The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 8, Issue 2, April- June, 2020
DIP: 18.01.089/20200802, DOI: 10.25215/0802.089
http://www.ijip.in

Research Paper

# Deliberate self-harm: An Update

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## ABSTRACT

Deliberate Self-Harm (DSH) is common, often repeated and associated with suicide. The person with DSH usually show emotional dysregulation and a lack of adaptive skills to regulate emotions. They are widely considered to be a vulnerable population in need of effective interventions. The purpose of this study is to explore the DSH, its risk factors and management issues. Literature has been searched the both electronic databases including PubMed and manual searches for this. Fifth edition of DSM proposes Non-Suicidal Self Injury (NSSI), a synonym for DSH as a new disorder. NSSI is the attempt to harm oneself deliberately, usually by cutting or burning, with no suicidal intent. NSSI is a maladaptive strategy to regulation emotion often triggered by negative events, like feelings of rejection. The prevalence of DSH among young adults is significant, and the behavior is associated with medical, psychological, and social consequences ranging in severity. Several interventions appear to hold promise for reducing NSSI, including dialectical behaviour therapy, emotion regulation group therapy, manual-assisted cognitive therapy, dynamic deconstructive psychotherapy, atypical antipsychotics, naltrexone, and selective serotonin reuptake inhibitors with or without cognitive-behavioural therapy.

***Keywords:*** *Self Harm Suicide, Adolescence, And Behavior Therapy.*

Self-harm is a common clinical problem, but poorly understood. Deliberate Self Harm (DSH) refers to behaviour through which people deliberately inflict acute harm upon themselves, poison themselves, or try to do so with non-fatal outcome. DSH is an intentional act of causing physical injury to oneself without wanting to die. Deliberate self-harm behaviours most commonly include cutting (with a knife or razor), scratching or hitting oneself, and intentional drug overdose. They may also include limiting of food intake and other 'risk-taking' behaviours such as driving at high speeds and having unsafe sex.(1) Many individuals who self-harm use more than one method of self-injury.. All these behaviours share one thing in common i.e. emotional turmoil. Findings indicated that high rate of self harm in individuals of Indian origin than whites have been noted even in western

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**Received: April 29, 2020; Revision Received: June 12, 2020; Accepted: June 25, 2020**

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studies (Klonsky ED, 2007) attributing to cultural differences. In India, self-poisoning by organophosphorous compounds have been the commonest mode of self harm with family conflicts, dowry and problems with in-laws being the commonest precipitants (Chowdhary et al., 2009). More specifically, with regards to studies that defined self-harm as either suicide attempt or NSSI, several studies have demonstrated that alexithymia is associated with self-harm in adolescents ( Lee, 2016), substance use disorders (Evren et al., 2009), and suicidal clients in the emergency department (Hsu et al.,2013). With regards to the association between alexithymia and NSSI alone, numerous studies have found a strong association with alexithymia among adolescents ( Gatta et al., 2016a; Gatta et al., 2016b), undergraduate students(Paivio and McCulloch, 2004; Rasmussen Hall L., 2006; Webb and Mcmurran, 2008; Wester and King, 2018), adults ( Swannell et al., 2012), substance use disorders (Evren and Evren, 2005; Oyefeso et al., 2008; Verrocchio et al., 2010), borderline personality disorder (Mojahed et al., 2018; Sleuwaegen et al., 2017), and women with a history of child abuse (Bedi et al., 2014). Among adolescents, those with recurrent NSSI, defined as more than 5 NSSI episodes per year, had particularly elevated levels of alexithymia compared with adolescents with occasional NSSI, defined as less than 5 NSSI episodes per year (Gatta et al., 2016a).

***DSH is a Symptoms or disorder***

It is very difficult to say about DSH is symptoms or disorder. For long been Deliberate self-harm is viewed as a symptom of different disorders. DSM IV uses the term 'repetitive self-mutilating behaviour' as a key feature of Borderline personality disorder. DSH have been a common feature in depression, dissociation, anxiety disorders, post-traumatic stress disorder and other personality disorders. But the fifth edition of DSM proposes Non-Suicidal Self Injury (NSSI), a synonym for DSH as a new disorder (Shaffer and Jacobson, 2009). Nonsuicidal self-injury (NSSI), the deliberate, self-inflicted damage of bodily tissue without the intent to die, is associated with various negative outcomes. Proposed criteria for NSSI in DSM 5:(A). In the last year, the individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body, of a sort likely to induce bleeding or bruising or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), for purposes not socially sanctioned (e.g., body piercing, tattooing, etc.), but performed with the expectation that the injury will lead to only minor or moderate physical harm.(B). The individual engages in the self-injurious behaviour with one or more of the following expectations: To obtain relief from a negative feeling or cognitive state, to resolve an interpersonal difficulty, to induce a positive feeling state. (C). The intentional injury is associated with at least one of the following: Interpersonal difficulties or Negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act. Prior to engaging in the act, a period of preoccupation with the intended behaviour that is difficult to resist. Thinking about self-injury that occurs frequently, even when it is not acted upon. (D). The behaviour is not socially sanctioned (e.g. body piercing, tattooing, parts of a religious or cultural ritual) and is not restricted to picking a scab or nail biting. (E). The behaviour and its consequences cause clinically significant distress or impairment in interpersonal, academic, or other important areas of functioning. (F). The behaviour does not occur exclusively during states of psychosis, delirium, or intoxication. In individuals with a developmental disorder, the behaviour is not part of a pattern of repetitive stereotypes. The behaviour cannot be accounted for by another mental or medical disorder (i.e., psychotic disorder, pervasive developmental disorder, mental retardation, Lesch-Nyhan syndrome, Stereotypic movement disorder with self-injury, Tricotillomania [Hair pulling disorder], Excoriation [skin picking] disorder).

NSSI has been a long-standing concern for health professionals and is an increasing focus of clinical research (Zetterqvist et al., 2013). NSSI is common, with a lifetime prevalence of 13–17% in adolescents and young adults (Swannell et al., 2014) and there is evidence to suggest that NSSI is associated with a range of psychological difficulties including depression, anxiety and post-traumatic stress disorder (Bentley et al., 2014). NSSI can have adverse effects on family and interpersonal relationships (Tan et al., 2014). NSSI also represents a risk factor for later suicidal behaviour (Ribeiro et al., 2016) despite protection from suicide being one reported function of the behaviour (Klonsky, 2007).

***DSH & Differential diagnosis***

Borderline personality disorder, Suicidal behaviour disorder, Tricotillomania, Stereotypic self- injury, Excoriation disorder.

***DSH & Related terms***

DSH is an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour 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" . Various terms have been used over the years to name behaviours centred on intentional but non-suicidal physical injury to the self: Some of the more common terms include: Partial suicide, Antisuicide , Delicate self-cutting ,Wrist-cutting syndrome . (a)**Attempted suicide:** It is an unsuccessful, but potentially lethal action, a risk factor for future committed suicide.(b) **Parasuicide:** This behaviour includes any deliberate destruction of body tissue, with or without suicidal intent , and, as such, may involve a clear intent to die, no intent to die, or varying degrees of ambivalence about the intent to die. (c)**Self- mutilation**: It refers to the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent .This includes major self-injuries causing major tissue damage or loss.(d)**NSSI**: It is defined as direct behaviour that causes minor to moderate physical injury, that is undertaken without conscious intent of suicide, and that occurs in the absence of psychoses and/or any organic intellectual impairment. (DSM-5) (e) **Suicide:** The word 'suicide' is derived from the Latin word suicidium which means 'to kill self'. Suicide is the death brought onto self that is deliberate rather accidental.

**Difference between Suicide/Failed Suicide and DSH**: Suicide/Failed Suicide and DSH both are different term, below mention table highlights these differences :-

| **Factor** | **Suicide/Failed Suicide** | **Deliberate Self Harm** |
|---|---|---|
| Age | All Ages | Adolescents And Young Adults |
| Illness | Anxiety Related Illness | |
| Intentionality | To End Life and Escape Pain | To Drain Pent-Up Emotions |
| Lethality | High to Medium | Medium to High |
| Methods | Significantly Harmful Like Shooting | Less Harmful |
| Repetition of Modes | Usually Single Mode | Usually Multiple |
| Stress | May Not Be Significant | Significant |
| Repetition of Modes | | |
| Past History of Similar Attempt | May Be Present | Usually Present |
| Family History of Suicide/Serious Attempt | May Be Present | Less Likely |

***Risk factors***

Age**:** Self-harm is rarely occurred before puberty. Adolescent age group is the most vulnerable group for self harm.Older people are at much lower risk and when they do self-harm they are much more likely to commit suicide later (Schmidtke et al, 1996).**Sex:** Mor**e** common in women (Schmidtke et al, 1996) Whereas being male is an important risk factor for suicide. Marital status**:** The risk of self-harm was reported to be 11 times higher for separated and divorced people than for those not in this category (Petronis et al, 1990). Employment status**:** Risks of self-harm may be raised in people or communities with insecure employment situations (Hawton et al 2013). Socioeconomic disadvantage: Low socioeconomic status, a low level of education, low incomes, and living in poverty are all risk factors for self-harm. Self-harm admission rates are higher in areas of socioeconomic deprivation (Gunnell et al, 1995)**.** Family factors**:** Risk is greater for children of separated or divorced parents, in families where there was marital discord, or where the mother was very young or poorly educated. Maladaptive parenting and childhood maltreatment may increase the risk of self-harm (Mittendorfer-Rutz et al, 2004). Religion/Religious beliefs prevented people from attempting suicide (Eagles et al, 2003). Moral objections were clearly a factor for depressed patients who had not self-harmed, compared with those who had (Malone et al, 2000). Sexual orientation Men and women with gay, lesbian, or bisexual orientation are more likely to self-harm than are heterosexuals (Skegg et al, 2003; Jorm et al, 2002). Physical illness**:** Physical illness is associated with self-harm, particularly in elderly people. Epilepsy, HIV infection and Past head-injury are few of the risk factors which can have causative or precipitator role (De Leo et al, 1999).Situational factors**:** An adverse life event, especially one involving interpersonal conflict or a relationship breakdown, could trigger self-harm in a vulnerable person (Beautrais et al, 2000).

***Psychiatric disorder and Motives***

Psychiatric disorder has been detected in about 90% of DSH patient who are seen in hospital (Souminen.,1996., Haw et al., 2001). Self-injury has long been linked to other disorders as well, including post-traumatic stress disorder (Briere and Gil, 1998; Bolognini et al., 2003), depressive disorders (Darche, 1990), obsessive-compulsive disorder (Bolognini et al., 2003), anxiety disorder (Darche, 1990; Simeon and Favazza, 2001), borderline personality disorder ( Nock et al., 2006), and eating disorder (Iannaccone et al., 2013).

Motive for DSH are difficult to identify, patient usually try to hide. Common motives are as follows: To die, to escape from unbearable anguish, to obtain relief, to change the behaviour of others, to escape from a situation, to show desperation to other, to get back at other people /make them feel guilty, to get help.

**A Cry For Help:** This motive of influencing other people in hope to call forth ‘action from the human environment ‘, was first emphasized by Stengel and Cook(1958).This behaviour since been referred to as ‘a cry for help’.

**Predictor of repetition after DSH:** One out of six patient of DSH repeat self -harm within 1 year and one out of four patient of DSH repeat self -harm within 4 year (Owens et al.,2002).The Predictor of repetition of DSH are previous DSH, Previous psychiatric treatment, personality disorder, alcohol or other psychoactive substance use, criminal record, unemployment, Psychosocial stressors etc.

## ASSESSMENT

The assessment procedure can itself be highly therapeutic. The assessment should be conducted in a way that encourage patient for self- help, as many of these people avoid to visit a psychiatrist again. Informants, such as a partner, relatives and friends, colleagues, General Practitioner should be inquired. Although attempt may be non-serious person must be taken seriously. Assessment is an ongoing process and person should be reassessed continually. No guess work approach should be used while working with self- destructive person. Assessment is concerned with following issues like (a)The Immediate risk of suicide (b)Repetition of DSH(c)Current medical or social problems etc.

Suicide intent is the degree to which the person wished to die at the time of act. It is difficult to assess because most people are ambivalent and because reported intent may change quickly. Factors to be assessed are :(i) Implementation Factors such as agent used, toxicity, impaired consciousness, reversibility and treatment required.(ii) Rescue Factors likes Place, Probability of discovery, accessibility to rescue, the delay before rescue etc**.**(iii) Preparation Action involves acquiring a method, Suicidal talk, Giving away prized possessions, making will, Suicidal note etc**.**

There are some factors that suggest high suicidal intent : (a)Act carried out in isolation(b) Act timed so that intervention is unlikely (c) Precautions taken to avoid discovery (d) Preparation made in anticipation of death(e.g. Making a will, organizing insurance, leaving a note) (e)Preparation made for act(purchasing means of suicide).The factors which predict future suicidal attempt are (a) Still thinking about suicide(b)Have made prior suicide attempt (c)Living alone(d)Depressed, manic, hypomanic, severely anxious, or have mixture of these states. Substance abuse alone or in association with mood disorders (e)Irritability, agitation, threatening violence to others, delusional or hallucinating(f)Low socioeconomic status (g)Criminal record (h)Unemployment**.**

## MANAGEMENT

There are some principles related with DSH: (a)Accurate diagnosis and appropriate treatment for associated psychiatric disorder is a major strategy for suicidal attempt.(b)Physician should always inquire about suicidal thought and plans as a routine part of every diagnostic evaluation and in every visit, both positive and negative findings should be documented.(c)The physician must establish a therapeutic relationship with the patient and should negotiated with the hope to improve patient's compliance and reduce the likelihood of further suicidal behaviour.(d) patient promises not to engage in suicidal behaviour and should inform the parents, therapist or other responsible adult if he/she has thoughts of suicide or develops plans to commit suicide.

### *Community based intervention*

Community based intervention is also required for reducing DSH. These activities are (a) Educating teacher, parents, peers to identify warning signs of an impending suicide (b)Direct case finding and screening in schools/colleges. (c) Media counseling to minimize imitative suicide (d)Training professional to improve recognition and treatment of mood disorders.

### *Outpatient and inpatient care*

Patient can be managed on outpatient basis, but the decision is based on: Physical status of the patents, absolute risk of suicide - social support, method used, patient's wishes, an appraisal of the patients ability to comply with the treatment plan, strength of the therapeutic relationship between patient and physician. In some cases inpatient care is required for

Provides safe environment, removal from the environmental stresses, opportunity for careful diagnostic workup, intensive psychotherapeutic and psychopharmacological intervention. If required admit in general medical or surgical unit.

***High risk management***

There are some precaution required for the management of DSH like, attendant to accompany the patient, scissors, razors and other potentially lethal objects should be removed and plastic utensil to be used, no medicine with the patient, not to be left alone, to be assisted even to toilet, constant supervision by staff, bed should be located close to the nursing station within easy view, shatter proof window of the room, doors of the room without latches/bolts from inside, patients to be protected from jumping from upper story windows and from falling down open stair, consultation with family member to be done to deal with their reaction and feeling about the attempt, physician should pay particular attention to the nurse's notes which often report the patients talk of wanting to die or symptom of depression**.**

***Psychopharmacological Intervention***

Those who self-harm is at increased risk of future episodes, including overdoses of medication. There are large differences in the toxicity of medication prescribed to people who self-harm (Hawton et al., 2010). Antidepressants: SSRIs have added benefit of greater margin of safety in overdose. However studies have reported that prescription of SSRIs may be associated with an increase in suicidal behaviour particularly in young people (Barbui et al., 2009),TCAs -High rate of death in overdose, Mood Stabilizers – Lithium, Maintenance therapy with lithium reduces the risk of future suicide and Lithium may have specific neuropharmacologic properties not found in other mood stabilizers Cipriani *et al.*, 2005; Meltzer *et al.*, 2003).Antipsychotics – Clozapine is found to reduce suicide rate in schizophrenic by 75-85% in several uncontrolled clinical trials and an epidemiologic study. Othwers advantages of this drugs are improved symptom control, cognitive improvement, direct antidepressant and mood stabilizing agent, reduced EPS, improved compliance and improved insight coupled to a decrease in hopelessness.(Cipriani *et al.*, 2009; Meltzer *et al.*, 2003).

***Psychotherapies***

Psychotherapist may be perceived as the last ballast of hope something worth for. Psychotherapeutic techniques should aim to decrease intolerable feeling and thoughts (of depression, worthlessness, anxiety, anger, hopelessness, inability to find solution to frustrating circumstances, impulsivity etc.) and to reorient the cognitive and emotional perspectives of the suicidal behavior.

1. **Problem Solving Therapy (PST):**PST can also effective for reducing DSH. The steps of PST are: Identification of personal problem, contracting a problem list which classifies and prioritizes them, reviewing possible solutions for a target problem, Implementing the chosen solution-appraising the problem, Reiterating the process, Training in problem solving skills for the future
2. **Dialectical Behaviour Therapy:** It is an adaptation of Cognitive Behaviour Therapy, specifically designed for chronically parasuicidal individual with BPD.It is a manualized treatment, combines treatment strategies from behavioural, cognitive and supportive psychotherapies. (Bateman and Fonagy,2009). Treatment goals are hierarchically ordered by importance as follows: Reduction of parasuicide that interfere with the process of therapy, Reduction of behaviors that interfere with the process of therapy, Reduction of behaviours that seriously interfere with quality of

life. DBT Sessions are concomitants weekly an hour for individual (1hr) and two and half hours for group therapy (2½ hrs).

3. **Interpersonal Therapy: This** is time limited therapy, focus on current Interpersonal relationships and immediate social context.
4. **Family Therapy:** Family intervention decreases discord, poor communication, disagreements, lack of cohesive values and goals, enhances effective family problem solving and conflict resolution, and reduce blame directed towards the suicidal patients**.**
5. **Crisis Card and Crisis Hotline:** The Card carries the advice about seeking help in the event of future suicidal feelings. Card can be used to speak to the psychiatrist at notice and to request psychiatric admission in a crisis. Crisis Hotline could not be popular, reason - patient severely disturbed, not able to reach the hotline, busy hotline, answers given may be stereotyped.

***Management issues***

Patient who refuse to be interviewed, or who seek to discharge themselves, have very high rates of repetition (Crawford and Wessely, 1998). Patient who has harmed him or herself but is alert and conscious should be presumed to have the mental capacity to refuse medical advice unless shown otherwise. If the patient insists on leaving, they have to be allowed to go,but they should be encouraged to return, and given an emergency contact number and options for further treatment. The situation should be discussed as soon as possible with patient's general practitioner. Frequent Repeaters :Some patients take overdoses repeatedly at times of stress, Often the behaviour seems intended to reduce tension or gain attention, When overdoses are taken repeatedly, relatives often become unsympathetic or even overtly hostile and staff of hospital emergency department may feel frustrated, Unfortunately, neither counseling nor intensive psychotherapy is usually effective.

## CONCLUSION

Prevalent general attitude of self-harm behaviours as either a 'Psychological blackmail' or a serious attempt to end one's life, among health care providers needs a revision. This needs to be supported by further research in the area. More consensual use of terminologies related to self-harm will improve the scope for research and improve clinical utility benefiting the 'distressed', thereby. Now a days several interventions appear to hold promise for reducing NSSI, including dialectical behaviour therapy, emotion regulation group therapy, manual-assisted cognitive therapy, dynamic deconstructive psychotherapy, atypical antipsychotics, naltrexone, and selective serotonin reuptake inhibitors with or without cognitive-behavioural therapy.

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***Acknowledgements***

The author appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interest***

The author declared no conflict of interest.

**How to cite this article:** A Jain, P Kumar & R Gupta (2020). Deliberate self-harm: An Update. *International Journal of Indian Psychology*, *8*(2), 740-749. DIP:18.01.089/20200802, DOI:10.25215/0802.089