SUICIDAL TENDENCY AND SELF-HARM AMONG TEENAGERS IN THE HELSINKI METROPOLITAN AREA :A LITERATURE REVIEW

Epwene, Samuel

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Laurea University of Applied Sciences
Otaniemi Unit

Suicidal tendency and self-harm among teenagers in the Helsinki metropolitan area: a literature review

Samuel Epwene
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Epwene Samuel

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Suicide and self-harm is an increasing global concern. Every year almost one million people die from suicide globally. It is among the three leading causes of death among those aged 15-44 years in some countries, and the second leading cause of death in the 10-24 years age group; these figures do not include suicide attempts which are up to 20 times more frequent than completed suicide. Suicide rates have been highest among in the male elderly, however rate among young people have been increasing to the extent that they are now the highest in group in many countries both in the developed and developing countries.

Adolescence or the teen age is a developmental phase during which several of the mental health disorders of adulthood appear which go a long way in increasing the suicide rate at adulthood. This paper seeks to discuss how current literature and knowledge available is being used by nurses in intervening and identifying teenagers at risk of committing suicide or self-harm and what effective care, guidance they can provide to the concerned and his or her family.

In Finland, girls attempt suicide more often than boys, but suicide mortality is higher among boys. Self-harm is more common among girls. A national project in the 1990's aimed at Suicide Prevention Strategies in Finland attained good results in suicide prevention, but much is still needed to be done as in international comparison suicide mortality is high in Finland. A substantial portion of suicides are committed under the influence of alcohol or drugs. The state of mental fitness also is a huge contributing factor to suicide or the tendency to self-harm. The socioeconomic background of the parents, single parenthood, and social assistance, are linked to self-inflicted injuries. The best indicator for suicide is an earlier attempt or expression of suicidal thoughts.

Key words: Suicide, self-harm, teenagers, nursing intervention, nursing guidance

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1 Introduction

Most studies on teenage and adolescent suicide has been focused on living subjects as such lack of standardized definitions of different suicidal behaviours, bias in selection and ignoring control groups have led to inconsistent findings (Berman & Cohen-Sandler,1982).Smith and Maris (1986) recommended that in order to avoid misinterpretations, specific life threating behaviours studied should be clearly well defined, and that different forms of self-destructive behaviours – suicide ideation ,suicide attempts ,and completed suicide –should be studied separately.

Suicide is the process of purposely ending one's own life. The way societies view suicide varies widely according to culture and religion. For example, many Western cultures, as well as mainstream Judaism, Islam, and Christianity tend to view killing oneself as quite negative. One myth about suicide that may be the result of this view is considering suicide to always be the result of a mental illness. Some societies also treat a suicide attempt as if it were a crime. However, suicides are sometimes seen as understandable or even honorable in certain circumstances, such as in protest to persecution (for example, hunger strike), as part of battle or resistance (for example, suicide pilots of World War II; suicide bombers) or as a way of preserving the honor of a dishonored person (for example, killing oneself to preserve the honor or safety of family members).

As opposed to suicidal behavior, self-harm is defined as deliberately hurting oneself without meaning to cause one's own death. Some researchers have some other names to refer to this phenomenon such as self-injurious behavior (Alpher & Peterson, 2001; Bockian, 2002). Deliberate self-harm (DSH also referred as self-mutilation) has been defined as the deliberated destruction or alteration of body tissue, without apparent or conscious suicidal intent but capable enough to result to sever to tissue damage to occur(Gratz 2003,192 – 205).Such self-injurious behaviors may include but not limited to drug or alcohol abuse, self-burning, head banging, pinching, wrist cutting.

 Although suicide in children under 10 years of age in Finland is extremely rare, suicidal thoughts and acts are quite common even in pre pubertal children. The risk factors most strongly associated with teenage suicidality and self-harm are psychiatric disorders, particularly depression, poor child-parent relationships, sexual exploitation, experience of violence (family violence, bullying) and suicide of a first degree relative. The risk factors have a cumulative effect. For preventing suicide in children it is essential to identify children who are burdened by adversity in their everyday life, and provide them support. In primary health care it is necessary for nurses and other clinicians to identify suicidal children, particularly those who cut themselves, and refer them to appropriate psychiatric evaluation and care without delay. In the acute psychiatric treatment of suicidal children securing the safety of the child, addressing the main cause of the child's distress and rekindling hope are the most important things.

1.1   Definition of Suicide

Suicidal tendency arises from complicated motives, and the intention is not necessarily death. As an individual process, suicidal behavior can be conceptualized as ranging from suicidal ideas and threats to suicide attempts and completed suicide (Brent et al.,1988a;Paykel,1974).

The definition of suicide has been a subject of controversy amongst researchers and scholars alike. The converging point or least ambiguous in their definitions of suicide is that the outcome of the act is death. In like manner a wide range of behaviors can be called suicidal or life –threatening with no assumptions about the intention or outcome (Lönnqvist, 1977).Lack of a clear cut definition of concepts has been a source of inconsistent results in studies dealing with suicidal behavior. According to Farmer (1988), to ascertain suicide, three principal stages are involved: the death must be recognized as unnatural, the initiator must be the deceased himself, and the motive of self-destruction must be established, while Stengel(1973) defined suicide as the fatal, act of self-injury undertaken with more or less conscious self-destructive intent, however ague or ambiguous". Completed suicide can be defined as those deaths officially recorded as suicidal deaths(Beskow,1979).In Finland, causes of death recorded is very reliable (Lönnqvist et al.,1988),deaths recorded as suicide are estimated to be about 90% correctly classified (Karkola,1990).

1.2   Self-harm

Self-harm is defined as a compulsion or impulse to inflict physical wounds on one's body motivated by a need to cope with unbearable psychological distress or regain a sense of emotional balance. This act is usually carried out without suicidal, sexual or decorative intent. (Sutton 2007, 22-23.) Other researchers have different concepts and names attributed to self-harm. Some examples are self-harm (Beasley, 2000), self-injurious behavior (Alper & Peterson, 2001; Bockian, 2002), repeated self-injury, para-suicide and self-mutilation. Deliberate self- harm (DSH also referred to as self-mutilation, self-injury or auto-aggression) is also defined as the deliberate direct destruction or alteration of body tissue, without apparent or conscious suicidal intent but resulting in injury severe enough for tissue damage to occur. (Gratz 2003, 192-205.)

In the plethora of definitions of self-harm, the behaviors that are usually identified include cutting, burning and overdosing (Pembroke 1994, 32-56). It is therefore important for researchers as well as nurses to identify the causative effects of self-harm among young adults and the proper way of preventing, teaching and empowering the young adults against it. Typically young men are prone to self-harm whereas girls would opt for self-poisoning.

According to ICD, definition of self-harm incudes; purposely self-inflicted poisoning or injury, suicide (attempted). Classification code for intentional self-harm / event of undetermined intent contain injuries resulting from ,self-poisoning, hanging, strangulation, suffocation, drowning, submersion, discharge of guns / firearms, explosive material, smoke, fire, flames, steam, hot vapours, hot objects, sharp / blunt objects, jumping from a higher place, lying before moving object, crashing of motor vehicle, other specified and unspecified means. (Mangnall et al, 2008, 176-177.)

Adolescents who deliberately self-harm have, in part become the focus of research because of their greatly increased risk of suicide as well as an association between self-harm and a range of psychological disorders (Hurry 2000, 12, 31-36). Different authors have varying definitions of self-harm in divergent ways. While some describe it as existing only when there is clear intent not to kill oneself, others define it in just the opposite way saying it exists only when there is a clear intent to kill oneself.(see Manghall et al 2008,176.) Self-harm and attempted suicide is often used interchangeably. To add further complication, self-harm can coexist with suicidality. Thus, just as it would appear wrong to say that self-harm is a subset of suicide. It is proven that people who self-harm may become suicidal and thus the link between the two is undeniable. (McAllister, 2003, 177-178.) A clear standard universal definition is necessary in order for the scientific community to wade out other meanings and advance its inquiry into this complex phenomenon. For the purpose of this paper, the term self-harm will be used for those whose intent is not to kill themselves.

I consider this topic to be very important especially after working in a psychiatric hospital which deals with young adults who had several mental ailments self-harm being one of them. Nurses have different opinions and view on how they view young adults who self-harm. This difference of opinion has created much debate and thus I decided to study suicide and self-harm by way of systematic literature review in order to identify and argue out the truth on how nurses can help young people who have the tendency to self-destroy.

2   Factors (risks) influencing adolescent suicide & self-harm

Psychological autopsy studies in recent years of adult suicides from many countries have consistently shown that the vast majority of suicide victims had sufferers from mental disorders. Over half of the suicides have been in psychiatric care and during the month preceding the actual suicide over 60% have been in contact with health care professionals (Henrikson et al, 1993).As opposed to adult suicide; fewer studies have addressed the characteristics of adolescents who end their lives by suicide. Young adults perform acts of self-harm to overcome and act towards a situation or life crisis that they are facing. People with physical disabilities

for instance may seem isolated from their peers and other normal adults in their community. The risk of self-harm might be higher in circumstances where close family members and the society as a whole discriminate against young adults with physical illnesses and abnormalities. A person may in these way feel neglected and seen as a burden resolving to suicidal ideations. (Kegg, 2005, 1474-1475.)

2.1   Mental Disorder

Mental disorder has been confirmed as a risk factor for suicide in the general population. The magnitude of the risk for patients who had previously received any kind of treatment for psychiatric disorder is estimated to be 11 times greater than expected (Harris & Barraclough 1997).Psychological autopsy studies of general population suicides have estimated a prevalence of current mental disorder at the time of suicide to be as high as 81 – 98% with the most prevent of them being depressive disorders, alcohol abuse or dependence and schizophrenia (Forster et al 1997). Mental health disorders are common among young people who self-harm. In the National Institute of Mental Health Methods for the Epidemiology of Child and Adolescent Mental Disorders study, 76% of youth, aged 9 to 17 years, who had ever attempted suicide met current criteria for 1 or more mental disorders. Due to the close link between mental health illnesses and self-harm and the health threats to young adults, professional guidelines recommend that all young adults admitted and treated for self-harm or related incidences should be sent to a mental health professional for possible evaluation before discharge. (Olfson et al 2005, 1122-1123.)

Self-harm prevalence has increased in recent years. Among psychiatric populations, depression, bipolar disorder, borderline personality disorder and suicidal behavior have consistent association among young adults who self-harm. Hintikka et al (2009) on a study on adolescents with mental health disorders indicates that major depressive disorders, eating and anxiety disorders were more common among adolescents who engaged in self-cutting.

2.2   Trauma

Several studies have indicated that there is a link between suicidal attempts and childhood trauma and/ or family factors. Children with an experience of family rivalry and the character of their parents have higher prevalence of self-harming compared to a normal child brought up in a normal family. This may be so especially when the child receives no or less attention from the parents and the community. (Mangnall, 2008 180-181).
Girls compared to boys have higher rates of self-harm in this domain. This is so because of their gender and place in society. Childhood abuse may include sexual, physical and emotion-

al abuse (Sansone, 2005) Forced sexual abuse, relationship problems and serious fights with parents or friends are some of the factors towards self-harm. The presence of childhood trauma has been shown to precipitate DSH in childhood and in later life. In a study on self-harming patients, 32.8% first harmed themselves as children 12 (years of age or younger) 30.2% as adolescents and 37% as adults. The result of this study suggests that when self-harm begins in childhood, the course of DSH may be particularly malignant. (Zanari et al, 2006, see Mangnall 2008, 180.) In a systematic literature review by Fliege (2008) on of risk factors and correlates of deliberate self-harm behavior, childhood trauma is highlighted as a causative factor for self-harm. The study reports an association between current self-harm behavior and a history of early childhood sexual abuse. Young people with childhood trauma have low emotional expressivity, low esteem and dissociation with respect to a vulnerability to self-harm. (Fliege at al, 2008, 490.)

2.3 Family History

Suicidal behavior tends to cluster in families. A follow up study of psychiatric patients which included a group of suicide victims, showed an increased risk of suicide among the first-degree relatives of both groups compared to the control patient's relatives (Tsuang 1983).Studies also with age matched general population controls have also shown that family history of completed suicide or suicide attempt and /or affective disorder is a maker for high risk of suicide (Brent et al 1996).

2.4 Alcohol and Drugs

Alcohol, as Anderson et al (2004, 871) states, is commonly a precursor to DSH whereas alcohol dependence is a risk factor for both DSH and suicide. From the study, alcohol misuse and suicidal behavior was demonstrated in a 25-year longitudinal study of Swedish male conscripts. Those who abused alcohol had an elevated risk of attempted suicide. Approximately one-third of those who self-harm regularly misuse drugs or alcohol.(Anderson et al,2004,871.)

In another investigational study in England, alcohol was said to be used in the six hour before or as part of the act of self-harm. Alcohol involvement in act of self-harm remained stable for both genders and somewhat surprising especially in women. (Bergen et al 2010,496 – 497.) Drug use is highly associated with the episodes of DSH for both boys and girls. Adolescents argue that use of drugs assists and relieves them from a terrible state of mind. Self-medication for psychological distress has also been reported to be central motive in adolescent drug use. Young adults experiencing distress attempts to relieve negative feelings through drug use and in some situations, self-harm. (McMahon et al 2010, 1816.)

Alcohol is known to have a rapid anxiolytic effect but when used frequently, it may provoke anxiety and depression. Depressive young adults who have the experience of self-cutting may use alcohol as means of self-help but in the long run this may exacerbate their symptoms and potentially increase the need to repeat self-harming for symptom alleviation. (Hintikka et al, 2009, 465 – 467.)

Self-harm is rare before puberty and becomes more common through adolescence, with the most common age for the first onset of self-harm at about 16 years in the USA. According to WHO/EURO study, the greatest risk of hospital representations was in women aged 15-24 and men aged 25-34 years. Older people are at a much lower risk, and when they do self-harm they are much more likely to commit suicide. (Skegg, 2005, 1473 – 1477.) It is important to note that socio-economic factors, such as unemployment and poverty, childhood experiences of abuse, and experiences of domestic violence are all associated with a wide range of mental disorders, as well as self-harm. How these experiences and factors interact needs to be explored and better understood. (Hawton et al, 2003, 989.)

3   Purpose of the study and research question

This paper has as objective to serve as a quick reference manual that nursing personal and other primary health care givers in the HUS area can call upon as a handy tool to better assess teenagers who self-harm or have suicidal ideation and the possible care pathways that may be afforded them aimed at providing better patient care, education and counselling among the teenage population.

The research question is;

How can nurses better assess the risk of self-harm and suicide among teenagers

3.1   Assessment

All professionals who work with children and young people share a duty keep them safe. Recognizing and reducing the potential risk of self-harm, suicide is central to their job. In essence the better the nurse's knowledge of a young person, the better his or her risk assessment is likely to be. Just as it is crucial to assess risk, so too it is important to assess strengths and protective factors in the young person, family and wider community network. This is to inform decisions about whether the risks and benefits of professional intervention outweigh the risks of non-intervention (Ryan and McDougall 2008).
Risk refers to the factors in a teenager's life that may have a negative impact on their health, development and psychosocial functioning. There are two kinds of risk; acute risks which are

those that occur in the context of a crisis and could further increase the likelihood of suicidal behaviour. Chronic risk refers to the long-term risk of self-harm and suicide (McDougall et al 2010).A 2009 poll by YoungMinds asked teenagers and young people about the difficulties they experienced which could be regarded as risks. These included just to name these few, bullying, siblings or friends being mean, parents getting divorced, family problems, living with parents who don't look after you, fears of being taken away from one's parents, parents always arguing, missing friends, relationship issues ,drugs and alcohol, isolation, boredom.

The process of suicide risk assessment is often a challenge for mental health nurses, especially when working with an adolescent population. Adolescents who are struggling with particular problems, stressors and life events may exhibit challenging and self-harm behaviour as a means of communication or a way of coping. Current literature provides limited exploration of the effects of loss, separation and divorce, blended families, conflict and abuse on child and adolescent development and the increased vulnerability of at-risk youth. There is also limited research that provides clear and practical models for the assessment and management of youth suicidal ideation and behaviour. This paper will discuss the integration of a number of theories to establish a comprehensive assessment of risk. The research study described the perspective of youth and their families who had experienced this particular model; however, this paper will discuss only the youth perspective. In order for this model to be successful, it is important for mental health nurses to make a connection with the youth and begin to understand the self-harm behaviour in context of the adolescent's family, and their social and school experiences. It also requires recognition that adolescents with challenging and self-harm behaviour are hurting and troubled adolescents with hurtful and troublesome behaviour.

The idea of adolescence being a time of 'stress and storm' is somewhat controversial (Puskar & Lamb 1991); however, adolescence does mark a time of particular bio-psychosocial developmental issues (Santrock 1998). As a result, this period of time can be a challenge even for an adolescent growing up in a relatively healthy and functional family and community. For less fortunate and underprivileged adolescents, this period of development is often characterized by rebellion and challenging behaviour (Ben-Zur 2003). Research indicates that behaviour is often a means of communication (Machoian 2001). This is particularly true for adolescents with disruptive behaviour who are coping with unhealthy or dysfunctional home, school or social environments (Langlois & Morrison 2002). Adolescents who are struggling with particular problems, stressors and life events may exhibit challenging and self-harm behaviour (SHB) as a means of communication, or as a way of coping.

Current research in the area of youth suicide identifies the magnitude of the problem and also supports the existence of a correlation between youth suicide rates and the contextual issues within families (Turner & Butler 2003). However, the literature provides limited explo-

ration of the effects of loss, separation and divorce, blended families, family conflict, and abuse on child and adolescent development and the increased vulnerability of adolescents at risk.

Second, the literature on youth suicide identifies possible risk factors, such as lack of family support, history of abuse or school problems (Eggert & Thompson 2002). However, this literature is limited in utilizing the identified risk factors to provide a clear understanding of youth suicidal behaviour. Third, there is limited literature that provides clear and practical models for the assessment and management of youth suicide.

This paper proposes a Youth Suicide Risk Assessment and Intervention model which emphasizes and approach that views the teenager in context of their family, their social world and the broader community. It encourages engagement and the development of a connectedness with youth and their families using the language of a Brief Solutions and Family Therapy approach (Corcoran 1998), emphasizing the power and resiliency of families as key components for change and resolution. An intergenerational perspective and use of the genogram (McGoldrick 1992) are also an integral part of the approach. This perspective recognizes family patterns over time and traces the history of abuse, alcoholism, trauma and loss (Mishara 2003). Recognition of developmental factors that contribute to individual and family struggles, and family interactional patterns and boundaries also assists in providing a broad and complete assessment.

Applied Suicide Intervention Skills Training (ASIST) (Ramsay et al.1994) provides the framework for risk assessment emphasizing the assessment of stressors, symptoms, prior suicidal behaviour, current plan and identified resources and support. An overall Rogerian approach (Rogers 1980) guides the interactions with youth and their families with a non-blaming, non-judgmental and unconditional positive regard approach to understand and process what the suicidal ideation or behaviour is really about. Integration of the model also assists in understanding the onset, the purpose, the maintenance and the escalation of the suicidal behaviour, and assesses specific risk factors related to the SHB. Referrals for the risk assessment were made through intake at Mental Health Youth Services. An initial outpatient admission interview was carried out via telephone or in person, and the patient was then referred to the Clinical Nurse Specialist (CNS) to do a comprehensive assessment of risk and family assessment. The assessments were approximately 2 h in duration. The first author, Lee Murray (CNS), engaged the adolescent in a one-to-one interview for approximately 1.5 h; family members were invited to join the interview for the remaining half hour. Follow-up family therapy by the CNS included both individual and group therapy with members of the family, as determined by the family and the CNS.

This study was conducted to explore the experience of suicide risk assessment as described and perceived by adolescents and their families who experienced this particular model described herein. Although both the youth and their families were involved in the research interviews, only the experiences of the youth will be described in this paper. The findings of this study proposed the following guidelines so as to enable nurses better assess teenagers who self-harm or have suicidal ideation.

3.2   Trust

Initially, the adolescents spoke of their fear, anxiety and shame after being referred for a suicide risk assessment. They also indicated the importance of a quick referral and immediate help to deal with their issues, and they indicated that it was important to have one therapist over a consistent period of time in order to establish a sense of trust within the client–therapist relationship

"It was really scary . . . you feel like everybody knows
what you're being there for . . . it's like sitting in the
waiting room of a doctor's office and they didn't give
you a gown . . . just like a total walk of shame.
I never liked how it ended, and I never liked how I
was supposed to get shoved off to a different counselor
and stuff like that. I got comfortable with one person".

3.3   Connection

The first step in establishing a meaningful relationship with adolescents is connecting with them and engaging them in the relationship. This requires genuine interest on the part of mental health professionals and an ability to set aside their own values and beliefs while allowing adolescents the opportunity to express themselves and tell their story from their point of view. The adolescents' perceptions of what is happening in their lives are vital in determining what their SHB is about. Establishing and maintaining a trusting relationship with adolescents is important in providing an opportunity for adolescents to share their concerns. Connection and the establishment of a relationship with adolescents may not be easy and it may take time. However, the time and effort is well spent if the result is a willingness of adolescents, together with their families working cooperatively to be involved in meaningful change of family interactional patterns and the challenging behaviours. Corcoran (1998) stated that joining or connection is the 'foundation for cooperative work'. Connection also involves active listening, on the part of the mental health professionals, and effective communication skills (Mitchell et al. 2003).

3.4   Communication

Active listening requires the therapist to be attentive to the adolescents in order to understand the meaning behind their stories or conversations. It requires listening with an open mind and questioning with genuine curiosity to gain clarity rather than to refute what the adolescent is saying .A non-blaming and non-judgmental approach will gain the respect and cooperation of the adolescent. It is important for the therapist to avoid lecturing, advice giving and nagging .Advice giving often puts people on the defensive and they are less likely to enter into a cooperative relationship (Berg 1994). Lecturing often puts the focus on the problem rather than the solution, and although it may give some relief to the advice giver, it is not likely to accomplish its goal or purpose: changing the behaviour of the adolescent (Corcoran 1998; Mitchell et al. 2003).Effective communication also avoids close-ended and/or leading questions. Open-ended questions with the intent of exploration and curiosity will provide the environment needed for a meaningful exchange of ideas and solutions. Listening to the concerns and issues confronting adolescents is often more important than changing or correcting the situation. Often, adolescents recognize that mental health professionals do not always have the power or influence to change problems that confront them, but they do appreciate the mental health professionals' ability to listen with the intent to understand the situation. People, including adolescents, tend to talk about what is upper most on their mind to a sympathetic and skilful listener. Sympathy may be useful initially; however, 'feeling sorry for an individual is not as empowering as exhibiting empathy and the ability to 'walk a mile in the adolescents' shoes' in order to understand the situation and the meaning of the challenging behaviour. Behaviours cannot be understood beyond feelings, emotions and sentiments; and sentiments are often difficult to identify. For this reason, it is important to view the challenging behaviour of adolescents in context of their family, social and school environment and the broader community.

3.5   Context

Adolescents bring with them, their own values, believes, hopes, fears and expectations as a result of previous family, social and group experiences. Behaviour is often a means of communication (Halliday & Mackrell 1998), and understanding the message behind the behaviour is vital to guide interventions. Youth are also part of a group or groups within the school and work environment, and membership within these groups also determines behaviour. It is important for mental health professionals to recognize and acknowledge how important membership, and a sense of belonging in a social group within the school environment, is to adolescents and begin to understand their behaviour in context of the expectations of the peer group. Adolescents must also be viewed in context of the broader community with behaviour

being a possible result of socio-economic issues or conditions within their neighbourhood and family. Connection and effective communication as well as viewing adolescents in context of their broader world promotes their cooperation, not for the purpose of compliance, but to encourage their input and cooperation, and utilization of their resources.

3.6 Cooperation

Behaviour often changes when adolescents have a sense that their opinions, suggestions and recommendations are important. Equally important is recognition of adolescent's hopes and fears in regards to their life aspirations. This recognition promotes an understanding of the challenging behaviour in relation to unmet needs and challenges of the broader environment. A focus on the adolescents' strengths and resources often promotes a shift away from their problems and inappropriate, challenging and self-harm behaviour towards that of participation and cooperation. Often, adolescents have done well in many aspects of their lives, despite the problems and issues they may have dealt with. Recognition of the strengths they have displayed to deal with these issues is important in identifying exceptions to the problematic behaviour (Corcoran 1998; Mitchell et al.2003). Exploring the context of the exception guides the mental health professionals in providing an environment that promotes a change in behaviour. Also the mental health professionals' expectation and confidence in the adolescents' ability for appropriate behaviour and cooperation promotes responsible participation, self-direction and self-control. A self-fulfilling prophecy can work both ways. If 'bad behaviour' is expected from a 'bad kid', then the opposite may also be true. It also holds true that a therapist's belief that adolescents are capable of creative and responsible problem solving and decision making promotes the utilization of their skills to resolve important issues.

Contemporary and established literature indicates that people with mental health problems are at a higher risk of suicide than the general population. Because suicide is a multifaceted, complex phenomenon, risk assessment within the mental health care system requires a pluralistic, multidimensional and multi professional response. While assessment tools may provide useful guidance, especially guarding against complacency and over confidence, the fundamental basis of risk assessment must involve a thorough examination of the personal, interpersonal and social circumstances of each individual. Such thorough and rigorous assessments, the authors of this paper would add, require a degree of 'clinical judgement'.
As a rule, inexperienced members of mental health care staff should not be charged with the responsibility of conducting suicide risk assessments without sound mentorship. However, with the right support and assessment tool, the novice practitioner might develop the kind

of clinical judgement necessary for this critical task. Accordingly, this paper traces the development of the Nurses' Global Assessment of Suicide Risk (NGASR). It illustrates the practice development context out of which the need for the tool arose; it outlines the key evidence that underpins the construction of the tool and it is described. It is important to point out that as yet, no wide scale, quantitative validation of the tool has been conducted. Therefore, at this point, the tool should be treated with a degree of appropriate caution. Nevertheless, the preliminary attempts that have been made to 'validate' or 'rate' the tool in practice are included. While acknowledging that any risk assessment tool represents only one aspect of the necessarily broader assessment of risk, the NGASR appears to provide a useful template for the nursing assessment of suicide risk, especially for the novice.

4   Systematic Literature Review

In writing this paper, systematic literature review was used. I did read and analyses materials and literature related to self-harm and suicide in teenagers so as to gain good knowledge and to identify many different ways that nursing personnel can better assess and intervene when caring for young people who self-harm. Literature was sought across a range of health care settings. Electronic databases were accessed. Literature review provides evaluation and appraisal of literature used relating to self-harm and suicide. (Polit and Beck 2004,11-13.)

Literature review is a comprehensive study and interpretation of literature that relates to a particular topic". Through summarizing and analyzing the related research results, literature review seeks to present an overview picture of this research field. (Aveyard, 2007)
Working as a research methodology, literature review is required to be undertaken systematically to ensure the validity and reliability of the review. Thus the following issue should be clearly explained in a literature review study, for instance, how the research questions are identified? Why literature review is chosen as the research method? How to search for appropriate literature for answering the research questions? How the selected literatures are critiqued and finally how the information is brought together.(Aveyard, 2007, p 16)

Secondly, literature review study can bring individual researchers together to accomplish the jigsaw on one specific topic. It compensates the weakness of any individual research, since the real impact and study power of any single research cannot be determined. Thus literature review study is a good way for the novice researcher pursuing a full picture on the studied field. In another way, it gives the possibility to provide over-all and objective opinions from theoretical research to real life practice.

4.1 Method

Systematic literature review was considered the best method in analysing research articles during the writing of this paper. (Giroux, 2000 see McAllister, 2003) mentions that systematic literature review assists to open up previously hidden aspects to self-harm and reveals that which is ordinarily obscured. In the process of making a literature review, the author searches, reads, analyses numerous sources of articles and information and combine then into one article. Therefore, large amount of information is put together and written in a language that can be well understood by the reader. Thus, Systematic reviews can help practitioners keep abreast of the medical literature by summarizing large bodies of evidence and helping to explain differences among studies on the same question. A systematic review involves the application of scientific strategies, in ways that limit bias, to the assembly, critical appraisal, and synthesis of all relevant studies that address a specific clinical question. (Cook et al,1997,377-378.)

4.2 Search strategy and process

In order to meet the aims of this paper, the literature review and research articles used focused on self-harm and suicide. To gain detailed insight of how health care professionals view young adults who self-harm, literature was sought across a range of health care settings which included both medical and mental health environments. (McHale 2010, 733-734.) Although the searches were limited to the year 2000, the writer uses a few of the articles published earlier as it had relevant information required in the writing of the thesis. Some of the searches found had no link for a full text even though they were appropriate for this review. Research articles were also available in webpages. An archive of general psychiatry is one of the webpage used by the writer. Two databases mainly CINAHL (EBSCOhost) and SAGE Journals were used, texts books and some other related earlier works. In all there was a general brainstorming.

International research articles were included during the search for a broader examination of self-harm as well as to provide opportunity for comparison of cultural influences. Twenty key words were used for the search on CINAHL database as well as SAGE Journals (see appendix 1 and 2). Finally after reading and analyzing the articles on nursing interventions, three articles were found to be relevant. On accessing the databases, articles related to self-harm and suicide were found. However for the interests of this topic, an exclusion criterion was formed to guide the writer.

➢ The research was published between 2000 to date

➢ Had to be in pdf form

➢ Was written in the English language

➢ The article was related to the research question

Year of Publi-cation	2004	2006	2010
No. of Articles	1	1	1

Table 1.

5   Findings

.... The interview with a suicidal person can be a chilling
affair. It is not for the faint hearted and clearly is not the
job for the novice..... Barker (1997p. 191)

Various research methods were used in the studies used these include; Literature review,
single blind study, randomized control trials and questionnaires. Two of the studies published
in the Canadian Journal of Psychiatric and Mental Health Nursing. One searched for papers
describing randomized and clinical control trials whereas the other reviewed treatment out-
come literature including meta-analyses and consultation between practitioners and patients.

The purpose of this thesis was to find out how nurses can better assess the risk of self-harm
and suicide among teenagers. The four articles reviewed had divergent as well as similar ways
on how nurses can intervene on self-harmers. Cutcliff et al(2004, 393–400) projects its "The
Nurses' Global Assessment of Suicide Risk (NGASR)" as a handy clinical practice assessment
tool to help both the experienced and the debutant nurse conduct a better risk assessment of
a potential suicide or self-harm patient. They argue that current literature indicates that
people with mental health problems are at a higher risk of suicide than the general popula-
tion. Because suicide is a multifaceted, complex phenomenon, risk assessment within the
mental health care system requires a pluralistic, multidimensional and multi professional
response. While assessment tools may provide useful guidance, especially guarding against
complacency and over confidence, the fundamental basis of risk assessment must involve a
thorough examination of the personal, interpersonal and social circumstances of each individ-

ual. Such thorough and rigorous assessments, the authors of this paper would add, require a degree of 'clinical judgment'. As a rule, inexperienced members of mental health care staff should not be charged with the responsibility of conducting suicide risk assessments without sound mentorship. However, with the right support and assessment tool, the novice practitioner might develop the kind of clinical judgment necessary for this critical task. It is important to point out that as yet, no wide scale, quantitative validation of the tool has been conducted. Therefore, at this point, the tool should be treated with a degree of appropriate caution.

In her paper entitled " A brief insight into how nurses perceive patients who self-harm" ,Amy-Laura Emerson(British Journal of Nursing, 2010, Vol 19, No 13) points out that self-harming patients attending hospital for problems not relating to self-harm, are perceived negatively (Hawton et al, 2006), and once self-harmers are recognized, their reason for being admitted to hospital is often disregarded. She used some earlier research studies on the perception of nurses towards self-harmers whereby Liggins and Hatcher (2005) and Anderson and Standen (2007) highlighted a major theme: applying the label of mental illness to those who self-harm, with a subsequent negative impact on care delivery. The World Health Organization (WHO) (1993) explains that an act of self-harm does not indicate a mental health risk, and to assume so is politically incorrect. However, the general public still affixes the label of mental illness to someone inflicting pain on themselves. This label of stigma
can be destructive and infringe on an individual's life by affecting how they act and how they continue to live their life. It lowers a person's self-esteem, and could result in a more dangerous health concern (Mayo Clinic staff, 2009).Like Nightingale F, said 'The process of repairing the body which nature has instituted, and which we call disease, has been hindered by some want of knowledge or attention' (Nightingale, 1860).

Those words of wisdom from the mother of nursing, Florence Nightingale brings me to my core findings of this paper which is buttressed in the works of Murray B & Wright K,(2006) entitled "Integration of a suicide risk assessment and intervention approach: the perspective of youth". They intimated that inspite of the studies nurses have had, the process of suicide risk assessment is often a challenge for mental health nurses, especially when working with an adolescent population. Adolescents who are struggling with particular problems, stressors and life events may exhibit challenging and self-harm behaviour as a means of communication or a way of coping. They proposed that it is important for mental health nurses to make a connection with the youth and begin to understand the self-harm behaviour in context of the adolescent's family, and their social and school experiences. It also requires recognition that adolescents with challenging and self-harm behaviour are hurting and troubled adolescents with hurtful and troublesome behaviour.I am of the opinion too that Effective and therapeu-

tic communications skills are also important to encourage the cooperation of the adolescent in addressing their own needs and the SHB they display.

6   Discussions

Suicide is a tragic event and a confusing death. It leads to the premature death of the committer, and the final act of suicide is usually preceded with periods of anguish and suffering. Suicide also causes extensive affliction to others. For those left behind it often has far-reaching consequences, which in addition to feelings of blame, grief reactions and mental disorders include even future suicides (Cerel, Jordan & Duberstein 2008).
Despite its individual feature, suicide is also to a great extent a public health problem. According to the World Health Organization (WHO 2000) each year worldwide approximately 900 000 individuals die of suicide, and the global mortality rate is about 16 suicides per 100 000 persons. Suicide mortality has increased during recent decades in many regions, and furthermore, suicide has been predicted to become an even larger global public health burden in the next two decades (Lopez & Murray 1998).
Among those aged 15 to 44 years suicide is among the three leading causes of death worldwide. As suicide often takes place in young or middle aged adults its burden on public health is large, and one way to estimate this is in terms of disability-adjusted life years (DALYs). According to this indicator, suicide was responsible for 1.8% of the total burden of disease worldwide in 1998. This is equal to the burden due to wars and homicide combined and roughly twice the burden of diabetes. (WHO 2000.)
Suicide is a common cause of death also in many European countries and in North America (Schmidtke, Weinacker, Apter et al. 1999). In Finland the suicide mortality trend has decreased during the last decade, yet among both Finnish men and women aged 15–64 years suicide was the fourth most common cause of death in 2006, meaning that every eleventh male and every fifteenth female death was a suicide (Statistics Finland 2007).

Considerable variation exists in suicide mortality rates between countries and in national trends (OECD 2007; Schmidtke Weinacker, Apter et al. 1999; Fernquist & Cutright 1998; La Vecchia, Lucchini & Levi 1994), and regionally within a country (Pesonen, Hintikka Karkola et al. 2001; Bunting & Kelly 1998; MMWR 1997). There are also specific mortality patterns according to sex and age, inter alia (e.g., McKeown, Cuffe & Schulz 2006; Morrel, Page & Taylor 2002). One of the notable factors that position people at different risk of suicide is socioeconomic status: those with low education (Lorant, Kunst, Huisman et al. 2005a), those employed in blue-collar occupations (Valkonen & Martelin 1988), and those having low income (Martikainen, Mäkelä, Koskinen et al. 2001), have been found to have an elevated suicide risk. Closely related to socioeconomic status is employment status.

Education and social class are important determinants of non-employment (both unemployment and economic inactivity) among people of working age, and this in turn is a major determinant of low income, and increased suicide risk has also been observed among the unemployed (Blakely, Collings & Atkinson 2003). In this study socioeconomic status and employment status are perceived as the most important indicators of social differences.Reducing social differences in health and mortality between population subgroups has been a salient objective in many national and international programmes (Europa 2008; Ministry of Social Affairs and Health 2008; WHO 1978). One of the central aims of the Finnish Health 2015 public health programme by the Government is to decrease accidental and violent deaths (Ministry of Social Affairs and Health 2001). Yet, our current understanding of the trends and causes of socioeconomic and employment status differences in suicide mortality is insufficient, and the purpose of this study is to provide a systematic analysis of these social differences in suicide mortality in Finland.

7   Limitations

The writer had limitations in the writing of this paper. Language was one of the major hindrance as self-harm is in itself a wide topic and subject that affects every group worldwide. Research articles were searched in English language, however articles written in other languages that also dealt with self-harm or suicide was not used thus relevant information was not put in use. The articles used herein are majorly from English speaking countries; United Kingdom, Canada, Australia and New Zealand. Therefore countries with less socioeconomic advantage as well as higher population rates of young adults were not covered in the research. Generally, the findings can be biased due to imbalance in the research processes done. Self-harm is one of the major concerns for health care workers globally. More research and debates are ongoing in an attempt to achieve relevant and evidence based solutions. Selection of articles from the many retrieved from the databases proved to be a heavy task especially for this topic as it is closely related to other injurious behaviours tried and done by young adults.

The search process used during the writing of this paper was done with little knowledge on research methods and techniques. Sufficient know-how and skills on search process could have produced a much better results for the literature review. Due to the broadness of the topic and the research studies on it, many relevant studies might have been omitted due to the limitations done in order to arrive at a certain number of articles required for the thesis. Given that self-harm is a relatively common problem in young adults, there have been few studies on the effectiveness of the interventions already in use. Before interpreting the data on the 4 articles, the author warrants comments concerning methodology. Bias may well have

been operated in the studies as far as global coverage is concerned. Additionally there might be contamination in the studies used.

Nursing interventions against self-harm were compared with normal or standard care. Normal treatment is usually developed through clinical wisdom but rarely supported by empirical evidence. The term "normal" is a misnomer since there is considerable heterogeneity in the care for young adults. Further methodological concerns include low participation rates of young peole who received the intervention in two of the studies. (Beautrais, (2010) & Hazell, (2009)

8   Trustworthiness

Based on literature, the validity and reliability of this thesis is a step forward as mental health researchers and professionals can use it in helping young adults from suicide and self-harm and create more options and coping strategies to the young adults who self-harm. (Burns et al, 2005) The validity of this paper is considered fair as the writer consulted and read many relevant articles, books and journals in the writing of the thesis. The writer strictly followed all the guidelines stipulated by the university in the use of articles found on the databases. The nursing interventions as a major topic herein was read and compiled from different sources and authors. The author was very keen in identifying the origin of the articles used and read. Studies from well know authors were identified and used in this paper. Studies that were occasionally referred by two or more articles were also considered. Journal and archives especially on psychiatry proved to be very meaningful to the author in a sense that the results and methodology could be compared and methods and ways of helping self-harm in young people identified.

9   Conclusion

Suicide and Self-harm is common among young adults as in the general population and causes distress and discomfort for them, family, friends and the society as a whole. Necessary service provision should be made available for its management and treatment. Health care professional must be educated well enough to cater for the rising number and cases of self-harm. The hospital management should be organized in a manner that necessary or rather further diagnosis are made by a mental health professional before discharge of a client. Follow up is advised as a way of showing care and encouragement to the client therefore reducing the chances of repeated self-harm. Careful attention should also be given to process evaluation to determine what hinders or helps the delivery of interventions in clinical settings. Addressing methodological limitations inherent in the study of interventions designed to prevent self-harm in young adults will facilitate better practice in the delivery of care in clinical settings.(Burns et al,2009).

Combination of pharmacological and therapeutic interventions is seen to be an appropriate measure only if medication is given during a dangerous situation. Therapeutic interventions should be carried out by trained personnel in order to achieve better treatment. However there maybe challenges to the self-harmers due to the limited number of trained psychologists and therapists. This is so depending on the location and the need or severity of one's problem. The literature highlights the significance of management and intervention of young people who self-harm and this is an important clinical area hence the need for the clinically valid research-based evidence. Indeed policy makers and public alike need a more clear understanding of self-harm in young people than ever before. (Anderson et al, 2004).

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Appendixes

Appendix 1. Database

Database:Cinahl Full text articles.Publication date 2002-2012

SEARCH WORDS	RESULTS
Self-harm	724
Deliberate self-harm	241
Self-identity	826
Self-mutilation	213
Self-injury	477
Suicide	5540
Teenage suicide	163
Para suicide	177
Young adults,sex	1
Young people	9903
Young adults,Drugs	48
Primary healthcare	5940
nurse	65454
Nursing care	12883
Nursing care plan	240
Nursing diagnosis	435
Nursing assessment	1493
Nursing ethics	1673
Evidenced based nursing	78
Public healthcare	460

Appendix 2. Search Results

Search Results From SAGE Journals

SEARCH WORDS	Results
Self-harm	1424
Deliberate self-harm	311
Self-identity	5107
Self-mutilation	470
Self-injury	728
Suicide	14230
Teenage suicide	30
Para suicide	15
Young adults,sex	2510
Young people	21124
Young adults,Drugs	4756
Primary healthcare	618
nurse	35142
Nursing care	4362
Nursing care plan	60
Nursing diagnosis	248
Nursing assessment	702
Nursing ethics	1784
Evidenced based nursing	11
Public healthcare	229

Appendix 3. Studies considered

Author(s)/Journal	Title and Year of Publication	Objective of the Research	Methodology Used	Place or setting of the Research	Summary of the Findings
Amy-Laura Emerson/ British Journal of Nursing, 2010, Vol 19, No 13	A brief insight into how nurses perceive patients who self-harm 2010	a basic introduction to selfharm, and recommendations for interventions that can mitigate the stigmatization of self-harmers entering the health system		Britain	- Self-harm is a heavily stigmatized condition in health care - Some nurses refuse to treat patients who self-harm, regarding them as time-wasting and attention-seeking, despite professional codes requiring equitable care - More education and training on self-harm is needed for health professionals to reduce negative attitudes
MURRAY B. L. & WRIGHT K./ *Journal of Psychiatric and Mental Health Nursing* **13**, 157–164	Integration of a suicide risk assessment and intervention approach: the perspective of youth 2006	This study was conducted to explore the experience of suicide risk assessment as described and perceived by adolescents and their families	Data were collected through the use of in-depth interviews with participants. Each participant was interviewed once for approximately 1 h. All interviews were audiotaped and transcribed.	Canada	Initially, the adolescents spoke of their fear, anxiety and shame after being referred for a suicide risk assessment. They also indicated the importance of a quick referral and immediate help to deal with their issues, and they indicated that it was important to have one therapist over a consistent period of time in order to establish a sense of trust within the client–therapist relationship
CUTCLIFFE J. R. & BARKER P. *Journal of Psychiatric and Mental Health Nursing* **11**, 393-400	The Nurses' Global Assessment of Suicide Risk (NGASR): developing a tool for clinical practice/Journal of Psychiatric and Mental Health Nursing 11, 393-400 2004	to provide a useful template for the nursing assessment of suicide risk	NGASR took the form of a simple scoring scale with 15 items, designed so that all the information necessary to score each of the predictor variables could be collected during the admission interview	Canada	By highlighting the predictor variables, which the P/MH nurse believes were specifically relevant to the client, and by totaling the variable scores, a single final score is achieved. This score represents a numerical estimation of the level of suicide risk and, with repeat ratings, provides an indication of changes in apparent risk of suicide, when supplemented by other data, such as informal observations and therapeutic interviews.