

Self-Harm: An Overview

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Epidemiology of Self Harm

- Ireland
 - 10,500 annually
 - 202 per 100,000
 - WHO EU Multi-centre study 1996 reported
 - 17% males lacerations
 - 9% females lacerations
 - Duration of self injury
 - Less than 5years 30%
 - 5-10years 22%
 - 10-20 years 33%
 - Over 20 years 14%
- | | UK |
|--------------------|----|
| • 170,000 annually | |
| • 750 per 100,000 | |

SELF-INJURY	PARA-SUICIDE	SUICIDE ATTEMPT	SUICIDE
HABITUAL →	NON-HABITUAL, but can be repeated		ONCE
Problem solving difficulty Emotional Instability	RESTRICTED PROBLEM SOLVING ANY MENTAL ILLNESS SUBSTANCE MISUSE		
Often motivated by Symptom relief. Impulse control. Low self-esteem Or as communication.	Not motivated by death For communication, Escape, revenge etc.	USUALLY HIGH SUICIDE INTENT	
MORE FEMALE	MORE MALE		
CUTTING METHODS	OVERDOSE MOST COMMON		LETHAL
<p style="text-align: center;">INCREASING INTENT/LETHALITY</p>			

Cultural?





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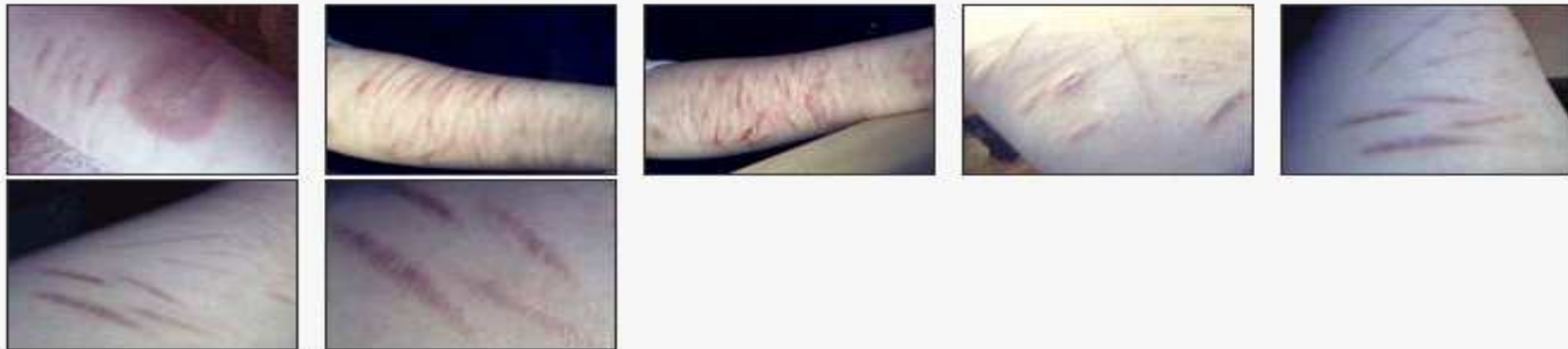
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Something else? – and not always about “tension release”.



You are not alone...



Myths in Self Harm

- SH is a failed suicide attempt
- SH is attention seeking and should be ignored
- People who SH enjoy pain
- SH is a habit which should be stopped
- SH is manipulative
- People who SH are a danger to others
- People who SH are 'mad', disturbed and need psychiatric admission

MEANING BEHIND THE BEHAVIOUR

- Survival – is a way to endure unbearable feelings/experiences. The only alternative may be suicide (can be viewed as a protective factor)
- Coping with feelings – expressing pain, ‘psych-ache’, anger etc
- Relieving tension, distracting oneself emotionally.
- Alleviating Fear
- Evoking ‘familiar’ pain – therefore feels safer.
- Relieving chaos by providing a focus.
- Demonstrating externally the internal turmoil.
- Communicating distress
- Relieving guilt and self hatred
- Cleansing oneself by bleeding/cutting out the evil/badness.
- Self Punishment – gaining a feeling of absolution by inflicting injury
- Injuries provide a justification for receipt of care
- Way of expressing neediness
- SI feels like a comforter/friendly ritual

Managing Self Harm

- What are the issues?
- Safety
- Assess need -
(physical/psychological/psychiatric)
- Support for person and worker
- Advice/self help
- Inter-agency working

Helpful responses to self-harm

- ***SHORT TERM***
- Show that you see the person behind the injury
- Show concern for the injuries themselves
- Communicate that SH is ok to talk about, and can be understood
- Convey respect for the persons efforts to survive.
- Acknowledge how frightening it may be to think of living without SH

HELPFUL RESPONSES TO SELF-HARM

- ***LONGER- TERM***
- Help the person make sense of the self injury
- Encourage the person to use the URGE to self injure as a signal to herself.
- Support the person in taking steps to keep herself safe and the reduce self injury but...
- Don't view the cessation of self injury as the only goal.

CLINICAL SCENARIO 2

- There is a weekly support group in a local voluntary sector service for people who SH. It is a facilitated group where all members have or currently SH. The behaviour is accepted and viewed as a way to cope with traumatic events. The attendees are encouraged to manage their injuries, with leaflets and information available regarding effective wound care. There is access to dressings, bandages and steri-strips.
- As professionals – what are the advantages/ disadvantages of this type of approach?
- As a patient – how well does this approach meet your needs? Advantages/disadvantages?

CLINICAL SCENARIO

- Acute inpt/day unit- setting offers drug treatments and OT (arts and crafts, group work, relaxation sessions, distraction techniques etc). The approach is to *reduce or prevent* self-injury. This is achieved by:
- Informing pts that SI is unacceptable. Pts are encouraged to approach nursing staff instead.
- Dissattend pts who SI – give attention to appropriate behaviours.
- Pts are asked to sign a “no-self harm” contract –if SI persists pts may be excluded or discharged from services.
- Pts are placed on ‘observation’ levels in a more secure environment and physical restraint is used to prevent SI.
- As professionals – what are the advantages and disadvantages of these approaches?
- As patients – how well do these approaches meet your needs? Advantages/disadvantages?

SELF-HARM - CLINICAL ISSUES

- Responsibility – having statutory responsibility for peoples safety, fearful of being blamed for injuries or even death.
- Conflict – how do workers reconcile safety with pts autonomy, choice and privacy?
- Expectations – from families, should be able to ‘cure’ the self injury.
- Co-working – other professionals may adopt opposing approaches.
- Therapy – dealing with the reality that SI may escalate or increase.
- Other service users – dealing with copycat episodes of self harm

USERS EXPERIENCES OF SERVICES

- What is unhelpful/harmful
- Condemnation and punishment
- Shock, fear, misunderstanding
- Excessive control
- Being viewed as disturbed
- Behavioural approaches/drugs alone

- What is helpful
- Acceptance, listening
- Counselling
- Supportive groups
- Crisis support in the community
- Alternatives to self injury
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