Date of Briefing – August 2005

Therapies and approaches for helping children and adolescents who deliberately self-harm (DSH)

Key messages

- There are a growing number of projects to help young people who self-harm
- There is a sizeable body of research into interventions to prevent or reduce episodes of self-harm among adults, but comparatively little for children and adolescents
- Interventions explored to help children and adolescents who self-harm include forms of cognitive behavioural therapy, and group and family therapy
- No form of treatment has been found to be effective in stopping or significantly reducing self-harm among children and young people, but some interventions do positively affect other factors associated with self-harm in this population, such as depression and emotional control
- Self-help groups and peer support programmes have been proposed as potentially effective means of providing some sort of help to children and adolescents who self-harm
- Young people have complained that many A&E and other health staff can be judgmental, unhelpful and unwilling to understand. They want to be treated with respect and sympathy
- No intervention is known which can stop young people self-harming completely, but there are therapies that can successfully reduce the amount a person self-harms. Also, young people can be reluctant to say they have stopped altogether

Introduction

This section introduces and defines the scope of the briefing and the topic.

A SCARE briefing provides up-to-date information on a particular topic. It is a concise document summarising the knowledge base in a particular area and is intended as a 'launch pad' or signpost to more in-depth investigation or enquiry. It is not a definitive statement of all evidence on a particular issue. The briefing is divided into the different types of knowledge relevant to health and social care research and practice, as defined by the Social Care Institute for Excellence (SCIE) [(1)]. It is intended to help health and social care practitioners and policy-makers in their decision-making and practice.

This briefing focuses on other therapies or measures to help children and young people who deliberately self-harm (DSH). The aim of the therapy is either to reduce the amount they self harm or to stop them self-harming completely. The population covered by this briefing are children and adolescents up to the age of 19 who live in the community. The characteristics of self-harm, and the psychological and psychosocial factors associated with self-harm among children and adolescents are covered in a previous briefing in this series [(2)]. This earlier briefing also covers the problems of identifying young people who self-harm. The interventions described in the current briefing are therefore for children and adolescents who have been identified as self-harming or who have approached professionals or services seeking some sort of help or support. A great deal of the research and policy literature on these interventions does not distinguish between self-harm with the intention of committing suicide or self-harm without that intention, sometimes called self-injury or self-mutilation. The interventions described here are also principally designed for use with people who self-harm repeatedly and have done so over a long period, rather than those who have self-harmed on a single occasion. Although this briefing recognises that self-harm, specifically self-injury or mutilation, and attempted suicide have very different motivations, the term "self-harm" is used throughout the briefing to denote both self-injury or mutilation and attempted suicide [(2)]. The focus of this briefing therefore is non drug-based interventions to prevent or limit self-harm, including suicide, among people who repeatedly self-harm.

Why this issue is important

Paracetamol overdose and cutting are the two most common forms of self-harm reported for children and young people [(3-7)]. Self-harm becomes more common after the age of 16, but is still prevalent among younger children and adolescents. Although it is generally difficult to provide accurate prevalence figures for self-harm, partly because of the various possible definitions of this concept, as described above, but also because it may not be reported, some

numbers can still be given. It is estimated that about 19,000 adolescents under 16 years of age are admitted to emergency hospital care each year in England and Wales after attempting suicide [8]. A national survey of more than 10,000 children found that the prevalence of self-harm among 5-10 year-olds was 0.8% among children without any mental health issues, but was 6.2% among those diagnosed with an anxiety disorder and 7.5% if the child had a conduct, hyperkinetic or less common mental disorder [9]. These figures increase dramatically for the 11-15 year-old age group, with the prevalence of self-harm being 1.2% among children without any mental health issues, but 9.4% among those diagnosed with an anxiety disorder, and 18.8% if the diagnosis is depression. The prevalence was between 8 and 13% for children with conduct, hyperkinetic or less common mental disorders [9].

A survey found that more than 60,000 young people aged 12-24 presented to A&E departments with recognised self-harm in 1996-1997, half of whom were admitted as in-patients [10]. The number of children disclosing self-harm to ChildLine counsellors has risen steadily since the mid-1990s, with a 65% increase between 2002 and 2004, although increased awareness of the issue by both children and counsellors may be responsible for some of the increase [5]. However, self-harming is usually a private act, and many people who self-harm, including children and young people, may not seek medical assistance or approach health services. For example, in a self-report survey of adolescents, less than 13% of reported episodes of self-harm had resulted in presentation to hospital [11]. This may be because cutting usually does not require medical assistance [11]. The numbers may therefore be much higher [12,13]. There is no difference in prevalence between adolescents from the white or black or ethnic minority communities [7,14].

Research has also shown that self-harm is often not a singular occurrence, but is commonly repeated and can go on for many years [4,5,13,15]. A self report survey of more than six thousand pupils aged 15-16 found that almost 400 (6.9%) had self-harmed in the previous year [11]. According to a survey of self-harming among participants of NCH projects, 27% of those who reported self-harming did so at least once a week, and 41% at least once a month [13]. Self-harming is therefore often performed regularly and persistently. Children and adolescents under 16 years of age account for about 5% of all self-harm episodes presenting to hospital, and 10-15% of these cases are repeaters with a history of self-harm [16]. It has been found that rates of repeated self-harm are increasing, rates of first-episode of self-harm have not reduced, and that the resulting pressure on services is affecting the response to the assessment and treatment of self-harm episodes [6]. A history of self-harm is also a significant risk factor for suicide [6,17-19], with repeated episodes of self-harm relatively more likely to result in suicide than single episodes [20]. There is no really effective primary prevention for identified self-harm. Interventions for helping children and young people who repeatedly self-harm usually have to be available to them for long periods because no one-off or short-term therapy has been found to be effective.

What do the different sources of knowledge show?

Organisational Knowledge

This section lists and briefly summarises documents that describe the standards that govern the conduct of statutory services, organisations and individuals in relation to the parents of disabled or chronically ill children.

Department of Health (2005). National Suicide Prevention Strategy for England: Annual report on progress
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/AnnualReports/DHAnnualReportsArticle/fs/en?CONTENT_ID=4101668&chk=ZALnoC
This document provides information about how the national suicide prevention strategy is to be implemented by Development Centres in each region of the England, including some specific plans for adolescents and looked after children. Self-harm is explicitly included in the strategy because it is a risk factor significantly associated with suicide.

National Institute of Clinical Excellence (2004). Self-harm. The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care
http://www.nice.org.uk/pdf/CG016NICEguideline.pdf
This is good practice guidance for primary and secondary health care professionals working with people who self-harm. The guidance focuses on what professionals should do in terms of immediate medical treatment, assessment, referral and admission or discharge. There is a small section specifically on special issues relating to children and young people (8-16 years). However, the guidance does not make recommendations regarding the longer-term management of self-harm. Only Dialectical Behavioural Therapy (DBT) is cited as a potential treatment for people with borderline personality disorder who self harm.

Department of Health (2004). National Service Framework for Children, Young People and Maternity Services: The mental health and psychological wellbeing of children and young people
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4089114&chk=CKZObO
This best practice guidance defines the standards on child and adolescent mental health which form part of the National Service Framework for Children, Young People and Maternity Services. It addresses the responsibilities of CAMHS and other services, and the provision of appropriate support or help for children with mental health needs. Although self-harm is not covered specifically, there is a clear association between self-harm and the presence of mental health issues [9,21-23].

Mental Health Act 1983
http://www.dh.gov.uk/PublicationsAndStatistics/Legislation/ActsAndBills/ActsAndBillsArticle/fs/en?CONTENT_ID=4002034&chk=lmZd%2Bu
Staff involved in the assessment and treatment of young people who self-harm need to understand when and how the Mental Health Act can be used. The issue of consent and young people is also covered by this Act.

Policy Community Knowledge

This section summarises documents describing proposed structural models and guidance for the delivery of policy and improved practice. These documents are published by public policy research bodies, lobby groups, think tanks and related organisations.

Women's Aid (2004). Principles of good practice for working with women with mental health issues
http://www.womensaid.org.uk/campaigns&research/health%20and%20dv%20campaign/Guidance_LocalDVServices_Mentalhealth.pdf
The aims of this good practice guidance are to increase safe choices for women and children who experience domestic violence, to raise awareness in refuges, outreach and other organisations, and to encourage joint working between domestic violence organisations and mental health professionals.

Dow P. (2004). "I feel like I'm invisible". Children talking to ChildLine about self-harm. ChildLine.
http://www.childline.org.uk/pdfs/selfharm.pdf
This document reports the findings of an 18-month inquiry conducted by the Mental Health Foundation and Camelot Foundation. It aims to connect research and practice, raise awareness and make policy recommendations. This document suggests that practitioners need to know why children self-harm and what the triggers are (eg. bullying); that there needs to be better training and sources of advice for professionals, including teachers; and that young people need direct-access to well-resourced mental health services.

Richardson G., Partridge I. (2003). Child and Adolescent Mental Health Services: An Operational Handbook. London, Gaskell.
http://www.rcpsych.ac.uk/publications/gaskell/96_X.htm
This book describes "in operational terms" how Child and Adolescent Mental Health Services (CAMHS) should be developed and delivered in line with the National Service Framework (NSF) for Children, Young People and Maternity Services. Specific examples are given for each of the four tiers of service provision. Click here for a review (http://pb.rcpsych.org/cgi/reprint/29/4/158-a)

Bywaters P., Rolfe A. (2002). Look Beyond the Scars. Understanding and responding to injury and self-harm

http://www.nch.org.uk/uploads/documents/selfharm.pdf
This reports the findings from interviews with a group of people who self-harm or who have self-harmed in the past, and some of their partners. It was commissioned by the NCH. The report concludes by making extensive recommendations to policy makers, commissioners, service providers, and staff in social care, health and education. The recommendations include ensuring that services focus on the whole family and not just the child who is self-harming, a reconsideration of institutional placements for adolescents, more support for self-help, and for relevant staff to be understanding and sympathetic.

Royal College of Psychiatrists (1998). Managing Deliberate Self-harm in Young People. Council Report CR64.
http://www.rcpsych.ac.uk/publications/cr/council/cr64.pdf
This report sets down the prerequisites for developing protocols for assessing and managing self-harm among young people, and outlines the roles and responsibilities of consultant child and adolescent psychiatrists.

Practitioner Knowledge

This section describes studies carried out by health and social care practitioners, documents relating their experiences regarding the topic, and resources produced by local practitioner bodies to support their work.

Young People and Self-harm, National Children's Bureau. Self-harm projects database
http://www.selfharm.org.uk/index.php?section=projects&projectid=6&backletter=C
This is a database of self-harm projects, including those with protocols, in the UK.

The Basement Project
http://freespace.virgin.net/basement.project/default.htm
This local Welsh project provides training, consultation and supervision for workers in community and mental health services.

42nd Street
http://www.nshn.co.uk/resources.html
42nd Street is a Manchester-based mental health service which provides suicide/self-harm training in the form of one-day workshops to other organisations.

Clarke T, Sherr L., Watts C. (2000). Young People and Self-harm. Pathways in Care.
http://www.bhha.org.uk/selfharm.pdf

This is an audit undertaken for Barking and Havering Health Authority into the delivery of services to young people who self-harm. The report concludes with recommendations on the development of care pathways for this client group.

Research Knowledge

This section summarises the best available research literature. The focus is on studies undertaken in the United Kingdom, so that the findings are as relevant as possible to the intended audience of the briefing.

The limitations of the research

There is very little research on interventions specifically for or involving younger people [5,15,24-26]. The largest studies have all been conducted on adult populations, usually above the age of 16 [27-34]. Adults have also been the focus of exploratory research, such as the effectiveness of self-help groups [35]. Some of the findings are also based on participants' own self report about their continuing self-harm, which may not be a reliable measure.

The research below only considers interventions that seek to affect personal emotional and psychosocial factors that are associated with self-harm in this age group. Interventions that aim to address the needs of children or adolescents with mental health problems generally tend to focus on promoting resilience, which is predicated on self esteem. This can be an effective strategy for helping all young people following adverse or abusive experiences [36]. However, this briefing only considers interventions investigated specifically for self-harm. Also, it does not seek to examine interventions to address broader social and economic factors known to be significantly associated with self-harm, such as socio-economic deprivation, living in care, and a disrupted or disruptive home life.

Therapy usually seeks to address the factors which are associated with self-harm. These include depression, anxiety, impulsivity, feelings of hopelessness, and negative perspectives on problem-solving. The principal aim of most of therapies for self-harm is therefore to help participants to adapt perspectives and to develop alternative coping strategies and ways of expressing their feelings. The interventions tend to focus on developing problem-solving and coping skills which are seen to be an effective alternative to self-harm. There has been a number of randomized trials of treatments to reduce rates of deliberate self-harm among adults populations, but relatively little comparable research specifically on children and adolescents. Dialectical Behavioural Therapy (DBT) is the only therapy known to be effective in reducing self-harm among certain adult populations (those with borderline personality disorder), but developmental group

therapy and multi-systemic therapy (MST) are both known to reduce rates of deliberate self-harm among children and adolescents [24,37,38]. Larger, more powerful randomized trials of these two potentially effective interventions are needed to confirm and develop the findings of the existing exploratory studies. Other interventions are known to have a positive effect on factors associated with self-harm, such as depression and suicidal thoughts, although they do not significantly affect rates of self-harm themselves. Also, none of the interventions has been evaluated for their long-term effectiveness. It is noteworthy that three of the four randomized studies of therapies for self-harm among adolescents have been published within the last year [24-26,38]. This reflects an appreciation of the need for more research in this area.

Therapies for children and adolescents

A group therapy programme for adolescents who repeatedly self-harmed found that this therapy was more effective at reducing future instances of self-harm than routine care [24,37]. Also, the more group sessions attended by participants, the fewer the number of incidents of deliberate self-harm. However, the effect was not very strong and the sample was very small, so the authors of the study have urged caution in accepting its findings. The therapy involved both problem-solving and cognitive-behavioural therapy (CBT) and was based on themes which are known to be associated with self-harm, such as hopelessness, problems with family and school relationships, depression, guilt and anger. The Royal College of Psychiatrists define CBT as “a talking treatment that emphasises the important role of thinking in how we feel and what we do. The treatment involves identifying how negative thoughts affect us and then looks at ways of tackling or challenging those thoughts“. The routine care was the conventional care provided to adolescents who self-harm, such as non-specific counselling and family sessions. The therapy also improved school attendance and led to reduced use of routine care, but did not affect depression, which is a key factor in self-harm among children and adolescents [24].

An arguably very local-specific US study has compared hospitalization and routine community aftercare with multi-systemic therapy (MST) [38]. MST involves the development of a plan with the young person’s family to eliminate the means and triggers of self-harming behaviours. MST was significantly more effective than hospitalization and routine care at reducing rates of self-harm, according to the report of the adolescent participants. However, the study population was not composed exclusively of individuals who self-harmed, but also included some who only had psychosis or homicidal thoughts. The population was therefore not entirely consistent with the outcome being examined. A US study of cognitive and problem-solving skills therapy, given over a period of 3-6 months, for adolescents who had attempted suicide found that depression and suicidal thoughts (suicidal ideation) were positively affected by the treatment, but rates of self-harm remained unaffected [25].

Dialectical behavioural therapy (DBT) combines measures to change behaviour with efforts to make participants accept negative feelings. It aims to teach better coping mechanisms, impulse control, self-awareness and emotional regulation or control. This therapy is usually given to certain inpatient populations only, but has been found by one Canadian study to be potentially effective in reducing self-harm, depression and suicidal thoughts in the short term, up to one year, among children and adolescents [26]. The therapy was given during an initial two-week stay in hospital. By contrast, an outpatient study of DBT for adolescents with borderline personality disorder conducted in the US had no effect on the number of repeated suicide attempts when compared with routine psychodynamic therapy [39]. However, this form of DBT did have a positive impact on the adolescents' suicidal thoughts, general psychiatric and personality disorder symptoms.

A family-based approach has been suggested by a systematic review, which found that poor family communication was an important factor in self-harm by adolescents [21]. Such family-based therapy has been examined and found to improve depressive symptoms significantly among certain adolescents, but to have no real effect on rates of self-harm when compared to routine care [15]. The therapy consisted of home visits by social workers to conduct "family problem-solving sessions".

An audit of calls received by ChildLine found that many young people phoned the service to ask about how they could help friends who were self-harming [5]. Given the possibility that some children and adolescents who self-harm are more likely to talk to friends than either family or professionals, "peer support programmes in schools" have been suggested as offering a viable means of helping these young people [5]. One UK survey of the incidence of self-harm found that rates dropped during school holidays, reinforcing the link between self-harm and pressures at school [40]. This suggests that more support should be provided by schools for children who self-harm. A US review has made some recommendations on how school counsellors can develop strategies for helping and managing students who self-injury [41]. However, US research has also raised the ethical and legal issue of education professionals and counsellors disclosing self-harm by a student to other parties [42]. Art therapy has also been investigated as a possible intervention, but there is very little research into its effectiveness for adolescents who self-harm [43].

It is perhaps noteworthy that all of the interventions which did not significantly reduce the number of repeated self-harm episodes did significantly reduce symptoms of depression and suicidal ideation for as long as 1 year after treatment [25,26]. However, treatments which did positively affect repeat rates of self-harm had no such significant effect on these secondary outcomes [24,38]. This underlines the complex, multi-faceted nature of the dynamics behind self-harm. Interventions which successfully addressed factors known to be associated with self-harm, such as depression, hopelessness and suicidal thoughts, had no

independent effect on rates of self-harm. The causal relationship between these factors and self-harm is clearly very complex. This is one of the reasons why predicting self-harm, and repeated self-harm, has been found to be very difficult [44].

Therapies investigated for adults

There is much more research on therapies to treat self-harm among the adult population, aged 16 and above. Dialectical behavioural therapy (DBT) has been found to be effective in reducing self-harm and thoughts about suicide in the short term, up to one year, among adult women with borderline personality disorder [30,31]. However, it is an intensive and expensive course of therapy involving group sessions, social skills training and the availability of crisis contacts [45]. Several other studies on adults who self-harm and have borderline or impulsive "personality disturbance" have compared standard psychiatric treatment with manual-assisted cognitive therapy (MACT) [27-29,46]. This used group sessions and self-help booklets based on the principles inherent in DBT. Compared to treatment as usual, such as short-term counselling, psychotherapy, or referral to voluntary groups or a GP, the MACT group had significantly lower rates of suicidal acts and better self-rated depressive symptoms, although the proportion of people continuing to self-harm was the same in both groups [27,29]. The therapy also significantly improved positive-thinking among both groups [46]. The therapy was also significantly more cost-effective than usual treatments [33,34]. An Indian study of cognitive-behavioural therapy (CBT) for forty adults who deliberately self-harmed found that the therapy was effective in managing most factors associated with self-harm, except impulsivity [32]. However, it did not prevent repeated self-harm.

A series of four interpersonal therapy sessions given to patients in their own homes has been found to reduce rates of self-reported self-harm among adults who had been hospitalised for self-poisoning, compared to patients who had "treatment as usual" provided by their GPs [47]. The interpersonal therapy aimed to "identify and resolve interpersonal difficulties that caused or exacerbated psychological distress" [47]. Treatment as usual involved patients being referred to their GP and approaching them if there was anything wrong. One primary care intervention, again for adults, involved GPs actively inviting people who had presented to A&E with self-harm to come to a consultation with them. They then treated or counselled the patient using a set of guidelines on the management of self-harm developed for the study [48]. The intervention had no effect on repeated incidents of self-harm.

Self-help groups have only been the subject of exploratory studies, and there is no evidence that they stop repeated self-harm among participants, although some have reported that the group helped them to reduce the frequency and severity of the self-harm [35]. However, like many of the other interventions, there were other positive effects of the therapy. Participants did not feel they were being judged, but rather felt accepted and valued, and also felt better for being

able to help others. However, some participants became concerned about the well-being of other members, and some also experienced distress due to hearing about others' self harm [35].

User & Carer Knowledge

This section summarises the issues raised by young people who self-harm, both as described by the literature and as defined through local consultation.

How do children and young people view health and support services?
Young people have said that having someone to talk to who showed understanding and respect was extremely helpful [13,49,50]. The majority of adolescents in one study said having someone to talk to was an important part of their treatment and care, and one quarter stated that they wished they had had access to such support before they overdosed [51]. The National guidance on self-harm also recommends that children and adolescents who self-harm should always be treated with understanding and respect by professionals [52]. Young people's personal experience of health professionals is mixed. They consistently say that staff in hospitals, social services and residential care need to show genuine interest and sympathy, and not be judgemental, and that it can be useful to speak to other people who self-harmed because they knew that their experiences would be understood [13,50,53-55]. However, only one third of those asked said they would attend a self-help or support group because they would not feel comfortable discussing their own experiences in a group and may be distressed by others' experiences [13].

Some feel that emergency care staff have positive attitudes towards them [13], especially in hospitals where there are psychiatric services [56], but the majority have reported that emergency care staff can be judgmental, unhelpful and unwilling to understand [13,49,55]. One group of young women said that those professionals with whom they were able to communicate most effectively were non-judgemental and sympathetic [54]. A small study of adolescents' views about the care they had received for an incident of self-poisoning found that about half thought it was good, but one third considered it to be poor [51]. Young people have therefore suggested that there should be more training programmes for staff to improve their understanding of self-harm and to develop greater empathy with people who do self-harm [13,49,57]. The provision of appropriate training is also a recommendation of national guidance [52].

Young people who received treatment in psychiatric wards and residential children's homes have said that it is unhelpful for self-harm to be treated as a routine event when in care, something that was not worthy of special attention [13]. They have also said that being monitored, or having their means of self-harming taken away from them, does not prevent them from self-harming. This is

because they often find alternative means, such as not eating, and can feel more distressed because they feel they have lost a means of control and have had responsibility for their own actions taken away from them [13]. Some young people have also said that talking with professionals can be difficult and unhelpful because it can mean addressing painful memories and speaking about personal issues with strangers [13]. National guidance recommends that people should be allowed to choose the gender of professionals involved in their treatment and assessment [52].

In one study, half of the adolescents who had self-poisoned felt, as a result of the treatment, that they were less likely to overdose again in future, but half felt the treatment had had no effect [51]. The young people interviewed for another study also admitted that stopping self-harm completely was not a likely outcome of any of the help they had received, and they were reluctant to say they had stopped self-harming or would stop completely [13]. The small number in this study who had stopped cited stability and a supportive environment, as well as "having something to lose", especially children, as important factors in ceasing to self-harm [13].

Finally, the divergent attitudes of young people to self-harm, especially the view that self-harm can be seen as something which is helpful and not needing of any intervention, raises legal and ethical issues for professionals. However, there is currently no research on this issue.

Useful Links

This section lists sources of information relevant to professionals who work within this field, and may also be of value to service users.

ABC of Adolescence. Suicide and Deliberate Self Harm in Young People
http://bmj.bmjjournals.com/cgi/content/full/330/7496/891
This is the tenth in a series of twelve brief overviews published by the British Medical Journal of findings on adolescence health and well-being. It is written by Keith Hawton and Anthony James.

Bristol Crisis Service for Women
http://www.users.zetnet.co.uk/BCSW/
This is a national voluntary organisation that supports women in emotional distress, especially women who harm themselves.

British Psychological Society
http://www.bps.org.uk/home-page.cfm
This organisation makes available a number of documents relating to DSH.

ChildLine
http://www.childline.org.uk/
ChildLine is the free 24-hour confidential helpline for children and young people in the UK. Children and young people can call this helpline about any problem, at any time.

Mental Health Foundation
http://www.mentalhealth.org.uk/
This web site provides access to information about mental illness, including a fact sheet on self-harm
http://www.mentalhealth.org.uk/html/content/selfharm.cfm

Mind
http://www.mind.org.uk/
Mind is a charity which that promotes and protects good mental health for all, and treats people with experience of mental distress fairly, positively, and with respect. The organisation also provides a leaflet aimed at people who self-harm and who can help
http://www.mind.org.uk/Information/Booklets/Understanding/Understanding+self-harm.htm?wbc_purpose=Basic&WBCMODE=PresentationUnpublished

National electronic Library on Mental Health
http://www.nelmh.org/home_suicide.asp?c=14
This national specialist library provides information on self-harm and suicide.

National Institute of Clinical Excellence. Understanding NICE guidance. Self-harm: short-term treatment and management. Information for people who self-harm, their advocates and carers, and the public (including information for young people under 16 years)
http://www.nice.org.uk/pdf/CG016publicinfoenglish.pdf
This document has sections written specifically for professionals, children and adolescents, and parents and carers, both about self-harm in gerenal, and about what should be expected in terms of treatment, assessment and referral.

National Self-harm Network
http://www.nshn.co.uk/
This national charity aims to provide support to people that self-harm and the people affected by self-harm, including family and professionals.

NCH
http://www.nch.org.uk/
The NCH is a charity which provides services to support some of the UK's most vulnerable and excluded children and young people. The web site provides a list of FAQs on self-harm by children and young people
http://www.nch.org.uk/information/index.php?i=136

Samaritans
http://www.samaritans.org/
The Samaritans provides a confidential help service for people who want to discuss issues or problems in their lives.

Trust for the Study of Adolescence
http://www.tsa.uk.com/
This organisation offers training and related resources for professionals working with young people who self-harm.

Young Minds
http://www.youngminds.org.uk/
This is the principal online information resource designed for young people who are experiencing personal or emotional problems. It has a section specifically on self-harm among young offenders
http://www.youngminds.org.uk/youngoffenders/2002_03_7/dsh.php

Young People and Self-harm
http://www.selfharm.org.uk/
This is the principal web resource for children and young people who self-harm. It is maintained by the National Children's Bureau (NCB).

Young People and Self-harm: a National Inquiry
http://www.selfharmuk.org/
This website provides access to the findings and documents of three national inquiries into self-harm among young people.

Related SCARE briefings

Deliberate self-harm (DSH) among children and adolescents: who is at risk and how is it recognised?
http://www.scie.org.uk/publications/briefings/briefing16/index.asp

The Health and Well-being of Young Carers
http://www.scie.org.uk/publications/briefings/briefing11/index.asp

ADHD: Background, assessment and diagnosis
http://www.scie.org.uk/publications/briefings/briefing07/index.asp

ADHD: How it is treated
http://www.scie.org.uk/publications/briefings/briefing08/index.asp

Acknowledgements

Thank you to the experts and service users for their contributions to this briefing.

References

1 **Pawson R., Boaz A., Grayson L., Long A., Barnes C.** (2003). Types and Quality of Knowledge in Social Care. Knowledge Review 3. Social Care Institute for Excellence (SCIE). **Title link:** http://www.scie.org.uk/publications/knowledge.asp [Accessed 18 October 2005].

This document analyses and defines the different types of knowledge and information which may inform social care research and practice.

2 **SCARE 16** (2005). Deliberate self-harm (DSH) among children and adolescents: who is at risk and how is it recognised? Social Care Institute for Excellence (SCIE). **Title link:** http://www.scie.org.uk/publications/briefings/briefing16/index.asp

This is a research briefing on the risk factors associated with self-harm among young people.

3 **Clarke T., Sherr L., Watts C.** (2000). Young People and Self Harm. Pathways in Care. Barking & Havering Health Authority. **Title link:** http://www.bhha.org.uk/selfharm.pdf [Accessed 18 October 2005].

This report sets out the key findings and recommendations of the Young People and Self Harm project conducted in Barking and Havering Health authority. It is a multi-agency retrospective case study of children and adolescents presenting to A&E departments with self-harm.

4 **Poustie A., Neville R.** (2004). Deliberate self harm cases: a primary care perspective. Nursing Standard, 18 (48), 33-36.

This study reports on the presentations and outcomes of 25 self-harm cases in an urban general practice.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15366398

5 **Dow P.** (2004). "I feel like I'm invisible". Children talking to ChildLine about self harm. ChildLine. **Title link:** http://www.childline.org.uk/pdfs/selfharm.pdf [Accessed 18 October 2005].

This document reports the findings of an 18-month inquiry conducted by the Mental Health Foundation and Camelot Foundation.

6 **Hawton K., Fagg J., Simkin S., Bale E., Bond A.** (1997). Trends in deliberate self harm in Oxford, 1985-1995: implications for clinical services and the prevention of suicide. British Journal of Psychiatry, 171, 556-560.

This study reviews trends in DSH between 1985 and 1995 in Oxford.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=9519096&dopt=Abstract

7 **Bhugra D., Thompson N., Singh J., Fellow-Smith E.** (2004). Deliberate self-harm in adolescents in West London: Socio-cultural factors. European Journal of Psychiatry, 18 (2), 91-98.

This paper reports on socio-cultural factors affecting adolescents from West London who self-harm.

8 **Hawton K., et al** (1996). Deliberate poisoning and self-injury in children and adolescents under 16 years of age in Oxford 1976-1993. British Journal of Psychiatry, 169202-208.

This study reports rates for self-poisoning in Oxford between 1976 and 1993.

9 **Meltzer H., Gatward R., Goodman R., Ford T.** (2001). Children and adolescents who try to harm, hurt or kill themselves. ONS. **Title link:** http://www.statistics.gov.uk/statbase/Product.asp?vlnk=7373&More=N [Accessed 18 October 2005].

This analysis looks in detail at the findings of the national survey of the mental health of children and adolescents in Great Britain in 1999 about children and adolescents who attempt to harm, hurt or kill themselves.

10 **Hurry J., Storey P.** (1998). Deliberate Self Harm among Young People. Institute of Education. **Title link**: http://www.ioe.ac.uk/tcru/pub-ib-7.htm [Accessed 18 October 2005].

This study investigates the service provided to young people (aged 12-24 years) when they present in Accident and Emergency (A & E) Departments after an episode of self-harm, and compares this with the level of provision recommended by the Department of Health and the Royal College of Psychiatrists.

11 **Hawton K., Rodham K., Evans E., Weatherall R.** (2002). Deliberate self harm in adolescents: self report survey in schools in England. British Medical Journal, 325 (7374), 1207-1211.

This study aims to determine the prevalence of deliberate self harm in adolescents and to identify the factors associated with it.
Full text available http://bmj.bmjjournals.com/cgi/content/full/325/7374/1207

12 **Hawton K., Arensman E., Townsend E., Gunnell D., Hazell P., van Heeringen K. et al.** (2005). Psychosocial and pharmacological treatments for DSH. Cochrane Database of Systematic Reviews, Issue 2. **Title link:** http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001764/frame.html

This is a systematic review of interventions for treating self-harm among all age groups

13 **Bywaters P., Rolfe A.** (2005). Look Beyond the Scars. Understanding and responding to injury and self harm. NCH. **Title link:** http://www.nch.org.uk/uploads/documents/selfharm.pdf [Accessed 18 October 2005].

This reports interviews with a group of young people who self-harm, and some of their partners. It was commissioned by the NCH.

14 **Bhugra D., Thompson N., Singh J., FellowSmith E.** (2003). Inception rates of deliberate self-harm among adolescents in West London. International Journal of Social Psychiatry, 49 (4), 247-250.

This paper studies the rates of adolescent self-harm over a calendar year in Ealing, London.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=14727691&dopt=Abstract

15 **Harrington R., Kerfoot M., Dyer E., McGiven F., Gill J., Harrington V. et al.** (1998). Randomized trial of a home-based family intervention for children who have deliberately poisoned themselves. Journal of the American Academy of Child and Adolescent Psychiatry, 37 (5), 512-518.

This study investigates an intervention given by child psychiatric social workers to the families of children and adolescents who had attempted suicide by taking an overdose.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=9585653&dopt=Abstract

16 **Nadkarni A., Parkin A., Dogra N., Stretch D.D., Evans P.A.** (2000). Characteristics of children and adolescents presenting to accident and emergency departments with deliberate self-harm. Journal of Accident and

Emergency Medicine, 17 (2), 98-102.

This study provides a description of the characteristics of children and adolescents presenting to the accident and emergency (A&E) department with deliberate self harm.
Full text available http://emj.bmjjournals.com/cgi/content/full/17/2/98

17 **House A., Owens D., Patchett L.** (1999). Deliberate self-harm. Quality in Health Care, 8137-143.

This paper reviews literature on self-harm.

18 **Hawton K., Houston K., Shepperd R.** (1999). Suicide in young people: study of 174 cases, aged under 25 years, based on coroners' and medical records. British Journal of Psychiatry, 175, 271-276.

This article reports on the personal characteristics of a 174 suicide cases.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=10645330&dopt=Abstract

19 **Hulten A., Jiang G.X., Wasserman D., Hawton K., Hjelmeland H., De Leo D. et al.** (2001). Repetition of attempted suicide among teenagers in Europe: frequency, timing and risk factors. European Child & Adolescent Psychiatry, 10 (3), 161-169.

This Swedish study seeks to identify patterns and risk factors for repetition of suicide attempts by older teenagers.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=11596816&dopt=Abstract

20 **Zahl D.L., Hawton K.** (2004). Repetition of deliberate self-harm and subsequent suicide risk: long-term follow-up study of 11,583 patients. British Journal of Psychiatry, 185, 70-75.

This study investigates the long-term risk of suicide associated with repetition of DSH by gender, age and frequency of repetition.

21 **Webb L.** (2002). Deliberate self-harm in adolescence: a systematic review of psychological and psychosocial factors. Journal of Advanced Nursing, 38 (3), 235-244.

This is a systematic review of the research literature considering the psychological and psychosocial factors associated with adolescent deliberate self-harm (DSH).

22 **Hawton K., Kingsbury S., Steinhardt K., James A., Fagg J.** (1999). Repetition of deliberate self-harm by adolescents: the role of psychological factors. Journal of Adolescence, 22 (3), 369-378.

This study examines the relationship between psychological variables and repetition of deliberate self-harm by adolescents admitted to a general hospital having taken an overdose.

23 **Fergusson D., Woodward L., Horwood L.** (2000). Risk factors and life processes associated with the onset of suicidal behaviour during adolescence and early adulthood. Psychological Medicine, 30 (1), 23-39.

This New Zealand study examines associations between childhood circumstances, adolescent mental health and life events, and the development of suicidal behaviour in young people aged between 15 and 21 years.

24 **Wood A., Trainor G., Rothwell J., Moore A., Harrington R.** (2001). Randomized trial of group therapy for repeated deliberate self-harm in adolescents. Journal of the American Academy of Child & Adolescent Psychiatry, 40 (11), 1246-1253.

This trial compares group therapy with routine care in adolescents who had deliberately harmed themselves on at least two occasions within a year.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=11699797&dopt=Abstract

25 **Donaldson D., Spirito A., Esposito-Smythers C.** (2005). Treatment for adolescents following a suicide attempt: results of a pilot trial. Journal of the American Academy of Child & Adolescent Psychiatry, 44 (2), 113-120.

This US trial compares the efficacy of a skills-based treatment protocol and a supportive relationship therapy for adolescents after a suicide attempt.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15689724&query_hl=17

26 **Katz L.Y., Cox B.J., Gunesekara S., Miller A.L.** (2004). Feasibility of Dialectical Behavior Therapy for suicidal adolescent inpatients. Journal of the American Academy of Child & Adolescent Psychiatry, 43 (3), 276-282.

This Canadian study evaluates the feasibility of dialectical behavior therapy (DBT) implementation in a general child and adolescent psychiatric inpatient unit and provides preliminary effectiveness data on DBT versus treatment as usual (TAU).
Abstract available

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15076260&query_hl=19

27 **Evans K., Tyrer P., Catalan J., Schmidt U., Davidson K., Dent J. et al.** (1999). Manual-assisted cognitive-behaviour therapy (MACT): a randomized controlled trial of a brief intervention with bibliotherapy in the treatment of recurrent deliberate self-harm. Psychological Medicine, 29 (1), 19-25.

This trial investigates the effectiveness of a manual-based treatment ranging from bibliotherapy (six self-help booklets) alone, to six sessions of cognitive therapy linked to the booklets, The treatment contains elements of dialectical behaviour therapy (DBT).
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=10077290&dopt=Abstract

28 **Tyrer P., Jones V., Thompson S., Catalan J., Schmidt U., Davidson K. et al.** (2003). Service variation in baseline variables and prediction of risk in a randomised controlled trial of psychological treatment in repeated parasuicide: the POMACT study. International Journal of Social Psychiatry, 49 (1), 58-69.

This study looks at the variation in service policies exercised by five centres involved in a randomised trial of a new therapy.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=12793516

29 **Tyrer P., Thompson S., Schmidt U., Jones V., Knapp M., Davidson K. et al.** (2003). Randomized controlled trial of brief cognitive behaviour therapy versus treatment as usual in recurrent deliberate self-harm: the POPMACT study. Psychological Medicine, 33 (6), 969-976.

This is a large randomized trial of brief, manual-assisted cognitive behaviour therapy (MACT), versus treatment as usual (TAU), for deliberate self-harm for adults.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Abstract&list_uids=12946081

30 **Linehan M.M., Armstrong H.E., Suarez A., Allmon D., Heard H.L.** (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. Archives of General Psychiatry, 48 (12), 1060-1064.

This is a US randomized clinical trial to evaluate the effectiveness of a cognitive-behavioral therapy, ie, dialectical behavior therapy, for the treatment of chronically parasuicidal women who met criteria for borderline personality disorder.

Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=1845222&dopt=Abstract

31 **Linehan M.M., Heard H.L., Armstrong H.E.** (1993). Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. Archives of General Psychiatry, 50 (12), 971-974.

This is a US randomized clinical trial to evaluate whether the superior performance of dialectical behavior therapy (DBT), a psychosocial treatment for borderline personality disorder, compared with treatment-as-usual in the community, is maintained during a 1-year posttreatment follow-up.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Abstract&list_uids=94071592

32 **Raj M.A.J., Kumaraiah V., Bhide A.V.** (2001). Cognitive-behavioural intervention in deliberate self-harm. Acta Psychiatrica Scandinavica, 104 (5), 340-345.

This Indian study examines the efficacy of cognitive behaviour therapy (CBT) in the management of adult deliberate self-harm (DSH) patients.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=11722314&dopt=Abstract

33 **Tyrer P., Byford S., Schmidt U., Jones V., Davidson K., Knapp M. et al.** (2004). Differential effects of manual assisted cognitive behaviour therapy in the treatment of recurrent deliberate self-harm and personality disturbance: the POPMACT study. Journal of Personality Disorders, 18 (1), 102-116.

This is a randomized trial of manual assisted cognitive behaviour therapy (MACT) for adults who self-harm.

34 **Byford S., Knapp M., Greenshields J., Ukuoumunne O.C., Jones V., Thompson S. et al.** (2003). Cost-effectiveness of brief cognitive behaviour therapy versus treatment as usual in recurrent deliberate self-harm: a decision-making approach. Psychological Medicine, 33 (6), 977-986.

This is a randomized trial to evaluate the cost-effectiveness of manual-assisted cognitive behaviour therapy (MACT) in the treatment of self-harm among adults.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=12946082

35 **Smith A., Clarke J.** (2003). Self harm self help / support groups. Mental Health Foundation. **Title link:**

http://www.mhf.org.uk/html/content/self_help_self_harm.pdf

This is small exploratory study of self-harm support group for adults.

36 **Payne H., Butler I.** (2003). Promoting the mental health of children in need. Research in Practice. **Title link:** http://www.rip.org.uk/publications/researchbriefings.asp [Accessed 18 October 2005].

This is number 9 of the Quality Protects Research Briefings series.

37 **Trainor G., Wood A.** (2001). Learning to live with life. Mental Health Care, 4 (8), 273-275.

This is a brief overview of the findings of a randomized trial of developmental group therapy for helping adolescents who self-harm.

38 **Huey S.J., Henggeler S.W., Rowland M.D., Halliday-Boykins C.A., Cunningham P.B., Pickrel S.G. et al.** (2004). Multisystemic therapy effects on attempted suicide by youths presenting psychiatric emergencies. Journal of the American Academy of Child & Adolescent Psychiatry, 43 (2), 183-190.

This US randomized trial evaluates the efficacy of multisystemic therapy (MST) in reducing attempted suicide among predominantly African American youths referred for emergency psychiatric hospitalization.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=14726725&dopt=Abstract

39 **Rathus J.H., Miller A.L.** (2002). Dialectical Behavior Therapy adapted for suicidal adolescents. Suicide and Life-Threatening Behavior, 32 (2), 146-157.

This is a quasi-experimental investigation of an adaptation of Dialectical Behavior Therapy (DBT) for a group of suicidal adolescents with borderline personality features.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12079031&dopt=Abstract

40 **Hawton K., Hall S., Simkin S., Bale E., Bond A., Codd S. et al.** (2003). Deliberate self-harm in adolescents: a study of characteristics and trends in Oxford, 1990-2000. Journal of Child Psychology and Psychiatry, 44 (8), 1191-1198.

This is a survey of the trends and characteristics in self-harm among young people in Oxford.
Abstract available

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=14626459&dopt=Abstract

41 **Kress V., Gibson D.M., Reynolds C.A.** (2004). Adolescents who self-injure: implications and strategies for school counselors. Professional School Counseling, 7 (3), 195-201.

This article explores strategies for school counsellors to use when seeking to manage self-harm among adolescents and provide appropriate support.
Full text available
http://www.findarticles.com/p/articles/mi_m0KOC/is_3_7/ai_114784735

42 **Froeschle J., Moyer M.** (2004). Just cut it out: legal and ethical challenges in counseling students who self-mutilate. Professional School Counseling, 7 (4), 231-235.

This is a US review of the literature examining issues faced by school counsellors in relation to students who self-harm.

43 **Milia D.** (1996). Art therapy with a self-mutilating adolescent girl. American Journal of Art Therapy, 34 (4), 98-106.

This article reports on a case study of a self-harming girl who expressed her distress through art.

44 **Chitsabesan P., Harrington R., Harrington V., Tomenson B.** (2003). Predicting repeat self-harm in children--how accurate can we expect to be? European Child & Adolescent Psychiatry, 1223-29.

This study examines which variables predict repetition of deliberate self-harm in children.

45 **Bowen A.C.L., John A.M.H.** (2001). Gender differences in presentation and conceptualization of adolescent self-injurious behaviour: implications for therapeutic practice. Counselling Psychology Quarterly, 14 (4), 357-379.

This reviews the current knowledge on gender differences in self-harm among adolescents.

46 **MacLeod A.K., Tata P., Evans K., Tyrer P., Schmidt U., Davidson K. et al.** (1998). Recovery of positive thinking within a high-risk parasuicide group: results from a pilot randomized controlled trial. British Journal of Clinical Psychology, 37, 371-379.

This is a trial of the effect of positive thinking on rates of suicide and factors associated with suicide risk.

47 **Guthrie E., Kapur N., Mackway-Jones K., Chew-Graham C., Moorey J., Mendel E. et al.** (2001). Randomised controlled trial of brief psychological intervention after deliberate self poisoning. British Medical Journal, 323 (7305), 135-139.

This trial looks at the effects of a brief psychological intervention (brief psychodynamic interpersonal therapy) compared with usual treatment for adult patients after deliberate self poisoning.
Full text available http://bmj.bmjjournals.com/cgi/content/full/323/7305/135

48 **Bennewith O., Stocks N., Gunnell D., Peters T.J., Evans M.O., Sharp D.J.** (2002). General Practice-based intervention to prevent repeat episodes of deliberate self harm: cluster randomised controlled trial. British Medical Journal, 324 (7348), 1254-1261.

This study evaluates the impact of a general practice-based intervention on the incidence of repeat episodes of deliberate self harm among adults.
Full text available http://bmj.bmjjournals.com/cgi/content/full/324/7348/1254

49 **Warm A., Murray C., Fox J.** (2002). Who helps? Supporting people who self-harm. Journal of Mental Health, 11 (2), 121-130.

This paper presents findings from a survey in which self-harmers were asked to indicate who they had consulted for help in the past and their level of satisfaction with these various sources of professional help.

50 **Storey P., Hurry J., Jowitt S., Owens D., House A.** (2005). Supporting young people who repeatedly self-harm. Journal of the Royal Society for the Promotion of Health, 125 (2), 71-75.

This paper explores the views and experiences of 74 young people aged 16-22 who had presented to A&E with self-harm.

51 **Burgess S., Hawton K., Loveday G.** (1998). Adolescents who take overdoses: outcome in terms of changes in psychopathology and the adolescents' attitudes to their overdoses. Journal of Adolescence, 21 (2), 209-218.

This is a study of treatment, compliance and outcomes for a small group of adolescents who had overdosed.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=9585497&dopt=Abstract

52 **National Institute of Clinical Excellence** (2004). Self-harm. The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. National Institute of Clinical Excellence. **Title**

link: http://www.nice.org.uk/pdf/CG016NICEguideline.pdf [Accessed 18 October 2005].

This is good practice guidance for primary and secondary health professionals working with people who self-harm.

53 **Cooper M.A., Glasper E.A.** (2001). Deliberate self-harm in children: the nurse's therapeutic style. British Journal of Nursing, 10 (1), 34-40.

This article examines child health nursing skills in the management of deliberate self-harm in children and young people.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12170482&dopt=Abstract

54 **Smith M.** (2002). Half in love with easeful death? Social work with adolescents who harm themselves. Journal of Social Work Practice, 16 (1), 55-65.

This paper offers possible explanations as to why adolescents harm themselves, provides extracts from three interviews conducted with young women in residential care who have engaged in self-harming behaviours, and discusses the impact of suicidal behaviour in residential care settings.

55 **Storey P., Hurry J., Brownjohn C.** (2004). Deep wounds. Community Care, 1517.

This article discusses how and when young people who self-harm are recognised.

56 **Crawford T., Geraghty W., Street K., Simonoff E.** (2003). Staff knowledge and attitudes towards deliberate self-harm in adolescents. Journal of Adolescence, 26 (5), 623-633.

This study investigates knowledge, attitudes and training needs concerning deliberate self-harm (DSH) in adolescents, amongst a variety of professionals involved in the assessment and management of adolescence who self-harm.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12972273&dopt=Abstract

57 **Machoian L.** (2001). Cutting voices: self-injury in three adolescent girls. Journal of Psychosocial Nursing and Mental Health Services, 39 (11), 22-29.

This is a qualitative US study examining the reasons why adolescent girls self-harm.
Abstract available

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=11725425&dopt=Abstract