Scoping review of academic literature

Providing support for self-harm in local communities

Written by Dr Veronica Heney
prepared by Make Space Collective CIC

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Make Space Collective CIC
makespaceco.org | info@makespaceco.org
@MakeSpace_Co

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Defining self-harm

It is widely accepted that self-harm is an important area for public health intervention and support. This need is often framed as rising or increasing. For example, a recent Cochrane review suggested that “self-harm has been a growing problem in most countries over the past 40 years” (Witt et al 2021a; 1). A recent study in England, comprising repeated cross-sectional surveys of the population, found that self-reported non-suicidal self-harm increased from 2.4% of the population in 2000 to 6.4% of the population in 2014 (McManus et al, 2019). Naturally the question of increased reporting mechanisms and potentially decreasing stigma might impact these figures, but the fact certainly remains that self-harm is an urgent area of concern.

Self-harm and Reporting

Locating accurate figures regarding self-harm can be difficult, in part because of uncertainty around the definition and boundaries of self-harm. This can be seen most clearly in the difficulty of distinguishing between broad and narrow definitions. Self-harm could be understood broadly as encompassing any and all “intentional self-poisoning or self-injury regardless of degree of suicidal intent or other types of motivation” (Witt et al, 2021a; 1). Defined more narrowly, self-harm could be “an act, normally a repeated, habitual act, which in some way causes direct harm to the body but one where the focus and purpose of the act is this harm itself and not some other goal” (Steggals, 2015; 9). Most significantly these two approaches differ on whether the category of self-harm includes experiences of attempted suicide; they also raise complex questions of intentionality, agency, and what counts as ‘harm’.

Self-harm, suicide, and intention

The question of self-harm’s association with suicide is both complex and important, not least because self-harm is often framed primarily in terms of its status as a risk factor for suicide. Once again, precise numbers are difficult to ascertain, but a recent multi-centre study researching admissions to general hospitals found that the risk of suicide in the first year following self-harm presentation was 49 times greater than the general population risk of suicide in

England and Wales (Hawton et al, 2015). Yet, it is often important for people with experience of self-harm to draw a clear distinction between self-harm and suicide; Klonsky and Muehlenkamp note that people with experience of self-harm often "characterise self-injury as a means of resisting urges to attempt suicide" (2007, 1050). At the same time, questions of risk aside, there is no doubt that self-harm and suicide can be overlapping categories, and that the intention of a particular act can be unclear even to the person carrying it out. As Chandler (2019, notes "it would be remiss to suggest that self-harm for some is not tied up with thoughts of suicide, of death".

This definitional uncertainty is evident in the clinical literature, in which some studies, especially those situated within Accident and Emergency hospital departments, group all non-fatal acts of self-harm together, while others focus specifically on what is sometimes termed 'Non-Suicidal Self-Injury' (NSSI). The extent to which findings from studies which refer to either category can be applied to the other is unclear.

Moreover, particularly within clinical literature, neither category tends to include practices and incidents where the association between harm and intention is less clear. Thus behaviour that might be described as 'risky' rather than straightforwardly self-harmful, such as use of drink or drugs, walking into traffic, unsafe sexual encounters, or even instigating violence are often excluded from research.

Key Learnings
• Self-harm is difficult to define, and hard to clearly separate from suicidal acts or from broader practices understood or felt to be self-destructive. • We can't take for granted who self-harms, or who is most likely to self-harm. • Any intervention needs to think carefully about different forms of self-harm and the wide variety of people who self-harm • The idea that self-harm is more prevalent in women can be self-perpetuating in research

Self-harm and intersections

Another area of significant research interest has been in establishing the demographic characteristics associated with self-harm, or alternatively the prevalence of self-harm within different populations groups. There is mixed evidence on gender and self-harm which largely explores differences in terms of binary gender categories[1]. Self-harm in transgender, non-binary, or otherwise gender non conforming populations is underexplored. The research that exists suggests that that non-suicidal self-harm is more prevalent in younger age groups, and more prevalent in women and girls than in men and boys (general conclusions borne out in McManus et al, 2019). Chandler, Myers, and Platt (2011; 101) note that the "typical" self-harming subject "is presented as female, white, young, and middle-class in many different disciplinary literatures". The research goes on to suggest that the conception of self-harm as a particularly "feminine" or "female" behaviour has in some ways been self-perpetuating. They argue that initial studies conducted among populations which were more likely to be predominantly female were then inaccurately interpreted as representative of self-harm as a general category, and "used to justify further research focusing on female-only populations" (Chandler, Myers, and Platt, 2011, 102, citing Schoppmann et al., 2007). While research often links self-harm to women and girls, this by no means indicates that male self-harm is rare. Moreover, as McManus et al note, sometimes assumptions embedded within research design exclude self-harm behaviours, such as punching or hitting against something, which are more common in men than in women (2019; 580).

Findings regarding race are mixed; a study from Borrill, Fox, and Roger (2011) found that ethnicity alone was not a significant predictor of self-harm, but that white and mixed ethnicity students were most likely to report any self-harm and Black participants were less likely to report repeated self-harm. Gender differences were not found in the white and Black ethnic groups but were observed in the Asian group as a result of unusually low rates of reported self-harm for Asian men. In direct contrast Cooper et al (2010) found that across

[1] Those wishing to explore self-harm among queer and gender nonconforming people may be interested in McDermott and Roen (2016) which explores issues surrounding self-harm and suicide among queer youth.

three UK cities (Manchester, Derby, and Oxford) young Black women were at increased risk of self-harm, while older ethnic minority people of both genders had lower rates of self-harm than their white counterparts. This uncertain evidence emphasises most strongly that although some general trends can be picked out, there is no 'typical' individual who self-harms, and that it is important to be aware of the way in which cultural assumptions can shape how self-harm is understood, and even researched.

Interventions

Clinical interventions

The question of how research, and research questions, are shaped by cultural contexts is of considerable significance to an exploration of clinical interventions aimed at the reduction of self-harm. Clinical interventions can broadly be divided into two categories – clinical and pharmacological, (this grouping is also grouping taken up by two recent Cochrane reviews (Witt et al 2021a, 2021b[2]). Cochrane reviews are particularly useful in attempting to gain an overview as they draw together evidence from varied sources, but also use stringent quality standards to attempt to maximise the reliability of evidence.

Pharmacological Interventions

The Cochrane review into pharmacological (drug) interventions groups these together with 'natural product' or 'dietary supplementation' treatments (Witt et. al, 2021b). The review found only seven trials that were deemed to be sufficiently reliable and robust to be included in the analysis. The Cochrane review concluded that "there is little evidence of beneficial effects of either pharmacological or natural product treatments" (2021b, pg. 2), with the category of pharmacological

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[2] Cochrane reviews are systematic reviews which attempt to "identify, appraise, and synthesise" all the available empirical evidence on specific questions of health care and health policy. Specifically, they attempt to find and use the 'best' evidence as a basis for policy making; this mostly refers to randomised controlled trials. This means that they draw together the available data from a wide number of studies, assess the methods used in the studies to minimise bias and maximise reliability, and attempt to draw general conclusions.

treatments including antidepressants, antipsychotics, and mood stabilisers. It is perhaps of interest that they found only uncertain evidence that newer generation antidepressants prevent repetition of self-harm, despite the high co-incidence of depression in people who present to hospital following self-harm (Hawton 2013). It is also important to note the review's recommendation for particular care regarding the relative toxicity of different pharmacological medications, given the co-occurrence of self-harm presentation and overdoses); they note that "pharmacological agents associated with lower case fatality indices should therefore be preferred" (2021b; 24 - see also (Gjelsvik et al, 2014)). In general terms, Witt et al 2021b highlights that there are very few trials which assess the effectiveness of pharmacological and natural product treatments, and so there is a general lack of evidence upon which to base any sort of recommendation regarding interventions for self-harm.

Key Learnings
• There is very little evidence to support the effectiveness of pharmacological (drug) interventions for self-harm. • Pharmacological interventions should be approached with caution.

Psychosocial Interventions

There is a greater evidence base assessing the effectiveness of psychosocial interventions for self-harm; as is apparent from the Cochrane review on this topic, which includes data from 76 randomised controlled trials (Witt et. al, 2021a). In the case of several different psychosocial approaches, the review found that there were some benefits. In particular the review suggested that individual cognitive behavioural therapy (CBT) based psychotherapy may reduce repetition of self-harm, although the exact impact is unclear. There is also some evidence that dialectical behaviour therapy (DBT) reduces self-harm, when compared to 'treatment as usual', although again the size of this reduction is not definitive. However, there seems to be little or no effect when considering different variants of DBT, including DBT group-based skills training, DBT individual skills training, or experimental DBT involving cognitive exposure to stressful events. There is moderate evidence that a group-based emotion-regulation psychotherapy may reduce repetition of self-harm, while a single trial suggested that mentalisation-based therapy (MBT) reduced repetition and frequency of self-harm. While this may show benefits for psychosocial interventions, it is important to note now that the studies discussed above treat reduction of self-harm or cessation as the primary outcome measure or indicator of “success” - even though this is not always the outcome that is most important to people experiencing self-harm (discussed below).

The Cochrane Review found only uncertain evidence regarding the efficacy of the provision of information and support, such as that assessed in the ‘Suicide Trends in At-Risk Territories’ (START) programme (see Amadéo et al 2015). The evidence suggests that psychodynamic psychotherapy, case management, general practitioner management, and remote contact interventions (e.g. emergency cards and postcards) have no benefits in terms of reducing frequency or repetition of self-harm. To surmise, the review found the greatest evidence for the benefits of CBT-based psychotherapy, of MBT, of group-based emotion regulation, and of DBT; the authors suggest that all of these approaches “warrant further investigation” (Witt et al, 2021a, pg. 3).

While there is significantly greater evidence of the effectiveness of psychosocial versus pharmacological interventions, the evidence base is still not strong. This is something the Cochrane review makes clear (Witt et al, 2021a; 2-3), noting that “there were a number of methodological limitations across the trials included in this review” and categorising the available evidence as “moderate or very low quality”. Such assessments are made on the success or failure of the studies to meet particular scientific standards for their methods, analysis, and broader study design. As a result, as the previous paragraph indicates, recommendations are made in extremely mild, far from definitive terms – CBT, for instance “may” have benefits and all the results summarised above are somewhat uncertain.

Key Learnings

- There is some evidence to support the effectiveness of psychosocial interventions, particularly individual cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT).
- However, the evidence base is uncertain, often of moderate or very low quality, and conducted on limited samples which cannot be generalised to the entire population of people who self-harm.
- While some psychosocial interventions may be helpful it is unclear what will be useful for any particular individual. In designing an intervention it may be important to explore the benefits of a range of options to reflect individual needs.

Methodological issues with the evidence base

Moreover, there are concerns regarding the applicability of the studies included in the reviews of both pharmacological and psychosocial interventions, which speak to the broader limitations and failures of research in this area. Across the studies the majority of participants were female, and several approaches reported benefits for women but not men. The review also note that poor attention is paid to outcomes for non-binary, transgender, and gender nonconforming populations (Witt et al, 2021a, pg. 69), despite high rates of self-harm in this group (Newcomb 2020). Other demographic markers, such as race, class, or sexuality, appear not to have been examined.

Similarly, the majority of studies were limited to individuals who presented to hospitals following self-harm, even though this is in fact quite a small subset of the general population of people who self-harm. In particular, the population of people who self-harm who go on to present at hospital generally reflects a much higher rate of drug overdoses or self-poisoning, whereas in the broader population self-cutting is more common (Müller 2016). Moreover, as Chandler, Myers, and Platt note (2011; 101), when making a similar critique of the broader construction of self-injury in the clinical literature, "the minority of people who self-injure and receive hospital treatment may well differ in significant respects from those who are not admitted to hospital". Therefore almost all the studies summarised above are applicable only to a sub-group of people who self-harm, and cannot be generalised across the entire population, as people engaging in different forms of self-harm may have different treatment needs. Further, the authors of the Cochrane review note that “the inclusion of outcomes that matter to those who engage in SH is required to further inform intervention development”; this reflects the fact the primary outcome of all the studies included in the review is reduction in repetition or frequency of self-harm. It is far from evident that this is the outcome most valued by people who self-harm; nor even is it clear that this is the outcome which best reflects health or wellbeing.

Non-clinical interventions

Non-clinical interventions include education/training in both healthcare and school contexts, and app-based interventions. It is worth noting that such interventions are perhaps formally assessed or evaluated less frequently, and thus are less in evidence within peer-reviewed literature. The evidence regarding mHealth tools has been usefully brought together in a recent scoping review by Cliffe et al (2021)., which mostly comprised text or call-based services or apps used on mobile phones or smartphones. These interventions most commonly included supportive messages or phone calls, but there were also examples of interventions which focused on coping skills, mood diaries, links to helplines and services, or information about problem-solving techniques and psychoeducation, among others. It is important to note that of the 34 studies included in Cliffe et al’s (2021) review, only 5 (13%) of the interventions described are publicly available; a further 5 (13%) are available for purchase by healthcare professionals and services (4) or service users (1). Only slightly more than half the studies (19) reported any outcomes; of these 5 did not report positive findings. Thus, while the remaining studies (14) reported what the review characterises as “overall promising findings” (Cliffe et al, 2021; 12), including in several a reduction in self-harm frequency, these findings are far from conclusive, and there seems to be no way of assessing which particular forms of mHealth intervention are more or less effective (i.e. text-based messaging or information provision). Cliffe et al 2021 also note the inadequacy of frequency as a sole outcome measure (a comment to which this review will return), and also that participants were mostly white adult females recruited from clinical populations; as discussed above, this significantly limits the generalisability of the findings. The review also raises the concern that several studies “did not specify any underpinning therapeutic models informing the content of their intervention” which introduces the possibility for them to contain unhelpful or even dangerous advice.

Non-clinical interventions in educational settings

A common site for non-clinical interventions is in education settings. Barker et al (2021) reviews studies exploring suicide and/or self-harm prevention and intervention training mostly provided in a healthcare setting, but also in schools, universities, and prisons. The studies analysed by Barker et al (2021) used a variety of training methods, including presentations, role play, group work, feedback, reflections, workbooks, case studies, and simulations. The training content included explanations, facts and introductory information, attitudes, awareness and risk factors of self-harm and suicide, risk assessment for self-harm and suicide, risk management and prevention of self-harm and suicide, and skills development. The review notes that few studies reported the wider impact of training on rates of suicide and self-harm; rather the studies measured the impact of training on the attitudes of people who receive the training, and sometimes also the impact on skills and practice (either self-reported or via videotaped assessment (Barker et al, 2021; 22)). Seven studies found training demonstrated improvement in skills and practice outcomes at least partially; other studies found perceived skills and practice improved, although there was no measurement of to what extent (i.e. significance) this was the case. Other studies showed improvements in at least some facets of attitudes towards suicide and self-harm, and in confidence or self-efficacy around responding to self-harm and suicide, particularly in the short term; data regarding long-term outcomes were significantly less common. Moreover, in both the short-term and long-term these measures were hard to validate. Thus while the scoping review concluded that there is “some evidence of effectiveness for attitudinal change following training” this is far from definitive, and there is “limited evidence of effectiveness of training on suicide and/or self-harm” (Barker et al, 2021, 43-6). The review specifically notes the predominance of healthcare contexts, suggesting an increased focus on professionals who come into contact with young people who self-harm. As with the more clinically focused interventions discussed above, the authors note the “lack of involvement from the service user perspective”, that is to say, there is no evidence whether service users judged practice, skills, and attitudes to have improved following the training (Barker et al, 2021, pg. 52)..

Barker et al's (2021) work can be helpfully supplemented by Evans et al.'s (2019; 236) paper considering the difficulties of addressing adolescent self-harm in secondary schools; the authors found that only 52% of schools have received some staff training, and of that group only 22% rated this training as "very high or highly adequate". Staff identified key barriers to addressing self-harm as: lack of time in the curriculum; lack of resources; lack of staff training and time; and fear of encouraging self-harm among adolescents. Similarly, a further qualitative study exploring staff perceptions towards self-harm in a secondary school emphasised that while staff are keen to help they do not always feel skilled or confident enough to do so: they often feel that a specialist might be required, and fear that they might make a situation worse. Education may therefore be a sector in which training and support around self-harm would be valuable (Walshe, 2016).

Outcome measures

Outcome measures broadly refer to the aims against which an intervention could be considered to have "worked". With regards to exploring outcome measures, work by Owens et al (2020)., which explored the views of service users on measuring outcomes in trials of interventions for self-harm, is particularly useful (2020). Through qualitative outcomes the authors found that while some participants did see the cessation of self-harm as a long-term goal, this aim was far from unqualified, and participants were quick to point out "that the relationship between self-harm and mental health was not straightforward and that it was wrong to assume that less frequent is necessarily better" (Owens et al, 2020; 2). The study noted several complexities or flaws in this form of measurement, for instance: that the relationship between severity and frequency of self-harm was not straightforward; that hospitalisation was not self-evidently a measure of either severity or frequency; and that hospital attendance could also be impacted by factors such as skill in self-management of wounds or previous hostile and punitive medical treatment. Moreover, nearly all participants noted that a reduction of more "typical" acts of self-harm, such as cutting and overdosing, "was by itself no indication of improvement" (Owens et al, 2020; 3) as an individual may have switched to alternative practices which were less likely to require medical treatment, or which fell less firmly within the category of self-harm but which were still in some way self-destructive or dangerous (such as excessive drinking or disordered eating). Furthermore, when self-harm was functioning as a means of survival, participants noted the "risks involved in relinquishing one's survival tool" (Owens et al, 2020; 3). In contrast, the outcomes that were important to participants were broader, including "general functioning or the ability to perform activities of daily living and engage in normal self-care" and "social participation" (Owens et al, 2020; 4). They also suggested that "proactively seeking healthcare or attending therapy sessions were signs of progress" (Owens et al, 2020; 5) which is in tension with standard study design where attendance at services is instead used as a measure of ill health, rather than recovery.

Other qualitative research similarly complicates the simple equation of recovery with cessation. In a study conducted by Lewis et al (2019) in Canada, even when cessation was seen as central to recovery people with experience of self-harm emphasised that recovery is more than cessation, also involving the absence of thoughts around self-injury, increased self-acceptance, psychological recovery, and increased coping skills. Participatory research conducted with young people with experience of self-harm in New Zealand also echoed Owens et al's (2020) findings (Knowles et al, 2022). Knowles et al 2022 found that reduction of self-harm thoughts and behaviours and sustaining engagement with therapy were seen as some of the *least* important outcome factors, again emphasising that "a reduction in self-harm itself may not mean that the factors responsible for the self-harm were reduced" (ibid; 1399). Instead young people prioritised better or more coping skills, and a safer environment "where the experience and disclosure of self-harm were normalised" and there was a greater understanding of self-harm, both at home and at school (ibid; 1399). More broadly, Chandler's (2015; 8) qualitative exploration of recovery in the context of self-injury has emphasised that "the individualisation of much discourse on recovery result in a minimisation of the problems leading up to or surrounding self-injury" including "factors which may be outside of the injury". This broader and more nuanced understanding of self-injury is aligned with "an acknowledgement that self-injury does not arise solely out of an individual's 'pathology'" (ibid; 8).

Key Learnings
• Clinical interventions often take it for granted that the best outcome is a reduction in self-harm. However for people with experience of self-harm this is not always the priority. • Interventions which prioritise help-seeking or improving access to support may result in what appears to be a rise in self-harm, while in fact it is simply a rise in people who self-harm accessing services. • It's important to co-create outcome measures with people with lived experience – this can lead to a wider range of priorities, including an improvement in general functioning or in social participation.

Sociological Literature

The literature outlined above has shown not only the paucity of conclusive research regarding interventions to reduce self-harm, but also the broader complexity of appropriate outcome measures, definitions of self-harm, and participant samples. The inadequacy and uncertainty of any conclusions which might be drawn from the above can be remedied in part by qualitative sociological research regarding self-harm. This body of work examines the experiences and contexts of self-harm, drawing out the ways it is understood, its common features, and the surrounding social dynamics. These facets are helpful in considering what sorts of interventions might be appropriate or acceptable to people with experience of self-harm, beyond clinical or medicalised outcomes and processes.

A survey of the sociological literature suggests five main themes surrounding or running through experiences of self-harm which might be pertinent to the development of future interventions - we will now go through each in turn.

Authenticity and self-harm

The first of the themes is authenticity. Self-harm can become a way of authenticating feelings of emotional or mental distress, which are otherwise easily dismissed or undermined. Yet simultaneously self-harm itself is always threatened by accusations of inauthenticity; this is most clearly seen as in the persistence of the belief that self-harm is an attention-seeking behaviour, and that such 'attention-seeking' de-values or de-legitimises the pain and distress which might otherwise be seen to accompany self-harm. As Chandler notes, this can also be seen in the frequent accusations of "copying and fashion" which are addressed towards self-harm (2016; 199); self-harm which is understood to be simply a 'fad' is inauthentic and separate from legitimate emotional distress . Tracing this theme suggests that any intervention that questions or undermines the legitimacy and authenticity of self-harm and any feelings of distress or difficulty which accompany it might be inappropriate or unhelpful.

Privacy and self-harm

A second key theme is that of privacy - the distinction between what is deemed private, and therefore must be kept secret, and that which can or should be shared with others. Leading on from the theme above, self-harm's social positioning as authentic or inauthentic is deeply linked to its ability to be purely personal, or private, rather than public. When analysing accounts of those with experience of self-harm, Steggals, Lawler, and Graham (2020; 780) note that "if kept private, cutting suggests serious distress and real psychological and emotional pain. On the other hand, any public display to peers was thought to undermine its credibility". This is significant with regard to help seeking and support; if any public avowal of self-harm is thought or felt to undermine its legitimacy, then people who self-harm are put in a difficult or even impossible position with regards to seeking support. Any intervention around self-harm must not only be sensitive to this difficulty, but must be at pains not to re-inscribe this binary division, whereby secret self-harm is considered more 'real' or 'serious' than self-harm which is known to others. We might go further and understand that, in some cases, self-harm itself can function to negotiate a tension between secrecy and disclosure; Scourfield, Roen, and McDermott (2011; 782) suggest that a tension “between wanting someone to listen but not feeling able to communicate that” is a common aspect of experiences of self-harm. This suggests that moments of disclosure might be extremely sensitive and should be handled with extreme care; this might be significant in designing any intervention to provide support around self-harm.

Key Learnings
• Sociological literature helps us to understand experiences of self-harm and the contexts in which they take place. • Existing literature suggests interventions should be sensitive to: the fraught authenticity of self-harm; the difficult relationship between self-harm and privacy or secrecy; differing experiences of being ‘in control’ or ‘out of control’; and the different functions self-harm can play in a person’s life. • There can be a wide variety in experiences and understandings of self-harm; interventions need to take this into account. • Interventions should also account for the role of social context, such as marginalisation or discrimination, in self-harm. • Interventions need to recognise and respond to existing failings of care, including stigmatisation and avoidance.

Self-harm and control

A third theme is that of control. Here, again, we can see tensions between two contradictory feelings or experiences. Chandler (2016; 76) notes, in accounts of experiences of self-harm, the need to be ‘in control’, and self-harm as a method through which this is achieved. This might be particularly salient when other aspects of individuals’ lives feel out of control, or simply beyond their control. Yet at the same time she found accounts which suggested that “the practice of self-injury itself could be or become ‘out of control’” (ibid; 79), often accompanied by a framing of self-harm in terms of addiction. While these seemingly contradictory accounts might seem to offer little guidance to the design of interventions, what they might suggest is the necessity of approaching questions of control with sensitivity, and the recognition that people might have divergent experiences or needs. In particular, the tendency for self-harm to perform a function with regards to control highlights the potential danger of interventions which limit individuals' ability to control or exercise agency over their own lives and decisions.

Self-harm as 'coping' or self-management

Issues of choice, agency, and control raise a four theme – that is the question of whether self-harm can or should be regarded as a purely pathological or 'dysfunctional' act, or whether it can be understood as a form of 'coping' or self-management. Historically self-harm has been taken to mean or suggest pathology or illness, to be an irrational act. Subsequent psychological literature has emphasised self-harm as a 'coping' mechanism, but one which is inappropriate; therefore interventions have focused on providing and encouraging alternative coping mechanisms which are judged to be more appropriate or 'positive'. Recent sociological approaches have gone beyond this, to explore the ways that self-harm can be experienced "as productive and meaning for the individual" (Gurung, 2018; 38) or even a form of self-care (Simopoulou and Chandler, 2020). This does not mean that every experiences self-harm positively or finds it beneficial, but it does highlight the wide variety of experiences within the category of 'self-harm' and highlights the difficulty of positioning the cessation of self-harm as the only desirable outcome of any intervention.[3]

Social drivers behind self-harm

Finally, sociological literature explores the need to be aware not just of the social facets of self-harm as an experience, but also of the social drivers behind self-harm. While this is an area in which more work remains to be done, we might note McDermott and Roen's (2016) in-depth study of self-harm and suicide

[3] To explore these four themes in more detail, see :
https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.853334

among queer youth. They note that because of their gender, sexuality, and age queer youth may be 'mis-recognised'; that is they might fail to meet norms of social legibility. They emphasise that some may find this "particularly distressing" (ibid; 13) and that continually attempting to meet unattainable norms can be a heavy burden for queer young people. This approach recognises that the distress which surrounds self-harm might not be straightforwardly reducible to psychiatric diagnostic categories. Thus it might be important for interventions around self-harm to be sensitive and responsive to social contexts, and particularly to issues of marginalisation, deprivation, and inequality.

Self-harm and helpseeking

Sociological literature highlights that while social contexts can impact experiences of self-harm they can also impact experiences of care or helpseeking, particularly through the attitudes or views of education and healthcare professionals. This is particularly significant given a recent report which suggests that many people who self-harm have "very difficult, sometimes punitive'' experiences in healthcare contexts, and that staff often mis-understand or mis-judge self-harm as "deliberately manipulative, attention-seeking, or time-wasting" (Rowan Olive & Faulkner, 2021). This is supported by literature reviews, which note that even when sometimes views are more positive or more informed, "where the problems specified leading to self-harm were within the control of the client then higher negativity was shown" (McHale and Felton, 2010; 737). Clare Hopkins' ethnographic study of nurses in emergency departments emphasised a feeling of being un-trained in responding to self-harm, but also noted that "people who harm themselves are seen as having a reduced entitlement to care when their needs for treatment are seen to be competing with the needs of what are termed the 'really ill, poorly people'" (2002; 151). Moreover, even when self-harm isn't viewed negatively its perception as 'difficult' or 'risky' can lead to avoidant behaviours in professionals; interestingly separate studies of GPs and of teachers both found that professionals avoid asking about self-harm because they don't want to open up a "can of worms" (Bailey et al, 2019; Parker, 2018). It is telling that the same metaphor was used in both studies across two separate contexts; it highlights simultaneously a failure of training, the unexpected consequences of fears around self-harm; and that the burden of such fears is borne by students and service users who remain isolated and unsupported. There is no doubt that stigma, negative attitudes, ignorance, and avoidance are all urgent aspects of the social context which any intervention would need to consider and address.

Conclusion

This literature review has explored the evidence around potential interventions which might provide both clinical and social support for people who self-harm. While there was negligible evidence to (back-up) pharmacological interventions, there was some (albeit low quality) evidence to suggest that psychosocial interventions may be helpful, particularly CBT-based psychotherapy, MBT, group-based emotion regulation, and DBT. While there was evidence that web-based interventions, particularly apps, might be helpful, these apps were often not available. Similarly while training could increase staff confidence and knowledge, in both healthcare and education settings, it was not always clear what this training comprised.

In general the quality of evidence around all interventions was low, meaning that any conclusions were far from definitive and often not generalizable. In particular the literature review revealed difficulties around the definition of self-harm, around the tendency to conduct research with clinical rather than community populations, around the tendency for research participants to be primarily young white women, and around the failure to use outcome measures that are relevant and useful to people who self-harm.

Any intervention is likely to be greatly strengthened by taking into account insights from sociological literature, particularly those around the relation between self-harm and authenticity, privacy, control, and ‘coping’. Qualitative, sociological research also provides valuable insight into the social drivers behind self-harm, the presence of stigma, and experiences of help seeking; these are all factors which are vital to consider when constructing interventions that are likely to be useful to those who self-harm.

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