Self-harm may be common, and may help many people cope with unbearable distress, but it also carries substantial risks. Patients who present to hospital having self-harmed have been shown to have an elevated risk of subsequent suicide and risk is particularly high for those who repeat self-harm. Risk appears to be highest in the month (and year) immediately following hospital presentation. Children who self-harm are approximately nine times more likely to die from unnatural causes over a 15-year follow-up period. Approximately 0.6% of young people who self-harm go on to die by suicide, and this risk is greatest for males, older adolescents, and those who repeatedly self-harm.

Risk factors for suicide in those who present to hospital having self-harmed include male gender, increasing age and area-level socio-economic deprivation. Beyond these broad risk factors, there is little that helps clinicians distinguish those who eventually take their own lives from those who do not. Risk assessment instruments are now understood to have poor predictive ability. This may leave clinicians unsure how to approach the assessment and management of self-harm, and indeed anxious about a perceived responsibility to predict and prevent suicide. However, whilst a reduction in suicide risk is a theoretical goal of interventions for people who self-harm, there are other secondary goals such as reduction in associated distress, and a reduction in the risk of repetition.

A range of treatments for self-harm have been investigated, yet evidence for their effectiveness remains weak or uncertain due to the relatively small number of trials and the poor methodological quality of some of these studies.

Definition and implications

- Self-harm is defined in England as 'self-poisoning or self-injury irrespective of apparent motivation or medical seriousness' (NICE, 2011), or more briefly, a non-fatal act of self-destruction. The terms non-suicidal self-injury and non-fatal suicide attempt are increasingly being used to distinguish some degree of intent. Self-harm has replaced the older term parasuicide, and the term deliberate self-harm (DSH).

- The rate of self-harm in Europe is estimated to be 140/100,000 for men and 193/100,000 for women. Evaluating the effectiveness of interventions is complex due to the variety of different outcome measures that have been investigated, and questions over whether reduction in self-harm repetition is a positive outcome or not.

- In the UK, NICE has issued guidelines advising on managing the first 48 hours following presentation (NICE, 2004) and further guidelines on the longer term management of self-harm (NICE, 2011). In Republic of Ireland, the National Strategy for Action in Suicide Prevention has also made general recommendations.

- National suicide prevention strategies are in place for England, Northern Ireland, Wales and Scotland.
Psychosocial interventions for self-harm include: continuing contact (by letters, telephone calls, postcards), an emergency card system, manual-assisted cognitive-behaviour therapy, brief psychodynamic interpersonal therapy, dialectical behaviour therapy (DBT), psychoanalytical psychotherapy, intensive in-patient and community interventions, and therapeutic assessment of adolescents and young adults.

The range of approaches developed reflects the assumption that one blanket intervention is unlikely to have universal positive outcomes, and of the danger of treating all those who self-harm as a homogenous group.

In adults who self-harm, clinical trials suggest that CBT is of value in the wider population of those who present following self-harm and that DBT has value in the sub-set of those with personality disorder.

In children and adolescents who self-harm, clinical trials suggest that therapeutic assessment and DBT are likely to have value in the wider population of those who present following self-harm, and that mentalisation therapy has value in the subset of those with multiple episodes of self-harm.

Few therapies, with the exception of manualised cognitive-behavioural therapy and group therapy for adolescents, have been the subject of economic evaluation. Manualised cognitive-behavioural therapy was found to be significantly cheaper than treatment as usual.

The public health value of many of these interventions is open to question since those that are simple and easily-accessible are of limited efficacy and those that are most useful require training and are labour intensive.

NICE guidelines on the longer term management of self-harm (NICE, 2011) advise considering 3-12 sessions of a psychological intervention that is specifically structured for people who self-harm with the aim of reducing self-harm. Such an intervention should be tailored to individual need and could include cognitive behavioural, psychodynamic, or problem solving elements. Therapists should be trained and supervised in the therapy they are offering and be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.

Further reading


