26.3.2 Self- harm 6457 Kate E.A. Saunders and Keit

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26.3.2 Self-harm 6457 26.3.2 Self-harm Kate E.A. Saunders and Keith Hawton ESSENTIALS Self-harm is one of the commonest reasons people present to hos- pital emergency departments and the most frequent form of self- harm is overdose. Most patients who self-harm have an emotional disturbance, commonly an adjustment or mood disorder, often in a context of situational or relationship stresses, and personality difficul- ties. Some have more severe psychiatric disorders. Intoxication with alcohol is common. All patients presenting with self-harm require both a medical and a psychiatric assessment. The latter should include an assessment of problems, needs and suicide risk. Children require particularly careful assessment. In assessing suicide risk, it should be noted that the medical dangerousness of the act does not necessarily reflect the intent, and that repeat self-harm greatly increases the risk of eventual suicide. Psychiatric management depends on the patient’s problems and diagnosis. There is some evidence that brief psychological inter- vention can decrease the risk of repeat self-harm. Introduction Self-harm is the term used in the United Kingdom (and much of Europe) to describe intentional nonfatal self-poisoning and self-injury, irrespective of motive. Self-harm is a significant and increasing problem in most developed (and some developing) coun- tries. Two-thirds of patients who self-harm are under 35 years of age. Self-harm is rare in children but becomes more common in adoles- cence. Self-harm is more common in females and more common in areas of socioeconomic deprivation. Most patients seen in general hospitals for self-harm have taken overdoses. In the United Kingdom, the substances most frequently involved are nonopioid analgesics, particularly paracetamol and paracetamol-containing compounds, and psychotropic agents, es- pecially antidepressants and minor tranquillizers. Some patients present with self-injury, most commonly self-cutting but sometimes following more violent self-harm such as hanging or jumping from a height. In lower- and middle-income countries, more toxic sub- stances, such as pesticides, are often used for self-poisoning (espe- cially in rural areas), with consequent higher fatality rates. Case examples Case 1. An 18-

year-old woman presents at 23.00 h on a Saturday having taken a packet of paracetamol following an argument with a boyfriend and while intoxicated with alcohol. She has presented previously in similar scenarios. The history reveals a troubled up- bringing with foster parents and ongoing difficulty with relation- ships with others. Further assessment reveals fluctuating mood but no depressive disorder. The assessment finds evidence of person- ality problems and problem drinking. Case 2. A 60-year-old man is admitted to hospital after attempted self-hanging. He is divorced, has lost his job, and is in debt. He left a suicide note. He has no pre- vious episodes of self-harm. Assessment reveals a severe depressive disorder and a high suicide risk. Relevant psychiatric disorders Most who present to hospital following self-harm will have a psy- chiatric disorder, the most common being depression, anxiety disorders, and personality difficulties and disorders. Adjustment disorders to interpersonal problems and broken relationships (es- pecially in the young), employment difficulties, legal and housing problems, and alcohol and drug misuse are also common. Self-harm may also occur in the context of a psychotic illness such as schizo- phrenia or bipolar disorder. Assessment Immediate assessment of risk In addition to the immediate assessment of the medical conse- quences of self-harm, a brief and early assessment of the patient's psychiatric state and risk is essential. In particular, it is important to know whether the patient has a serious psychiatric disorder (e.g. psychosis or severe depression) and/or is actively suicidal in order to determine the need for urgent psychiatric attention. Risk may be ongoing and dangerous tablets or other potential methods of self- harm (e.g. blades, ligatures) should be removed from the patient's possession. Patients who self-harm may leave hospital before a psychiatric assessment can be completed. Such patients tend to have a his- tory of substance abuse and previous self-harm, and may exhibit disturbed behaviour in hospital. Where a patient is thought to be at serious risk and wanting to leave hospital, medical staff can (in England and Wales at least) detain the patient under the Mental Capacity Act until a psychiatric opinion can be obtained. Then, if necessary, detention under the Mental Health Act can be arranged. Refusal of medical treatment Difficulty commonly arises when patients refuse potentially life- saving medical treatment. This problem is most common in those who have poisoned themselves, such as with large overdoses of para- cetamol, for which early treatment can prevent the development of potentially fatal liver damage. The dilemma then is whether to in- stigate medical treatment against a patient's will. In most countries, the issue is one of mental capacity. To show that patients have the capacity to refuse treatment, they must: • Be able to understand and retain information on the treatment proposed, its indications, and its main benefits, as well as possible risks and the consequences of nontreatment • Be capable of weighing up the information in order to arrive at a conclusion • Be able to communicate this decision Efforts should be made to optimize a patient's capacity before con- cluding that it is lacking. If a clinician instigates treatment against a

 patient's wishes in a patient who has capacity, then the clinician is at risk of being accused of assault. Where the patient is judged to be lacking capacity, essential medical treatment can be instigated (in England and Wales) under the Mental Capacity Act. In situations of dire emergency, most clinicians would choose to instigate essential medical treatment to save the patient's life and sort out legal issues afterwards. Such understandable action is unlikely to lead to suc- cessful litigation as long as the clinician is seen to act in the patient's best interest. Psychiatric and social assessment General hospital medical and nursing staff should be able to as- sess the patient who has self-harmed, but in many hospitals there are specialist mental health teams who do this. The main topics to be covered when

interviewing the person who has self-harmed are listed in Box 26.3.2.1. A useful way of assessing the events and dif- ficulties that preceded the act, the nature of the act, possible motiv- ation, and suicidal intent, is to obtain a detailed account of the few days leading up to the self-harm. Whenever possible the patient's account should be supplemented with reports from informants such as a partner, relatives, and friends and other involved in the patient's care, including their general practitioner. Assessment of the motives or intentions underlying self-harm is based on the circumstances of the act, the patient's account, that of other informants, and deduction by the clinician. Common motives or intentions for attempted self-harm are shown in Box 26.3.2.2. Suicidal intent (that is to say, the extent to which the patient wished to die at the time of self-harm) can usefully be assessed by reviewing the circumstances of the act and the explanation given by the patient and by relatives or friends. Factors suggesting high suicidal intent are shown in Box 26.3.2.3. It is also important to take account of what the patient and others say about the purpose of the act. About one-third of patients will say that they definitely wanted to die, although in some cases the circumstances of the act will suggest otherwise. However, there is a small but important group of patients who will claim they did not wish to die when the circumstances sug- gest high suicidal intent; such patients may be at increased risk of repeated self-harm, which has a high chance of being fatal. Scoring systems can assist in the assessment of suicidal intent (e.g. the Beck Suicide Intent Scale). It is important to recognize that the objectively assessed risk to life judged by the method used is a poor and potentially misleading measure of the extent to which a patient wanted to die. Many pa- tients have little idea about the relative dangers of substances taken in overdose. Thus, a small overdose of a benzodiazepine hypnotic or even an antibiotic may be a serious suicide attempt for some patients, whereas a large overdose of a highly dangerous analgesic might be taken with low intent by others. People in the medical and allied health professions are an exception, and usually the danger of their acts is a good measure of intent. Very dangerous self-injuries such as jumping from a height are usually associated with high sui- cidal intent, but not always. Estimation of the risk of repetition and of suicide following self- harm both short-term and long-term, is an important part of the assessment. Factors associated with an increased risk of repeated self-harm and of suicide are shown in Table 26.3.2.1. However, it is essential to recognize that such predictive measures are notoriously imprecise. Patients with risk factors for repetition have a high risk of repeating, but many who repeat—possibly more than half—have few risk factors. The prediction of suicide is difficult, in part because the risk of suicide is relatively low. Assessment of protective factors is based on past behaviour under stress and the patient's account of whom they can turn to for sup- port. It is important to assess whether the patient has difficulties in problem-solving, as these can be a target for therapy. The best evi- dence for such difficulties will be a description of the methods used to solve problems in the past. It is always important to determine Box 26.3.2.1 Areas to be covered in the assessment of patients who have self-harmed • Life events that preceded the act • Motives for the act, including suicidal intent and other reasons • Problems faced by the patient • Psychiatric disorder • Personality traits and disorder • Alcohol and drug misuse • Psychiatric treatment • Previous self-harm and its consequences • Family and personal history • Exposure to suicide/self-harm in friends and/or the media (including the Internet and social media) • Current circumstances, such as: • social (e.g. extent of social relationships) • domestic (e.g. living alone or with others) • occupation (e.g. whether employed) • Psychiatric history, including previous suicide attempts • Risk of a further self-harm • Risk of suicide • Coping resources and supports Box 26.3.2.2 Common motives or intentions for self-harm • To die • To escape from an unbearable situation • To get relief from a distressed state of mind • To change the behaviour of others • To show desperation to others • To

get back at other people/make them feel guilty • To get help Box 26.3.2.3 Factors suggesting high suicidal intent • Act carried out in isolation • Act timed so that intervention 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 means, saving up tablets) • Communicating intent to others beforehand • Extensive premeditation • Leaving a note • Not alerting potential helpers after the act

26.3.2 Self-harm 6459 whether current problem-solving is impaired by depression or other psychiatric disorder. Management The management of self-harm will depend in part on the medical and psychiatric diagnoses. However, there are general principles that apply to the psychological management of all patients. Some patients who have self-harmed appear ambivalent about accepting help, or even frankly dismissive of it. Clinicians may have to work hard in some cases to explain to patients how treatment might be of benefit to them. The assessment procedure can itself be therapeutic. It may provide patients with a first opportunity to discuss their difficulties with a clinician. Joint interviews with family members can improve com- munication. The psychosocial assessment probably reduces the like- lihood of repetition of self-harm. Some patients thought to be at high risk of suicide refuse psy- chiatric treatment when this is judged essential. Their subsequent management depends on whether the patient is suffering, or likely to be suffering, from a mental illness that necessitates hospital assessment and/or treatment. In most countries, if a patient is thought to be at serious risk or seriously mentally ill, emergency department staff would be judged to be acting reasonably if they held the patient in the department until a psychiatric opinion could be obtained. Major psychiatric disorders should receive appropriate treatment. Caution is needed where there is ongoing risk of self-poisoning with consideration given to the toxicity of the treatment and the amount prescribed. The evidence that simple interventions reduce the risk of repeated self-harm is not strong, but there is increasing evidence for the efficacy of psychological treatments, especially brief cognitive behavioural therapy, including for reducing depression, hopeless- ness, and suicidal ideation. Furthermore, intensive and prolonged psychological therapy (dialectical behavioural therapy) can re- duce the frequency of self-harm in patients with a history of mul- tiple acts of self-harm and borderline personality disorder. Contact interventions such as sending postcards to patients at regular inter- vals following self-harm may reduce repetition where community psychiatric services are minimal or absent. Most evidence for spe- cific interventions following self-harm comes from studies in adults and far less is known about the benefit of intervention for children and adolescents or older adults. The assessment of patients who have engaged in self-harm is re- garded by some physicians as primarily the responsibility of psy- chiatrists. However, it has been found that nurses, social workers, and other clinicians can assess these patients reliably, make ef- fective aftercare arrangements, and provide therapy. Staff of what- ever discipline should have the experience and skill to manage patients with emotional and psychiatric disorders, and have been trained in the assessment and treatment of patients who have self- harmed. They also require supervision and support from senior psychiatrists, especially when managing patients with severe psy- chiatric disorders and where compulsory admission to hospital may be required. Outcome Self-harm is often repeated; 12–25% of people repeat the act within a year. In the United Kingdom, around 1% will die by suicide within a year and 3–5% within 8–10 years. More than half of people dying by suicide have a prior history of self-harm. In older patients, the risk of suicide is higher. Self-harm is also associated with physical illness as well increased mortality from natural causes, especially alcohol- related disorders. Specific subgroups of patients Alcohol and drug abusers Many patients who self-harm have problems related to alcohol and drug abuse, and these factors—especially alcohol abuse—increase the risk of both repetition

and suicide. Screening for substance abuse should therefore be part of self-harm assessment. Patients with personality disorders Personality difficulty or disorder is a common primary or comorbid diagnosis in patients who self-harm. Repetition of self-harm is very common in this group and their suicide risk is significant. At pre- sent, there are no licensed medications for personality disorder and admission to inpatient psychiatric wards is only advised for crises where all community options have been exhausted. Some areas have designated services for people with severe personality dis- orders. For those who repeat very frequently it can be useful to have a pre-agreed approach to management in order to ensure safe and consistent care. Children and young adolescents It is usually advisable that children and young adolescents who self-harm be admitted to hospital as they may require particularly complex and often prolonged assessment, including interviews with their families and the possible involvement of community statutory services (e.g. social services). Table 26.3.2.1 Factors associated with an increased risk of a repeat self-harm and of suicide Self-harm Suicide • Previous episodes of self-harm • Personality disorder • Alcohol or drug abuse • Previous psychiatric treatment • Unemployment • Socio-economic deprivation • Criminal record • History of violence • Single, divorced, or separated • Older age • Male gender • Unemployed or retired • Separated, divorced, or widowed • Living alone • Poor physical health • Psychiatric disorder (particularly depression, alcoholism, schizophrenia, and personality disorder) • High suicidal intent in current episode • Violent method involved in self- harm (e.g. attempted hanging, jumping) • Leaving a suicide note • Previous self-harm, especially multiple episodes

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