

Self-harm

Self Harm - X60-X84 (Clinical term: Self-harm U2...)

Presenting complaints

The majority of people who present either to Accident and Emergency or to primary care following non-fatal self-harm do so after:

- an overdose
- an episode of self-cutting
- other more violent forms of deliberate self-harm such as asphyxiation or self-poisoning using car exhaust fumes (these suggest a high degree of suicidal intent).

Best practice suggests that GPs should try to contact and assess their patients when notified that they have self-harmed, although current evidence does not yet show that this significantly reduces repetition rates.

Assessment

There are three assessment tasks:

- To assess and manage the current episode
- To identify and manage any associated conditions
- To prevent a repetition of the self-harm.

Assessing and managing the current episode

- Prompt attention to any medical sequelae, including long-term physical damage, eg liver damage from overdose.
- Identify relevant/ongoing trigger(s) (note that precipitating events that surround episodes of self-harm are poor predictors of suicide risk, making the notion of a 'suicidal gesture' following interpersonal crisis difficult to sustain).
- Assessment of suicidal intent, including:
 - deliberate isolation at time of self-harm
 - precautions made against discovery
 - 'final acts' in anticipation of death, eg giving possessions away, making a will
 - communication of intent before the attempt and self-report of motivation for self-harm (to solve a problem or escape a situation)
 - patient's perceptions of barriers/incentives, eg "I could never actually kill myself because of the children" (generic, therefore safer) or "I'll kill myself if she doesn't come back by next Monday" (specific, therefore riskier).
- Assessment of background history, including past and current contact with mental health services, social problems and substance misuse problems.
- Note that socio-demographic groups at increased risk include men, those aged 15-25 or over 55, those who are widowed, separated or divorced, those who are socially isolated, unemployed, those with a family history of suicide and a previous history of self-harm.
- Note that rates of suicide are particularly high in the period following discharge from psychiatric hospital, release from prison, and in the months following an episode of non-

fatal self-harm. (The suicide rate increases 100-fold in the year following an episode of self-harm). Patients who regularly present with self-harm have an even higher rate of eventual suicide.

- Note that the most important risk factor for suicide is the presence of depression, drug/alcohol abuse, or other mental health problems (see below).
- Identify current life problems, social stresses and precipitating factors. Episodes often occur in the context of multiple social difficulties and interpersonal problems. It is therefore important to assess the nature and extent of unresolved problems and how the patient would cope with future crises (see below). Focus on small, specific steps patients might take towards reducing or improving management of these problems. Avoid major decisions or life changes.
- Support the family. It is likely to be very distressing to discover that a family member is self-harming.

Identification and management of any associated conditions:

- Mental disorders, most commonly Depression - F32#, Alcohol misuse - F10 or Drug use disorders - F11 - F19#, but also psychoses.
- Bereavement and loss - Z63.
- Painful, disabling or life-threatening physical illnesses.
- Being the victim or perpetrator of violence (see Domestic violence or partner abuse).

Prevention of repeated self-harm

This requires a thorough assessment of suicidal intent:

- Does the patient think that life is not worth living?
- Does the patient have a sense of hopelessness?
- Does the patient have a suicide plan and the (immediate) means to carry it out?
- Is the patient likely to act on the plan?

The belief that enquiring about suicidal ideation may prompt some people to consider self-harm is not supported by research findings or clinical experience. Placed in the context of asking people about symptoms of depression such questions feel less awkward for the interviewer, eg "It sounds as if you have been feeling very down recently; has there ever been a time when you have felt as though you couldn't be bothered carrying on? Have you ever felt that life was not worth living/that you would be better off if you were dead? Have you ever thought of harming yourself in any way?".

Some people self-harm by repeatedly cutting or, more rarely, burning themselves.

- Cutting usually occurs when the person is experiencing strong feelings such as tension or frustration. Patients often report that cutting provides temporary relief from distress.
- Patients usually deny having thoughts of suicide.
- Some patients lead ordinary lives and do not experience self-cutting as a major problem; for others it is part of a wider problem that includes long-standing feelings of low self-esteem and deep-rooted sadness and is associated with other forms of self-harm such as alcohol abuse or drug problems.

Essential information for patient and family

- Patient confidentiality may be particularly sensitive when patients present with self-harm. It may be necessary (and appropriate) to override patient confidentiality when life is at risk.
- It can come as a great shock to family members that a relative is experiencing thoughts of self-harm.
- Feelings of self-harm are common among people who experience mental distress and only a small proportion of people with suicidal thoughts actually act on them.
- The family should take any possible specific steps to reduce the opportunity for further self-harm, for example, by removing weapons, drugs, etc.
- Patients and family members may be reassured by being told about helplines and local services that are available 24 hours a day, eg the Samaritans.

General management and advice to patient and family

(ref 211)

- Assessment of suicidal ideation is an important part of the mental state examination of anyone who presents with a mental health problem.
- Any underlying mental disorder needs to be treated.
- Patients who, as a result of assessment, are considered at risk of further self-harm should be reviewed regularly by the GP.
- Psychological treatments may help the person make sense of their difficulties without feeling the need to self-harm (ref 212). The approach that therapists usually use involves paying attention to how a person is feeling rather than concentrating directly on whether or not they are harming themselves.
- Clinicians managing complex or protracted cases of self-harm should consider seeking peer support or supervision.

References

211 NICE will publish a guideline on the management of self-harm in March 2004.

212 Hawton K, Townsend E, Arensman E et al. Psychosocial and pharmacological treatments for deliberate self harm (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI) Twenty-three studies were analysed. Promising results were found for problem-solving therapy, provision of a card to allow emergency contact with services, depot flupenthixol for recurrent repeaters of self-harm and long-term psychological therapy for female patients with borderline personality disorder and recurrent self-harm

Medication

Medication needs to be given as required for any underlying psychiatric disorder.

Use of antidepressants such as SSRIs, selective noradrenalin reuptake inhibitors (SNRIs) and lofepramine is recommended for all those who have depressive symptoms and are felt to be at risk of suicide as they are relatively safe in overdose.

Referral

- Those with active suicidal intent or continuing suicidal ideation may need to be referred to specialist medical services.
- Where a mental disorder has been diagnosed, refer to the relevant guidelines for that disorder.
- Consider referral for psychological therapies, as appropriate.
- It has been argued that because of the rates of underlying mental disorder and greater risk of subsequent suicide in the elderly, all elderly people who present to primary care services following deliberate self-harm should be referred to secondary care services.

Resources for patients and families

Self Harm Alliance Helpline 01242 578820 (6pm–7pm, Tuesday, Sunday; 11am–1pm, Thursday)

Email: selfharmalliance@aol.com; website: <http://www.selfharmalliance.org>

Helpline, produces monthly newsletters, provides postal and email support, and offers an advocacy service.

Self Injury and Related Issues (SIARI)

Email: jan@siari.uk; website: <http://www.siari.co.uk>

Forum for self-harmers.

The Samaritans 08457 909 090 (24-hour helpline, everyday)

Email: jo@samaritans.org; website: <http://www.samaritans.org.uk>

Offers confidential emotional support to any person who is despairing or suicidal.

Cruse Bereavement Care 020 8940 4818 (for details of local services)

Helpline: 0870 167 1677 (9.30am–5.00pm, Monday–Friday)

Email: info@crusebereavementcare.org.uk; website: <http://www.crusebereavementcare.org.uk>

Offers support, information, training and direct telephone help to anyone who has been affected by a death.

Bereavement Information Pack for those affected by a suicide. A copy of the booklet can be purchased from the Royal College of Psychiatrist, Book Sales, 17 Belgrave Square, London SW1X 8PG.