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Self-Harm Among Rural Australian Adolescents: A Literature Review

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Abstract

This review examines the current literature regarding self-harm among rural Australian adolescents. The objective was to determine the vulnerabilities and impacts of self-harm among adolescents in rural Australian communities and explore potential treatment interventions. Twenty-five papers were selected from approximately 438 abstracts. Limited data were found reflecting self-harm, specifically among adolescents residing in rural communities, indicating that further research is needed. The literature revealed that the prevalence of self-harm among adolescents in general ranges from 4-18% and is almost

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proposed intervention offers a 16-week DBT program, alongside a psychoeducational workshop for parents, delivered within a school setting. It also recommends mental health promotion within rural communities and schools.
Self-Harm Among Rural Australian Adolescents: A Literature Review

Adolescent self-harm (ASH) is a significant health concern in Australia (Guerreiro et al., 2013). Prevalence rates range from 4-18% among the general adolescent population with many of these individuals later attempting suicide (Freeman et al., 2016). This review explores self-harm among adolescents residing in rural Australia, where the prevalence of self-harm and suicide is almost double than urban Australia (AIHW, 2014). This review explores the literature regarding ASH in rural communities, including prevalence, risk factors, consequences and needs of this group. It further explores evidence-based treatment interventions that may be effective in supporting youth resorting to self-harm. A comprehensive approach, incorporating group DBT and family psychoeducation, implemented within rural schools, is predicted to be a viable intervention for self-harming among rural Australian adolescents.

**Definitions**

Self-harm refers to deliberate damage to one’s own body, without intent of dying,

This review refers to experiences of self-harm in the context of adolescents, specifically aged 13-18, residing in rural areas of Australia. ‘Rural’ refers to individuals living in regional and remote geographical locations, both of which can be included in the loose definition of ‘rural’ (Kõlves et al., 2012). The review explores the literature within this context.
Database Search

A literature review was undertaken to examine self-harm among rural Australian adolescents. Twenty-five papers were selected from approximately 438 abstracts using EBSCO Host, Google Scholar and internet searches. Articles were chosen on the basis that they were; reliable research, relevant to the rural Australian context, referred to adolescents and published in the last decade. Search criteria included: ‘Self-harm in adolescents in rural Australia’; ‘Rural adolescent mental health’, ‘Self-harm in rural areas Australia AND adolescents’ and ‘DBT for self-harm’. Self-harm’ was also searched among E-book databases which yielded two suitable results. This literature was reviewed by the author, resulting in the selection of those appearing in this paper.

Review of the Literature on Self-Harm

Prevalence

Prevalence rates for self-harm among adolescents vary from 4% within the general population to 60–80% among hospital inpatients (De Kloet et al., 2011). Numerous studies

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Self-harm data are much more limited for those in rural communities. In rural areas, the prevalence is documented to be higher than the general population, increasing with remoteness (NRHA, 2017). The National Rural Health Association (NRHA) undertook studies, in 2009 and 2017, which showed that in a one-year period there were 191 hospital admissions in regional areas and 231 in remote areas following self-harm, as compared to
125 in major cities. This suggests that rates of self-harm are almost twice as likely in rural adolescent populations as compared to the general population.

**Risk-Factors**

There are a multitude of risk-factors documented to predispose adolescents to self-harm. Most notably, psychopathology has been found to be highly predictive of self-harm. Studies suggest that at least 87% of adolescents who self-harm have coinciding diagnoses including depression, post-traumatic stress and personality disorders (De Kloet et al., 2011; Freeman et al., 2016; Guerreiro et al., 2013; Hawton et al., 2009; Madge et al., 2011; Ougrin et al., 2012). Furthermore, previous suicidal behaviour is one of the most significant predictive factors for self-harm (Shaffer & Pfeffer, 2001, as cited in, Guerreiro et al., 2013). This suggests that adolescents are resorting to self-harm due to enduring immense psychological burden.

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common concerns for adolescents (De Kloet et al., 2011; Hawton et al., 2009). Many studies have linked parental criticism, unresponsiveness, lacking support and rejection with self-harm, which is frequently preceded by parental conflict (Scott, Diamond & Levy, 2016). Again, this suggests adolescents may be lacking support and developing more supportive family relationships may be a protective factor for self-harm. Scott et al. (2016) suggested that family involvement in treatment would support positive outcomes by addressing this risk-factor.
In rural areas, specific risk-factors affect young people including, unemployment, reduce availability of support. It is evident there are a combination of factors that may predispose adolescents to self-harm including, psychological disorders, personal characteristics, family difficulties, as well as additional factors affecting rural communities.

**Social and Psychological Impacts**

There are significant and detrimental consequences for ASH. The most serious implication highlighted across the literature was the increased risk of suicide, with at least 70% of adolescents who had self-harmed having also attempted suicide (De Kloet et al., 2011; Freeman et al., 2016; Guerreiro et al., 2013; Hawton et al., 2009; Ougrin et al., 2012). In fact, Bennardi et al. (2016) highlighted that repeated self-harm is the strongest suicide risk-factor. Considering rural communities, where adolescent suicide occurs almost twice as often than in urban areas (NRHA, 2017), addressing self-harm may also reduce suicide prevalence.

**Needs**

Various needs have been identified for rural ASH arising from the risk-factors and impacts. These include addressing poor emotion regulation skills, difficult family relationships and barriers to utilising treatment services. Freeman et al. (2016) highlighted that developing effective coping strategies and emotion-regulation skills is needed for adolescents. An appropriate intervention should include such skill development.
Research suggests that adolescents more commonly seek support from family and friends as opposed to mental health professionals (Hernan et al., 2010; Rughani, Deane & Wilson, 2011). This preference was also observed by Ougrin (2012), who asserted that wider systems, such as school and family, play important roles in addressing ASH. The notion that family and peers are a preferred support system for adolescents and family difficulties can be a risk-factor for ASH, involving them in treatment interventions could enhance benefits.

The barriers affecting treatment utilisation among rural youth such as stigma, poor mental health literacy (Boyd et al., 2007) and insufficient access to mental health services (AIHW, 2014; NRHA, 2009) require attention. Findings suggest that increasing mental health literacy and understanding of the benefits of seeking help may increase the use of services (Rughani et al., 2011). It would therefore be important to ensure that intervention strategies seek to mitigate these barriers by de-stigmatising mental health, providing accessible services and improving mental health literacy.

While these issues require attention, another factor is that limited literature exists regarding self-harm among rural adolescents and no interventions have been established as entirely effective for adolescents (Ougrin et al., 2012; Scott et al., 2016). Therefore, more research is required among this population to find effective treatments.

**Review of Interventions**

The evidence suggests various interventions that would be potentially effective in addressing self-harm. Trials of DBT and family therapies are yet to determine results among adolescent populations, however, have been found effective among adults (Ougrin, 2012). DBT is the recommended treatment for adults engaging in self-harm and has been widely
the specific needs of adolescents, DBT programs for young people differ from standard adult approaches. Despite this, Muehlenkamp (2006) highlights that adapted versions of DBT with adolescents have been trialled (as cited in, Freeman et al., 2016).

DBT has a variety of components. Interventions may include, individual psychotherapy and group skills training (Linehan, 1993, as cited in, Freeman et al., 2016). Core components include teaching emotion regulation, interpersonal skills, distress tolerance and mindfulness (Rathus and Miller 2002, as cited in Freeman et al., 2016; James et al., 2008). Adolescent adaptations of DBT, as recommended by Miller, Rathus and Linehan (2007) for the development of coping skills among adolescents, while the additional components in adolescent versions attend to familial risk factors associated with self-harm.

While there is growing evidence to support DBT as a viable intervention for ASH, some challenges need to be addressed (Freeman et al., 2016). These include; the need for consistency across studies in defining self-harm, treatment length and measures, incorporation of all DBT treatment components tailored for adolescents and longitudinal studies to determine efficacy long-term (Freeman et al., 2016). This suggests further clinical trials should be undertaken using consistent methods to determine efficacy among rural adolescents.
al., 2008). There are various avenues for achieving this such as, group psychoeducation for parents and family therapy to improve relationships (James et al., 2008; Scott et al., 2016). De Kloet et al. (2011) validates the importance of parental involvement in treatment due to family difficulties being a risk-factor for self-harm. Parents are increasingly included in treatments to target family dynamics linked to risk and protection from self-harm and increasing family cohesion (Diamond et al., 2014, as cited in, Scott et al., 2016). The evidence suggests that family involvement in the treatment of ASH has the potential to improve outcomes and addresses this risk-factor for ASH.

In terms of implementation within a rural setting, other factors would need to be taken into consideration to address barriers to help-seeking. Boyd et al., (2007); Hawton et al. (2009); Fortune et al. (2008) assert that for adolescents, access to help is primarily school-based and Hawton et al. (2009); Hernan et al. (2010) suggest that school-based initiatives may offer the most potential for this population. Hernan et al. (2010) further suggest that health promotion strategies should promote school-based interventions utilising family involvement for adolescents. Therefore, a viable treatment intervention for self-harm, specifically adapted to adolescents residing in rural communities should incorporate DBT with family involvement, delivery within a school setting and health promotion initiatives in order to address the identified needs of this group.

**Proposed Intervention**

A recommended intervention program that is evidence-based, and addresses the needs of rural adolescents who self-harm, would be most effective. Growing evidence suggests DBT is a promising intervention for ASH (Freeman et al., 2016). The proposed intervention
The DBT program would be adapted for adolescents. In addition to the inclusion of core components of DBT, the intervention would also include improving communication between adolescents and their parents, skills training for parents, 16-week treatment length and age appropriate materials (Miller, Rathus & Linehan, 2007, as cited in, Freeman et al., 2016). Furthermore, Boyd et al., (2007); Hawton et al. (2009); Hernan et al. (2010); Francis et al. (2006); Tormoen et al. (2013) suggest the delivery of ASH interventions should be school-based for enhanced effectiveness. These elements would be implemented to support the additional needs of adolescents.

Additionally, family involvement is recommended as being predictive of enhanced increasing family cohesion (Scott et al., 2016). Incorporating family and school involvement within the intervention is likely to support treatment outcomes.

While no specific intervention has proven effectiveness for treating rural ASH, by incorporating elements the literature suggests as effective for this population, there is increased potential for positive outcomes.

### Conclusion

The aims of this review were to examine the literature regarding ASH within rural Australia. As this population has not been extensively studied, much of the data refer to Australian adolescents in general. However, some key considerations were identified for this population, including prevalence of self-harm being almost double, coupled with various barriers to treatment utilisation. The identified needs for this group included; development of
incorporate family involvement and be delivered within school-based settings to increase potential for benefit among this population. The proposed intervention offers a 16-week DBT program, alongside a psychoeducational workshop for parents, delivered within a school setting. It also recommends mental health promotion within rural communities and schools. In delivering an evidence-based and comprehensive intervention, self-harm may be addressed more effectively among these vulnerable Australians, as well as contribute to the existing literature.
References


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