UNIT 1  DELIBERATE SELF-HARM AND SUICIDE

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1.0  INTRODUCTION

Self-harm, self-inflicted violence, self-injurious behaviour or moderate self-mutilation is defined as a deliberate, intentional injury to one’s own body that causes tissue damage or leaves marks for more than a few minutes.

Several synonyms have appeared in the literature including para-suicide, attempted suicide, deliberate self-harm, deliberate self-poisoning, and more recently simply “self-harm”. In this unit, you will learn and understand deliberate self-harm and suicide – their causes and prevention.

1.1  OBJECTIVES

After studying this Unit, you will be able to:

- define self-harm and suicide;
- describe epidemiology of self-harm and suicide;
- know the risk factors associated with self-harm and suicide;
- explain the causes of self-harms and suicide;
- describe the importance of prevention of self-harm and suicide; and
- discuss the management of patients who self-harm and attempt suicide.
1.2 MEANING AND DEFINITION

World Health Organization (1986) defined self-harm as, “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”. On the other hand, suicide is defined as the act of deliberately killing oneself.

Self-harm is a complex behaviour that can be best thought of as a maladaptive response to acute and chronic stress, often but not exclusively linked with thoughts of dying. It is a form of non-fatal, self-destructive behaviour that is believed to occur when an individual’s sense of desperation outweighs his/her inherent self-preservation instinct.

The word suicide was first used by the English author Sir Thomas Browne in 1642 in his treatise “Religio Medici”. The word originated from SUI (of oneself) and CAEDES (murder). Suicide is a complex phenomenon determined by several factors. It not only affects the individual but also family and friends. It also impacts the community and the larger society in terms of loss of valuable human resource. There are several terms related to suicide: suicidal ideation, attempt and completion of the act.

Suicidal ideation refers to the thoughts about suicide. This may again consist of ideas of intent or death wishes; reflecting the degree of seriousness.

Suicide attempt refers to the acts taken by the individual to die. It may result in failure attempts where the individual could not die despite the attempt to die. In the other case, it is only an attempt and results in deliberate self harm or intentional self harm. They intentionally injure themselves but do not have an intention to die.

Completed suicide refers to suicide attempt resulting in death. It is marked by ‘intent’ or ‘intentionality’ and ‘lethality’. Intent is inferred by the nature, elaborateness, confidentiality and secrecy of the suicide plan; and also attempts to finish the unfinished tasks of life and sort of trying to wind up things in his life. Lethality refers to the degree of severeness of the method used for suicide where the person sees the attempt as a final one.

1.3 EPIDEMIOLOGY

Data from developed countries suggest that about 1 in 200 people attempt self-harm. Two thirds of patients who self-harm are less than 35 years old and two thirds of people in this age group are female. There is particular concern that the rate in young men aged 15-24 years of age is rising more quickly than in any other group. Here, it should be emphasized that self-harm and suicide are related yet somewhat different phenomena, and this is best illustrated by the differences in their epidemiological features. Suicide is more common in older men while self-harm is more common in younger women; and the gap between the two genders seems to be widening as the rate of suicide among men is increasing (as is the case also for self-harm in young men).

The importance of deliberate self-harm behaviour is illustrated by the subsequent risk of suicide, which, in the subsequent year, is at least 100 times more in those who have self-harmed as compared to the general population and the risk of suicide is about 3%
even after 10 (or more) years of the first attempt. The risk of repetition of self-harm is also extremely high; up to 40% will go on to repeat, including 13% in the first year. Self-harm is found to be one of the top five causes of acute medical admissions for both men and women.

Suicide has been found to be the third leading cause of death among the youth worldwide. The suicide rate in India is comparable to that of Australia and the USA and the increasing rates during recent decades is consistent with the global trend (Radhakrishnan & Andrade, 2012).

Data on suicide in India are available from the National Crime Records Bureau (NCRB), Ministry of Home Affairs. As per the report of NCRB (2010), of late, suicide rates show an increasing trend in India. NCRB 2010 Report cites consumption of poison as the most common mode of suicide. Followed by it are hanging, self-immolation, drowning, jumping from buildings as other commonest modes of suicide in India.

Table 1.1 gives the features that predict repetition of self-harm or eventual suicide.

### Table 1.1: Features which predict repetition of self-harm or eventual suicide

<table>
<thead>
<tr>
<th>Repetition of self-harm</th>
<th>Eventual suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A history of self-harm prior to current episode</td>
<td>• Older age</td>
</tr>
<tr>
<td>• Psychiatric history, especially as in-patient</td>
<td>• Male gender</td>
</tr>
<tr>
<td>• Current unemployment</td>
<td>• Previous attempts</td>
</tr>
<tr>
<td>• Lower social class</td>
<td>• Psychiatric history</td>
</tr>
<tr>
<td>• Alcohol or drug-related problem</td>
<td>• Unemployment</td>
</tr>
<tr>
<td>• Criminal record</td>
<td>• Poor physical health</td>
</tr>
<tr>
<td>• Antisocial personality</td>
<td>• Living alone</td>
</tr>
<tr>
<td>• Hopelessness</td>
<td></td>
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<tr>
<td>• High suicidal intent</td>
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</table>

### Self Assessment Questions 1

1) Which of the following terms should not be used interchangeably with self-harm?
   i) Self-injury
   ii) Para-suicide
   iii) Self-inflicted violence
   iv) Deliberate self-poisoning
   v) Suicide

2) While interviewing a client who is facing family-related stressors, you see cut-marks on her wrists. On asking, she reveals that she indulged in self-harm (i.e.
slashed her wrists) on a few occasions about 6 months back after a break-up. She also informs that now she is much more stable and settled in life. Should you be concerned about the possibility of recurrence of self-harm? Give reasons for your answer.

- Yes
- No

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1.4 CAUSES

This aspect can be viewed from several perspectives, such as:

- Individual’s motive for committing the act;
- Intentions at the time of the act;
- Functions served by the act of self-harm;
- Social precipitants; and
- Mental health reasons.

1.4.1 Intentions and Motives

Self-harm may involve little pre-mediation or may have been contemplated for some time. Some individuals, especially the elderly, may have serious suicidal ideas before the act and survive only as a result of misjudgement or chance events. The motivation for self-harm may appear to be complex and very personal. Given below are examples of motives given by some individuals who have self-harmed:

- “It expresses emotional pain or feelings that I’m unable to put into words!”
- “It’s a way to have control over my body because I can’t control anything else in my life”
- “I usually feel like I have a black hole in the pit of my stomach, at least if I feel pain it’s better than feeling nothing”.

Suicidal intent is said to be the extent to which the person wishes to die at the time of committing the act. While it can be difficult to assess the difference between an attempt to self-harm and to commit suicide in some situations, as many individuals are ambivalent about the intent to die and the reported intent may change fairly quickly, it is clear that most people who attempt self-harm do not wish to die; rather it serves various other functions, e.g. an attempt to regain some control over oneself; to combat feelings of inner emptiness; or simply to express unbearable pain. This is discussed in greater details in the next section.

1.4.2 Functions Served by Self-Harm

Klonsky (2007), on the basis of examination of empirical literature, delineated seven functions served by the act of self-harm; as shown in Table 1.2.
Table 1.2: Functions of Self-Harm

<table>
<thead>
<tr>
<th>Function</th>
<th>Description</th>
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<tbody>
<tr>
<td>Affect Regulation</td>
<td>To alleviate acute negative affect or aversive affective arousal</td>
</tr>
<tr>
<td>Anti-suicide</td>
<td>To replace, compromise with, or avoid the impulse to commit suicide</td>
</tr>
<tr>
<td>Feeling generation</td>
<td>To end the experience of depersonalization or dissociation</td>
</tr>
<tr>
<td>Interpersonal-influence</td>
<td>To seek help from (or manipulate) others</td>
</tr>
<tr>
<td>Interpersonal boundaries</td>
<td>To assert one’s autonomy or a distinction between self and other</td>
</tr>
<tr>
<td>Self-punishment</td>
<td>To derogate or express anger towards oneself</td>
</tr>
<tr>
<td>Sensation-seeking</td>
<td>To generate exhilaration or excitement</td>
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</table>

**Affect regulation:** It is believed that an early family environment that does not validate (support or corroborate) the experiences of the growing child may impair his/her ability to cope with emotional distress. Individuals from these environments and/or with genetic disposition for emotional instability are more prone to use self-harm as a maladaptive affect-regulation strategy.

**Anti-suicide:** Individuals may use self-harm as a coping mechanism for resisting urges to attempt suicide. From this perspective, self-harm may be thought of as a means of expressing suicidal thoughts without risking death.

**Feeling generation:** It has been suggested that individuals who self-harm may have experienced dissociation (a perceived detachment of the mind from the emotional state or even from the body) when loved ones were perceived as absent (e.g. a very erratic or depressed mother) for prolonged periods (this is psychologically very distressing to the child). Episodes of dissociation or depersonalization may then recur (later in life) in response to intense emotions. Causing injury to oneself creates physical sensations that interrupt a dissociative episode, and leads one to regain a sense of self.

**Interpersonal-influence:** At times self-harm may be used to influence (or even manipulate) people. Self-harm has often been conceptualized as a cry for help, a means of avoiding abandonment, or an attempt to be taken more seriously or otherwise affect people’s behaviour. For example, an individual might self-injure to elicit affection from a significant other (e.g. parents, spouse).

**Interpersonal boundaries:** Individuals who self-harm are thought to lack a normal sense of self due to insecure attachment with early attachment figure(s) and a subsequent inability to individuate (form a cohesive self-identity). Self-harm (e.g. cutting) as a deliberate or autonomous act is perceived as an assertion of one’s identity or autonomy; and thus an affirmation of a distinction between oneself and others.

**Self-punishment:** Self-harm can be an expression of anger or derogation towards oneself. It has been hypothesized that individuals who self-harm have learned from their environments to punish or invalidate themselves.

**Sensation-seeking:** Self-harm may be perceived as a means for generating excitement or exhilaration in a manner similar to Russian roulette (a potentially lethal game of chance in which participants place a single round in a revolver, spin the cylinder, place the muzzle against their head and pull the trigger).
1.4.3 Social Factors

Those who are isolated or living in areas of socio-economic deprivation have increased rates of suicide and deliberate self-harm. Vulnerability or predisposing factors such as early loss or separation from one or both parents, childhood abuse, unemployment, and absence of living in a family unit are also found to be contributory. Evidence also suggests that the person may have suffered an excess of life events, especially in the month before the self-harm attempt. Frequently, the type of events experienced by younger people is related to relationship difficulties, but in older people it is more likely to be health or bereavement related.

Certain factors in the family’s environment may also be important, such as parental discord and violence, parental depression or substance abuse, role models of suicidal behaviour in the family, abuse of all kinds (e.g. physical, verbal or sexual) and bereavement.

1.4.4 Mental Health Factors

Mental health difficulties are frequently seen in individuals who self-harm. Individuals diagnosed with certain types of mental disorder are much more likely to self-harm. These include depression, psychotic illnesses like schizophrenia, phobias, alcohol and substance problems and personality disorders. Sometimes, repetitive self-injury is also seen in individuals with mental retardation; however, this must be differentiated from the deliberate self-harm caused with a conscious intent of harming oneself.

Certain psychological characteristics are more commonly found among the group of people who self-harm; including hopelessness, impulsiveness, aggression, inflexible and impulsive cognitive style, impaired decision-making, poor coping skills, poor frustration-tolerance, and poor problem-solving abilities.

While nearly all mental disorders have the potential to increase the risk for suicide, studies show that the most common disorders among people who die by suicide are major depression and other mood disorders, and substance use disorders, schizophrenia and personality disorders (Bertolote & Fleischmann, 2002). Findings regarding the relationship between mental disorders and suicide mostly come from “psychological autopsy” studies. These in-depth investigations rely on interviews with family, close friends, and others who were in close contact with the person who died by suicide, in order to identify factors that likely contributed to the death. Such studies have consistently found that the overwhelming majority of people who die by suicide—90% or more—had a mental disorder at the time of their deaths. Often, however, these disorders had not been recognized, diagnosed, or adequately treated (Bertolote & Fleischmann, 2002).

Depression has been found to increase the risk of suicide. Even in case of bullying, the high school students who had symptoms of depression at the time they were bullied were found to have suicidal ideation and behaviour in post-high school follow up. On the other hand, the bullied youth who did not have co-existing depression had significantly lower risk for later mental health problems (Klomek, et al, 2011).

Understanding suicide

Suicide is precipitated by a wide range of factors that interplay with each other to influence the act of suicide. As reported by Gajalakshmi and Peto (2007), a complex array of factors such as poverty, low literacy level, unemployment, family violence, breakdown of the joint family system, unfulfilled romantic ideals, inter-generational conflicts, loss of job or loved ones, failure of crops, growing costs of cultivation, huge
debt burden, unhappy marriages, harassment by in-laws and husbands, dowry disputes, depression, chronic physical illness, alcoholism/drug addiction, easy access to means of suicide contribute to committing suicide.

Exposure to completed and attempted suicide in the family has also been found to increase suicide risk among family members by providing a “social model” of self-harm behaviour (de Leo & Heller, 2008). Imitative behaviour (“contagion”) plays a role in the precipitation of suicide. Recent studies have concluded that media coverage of suicide is connected to the increase—or decrease—in subsequent suicides, particularly among adolescents (Sisask & Varnik, 2012). High volume, prominent, repetitive coverage that glorifies, sensationalizes or romanticizes suicide has been found to be associated with an increase in suicides (Bohanna and Wang, 2012). There is also evidence that when coverage includes detailed description of specific means used, the use of that method may increase in the population as a whole (Yip et al., 2012). The emerging phenomenon of “cyber-suicide” in the internet era is a further cause for concern (Rajagopal, 2004; Birbal et al., 2009).

Various theories have attempted to explain suicide. Biological theories cite the role of neurotransmitters in the causation of suicide and underlie the genetic basis of suicidality. On the other hand, sociological explanations emphasize the role of society in causing the suicide act. e.g., Emile Durkheim explains suicide in terms of social integration and social regulation. Thus suicide is viewed not on an individual level, but at a community and societal level.

Psychoanalytic theory of Freud talks about ‘death instinct’ as a basic instinctual force which in some situations may be turned inward to harm oneself. Other theories have also discussed about sense of hopelessness, stress, extent of perceived threat to life as contributing to suicidal behaviour.

<table>
<thead>
<tr>
<th>Self Assessment Questions 2</th>
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<tbody>
<tr>
<td>1) Self-injury should not be termed self-harm if it is due to:</td>
</tr>
<tr>
<td>i) Desire to seek attention</td>
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<tr>
<td>ii) Desire to manipulate others</td>
</tr>
<tr>
<td>iii) Childhood abuse</td>
</tr>
<tr>
<td>iv) An underlying mental illness</td>
</tr>
<tr>
<td>v) An inability to solve problems</td>
</tr>
<tr>
<td>vi) Mental retardation</td>
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1.5 PREVENTION

The ideal method of protection against self-harm is prevention, i.e., reduction of number of new cases as well as prevention of further self-harm in individuals who have harmed themselves at least once. The former can be attained by using public health measures that can modify social, economic, and biological conditions, such as reduction of poverty, violence, divorce rates, and promotion of a healthy lifestyle. Also, measures for mental health promotion and life-skill training (e.g. in schools) are useful ways for prevention of self-harm and suicide.

Clinicians can minimize the risk of self-harm and suicide among their patients/clients by thoroughly assessing for the presence of psychiatric illnesses, being aware of clinical
and social situations that might precipitate self-harm and initiating treatment with or facilitating access to treatment for patients with psychiatric disorders. Also, they can do a careful risk-assessment; provide easy access to help for psychosocial problems and also scrutinize prescriptions (medication). Educating patients and their families about mental illness (if any), and the safe storage of medications and pesticides also is useful in prevention of self-harm and suicide.

1.6 MANAGEMENT

Important principles of management are:

- Establishing adequate rapport with the patient
- Privacy and maintenance of confidentiality
- Conduct interview safely and with adequate time
- Let patient tell their story
- Question relatives and friends about what patient has recently said

Illustrative Case

A 24-year-old man presents to a counsellor’s office complaining of difficulty falling asleep. During the interview, he says that something is wrong — he has no energy, is crying almost every day, has lost his usual healthy appetite, and has started using alcohol frequently in an attempt to fall asleep. He admits that he sees the world as hopeless and has considered driving his motorcycle into a wall. He says that he would not kill himself, however, because suicide is a sin, and his parents would be saddened and shamed by such a death. Until his girlfriend left him two months earlier, he had never had these symptoms. Also due to not being able to sleep, he is reaching office late since a few days and getting scolded by his boss everyday. In frustration, he has started engaging in cutting himself whenever the thought of suicide or his girl-friend occurs to him. He wants help in sleeping but fears the impact of treatment on his ability to continue his job which involves a lot of driving. History also revealed presence of depressive symptoms in mother, and frequent fights between the parents. Patient’s premorbid personality revealed poor frustration tolerance and a high need for achievement.

1.6.1 Assessment

There are countless ways that someone may self-harm, the most common being cutting, used by over two thirds of those who self-harm followed by self-poisoning (e.g. overdose of medications, use of pesticides). The other methods of self-harm include burning, punching, etc. A person with self-harm may exhibit signs like cuts, scratches, burns or scars, bruises or even broken bones. There may be other give-aways like missing razors or pills, or razors/medicine wrappers/pesticide bottles found in the dustbin.

The purpose of the assessment is to identify factors associated with suicidal behaviour, to determine the motivation for the act, to identify potentially treatable mental disorders, and to assess continuing risk of suicidal behaviour. It also includes assessment and treatment of the patient’s physical condition, having a basic understanding of medico-legal issues, and drawing up and implementing a treatment plan.

All patients presenting with deliberate self-harm should be offered not only a sensitive assessment of risk, but of psychological and social needs as well. The main issues to be determined in the assessment process are:
- What were the patient’s intentions?
- Does the patient still want to die?
- Are there current mental health difficulties?
- What is the risk of further self-harm or suicide (assessment of risk)?
- Are there any current medical or social problems (assessment of need)?

Assessor should regularly inquire about current depression, hopelessness, and suicidal-ideation. The risk of suicide should be considered imminent if the patient reports the intention to die, has a suicidal plan, and has lethal means available. Expressions of despair and hopelessness also suggest an imminent risk. A common myth is that enquiring about suicide would put ideas into the patient’s mind. However, that is not the case and it is important to ask in detail about whether the patient has any intention of committing suicide and he/she should be allowed free expression. Useful questions in relation to hopelessness, wish to die, and suicidal ideas that should be considered in any evaluation for self-harm can be formulated as follows:

- Are things so bad to make you take such a step?
- Who all are there in your family? What do they think about this?
- How do you see the future? Do you think that things would work out?
- Do you ever feel that life isn’t worth going on with?
- Do you think that you might do something to harm yourself?
- What stops you from carrying it out?
- Have you ever felt like this before? If so, how frequently and under what circumstances?

On the basis of assessment, a formulation may be reached that includes:

- **Long-term vulnerability factors**: It includes early loss or separation from parents, difficult relationships with parents, or abuse in early life. Although sexual abuse has been highly associated with self-harm, emotional or physical abuse is also important. Enduring psychological characteristics and other psychiatric problems need to be identified.

- **Short-term vulnerability factors**: These are current difficulties in relationships and lack of social support, work or health related problems, drug and alcohol misuse, or exacerbation of psychological symptoms.

- **Precipitating factors**: These are usually stressors experienced in the few days immediately prior to self-harm. Again relationship problems, financial worry, anniversaries, deaths or other losses can act as precipitators to the act of self-harm.

### Self Assessment Questions 3

1) A 13 year old girl comes to you with presenting complaints of not being able to adjust to new school and feeling low, and you see lots of cut-marks on her arms. How should you react?

   i) Ask the child
   ii) Ask the parents
   iii) Ignore, as no one has complained of self-harm
On the basis of the above three factors (long-term/short-term vulnerability and precipitating factors), make a formulation of the illustrative case given in 1.6.

1.6.2 Treatment

A crisis intervention model is often most appropriate, when initiating treatment. At the end of the interview, the assessor should be able to plan what action is to be taken collaboratively with the patient. This may involve treating any underlying mental illness or substance abuse appropriately, counselling, improving lifestyle, helping patient to develop coping skills to resolve stressful situations.

**Useful Tips when Dealing with a Case of Self-Harm**

- Understand that self-harming behaviour is an attempt to maintain a certain amount of control which in and of itself is a way of self-soothing
- Let the person know that you care about him/her and are available to listen
- Encourage expressions of emotions including anger
- Don’t make judgemental comments or order the person to stop the self-harming behaviour - people who feel worthless and powerless are even more likely to self-injure

Management of persons who engage in deliberate self-harm should focus on three major areas:

- Immediate medical management of self-harming behaviour
- Management of underlying psychopathology (medications and psychosocial therapies)
- Measures to prevent the recurrence of self-harming behaviour

Support, and especially company, should be mobilized, especially in the short term. A significant aspect of such intervention is the elimination of the patient’s access to potentially lethal means of suicide. Other health strategies that may prove important are telephone helplines, and more global social support measures. The patient may be given a “crisis-card”, which carries advice about seeking help in the event of future suicidal feelings. Self-help booklets may also be helpful in reducing repeat attempts in those without a borderline personality disorder.

Some of the **specific psycho-therapeutic modalities** that have been used with the individuals who self-harm are:

**Problem-solving therapy:** Problem solving therapy is a brief treatment aimed at helping the patient to acquire basic problem solving skills, by taking him through a series of steps:
- Identification of personal problems;
- Constructing a problem list which clarifies and prioritizes them;
- Reviewing possible solutions for a target problem;
- Implementing the chosen solution;
- Reappraising the problem; and
- Reiterating the process.

The therapy also includes training in problem-solving skills for the future. It usually involves about six sessions lasting one hour, with some reading materials and work to be undertaken between sessions. Problem solving therapy has been shown to be an effective treatment for self-harm and mood and social adjustment.

**Dialectical Behaviour Therapy (DBT):** This treatment was introduced to primarily help those who engage in chronic and repetitive self-harm, particularly when they have associated borderline personality characteristics. This treatment is intensive, involving a year of individual treatment, group sessions, social skill training, and access to crisis contact. Treatment studies indicate that DBT is effective in reducing some of the features associated with patients with borderline personality disorder, particularly self-harming behaviour.

**Family therapy:** Family therapy has been found to be especially useful for adolescents and young adults who self-harm. It has been found that many adolescents who self-harm have family problems. Moreover, when an adolescent or young adult engages in self-harm, it can be a very distressing event for the family members. They may be confused about their role or feeling guilty about the child’s act. It is important to establish an alliance with family members (without taking sides) by empathizing with their situation and giving them a reflective listening.

The main aim of family therapy is to help the adolescent and her/his family to resolve the difficulties that led to self-harm. Family therapy is focussed on improving communication and problem-solving within the family. It can also help to restore the equilibrium of the family system if it had been negatively affected by the episode of self-harm. Finally, family therapy may help in prevention of further episodes of self-harm.

Certain key issues may need to be addressed in family therapy:

- **Privacy:** Parents of children who harm themselves often fear that their child may self-harm behind closed doors. The youngster demands privacy by stating, “I am independent, leave me alone,” while at another level he may be testing whether the parents are able to understand the unsaid, “I am hurt and I need your help.” These conflicting messages need to be dealt in family therapy sessions wherein the competing tension within each conflict can be taken up in discussions. The issue of parent-child boundaries must be continually addressed and appropriate roles must be clearly defined and reinforced.

- **Suicide and serious harm:** A clear contract for ensuring that the adolescent does not intend and will not seriously harm him/her self may be made (a written and signed “No suicide contract”). It often has the conditions for immediate hospitalization spelled out. Parents also need continuous support in setting limits to unacceptable behaviours (saying “No” firmly but without harshness) despite their worries of sparking a self-harm episode.
Specific Issues on Mental Health

- **Balancing needs and desires:** Families often need help on where to draw a line between freedom and firm limits. The role of the therapist is to facilitate understanding between family members as to their needs and desires and also to negotiate some practical compromises between competing interests. Helping families acquire strategies for communicating and negotiating even in the midst of charged emotional encounters also models to the adolescent the need to use problem-solving strategies and directly address tough issues rather than acting them out.

- **Cutting and blame:** Often the adolescent who indulges in self-harm attributes it to external stressors, which is very often the parents and their behaviour, “My parents just don’t understand me; they think I am still a kid and can’t make any decisions”. On the other side, parents may take this to heart and assume that they, solely, are responsible for their child’s dysfunctional behaviour. Thus, the goal in therapy is to place the blame squarely to where it belongs. If it’s the adolescent’s mistake, then it’s the therapist skills that would come handy in making him/her accept the mistake without losing face. One way of achieving it is to make the parents talk about their “faults” when they were adolescents. Also, the adolescent should be appreciated for honestly accepting their role in their behaviour and the parents can be quieted in their critical, judgmental and “I told you so” attitude.

**Pharmacological and clinical management:** Antidepressants have a proven role when depression or anxiety is detected but are unlikely to have a role in cases where mood disorder has been carefully excluded. Psychiatric admission remains a valuable option when risk is high and/or serious mental health problems cannot be otherwise resolved. Regular follow up reduces the subsequent rate of deliberate self-harm.

<table>
<thead>
<tr>
<th>Useful tips that can be given to patients for stopping self-harm</th>
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<tbody>
<tr>
<td>• Writing about how you are feeling.</td>
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<tr>
<td>• Doing relaxation exercise.</td>
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<tr>
<td>• Distraction (doing some pleasurable activity).</td>
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<tr>
<td>• Going for a run, brisk walk, dancing, any form of exercise.</td>
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<tr>
<td>• Talk to a friend or your therapist — have a list of people you can ring.</td>
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<tr>
<td>• Find meaningful activities to do (e.g. voluntary work).</td>
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<tr>
<td>• Do not keep extra medicines/pills or pesticides in the house.</td>
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<tr>
<td>• Do not keep sharp objects (e.g. knife, blade etc.) near you.</td>
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</tbody>
</table>

Early detection of suicidal ideation and prevention measures are crucial. Various steps such as community awareness, media guidelines regarding reporting suicide, and helplines can work in the prevention of suicide. Further, counseling centres and NGOs can also contribute towards this. A multidisciplinary team consisting of psychiatrist, general physicians, psychiatric nurses, psychiatric social workers, and NGOs play a significant role in addressing the issue of suicide that contributes to a major loss of potential human resource.

### 1.7 REFERRAL

Risk of subsequent suicide is particularly high in those with high unresolved suicidal intent, depressive disorder, chronic alcohol and drug misuse, social isolation, and current physical illness.
The most common psychiatric condition associated with suicide or serious suicide attempts is depression, and also rates of depression are substantial after self-harm. Depression is a strong predictor of further self-harm. Suicidal thoughts and behaviour are state related in depression; and resolution of the depression will almost invariably alleviate thoughts of suicide. Personality disorders, alcohol and substance abuse, anxiety disorders, and schizophrenia are also frequently associated with suicidal behaviour. About 20% of those who attempt self-harm repeat it multiple times. This group is much more likely to include individuals with persistently maladaptive ways of coping, typically in the form of unhelpful personality traits. Chronic alcohol and drug problems are a strong risk factor for self-harm and eventual suicide. Current intoxication at the time of self-harm may indicate an impulsive (disinhibited) attempt, but its link with chronic alcohol problems should be explored and taken seriously.

Physical illness can be very distressing, especially when progressive or unpredictable. In a large multi-centered transnational study, 50% of people had a physical illness at the time of the attempt for which they had sought help. Frequently, physical illness is a risk factor for complete suicide without a previously detected attempt. Isolation is a risk factor for suicide and particularly for self-harm. The majority of suicides in the elderly involve those who are single or widowed.

Frequent repeaters, those with alcohol and substance use problems, those with physical or mental illness, and those who are isolated also require input from specialist mental health professionals. It is also recommended that adolescents and elderly people warrant a mandatory specialist assessment. Patients with one or more of these risk factors should be offered enhanced care that may include inpatient or outpatient follow up care, a list of local support resources, and, where possible, self-help material.

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<th>Self Assessment Questions 4</th>
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<td>1) List some of the therapist’s characteristics when dealing with a patient with history of self-harm.</td>
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1.8 LET US SUM UP

Self-harm is more common than it is usually believed. It is usually defined as an expression of personal distress. An individual episode of self-harm might be an attempt to end life. Self-harm may be more common in young females but it may occur in any age group and in both genders. Various ways of harming self are used, with cutting and self-poisoning being the most common. The nature and meaning of self-harm vary greatly from person to person. In addition, the reason a person harms him or herself may be different on each occasion, and should not be presumed to be the same. Many people self-harm as a way of coping or escaping from a painful situation. Many biological, familial, social and psychological factors have been implicated in self-harm. Management includes immediate medical management of injury and then long-term help to deal with underlying issues. While dealing with individuals with self-harming behaviour, it is essential for the counsellor to maintain an empathic and non-judgemental approach in both assessment as well as treatment; and adopt evidence-based and longer-term strategies to help individuals with self-harm problems.
1.9 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) (v) Suicide

2) Yes. A person who indulges in self-harm once (whatever be the reason has a very high probability that he/she may do it again.

Self Assessment Questions 2

1) Option (vi) - Mental Retardation. Self-injury that has not been carried out without an understanding of its nature and consequences, as in the case of mental retardation, is not considered self-harm.

Self Assessment Questions 3

1) Option (i) - As a counsellor, you should never ignore such signs. It is important to approach the patient in an empathic and non-judgemental manner and enquire about the injury marks. It is also important not to talk to family members before talking to the patient.

2) Long-term vulnerability factors: Depression in mother, conflictual family environment, dysfunctional personality variable, like, poor frustration-tolerance

   Short-term vulnerability factors: Break-up with girl-friend, difficulties in office, symptoms of depression

   Precipitating factors: Distressing thoughts about suicide and his girl-friend, lack of sleep

Self Assessment Questions 4

1) Therapist should be empathic, non-judgmental, good listener, and be able to deal with counter-transference issues.

1.10 REFERENCES AND SUGGESTED READINGS


