A GUIDE FOR FAMILY & LOVED ONES

# Understanding Self-Harm

Understanding what self-harm may communicate or regulate, responding without panic or shame, supporting safer coping and professional help, and protecting the wellbeing of loved ones too.

**Self-harm needs a calm, serious response**

Self-harm means intentionally harming oneself. It can occur for many reasons and is not automatically a suicide attempt, but self-harm and suicide risk can overlap. Every disclosure deserves compassionate attention, appropriate assessment and a clear plan for safety. Avoid assuming either 'they are only attention seeking' or 'they definitely want to die'. Ask, listen and seek professional help when needed.

## Why somebody may self-harm

Self-harm can serve different functions for different people. It may temporarily reduce unbearable emotional intensity, interrupt numbness or dissociation, express distress that feels impossible to put into words, punish the self, regain a sense of control, or communicate that coping has reached a limit. Understanding the function is more useful than judging the behaviour.

## The relief can make the behaviour repeat

If distress falls immediately after self-harm, the brain can learn that the behaviour 'works' in the short term. Shame, secrecy, physical consequences and family conflict may then increase distress later, creating another cycle. Recovery involves building other ways to survive the peak of an urge and addressing the difficulties underneath it.

## Self-harm is not one presentation

People may injure themselves in different ways, neglect wounds, interfere with healing or engage in other intentional self-injury. This family guide deliberately avoids procedural detail. The important questions are the person's current physical safety, emotional state, suicide risk, triggers, support and access to appropriate care.

## What it may feel like for them

A person may feel frightened by their own urges, ashamed of scars, desperate for somebody to notice, terrified that anybody will find out, or all of these at once. They may genuinely want to stop while also fearing the loss of the one coping strategy that has reliably changed how they feel.

## What it may feel like for you

Discovering self-harm can produce shock, fear, anger, guilt and an urgent need to make it stop immediately. Parents may wonder what they missed; partners may feel responsible for keeping the person alive; siblings may feel frightened or overlooked. These reactions are understandable, but the first conversation is safer when the supporter's panic does not become the person's additional burden.

## How to respond to a disclosure

Stay as calm as you can. Thank them for telling you. Ask what they need right now and whether any injury requires medical attention. You can say: 'I'm really glad you told me. I'm not angry with you. I want to understand what was happening for you and work out what support you need.'

## Do not demand promises

Statements such as 'Promise me you'll never do it again' may create secrecy if another episode occurs. A more useful commitment is to a safety plan: who they will contact, what helps delay an urge, when medical help is required and how professional support will be accessed.

## Ask about suicide directly

Asking about suicide does not put the idea into somebody's head. If you are concerned, ask clearly whether they are having thoughts of ending their life, whether they feel able to stay safe and whether they have taken steps towards acting on those thoughts. If there is immediate danger, call 999 or attend A&E.;

**Self-harm and suicide are not the same - but never ignore the overlap**

Some people self-harm without wanting to die. Some experience both self-harm and suicidal thoughts, and risk can change. Do not try to calculate risk from the appearance of an injury or from whether previous episodes were non-suicidal. New suicidal intent, inability to stay safe, severe injury, overdose or acute deterioration requires urgent professional assessment.

## What not to say

Avoid: 'How could you do this to us?', 'You're doing it for attention', 'That's disgusting', 'Other people have it worse', 'If you loved me you would stop', or threats to abandon the person unless they promise never to self-harm. Shame may increase secrecy without reducing the underlying distress.

## Attention is not a dirty word

If behaviour communicates a need for care, connection or recognition, the need still matters. The aim is to help the person communicate distress more directly and safely, not to punish them for needing somebody to notice.

## After an episode

Deal with immediate physical needs first. Medical advice may be required depending on the injury or any ingestion. Once the crisis has reduced, explore what happened before the urge, what the person noticed in their body and thoughts, what made things worse, what interrupted the episode and what could be added to the plan next time.

## Wound care and medical attention

Families should encourage appropriate first aid and medical assessment rather than trying to become wound-care specialists. Severe bleeding, deep or gaping wounds, loss of sensation or movement, burns, poisoning or overdose, signs of infection, head injury or any other concerning injury needs appropriate medical advice. Call 999 for life-threatening emergencies.

## Privacy versus secrecy

Respect matters, but confidentiality has limits when safety is at stake. With children and young people, involve appropriate adults and professionals according to safeguarding needs. With adults, avoid unnecessarily broadcasting private information, while being clear that immediate danger cannot be kept secret.

## Triggers and patterns

Possible triggers include conflict, rejection, shame, trauma reminders, sensory overload, loneliness, bullying, academic or work pressure, relationship breakdown, body distress, dissociation or feeling emotionally numb. Sometimes the person cannot identify a trigger. A pattern can still emerge by tracking context without interrogating them.

## Urges rise and fall

An urge can feel permanent while it is happening. A useful goal is often to create time between urge and action. This may include moving to a safer environment, contacting somebody, grounding, paced breathing, sensory regulation, writing, music, movement or another personalised strategy. What helps should be developed with the person rather than imposed as a generic list.

## Distraction is not the whole treatment

Distraction can help someone survive a peak, but longer-term recovery usually needs work on the emotions, trauma, relationships, beliefs or circumstances driving self-harm. A person should not be told they have failed because a distraction technique did not remove an intense urge.

## Removing means and safety planning

Reducing access to items or substances associated with serious risk may be part of a collaborative safety plan, particularly during acute crises. This should be proportionate and ideally informed by professionals. Turning a home into a punitive search environment can increase secrecy; the goal is safety, not humiliation.

## Online content and contagion

Graphic images, competitive discussion of injuries or detailed methods can intensify urges. Encourage safer online spaces and consider muting triggering content. At the same time, supportive communities can reduce isolation. The question is whether the content moves the person towards safety and recovery or towards escalation.

**A helpful response to an urge**

Try: **'You do not have to solve everything tonight. What would help you get through the next ten minutes safely? Do we need professional help, or can we use your safety plan together?'** Small periods of safety can be joined together.

## Professional assessment and treatment

Assessment should explore the self-harm, physical injuries, suicidal thoughts, mental health, relationships, trauma, substance use, neurodevelopmental needs, safeguarding, strengths and support network. NICE recommends psychosocial assessment after self-harm rather than relying on simplistic risk scales to predict future suicide or decide access to treatment.

## Psychological support

Treatment is individualised. Depending on age and needs, it may include cognitive behavioural, problem-solving, emotion-regulation, trauma-informed or other psychological approaches. For some people, dialectical behaviour therapy skills are relevant. The aim is not only stopping a behaviour but improving the person's ability to manage distress and build a life that requires it less.

## Medication

There is no medication that simply 'treats self-harm'. Medication may be prescribed for underlying or co-occurring mental-health conditions. Any overdose risk should be discussed with the prescriber so medicines can be supplied and stored safely where appropriate.

## Recovery and setbacks

Recovery may include fewer episodes, less severe harm, longer delays, earlier disclosure of urges, using support before a crisis, improved wound care, reduced shame and greater ability to name emotions. A recurrence does not erase previous progress. Review what changed and strengthen the plan.

## School, college and work

Self-harm can affect concentration, attendance and confidence. A trusted staff member, wellbeing plan, agreed time-out space or adjustments may help. Avoid forcing the person to disclose scars or personal details to people who do not need to know.

## Scars and body autonomy

Do not demand that scars be shown or hidden for other people's comfort. The person may have complicated feelings about them. Medical advice may be appropriate for scar care, but emotionally the focus should be dignity, choice and reducing shame.

## Children and young people

Parents may feel compelled to monitor constantly. Young people need both safety and developmentally appropriate privacy. Work with professionals on what supervision is necessary, how bedrooms or bathrooms are managed during high-risk periods, and how to keep the relationship from becoming only surveillance.

## When urgent help is needed

Call 999 or attend A&E; when there is immediate danger to life, serious injury, significant overdose or poisoning, loss of consciousness, severe bleeding, or the person has suicidal intent and cannot remain safe. NHS 111 can advise on urgent health needs. For emotional crisis support, Samaritans is available on 116 123.

**The recovery goal**

The aim is not to force somebody to hide self-harm more effectively. It is to create enough safety, trust and alternative coping that they can **tell somebody earlier, survive the urge, receive treatment and gradually need self-harm less**.

## Safeguarding yourself as the supporter

Supporting self-harm can make loved ones hypervigilant. You may listen outside doors, check sleeves, monitor bathrooms, fear every unanswered message or wake during the night to make sure the person is alive. Living in permanent emergency mode is not sustainable.

## You cannot provide 24-hour risk management alone

A partner, parent or friend cannot be the entire crisis service. Ask clinicians who to contact out of hours, what signs require urgent assessment and what the family should do if the person refuses help. Write this down before the next crisis.

## Support versus rescue

Support means listening, helping use the safety plan, encouraging treatment and responding to genuine risk. Rescue means believing you must prevent every difficult feeling, remain constantly available or accept responsibility for whether the person self-harms. You can influence safety; you cannot control another person's every action.

## Boundaries

Examples include: 'I will listen and help you contact support, but I cannot stay awake every night.' 'I won't keep suicidal intent secret.' 'I can sit with you while the urge passes, but I cannot be the only person you contact.' 'I care about you, and threats or violence towards me are not acceptable.'

## When self-harm appears during conflict

If a person mentions self-harm or suicide during an argument, take the safety content seriously without surrendering every boundary. Pause the dispute, assess immediate safety and involve professional help when needed. Once safe, the original relationship issue can be revisited. Risk must not become the only way difficult conversations are resolved.

## Guilt and blame

Families often search for the moment they 'caused' the behaviour. Relationships and environments matter, and harmful situations should be addressed, but self-harm is usually more complex than one person's mistake. Productive responsibility asks what can change now rather than using blame to explain everything.

## Siblings and children in the household

Do not make children responsible for watching the person. Give age-appropriate explanations without graphic detail. Preserve routines and individual attention. If there is risk of children witnessing severe injury, dangerous behaviour or violence, seek safeguarding advice.

## Your own nervous system

After a crisis you may shake, cry, become angry or feel numb. Your body has also been through an emergency. Debrief with an appropriate adult or professional, sleep when you can, eat, step outside and return to your own routines. Supporters may need therapy or carers' support themselves.

## Eight practical coaching tools

**1. Urge map.** What happened before the urge? What emotions, thoughts and body sensations appeared? What did self-harm promise to change? What happened afterwards?

**2. Ten-minute safety card.** Where can I go? Who can I contact? What grounding or sensory action helps? What reason can I give myself to wait ten minutes? When do I escalate to urgent help?

**3. Personal safety plan.** Warning signs, internal coping, safe people and places, professional contacts, urgent services, environmental safety and reasons for staying alive. Develop collaboratively and review after crises.

**4. Communication menu.** The person chooses phrases that are easier than explaining everything: 'I'm having urges', 'I need company', 'I need quiet', 'Please help me contact someone', or a pre-agreed code word.

**5. After-episode review.** What helped? What increased shame? Was medical care adequate? Was suicide risk checked? What can change before the next high-risk period? Keep it curious rather than punitive.

**6. Supporter boundary plan.** What I can offer / what I cannot safely offer / who shares responsibility / when I call professionals / what I need after a crisis.

**7. Reasons-for-life map.** People, animals, values, future experiences, responsibilities, places and tiny everyday reasons to continue. It should belong to the person, not become a guilt list.

**8. Recovery evidence.** Track asking earlier, delaying urges, using another coping response, accepting treatment, fewer injuries, repairing relationships and reconnecting with ordinary life.

## Common myths

**'It is attention seeking.'** Distress and need for connection deserve care. **'Talking about suicide causes suicide.'** Direct, calm questions can support assessment. **'If they wanted help they would stop.'** Ambivalence is common. **'A small injury means low risk.'** Physical severity alone does not determine suicide risk. **'Families must watch them every second.'** Safety requires a wider professional plan, not one exhausted person.

## Recommended reading

**Understanding and Responding to Self-Harm** - Allan House, a clinically informed introduction. **Helping Teens Who Cut** - Michael Hollander, particularly relevant to parents of adolescents. **The Dialectical Behavior Therapy Skills Workbook** - Matthew McKay, Jeffrey C. Wood and Jeffrey Brantley, a skills resource that may complement professional treatment for some people.

## UK resources and clinical sources

Useful UK starting points include NHS information on self-harm, NICE guideline NG225 on self-harm: assessment, management and preventing recurrence, GP and local mental-health services, YoungMinds for young people and families, and Samaritans. For immediate danger call 999 or attend A&E; NHS 111 can advise on urgent health needs.

### Clinical note

This guide is educational and is not a substitute for medical treatment, psychosocial assessment or an individual safety plan. Self-harm methods and injuries vary, and families should not attempt to judge suicide risk using wound appearance, frequency or a numerical risk score. Serious injury, poisoning or overdose requires appropriate medical assessment.

## A message from Maggie

*When somebody you love self-harms, fear can take over very quickly. You may want to remove every risk, ask a hundred questions and make them promise that it will never happen again. That response comes from caring, but fear can sometimes make the person feel watched rather than understood.*

*Try to hear what sits underneath the behaviour. Self-harm may be the way somebody has learned to survive an emotion, numbness or experience they do not yet know how to carry differently. We do not have to approve of the behaviour to understand why letting it go can feel frightening.*

*You can be calm and still take it seriously. You can say, 'I am here. We need to make sure you are safe. We will get help with this.' You can ask directly about suicide. You can involve professionals. You can hold boundaries. None of those things cancels out warmth.*

*And please remember that you cannot become somebody's entire safety system. Loving them does not mean never sleeping, never leaving the house or believing that one wrong sentence makes you responsible for what happens next. A good safety net has more than one strand: the person, family, professionals, crisis services and a plan.*

*Recovery can be quiet. It may begin with telling you about an urge before acting, waiting ten minutes, accepting help, choosing another response once, or allowing somebody to see the pain without hiding it. Those moments matter. Keep making room for the person beyond the crisis, and make room for yourself too.*

**Maggie Learoyd**
**Space to Breathe Therapy**

### Final reflection

Can the family move from asking only **'How do we stop this happening?'** towards also asking **'What is the self-harm helping them survive, what safer support can meet that need, and who supports us while we support them?'**