The psychology of self-harm and self-injury: does the wound management differ?

KEY WORDS
- Borderline personality disorder
- Deliberate self-harm
- Deliberate self-injury
- History, examination, investigation, diagnosis, intervention (HEIDI)
- Psychosis

Background: The discovery that a person is deliberately hurting themself is often met by a mixture of revulsion and fear, especially by those with a limited understanding of why a person may do it.

Content: This article seeks to elucidate the drivers of deliberate self-harm (DSH) and deliberate self-injury (DSI), to dispel some common myths about it, and differentiate where mental ill health is a factor and affects wound management. This article also provides pointers for supporting wound management. The acronym HEIDI (history, examination, investigation, diagnosis, intervention) is used as a framework for explaining wound assessment and how to identify the care needed.

Conclusion: Health professionals must understand the different approaches for patients who harm or injure themselves, and only then can empathic and holistic plans be agreed.

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Standard definitions put deliberate self-harm (DSH) and deliberate self-injury (DSI) in the same bracket. Depending on the source, these definitions can have either an emotional or a literal context. For example, MIND (2010) describe DSH and DSI as "a way of expressing very deep distress … a means of communicating what can't be put into words". The Royal College of Psychiatrists (RCP, 2014) state they are "an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent".

Neither of the two definitions above comfortably encompass the separate drivers that may motivate a person to self-harm or self-injure. The MIND (2010) definition is inaccurate for people injuring themselves due to hearing 'voices' or in a delusional state, and the RCP (2014) definition, while being clinically correct, is a 'cold' statement for describing people in emotional pain. For the purposes of this article, the author will separate DSH and DSI and refers to people with DSI as soley those with a psychotic illness.

BACKGROUND

Despite many of us practising DSH in socially acceptable forms, such as consuming alcohol, comfort eating and hard exercise, it remains a largely taboo subject (Sutton, 2007; MIND, 2010). None of these socially acceptable forms of DSH are considered abnormal when it comes to managing our personal stress levels, regardless of the causes.

Due to the extent to which DSH is misunderstood, the National Institute for Health and Care Excellence (NICE) has published two guidelines (NICE, 2004; 2011); they aim to ensure people in contact with services receive the non-judgemental and timely support they need. Initially, this support is delivered in the first 48 hours, and then it is continued on a longer-term basis.

Despite these guidelines, assumptions may still be made regarding people who DSH. Assumptions usually relate to pain management and labelling people as time wasters (McDougall and Brophy, 2006; MIND, 2010; Selfharm UK, 2015a).

Ousey and Ousey (2012) identified the emotional state a person may be in when seeking help and the need to be sensitive to this. While their paper refers to people who self-harm, the same is true of people with a self-injury. In fact, this group may be in a heightened state of mind due to their mental illness and lack of insight.

WHO MAY DO IT?

Despite DSH spanning all age groups, it is more common among young people (Lifesigns, 2008; NICE, 2011). A National Self-Harm Network (NSHN, 2009) survey identified that just over 50% of respondents were 17–25 years old. The studies report no boundaries in prevalence rates relating to ethnicity, social status or gender.

Eating disorders, such as anorexia nervosa and bulimia, are now considered a form of DSH. While it is beyond the scope of this article to explore the link between eating disorders and DSH, many experts think the origins lie in efforts to regain a sense of control — a factor associated with self-harm (Emerson, 2010).

The Royal College of Psychiatrists (RCP, 2014) assert that DSH is more frequent in prisoners, the mentally ill, ex-servicemen and women and asylum seekers. These groups of people are also likely to have challenges relating to control in their lives. Prisoners are one group who may use self-harming behaviour to manipulate their situation, for example, a change of cell or access to privileges (Deroo et al, 2013). Identifying the reasons behind a person's DSH should form part of their holistic assessment as the prison environment can be a place for bullying, loss of privacy and powerlessness (Sutton, 2007).

Historically, women have been identified as more likely to self-harm than men (Rethink, 2013), which correlates with a greater number being diagnosed with borderline personality disorder (BPD) and depression (MIND, 2013a). The incidence of self-harm among people with BPD is high (Perseius, 2006; Byrne and Rosen, 2014). Health professionals treating a person with this diagnosis must be aware of the key diagnostic features (see *Box 1*) to ensure careful management, ongoing treatment and discharge from care.

Box 1. Key diagnostic features of borderline personality disorder.

Difficulty maintaining stable relationships
Impulsive behavior
Overwhelming feelings of distress, anxiety, worthlessness and anger
Severe mood swings – can be suicidal in the morning and fairly positive a few hours later
Difficulty managing feelings without harming themselves
Over-developed sense of rejection, real or imagined
Can switch quickly from idealising to devaluing the care giver

Anyone experiencing a psychotic episode is at risk of DSI. While this is often a patient with a diagnosis of paranoid schizophrenia or psychotic depression, any auditory hallucinations (voices) could cause a DSI response. The presence of persecutory delusions and voices that threaten or give commands characterises paranoid schizophrenia (World Health Organization [WHO], 2015). The WHO (2015) class psychotic depression as "an episode of depression but with the presence of hallucinations and delusions". In the author's experience, these groups of people who are experiencing a psychotic episode often have more severe injuries, which frequently involve full-thickness burns (see *Box 2*).

WHY DO PEOPLE DO IT?

A healthy childhood that nurtures growth and development puts building blocks of warmth, love, security, food and trust into place (Resnick,

Box 2. Deliberate self-injury case examples.

Case 1
A 38-year-old Sikh gentleman diagnosed with psychotic depression. Voices in his head told him to pour petrol over his head. Using a petrol can from home he purchased petrol, poured it over his turban and set fire to it
Full-thickness burns covering the top of his skull, forehead and ears
Treated at a major burns centre where his skull was crosshatched and drilled to promote granulation 'burrs'
Treated with topical negative pressure initially; however, the gentleman was unable to tolerate this in the long term
Three years later, this gentleman is still receiving treatment for a non-healing area
Case 2
A 44-year-old gentleman with schizophrenia
Admitted via the burns and plastics department at a local hospital after pouring three kettles of boiling water over his head
Partial- and full-thickness burns to the gentleman's head, neck and shoulders
Informed staff that he had not stopped after the first kettle, despite the pain, because the voices had told him to carry on

Box 3. Psychological drivers of deliberate self-harm (DSH) and deliberate self-injury (DSI).	
DSH	**DSI**
Form of communication used when deeply distressed	Command voices instructing them to do something
Emotional release valve	'Thought insertion'
Self-punishment for perceived guilt	Delusional thoughts causing an inability to recognise reality
Prevent suicide	May have accompanying paranoia
Cleanse the past	
Attempt to gain some control of life	
End or enter a dissociated state	
Unable to cry	

2000; Bagdi and Vacca, 2005). Low self-esteem has been linked to DSH (MIND 2013b; Selfharm UK, 2015b) and may be seen where any of these building blocks are missing. Low self-esteem can manifest in a person's negative core beliefs of inferiority, uselessness, worthlessness and a sense of not belonging; deep-seated values such as these cause acute emotional distress that need an outlet.

Emotional, physical and sexual abuse are common historical factors among people who self-harm (RCP, 2009; MIND, 2010; Broadbent, 2011), all of which relate to the removal or exploitation of one of the developmental building blocks. For the child who is sexually abused, security and trust are removed; for the bullied adolescent, it may be the absence of the warmth, love and security associated with friends.

Sutton (2007) posits that the earlier the trauma, the greater the risk of long-term psychological and interpersonal problems. The practice of dissociation may also become embedded. Dissociation can be described as interference in patterns of memory, consciousness and perception that allows a psychological detachment from the trauma. Some people will self-harm to bring themselves out of a dissociative state, while others will do it to enter one (Perseius, 2006).

Crying can be an intrinsic part of our development and is used throughout life as an expression of our feelings; for example, happiness, sadness, pain, rage and grief. An inability to cry can lead to a bottling of emotion that, when it becomes unbearable, must have an outlet (Lifesigns, 2008; RCP, 2014). Where talking is not an option, cutting and burning may be. *Box 3* shows an overview of the drivers that motivate people to DSH and DSI.

COMMON MYTHS

DSH and DSI are symptoms rather than the core problem itself. People displaying DSH may not have a mental illness, although Emerson (2010) states that "nurses assume an association between self-harm and mental illness". It should be remembered that the majority of people who harm themselves do not have a mental illness but are managing their traumas in the only way they know how.

One of the most frequent misconceptions is that people who deliberately cut or burn themselves do it for attention (NICE, 2004; NSHN, 2009; Emerson, 2010). Conversely, the majority of people who self-harm do so without others knowing and care for the wound themselves, only presenting to healthcare services when they are unable to do this (NSHN, 2009; MIND, 2010). Historical evidence suggests this is due to the often dismissive attitude that some health professionals continue to have (NICE, 2004; MIND, 2010).

Ousey and Ousey (2010), when discussing the assessment of an individual who has harmed themself, states the need to identify whether the episode is due to trauma or attention seeking. This is disappointing as it perpetuates the myth of attention seeking and the statement needs further clarification regarding when it may apply. A review of a portion of the literature concludes that except in the case of some prisoners (as mentioned earlier), a person may self-harm to ask for help in a non-verbal way (Sutton, 2007; MIND, 2010; Rethink, 2013). The differentiation between this and attention seeking is that the person's aim is not to seek attention for their self-harm but to ask someone who hasn't heard to truly listen to them.

One of the original drivers for the NICE guidance of 2004 was the misconception that

people who self-harmed did so because they enjoyed pain and, therefore, didn't need analgesia during such interventions as wound stitching. Pain receptors can be numbed during an episode of self-harm or over-ridden by the psychotic compulsion during an episode of self-injury. If dissociation is used, the individual will separate their mind from their body during the act itself thus feeling little at a conscious level (Perseius, 2006). However, the person experiences pain when this state is released. For some people who self-harm, they wish to feel the pain to punish themselves for something they consider they are guilty of (Young Minds, 2015). Where a person is experiencing psychotic phenomena, they may have no control over their actions and the command voice may be so intense they have an over-riding urge to do something dangerous (MIND, 2013c). Meltzer et al (2002) estimated that 50% of people with a diagnosis of schizophrenia will self-injure during their illness.

Sutton (2007) asserts that far from being an attempt at suicide, DSH is an act that can prevent suicide. This supports MIND's (2010) assertion that self-harm is about "trying to stay alive". Although there have been incidences where people who self-harm have killed themselves, this happened either accidentally or due to an underlying illness, such as depression (Selfharm UK, 2015c). The NSHN (2009) also assert that self-harm is used to prevent suicide by providing an emotional outlet; those who do kill themselves do so not because they self-harm but due to their reasons for self-harming.

MANAGING WOUNDS

This article uses the Heinrichs et al (2005) acronym, HEIDI (history, examination, investigation, diagnosis, intervention), as a framework for discussing the assessment of wounds and for identifying the care needed.

History

It is vital to take detailed medical histories of people who self-harm or self-injure to identify any underlying conditions or medications that may delay healing. This may be difficult with both groups as levels of personal distress, previous experience or acute mental illness could inhibit dialogue. Essential information within the history taking involves identifying what the person used to inflict the wound and when they did so, what care the wound has received so far and what pain levels they are experiencing. An immediate risk assessment is needed at this stage to ascertain the potential for the person to harm themself or, in the case of psychosis, others (Broadbent, 2011).

Although it is beyond the scope of this article, the author strongly recommends readers familiarise themselves with the Mental Capacity Act (2005) and the principle of allowing a person to make an 'unwise' decision. This is a key element in self-harm as it is a coping mechanism that we, as health professionals, need to support while offering alternatives (Lifesigns, 2008; MIND, 2013c).

Where possible, professionals should seek to identify the underlying reasons for the wound. Such information may identify an ongoing safeguarding risk to the patient, an adult or a child. Health professionals must be aware of their responsibilities under local safeguarding policies.

History taking also provides an opportunity to consider longer-term management strategies, such as referral to mental health services or drug and alcohol teams, self-reporting cards and harm minimisation (NSHN, 2009; Ousey and Ousey, 2012). The NSHN have a 'self-harm report card' that provides health professionals with immediate information about the wound and the implement the person used and their mental state. People who are interested in downloading this report card can obtain it from the NSHN website (2009).

Examination

Whenever treating a self-harm wound, health professionals should remember that the size and depth of the wound is not indicative of the emotional distress felt (Sutton, 2007; MIND, 2010). Examination of any wound should involve noting: the tissue type; peri-wound; exudate volume and viscosity; infection indicators; size; and depth (Heinrichs et al, 2005; Fletcher, 2007). Consideration should also be given to potential tendon and nerve damage and the need to refer the person to plastic surgeons. Any referral, regardless of the discipline, needs full discussion with the patient to maximise their concordance (MIND, 2013c).

Investigations

The nature of self-harm and self-injury entail a high risk of infection (Corser and Ebanks, 2004; Hughes,

2013). A non-sterile implement used for cutting, gouging, or scraping can embed microscopic contaminants within the tissue. Partial- and full-thickness burns entail a high risk of infection due to the depth and extent of dead tissue and oedema (Wounds UK, 2013). Where burning is the chosen method of repetitive self-harm, thick scar tissue may be present that will inhibit oxygen and nutrient delivery to the wound. This hypoxia inhibits macrophage action and collagen synthesis, increasing the risk of wound infection.

Where known contamination is a factor, the author suggests not immediately swabbing the wound unless the practitioner can identify what they will do with the result. The nature of contamination means that infection is a possibility but it may not yet be apparent to the eye, i.e. clinical symptoms. The methods used to undertake swabbing are an inexact science (Patten, 2010). Angel et al (2011) recommend the Levine technique. Where contamination is a known factor, the author suggests treating the wound as infected for the first 48 hours by irrigating it with a PHMB (polyhexamethylene biguanide) solution; this allows time for infection to become evident if it is going to (WHO, 2009).

Diagnosis

When assessing a wound, professionals must consider its healing potential (Heinrichs et al, 2005). In addition to underlying pathologies, a wound's healing potential can vary according to the person's levels of ongoing emotional distress, concordance with the treatment plan, continuing wound harm and their insight.

Woo (2010) stated that levels of stress directly affect healing rates due to the release of cortisol reducing the inflammatory response and collagen synthesis. In addition, some patients require continued 'access' to their wounds as they represent an episode within their lives they are struggling with; the challenge for health professionals is how to support this. Stress levels within people who are floridly psychotic (experience full-blown hallucinations and/or develop delusions) may be raised due to enforced treatment for their mental health (Mental Health Act, 2007) or distress from the voices they hear. In addition, anti-psychotic medication can reduce neutrophil presence (Hughes, 2013). Therefore, diagnosis must consider the whole patient experience, the wound's aetiology, any contributing factors and results of any investigations or referrals.

Intervention

Any decisions regarding treatment interventions must be made in a partnership between the patient and the health professional; without this, the treatment is unlikely to be effective (Deroo et al, 2013). Ousey and Ousey (2010) posit the ideal that people who self-harm are referred on, with their agreement, to mental health services. However, Broadbent (2011) identifies that people who self-harm often decline talking therapies and Emerson (2010) suggests that some health professionals don't know how to approach people who self-harm. This difficulty can multiply due to a health professional's lack of knowledge about this issue and their fear of unpredictable behaviour from the people who are actively responding to voices (Brinn, 2000; Rethink, 2010).

Addressing the infection risk and engaging the patient in the treatment plan is the priority for people with either self-harm or self-injury wounds; this can be challenging where mental ill health precludes insight. NICE (2004) concurred with charities familiar with self-harm (NSHN, MIND, Lifesigns), in stating that successful treatment plans involve negotiating with respect for the person's needs and recognising that non-judgmental support for and validation of them are key.

In the author's experience, the most important first contact with self-harm involves reassuring the person you are not seeking to tell them to stop. This simple message immediately communicates to people who self-harm that you respect them and are not trying to take away their control (McDougall and Brophy, 2006; Lifesigns, 2008). On this basis a discussion can ensue, sharing what the examination has identified, any concerns relating to underlying structural damage or infection and the patient's aims.

The patient's aims are imperative to joint working, as some patients may need regular access to the wound to manage distressing thoughts; therefore, the health professional must tailor dressing requirements and advice to facilitate this (*Box 4*). The NICE (2004) recommendation that uncomplicated injuries

less than 5 cm in length are sealed with tissue adhesive does not take this into consideration. Sutton (2007) states that the "aim of reopening wounds is to keep the pain on the outside to distract from that inside." Health professionals should be aware that while a patient may, on presentation, wish the wound to heal, subsequent distress may cause them to re-open it; this may require an alternative strategy.

Delayed healing may occur in self harm due to repeated injury at the site, use of dirty objects and neglect, or a delay in seeking help (Deroo et al, 2013). The risk with repeated site injury is that the wound will change from acute to chronic. While that is beyond the scope of this article, it is important for practitioners to recognise this potential situation and its consequences for thewound.

Harm minimisation is a cornerstone for helping people who would like to limit or stop harming themselves as a way to cope. Health practitioners caring for those who self-harm are referred to the Selfharm UK (2015d) website for more information on this.

Treatment interventions for DSI wounds and the service user's active involvement will vary in accordance with their mental state. An initial contact may be with a person who cannot engage in a discussion about their wound or who is distracted throughout the consultation by voices. A skilled assessment will identify whether the patient is able to make an informed decision or whether the person requires a best interests decision to be made for them, as defined in the Mental Capacity Act (2007). Delusional thoughts and auditory hallucinations can cause extremes of violence to the body without thought of consequences. Health professionals involved in the early treatment stages need to accept that rationalisation is not an option as the patient is unlikely to have any insight; therefore, addressing the underlying emotions, such as fear, may be more supportive as this may help to establish a good therapeutic relationship (MIND, 2014). Explanations about interventions must also be uncomplicated and clear to avoid misinterpretation (MIND, 2014).

When devising treatment plans for people who are mentally unwell, health professionals must consider ligature risks as the use of a bandage or tubular retention is ill advised in such situations. Any health professional assessing an inpatient needs to liaise with staff prior to seeing the patient to identify whether ligatures present a risk.

Box 4. Joint working: case example.

A 23-year-old lady with history of domestic violence, who was due to give evidence against ex-partner
She had scarring from previous cutting, which she re-opened after a visit from a solicitor
Wound was gouged with sub-cutaneous tissue visible
The lady wanted to be able to access it to avoid cutting open any other areas when distressed
Provided with a silicone foam dressing that could be lifted/reapplied and packets of sterile forceps to minimise infection risk from actions
Information leaflet to help self care

CONCLUSION

Correcting the aetiology for people who self-harm is not an option as this is a relied-upon coping mechanism that cannot be stopped until either the underlying cause is addressed or alternative strategies are found. This also applies to people who self-injure in response to voices or delusional thoughts.

Empowering patients should be at the heart of all interventions, facilitating informed decisions through providing knowledge tailored to their needs. Empowerment encompasses not only first aid and dressing rationales and options, but also alternative coping strategies where appropriate. The author's organisation has used patients' input to provide an information leaflet for to the community, hospitals and the police. This leaflet aims to help people recognise when to seek help and how to care for themselves.

Sutton (2007) wrote of 'healing the hurt within' by breaking the cycle of negative beliefs that can lead to self-harm. Recent articles in the nursing press have focused on the psychological and wound management of self-harm; however, they have neither differentiated nor identified the important sub-group of self-injury due to psychosis. The management of DSH wounds differs from that of DSI as people who DSH may need continued access to express themselves

or cope with deep-seated distress. This does not preclude them from having meaningful discussions relating to their wound care and future management; instead, it should enhance that relationship when the health professional listens to and agrees the plan with them (Broadbent, 2011). While the risk of relapse is high, people who injure themselves as a result of a psychotic episode are unlikely to do so again once their delusional beliefs or auditory hallucinations have been controlled.

Health professionals need to understand the different approaches that may be needed for patients who harm or injure themselves, and only then can empathic and holistic plans be agreed. WUK

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