The psychodynamics of self-harm*

ARTICLE

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SUMMARY

This article examines the complex phenomenon of self-harm, exploring its motivations, theoretical underpinnings and the intricate transference and countertransference reactions that arise in clinical settings. It aims to integrate psychiatric understanding with contemporary theories of the impact of trauma on both the body and the mind, to deepen the knowledge of self-harm and increase the effectiveness of treatment approaches. The article argues for a nuanced view of self-harm and emphasises the need for compassionate, well-informed care. By addressing the psychodynamics of self-harm, the article seeks to improve therapeutic outcomes and foster an empathetic and effective clinical response. Fictitious case studies are used to illustrate these concepts, demonstrating the critical role of early attachment experiences and the challenges faced by healthcare providers in management.

LEARNING OBJECTIVES

After reading this article you will be able to:

- understand the unconscious motivations behind self-harm
- demonstrate increased confidence in assessment, formulation and management for individuals presenting with self-harm
- demonstrate improved empathy and compassion for those presenting with self-harm.

KEYWORDS

Self-harm; psychotherapy; countertransference; complex post-traumatic stress disorder; borderline personality disorder.

> 'He remembered the sensation, the satisfying slam of his body against the wall, the awful pleasure of hurling himself against something so immovable […] he soon grew to appreciate the secrecy, the control of the cuts. […] When he did it, it was as if he was draining away the poison, the filth, the rage inside him.'
>
> (Yanagihara 2016: p. 196)

One of the greatest challenges in psychiatric work is engaging with self-harm. It is a symptom mental health professionals frequently encounter and are expected to understand – yet they often lack the time, space and training to fully reflect on its meaning or grasp its deeper implications. Self-harm, involving acts that cause pain, injury and scarring, can seem as perplexing as suicide. It starkly contrasts with the more socially acceptable and seemingly rational urges to protect and care for oneself. Yet, violence directed against the self is common. When an individual is in a disturbed and less rational state of mind, as described in the epigraph above, from the novel *A Little Life* (Yanagihara 2016), such actions can seem a reasonable outlet for distress.

If professionals do not take the time to think and understand, they can feel overwhelmed and, instead of turning towards the individual with compassion, they may turn away in disgust or contempt as a way of managing their own confusion. Some of the most shocking and perplexing experiences I have had as a psychiatrist are related to self-harm, at times leaving me horrified, distressed and deeply frightened.

Most self-harm occurs in the community, making accurate figures hard to establish, with 80–90% of individuals never coming to the attention of professionals (Madge 2008). Research shows that 10–25% of people in England report having self-harmed at least once, and self-harm is three times more common among women than men in the 16–24 age group. In recent years, there has been evidence of a three-fold increase in reported self-harm among young people, particularly women (National Institute for Health and Care Excellence 2023). The reason for this is unclear and the finding could represent a rise in incidents or an increase in reporting (Bould 2019; McManus 2019).

This article explores self-harm motivations, theoretical frameworks, challenges in management and approaches to treatment. By integrating an understanding of early trauma and deprivation, the aim is to enhance empathy, improve outcomes and provide more effective therapeutic support. Ultimately, the goal is to transform mental health professionals' feelings from confusion and fear – often perceived as hateful and potentially causing iatrogenic harm – into feelings that are compassionate, loving and therapeutic.

All case vignettes presented here are fictitious and represent composites of various experiences encountered in clinical practice.

Definition

The National Institute for Health and Care Excellence (NICE) has defined self-harm as

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'an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act, and [an] expression of emotional distress' (NICE 2023). The term 'self-harm' serves as a catch-all for a range of self-destructive behaviours that, even within a single individual, can have different meanings at different times. Historically, terms like 'deliberate' were used, but these are now avoided as they imply purposeful, rational determination and add to the stigma surrounding self-harm. In fact, self-harm is primarily driven by unconscious processes. It spans behaviours from non-suicidal self-injury (NSSI) to serious attempts to die by suicide, with ongoing debate about whether these categories represent distinct aetiologies (Griep 2022). It has been argued that separating them can dangerously underestimate suicidal risk (Kapur 2013; Hawton 2020).

Although acknowledging that separating these two groups is not feasible in practice, I believe that there is a significant difference between those with profound suicidal intent and those who engage in self-harm (NSSI) (Gibbons 2024). In this article I will focus on the latter. To summarise the difference: individuals with profound suicidal intent experience a decathexis (withdrawal of energy) from attachment relationships, which often leaves those bereaved unaware of the extent of the suicidality until after the death. In contrast, the aim of self-harm is not to extinguish life, and relationships with loved ones generally remain intact. However, it is agreed that the degree of dissociation needed to cross the body boundary to harm oneself is the strongest indicator of future death by suicide (Hawton 2015). The risk of suicide within 12 months after a presentation to services with self-harm is about 30 times higher than in the general population and nearly half of those who die by suicide have previously self-harmed (Kapur 2013); more violent methods increase the likelihood of a fatal attempt (Beckman 2018).

Interestingly, most self-harm occurs in individuals without diagnosed mental illness. For some, it is a brief, isolated response to stress; for others, it is a chronic behaviour tied to self-perception.

Types and methods

Self-harm encompasses a wide range of activities that often carry significant unconscious meaning for the individual involved. These different methods fall into several categories:

- habitual and less acutely dangerous: such as cutting, burning, asphyxiation, poisoning, head banging, inserting objects, bloodletting, swallowing harmful substances and objects, binge drinking and unprotected intercourse
- severe and bizarre: such as disembowelling, self-castration and auto-cannibalism
- clearly life-threatening: including overdosing, stabbing and ligatures.

Motivations

> 'Unexpressed emotions will never die. They are buried alive and will come forth later in uglier ways'
>
> (attributed to Sigmund Freud: www.sigmundfreud.net/quotes.jsp)

A variety of unconscious intentions have been theorised to underlie self-harm. For example, it has been seen as:

- a means of containing pain and communicating
- a means of containing traumatic memories
- a means of regulating overwhelming emotions and maintaining a sense of coherence
- a dysfunctional way of eliciting care
- serving the biological purpose of an addictive behaviour
- a means of providing protection for both the self and others
- a defence against intimacy.

Containing pain and communicating

Articulating feelings in words, or 'mentalising' (Bateman 2016), is complex. Emotions often begin as bodily (somatic) responses to events, which can be painful and frightening. Transforming these bodily experiences into mental representations using words requires symbolic transformation. For example, identifying a rapid heartbeat, tight chest and throat constriction as 'anxiety' helps make the emotion familiar and gives it a cognitive construct that can be stored in memory and expressed. When the symbolising of emotions is compromised (alexithymia), individuals can be overwhelmed by painful emotional bodily states. In such cases, self-harm, which localises the pain in a specific area, allows the individual to regain control and recognise the pain themselves and communicate it to others (Box 1).

Containing traumatic memories

Self-harm often occurs when individuals are overwhelmed by unresolved traumatic childhood memories. These 'original pains' (Bell 2001) can be triggered in the present by seemingly insignificant events. The existential pain from these memories is temporarily relieved through self-harm, which grounds the individual in the present and alleviates the numbness and dissociation that often accompany such memories. This process allows individuals to re-enact a past traumatic event – where they previously felt powerless and helpless – with a

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BOX 1 Case vignette: Self-harm as a means of containing pain and communicating

Alan was admitted to a psychiatric ward after presenting to an accident and emergency (A&E) department. He had taken a life-threatening overdose following an argument with his partner. He appeared composed and articulate, shocking the ward team during the first ward round by wearing a T-shirt that exposed bright red cuts and old scars interwoven up both arms.

In this case, Alan communicated his distress through self-harm, revealing how disconnected he was from his own emotional experience. These visible scars served as a stark warning to the staff, who, through their transference/countertransference, experienced the full force of his underlying disturbance. This prevented them from being misled by his seemingly self-possessed façade.

sense of subjective control in the present (van der Kolk 2014).

Regulating overwhelming emotions and maintaining coherence

Anna Motz argues that self-harm reflects a split and divided self (Motz 2010). When the ego is overwhelmed by anxiety, it fragments and splits into 'good' and 'bad'. The 'bad' is projected into the body, where it is attacked and punished for its aggressive feelings. Motz emphasises that nursing the wounds plays an important role in self-harm. She argues that, besides protecting the ego from disintegration, self-harm allows for a reunion where the attacking self becomes the caring, nursing self.

Eliciting care

Self-harm can be triggered by fears of abandonment or neglect in relationships. In such cases, the behaviour serves the function of eliciting care from others. When this dysfunctional method succeeds in extracting attention and reassurance not provided under other circumstances, it can lead to damaging spirals where the frequency and severity of self-harm increase.

Addictive behaviour

Recent literature suggests that repeated self-harm can be understood as an addictive behaviour, sharing features with addictions such as gambling and substance misuse. Self-harm is believed to release endogenous opioids and stimulate the dopamine reward pathway. This biological response helps explain why self-harm can become compulsive and entrenched, hindering the development of healthier communication methods (Blasco-Fontecilla 2016; Dimick 2023; Rodrigues 2023). Additionally, some authors note the masochistic excitement from self-inflicted cruelty, describing cases where there is 'a frenzy of self-harm not unlike sexual satisfaction' (Bell 2001).

Protection of both self and others

Some psychoanalysts suggest that self-harm reduces the intensity of violent or suicidal impulses. They view it as a manifestation of the defence mechanism 'anger turned against the self', which, when managed this way, prevents harm to others (Bell 2001; Scanlon 2009).

Defence against intimacy

Individuals who have been traumatised and/or abused may experience a terror of intimacy. Evidence of self-harm can serve to keep others at a distance, acting as a barrier to unwanted closeness.

Theoretical understanding

> 'Trauma results in a fundamental reorganisation of the way mind and brain manage perceptions. It changes not only how we think and what we think about, but also our very capacity to think.'
>
> (van der Kolk 2014: p. 21)

Neuroscience

During normal development, the left and right hemispheres of the brain mature at different rates and serve distinct functions. The right hemisphere, often considered the emotional side, is active from birth and processes emotional and sensory memories. In contrast, the left hemisphere, associated with rational thought and language, begins developing around the age of 3. This allows memories to be stored linguistically and organised in time, whereas earlier they are primarily stored as sensory experiences without mental representation (van der Kolk 2014). This explains why it is difficult to recall very early events.

In states of heightened anxiety, blood flow to the left hemisphere decreases as the brain prioritises survival, redirecting energy from higher-order cognitive functions to immediate threat response in the right hemisphere. This 'fight or flight' response impairs rational thinking, language processing and the organisation of experiences (van der Kolk 2014).

Research highlights the profound and lasting impact of early trauma on brain development, affecting neuronal, endocrine, immune and genetic systems, with epigenetic effects that may persist across generations. Trauma disrupts connectivity and communication between key brain regions, such as the amygdala, prefrontal cortex, hippocampus and striatum, which are central to emotion regulation. This disruption accelerates the development of adult-like brain networks during adolescence as a protective

mechanism, but at the cost of emotional flexibility (Dimick 2023; Laricchiuta 2023; Jiang 2019).

For individuals who have experienced early trauma, the emotional system responds to stimuli with greater speed and intensity. When 'triggered' by present events that echo past experiences, functioning shifts from the left (rational) brain to the right (emotional) brain, causing the individual to relive past trauma somatically, as if it were happening in the present. In these situations, self-harm can become a method to manage overwhelming pain (van der Kolk 2014).

Attachment theory

The quality of early childhood attachment is crucial for the capacity to mentalise and regulate emotions later in life. Language development depends on having an attuned caregiver who recognises and verbalises a child's emotional experiences. This containment helps develop emotional articulacy, which in turn aids in regulating emotions throughout life. Difficulties in this primary relationship can lead to an inability to verbalise feelings (alexithymia), often linked to insecure attachment. Research shows that 70–75% of those who self-harm have an insecure attachment style, compared with 15–20% of those who do not (Cicchetti 1987; Fung 2006; Adshead 2010; Silva Filho 2023).

Attachment system activation

For those with insecure attachment, minor events in the present can trigger emotionally dysregulated responses. These 'trigger' events elicit unconscious memories of past trauma and may be perceived as overly abandoning or rejecting. A delayed reply to an email or text can ignite an emotional fire, activating the attachment system. When stimulated, the attachment system generates a powerful drive to seek care and closeness to the primary attachment figure. As John Bowlby noted, 'at highest intensity, when distressed and anxious, nothing but a prolonged cuddle will do' (Bowlby 1969). This mechanism works well in securely attached individuals but less so in those with insecure attachment, where proximity can be sought to the source of maltreatment. In later life, clinging, controlling (perceived as manipulative) or panicked behaviour can re-enact the original trauma, perpetuating a vicious cycle (Box 2).

Mentalisation theory and 'the alien self'

Anthony Bateman and Peter Fonagy, pioneers of mentalisation-based treatment (MBT), describe how a lack of attunement and inaccurate mirroring in early caregiving lead to an 'internalisation of representations of the parents' state rather than a usable version of the child's own experience' (Bateman 2004: p. 88). They call this internalisation 'the alien self'. This 'alien self' is an incongruent aspect of the child's identity, projected onto them by their caregiver. It is experienced as part of the self but feels foreign, disrupting the sense of coherence. This coherence can only be restored by constantly and intensely projecting this alien self onto another, maintaining a fragile equilibrium. When the recipient of the projection is absent, the equilibrium breaks down and can only be restored by projecting this 'alien self' onto the body. This act occurs in the mode of 'psychic equivalence', meaning that symbolic capacity has broken down and the body is experienced as 'isomorphic with the alien parts of the self' (Bateman 2004). The hatred felt towards the abandoning attachment figure is then externalised and violence is enacted. Bateman & Fonagy note that the sense of despair stems not from the loss of the object, who was not a genuine attachment figure, but from the anticipated loss of self-cohesion (Bateman 2016) (Box 3).

BOX 2 Case vignette: Attachment system activation

Ellen had been seriously neglected as a child and was removed from her mother's care and placed with foster parents. She had a history of self-harm and had recently been referred to her local mental health team for depression. She met for the first time with her new keyworker, Claudia, who had little experience with self-harming behaviour. Claudia found Ellen appealing, and during this meeting, Ellen felt especially understood and cared for. Ellen found it very difficult to leave the appointment and go home to an empty flat.

In the days after the meeting, Ellen felt anxious and abandoned. She tried phoning Claudia to seek reassurance. When Claudia did not answer her calls, Ellen's emotions overwhelmed her. She cut her arms very deeply and sought care for these wounds at the accident & emergency (A&E) department. Claudia had thought that she had a good session with Ellen and was surprised to get a call from the mental health team in A&E. She felt confused, let down and angry. She did not want to talk to Ellen the next time she called and gradually withdrew from contact. Ellen felt rejected and abandoned, her self-harm increased, and she had a brief hospital admission.

In this case, Ellen's attachment system was activated by the intimacy with Claudia, leading to emotion dysregulation and self-harm. Claudia's difficulty in fully formulating the case left her ill-equipped to manage her own feelings of rejection and disappointment, leading her to withdraw.

Psychoanalytic theory

Contemporary psychoanalysts (Bell 2001; Campbell 2017) emphasise the role of the persecutory

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BOX 3 Case vignette: The alien self

George, a psychiatric nurse, was accompanying Amy on a home visit. They were on the bus. Amy was calm and chatty, and George wondered why she had been admitted to hospital. She was smiling and looked very relaxed. Suddenly, after receiving a text, she opened her mouth in a silent scream, grabbed the seat in front and shook herself back and forth. She then started scratching her wrists with her nails and gradually calmed down. This happened so quickly that George was shocked and frightened. Feeling unable to manage Amy alone, they returned to the hospital. He later learned the text was from Amy's boyfriend, informing her he could not visit that afternoon.

In this case, Amy received a trigger she perceived as abandoning and rejecting. Her equilibrium was lost, her alien self returned and she was emotionally overwhelmed by aggressive feelings. She then functioned in the mode of 'psychic equivalence' and was only able to re-establish some stability by projecting onto her body and becoming the recipient of her own aggression. The distress and shock projected into George felt overwhelming, causing him to lose confidence in managing Amy on the home visit.

superego, fragile ego and primitive defences in self-harm. They propose that childhood difficulties result in an inability to individuate and differentiate from the caregiver. This leads to an underdeveloped, barren internal world. The individual lacks the healthy internal objects that would follow successful separation. A primitive 'ego-destructive' superego dominates a vulnerable ego, inflating 'ordinary faults and failures, turning them into crimes that must be punished' (Bell 2001). There is 'psychic claustrophobia' and a terror of disintegration when left alone. Owing to the lack of psychic development, the only way to cope is through primitive defences, including projection, splitting and denial. The weak ego is divided, and the part identified with the hated, abandoning object is located in the body and attacked. The violence serves two functions: to punish the abandoning other and to provide self-punishment for the hatred and cruelty. A vicious circle occurs: more attacks lead to more guilt, requiring more punishment.

The role of the skin

Esther Bick (1968), a psychoanalyst who emphasised observing babies with their mothers as part of psychotherapeutic training, wrote a seminal paper on the importance of the skin as the physical and psychic container of the self. She described how problems with separation and individuation can be expressed through the skin. Bell (2001) emphasises that the skin itself may be felt concretely as the prison where the ego is trapped and tortured relentlessly by the persecutory superego (Box 4).

Challenges that complicate management

Enactment of the internal world in the care setting

The internal torturous experience that leads to self-harm can be projected into the outside world and enacted in the external environment. This is unfortunately still a common occurrence in psychiatric settings. Relationships between those who self-harm and their care providers can break down, leading to a decline in the mental health of all involved. This is more likely to happen in highly pressured environments where staff lack both a psychological model for their work and reflective spaces to process and think about their experiences (Box 5).

Bell (2001) offers the following helpful explanation:

> 'Such situations can result in a particularly deadly scenario. The patient recruits more and more people to become responsible for his own life. But the more individuals allow themselves to feel so responsible, the more the patient dissociates himself from the wish to live, now located in others. Further, as the patient becomes increasingly taken over by the cruel inner organisation, the sanity and concern now located in external others becomes the object of scorn and derision.'

Transference and countertransference reactions

Transference and countertransference refer to how early relationship templates are projected onto present relationships. This occurs very potently in

BOX 4 Case vignette: The role of the skin

Jessica was a successful lawyer. On weekends, she habitually harmed herself. She secretly 'blood let' using small tubes she inserted into her arms and then hid the blood. She was admitted to hospital after collapsing and was found to have low haemoglobin. During her admission, she disclosed this self-harm and was transferred to a psychiatric ward. She said that while working she felt fine, capable and on top of things, but on weekends, she felt abandoned, alone and terrified. She heard a voice she recognised as her own yet felt as 'other', telling her she was 'bad through and through' and 'deserved to die'. She felt hopeless. There was no escape, and self-harm was her only relief from this terrible experience.

In this case, Jessica's apparently bizarre behaviour can be understood with reference to the theory that the skin may be seen as both the physical and psychological container of the self. She felt imprisoned by her skin and tortured by her sadistic primitive superego. The only way to escape was by identifying her self with her blood, which she then furtively helped to escape by bloodletting.

BOX 5 Case vignette: Enactment of the internal world in the care setting

Chloe was admitted to an adolescent mental health unit after a shocking and unexpected overdose that nearly killed her. Her parents, struggling with anxiety, felt they could not trust her to stay alive. In the unit, Chloe would claim she was fine but would overdose when given some independence. As restrictions increased, so did her self-harming behaviour. Chloe started putting shoelaces and belts around her neck repeatedly. The exhausted team caring for her lost confidence in her improvement and focused solely on preventing self-harm, neglecting other patients. They became very frightened of Chloe, worrying about the consequences if she died and fearing they would be held responsible and punished. Chloe's level of observation and restriction increased until she was eventually transferred to a secure adult in-patient facility.

In this case there was an escalation and a re-enactment of Chloe's disturbed inner state.

care settings and can provide important information if understood, but can also be a dangerous barrier to effective treatment if not. Self-harm is an acting-out behaviour that powerfully communicates early experiences though projection that can stimulate strong transference and countertransference responses from staff.

These responses include:

- the promise of omnipotent mothering
- helplessness, confusion and uncertainty
- repulsion
- hatred
- frustration and anger
- pain and fear.

The promise of omnipotent mothering

> 'The diagnosis (personality disorder) describes an enmeshed clinical dyad in which at least the inner experience of both participants can begin to meet the criteria for the disorder.'
>
> (Vaillant 1992)

The projection of early infantile distress by those who self-harm communicates powerfully and primitively, reciprocally activating the attachment system of the mental health professional. This can elicit an idealised maternal response in the professional, increasing rather than decreasing distress, and obstructing a helpful, reality-based therapeutic intervention.

Helplessness, confusion and uncertainty

Self-harm communicates undigested distress without a clear indication of the cause or solution. Healthcare workers often want to feel effective, leading to a need to 'do' something to reduce their own helplessness. This can interfere with a reality-based therapeutic response and lead to inappropriate certainty about diagnosis and treatment.

Repulsion

Self-harm can project the individual's experience of undigested abusive boundary violations, such as in genital mutilation or very deep cutting, eliciting aversive responses in others.

Hatred

Self-harm generates confusion and helplessness, which in turn can be psychically organised into hatred. Denying the hatred in the transference and countertransference can lead to disavowed hostility and iatrogenic harm (Box 6).

Frustration and anger

Self-harm can communicate a complaint about care. Taking this personally is a mistake because it is not directed primarily at current care but is a historical grievance rooted in mistrust of the primary attachment figure (Scanlon 2009).

Pain and fear

Powerful identification can occur, with the projection of early separation anxiety, loss and fear of disintegration, leaving care professionals in psychic pain, anxious and distressed (Box 7).

The challenges of the day-to-day mental health environment

In recent years, the demand for mental health services has surged without a corresponding increase in resources. This has been compounded by severe workforce challenges and limited funding for developing treatments, despite evidence of their effectiveness (Nawaz 2021; McLean 2024). Additionally, there has been an intense focus on predicting and preventing suicide, driven by the fear of blame or persecution if someone harms themselves or dies (Gibbons 2023). These factors have significantly

BOX 6 Case vignette: Hatred in the transference and countertransference

When Dr F was the psychiatric doctor on call, he was frequently called to the A&E department to assess patients. The referring staff would often start with contemptuous remarks: 'Is that the on-call psychiatrist? We have PD [personality disorder] for you down here. One of yours'. He noted that frequently, patients presenting with self-harm were ignored while waiting and rarely treated with the same care as other patients deemed more deserving.

BOX 7 Case vignette: Pain and fear in the transference and countertransference

The community mental health team had been working with Gloria for a long time. She had seriously self-harmed early in their work with her. The team avoided acknowledging their fear that she would harm herself or die by suicide if they did something she didn't like. Gloria was not improving with the treatment, and the team felt despondent and disappointed, feeling they had failed. They decided they had no more to offer and blamed Gloria for not improving, thinking she 'didn't want to try' and was 'manipulative'. They planned to discharge her without informing her themselves, fearing her response. A new resident psychiatric doctor joined the team and was instructed to facilitate her discharge. When he informed her of the decision at the next out-patient meeting Gloria was overwhelmed, distressed and very angry. She ran out of the meeting, leaving the doctor upset and frightened. The team was later contacted by the local hospital liaison team, saying that Gloria had been admitted following a serious overdose.

In this case, there was a re-enactment of early abandonment trauma, triggering Gloria back into the emotional state and panic of childhood. She acted on this because the team could not admit to and process their complex countertransference and transference feelings.

increased the pressure within the mental health setting, making it very challenging to find the space to therapeutically engage with those in acute distress. Additionally, many mental health workers receive limited training on self-harm, leaving them exposed and inadequately prepared.

Recommended management

Management of self-harm varies depending on the underlying aetiology and care setting. Ideally, it should be guided by a detailed biopsychosocial assessment and holistic formulation (Royal College of Psychiatrists 2020; Hawton 2022; NICE 2022). However, mental health workers in acute care settings often have limited information when meeting someone for the first time. Regardless of the environment, early traumatic experiences are often relived, and without understanding the history, management means very little. When someone self-harms, they are in a right-brain mindset, where their capacity to symbolise and think clearly has broken down. They need time, space and compassionate care to regain their ability to mentalise and re-engage left-brain functioning.

Management principles

The following key principles are based on guidance published by the Royal College of Psychiatrists (2020) and NICE (2023).

Approach

Clinicians should approach individuals who self-harm in a compassionate, non-judgemental manner and collaborate with them. It is important to maintain professional boundaries and stay within the responsibilities of the clinical role. Working with individuals who self-harm can challenge these boundaries, and responsibility can easily become distorted. Early caregiving dynamics may trigger inappropriate or omnipotent responses. It should be remembered that responsibility cannot be taken for someone else's thoughts or behaviours. If someone expresses an intention to harm themselves, it is unlikely that this can be controlled or prevented through coercion. The key is to work with the person as an equal and responsible adult. The clinician's role is to provide containment, offer support to help the individual think through their distress, and plan for the future. The clinician should:

- avoid confrontation and consider themselves as a travelling companion trying to view the world from a similar vantage point; sometimes there may be a need to 'agree to disagree'
- be curious about the history and feelings driving the action
- recognise and validate the pain.

Assessment and formulation

A holistic biopsychosocial assessment should be carried out whenever possible. This includes exploring the individual's past and identifying any loss events that may be central to their distress (Gibbons 2023). Risk assessment should not be the primary focus of the assessment and risk assessment tools should not be used to predict future risk, as such tools are not able to do this (Chan 2016).

A case formulation should be developed (Gibbons 2021). This involves taking the time and space to understand the personal meaning of the self-harm for the individual at this specific point in thier life.

Supporting the individual to recognise and manage distress

Individuals should be supported to develop alternative ways to recognise and manage their distress. A safety plan can be a useful tool, but its true value lies in fostering deeper discussions and strengthening the therapeutic alliance.

Involving family and caregivers

It is important to communicate with and provide support and information to family members and/or carers. They should be involved in decision-making where appropriate. If the individual does

MCQ answers
1 b 2 c 3 e 4 c 5 b

BOX 8 Case vignette: Pressured decision-making

Dr M had just started his night shifts when the bed manager informed him that there were no available beds in the organisation. He felt overly responsible and did not want to exacerbate the bed pressures. He approached Ethan, who had self-harmed following an argument in his relationship, fearing that Ethan would request a hospital admission. To counter his anxiety Dr M immediately informed him that no beds were available. Ethan perceived this as a sign that he was unwanted, increasing his distress.

Dr M recognised that he had approached Ethan in an abrupt and unhelpful manner and offered an apology. Ethan responded well, allowing them to reflect together. Dr M expressed curiosity about Ethan's life experiences and his fear of abandonment in a relationship that had been going well until recently. They collaborated on a safety plan, and Ethan contacted his partner, who reassured him and supported his return home.

not want their family informed this should be explored, not accepted at face value.

Protecting mental health staff

In working with individuals who self-harm, mental health professionals should not make decisions in isolation. Although it may be tempting under pressure not to seek consultation, such decisions are often regretted later (Box 8).

It is also important to ensure regular, structured reflective spaces, including supervision and case discussion groups.

Conclusion

Those who have self-harmed need to be treated with compassion. This is not always easy because of the intense transference and countertransference responses that self-harm elicits as well as the pressures healthcare professionals may be under. Those who have recently self-harmed are in a vulnerable emotional state and can be particularly sensitive to accepting or rejecting responses from professionals. Meeting individuals who self-harm with an open heart requires an understanding of the nature of the act, thoughtful and containing team structures, a therapeutic model that includes reflective spaces, and compassionate, insightful leadership. When these conditions are met, clinicians approach those expressing their distress in this way with greater confidence and less fear and uncertainty, leading to a more reparative and therapeutic outcome.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

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MCQs

Select the best single option for each question stem

1 The primary goal of this article regarding the treatment of self-harm is to:
- a develop new, targeted medications
- b enhance understanding and empathy towards those who self harm
- c implement stricter regulations and monitoring of self-harm incidents
- d reduce overall healthcare costs through preventive measures
- e advocate for selective in-patient care for high-risk self-harming patients.

2 If someone with self-harm presents to services, compared with the general population, their risk of suicide in the year following the presentation:
- a is 2 times higher
- b is 10 times higher
- c is 30 times higher
- d is 100 times higher
- e is the same as for the general population.

3 Which of the following is not a motivation for self-harm?
- a communicating
- b regulating emotions
- c reducing risk of violence to self or others
- d a defence to intimacy
- e seeking social acceptance.

4 It is crucial to understand early trauma in individuals who self-harm because this understanding:
- a helps treatment adherence
- b helps in reducing long-term healthcare costs
- c aids in formulating effective management plans
- d prevents escalation of self-harm incidents
- e facilitates quicker patient discharge.

5 The recommended approach for clinicians when dealing with those who self-harm is to:
- a have a low threshold to challenge the behaviour
- b view the patient as an equal and responsible adult
- c try to acknowledge the self-harm as little as possible
- d do not explore underlying issues too deeply as it may cause distress
- e reassure the individual.