CHAPTER 9

Specific problems in adolescence

9.1 Introduction

Case 9.1

Sixteen-year-old Abra's mother came to see a health professional saying she was worried about her son and that she could not sleep and was off her food. She said she could not concentrate on her office job; she was getting told off by her boss, who said she was making too many mistakes. She said that Abra had given up going to school, and did not have a job. He was smoking and drinking. She thought he was seeing a girl who was 'no good'. He always came home late at night and sometimes did not come home at night at all. She had no idea where he was. Then he would lie in bed in the morning saying he was too tired to get up. If she asked him to do some shopping, he snapped at her and told her he was not 'her slave'. His father gave him money, which was how he could afford the cigarettes and alcohol. She herself had attended a convent school with nuns as teachers and had been kept at home by strict parents in her teenage years and this was what she wanted to do with Abra, but it was impossible. She went to mass regularly, but Abra never came. Her husband said Abra was just a normal adolescent. Abra had never been very good at schoolwork and had often been in trouble at school, which he had left when he was 14. She felt the school had been quite pleased when Abra stopped attending. He had never been in trouble for breaking the law. What should the health professional do?

9.1.1 Information about adolescent problems

In most high-income countries, adolescence is defined as the period between puberty and adulthood, from about 13 to 19. In these countries it is often thought 'normal' for young people of this age to rebel against their parents and other authority figures and to become involved in risky behaviour such as drinking alcohol, smoking, taking drugs and engaging in sexual promiscuity. Other features thought to be normal in adolescence are irritability and mood swings. There are two relatively new features of normal adolescence seen in different countries and cultures.

1. Many young people, especially those in continuing education, are financially dependent on their parents not just during their teenage years, but into their mid-20s or even longer.
2. Spending of large amounts of time participating in various forms of social networking.

A child from a high-income country is more likely to experience adolescence as described above, as families are able to manage financially without their child's contribution. However, in families that depend on their children going to work at a young age (e.g. going to work

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in the fields), children may move from childhood to young adulthood without a phase of life in between.

A 'Western' type of adolescence is also absent in societies in which there are strong religious beliefs prohibiting the use of alcohol and early sexual experience. In such societies there is often a culture of early marriage, especially for girls, so that there is only a very short period between the onset of menstruation and marriage.

The physical changes of puberty occur during the teenage years (sometimes beginning even earlier). The behavioural and emotional changes often associated with adolescence vary greatly between societies. It is important for health professionals to be aware of the features of adolescence in the societies in which they work.

In most countries the rate of mental health problems is about the same in adolescence as it is in childhood and adult life. There are, however, some changes that begin to occur during this time.

- While before adolescence boys and girls experience emotional problems equally, during this period girls are more frequently affected.
- Certain serious mental illnesses such as schizophrenia and bipolar disorder (see Sections 11.1 and 11.2) are rare before adolescence but begin to occur more frequently during this time.
- Similarly, self-harm is unusual before adolescence but then begins to become more common.
- Where a Western type of adolescence exists, the roots of addiction to alcohol, tobacco and illicit drugs are often laid down at this time.

Because of the false idea that adolescence is necessarily a time of great emotional turbulence, some serious mental health problems may be regarded as normal and not considered significant. Teenagers who are disabled by emotional or behaviour problems are in just as great a need of attention to their mental health as in any other phase of life. It is sometimes said that teenagers resist the idea of attending healthcare clinics. Some certainly do, but the rate of adolescent attendance at health clinics is about the same as with older age groups.

As a result of the spread of Western culture, especially through the media, a Western type of adolescence as described earlier is now regarded as normal in many more parts of the world. This is particularly the case in urban areas in LAMI countries that are experiencing increasing prosperity.

Although the freedom, opportunities for exploration and enjoyment of the Western lifestyle of adolescence clearly have positive aspects, there are two major negative features.

1. Patterns of behaviour laid down during adolescence may be a major disadvantage later on. For example, it may be difficult later on for teenagers to accept the routine and self-discipline necessary to hold down a job in contemporary society.
2. The parents of teenagers who are living a rebellious, turbulent adolescence may themselves suffer mental health problems as a reaction.

9.1.2 Finding out about mental health problems in adolescence

The health professional needs to be aware of the various 'normal' ways in which teenagers behave in the society in which she is working. Note that in many societies where it is assumed that teenagers will be drinking or smoking heavily, on drugs, out of school, moody and rebellious to their parents, the majority may be leading lives nothing like this. They may be generally obedient and working hard at school, although they are very likely to be spending a considerable amount of time in social networking.

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The same criteria should be used in deciding whether a young person has a mental health problem as at any other age. The first question to be asked is whether they are distressed or disabled in their daily lives by emotional and behaviour problems (see Section 3.1). The second question is what sort of problem do they have and how can they be helped. The approach should depend on the nature of the problem, as described in other sections of this book. 'Adolescent disorder' is not, in itself, a diagnosis.

Where a young person in their teenage years is showing a mental health problem, it is often difficult to encourage them to attend a clinic for assessment. In large cities there may be drop-in centres to which adolescents can refer themselves.

If young people do attend but are reluctant to say what is on their mind, it may be helpful just to get them to talk about their lives and how they see the future if they go on as they are. Most young people of this age prefer to be listened to and talked to as one would with an older adult. It is not a good idea to pretend to be familiar with teenage culture or to act as 'one of the boys/girls'.

When teenagers are living turbulent lives, it is often the parents who are suffering, with their adolescent children either quite happy with their lives or unwilling to ask for help. In these cases it may be the parents who attend a clinic, often with an emotional problem such as depression and/or anxiety. In exploring the reasons for their emotional state it becomes clear that a 'difficult' teenager is the focus of their concerns. Assessment of a mental health problem in a teenager may require finding out information from a parent who may, himself, need advice and counselling.

With younger adolescents it will always be a good idea to have a discussion with one of the child's teachers to find out how the young person is getting on at school.

9.1.3 Helping adolescents with mental health problems

If the young person is affected in everyday life by a mental health problem, the first challenge is to help him to accept that he does require help of some sort. The first step is to discuss with him what he feels is the matter and how he thinks he might be helped. This discussion will often make it clear what can be done. Often the young person feels that people other than himself are responsible for what is happening. The health professional can agree to discuss this issue to start with as an opportunity to negotiate for later follow-up visits.

Where the young person is not seeking help but one or both parents is seriously depressed or anxious about the matter, counselling should be provided for the parents.

Now make a list of the ways in which the health professional might be able to help Abra.

9.2 Sexual development

Case 9.2

Mandara is a 4-year-old girl brought to the clinic by her very anxious mother because she has caught Mandara playing a 'sex game' with a boy of the same age who lives next door. The two of them were half undressed, with their underwear off, in a field at the back of their dwellings looking at each other's genital areas when a passer-by saw them, brought them back to their homes and told their mothers very angrily what he had seen. Mandara's mother did not know what to do. There was nothing 'sexual' going on in the home. She and her husband were very careful not to walk about undressed in the home. She whispered to the health professional that when she and her husband 'had relations', which they hardly ever did, they always made sure the children were fast asleep. There were no other problems. What should the health professional do?

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9.2.1 *Information about sexual development*

Sexual drive, the tendency to seek pleasure from stimulation of the genitalia, is present from birth, although there is a marked increase in this drive during adolescence. Before puberty, sexual drive varies greatly. It mainly shows itself by:

- sexual curiosity – boys and girls noticing the physical appearance of adults when naked and examining each other's genitalia
- masturbation or self-stimulation of the genitalia (penis and clitoris) to produce pleasurable sensations.

Both of these are normal activities.

Before puberty, children develop in their sexual thoughts and ideas in three main ways.

1. Gender identity. Thinking of oneself as boy or girl, male or female. By 2–3 years, most children have a strong sense of identity and this nearly always remains stable. A very small number of boys and girls have a gender identity which is the opposite of their anatomical gender: normal-looking girls have the fixed idea they are boys and vice versa.
2. Gender role behaviour. In most, but not all, societies, before puberty, boys and girls behave in different ways. For example, boys usually play with boys and girls with girls. Boys tend to be more physically adventurous and girls more interested in playing with dolls and in domestic activities. However, there are considerable differences between cultures in how important these differences are thought to be. It is not uncommon for girls to be tomboys and boys to be effeminate.
3. Sexual orientation. This refers to a child's preference for the same or opposite gender when achieving sexual arousal, especially in masturbation. By the beginning of adolescence sexual orientation is usually well established.

The first visible signs of puberty in girls (e.g. breast changes) usually occur between 8 and 13 years and a couple of years later in boys (e.g. pubic hair growth). In countries with poorer nutritional levels, these changes occur later, sometimes as much as 4 years later than stated. In general, pubertal changes from childhood to mature adulthood usually take around 5 years, but there is great variation both within societies and between societies in the ages at which puberty occurs.

Masturbation in adolescence is normal, although it is often condemned by adults. Many adolescents feel extremely guilty about masturbation because they have been brought up to believe it is harmful and wrong. It is, in fact, harmless.

The age when sexual behaviour between boys and girls or men and women normally occurs varies greatly between societies. Similarly, the frequency of sexual behaviour before marriage varies greatly: in some societies it is very common; in others it is very infrequent. In some societies where it is common, often girls in their early and mid-teens become pregnant, sometimes as a result of unprotected sexual intercourse, especially under the influence of alcohol. Pregnancy during adolescence has a number of marked disadvantages both for the young mother and for the baby: birth complications are more common, the mother may not be sufficiently mature to look after her child and her education may be irreversibly interrupted. Sexually transmitted diseases are relatively common in adolescents in some societies.

A small number of boys and girls discover during their early teenage years (or even earlier) that their sexual preference is for individuals of the same gender. Sometimes they do not have a marked sexual preference for one or other gender: they are bisexual. In both cases, sexual preference may change again during adolescence.

Often, young people will feel the need to keep their sexual orientation a secret if it does not conform to their family's or culture's beliefs. Young people with homosexual or bisexual

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preferences may come to the attention of health professionals because they are depressed or have even been involved in self-harming behaviour. Note that whatever the attitude to homosexuality in the society in which the health professional is working, he should not make moral judgements herself about whether such behaviour is right or wrong. She should provide whatever helps she can in an understanding way. Remember there are no interventions that can change someone's sexual preference.

In many societies, especially those most influenced by Western media, there is a widespread view of the way adolescents 'naturally' behave. In fact, although the physical changes of puberty and adolescence occur everywhere, the existence of a teenage way of life varies greatly from society to society. Whether adolescents enter into a teenage way of life depends more on the lifestyle of the friends they mix with than on the stage of physical puberty they have reached.

9.2.2 Finding out more about sexual problems

Sexual abuse is discussed in Section 14.4 and not in this section.

When a child is brought to the clinic with a problem concerned with sexual development, it is important that the health professional has a clear view of the range of normal sexual behaviour in the society in which she works. All the same, it is always relevant to enquire:

- What exactly is the sexual problem about which the parent or perhaps the adolescent is worried about?
- When did it begin and how often does it occur?
- Does the child feel guilt or distress about the problem, whatever it is?
- Why have they come now, at this point in time, to ask about the problem?
- What effect do they think will occur as a result of the problem?
- Do they think this problem is widespread among other boys and/or girls or do they think it is unusual?
- Is there any possibility that the child/adolescent is being sexually abused or is abusing others? Is there any sign of bruising or other trauma in the genital area? (Do not examine unless there are grounds for suspicion.)
- Has the parent/adolescent noticed any sign of a sexually transmitted disease, for example is there a discharge from the penis or vagina, or any lesion in this area? (Do not examine unless there are grounds for suspicion.)
- In the case of an adolescent girl, is she sexually active? If so, is she engaging in unprotected sex?
- Generally, what are the attitudes to sex and sexual behaviour in the family? Is sex something that is talked about from time to time, hardly ever, or never?

In areas where HIV/AIDS is prevalent, it may be appropriate, after explaining the implications and obtaining consent, to refer the child for a blood test (see Section 12.8).

Now, given the information you have obtained, try to understand how this particular child has developed a sexual problem. Then go on to work out a plan to help.

9.2.3 Helping children and adolescents with sexual problems

Management of suspected sexual abuse is dealt with in Section 14.4.

Any positive results of tests for sexually transmitted disease, including HIV/AIDS, will require treatment as laid down in local protocols (see Section 12.8).

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For most other reasons for referral for a sexual problem, the health professional will be able to reassure the parent/child that the behaviour in question is quite normal. When providing reassurance, health professionals should:

- take care to use very simple language, using words for penis and clitoris that the child/parent will understand
- make sure they do not mock or humiliate the parent/child because they have not understood that the problem is part of normal behaviour
- provide additional information about sex and sexual behaviour that might otherwise be neglected; the opportunity for sex education, including contraceptive advice, should not be missed
- in the case of a pregnant girl, ensure as good antenatal care as possible; work out how the girl can be supported by her family during the pregnancy and after birth
- make sure the parent/child feels they can return to the health professional for advice on the problem, especially if they do not feel reassured.

Now make a list of the ways in which the health professional might be able to help Mandara and her mother.

9.3 Self-starvation (anorexia nervosa)

Case 9.3

Ekta is a 15-year-old girl brought to the clinic by her parents because she will not eat and is losing weight. She was a slightly plump girl until about a year ago when, in the company of two other girls at school, she went on a diet. One of the other girls failed to start the diet and the other lost a few pounds and then went off the diet and put all the weight that she had lost back on. But Ekta just carried on dieting. Her parents, who to begin with were quite pleased that she had gone on a diet, began to get worried when her periods stopped. They took her to a clinic thinking that maybe she had a serious physical problem but the doctor could not find anything wrong with her and told them not to worry. She was a normal, healthy girl. But the dieting continued and now she looks terribly thin. Her parents do not know how much she has lost but clearly it is a considerable amount. She has also started to exercise every day to lose even more weight. Now her parents and her older sister get angry with her when she refuses to eat her meals, but it makes no difference. Ekta is a very bright, conscientious girl who has always been at the top of the class. Everyone likes her because she is so helpful to other people, for example, visiting her sick grandmother every day to make sure she is all right. The health professional cannot find anything physically wrong with her except that she is very thin and has rather low blood pressure. She weighs 35 kg, very little for a girl who is 5′ 6″ (168 cm) tall. What can the health professional do?

9.3.1 Information about self-starvation (anorexia nervosa)

The problem begins most commonly in the mid-teens, but can begin before puberty. It used to be very rare in LAMI countries; however, with increasing exposure to television

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programmes and advertisements in which the ideal shape for a girl is extremely thin, the problem is becoming more common in these countries. It is ten times more common in girls than in boys, and girls are often high achievers, unusually conscientious, kind and helpful. Self-starvation usually occurs in older girls in their late teens or early 20s. It often responds well to CBT (see p. 7).

In anorexia or self-starvation, the onset of menstrual periods is delayed or, if they have started, periods stop when the girl has lost a significant amount of weight.

Girls who self-starve often see themselves as fat and ugly even though they are not. This gives them the drive to lose weight. They refuse to eat, saying they are not hungry. To lose more weight they often vomit food they have just eaten and exercise excessively, and/or use laxatives to cause diarrhoea. They may have episodes of binge eating when they consume too much food. Binge eating or bulimia nervosa may occur in the absence of anorexia nervosa.

The cause of self-starvation is usually unknown, but:

- the problem is exacerbated in societies exposed to Western media, with its emphasis on the thin ideal
- there may be a genetic predisposition in affected girls
- there may be a particularly vulnerable personality type: stubborn, obsessional and self-sacrificing
- there may be fears about growing into adulthood regarding bodily changes and increased independence
- communication within the family about feelings may be limited
- there may be serious conflict between the parents.

Associated depression and anxiety are common, and constipation often arises as a result of the small food and liquid intake. With or without treatment, although about half of girls recover, the problem may become chronic with lifelong concern about diet and thinness. A very small proportion of girls die as a result of self-starvation or suicide.

9.3.2 Finding out more about girls who are self-starving

Take a careful account from both the parents and the girl separately. Find out especially:

- When did the problem begin?
- What triggered it?
- Who is present at meal times?
- Is there any binge eating?
- Is there any vomiting after meals or use of laxatives?
- What approach are the parents taking when their daughter will not eat: are they angry and pressurising or accepting and passive?
- How much exercise is the girl taking?
- What has happened to menstruation?
- Is the girl depressed? Is it possible that food refusal arises from depression or is it probably the other way round?
- Are there any delusional ideas suggestive of schizophrenia?
- What sort of personality did the girl have before the problem began: obsessional, perfectionist?
- How do the parents get on?

It is important to find out how the girl feels about her appearance. You can ask questions such as ‘How do you feel about the way you look?’, ‘What weight would you ideally like to be?’ and ‘How do you feel about the portions of food your mum puts on your plate?’ It is important not to be judgemental even if the girl’s answers reflect gross distortions.

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Ask how the girl feels about her adolescent development, for example 'How do you feel about growing into a woman?' A history of sexual abuse may be relevant in some cases.

In addition, carry out a full physical examination. The most important part of this is establishing an accurate height and weight. It is preferable for the girl to wear simple plain clothing and ensure that she is not hiding heavy weights inside her clothing to disguise how little she weighs. You will need a chart to establish just how much below the expected weight for her height she is. Less than 85% of the expected weight is a matter for concern (see WHO growth charts, www.who.int/childgrowth/standards/en/).

Also, is there any dehydration? Very occasionally, self-starvation may be due to endocrine disorders such as hyperthyroidism, hypopituitarism, malabsorption syndromes or a brain tumour.

Now, given the information you have obtained, try to understand how this particular girl has become involved in a pattern of self-starvation. Then go on to work out a plan to help.

9.3.3 Helping children and young people who are starving themselves

If the girl is dehydrated (look for dry, inelastic skin) and has a very low blood pressure (less than 80/50 mmHg), she is at risk of dying. If this is the case she needs admission to hospital for intravenous fluids or nasal tube feeding, compulsorily if she refuses. If this is not possible, then she needs treatment at home and given drinks of water or nutritious broths until she is reasonably well hydrated.

Girls need to be told that they have a very serious condition and may die if they carry on dieting. In girls under 18, the best result is likely if parents are involved and are encouraged to be firm about eating. She should be given frequent, small meals, perhaps four to six times a day. The aim should be to put on 1.5–2.0 kg (3–4 lbs) a week until she is at least 90% of the expected body weight. More rapid weight gain than this is undesirable, as too rapid a gain is likely to be followed by an equally rapid loss. In fact, weight gain is often disappointingly slow.

The girl should be kept in the home initially. When she puts on weight she should be allowed a little more activity. It is unwise to tell girls that they are looking better when they put on weight. They often perceive this as being told they are fat and ugly. At the same time as there is this emphasis on putting on weight, the girl should, if possible, have the opportunity to talk about her fears, especially those of growing up.

Parents also need help to keep the problem in perspective. They should try to be firm even if their daughter becomes angry with them. They will probably need support from the health professional if they are to succeed in this. Once the girl has put on sufficient weight and her periods have started or re-started, there is such a high rate of relapse that the health professional will need to check on progress from time to time.

When there are significant family conflicts or relationship difficulties, and in cases where this is maintaining the symptoms, family intervention is an important component of the treatment programme.

Now make a list of the ways in which the health professional might be able to help Ekta.

9.4 Self-harm

Case 9.4

A 15-year-old girl rushed into a health clinic in a rural area to ask the health professional to come to her home straight away. She thought her father had swallowed some liquid and was dying. The health professional rushed to the small

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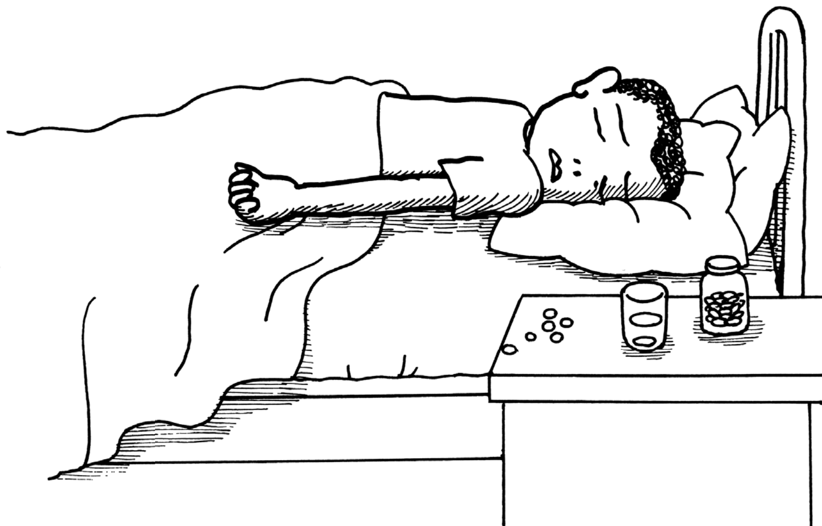
farm where the family lived but the man was beyond help. He had killed himself by swallowing a large quantity of liquid pesticide that had been left lying around. The girl told the health professional that she was supposed to be married this year. Her father had offered a good bride price but when the harvest failed he had to tell his daughter that it would not be possible for him to find the money and she could not be married. She had set her heart on marrying the boy with whom a marriage had been arranged. Her father was deeply upset he had not been able to meet the cost. He was very fond of his daughter. Now the girl said she blamed herself and felt like killing herself. What can the health professional do?

Case 9.5

Daniel was a 14-year-old boy who was brought half-conscious by his father to a health clinic in a shanty area of a large city. The father said that the previous evening he had had an argument with his son about staying out late and not going to school regularly. He thought Daniel was being bullied at school and that this was the reason why he sometimes did not go, but his father thought his son ought to be able to stand up for himself against the bullies and had not accepted this as an excuse. This morning he had discovered that Daniel was deeply asleep and there was a half-empty bottle of paracetamol beside him. He had thrown cold water over him and eventually Daniel had woken up and admitted to having swallowed 15 of the tablets because he wanted to die. What can the health professional do?



9.4.1 Information about self-harm

In many LAMI countries, suicide is an important cause of death in adolescents. The methods used depend on what is available. In rural areas, pesticides and poisonous domestic products are commonly employed. In urban areas, overdosing on tablets is increasingly used. Hanging occurs in both settings. Boys and girls are equally at risk of suicide.

Tablets are also most commonly used in non-fatal self-harming acts. Cutting or self-mutilation is another means of self-harming. Girls outnumber boys in self-harming that is non-fatal. The circumstances of both fatal and non-fatal self-harm are very variable. It may arise as:

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- a sign of a chronic depressive disorder
- an impulsive, angry act arising from frustration, often in a young person with a history of aggressive behaviour
- a means of obtaining attention in a young person who feels neglected and unwanted
- a response to intolerable stress.

All suicidal thoughts and actions in children/adolescents should be taken seriously. They are usually a communication of desperation and a sign of limited problem-solving skills. If a child/adolescent has expressed suicidal thoughts, appraise the risk of a suicidal attempt. This will be greater if:

- the child has thought out how they would end their life
- they have actually taken steps to do this, such as getting a gun or buying poison or tablets
- they have marked depressive symptoms with distorted thinking
- they have shown violent, aggressive behaviour
- they have made a previous attempt.

In a young person who has self-harmed, the risk of repeated self-harm is greater if:

- the problem triggering the event has been present for more than a month
- the young person was alone in the house when he self-harmed
- the overdose was planned beforehand and was not an impulsive act
- the young person is still feeling hopeless about the future
- the young person was feeling sad for most of the time before the overdose
- measures were taken to avoid discovery
- a suicide note was left behind
- no attempt was made to obtain help after the suicidal act
- a violent or dangerous method was used.

Because of the risk of recurrence, all children/adolescents who have made a suicide attempt should be carefully assessed.

All children/adolescents with active suicidal thoughts or behaviour or who have recently made a suicide attempt should be carefully supervised by members of their family or friends. If the suicidal risk is serious, they should not be left alone at any time. At the same time, active steps should be taken to reduce the stress that has led to the self-harming behaviour.

9.4.2 Assessing children and adolescents who are at risk of self-harm or who have harmed themselves

The following approach can be used with children who are thought to be at risk of self-harm. If possible, they should be seen separately from their parents. After setting them at ease by talking about neutral subjects, you might go on to ask: 'What sort of things do you like doing with your friends? Do you still enjoy those things? What is it you've been most upset about recently?', and not 'Have you been upset about anything recently?', as this allows them to avoid talking about painful subjects.

'Do you sometimes think that people don't like you very much?', 'What makes you think that?'

'Do you feel you've done something bad?', 'What might that be?'

'How do you feel about the future?', 'Do you feel hopeless about what is going to happen to you?'

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This may lead to questions probing suicidal thoughts and actions. These need to follow a progression moving from slight to serious suicidality:

'Have you felt at any time recently that really life isn't worth living?'

If answered positively: 'Do you mean that you have felt that you would be better off dead?'

If answered positively: 'Have you even thought of taking your own life?'

If answered positively: 'Have you even tried to take your own life?'

Again, if positive: 'When was that?', 'What did you do?', 'What happened?', 'Do you feel as bad as that now?'

The following questions might be used with children or adolescents who have recently self-harmed:

'You've obviously been feeling very upset recently. Please could you let me know what has been happening?'

'What was in your mind when you took the tablets?'

To help you decide what to do, you need to find out as much as you can about:

- whether the young person had emotional or behavioural problems before the attempt
- if so, whether these are still present
- how she gets on with other family members
- whether she has friends that can be confided in.

By asking the above questions you can find out whether the young person still has suicidal ideas.

In these circumstances, in order to make sense of the situation and decide on the risk of a further attempt, it is always necessary to see another family member. As well as finding out more about the information the young person has provided, it will be necessary to check on the amount of supervision it will be possible for the family to provide if suicidal ideas persist. If possible, talking to a friend and getting information from school would be helpful.

Now, using the information you have obtained from the young person and the family member(s) you have seen, try to understand what has happened and decide what is the best course of action.

9.4.3 Helping young people who have harmed themselves or attempted to do so

Once you have decided on the risk of self-harm, you need to discuss with the family how family members can protect the young person until the risk has reduced. Try to work out ways to reduce the stresses on the young person that have triggered the attempt or might trigger an attempt in the future. This may well involve contacting the school to talk to the young person's teacher.

Using the guidelines in other sections, try to treat any behaviour or emotional problems from which the young person is suffering. If possible, try to improve the communication in the family so that if the young person feels desperate again, he can talk about what is on his mind rather than communicating by self-harming.

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Make it clear to the young person that you would be happy to see him if he is feeling desperate at any time in the future. Talk to family members about the importance of keeping safe all possible means of self-harm, such as pesticides, poisonous domestic products, firearms and dangerous medication.

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