Deliberate Self Harm, Causes, Management and Management of Risk

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This paper explores the various issues with regard to self-harm behaviour, the various risk factors involved and the management of the behaviour and the management of risk.

Deliberate Self-Harm (DSH): A deliberate non-fatal act, whether physical, drug overdose or poisoning, done in the knowledge that it was potentially harmful and in the case of overdose, that the amount taken was excessive. (Morgan 1979).

Management
There are no specific management techniques for self-mutilation per se, and indeed focusing on the act may heighten its importance and may worsen the situation or increase the frequency of self-harm (Hawton and Catalon 1987)

Socio-demographic risk factors

Suicide	**DSH**
Male	Female
Increases with age	Usually less than 25 years
Unemployed	Unemployed or non-attendance at school
Single / Divorced	Single / Divorced
Lower social class	Lower social class
Economically deprived, debts	Significant debts

Clinical Risk Factors

SUICIDE	**DSH**
Previous suicidal behaviour	Previous deliberate self-harm
Family history of suicide	Family history of psychiatric illness
Evidence of mental Illness, especially depression or schizophrenia	Psychiatric illness in the young person especially personality disorder or PTSD
Alcohol/Substance misuse	Alcohol/Substance misuse
Serious Physical illness e.g. debilitating or terminal	Recent physical illness; admission to hospital
Cognitive dysfunction especially apathy, anger, hopelessness	Cognitive dysfunction
Significant life event e.g. bereavement	History of care and/or sexual abuse

Factors commonly linked to suicide and DSH in young people

- family dysfunction
- relationship problems
- drug & alcohol abuse
- physical and sexualabuse
- custody – yoi/prisons
- personal knowledge of dsh/suicide victim

Myths about DSH

“self injury is a sign of madness or deep mental disturbance”.
“people who self injure are trying to kill themselves”.
“people who injure themselves are a danger to others”.
“self injury is about attention seeking”.
“self injury is used to manipulate others”.
“self injury is just a habit to be stopped”.
“people who self injure enjoy or do not feel physical pain”.

Reasons for Acts of Self-Harm

- to end life
- expression of psychological state
- externalising pain
- self punishment/guilt
- learned defence mechanism
- release of tension
- response to psychotic stimuli
- wanting someone to care
- control
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Some of the Functions of DSH Identified by Young People

- getting rid of unwanted, distressing feelings and emotions.
- focusing on transferring emotional pain onto a physical, more manageable and tangible “thing”
- not having to think about painful (and preoccupying) memories, thoughts and worries.
- providing relief from and release of distress.
- getting out of a difficult situation for a while.
- creating a situation of comfort and security, like a “haven in a heartless world”.

Methods of DSH

- drug overdose
- laceration/foreign body insertion
- self asphyxiation
- jumping in front of vehicles
- self immolation/burning
- falls/jumping from high places
- substance abuse
- eating disorders
- promiscuous behaviour
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Management

1. Assessment
2. Problem Solving

- clarify the problems to be tackled
- establish goals – realistic and specific
- how to attain goals – small steps
- agree what the young person has to do as “homework”

- review progress – explore difficulties

3. Preventative measures
- explore alternative approaches
- enhance coping skills

4. "Staying with" the young person and preparation for termination

Risk Assessment Should be Able to Answer the Following

- what makes the person harm themselves?
- do they want to die when they commit the act of self-harm?
- have they felt this way before?
- have they had any previous help with self injurious behaviour?
- do they still feel like harming themselves?
- do they want help?

Risks are Increased When:

- Systematic assessment of risk not carried out.
- Risk indicators denied or minimised by responsible professionals
- Information not passed from one professional to another
- Clinical responsibility not clearly defined or transferred inappropriately
- Inadequate community support (includes family and friends as well as community-based services).
- Carers unaware of services available locally
- Provision of resources inadequate (includes inpatient beds and access to secure beds)
- Management has failed to introduce a risk strategy appropriate to local circumstances. Includes policies and procedures for clinical risk assessment and management; induction training for new staff and continuous training for established staff; serious incident review; and clinical audit.

Treatments

- individual therapy
- cognitive/behavioural therapy
- counselling
- group therapy
- non-verbal therapies

Liaison with:

a) family
b) social services
c) education
d) health – occasional use of prescribed drugs

Therapy Guidelines

1. Making and Maintaining a Relationship
- stay calm
- empathic listening
- try to perceive self wounding as an expression of feeling
- attempt to understand self harm by working together

- avoid threats or promises
- stick to limits agreed in care plans
- if possible leave responsibility with the young person
- “stay with” the adolescent
- don’t expect too much too soon
- agree with the patient the aims of their treatment

2. Breaking the Habit, if appropriate

- support the adolescent if withdrawal symptoms occur
- assist with learning new ways of coping
- work together on increasing motivation to change

3. Maintaining Change

- reward new behaviour
- minimise medicalisation
- work with the young person to resolve emotional conflicts
- bring psychological or behavioural games out into the open
- individual and/or group therapy

Providing Care for People who Self-Harm

- consistency of approach to assessment and treatment for the multidisciplinary team
- adequate clinical supervision and reflective practice
- multidisciplinary support
- accepting failure
- adequate knowledge base regarding self injury and continual updating
- empowering the people who self injure
- destigmatising self injury
- professionals to act to change the perception of self injury

Lack of Faith in Hospital Care

- young people’s perceptions:
- feeling that they were being lectured or told off
- being patronised
- not having their wishes respected
- being put on a mixed sex ward
- not having a choice of seeing a nurse of the same sex
- being given drugs/being restrained
- feeling processed “like a number”
- being threatened e.g. “stomach pump”
- not being given the time and space to talk

What Young People Want

A crisis service which provides respect and acceptance, medical care where necessary, counselling if wanted, in a setting which has both safe/quiet rooms and rage/anger rooms.

Such a service should be easily available and accessible 24 hours a day. It should be flexible, confidential, non-compulsory and staffed by non-clinical personnel who are deemed to be "aware".

What Can You Do to Help?

- listen
- don't be critical
- go for a walk together
- do any exercise with them
- listen to music
- watch tv
- encourage writing or drawing about feelings
- suggest keeping a diary to help to identify triggers to dsh
- boosting self-esteem, give verbal praise, encourage positive thinking and set achievable goals
- recommend alternative strategies e.g. biting lemons, crushing ice cubes, punching pillows and "safe" cutting
- plan daily activities e.g. education, self-care; also concentrate on normal sleep patterns

Conclusions

Management of deliberate self harm behaviour involves recognition of the behaviour and triggers of the behaviour, the frequency of the behaviour, the degree of self-harm, exploration of the factors underlying the behaviour, liaison with family, friends and health care providers and long-term therapeutic involvement, hopefully with one main person.