engaging in self-injury, but anxious about losing their friendship if they tell an adult who could help. (Kids Helpline, p.21)

11. Parents frequently feel a variety of strong emotions when they discover that their child is self-harming. These include anxiety, powerlessness, alarm, repulsion and anger. It is easy to feel frustrated by what looks like irrational and destructive behaviour and simply want it to stop immediately. (Parent Line, p.29)

12. Individuals who self-harm may be considered at higher risk of further, more severe self-harm and later suicide. Self-harm and suicide attempts can be performed by the same individual – and in some cases the intent may not be completely clear. (MindFrame, p.43)
Complete the following multiple choice questionnaire by circling or matching your preferred responses. The answers are at the end of the next page.

1. Which one of the following are not considered to be examples of direct ‘self-harm’:
   a. binge drinking
   b. cutting areas of the body, such as the stomach, arms and thighs
   c. burning skin with cigarettes or a lighter
   d. self-starving
   e. picking at wounds/scars
   f. self-hitting
   g. dangerous driving
   h. pulling hair out by the roots
   i. deliberately breaking bones
   j. hanging
   k. train surfing
   l. smoking and other drug use
   m. deliberate overdose on medication
   n. repeated acts of unsafe sex (while knowing about safe sex practices)

2. Self-harm is ....
   a. an illness
   b. a behaviour or symptom
   c. a disorder
   d. a mental illness

3. Which of the following are common triggers of self-harm:
   a. Bullying
   b. Sexual problems
   c. Poor body image
   d. Anxiety/depression
   e. Emotional numbness
   f. Alcohol and drug abuse
   g. Physical health problems
   h. School or work problems
   i. Low self-esteem/self-loathing
   j. Belief that punishment is deserved
   k. Physical, sexual or emotional abuse
   l. Difficulties or disputes with boyfriends or girlfriends
   m. Difficulties or disputes with parents, other family members or peers

4. Decide which of the following statements relating to self-harm are ‘myth’ or ‘fact’:
   a. Self-harm is an attempt at suicide
   b. Self-harm is just attention seeking
   c. Self-harm is an ‘emo’ or ‘goth’ thing
   d. Supporting someone who self-harms can be stressful and confusing
   e. If you self-harm it means you must be mentally ill
   f. People who self-harm have borderline personality disorder
   g. Self-harming seems to help the person manage their strong feelings
MULTIPLE CHOICE

Complete the following multiple choice questionnaire by circling or matching your preferred responses. The answers are at the end of this page.

5. Which of the following are appropriate treatment options for self-harm:
   a. Psychological intervention and/or counselling
   b. Psychiatric treatment
   c. Learning other forms of effective coping techniques
   d. Not telling anyone about self-harming to avoid shame and stigma
   e. Understanding and support from family members, friends and doctors
   f. Medical treatment for the physical injuries
   g. Until the self-harming behaviour is under control, getting advice on harm minimisation techniques (e.g. keeping piercing and cutting implements sterile)
   h. Ignoring self-harming urges until they go away
   i. Until the self-harming behaviour is under control, first aid training and adequate supplies of first aid equipment in the home (e.g. bandages and antiseptic solution)

6. Match the following terms to their corresponding definitions:
   a. Attempted suicide
   b. Compulsive self-harm
   c. Impulsive self-harm
   d. Major self-harm
   e. Moderate self-harm
   f. Risk-taking behaviours
   g. Self-harm
   h. Suicidal behaviour

   1. This type of self-harm is considered to be linked to obsessive-compulsive disorder (OCD). The person may be overwhelmed by anxiety, and so self-harms to relieve the tension
   2. Occasional self-harm, in which self-injury is used on a regular basis as a means of coping. The person may not even consider themselves to be a self-harmer
   3. Examples of this type of self-injury include cutting, burning, piercing, biting and hair pulling
   4. Extreme harm to oneself, such as amputation and castration. Often associated with some form of psychosis
   5. Non-fatal self-injury with the intention of causing death
   6. Involves repeatedly putting oneself in dangerous situations, (e.g. train surfing or driving at high speeds), in which there is a high risk of severe harm or even death occurring
   7. Includes the spectrum of activities related to suicide and self-harm including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts
   8. When an individual deliberately hurts or mutilates their body without the intent of suicide

MULTIPLE CHOICE ANSWERS

1 = a, d, g, k, l, n ; 2 – a = no, b = yes, c = no, d = no ; 3 = all of them ; 4 – a = myth, b = myth, c = myth, d = fact, e = myth, f = myth, g = fact ; 5 = a, b, c, e, f, g, i ; 6 – a = 5, b = 1, c = 2, d = 4, e = 3, f = 6, g = 8, h = 7.
Self-harming is a behaviour and not a mental illness. (p.1)

The number of young people who commit suicide is relatively low compared with the number who commit self-harm. (p.3)

In 2005-06, there were 7,299 hospitalisations of young people due to intentional self-harm – a rate of 197 per 100,000 young people. (p.3)

For females, self-injury peaked between 15-24 years of age. For males, it peaked between 10-19 years of age. The average age of onset was 17 years, but the oldest was 44 for males and 60 for females. (p.4)

The intentional self-harm hospitalisation rate was almost twice as high among Aboriginal and Torres Strait Islander young people compared with other young Australians in 2005-06. (p.4)

An estimated 200,000 Australians, or 11 per 1,000 people per month, self-injure. (p.5)

One in twelve teens self-harm during their adolescent years, with 15 years of age identified as the most likely age for self-harm, a study from the Murdoch Childrens Research Institute and Kings College in London has found. (p.7)

About 230,000 Australians deliberately self-harm in a 4-week period and about 24,000 cases each year result in hospitalisation. (p.8)

8% of 15-24 year olds have self-harmed at some point in their life. (p.8)

Up to 40% of self-harmers have thought about, or attempted, suicide. (p.10)

6-7% of young Australians (aged 15-24) have self-harmed in any 12-month period. (p.11)

The average age at which self-harm first occurs is 12-14 years. (p.11)

For some young people self-harm is a ‘once off’ event, but for over 50% it can become repetitive. (p.11)

Self-harm is not a new behaviour that arrived with a certain subculture or ‘trend’ amongst young people. (p.12)

Borderline Personality Disorder is the only mental health disorder for which self-harm is a diagnostic feature. (p.13)

A person who is suicidal is desperate to never feel anything again, whereas the person who self-harms is only trying to make themselves feel better. (p.16)

Compulsive self-harm is thought to be linked to obsessive-compulsive disorder. (p.16)

The predominant forms of self-harm are cutting the skin of arms or legs and/or deliberate overdoses of both prescription and over-the-counter medications not designed to be fatal. (p.21)

The rate of young people reporting self-injuring behaviours is increasing – in 2008, self-injury was reported 7,710 times; in 2009, this had risen to 8,166 reports, with 15% of all counselling type contacts reporting these behaviours. (p.21)

Dialectical Behaviour Therapy is an effective way of treating self-injuring behaviour. It teaches how to identify and challenge faulty and rigid thinking, and change the resulting unhealthy behaviours. (p.22)

Self-harm often begins in the teenage years and is more common in young people aged between 11-25 years. (pp.24,37)

Self-harm is distinguished from risk-taking behaviour, which involves repeatedly putting oneself in dangerous situations. (p.24)

More than 50% of self-harmers have been abused. (p.26)

The extent of self-harming is hard to research because it is often done in secret and may be hidden under clothes. (p.28)

Behaviours such as tattooing and body piercing are not generally considered to be self-harming behaviours in our culture. (p.28)

In any year, more than 24,000 people are admitted to hospitals in Australia as a result of self-harm, and thousands more are treated in emergency departments and not admitted. (p.31)

Usually, more women than men self-harm. Women more commonly take overdoses than men. Overdose is the most common form of self-harm in Australia. (p.31)

People who self-harm often struggle with problem-solving, and they find it particularly hard to ask for help. (p.31)

Of those who present to a hospital after self-harm, about half will never again attend with the problem. (p.32)

1% of those who self-harm die by suicide within the first year of going to hospital with the problem. (p.32)

Even if there is no suicidal intent accompanying the deliberate self-harm, the risk of accidental death is very real. (p.38)

People who repeatedly injure themselves may come to feel that they cannot stop, and this may lead to feelings of hopelessness and possibly suicidal thoughts. (p.38)

About 80% of young people who complete suicide told someone they intended to kill themselves. (p.39)

Those who have a history of harming themselves deliberately are also at higher risk of suicide. (p.39)

Whilst suicide tends to run in families, it is not hereditary. (p.40)

Although suicide attempts are more common in women than men, generally men take their own lives at a rate four times that of women. (p.41)

The rate of suicide deaths in males has fallen by 29% in the last decade and the rate for females has dropped by 46%. (p.41)

For men, the largest drop in suicide rates between 2000 and 2009 is observed for 20-24 year olds and 25-29 year olds, with a fall of 42% in suicide rates for each of these groups. (p.42)

For women the largest drop in suicide rates between 2000 and 2009 is observed for 15-19 year olds, with a fall of 46% in suicide rates for this group. (p.42)

Since the late ‘90s, more than 40% of suicide deaths have been from hanging – the most common method. (p.43)

Females who take their own lives do so via drug poisoning in more than a quarter of cases. (p.43)

Substance abuse (including alcohol consumption) can be both a risk factor and a precipitant of suicide. (p.44)

Having a mental health problem does not mean a person will have thoughts of suicide. (p.45)
**Glossary**

**Attempted suicide**
Non-fatal self-injury with the intention of causing death. It should be noted people have varying degrees of intention to kill themselves, or self-harm.

**Deliberate self-harm**
Also called self-harm and self-injury. When you deliberately inflict physical harm on yourself, usually in secret. It is not necessarily a suicide attempt and most commonly deliberate self-harm is a behaviour that is used to cope with difficult or painful feelings.

**Help seeking**
The process of an individual asking for help or support in order to cope with adverse life events or other difficult circumstances.

**Intervention**
To take action or provide a service to produce an outcome or modify a situation. Also, any action taken to improve health or change the course of, or treat, a disease or dysfunctional behaviour.

**Mental disorder**
A recognised, medically diagnosable illness or disorder that results in significant impairment of thinking and emotional abilities in an individual – intervention may be required. There are many different categories of mental disorder.

**Medication**
Anti-depressant medications have been shown to be effective in treating depression and, if indicated, may be prescribed by your doctor. For the treatment of bipolar disorder, mood stabilisers or antipsychotics may be indicated. If you have one of these disorders and are prescribed such medication, you may find the relevant Royal Australian and New Zealand College of Psychiatrists (RANZCP) guides helpful.

**Prevention**
Preventing conditions of ill health from arising.

**Protective factors**
Capacities, qualities, environmental and personal resources that drive individuals towards growth, stability, and health.

**Psychological therapies**
Cognitive behavioural therapy (CBT), problem-solving therapy (PST) and interpersonal therapy (IPT) are short-term forms of psychological treatments, whilst dialectical behavioural therapy (DBT) and psychotherapy are therapies carried out over a longer period. These treatments are provided by health professionals with specialist training, and have proven effectiveness for helping people with depression, anxiety disorders and other mental disorders, and may help people to reduce the risk of self-harm.

**Resilience**
Capacity of a person to encourage positive outcomes, such as mental health and wellbeing, and provide protection from factors that might place that person at risk of suicide. Resilience is often described as ‘the ability to bounce back from adversity’. Factors that contribute to resilience include personal coping skills and strategies for dealing with adversity, such as problem-solving, cognitive and emotional skills, communication skills and help-seeking behaviours.

**Risk factors**
Factors such as biological, psychological, social and cultural agents that are associated with suicide and suicide ideation. Risk factors can be defined as either **distal** (internal factors, such as genetic or neurochemical factors) or **proximal** (external factors, such as life events or the availability of lethal means).

**Self-harm**
Self-harm is when an individual deliberately hurts or mutilates their body without the intent of suicide. There are many reasons why someone may self-harm including a cry for help, a way of coping with stress, a symptom of a mental illness like depression, and/or it may show someone is thinking of suicide. Self-harming is a behaviour and not a mental illness. There are many different types of behaviours that can be considered self-harming: self-cutting (cutting of upper arms/wrists/thighs etc), self-poisoning (swallowing excessive amounts of prescribed or illegal drugs), self-burning (using cigarettes or lighters to burn the skin). More extreme examples of self-harm can include breaking bones, hanging and deliberately overdosing on medication. Stereotypic self-harm includes head banging and may be associated with other disabilities; and major self-harm might include amputation and castration, and is often associated with some form of psychosis.

**Self-injury**
Sometimes called non-suicidal self-injury, self-inflicted injuries or self-harm.

**Suicide**
The act of deliberately taking one’s own life.

**Suicidal behaviour**
Includes the spectrum of activities related to suicide and self-harm including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts.

**Suicidal ideation**
Thoughts about attempting or completing suicide.

**Suicide prevention**
Actions or initiatives to reduce the risk of suicide among populations or specific target groups.

**Warning signs**
Behaviours that indicate a possible increased risk of suicide, such as giving away possessions, talking about suicide or withdrawing from family, friends and normal activities.
Websites with further information on the topic

Better Health Channel  www.betterhealth.vic.gov.au
Beyond Blue  www.beyondblue.org.au
headspace  www.headspace.org.au
Kids Helpline  www.kidshelp.com.au
Living is for Everyone  www.livingisforeveryone.com.au
Lifeline  www.lifeline.org.au
MindFrame  www.mindframe-media.info/mentalhealth
Orygen Youth Health  http://oyh.org.au
Reachout.com  http://au.reachout.com
SANE Australia  www.sane.org
Suicide Call Back Service  www.suicidecallbackservice.org.au
Suicide Prevention Australia  www.suicideprevention.com.au
Youth Beyond Blue  www.youthbeyondblue.com

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THANK YOU
✶ headspace
✶ Better Health Channel
✶ Crisis Support Services
✶ The Royal Australian and New Zealand College of Psychiatrists.

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