

Suicide and self harm: psychological therapies, prevention and risk factors

Definitions and background

Suicide is defined as a deliberate act that intentionally ends one's life (HM Government, 2012).

In the UK, deaths are coded using the World Health Organisation's International Classification of Diseases diagnostic tool (Office for National Statistics, 2014), with the most recent figures indicating that there were 6,233 suicides in the UK in 2013 (Samaritans, 2015).

Suspected suicides are subject to a coroner's inquest, with the coroner recording a verdict of suicide if there is evidence beyond reasonable doubt that the individual intended to take their own life and the injury was self-inflicted (Department of Health, 2015).

Self-harm is defined as intentional self-injury or self-poisoning, irrespective of the motivation or degree of suicidal intent and includes both suicide attempts and acts with other intentions (Hawton, 2012).

Accurate numbers of people self-harming annually in the UK are difficult to establish and often out of date, with data often compiled using the number of hospital admissions due to self-harm. This fails to take account of those individuals who seek no help.

The most recent, widely quoted, study on self-harm from 2002 found that the UK had one of the highest self-harm rates in Europe, with around 400 incidents per 100,000 people (Horrocks and House, 2002). It also found that two per cent of men and three per cent of women in the UK have self-harmed without the intention of suicide (Meltzer, 2002).

The relationship between self-harm and suicide is complex. Not all individuals who self-harm have

suicidal intentions and not all those who complete or attempt suicide have a previous history of self-harm.

Despite this, mortality remains elevated amongst the self-harm population (Bergen, 2012). A study into the deaths of children and young people presenting at hospital with self-inflicted injuries, found that almost half of deaths were due to suicide (Hawton, 2012). Another study of self-harm patients found the risk of suicide to be 49 times higher than the general population risk (Hawton, 2015).

Facts of suicide and self harm

- Suicide is the thirteenth leading cause of death worldwide (World Health Organisation, 1999a) and the fourth leading cause of death amongst those aged 15–44 (World Health Organisation, 1999b).
- In the year 2000 an estimated 815,000 people died from suicide around the world. A global mortality rate of 14.5 per 100,000 and equating to one death every 40 seconds (World Health Organisation, 1999a).
- In 2013 there were 6,233 suicides in the UK. A rate of 11.9 per 100,000 (19 per 100,000 for men and 5.1 per 100,000 for women) (Samaritans, 2015).
- The group with the highest rate of suicide is men aged 45–59 with a rate of 25.1 per 100,000 (Samaritans, 2015).

Risk factors

A number of factors are associated with an increased risk of suicide and suicidal behaviour, these can include unemployment, poverty, substance misuse and personality traits (McLean, 2008), the significance of which varies amongst individuals.

For example, the disclosure of suicidal thoughts is known to vary between ethnic minority and non-ethnic minority clients (Morrison and Downey, 2000) and evidence indicates a strong link between alcohol use and repetition of self-harm in Black and South Asian individuals (Cooper, 2013). In older populations, physical health problems have been identified as the most important predictor of self-harm (Oude, 2011).

Although self-harm and suicide are not in themselves mental illnesses, they often occur in the context of mental distress. For example, rates of self-harm in those discharged from mental health in-patient care are more than twice those reported in the general population, with the greatest risk of self-harm coming during the four weeks post-discharge (Gunnell, 2008).

Depression is the most common mental health disorder in those who commit suicide (Hawton, 2013). Suicide is also the leading cause of death in people with bipolar disorder (Saunders and Hawton, 2013). Individuals with borderline personality disorder (BPD) are at high risk for completed suicide, as the disorder is associated with numerous risk factors including impulsivity, suicidal thoughts and recurrent suicidal attempts (Brown, 2004).

Protective factors

Protective factors act to buffer individuals from thoughts and behaviour relating to suicide and self-harm (Centre for Disease Control, 2015). An individual's ability to resist these thoughts and behaviours develops and changes over time, but is understood to be enhanced by protective factors within the individual's life and environment.

Research has identified two forms of resilience relating to protective factors (Scottish Government, 2008).

- **Incidental resilience** – actions an individual has been doing for a long time and which promotes health and well-being, but which becomes a very important part of coping when difficulties arise.
- **Reactive resilience** – something that an individual does in direct response to difficult circumstances.

Despite the importance of protective factors in efforts to reduce cases of suicide and self-harm, research has focused on risk factors, failing to study as extensively or as rigorously the impact of protective factors (Centre for Disease Control, 2015).

While, what is found to be a protective factor for one individual may not be for another individual in similar circumstances (Scottish Government, 2008). The following strategies may be effective protective factors:

- Coping skills
- Reasons for living
- Physical activity and health
- Family connectedness
- Supportive schools
- Religious participation
- Employment
- Exposure to suicidal behaviour
- Social values
- Health treatment

Policy context

Suicide and self-harm remain a major public health concern in the UK and appropriately the four UK nations all have in place a suicide prevention strategy. Whilst the strategies vary regarding the extent to which they cover self-harm and suicidal behaviour, all acknowledge self-harm as being part of wider suicide prevention.

Interventions

The most effective interventions for suicide are those that ensure continuity of patient care after discharge from hospital or that provide therapeutic care within the hospital department (du Roscoat and Beck, 2013).

This recommendation fits within findings from a review of studies across Europe, the US and Australia, which found that 75% of suicide decedents had contact with primary care providers in the year of their death (Luoma, 2002).

In the UK, the National Institute for Health and Care Excellence (NICE) has published two clinical guidelines for the management of self-harm, both of which recommend psychological assessments of risk before referring onto psychological therapies to treat the underlying causes of self-harm.

- **CG16:** Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care (NICE, 2004)
- **CG133:** Self-harm: longer term management (NICE, 2011)

Given the link between mental health disorders and an increased risk of suicide and self-harm, it is clear that psychological therapies may have a positive impact on this group.

Research has shown that Dialectical Behaviour Therapy (DBT), Cognitive Behavioural Therapy (CBT) and problem solving therapy are effective interventions for people at risk of suicide (Winter, 2013).

Evidence has also shown that psychosocial assessment forms an important aspect of the management of self-harm in hospitals, and is associated with a decreased risk of repeat self-harm (Gunnell, 2013).

Problem solving therapy (Bannann, 2010) and DBT (Hawton, 1999) has been shown to reduce repetition and further self-harm. Patients receiving counselling and psychotherapy after deliberate self-poisoning showed greater improvement, including a reduction in suicidal thoughts. The positive impact of counselling and psychotherapy was also maintained at six-month follow-up, with nine per cent of those receiving counselling and psychotherapy repeating self-harm compared with 28 per cent of those receiving usual treatment (Guthrie, 2001).

Conclusions and recommendations

BACP recommends that counselling and psychotherapy are provided to those at risk of suicide or self-harm, along with those affected by suicide.

Suicide and self-harm remains a serious public health concern in the UK and current Government and clinical guidelines acknowledge the role of psychological interventions as part of wider suicide and self-harm prevention strategies.

This approach is supported by research which shows that a range of psychological interventions are effective in the prevention of suicide and self-harm and the treatment and management of underlying mental health problems and emotional distress.

References

Bannan, N. (2010) *Group-based problem-solving therapy in self-poisoning females: A pilot study*. *Counselling and Psychotherapy Research*, 10(3), 201–213

Bergen, J., L. Hawton, N. Kapur, J. Cooper, S. Steega, J. Ness and K. Waters (2012) *Shared characteristics of suicide and other unnatural deaths following non-fatal self-harm? A multicentre study of risk factors*. *Psychological Medicine*, 42(4), 727–741

Brown, G.K., C.F. Newman, S.E. Charlesworth, P. Crits-Christoph and A.T. Beck (2004) *An open clinical trial of cognitive therapy for borderline personality disorder*. *Journal of Personality Disorders*, 18(3), 257–271

Centre for Disease Control (2015) <http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html> [accessed 16 September 2015]

Cooper, J., S. Steeg, R. Webb, S.L.K. Stewart, E. Applegate, K. Hawton, H. Bergen, K. Waters and N. Kapur (2013) *Risk factors associated with repetition of self-harm in black and minority ethnic (BME) groups: a multi-centre cohort study*. *Journal of Affective Disorders*, 148(2–3), 435–439

Department of Health (2015) *Statistical update on suicide February 2015*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405411/Statistical_update_on_suicide_acc.pdf [accessed 28 August 2015]

du Roscoät, E. and Beck, F. (2013) *Efficient interventions on suicide prevention: A literature review*. *Revue d'Épidémiologie et de Santé Publique*, 61, 363–374 (p372)

Gunnell, D., K. Hawton, D. Ho, J. Evans, S. O'Connor, J. Potokar and N. Kapur (2008) *Hospital admissions for self-harm after discharge from psychiatric inpatient care: cohort study*. *BMJ* 2008; 337:a2278 doi: 10.1136/bmj.a2278

Gunnell D, Hawton K, Bennewith O, Cooper J, Simkin S, Donovan J, et al. (2013) *A multicentre programme of clinical and public health research in support of the National Suicide Prevention Strategy for England*. *Programme Grants Appl Res* 2013;1(1). Available at: http://www.journalslibrary.nihr.ac.uk/_data/assets/pdf_file/0006/87099/FullReport-pgfar01010.pdf [Accessed 17 March 2015]

Guthrie, E., Kapur, N., Mackway-Jones, K., Chew-Graham, C., Moorey, J., Mendel, E., Marino-Francis, F., Sanderson, S., Turpin, C., Boddy, G. and Tomenson, B. (2001) *Randomised controlled trial of brief psychological intervention after deliberate self poisoning*. *British Medical Journal*, 323, 1–5

Hawton, K.K.E., Townsend, E., Arensman, E., Gunnell, D., Hazell, P., House, A. and van Heeringen, K. (1999). *Psychosocial and pharmacological treatments for deliberate self harm*. *Cochrane Database of Systematic Reviews* 1999, Issue 4.

Hawton, K., H. Bergen, K. Water, J. Ness, J. Cooper, S. Steeg and N. Kapure (2012) *Epidemiology and nature of self-harm in children and adolescents: findings from the multicentre study of self-harm in England*. *European Child and Adolescent Psychiatry*, 21(7), 369–377

Hawton, K., C. Casanas I Comabella, C. Haw and K. Saunders (2013) *Risk factors for suicide in individuals with depressions: a systematic review*. *Journal of Affective Disorders*, 147(1–3), 17–28

Hawton, K., H. Bergen, J. Cooper, P. Turnbull, K. Waters, J. Ness and N. Kapur (2015) *Suicide following self-harm: Findings from the multicentre study of self-harm in England, 2000–2012*. *Journal of Affective Disorders*, 175, 147–11

HM Government (2012) *Preventing suicide in England: a cross-government outcomes strategy to save lives*. P5. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf [accessed 27 August 2015]

Horrocks, J and A. House (2002) *Self-poisoning and self-injury in adults*. *Clinical Medicine*, 2(6), 509–512

Luoma, J.B., Martin, C.E. and Pearson, J.L. (2002) *Contact With Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence*. *American Journal of Psychiatry*, 159, 909–916

McLean, J. M. Maxwell, S. Platt, F. Harris and R. Jepson (2008) *Risk and Protective Factors for Suicide and Suicidal Behaviour: a literature review*. Scottish Government Social Research. <http://www.gov.scot/Publications/2008/11/28141444/0> [accessed 28 August 2015]

Meltzer, H., D. Lader, T. Corbin, N. Singleton, R. Jenkins and T. Brugha (2002) *Non-fatal suicide behaviour among adults aged 16–74 in Great Britain*. London: The Stationary Office. <http://www.ons.gov.uk/ons/rel/psychiatric-morbidity/non-fatal-suicidal-behaviour-among-adults/aged-16-74-in-great-britain/index.html> [accessed 28 August 2015]

Morrison, L.L. and D.L. Downey (2000) *Racial differences in self-disclosure of suicidal ideation and reasons for living: implications for training*. *Cultural Diversity and Ethnic Minority Psychology*, 6(4), 374–386

NICE (2004) *CG16 Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*. Available at: <http://www.nice.org.uk/guidance/cg16/chapter/1-guidance> [Accessed 17 March 2015]

NICE (2011) *CG133 Self-harm: longer-term management*. Available at: <http://www.nice.org.uk/guidance/cg133/chapter/1-guidance> [Accessed 17 March 2015]

Office for National Statistics (ONS) (2014) *Statistical bulletin: suicides in the United Kingdom, 2012 registrations*. http://www.ons.gov.uk/ons/dcp171778_351100.pdf [accessed 27 August 2015]

Oude Voshaar, R.C., J. Cooper, E. Murphy, S. Steeg, N. Kapur and N.B. Purandare (2011) *First episode of self-harm in older age: a report from the 10 year prospective Manchester self-harm project*. *Journal of Clinical Psychiatry*, 72(6), 737–743

Samaritans (2015) *Suicide Statistics Report 2015*. http://www.samaritans.org/sites/default/files/kcfinder/branches/branch-96/files/Suicide_statistics_report_2015.pdf [accessed 27 August 2015]

Saunders, K.E.A and K. Hawton (2013) *Clinical assessment and crisis intervention for the suicidal bipolar disorder patient*. *Bipolar Disorders*, 15(0), 575–583

Scottish Government (2008) *Risk and Protective Factors for Suicide and Suicidal Behaviour: A literature review*. <http://www.gov.scot/resource/doc/251539/0073687.pdf> [accessed 16 September 2015]

U.S. Public Health Service (1999) <http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html> [accessed 16 September 2015]

Winter, D., Bradshaw, S., Bunn, F. and Wellsted, D. (2013) *A systematic review of the literature on counselling and psychotherapy for the prevention of suicide: 1. Quantitative outcome and process studies*. *Counselling and Psychotherapy Research*, 13(3), 164–183

World Health Organisation (1999a) *World Report on Violent and Health*

World Health Organisation (1999b) *Injury: a leading cause of the global burden of disease*. Geneva, World Health Organisation, 1999 (document: WHO/HSC/PVI/99.11)

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