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A summary on self injury

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Introduction

"*I have had 2 891 stitches done. I have cut and cut and cut and taken tens of overdoses. Because I was so bloody angry and so incredibly sad that I didnt know what to do with myself.*

People are not concerned with the tears when someone cries. They are concerned about the reason for the tears.

The blood and the cutting was my way to cry.

Why were my tears nothing but trouble to everyone? Why didnt the doctor take a minute to find out why, or to send me to a psychiatric ward where they might understand me and help me? Why couldnt he make that phone call to see if they could take me in?

When I didnt have the courage to ask for help from a psychologist, it was actually nice when the doctor took me side and said, "I want you to stay in the psychiatric ward for a few days" or "My God, what they're doing over there? They must help you. I will have them admit you." Sometimes such words were of great value. I got the feeling that someone cared about me.

I once met a doctor who looked at all my scars and said, "I know you have had some rough times". It was not a question, he was not being curious or stupid, he just gave me a confirmation. He gave me a confirmation that I was seen. He did not just stitch me up and discharge me. He became the doctor that finally helped me.

You have to understand. Everyone who meets people who harm themselves has to understand; Cutting oneself is an admission, a shameful admission, that one needs help. Yes, please help me, I need someone, I need help. I admit it"

(Den norske legeforening, 2009)

Self injury is a common problem in our society today. A large percentage of adolescents engage in this behavior and health care workers will most probably meet some of these as patients at some point in their career. There has been a lot of research on self inflicted injury over the last decade or so, but it is rarely a part of the curriculum for most health care workers.

This article aims to give a brief summery on today's' knowledge about self injury. It contains a description of the behavior, it discusses possible causes, treatments and consequences and suggests what can be done in order to prevent this behavior. The article is based on on a literature search from PubMed and articles from The Journal of the Norwegian Medical Association.

The article concentrates on self injury as an act of deliberately doing damage to one self, and this damage is the primary cause of the behavior. It does not include self injuries done in the name of religion or damage to tissue as an adverse effect, as would be the case in for example drug abuse, eating disorders and smoking. Body modifications that are intended for ornamentation are not considered a form of self-mutilation, as they are done for spiritual or social purposes. The modification of one's body by tattooing, piercing or plastic surgery for the purpose of decoration is considered culturally sanctioned and is not measured as a form of self-mutilation.

The act of doing harm to one's own body has several names and can for example be described as self harm, self injury, self mutilation, self injurious behavior or self inflicted violence. Some give these words slightly different meaning but in this article they are used interchangeably.

What is self injury?

`Self-injury,

n. the act of intentionally hurting oneself.`

(www.thefreedictionary.com)

`An act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behavior that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which the subject desired via the actual or expected physical consequences'

(Definition from World Health Organisation)

Self injury is the intentional act of tissue destruction with the purpose of shifting overwhelming emotional pain to a more acceptable physical pain.

(Hicks & Hinck 2008)

The methods of self-harm can be divided into two broad groups: self-poisoning and self-injury .

The methods for self injury may take many forms, the most common one is cutting. It is pointed out that 75% of self-mutilators engage in this as the means for relief. Most have a preferred instrument for the mutilation, but sometimes the item used may be one of opportunity. Some of the items of choice include pencil tips, paper clips, pins, shards of glass, razors, box cutters, scissors and drinks can tabs. Areas most often cut are wrists, arms, ankles, calves, inner thighs, belly, brassiere line, panty line, armpits and feet.

Other ways to injure skin is also common; burning, scratching and interfering with wound healing. Self hitting, hair pulling and banging of body parts is also conducted. (Hicks & Hincks, 2008).

Self-poisoning consists of minor overdosing with non-suicidal intent. It can take the form of ingesting a medication in excess of the prescribed dose, or ingestion of a recreational or illicit drugs or alcohol can also be used with the intention to harm one self. In over 50% of cases of overdosing Acetaminophen is the ingested drug.

People who self-poison are more likely to seek help than those who self-injure and is the most common method in patients that present to hospitals. For this reason, studies that focus on people who attend emergency departments paint a different picture about the respective prevalence of these two forms of self-harm from studies of the general population. About 80% of people who present to emergency departments following self-harm will have taken an overdose of prescribed or over-the-counter medication (Rassool, 2006). A small additional percentage will have intentionally taken a dangerously large amount of an illicit drug or have poisoned themselves with some other substance.

The intentional tissue destruction has a purpose, but those who injure themselves are not masochists. Masochists find pleasure in deliberately causing themselves pain, while self harmers use pain as a means for relief (Clarke & Whittaker 1998). Pain is not the only goal when cutting; it is often the sight of blood that is effective in restoring a sense of authenticity.

The act of self-mutilation is not a suicide attempt. A person who is attempting suicide wants to die, but a self-mutilator cust to feel better. It has been said that suicide is a permanent solution to a temporary problem, while self-mutilation is a temporary solution to a permanent problem (Hicks & Hincks, 2008).

However, self-mutilators are at risk for accidental or intentional suicide, being 18 times more likely to commit suicide (Van Sell et al. 2005).

Two defining attributes are found in all patients that injure themself, these are the physical self-injury and the intent to provide a release of emotional pain. The self-injury provides for a cleansing of their feelings, in settings where emotional oppression and social suffocation are common.

There is a contradictory nature to the behavior of a self mutilator. Many self-mutilators have been taught that the thoughts, emotions and feelings others take for granted, such as feelings of anger or sexual desire, are bad and they need to be punished for having these feelings. Self-mutilators experience these emotions as self-hate, and they have to pay for them with this show of blood. They are then ashamed of what they have done. And it all easily turns into a vicious circle. The self-mutilation is a visual plea for help, but it is also a source of shame that the person is compelled to repeat in secret. Tissue damage is a visual demonstration of extreme emotional distress, and the physical act of self injury seems to reconcile this emotion. A release of endorphins after the physical damage contributes to a feeling of relief, and an addictive maladaptive coping cycle of

pain, relief, shame and self-hate. Self-mutilators typically wear long sleeves and baggy clothes, even in hot weather, to cover their actions. They may have an unusual need for privacy and are often hesitant to change clothes or undress in the company of others for fear that they will be found out (Hicks & Hincks, 2008).

Self-mutilation occurs across race, gender, age, education, sexual preference, religious beliefs and socioeconomic status. But research shows that some people that are more prone to become self mutilators.

-It is most commonly seen in Whites, although this may be because members of minorities are not being counted as often. This because they are less likely to seek psychiatric treatments (Clarke & Whittaker 1998).

-Females are four times more likely to self-mutilate, especially in the teenage years. Later in life the prevalence evens out between males and females. Ages as young as 6 and as old as 90 years have been documented among self-mutilators, but the mean age of onset is around 14-15 years. The self injurious behavior commonly appears at the onset of puberty and may continue for many years or it may be a onetime event. However, the duration and potential for recovery have not been well documented.

-All socioeconomic levels are seen, and many are professional people with careers in education or health care fields (Hicks & Hincks, 2008).

Self mutilation is also defined as the intentional act of tissue destruction with the purpose of shifting overwhelming emotional pain to a more acceptable physical pain (Hicks, 2008). Tissue damage is a visual demonstration of extreme emotional distress, and the physical act of mutilation seems to reconcile this emotion. This can lead to repetition of the self injuries. A survey done amongst Canadian youth show concluded that the act of self injuring occurred one time for 29%, 2-3 times for 33% and more than 3 times for 38%. For those who had stopped the mean duration was 1.8 years. The majority of those who self injure reported that the idea to self harm had been their own,

75%. 30% reported that they had gotten the idea from a friend, 28% from media (television, books or movies. 2% reported to had gotten the idea from a family member. The mean number of sources amongst the youth was 1.4. However, self-mutilators are at risk for accidental or intentional suicide, being 18 times more likely to commit suicide (Van Sell et al. 2005).

Research has explored self-injurious behaviors and disordered eating among adults in clinical settings, little research has been conducted examining self-injury and eating disorders in adolescents. In a study that included 440 students a prevalence rate of 13.9% was found (Ross et al, 2009). Results indicate that students who engage in self injury has a significantly higher incidence of eating eating disorders than those who do not. Included in eating pathology is poor interoceptive awareness; difficulties with impulse regulation; an increased sense of ineffectiveness, distrust, and social insecurity; and increased bulimic tendencies and body dissatisfaction. Relationships were found between increased frequency of self harming behaviors, poor impulse control and deficits in affective regulation. In addition, adolescents who had stopped self injuring reported comparable rates of eating pathology as did adolescents who continued to self-injure (Ross et al, 2009).

Prevalence

Self-mutilation is not limited to any race, gender, age, education level, sexual preference, religious belief, or socioeconomic status. However, it has been identified most often among Caucasian, female adolescents. Although the literature regarding self-mutilation often discusses adolescents, clinicians report that individuals as young as 6 years and as old as 90 years have been treated for self-mutilation (Wikipedia).

Since many acts of self-harm do not come to the attention of health care services, hospital attendance rates do not reflect the true scale of the problem as much of self harming is carried out in secret. A British survey suggested that between 4.6% and 6.6% of people have self-harmed. Another British community survey concluded 6.9 per cent of a school population of 15 and 16 year olds had engaged in an act of deliberate self-harm in the previous year. However, even this might be an under-estimate. In a school survey, 13% of young people aged 15 or 16 reported having self-harmed at some time in their lives and 7% as having done so in the previous year. The lifetime prevalence of self injuring among adolescents in the different regions ranged from 4.1% in the Netherlands to 13.2% in the United Kingdom. Surveys in Ireland and Norway counted a life time prevalence of 9.1% and 8.1% respectively. The large differences can be explained by different definitions of self harm or by different samples of the population.

The exact prevalence might be difficult to estimate. However, all these surveys agree that self-harm occurs in all sections of the population. It is more common among people who are disadvantaged in socio-economic terms and among those who are single or divorced, live alone, are single parents or have a severe lack of social support . Life events are strongly associated with self-harm in two ways. First, there is a strong relationship between the prevalence of self-harm and adverse events experienced

during the course of his/her life. These include having suffered victimization, in particular, sexual abuse. Second, ongoing life events, particularly relationship problems, can precipitate an act of self-harm (Heath et al, 2009).

The onset of self mutilating behavior is found to have a mean age of 15.2 years. While deliberate self-harm is particularly common among adolescents and has been on the rise in recent years, it also continues into adulthood. Its incidence and prevalence in adulthood is also difficult to estimate accurately, and figures based on hospital attendance again probably underestimate its impact. It has often been assumed that the behavior declines as people age. It may be, however, that the behavior is even more taboo in older adults than in the young. One review reported prevalence estimates of between 400 and 1400 per 100 000 of population per year (Swales).

Of those who had harmed themselves, 45.9% had done so more than once. Girls were three times more likely to harm themselves than boys. Overall, women are more likely to self-harm than men. This is most pronounced in adolescence, where girls may be three times more likely to self-harm than boys (Morey, 2008).

Living arrangement was associated with significant variation in the prevalence of self harm. Living with both parents was protective. Relative to teenagers with this living arrangement, self harm was significantly more common among those living with one parent or one parent and a step parent.

It is notable that boys use a greater variety of methods to harm themselves than girls. Of the teenagers who harm themselves, 20% do so under the influence of alcohol, while 12% under the influence of an illegal drug at the time when they harmed themselves. Boys were twice as likely as girls to have been under the influence of alcohol when they engaged in self injury (Morey, 2008)

About one-half of people who attend an emergency department following self-harm will have consumed alcohol immediately preceding or as part of the self-harm episode. For many, this is a factor that complicates immediate management either by impairing judgment and capacity, or by adding to the toxic effects of ingested substances. About one-quarter of those who self-harm will have a diagnosis of harmful use of alcohol. Men are more likely to drink before an episode of self-harm than women, and are more likely to be misusing drugs or alcohol, as well as to have higher rates of several risk factors for suicide.

Causes

We all go through times of stress and difficulties, and we all have different way of coping with this. People who self-injure have chosen a method of coping that is extreme, but effective for them. Although the act of self-harm is often regarded as a morbid behavior, it can be understood as a type of self-help practice that provides temporary, often rapid relief from psychological distress (Center for Suicide Prev.). It has been said that there are as many reasons for self injuring as there are patients engaging in this behavior.

Self-harm is not an illness, but is a more or less dangerous behavior that should alert to an underlying problem, difficulty or disorder. People who self-harm are no more homogeneous as a group than people who have a cough. Coughs have numerous possible underlying causes including smoking, the common cold, tuberculosis and lung cancer. The same variability applies to self-harm. We know that gender, age and social and economic factors all influence the likelihood of a person self-harming, as do past personal history, mental ill health and substance misuse. Precisely why an individual self-harms at a particular point in their life will be unique, even in someone who harms them self frequently.

The motivation for harming oneself can include:

• *easing tension & anxiety*

• *escaping feelings of depression & emptiness*

• *escaping feelings of numbness*

• *relieving anger & aggression*

• *relieving intense emotional pain*

• *regaining control over one's body*

• *maintaining a sense of security or feeling of uniqueness*

• *continue previous abusive patterns*

• *obtaining a feeling of euphoria*

• *expression or coping with feelings of alienation*

• *a response to self-hatred or guilt*

Self injuries can in some cases also be a symptom of a more severe mental disorder, e.g. borderline personality disorder or autism (Center for Suicide Prevention).

In the DSM-IV, the only diagnoses that mention self-injury as a symptom or criterion for diagnosis are borderline personality disorder, stereotypic movement disorder (associated with autism and mental retardation), and factitious (faked) disorders in which an attempt to fake physical illness is present. It also seems to be generally accepted that extreme forms of self-mutilation (amputations, castrations, etc) are possible in psychotic or delusional patients. Reading the self injuries, one can easily get the impression that people who self-injure are doing it willfully, in order to fake illness or be dramatic .

However, self-injurious behavior is seen in patients with many more diagnoses than the DSM suggests. In interviews, people who engage in repetitive self-injury have reported being diagnosed with depression, bipolar disorder, anorexia, bulimia, obsessive-compulsive disorder, post-traumatic stress disorder, many of the dissociative disorders including depersonalization disorder, dissociative disorder not otherwise specified, and MPD/DID, anxiety and panic disorders, and non-specific impulse-control disorders. In addition, the call for a separate diagnosis for self-injurers is being taken up by many practitioners (Diagn. Ass. With self injuries).

It is beyond the scope of this article to provide definitive information about all of these conditions.

Acts of self-harm are often mistaken for suicidal behavior. But as a matter a fact a survey where 333 students admitted to self harming, non of them reported wanting to die as the only motive for the self injuries (Morey, 2008).It is more rather an attempt to communicate with others, to influence or to secure help or care from others or as a way of obtaining relief from a difficult and otherwise overwhelming situation or emotional state. Other reasons can be to "check that I am alive", to feel something, to punish oneself or others, to dissociate, to survive, to transfer emotional pain to one of physical character, to get help, to cope or as an attempt to control something (Smith).

Paradoxically, the purpose of some acts of self-harm is to preserve life. Professionals sometimes find this a difficult concept to understand. One particular intention or motive might predominate or many might co-exist.

Research has been done to find out which events and situations can cause emotional stress and engagement in self harming. Analyses revealed differences in family psychiatric history between self-injurers and non-injurers. Self-injurers were significantly more likely than non-injurers to have personal or family history of alcoholism, drug abuse, eating disorders, gambling disorders, lack of social support, promiscuity, broken homes, violence, suicidal ideation and lack of coping skills. However, no difference was observed for family history of anxiety, depression, bipolar disorder, or other psychiatric problems examined. Analyses also revealed significant differences in sexual orientation between self harmers and control groups. More specifically, 33% of participants in the self harm group reported a non-heterosexual orientation compared with only 11% of participants in the control group (Deliberto & Nock, 2006).

The following list sums predisposing factors:

• drug & alcohol abuse

• eating disorders

• signs of depression, e.g. weight loss, insomnia

• history of childhood physical & sexual abuse

• institutionalization in correctional facilities or drug treatment centers

• inability to tolerate & express feelings

• feelings of worthlessness, hopelessness, & helplessness

• sense of abandonment, loneliness, & un-lovability as children

• early history of surgical procedures or medical illness requiring hospitalization

• disruption or lack of supportive relationships or systems, e.g. social isolation secondary to imprisonment, death of a valued person, & family disruption such as divorce or separation.

(Center for Suicide Prevention)

Personality characteristics found to have increased incidence of self harm include perfectionist tendencies, dislike of body shape, inability to tolerate intense feelings, inability to express emotional needs or experiences and rapid mood swings.

The following information describes how patients themselves categorizes their motives for engaging in self injury:

The participants responded to some questions designed to find out their thoughts on underlying motivations for the self injuring. The reasons most often used when describing their motivations “to relieve/escape unwanted thoughts and feelings”, “to feel a sense of control”, “to communicate hurting”, and “to punish myself”.

Two categories of motivations were examined: emotional/internal and social/external. 91% of participants endorsed emotional/internal motivations, such as escape unwanted thoughts and feelings, gain a sense of control, or feel alive. Social/external motivations (e.g., feel close to someone, get attention, to not feel like an outsider) were endorsed by 65%. 57% percent of participants endorsed reasons that crossed both emotional and social domains.

Interestingly, when participants were asked to indicate what they felt were the main reasons for *other* people to engage in self-injury, the responses differed slightly. The most commonly endorsed item was "to get attention", followed by "to relieve/escape unwanted thoughts and feelings", "to communicate hurting", and "to punish themselves". 95% of participants felt that others' self-injury had emotional/internal motivations, and 79% endorsed social/external motivations. 78% of participants endorsed reasons for others that crossed both emotional and social domains.

As a conclusion to causes of self injury one may say that the precipitating happenings are situational circumstances that cause unbearable emotional distress and impaired coping skills. The self-injury is a dysfunctional act that expresses emotional pain.

Woldorf (2005) describes the emotional buildup:

In the hours or minutes leading up to the episode, individuals experience mounting tension, which may comprise any of a number of negative emotions. This tension gives rise to seemingly irresistible urges to self-injure, about which the individual may deliberate. Many begin to dissociate just before they self-injure. (p. 197)

Self-mutilation accomplishes two things. First, it allows individuals a choice as to when they want physical pain to replace the emotional pain they are experiencing. Second, the act of self-mutilation acts as a diversion from the emotional pain they believe they cannot handle.

Woldorf (2005) noted that:

"Some report that they do not experience pain, even with severe injuries. The act itself brings immediate relief, which individuals may attribute to the pain, the site of blood or other proof that they are still alive. "

Any positive feelings, however, are soon replaced by guilt, embarrassment, self-hatred and anger, thus fueling the next cycle. This pattern of self-mutilation can be just as addictive as smoking, over eating and drinking alcohol in excess. When self-mutilators cause tissue damage there is a flood of endorphins, which produces a sense of relief. Self-mutilation then becomes a coping strategy for dealing with anxiety, anger and other painful emotions. An addiction comes from wanting to retain this feeling of euphoria. More and more destruction of tissue is needed to achieve relief, with the result of a higher risk of inflicting a serious or fatal injury. Self-mutilation is more difficult to stop the longer it continues (Woldorf, 2005).

Treatment

Deliberate self harm represents one of the leading causes of admission of adolescents to general hospitals and is a major health and social problem in this age group. But the help seeking behavior among those who harmed themselves is complex. Most self injuries are not life threatening and patients who self harm seldom present to hospitals or need involuntary hospitalization. Research has shown that only 11-12% present to a hospital after injuring themselves. With all the research that has been done over the last years it turns out that mostly the person who self-mutilates seeks to feel better and is usually crying out for help. With these aspects taken into account the treatment of people who self mutilate is also very complex.

Adolescents are more likely to contact health services after they had harmed themselves rather than before, likewise family members are more likely to be aware of the self harm after the event. Self mutilation can be interpreted as a sign that the person has problems that he or she can not cope with. The best way to eradicate self harming is to control the cause of it. Information on prevention is found in the next chapter.

These following paragraphs will discuss treatment after an event of self harming. Most of them are key points from The Clinical Guidelines from National institute for health and clinical excellence;

Aims and principles of treatment

As with any other treatment, the overarching aims are to reduce harm and improve survival while minimizing the harm that may result from the treatment. In addition, the experience of treatment and care needs to be acceptable to patients and carers. This is especially so for people who self-harm and who may be suffering psychological, social or drug- and alcohol-related problems, which need further help after the immediate physical problems have been taken care of.

Primary care

Primary care professionals, community-based mental health workers, ambulance staff and others come into contact with people who have self-harmed with varying frequency. In this context, assessment and referral to the emergency department is the most common action undertaken, in particular for self-poisoning. Sometimes, self-injury (but

not self-poisoning) will be dealt with in primary care without referral for further physical treatment, usually by a GP who has already had contact with the person. Often on-site counseling and psychological therapy services are available in primary care. In any event, psychosocial assessment should be undertaken by a professional as soon as possible. One type of such an assessment is in the chapter below.

For workers who meet patients after self inflicted injury it is important to first separate self harm from suicide. Self harm is never the real problem so don't focus too much on it when assessing tha patient. Self harm is a messenger that there is a problem elsewhere, help the person listen to and understand the cause of the act. Don't aim for the self harm to stop to begin with, aim for the person to have more control or to make choices. Help the person to make sense of what is happening and to make choices for futher treatment (Self Harm Website)

The emergency department

On entry to the emergency department all patients undergo triage, a utilitarian system using predefined criteria in which the urgency with which a person needs treatment is evaluated using a formal and structured assessment. Triage allows patients to be categorized according to their needs and the urgency for treatment. Following triage, patients who have self-harmed should receive the necessary treatment for their physical condition, undergo risk and full psychosocial needs assessment and mental state examination, and they should be referred for further treatment and care if necessary.

Medical and surgical treatment

A range of medical and surgical interventions is available for the physical treatment of people who have self-harmed, including general and specific treatments for self-poisoning and self-injury. This includes triage, paracetamol screening, the general management of ingestion using gut decontamination, the specific treatment of overdose of paracetamol, benzodiazepine, opioid and other substances, and the treatment of superficial wounds. The closure of more complex wounds needs to be referred to more extensive surgery.

Psychological and pharmacological treatment

Given the potentially serious consequences of self-harm, with a number of people going on to kill themselves at a later date, assessment should be a priority for people who self-harm and present to hospitals/GPs. After the assessment patients may be referred for further pharmacological or psychological treatment in inpatient, outpatient or other settings.

Psychological treatments reviewed are: problem oriented therapies, dialectical behavior therapy, inpatient behavior therapy and insight-oriented therapy, long- and short-term therapy, home-based family therapy and group therapy. Therapy usually focuses on helping the person to tolerate greater intensities of emotions without resorting to self-harm, to develop the ability to talk about emotions and needs and to learn alternative, healthy means for discharging these feelings. Drug treatments include antidepressants and antipsychotics.

The details' are beyond this article.

Less than half of adolescents with a history of self injuring is today in any form of treatment. In an American survey amongst people who self mutilate 43.2% were receiving psychosocial treatment and 45.7% were receiving pharmacotherapy. However there is still a lot of uncertainty as to which type is the most effective.

Although self-harming behavior may continue for decades, in many cases it seems to run a natural course of two to ten years. Many adolescents with help, will outgrow their self-harming behavior as they mature and learn better coping skills. Patients and families can be offered the hope that the behavior will not continue forever.

Self harm assessment of risk/safety

Self harm is a way of expressing distress. Often people don't know why they self harm. It is a means of communicating and has been described as expressing an inner scream (Patient UK). It is important that all people who have self harmed are properly assessed by local psychiatry services and appropriately managed and supported by all health professionals involved in their care.

The assessment of patients who self harm should include identification of the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk, especially depression, hopelessness and continuing suicidal intent (Clinical gudelines).

A study done in 2001 concluded that introduction of simple service development resulted in an improvement in the quality of the psychosocial assessment of patients presenting with self harm to emergency departments. Encouraging staff to use a comprehensive checklist, proved particularly beneficial.

There are many ways of making such an assessment. The following two guidelines are of the simpler type and can give a relatively quick and accurate assessment of risk/safety level of the patient.

The first example is the modified SAD PERSONS scale. “S” stands for sex. It has been proved that females have a higher prevalence of self harm, especially during adolescent. “A” stands for age. “D” stands for depression. Does the patient have symptomatology or diagnosis of depression? “P”, previous attempt. Has the person engaged in self injury before? “E” stands for ethanol abuse. “R” stands for rational thinking. Is the patient thinking rationally? “S” stands for social support deficit. Does the patient have a support system? “O” is for organized plan. Does the patient have a thought out plan for taking the steps to act on the thoughts? “N” is for no spouse/broken family. “S” is for sickness. Does the person have a medical, mental or physical illness?

These letters represent 10 areas of assessment. The scoring for this is a follows- 0-2 equals little risk, 3-4 equals following patient closely, 5-6 equals strongly considering hospitalization, and 7-10 equals a very high risk, hospitalize or commit (Sad Person Scale).

The next scale attempts to consider the risk/safety level of a patient involved in self harming in order to make choices for the future, such as how to keep safe. This scale is based upon judgment. The judgment should be that of the patient together with his/hers contact people and family/support. Each factor are given a score between 0 - 5.

The five factors that are important in considering risk and safety are:

1. Intent

How determined is the patient that the intent of the act was non-suicidal?

2. Directness

To what degree is your self-harm related to how you feel? Is your self-harm related to something that happened in your life? Do you know why you self harm?

3. Control & Current distress

To what degree can the patient control his/her self injuries? When and how and how does he/she injury him/herself?

4. Repetitiveness

How often does he/she self harm? Are there predictable patterns in the self-harm? Is it increasing or is it changing?

5. Potential lethality

Considering the way of self harm, regardless of the intent, how likely is it that the patient could die as a result of it, through accident or mistake? Some forms of self-harm are far more potentially lethal than others. (www.bhicare.org)

Consequences

Physical health

Regardless of the person's intention, self-harm can result in long-lasting health problems or disability. Paracetamol poisoning is a major cause of acute liver failure requiring liver transplantation. To illustrate this it can be pointed out that 111 liver transplants were carried out in England and Wales between 1998 and 2001 on people who had taken an overdose of Paracetamol. This accounted for 4% of all liver transplants but 23% of all 'super-urgent' transplants – those in which the person is expected to die within 72 hours from fulminant liver failure.

Self-cutting can result in permanent damage to tendons and nerves and scarring leading to disfigurement. More violent forms of self-injury often lead to permanent disability and/or hospitalization.

Repetition and suicide

Following an act of self-harm the rate of suicide increases to between 50 and 100 times the rate of suicide in the general population. Men who self-harm are more than twice as likely to die by suicide as women and the risk increases greatly with age for both genders. It has been estimated that one-quarter of all people who die by suicide would have attended a general hospital following an act of self-harm in the previous year. About one in six people who attend an emergency department following self-harm will self-harm again in the following year, a small minority of people will do so repeatedly. The frequency with which some of the latter group self-harms means that they are over-represented among those who present at an emergency department or receive psychiatric care. There is no good evidence to support the widely voiced opinion that

people who harm themselves repeatedly, particularly by cutting, are less likely to die by suicide.

The economic cost of self-harm

The assessment and treatment of people who self-harm uses a substantial amount of resources in a health system. In Great Britain most of the direct cost is accounted for by the estimated 150,000– 170,000 attendances at an emergency department each year and the subsequent medical and psychiatric care. Self-harm resulted in 68,716 hospital admissions in 2001/02. At the same time the average daily number of beds available for mental illness in England has almost halved. As one of the most common presentations to general hospitals and one which has a strong tendency for recurrence and increased severity, self-harm presents a considerable economic burden to the individual, family, health services, and society as a whole. (Clinical Guidelines)

Prevention

There is an urgent need to address the issue of deliberate self harm. Programs and interventions that raise awareness about positive mental health and help seeking behaviors should be considered. Along with health services finding ways to eliminate the barriers felt by adolescents that may prevent them from seeking help and to make contact with adolescents in a youth friendly medium rather than waiting for patients to come to health services.

It is important to acknowledge the potential for action that might reduce the number of people who self-harm or the seriousness of the consequences. The following is taken from The British Clinical Guidelines. The factors overlap with those that influence suicide rates and they include:

● The socio-economic conditions, such as poverty, unemployment and housing problems, that influence the prevalence of self-harm and problems with which it is associated, such as alcohol and substance misuse and mental illness.

● The relationship between self-harm and child sexual and physical abuse, and the association with domestic violence, suggests that if these could be addressed in the public services that have direct contact with children in terms of detection, protection and help, the need for many women to self-harm later in life could be reduced. This is also important with regard to secondary prevention: how health care workers respond to people who have been abused and go on to self harm needs to be directly addressed through training.

● The availability of the means of self-harm. There is some evidence that a reduction in pack size for over-the-counter drugs has reduced the severity of the adverse consequences of overdose of aspirin and paracetamol.

● The development and use of prescription drugs that are safer in overdose: the advent and rapid uptake of SSRIs was at least in part the result of their reduced toxicity in overdose compared with the older tricyclic antidepressants, although a parallel reduction in the death rate from tricyclic overdose has not been forthcoming.

● The overall rate of prescribing of psychotropic medication may causally influence the rate of self-poisoning; suggesting that prescription of psychotropic medication should be considered a public health issue.

● Factors that might promote self-harm as a culturally acceptable behavior, particularly in the young. This would include the connection between self-harm and its portrayal in the media.

● Product information may have a place in suicide prevention strategies. Improvements of safety warnings for over-the-counter medicines should be placed if the drug has an overdose potential. However, it can be argued that the information on the risks of overdose and poisoning could be used to aid self poisoning or suicide.

Specific strategies of management and prevention of problems that can cause self injury:

Primary intervention may prevent problems in targeted groups or individuals and should be given attention by health services, family and school environment. Health services (primary and specialized health care) should provide screening and monitoring as a part of preventive health care. If diversions are found further diagnostics and treatments should be done by specialists (e.g. psychologist, psychiatrist, and neurologist). Family members should be educated on how to create a good environment for children, and they should cooperate with health professionals and relevant institutions. The school should have programs for teachers to

evaluate emotional, behavior and psychosomatic problems amongst their students. They should cooperate with pediatricians, psychologists, psychiatrists and social workers. They should provide teaching on different skills needed, for example communication, problem solving skills and sex education (Schneidrova, 2010).

There are many movements among the general self-harm community to make self-harm itself and treatment better known to mental health professionals as well as the general public. For example, Self-injury Awareness Day is set for March 1 of every year, where on this day, some people choose to be more open about their own self-harm, and awareness organizations make special efforts to raise awareness about self-harm. Some people wear an orange awareness ribbon or wristband to encourage awareness of self-harm (Wikipedia).

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