Deliberate self-harm

Introduction

- The terms *deliberate self-poisoning, parasuicide* and *deliberate self-harm* were introduced to describe episodes of intentional self harm that did not lead to death and may or may not have been motivated by a desire to die.
- DSH is defined as 'a non-fatal act in which an individual deliberately causes self-injury or ingests a substance in excess of any prescribed or generally recognized dosage. The Royal College of Psychiatrists encourages the use of the term *self-harm,* and *non-suicidal self-injury (NSSI)* has also been proposed.

The act of deliberate self-harm

- **Methods of deliberate self-poisoning**
- In the UK, about 90% of the cases of DSH that are referred to general hospitals involve a drug overdose, and most of them present no serious threat to life. The type of drug used varies somewhat with age, local prescription practices, and the availability of drugs. The most commonly used drugs are the non-opiate analgesics, such as paracetamol and aspirin. Paracetamol is particularly dangerous because it damages the liver and may lead to the delayed death of patients who had not intended to die. It is particularly worrying that younger patients, who are usually unaware of these serious risks, often take this drug. Antidepressants (both tricyclics and SSRIs) are taken in aboutm25% of episodes. About 50% of people consume alcohol in the 6 hours before the act.

- **Methods of deliberate self-injury**
- Deliberate self-injury accounts for about 10% of all DSH presenting to general hospitals in the UK. The commonest method of self-injury is laceration, usually cutting of the forearms or wrists; it accounts for about 80% of the self-injuries that are referred to a general hospital.

The epidemiology of deliberate self-harm

- DSH is more common among younger people, with the rates declining sharply in middle age. Over recent years, the proportion of men presenting following DSH has risen. In the 1960s and 1970s the female-to-male ratio was about 2:1, whereas recent studies show much smaller differences. The peak age for men is older than that for women. For both sexes, rates are very low under the age of 12 years. DSH is more prevalent in those of lower socioeconomic status and who live in more deprived areas. There are also differences in relation to marital status. The highest rates for both men and women are among the divorced, and high rates are also found among teenage wives, and younger single men and women.

Causes of deliberate self-harm

- **Precipitating factors**
- Compared with the general population, people who harm themselves deliberately have experienced four times as many *stressful life problems* in the 6 months before the act.
- **Predisposing factors**
- *-Familial and developmental factors* may predispose to DSH. There is some evidence that early parental loss through bereavement, or a history of parental neglect or abuse, is more frequent in people who harm themselves.
- *-Personality disorder.* In the UK personality disorder is identified in almost 50% of DSH patients. Borderline personality disorder has been reported to be common.
- *-Long-term problems with partner.*
- *-Economic and social environment.* Rates of DSH are higher among the unemployed.
- *-Ill health.* A background of poor physical health is common.

- **Psychiatric disorder**
- psychiatric disorder has been detected in about 90% of DSH patients who are seen in hospital.
- Depressive disorder is the most frequent diagnosis in both sexes, followed by alcohol and drug abuse in men, and anxiety disorders in women. Comorbidity is frequent.

Motivation and deliberate self-harm

- The motives for DSH are usually mixed and often difficult to identify with certainty. Even when patients know their own motives, they may try to hide them from other people. For example, people who have taken an overdose in response to feelings of frustration and anger may feel ashamed and say instead that they wished to die. Conversely, people who truly intended to kill themselves may deny it.

- **Reasons given for deliberate self-harm**
- To die
- To escape from unbearable unguish
- To change the behavior of others
- To escape from a situation
- To show desperation for others
- To get back at others / make them feel guilty
- To get help

The outcome of deliberate self-harm

- **Repetition of self-harm**
- In the weeks after DSH, many patients report changes for the better. Those with psychiatric symptoms often report that they have become less intense. This improvement may result from help provided by professionals, or from improvements in the person's relationships, attitudes, and behaviour. Some people do not improve and harm

themselves again, in some cases fatally.

- **Suicide following deliberate self-harm**
- People who have intentionally harmed themselves have a much increased risk of later suicide.

- between 1 in 200 and 1 in 40 commit suicide within1 year

about 1 in 15 commits suicide within 9 years or more

Factors that suggest high suicidal intent

Act carried out in isolation
Act timed so that intervention is unlikely
Precautions taken to avoid discovery
Preparations made in anticipation of death (e.g. making a will, organizing insurance)
Preparations made for the act (e.g. purchasing the means of suicide, saving up tablets)
Communicating intent to others beforehand
Extensive premeditation
Leaving a note
Not alerting potential helpers after the act
Admission of suicidal intent

The management of deliberate self-harm

The assessment of patients after deliberate self-harm

General aim:

:Assessment is concerned with three main issues

1. the immediate risks of suicide 2. the subsequent risks of further DSH 3. current medical or social problems.

Specific enquiries The interview should address five questions. 1. What were the patient's intentions when they harmed themselves? 2. Do they now intend to die? 3.what are ?their current problems

4. Is there a psychiatric disorder?

5. What helpfull resources are available?

- **Management after the assessment**
- Around 5-10% of DSH patients require admission to a psychiatric unit; most need treatment for depression or alcoholism, and a few for schizophrenia. Some need a period of respite from overwhelming stress.
- Plans should he discussed with the patient, and if they are not agreed, an alternative plan that is mutually acceptable should be negotiated.

Patients' needs fall into three groups:
1.a small minority need admission to a psychiatric unit for treatment
2. about one-third have a psychiatric disorder that requires treatment in primary care, or from a psychiatric team in the community
3. the remainder need help with various psychosocial problems, and assistance with improving their ways of coping with stressors. This help is needed even when the risk of immediate suicide or non-fatal repetition is low, as continuing problems increase the risk of later repetition. Apart from practical help, problem solving is usually the best approach, starting with the problems identified during the assessment interview. Unfortunately, such help is often refused.