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SELF-HARM 'THE NEW ADOLESCENT MENTAL HEALTH PANDEMIC'

There has been a significant increase in self-harm in the last decade among adolescents with the prevalence rates increasing due to the heightened levels of stress, anxiety, and depression within their age group. It's one of those symptoms that create a sense of helplessness in parents, caregivers and teachers as well as healthcare professionals with self-harm amongst the commonest reason for referral to child and adolescent mental health services.

Adolescent self-harm is a major public health concern, and prevention and treatment require universal measures aimed at youth in general and targeted interventions in those groups identified as high risk. The risk factors for self-harm include genetic vulnerability, psychiatric, psychological, familial, social and cultural factors. The effects of media and contagion play an important contemporary role. Self-harm often creates confusion among healthcare professionals, and it's important for healthcare professionals to gain a better understanding of what self-harm is, the function and triggers of self-harm, and the assessment and management of adolescents who self-harm.

WHAT IS SELF-HARM?

Self-harm is defined as any form of intentional non-fatal self-poisoning or self-injury (such as cutting, taking an overdose, hanging, self-strangulation, restricting, etc.), regardless of motivation or the degree of intention to die. Only a small percentage of individuals who self-harm present to the hospital and this behaviour is largely hidden (from clinical services) at the community level. Fear of stigma, and reactions of parents, peers, and other adults are among the reasons that adolescents who self-harm, don't seek help.

HOW COMMON IS SELF-HARM?

The age of onset is approximately 12 years, although there is a stronger association with puberty rather than chronological age. Self-harm is more common in adolescent females than males and community studies show a prevalence of 10% of adolescents reporting self-harm. The male: female ratio in 12–15-year-olds is 1:5-6. Presentation to the hospital only occurs in approximately one in eight adolescents who self-harm, with overdose being the commonest presentation. Research shows that fifty percent of adolescents who self-harm will use self-harm repeatedly.

WHAT ARE THE FUNCTIONS OF SELF-HARM?

The major purpose of self-harm appears to be affect regulation and management of distressing thoughts. When an adolescent feels overwhelmed by negative feelings, self-harm can be an effective, although maladaptive strategy to stop or reduce the negative thoughts and emotions. Experimental data support the affect regulating aspect of self-harm, as adolescents with self-harm demonstrated higher levels of physiological arousal during a stressful task compared to adolescents without self-harm. Self-harm is associated with a rapid decrease in heart rate. Self-harm may also regulate emotions by increasing the affective experience, as they may have a subjective experience of being 'emotionally numb' or 'empty'

or feeling disconnected from others. Others may feel a sense of 'pain relief', or a sense of control, or excitement or to stop a dissociative experience. It may also serve as an interpersonal function for the adolescent, as it may elicit positive re-enforcement, in the form of attention from others, or may assist in avoiding difficult situations, or the threat of self-harm may cause adults or peers to decrease interpersonal pressure.

FUNCTIONS OF SELF HARM
AFFECT REGULATION • Anxiety • Frustration • Depression
CHANGE COGNITIONS • Distraction from problems • Stopping suicidal thoughts
SELF PUNISHMENT
STOP DISSOCIATION
INTERPERSONAL • Secure care and attention • Fit in with pee

CASE EXAMPLE

Rachel was a 15-year-old girl whose parents were currently going through a divorce. Her father had moved out of the house and she was seeing him once a week. They had shared a very close relationship and Rachel secretly hoped that her parents would get back together. She was at home when her father came to fetch her for her weekly visits when she heard her parents arguing. She immediately went upstairs to her bedroom, locked the door, and cut herself on the wrist several times with a razor blade. Although she wore long sleeves to his house that evening, her father spotted the wounds and brought his daughter to the emergency room, saying his daughter had tried to kill herself. Rachel, however, stated emphatically that she did not want to die. "I cut myself because it made me feel better," she said.

A consulting psychiatrist interviewed Rachel in the emergency room. A nurse had warned the psychiatrist that Rachel was "borderline" and "gamey," stating, "She just cut herself for attention. Don't let her manipulate you." However, after an extensive interview with Rachel, there were insufficient criteria to merit a diagnosis of borderline personality disorder. In fact, despite her obvious problems coping with distress, Rachel did not meet the criteria for any major mental disorder in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. (DSMV)

Rachel explained to the psychiatrist that she cut herself because it was "calming." She said that a year ago she first started pinching herself as a way to hurt herself. One day she saw her brother's razor blades and started cutting herself on her arms. "It helps me chill," she said. "My mind slows down, I stop crying, and I just feel better." She said the razor slicing into her skin did not hurt badly—just enough for her to "feel alive." She felt so much better after cutting herself that afternoon that she was able to concentrate on her homework and not think any more of her parent's conflictual relationship and impending divorce.

RISK FACTORS FOR SELF HARM

There are multiple and variable predisposing factors that contribute to self-harm and includes the following:

1. Sociodemographic and educational factors
   a. Female gender
   b. Low socioeconomic status
   c. LGBTQ+ adolescents
   d. Poor academic achievement
2. Individual negative life events and family adversity
   a. Parental separation or divorce
   b. Death of a parent
   c. Adverse childhood experiences
   d. History of physical or sexual abuse
   e. Parental psychopathology
   f. Marital or family discord
   g. Bullying
   h. Interpersonal difficulties
3. Psychological and psychiatric factors
   a. Psychiatric disorders especially anxiety, depression, and ADHD
   b. Drug and alcohol misuse
   c. Low self-esteem
   d. Poor problem solving
   e. Perfectionism
   f. Hopelessness

THE SIGNS TO LOOK OUT FOR?

1. Unexplained cuts, bruises, or burns, often on wrists, arms, thighs and chest
2. Wearing long sleeves and trousers or tights, even in hot weather
3. Refusing to get changed in front of other people, for example for PE or in changing rooms
4. Signs of hair pulling
5. Changes in eating habits - over-eating or under-eating
6. Exercising excessively

ASSESSMENT AND TREATMENT OF SELF HARM

1. Complete a comprehensive assessment that includes the following:
   a. History and physical examination
   b. Identify co-morbid psychiatric conditions
   c. Suicide risk assessment
   d. History of physical or sexual abuse
   e. Substance abuse history
   f. Evaluation of risk factors
   g. Evaluation of social support and family functioning
2. Identify the function and characteristics of the self-harm
   a. Antecedents- situations/ stressors leading to self-harm
   b. Characteristics-frequency, intensity, duration
3. Develop a therapeutic alliance based on acceptance and validation strategies (non-judgmental)
4. Treat co-morbid psychiatric conditions
5. Target behavioural interventions for self-harm based on behavioural analysis and the need for the following:
   a. Affective language skills
   b. Self-soothing skills
   c. Communication skills
6. Provide psychoeducation for the patient and the family
7. Monitor response to behavioural interventions for reducing self-harm
8. Consider dialectical behaviour therapy(DBT) (treatment of choice for self-harm) and family therapy

CONCLUSION

Self-harm among adolescents is common and has increased significantly. While many adolescents with self-harm may not have severe psychopathology, adolescents presenting with self-harm should have a thorough psychiatric assessment that includes screening for suicidal ideation and risk factors. It's important to assess family and other interpersonal supports as part of the treatment plan. Pharmacological treatment is indicated for the treatment of comorbid psychiatric conditions. Psychotherapy is the treatment of choice, to assist with the development of more adaptive coping skills and should be initiated early.

References available on request. MHM