



Adolescents who self-harm: How to protect them from themselves

Strengthen coping skills, develop a safety plan, and treat comorbid disorders

Josh, age 16, gets poor grades in school and occasionally smokes marijuana and abuses inhalants. After his girlfriend breaks up with him, he cuts his wrist with a hunting knife. While bleeding profusely, Josh calls his mother at work, who calls 911. The cut is deep and requires sutures. Josh says he did not try to kill himself; he only wanted to carve his girlfriend's initials into his wrist to show his love for her.

When treating teenagers with self-harming thoughts and behavior, it may be difficult to distinguish suicide attempts from self-injury without intent to die. Understanding adolescent self-harm, suicide risk assessment, and treatment options guides clinicians to appropriate interventions. Recognizing the need for aggressive treatment—including psychiatric hospitalization—is essential to keeping self-harming teenagers safe.

Suicidal vs nonsuicidal self-harm

Suicidal behavior involves intent to end one's life and includes ideation (thoughts) and actions (nonfatal or fatal attempts).¹ Nonsuicidal self-injury (NSSI) involves socially unacceptable, self-inflicted harm to one's body without intent to die.²

Suicide is the third leading cause of death among youths age 12 to 19, claiming almost 2,000 lives each year.³ Nearly 1 in 5 (17%) U.S. high school students has suicidal thoughts each year, and almost 1 in 10 (8%) attempts suicide.⁴

Studies report a 13% to 23% lifetime prevalence of



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Teenagers who hurt themselves but do not intend to die are at high risk for suicide and suicide attempts

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Table 1

Characteristics of teens who harm themselves

Factor	Comments
Older age	Both suicide attempts and NSSI are more common in mid-adolescence (age 13 to 15)
Sex	Males complete suicide more often (4:1) but more females make attempts. Sex differences have not been consistently identified for NSSI
Psychiatric illness	Diagnoses associated with adolescent suicide include major depression, substance abuse, and conduct disorder
Psychosocial and situational risks (usually combined with psychiatric illness)	Recent loss or rejection, living alone (eg, running away or homeless), poor social supports, family conflicts, family suicidal behavior, poor communication with parents, availability of firearms, exposure to suicide in the community or media, academic difficulties, legal problems, gender identity conflicts, history of maltreatment, being bullied, and risky behaviors

NSSI: nonsuicidal self-injury
Source: References 2,5,6,10,11

NSSI.⁵ These behaviors often begin between age 13 to 15.⁶ Cutting and hitting are the most common forms of NSSI; other methods include burning, scratching, and interfering with wound healing. Most teens who harm themselves without suicidal intent report that they feel little or no pain during the act.⁵ Unlike suicide attempts, NSSI can be viewed as a means to stay alive. Many adolescents injure themselves to cope with overwhelming feelings that can produce suicidal thoughts. Self-injury may distract the adolescent from painful emotions, reduce tensions, or penetrate numbness.⁷

Teenagers who hurt themselves but do not intend to die are at high risk for suicide and suicide attempts. Adolescents who engage in NSSI are more likely to experience suicidal behaviors, and vice versa.⁸ In a large study, 70% of adolescents who engaged in NSSI had made at least 1 suicide attempt and 55% made multiple suicide attempts.² Current suicidal ideation is a risk factor for suicide, and a past suicide attempt is the strongest predictor of future suicidal behavior.⁹

Risk factors for suicidal behavior and NSSI overlap (Table 1)^{2,5,6,10,11} and include:

- depression
- substance use
- anxiety
- impulsive aggression
- history of childhood trauma.

Many teens who engage in NSSI report

depression.² A history of psychiatric illness—especially depression—increases the likelihood of adolescent suicide.⁸ A study comparing adolescents who engaged in NSSI with those who attempted suicide found that both groups reported similar levels of suicidal ideation and depressive symptoms.⁶ However, adolescents with a history of NSSI and attempted suicide reported higher levels of suicidal ideation and fewer reasons for living than those who attempted suicide but have no history of NSSI.¹²

Factors that protect against suicidal behavior include:

- a good parent-child relationship
- strong cultural or religious values
- an intact family
- a sense of connection with peer group and community.¹³

No studies have determined protective factors for NSSI.

CASE CONTINUED

'No point in living'

As Josh becomes less guarded, he says that he sees "no point in living" without his girlfriend. He thought the only way to feel better was to "get high," but this left him feeling even more despondent and anxious. He wrote a suicide note, but after cutting himself he was unsure he wanted to die. Josh says that when he feels depressed he can't talk to his parents because "they wouldn't understand and don't care."

Table 2

Strategies for assessing adolescent self-harm

Complete a thorough psychiatric evaluation
Interview the adolescent separately from parents
Obtain collateral information from parents and family, teachers, caseworkers, and others as needed
Use an empathic, nonjudgmental manner
Note appearance and presence of scarring and bruises, and patient's clothing style
Ask about current and past self-harming thoughts and behavior: <ul style="list-style-type: none"> • suicidal thoughts: frequency, duration, plans, and any triggers • suicide intent: extent of desire to carry out suicidal thoughts and die • past suicide attempts: number of attempts, methods, intentions, and consequences • nonsuicidal self-injury: total episodes, duration, frequency, and triggers for self-harm
Ask about acute stressors (eg, break-up, loss or rejection, conflict with parents)
Inquire about thoughts, feelings, and events leading up to the self-harm episode
Assess for psychosis and ask about homicidal thoughts. If yes, assess whether there is a duty to warn others
Ask about drug/alcohol use and consider a urine toxicology screen to help clarify whether substance abuse problems may be contributing to self-harm
Assess family interaction and communication style, noting conflicts that might impact safety
Consider using a standardized measure, such as the Scale for Suicidal Ideation ^{14,15}

Assessing self-harming adolescents

Distinguishing between suicidal behaviors and NSSI can be challenging (*Table 2*). Identifying risk factors for adolescent suicidal behavior must be coupled with a thorough psychiatric evaluation. If possible, interview the adolescent alone and obtain collateral information from parents, family members, teachers, caseworkers, probation officers, and others as needed. Also examine family interactions because conflicts and communication problems could undermine the teenager's safety.

Consider using standardized measures of suicidal intentions such as the Scale for Suicidal Ideation (SSI).¹⁴ Although the SSI was developed for adults, a large case-control study validated the scale's use in adolescent psychiatric outpatients and students.¹⁵ In addition to assessing subjective reports of suicidal intent, the SSI also takes into account objective indicators of increased risk, such as planning an attempt, hiding details from others, and making preparations for death.

Questions to ask. After a self-harm incident, it may be helpful to begin the psychiatric interview with a general question

such as, "What happened that led you to hurt yourself?" This does not categorize the act as suicidal and allows the adolescent to describe it in his or her own words. Shea¹⁶ suggests normalizing the act by assuming that self-harm occurred, rather than making the patient admit to it. For example, an interviewer might say "Many people I know who are hurting inside also try to hurt their body; how often do you do that?"

Inquire about suicidal intent in a few ways. For example, first ask, "Do you ever wish you were dead?" and follow up with, "Would you ever do anything to try to make yourself dead?" Asking about suicidal thoughts does not increase suicidal thoughts or behavior.^{10,17}

Reviewing thoughts and feelings leading up to a self-harm act can help identify triggers, coping difficulties, and issues to address in treatment. This behavioral analysis can be completed using the mnemonic ABC:

- Antecedents (situations or stressors leading to self-harming thoughts or actions)
- Behavior characteristics (frequency, intensity, and duration of self-harming)

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First determine if self-harming adolescents are in imminent danger of suicide and if more intensive services are needed to maintain safety

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- Consequences (eg, emotional relief, care and attention from others).

The results of this analysis could suggest treatment strategies, such as cognitive restructuring or techniques for decreasing feelings of distress.

The Risk of Suicide Questionnaire, which is designed for adolescents, asks:¹⁸

- Are you here because you tried to hurt yourself?
- In the past week, have you been having thoughts about killing yourself?
- Have you ever tried to hurt yourself in the past?
- Has something very stressful happened to you in the past few weeks?

Research has yet to determine whether this simple, rapid screen accurately identifies the need for psychiatric hospitalization or risk for suicidal outcomes. Although clinician- and self-administered suicide questionnaires may be useful for screening large populations, they are not a substitute for a thorough clinical assessment.

Inpatient or outpatient? When evaluating self-harming adolescents, first determine if they are in imminent danger of suicide and if more intensive services, such as hospitalization, are needed to maintain safety. Inpatient psychiatric services are appropriate for adolescents with suicidal thoughts or self-harm behaviors in addition to acute psychiatric disorders, significant substance abuse, serious medical issues, poor social supports, or inability to be managed safely as an outpatient.¹⁹ Visit this article at CurrentPsychiatry.com for a list of additional factors to consider.

Consent for treatment may be required because many self-harming adolescents do not present with life-threatening symptoms. Laws regarding consent vary among states. In some jurisdictions, patients age ≥ 15 can consent to mental health treatment without parents' knowledge or consent. If an adolescent is in imminent danger and cannot voluntarily consent to treatment, physicians can initiate mental health "holds." Some states allow registered nurses, psychologists, licensed social workers, and others to initiate mental health holds.

CASE CONTINUED

Inpatient treatment

After the interview Josh says he still feels that "there is no point in living" and he cannot develop an adequate safety plan with his family. He is hospitalized to maintain safety, improve his coping skills and communication with his family, and mobilize safety plans, social supports, and follow-up care.

Maintaining safety

Psychosocial treatments for suicidal behaviors and NSSI are similar because with both, the priority is to help the patient maintain safety. This may include:

- developing a collaborative safety plan with family
- increasing monitoring
- removing access to firearms or other lethal means
- helping the adolescent to develop alternate, safer coping methods.

Many clinicians rely on no-harm contracts or agreements; however, there is no evidence that they are effective.²⁰ The American Psychiatric Association recommends against using no-harm contracts with patients who are new, in an emergency setting, using substances, agitated, psychotic, or impulsive.²¹ Instead, clinicians, adolescents, and families can discuss specific steps the patient can take to remain safe. This collaborative plan should identify situations likely to trigger self-harming impulses; adaptive ways the teenager can cope, such as taking a nap or jogging; methods for communicating distress to family members and other helpers; and places to go for help, such as an emergency room. These safety plans should draw on the patient's internal and external resources.

CASE CONTINUED

Strengthening relationships

While in the hospital, Josh finds it helpful to use a 0-to-10 scale to measure his distress and let his family know the intensity of his feelings. He identifies situations when he felt like hurting himself, such as being humiliated in math class. Josh learns about cognitive distortions—such as "they don't care" and "there is

no point in living”—and discusses methods for managing his feelings if he encounters further disappointments. His parents become more attentive when Josh explains his feelings, which allows the family to develop a collaborative safety plan. Josh decides to strengthen friendships he had been neglecting and agrees to attend a substance abuse treatment program.

Psychosocial treatment

In addition to maintaining safety, treatment goals for self-harming adolescents include:

- managing underlying psychiatric disorders
- identifying triggers for self-injurious acts
- improving family relationships
- developing better communication and coping skills.

Improving affective language skills, acquiring frustration tolerance, and learning alternatives to self-injury are key to strengthening coping abilities. Address problem-solving skills because self-harming adolescents often lack these abilities.²²

Treatment of self-harming adolescents often consists of cognitive-behavioral therapy (CBT)²³ or dialectical behavior therapy (DBT).²⁴ CBT involves examining cognitive distortions or otherwise unhealthy beliefs about oneself, others, and life in general, focusing specifically on thoughts the patient has immediately before engaging in self-harm. DBT also integrates emotion regulation training and mindfulness. A review of 28 studies found these therapies effectively reduced self-harm behaviors in adults.²⁵ However, few studies have examined these therapies' efficacy in self-harming adolescents.

Pharmacotherapy

Psychopharmacology should focus on treating underlying psychiatric disorders. No medications are specifically effective for treating suicidal thoughts, suicidal behaviors, or NSSI. Some evidence suggests that antidepressants may trigger suicidal

thoughts in a small proportion of youth,²⁶ but the benefits of antidepressants outweigh the risk of suicidal thoughts.²⁷ When prescribing antidepressants, inform patients and their parents of possible adverse reactions and monitor the patient regularly.²⁸

Take precautions when prescribing medication for self-harming adolescents. For example, benzodiazepines may cause disinhibition, and larger quantities of medication could be lethal in an overdose. If possible, arrange for parents or guardians to monitor medication use.

What to document

Good documentation is especially helpful when an adolescent requires involuntary commitment or is discharged home. Involuntary commitment is based on legal interpretation of 3 circumstances—danger to self, danger to others, or gravely disabled—in which safety concerns may override an individual's civil rights. If involuntary commitment is needed, a physician must clarify how the youth meets ≥ 1 of these criteria. If the adolescent is discharged, document that the patient is not an imminent danger to self or others and *why* you made this determination. Also note that follow-up services and a safety plan are in place, a parent will monitor safety issues and remove firearms and other lethal means from the home, and acute conflicts have been resolved. Other details, such as using the patient's words to describe reasons for living, can be helpful.

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Related Resources

- National Alliance for the Mentally Ill. National Helpline. 800-950-6264.
- American Foundation for Suicide Prevention. www.afsp.org.
- American Association of Suicidology. www.suicidology.org.
- National Suicide Prevention Lifeline. 800-273-TALK (8255).

Acknowledgements

The authors wish to thank students Scott Schubert from Regis University, Denver, CO, and Emily Peterson from Beloit College, Beloit, WI, for their help in preparing the manuscript.

Disclosure

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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Bottom Line

Treating self-harming teens starts with a thorough evaluation that includes information from collateral sources. Involve parents or guardians in evaluation, safety planning, and treatment. Psychiatric hospitalization is needed when an adolescent cannot be safely managed as an outpatient. Focus initial treatment on maintaining safety, treating underlying psychiatric disorders, strengthening coping skills, and improving communication with family.

Hospitalization or home? Acute crisis planning for self-harming youth

Hospitalization is more appropriate when ≥ 1 of the following is present with suicidal or self-injurious thoughts:

- Current suicidal thoughts or plans
- Previous serious suicide attempts
- A need for a more lengthy evaluation in a safe setting
- Significant psychiatric symptoms (especially a mood disorder and/or psychosis)
- Significant impulsive and unpredictable behaviors
- Continued substance abuse problems or intoxication
- Conflicts with parents, family members, or a significant other
- Inability to form a therapeutic alliance with the clinician
- Inability to honestly participate in a safety evaluation

Home is more appropriate when:

- The youth has no active suicidal thoughts or plans, history of suicide attempts, medical problems requiring hospital care, significant substance abuse problems, or psychiatric disorders (especially a mood disorder) needing acute stabilization
- Precipitating conflicts or situations have been adequately diminished or resolved
- A supportive adult in the home will monitor the youth's safety and the relationship is positive and stable enough to allow a safe return
- The adolescent has a strategy for communicating unsafe or overwhelmed feelings to the parent, guardian, or supportive adult, such as the use of "check-in" times and a rating scale for upset or unsafe feelings
- The youth will begin or continue outpatient psychotherapy
- Family has been cautioned about how alcohol and drugs can cause disinhibition and increase impulsivity, and will prevent access to substances
- Parent or guardian agrees to remove or secure lethal means of suicide such as firearms
- The youth and parent or guardian agree on a safety plan and follow-up services and an appointment is scheduled
- The youth and parent or guardian have an identified contact person or a safe place to go, such as a hospital emergency department, if a situation deteriorates and becomes unsafe