

# Seeking Solutions to Self-injury



## A GUIDE FOR FAMILY DOCTORS

# SEEKING SOLUTIONS TO SELF-INJURY: A GUIDE FOR FAMILY DOCTORS

The fifth in a series of five guides - 'Seeking Solutions to Self-Injury' (Young People, Parents and Families, School Staff, Emergency Staff and Family Doctors).

## ACKNOWLEDGEMENT

We would like to acknowledge the phenomenal assistance of Heather Valentine, in copyediting all the guides in this series of 'Seeking Solutions to Self-injury', as well as managing the extensive distribution throughout Australia.

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Martin, G., Swannell, S., Hasking, P. & McAllister, M. (2014). *Seeking Solutions to Self-injury: A Guide for Family Doctors*. Centre for Suicide Prevention Studies, The University of Queensland, Brisbane, Australia.

ISBN 978-0-9875603-6-0

Printed by Bluestar Group, Brisbane, Queensland.



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# 1. WHAT THIS BOOKLET IS ABOUT

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This guide is about understanding self-injury and providing optimal management in General Medical Practice.

The guide is for you if:

- *You are a Family Doctor (GP, Local Medical Officer or Family Physician) who may see patients seeking care for self-injury;*
- *You are confused about why someone would self-injure;*
- *You would like to know how a family doctor can best help people who self-injure.*

Self-injury can be a confusing behaviour. You may know the family very well, and be surprised that self-injury has emerged in a young person from this family. Conversely, you may have been expecting some sort of problem to emerge, given hints in previous consultations with members of the family. Alternatively, this may be the first time you have met this individual and/or their family; they may be new to your district, or perhaps they were reticent to return to their previous doctor for this particular problem.

The self-injurer and their family *may simply be seeking treatment for the physical injury*, and your management and practical advice about wound care is likely to be straightforward. However, knowing what (or how much) to say, and how best to relate to the patient, may be uncomfortable or perplexing. And broaching the subject of self-injury, or suicidality, may depend on whether you have an interest in, and some training for, managing emotional problems. It may also depend on whether you feel you can take the necessary time to open up 'a can of worms'.

If a young person presents on their own, or with a friend, it may be difficult to know whether (or indeed 'how') to disclose the self-injury to their parents or caregiver. There is always the need to balance confidentiality with duty of care. Gaining the trust of your primary patient will be important in your ongoing care, and you should always discuss possible disclosure upfront with them before disclosing their self-injury to an appropriate family member or caregiver. You also need to consider how the carers might react!

We never said this was going to be easy.

This guide was developed specifically to help family doctors feel more confident about responding in the most helpful and appropriate manner to patients who present with self-injury. It is based on our best understanding of the current international literature on self-injury, as well as our own research studies over many years. In addition, we have consulted with many health care professionals, families and parents of young people who self-injure, as well as the young people themselves.

We also drew on the first author's practical experience of working as a family doctor for many years, but also the provision of prize-winning educational materials and training programs for family doctors across Australia about Youth Suicide and its prevention ('Keep Yourself Alive', 1997).

The guide explains self-injury and provides effective strategies for assessing, responding and referring patients. We hope you benefit from the information we provide.

## 2. WHAT IS SELF-INJURY?

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We define self-injury as: **‘Deliberate destruction or alteration of body tissue *without suicidal intent*’**. Other terms include: *‘Non-suicidal self-injury’ (NSSI), ‘Self-mutilation’, ‘Auto-aggression’, ‘Self-wounding’, and ‘Cutting’*. *‘Deliberate self-harm’ (DSH)* is a term commonly used to describe the phenomenon, but includes both self-injury **and** the wish to die (i.e. ‘a suicide attempt’). Distinguishing between NSSI and DSH is important because **self-injury and suicide attempts require different management strategies**. Thinking self-injury may be a suicide attempt can interfere with best practice management of self-injury.

This guide focuses on non-suicidal self-injury. We do **not** include drug use, alcohol abuse, anorexia or bulimia as self-injury - although we understand it can be argued they are forms of self-abuse. **Our focus is on those who damage the outside of the body to relieve painful feelings inside**. This may include cutting, scratching, burning, hitting a part of the body on a hard surface, or deliberately interfering with wound healing. We accept, and also include, swallowing of objects or chemicals to damage the body, as long as it can be clarified this was **not** a suicide attempt.

The majority of self-injurers presenting to a family doctor do not want to be there. Even when they attend willingly, it is only because they accept that practical medical care is required. Patients ‘brought’ against their will are often angry and resentful about being brought, and can present as tearful and upset. This picture of being upset, with a self-inflicted injury, may initially look like suicidal behaviour, but it is a mistake to automatically assume this.

Patients in this situation will have their guard up, expecting you to judge or label them as ‘attention-seeking’ or manipulative. **Your first step is to recognise and accept their internal experience as being valid**, and avoid rejecting, ignoring, or judging their experience. You don’t have to agree with or support their feelings or thoughts - just recognise them as valid. Try something like: “You must have been feeling really awful.”

Even in the middle of turmoil, the best way to distinguish between suicidal behaviour and self-injury is to ask questions: **“What were you trying to do?” “What did you want to happen as a result of hurting yourself?” “Did you think you might die?” “Did you really want to die?”**

If they admit to suicidal thoughts, you need to know whether these are frequent or chronic, intrusive and/or cannot be banished. In addition a key question is whether they have developed a plan; details about this will help your decision on seriousness. A history of discussing plans with friends may suggest heightened risk, and leads in to a question about whether they have attempted before. If they have attempted before, then a good question relates to whether they were happy they survived the attempt.

Negative responses to each of these questions may reassure you this is NSSI with a low risk of suicidality; conversely, positive responses on intrusive suicidal thoughts, detailed plans, talking freely with others, and one or more previous attempts, means they will require specialist mental health care, a thorough suicide risk assessment, possible hospital admission for observation, and intensive follow up.

### 3. WHO IS LIKELY TO SELF-INJURE?

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Self-injury is surprisingly common, and has been part of being human for centuries. Grief and contrition have been publicly demonstrated through self-injury (e.g. wearing a hair shirt, or flagellation), and in many religions being devout has been shown through self-injury in the context of ritual.

Our recent research shows that about 8% of Australians claim to have self-injured at some time in their life, and 1% admit to hurting themselves at least once in the previous month (Martin, Swannell, et al., 2010).

Although there is no particular ‘type’ of person more likely to self-injure, international research indicates a common thread is **difficulty in emotion regulation**. This may include reacting more intensely than others to daily difficulties, as well as taking longer to recover from an emotional upset. These difficulties are often the result of chronic adverse life experiences (like early trauma, neglect or abuse). They are not simply addressed by telling the individual to ‘toughen up’ or ‘think positive’. Be assured that individuals who self-injure repeatedly tell themselves to ‘toughen up’ and ‘think positive’, as they try to find ways to manage their emotions.

While people who self-injure tend to begin as an adolescent or young adult, our research shows adults *and* older people also self-injure. Males and females, rich and poor people, and people from different cultural backgrounds - all can self-injure.

A common misconception is that self-injury occurs almost exclusively among females. Research now suggests it occurs with similar prevalence across gender, and apparent differences relate mostly to the methods used. Females are more likely to

cut and scratch; males are more likely to hit a part of themselves against a wall, or kick something – perhaps more easily explained away as ‘an accident’.

Again, while many people assume self-injury occurs most commonly among adolescents, in fact prevalence is highest among 18 to 24 year olds.

An important fact is that **you don’t have to have a mental illness to need to self-injure**. Despite this, the Royal Australian and New Zealand College of Psychiatrists has produced guidelines that identify **people and groups who may be at more risk**. The guidelines use the term ‘self-harm’, but are still helpful to us. Those more at 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 misuse alcohol or other substances*
- *Those who have experienced childhood trauma or abuse*
- *Those who have a debilitating or chronic illness*

Risks themselves **do not cause** the problem. Rather, each one contributes to an increased possibility of self-injury occurring in the first place, or of self-injury being repeated. This leads us to the idea that if you are able to help someone sort out any problems that seem to be contributing to self-injury, then the self-injury may not need to occur, or will happen less often.

Perhaps what is more important is to discover **what protects** people from needing to self-injure in the first place, or **what may reduce the likelihood** of self-injury or perhaps reduce the

likelihood of repetition or increasing severity. These **protective factors** include:

1. *Availability of opportunities for support at critical turning points or major life transitions (like 'leaving school', 'moving interstate', or 'losing a parent')*
2. *Generally supportive family and friends*
3. *Physical wellbeing, good nutrition, sleep and exercise*
4. *Secure, appropriate and safe accommodation*
5. *Financial security*
6. *Positive school (or work) climate*
7. *Prosocial peers*
8. *Problem-solving skills*
9. *Optimism*
10. *Meaningful daily activity*
11. *Sense of control and self-efficacy*
12. *Good coping skills*
13. *Effective use of medication (when required/ prescribed).*

You may think that as a family doctor there is nothing you can do to facilitate development of protective factors or reduce risks for your patients. **However, do not underestimate your power to influence, or the authority of your role.** People have told us (and this is reflected in the research literature) that those working at the front line of health care, are critical to modifying, or lessening risks for patients in the future.

### **Why?**

Because:

- *The problem of self-injury is just as real as a chest infection, recurrent migraine, or an anxiety attack;*

- *Experiencing a crisis may be the turning point the person needs to realise they have a problem. Most self-harm, contrary to popular opinion, is **not seen by health professionals**. When it is, you have the critical opportunity to demonstrate to the person that they have a serious problem and there is help available;*
- *Self-injury often involves a vicious cycle. Part of that cycle involves guilt or other negative feelings that mount leading to the urge to self-injure. When patients seek emergency care for the results of their self-injury, they find it very easy to feel guilty for taking up your valuable time. You can minimise that guilt by conveying to them they have a right to care, and that you do not judge them; and*
- *If you treat patients badly, you reduce the likelihood they will seek help in the future.*

## 4. WHY DO PEOPLE SELF-INJURE?

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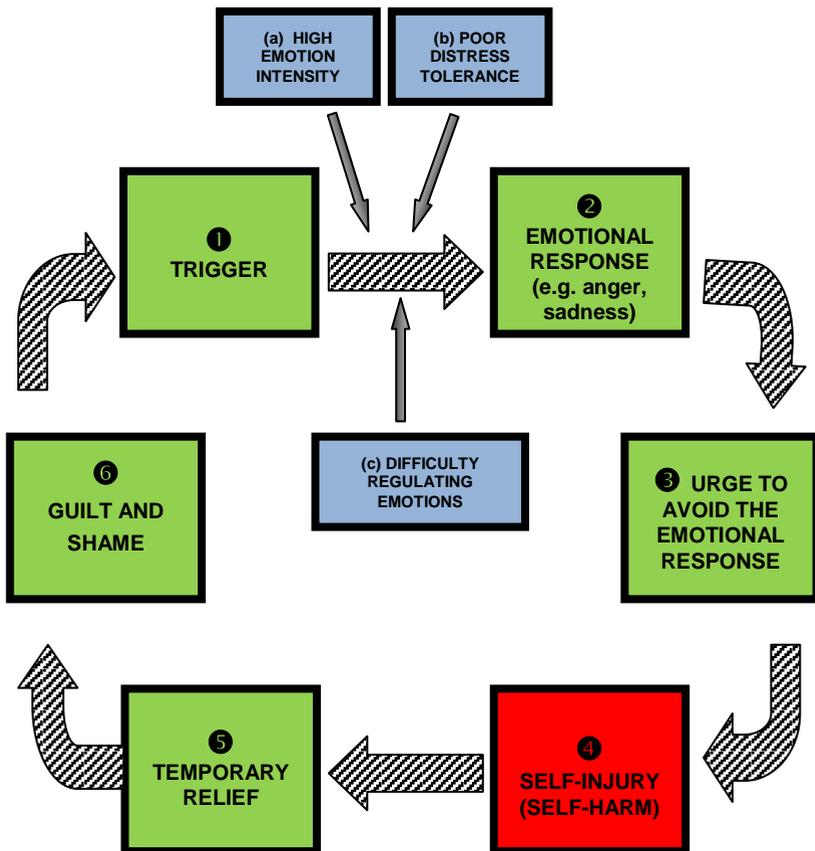
Our research shows there are many reasons someone may self-injure. These include:

- *Releasing unbearable mounting tension*
- *Relieving feelings of aloneness, alienation, hopelessness, or despair*
- *Combating desperate feelings or thoughts*
- *Discharging rage or anger*
- *Self-punishment – either because they felt bad inside and could not change the feeling, or in some way to purify the inner self*
- *Attempting to feel alive again; the external injury accompanied by pain brought them back to reality*
- *Regaining a sense of control over inner feelings or some sense of having ‘lost it’*
- *Self-soothing; after the damage they find ways to look after the wounds, and therefore themselves*
- *Reconfirming personal boundaries and a sense of self*
- *Communicating with others; letting them know how bad they were feeling, but could not express in words*
- *Expressing conflict*
- *Bringing them ‘back’ from dissociative states: cutting or other actions can be grounding, bringing awareness to the physical body*

**Do not jump to conclusions.** Always ask the patient what best describes what they are going through.

We think the following model is helpful. The diagram describes how a person can get into a cycle of self-injury.

Adapted from: Chapman, A.L., Gratz, K.L. & Brown, M.Z. (2006). Solving the puzzle of deliberate self-harm: The experiential avoidance model. *Behaviour Research and Therapy* 44, 371-394.



1. The cycle begins with a **STIMULUS OR TRIGGER**. This can be something stressful - like witnessing an accident, a conflict in a relationship, having an upsetting thought ('no one likes you'), or uncomfortable emotions (feeling you are about to have a panic attack). Often, the stimulus or trigger involves feelings of loss, rejection or abandonment.

2. The trigger leads to an intense, unbearable **EMOTIONAL RESPONSE** (anger, sadness, anxiety, shame, fear), which increases over time, or leads to psychological *numbness*.

People who self-injure:

- a. Are likely to have **HIGH EMOTION INTENSITY**.
  - b. Find it difficult to *tolerate* uncomfortable emotions (they have **POOR DISTRESS TOLERANCE**).
  - c. Don't know what to do about emotions (they have **DIFFICULTY REGULATING EMOTIONS**).
3. This all leads to an **URGE TO AVOID THE EMOTIONAL RESPONSE**.
  4. Other ways to reduce the emotional pain fail. Attempts may be made to avoid self-injuring, but once a critical level is reached the urge to **SELF-INJURE** becomes the 'only alternative'. If it has worked in the past, then it is likely the person will use it again.
  5. Self-harming provides **TEMPORARY RELIEF** from intense and uncomfortable feelings. It is this relief that makes self-harming seemingly 'addictive', like a drug.
  6. Relief does not last long, and within minutes or hours, feelings of **GUILT AND SHAME** usually appear. Other emotions may creep in, such as anger towards the self, or sadness about their situation. At this time the person may avoid others, or alternatively, may seek help. Sometimes the feelings of guilt and shame can even serve as the trigger or stimulus for another cycle of self-harm.

## Why does self-injury emerge?

A number of different theories have been proposed to help us better understand and explain self-injury. These include: Biological influences or differences in how the brain works; internal and often unconscious conflicts; old patterns of behaviours that we have learned over time; and influences in our social and cultural environment.

**Biological:** Psychological trauma from prior abuse, emotional neglect, or familial hostility and criticism, can affect the brain and the body in powerful, subtle and enduring ways. Research has shown that traumatic memories return to people vividly and with little warning, triggered by many unpredictable things. These memories can be just as frightening as the original event. Anxiety and inner tension are almost always the result. Like any anxiety, people feel a need to minimise it – ideally through relaxation, diversion or exercise, but sometimes through comfort eating, drinking, or smoking and, yes, through deliberate injury to the body. Self-injury triggers an endorphin surge that temporarily calms, or numbs feelings.

Traumatized people can also develop a sensitized biology – alert to even the slightest triggers in the environment, and with a heightened response to stress. Because it occurs more frequently, understandably they find it difficult to keep finding ways to manage.

Change is possible by expanding anxiety reduction strategies, learning to avoid triggers, delaying urges to self-injure, and resolving earlier traumas.

**Psychodynamic:** Vulnerable individuals who have had rough times in their early days may experience a new situation according to an old family pattern or personal experience. They

may unconsciously seek to relive the original problem or relationship and react as they did in the past. Hidden old tensions in the mind and old patterns of behaviour can be difficult to identify, difficult to bear and difficult to sort out. They may use coping mechanisms that are not even fully understood, because they are sub-conscious. Turning anger inward (rather than expressing it appropriately outward) is an example.

These 'vulnerable' individuals may have an increased need for self-soothing to calm down. Sometimes (often initially by accident) self-injury can become a self-soothing mechanism. Change is focused on raising awareness about these old internal conflicts and patterns, and finding relief and comfort in safer, less destructive ways.

*"Some people say  
it's to seek  
attention.  
So why am I so  
careful to hide it all  
the time?"*

**Behavioural:** An alternative explanation is that self-injury becomes a learned behaviour and escalates into a habit. This suggests possible methods leading to change - replacing self-injury with less destructive habits, and reinforcing healthier habits for coping both emotionally and practically. The changes are made slowly, bit by bit.

**Social and Cultural:** Self-injury may be more common in marginalised and oppressed people and cultural groups, those who may not have a voice, or who have difficulty making their voice heard. Change in this case is focused at a different level - on cultivating a more just society, facilitating release of anger and grief associated with disempowerment, and enabling the person to build, or rebuild, effective strategies through affirmative social action.

Matthew Nock, an accomplished researcher of self-injury, has developed an integrated theoretical model of the development and maintenance of self-injury, which may help if you want to know more (Nock, M., 2009).

As a family doctor, you can help a self-injurer by:

- *Appreciating there are reasons why self-injury has become part of this patient's life (even if you can't yet understand them);*
- *Accepting self-injury may have become the patient's only choice (at this time) to contain their emotion and avoid becoming overwhelmed;*
- *Accepting ingrained habits cannot simply be told to go away, and they do not change overnight;*
- *Avoiding becoming resentful and frustrated to the point of ignoring them; and*
- *Dealing with your own irritation so that you do not further inflame the situation, increasing their anger, sadness and feelings of alienation and rejection.*

It is vital in this context to understand that ***it is not the person who is the problem***. *The behaviour is the problem* (in this case, self-injury); it is damaging, repetitious and distressing to everyone concerned - including the patient.

Perhaps the best way to understand the experience of self-injurers is to ***listen to what they have told us***:

- *Many really don't know why they self-injure;*
- *They hide while self-injuring, doing it somewhere private or at a time of day where they feel they will be less likely to be discovered;*

- *They say it is an impulsive act; some talk about having a ritualised way of doing it;*
- *They feel really bad in some way before the act of self-injury (e.g. depressed, stressed, angry, memories of trauma), with ‘everything building up’;*
- *Some talk about feeling no physical pain during the act of self-injury, while others tell us they need to feel the physical pain ‘to make all the bad stuff go away’;*
- *Some feel good while cutting, some don’t;*
- *Some say the sight of their own blood makes them ‘feel real’, where they had felt like they were ‘not part of life’;*
- *Some are not able to describe the experience, as if they have ‘switched off’ (dissociated) during the act;*
- *Some feel immediate release or relief after self-injury, but many also talk about feeling ashamed, or even frightened; and*
- *Most cover up their self-injury scars/wounds (e.g. long sleeves in summer, lots of bracelets) so as not to draw attention to the solution they feel they have to use.*

Every person we have talked to agrees that self-injury is ***‘not about seeking attention’***.



***“It was an accident that I started. There was this other girl, and she was hurting herself. Her problems and feelings seemed just like mine, and nothing else had worked. So...”***

***“Sometimes I get so angry, I just need to hit something; the pain over the next few days seems to help me focus on stuff...”***



## 5. UNDERSTANDING CHANGE

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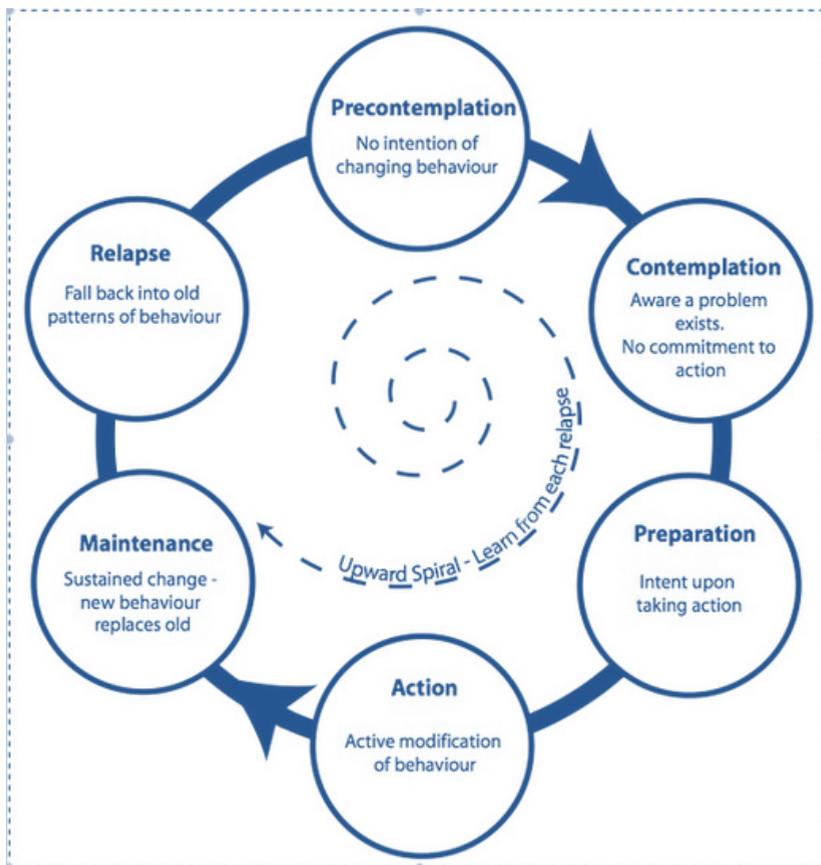
We know that, as a family doctor, you have major constraints on the time for each patient you see, and tend to be action-oriented. This is what you have been trained to do – make an accurate diagnosis as quickly as possible, and then act to change the situation for the better. You are changing people's lives every time you provide care.

We accept it may be frustrating when you attempt to provide care for a patient who doesn't seem to share your need for rapid change, or your belief that change is easy. People who self-injure may not yet be ready to take action to change their lives; they may be terrified of being left with no method of controlling or containing their emotions. And they may have some understanding that a 'quick fix' solution will only be temporary in the absence of deeper change in their coping with past trauma.

But if you take a few moments to reflect on the idea that change is a process, and you have to begin somewhere; then perhaps taking tiny steps over a series of consultations will build to substantial change. There are many things that you can do to help a patient get started – even in an 8-12 minute consultation.

Part of change is the 'readiness' for change. Let us consider a useful model.

A model of the change process looks like this.



From Prochaska et al.; 1992

Patients you see could be anywhere on this continuum. Your assessment of where they are at will help you to focus on the kind of support strategies you offer.

In the **Precontemplation** stage, the person does not consider the self-injurious behaviour problematic, so they will not have

even considered stopping, and may resent any suggestion to stop. The most helpful conversation you can have is about possible consequences of self-injury. One issue relates to using clean tools to cut, and cleansing the skin afterward. Your patient may come up with their own set of negative consequences, which allows you to begin to discuss those. Remember to be validating and accepting as far as you can. It may also be helpful to provide written information (like our 'Guide for Young People' for them to take away, or download) to 'plant the seeds of change'. If you come up with specific strategies for change too early, they may be defensive and simply reject them (and you).

In the **Contemplation** stage, the patient is aware of the negative consequences of self-injury, but is yet to commit to change. Perhaps they wish to change, but don't feel strong enough or skilled enough. With gentle coaxing, they might be willing to accept a referral to a counsellor or psychologist who can strengthen their resolve and give them new skills.

In the **Preparation** stage, the patient has made a commitment to make changes. They may say: *"I've got to do something about this - this is serious. Something has to change. What can I do?"* They will be more receptive to information, suggestions and strategies you offer, including your making contact with family members, or a therapy service to set up counselling sessions.

In the **Action** stage the patient is actively involved in taking steps to change their behaviour; but lapsing and re-engaging in self-injury is common. Your words of motivation and hope in the context of being 'non-judgmental', will be very important and confirm their resolve.

In the **Maintenance** stage, the patient has spent some time successfully avoiding self-injury, through making significant

changes in their lives, acquiring new skills, anticipating situations which could trigger a relapse, and preparing coping strategies in advance. If a patient presents to you after a period of time like this, your role is to help them see the episode as a temporary setback. How you respond to a patient in this stage could be the difference between them getting back on track, versus falling into a full relapse of continuing self-injurious behaviour.

**Supporting your patient to maintain positive self-talk at this time is very important.**

**Relapse.** Along the way to permanent behaviour change, most people experience relapse, sometimes more than once. In fact, it is much more common to have at least one relapse than not. There may be feelings of hopelessness and worthlessness, and your role is to remain optimistic for your patients and help to get them back on track.

So you see, at any stage in the process, (even within the constraints on your consultation time) there **are** things you can do to motivate, support, educate, and care for a patient without feeling helpless. But you *do* have to believe you can do this...

## 6. ABC PROVIDING EMERGENCY SUPPORT

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You are fully trained in, and very familiar with, the ABC of physical life support (Maintain **A**irway, **B**reathing, **C**irculation). Even if you don't feel able to do psychotherapy of any sort, it should be easy for you to step across into learning and using a very similar framework for mental health problems, in this context of self-injury (Kanel, 2007).

- A** **ATTEND** to the person, so they feel listened to
- B** **BREAK DOWN GOALS** into manageable parts
- C** Focus on possible **COPING** mechanisms.

There are many ways that you can implement this, and they do not need to be lengthy or time-consuming, just part of your daily, respectful, high quality care.

Some of these ideas may depend on which stage of change your patient is in. Use your judgment.

- (A) Separate your professional role from any personal values you may hold, or adverse feelings in you brought on by the self-injury, so that you can care for this patient just as you might care for anyone else;
- (A) Address the person by name, remembering they are already likely to feel 'undeserving' and of little worth (self-injury does not mean they are attention-seeking or stupid);
- (A) Attend to the injuries respectfully, gently, and immediately. If you hand this part over to your practice nurse, ensure they tend to the injuries respectfully, gently, and immediately (and have read this guide);
- (A) Let your patient express their story and their feelings in their own way.

- (B) Ask about the range of solutions they have tried so far (remembering that their current solution to problems may be the best they can manage at this time);
- (B) Ask them how you can be most helpful to them right now. (This gives the person a little power in the situation, giving them voice);
- (B) Ask them to be specific about their plans for when they leave your surgery.
- (C) Check out who is available to provide genuine support for them, once their injuries are sorted out;
- (C) Think about the change process. Where do you think your patient is at? If you think they are ready, you could gently plant the seed of change, by asking if they are aware of support services for this issue, and if they would like you to provide a referral;
- (C) Check out whether they have been attending a counsellor, and how they have been helped so far;
- (C) Ask whether they have accessed online services, or read any booklets to explain and help change self-injury.

## 7. IF YOU HAVE ESTABLISHED RAPPORT, MOVE ON TO ASKING SOLUTION-FOCUSED QUESTIONS

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When confronted by self-injury, it is easy to get overwhelmed and just want to focus on the problem and get rid of the patient as soon as possible. But the self-injury is not the whole person. Everyone may be obsessed by the problem at this point, but beginning to think about possible solutions ‘down the track’ may be helpful (and may stop you from feeling ‘helpless’).

Your patient may not yet be ready to talk about change; and that is ok! Simply by you conveying acceptance, you may have interrupted their cyclical pattern of guilt-urge-harm, and change actually may be occurring. At this point, you do not *have* to continue, you do not *have* to push for change.

**But**, if they are willing to talk, and you can manage the time (and your own feelings), don’t be afraid to help them focus away from the presenting problem and on to the future by asking:

- *“When self-injury is not in the picture so much, what is your life like? Tell me about what you are able to do at work, school, with friends and family?”* You are defocusing on the self-injury, and talking this way may begin to help your patient imagine a brighter future.
- *“If you were to wake up tomorrow and the urge to self-injure was no longer there, what do you imagine you would be doing, thinking, feeling?”* Having a conversation about an imagined future can help to make it feel real and possible.
- *“Who do you think would be most pleased that you had been able to stop self-injury?”* This begins to look for people who may add *their* support to helping your patient cease self-injury.

- *“What is one thing that you could do differently from now on?”* Helping the person to plan just one little change in their life, could have a ripple effect to help this episode become a turning-point.
- *“What are you really good at? What makes you feel really good when you can manage to do it?”* These kinds of questions are often a surprise to someone who is in turmoil, and the answers can sometimes be just as surprising, reminding them they do have a place in life. Be prepared for the patient to say *‘nothing!’*, but continue to coax a response out of them – everyone has something they are good at or feel good doing!
- *“When you stop self-injury, what kinds of things will you be able to do? What plans do you have?”* It is common at this point to get very negative answers – *“I don’t see any future.”* *“I will never be able to get a job.”* *“Can’t see anyone ever loving me, with all these scars.”* **Just accept the answers, don’t denigrate the responses**, but you can say something like: *“You may feel like that now, but over time, most people find a way to stop self-injury. There is really good research supporting that.”* (Rotolone & Martin, 2012; Andrews et al., 2013; Caltabiano & Martin, 2014).
- If the negativity continues, or you feel overwhelmed by it, trust your gut feeling, and check through your suicide risk checklist to reassess. If there is a need, call in a mental health professional to support the process.

## 8. ADVICE YOU CAN PROVIDE TO FAMILY MEMBERS AND CARERS

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Self-injury can be difficult to understand when you are a parent, family member or friend, and emotionally attached to a person who is hurting themselves. Remember, during times of high pressure, people may not remember much of what you tell them. Keep information simple. Follow it up with a brochure or card, or a relevant booklet (see our Guide for Parents and Families). The following strategies may help you to advise family members. Explain they could:

- ***‘Listen rather than talk’***. Get them to say to the person, *“I am here to listen. Talking things through may help to release the tensions and stress that you could be holding inside.”*
- ***‘Simply sit with the person’***, in silence if need be. Being there, showing you are prepared to give them time, space and concern is a way to demonstrate care.
- ***‘Let them express their feelings’***. Sometimes it is blowing off steam; sometimes there are serious things to be angry about. *‘Getting it off their chest’* will be helpful.
- ***‘Offer to talk openly and honestly’***. Don’t hold back or pretend you have not noticed. Choose the right moment, when you yourself are feeling calm.
- ***‘Explore why they believe they have hurt themselves’*** so you can ensure any problems are dealt with.
- ***‘Offer to go with them’*** to talk to a counsellor; it just may help them to take that first step.
- ***‘Share the resources at the end of this book’***.

## 9. A NOTE ABOUT SELF-INJURY AND SUICIDE

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When we spoke to people who self-injure, what was really important to understand was that many of them talked about self-injury **actually keeping them alive** and reducing their wish to suicide; in other words self-injury became a coping mechanism. They resented responses from professionals who assumed they were suicidal, when they were ‘just self-injuring’ to release or manage feelings.

So, **individual self-injurious episodes are usually not based in suicidal thoughts or feelings**. However, many self-injurers have reported feeling ‘life is not worth living’, and some **have** had feelings of wanting to die. This seems to be more in the longer term, when background problems have not been able to be solved.

Despite the distinction we draw between self-injury and self-harm (which includes a suicide attempt), it is possible the risk of subsequent suicide is higher among people who self-injure and require emergency medical care compared with people who self-injure but do not require emergency medical care. Research shows that people who attend emergency departments for ‘self-harm’ are five times more likely to complete suicide within the subsequent 10 years compared with people who attend emergency departments for other complaints (Crandall et al., 2006).

As a Family Doctor, you may be the professional in the best place to follow your patients over time, and provide best practice care, while also monitoring risks over time.

## 10. ONGOING HELP

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**“It is perfectly acceptable to shop around and eventually find someone who is the right person to help”**

It is generally agreed that an important part of treatment is facing up to underlying or old issues and problems that relate to, or underpin, the self-injury. If our patients can do this, the old feelings stop returning, or stop returning with the same force, and they can cope better, and be far less likely to self-injure.

The people we have interviewed had a range of experiences with professionals and others in regards to self-injury. The experiences ranged from positive and helpful to the negative (or even punitive) and unhelpful.

The people we interviewed considered the following to be the most helpful responses from professionals: (1) good listening skills; (2) a non-judgemental attitude; (3) effort to build rapport; (4) not forcing them to stop self-injury prematurely (i.e. before they were able to use alternative coping strategies); (5) assisting with coping skills; (6) working in a person-centred, solution focussed way; and (7) not ‘freaking out.’

Although, as yet, there are no empirically validated treatments for self-injurious behaviours **as such**, a number of treatments designed for other mental health problems have shown promise in reducing both frequency and severity of self-injury. These include Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), Mindfulness (MBCT, MBSR and ACT), and Problem Solving Therapy (PST). Other therapies may be helpful – for instance expressive therapies like Voice and

Movement Therapy (VMT; Martin et al., 2012) – but these have been less researched, and most professionals prefer therapies that have a strong evidence base for efficacy and effectiveness.

**Cognitive Behaviour Therapy** (CBT) is a psychological therapy that aims to address issues such as anxiety and depression, as well as a range of other mental health concerns. The focus is on changing the way individuals think, which impacts on the way they feel and the way they act. The approach often involves teaching effective problem solving skills, coping strategies, how to manage exposure to challenging situations, relaxation, identifying thoughts and feelings, and challenging individual beliefs.

**Dialectical Behaviour Therapy** (DBT) was specifically developed for the treatment of people who engage in self-injury and/or suicidal behaviours. The focus of DBT is both accepting the individual being treated (from the perspective of the therapist conveying acceptance and the patient learning acceptance), helping the person to change behaviours that may be self destructive (such as self-injury), and working towards a life that is fulfilling to them.

Learning **Mindfulness** is one of the many ideas that are part of DBT, and can in itself assist people who are anxious or depressed, or who engage in self-injury. Mindfulness is being aware, or paying attention to the present moment without judgement (the ‘unfolding of experience in the present moment’). It includes being attentive to stimuli coming through your five senses (sight, hearing, smell, taste and touch) as well as to your thoughts and feelings. An essential element of mindfulness is cultivating a non-judgmental attitude, just accepting whatever comes to your mind, moment by moment.

Potential benefits of mindfulness include lowering stress levels and staying focused, particularly in times of high emotion when the many incoming thoughts or ideas or stimuli may cause one to feel 'scattered'. It helps people to act less impulsively by enhancing awareness of urges to action. For those who go over and over upsetting things ('ruminate') at length, it may help them to turn attention to other things or turn off the stream of images and thoughts. It increases the capacity to experience joy, and has been shown to reduce depression. Ultimately, (once you have gotten the idea and practice regularly), the awareness can help you experience an overall richer quality of life.

Is there any evidence specifically for Mindfulness and its impact on self-injury? A recent, as yet unpublished, community based study has shown that current self-injurers have very low levels, but that self-injurers having given up for at least one year, have mindfulness very similar to non-self-injurers (Caltabiano & Martin, submitted).

**Problem Solving Therapy** (PST) is a brief psychological intervention that focuses on identifying specific problems and generating alternative solutions for these problems. Individuals learn to clearly define a problem they face, brainstorm multiple solutions, and decide on the best course of action. A key element of PST is testing the chosen solution to see if it is effective, and refining the decision-making and problem solving strategy if necessary. Learning and practicing the process can provide you with the skills to help identify and effectively solve problems in the future.

## **IN SUMMARY**

We understand the pressures that you as a Family Doctor work under, and that it may be difficult to cope with emergency problems in mental health for which you may not have received specific training. If you have had training in any of the therapies mentioned above, you will be able to help your self-injuring patients, whatever your own time constraints. If not, then you will have to refer them on for more in-depth therapy focused on self-injury.

We have tried to clarify the problem of self-injury for you, noting the differences to suicidal behaviour. We have suggested steps you can take to provide best practice care of this surprisingly common behaviour.

We believe you are in a unique and pivotal position to assist patients who self-injure, using skills you may already have.

We hope that you have found this guide helpful.

## 11. USEFUL RESOURCES

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### **National Services**

- *Kids Help Line (instant telephone support – special expertise for young people) (1800 55 1800) [www.kidshelp.com.au](http://www.kidshelp.com.au)*
- *Lifeline (instant telephone support – special expertise in self-harm) (13 11 14) [www.lifeline.org.au](http://www.lifeline.org.au)*
- *SANE Australia (complaints about services or media/support) (1800 187 263) [www.sane.org](http://www.sane.org)*
- *Aboriginal and Islander Community Health Service [www.aichs.org.au](http://www.aichs.org.au)*
- *Australian Drug Information Network [www.adin.com.au](http://www.adin.com.au)*
- *Headspace [www.headspace.org.au](http://www.headspace.org.au)*
- *Homelessness <http://www.homelessnessaustralia.org.au>*
- *Department of Human Services [www.humanservices.gov.au/customer/subjects/domestic-and-family-violence](http://www.humanservices.gov.au/customer/subjects/domestic-and-family-violence)*
- *The Salvation Army – Domestic Violence [www.salvationarmy.org.au/find-help/domestic-violence/](http://www.salvationarmy.org.au/find-help/domestic-violence/)*
- *Reach Out! (by young people for young people - broad information) [www.Reachout.com.au](http://www.Reachout.com.au)*

### **State-based Services**

- *Child and Youth Mental Health Services [www.health.qld.gov.au/](http://www.health.qld.gov.au/)*
- *Child and Adolescent Mental Health Services (State specific)*
- *[www.health.vic.gov.au/mentalhealth/services/child/](http://www.health.vic.gov.au/mentalhealth/services/child/)*
- *[www.health.nsw.gov.au/mhdao/camhs.asp](http://www.health.nsw.gov.au/mhdao/camhs.asp)*

- [www.health.wa.gov.au/services/detail.cfm?Unit\\_ID=370](http://www.health.wa.gov.au/services/detail.cfm?Unit_ID=370)[www.dhhs.tas.gov.au/mentalhealth/mhs\\_tas/gvt\\_mhs/child\\_and\\_a\\_adolescent\\_mental\\_health\\_services](http://www.dhhs.tas.gov.au/mentalhealth/mhs_tas/gvt_mhs/child_and_a_adolescent_mental_health_services)[health.act.gov.au/c/health?a=sp&pid=1316133581&site=51103&servicecategory=23](http://health.act.gov.au/c/health?a=sp&pid=1316133581&site=51103&servicecategory=23)
- [www.health.nt.gov.au/Mental\\_Health/index.aspx](http://www.health.nt.gov.au/Mental_Health/index.aspx)

### **Additional Mental Health Websites**

- *Beyondblue (information about depression)*  
[www.beyondblue.org.au](http://www.beyondblue.org.au)
- *Headroom (mental health info for young people)*  
[www.headroom.net.au](http://www.headroom.net.au)
- *LiFe (Commonwealth funded site with all info on suicidality)*  
[www.livingisforeveryone.com.au](http://www.livingisforeveryone.com.au)
- *Mental Health Associations across Australia*  
[www.mentalhealth.asn.au](http://www.mentalhealth.asn.au)
- *The MoodGYM* [moodgym.anu.edu.au/welcome](http://moodgym.anu.edu.au/welcome)
- *National Institute of Mental Health (US site – good info on mental health)* [www.nimh.nih.gov](http://www.nimh.nih.gov)
- *Psychcentral* [www.psychcentral.com](http://www.psychcentral.com) *Reality Check/Media Check* [www.realitycheck.net.au](http://www.realitycheck.net.au)
- *Mobile Safety Services* [www.ruok.com.au](http://www.ruok.com.au)
- *Young Adult Health* [www.cyh.com/HealthTopics](http://www.cyh.com/HealthTopics)

## **Websites – Self-Injury Specific**

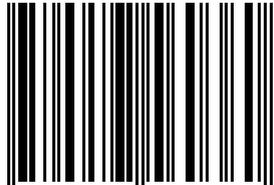
- *ASHIC: American Self-Harm Information Clearinghouse*  
[www.selfinjury.org/](http://www.selfinjury.org/)
- *LifeSIGNS: Self Injury Guidance and Network Support*  
[www.selfharm.org/](http://www.selfharm.org/)
- *RecoverYourLife.com* [www.recoveryourlife.com/](http://www.recoveryourlife.com/)
- *S.A.F.E. Alternatives®: Self Abuse Finally Ends*  
[www.selfinjury.com/](http://www.selfinjury.com/)
- *Self-Injury And Related Issues* [www.siari.co.uk/](http://www.siari.co.uk/)
- *Self-Injury Support* [www.sisupport.org/](http://www.sisupport.org/)
- *The International Self-Mutilation Awareness Group*  
<http://flmac.tripod.com/ismag/index.html>
- *The National Self-Harm Network* <http://www.nshn.co.uk>
- *Therapy for Self-Injury on Facebook*  
<http://www.facebook.com/groups/132968936724268/> (Closed group, but you can join by asking the administrator)
- *Self-injury Recovery*  
<https://www.facebook.com/groups/2249462087/> (Closed group, but you can join by asking the administrator)
- *To Write Love on her Arms*  
<https://www.facebook.com/towriteloveonherarms>
- *Understanding Self-Harm* <http://harm.me.uk/>

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ISBN 978-0-9875603-6-0



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