

# Suicide and Deliberate Self Harm

## ***Introduction***

This section deals with both the subject of people who commit suicide and those that survive after taking an overdose or harming themselves (deliberate self-harm, DSH, previously known as parasuicide). These two groups of people have rather different characteristics. The first group are more often male with a psychiatric illness. Typically they also plan their acts carefully, take steps to avoid detection, and use dangerous methods. Those in the DSH group more often are female, act impulsively, and in such a way as to be discovered. These differences will be discussed further later. However, it is important to realise that despite these differences there is considerable overlap between the groups.

## ***Suicide***

### **Overview**

There are around 4000 suicides per year in the UK, it being amongst the 10 commonest causes of death, and the fourth commonest for young adults. In addition, due to the strict legal criteria required for a verdict of suicide, it is estimated that it is under-reported by 30% to 50%. It is often classed by Coroners as 'accidental death', or 'open verdict', since for a verdict of suicide to be given it must be proven beyond reasonable doubt. When it comes to the actual suicidal act 2/3 of women and 1/3 of men who commit suicide take overdoses, although with increasing numbers of men taking overdoses these figures are converging. Men are more likely to use violent means (hanging, shooting, jumping, cutting) or car exhaust than women. 1 in 6 people who kill themselves leaves a note.

Such is the importance of suicide in epidemiological terms that there is currently a government funded research project looking at both suicide and homicide in psychiatric patients with the aim of making recommendations to reduce the incidence of both in this population group.

### **Epidemiology**

There have been few dramatic changes in the crude rate of suicide over the years, the exceptions being:

- falls during the two world wars
- a rise during the depression in the 1930's
- a fall after 1960 when carbon monoxide was removed from domestic gas.

Since the 1960's the rates have been increasing.

**Season:** Suicides peak in April, May and June and are at their lowest in December. This variation is most marked in women.

**Age & Sex:** Men are more likely to kill themselves than women for all age groups. Rates increase with age to peak at 60-75. However, in recent years there has been a large and steady increase in the incidence in younger age groups and some decline in the elderly, so the rates are now more evenly distributed with age.

**Marital Status:** The greatest incidence is in divorcees, widows, and widowers the lowest in those that are married.

**Social Class:** Highest rates are in socio-economic classes 1 and 5, the lowest in 2 and 3.

**Employment:** Rates are higher in the unemployed. Some employment groups have high rates, including university students, doctors, lawyers, farmers, policemen and insurance agents.

**Psychiatric Illness:** Up to 90% of suicides have a psychiatric illness. Around 70% of people committing suicide have some depressive symptoms if not a clear depressive illness. Patients treated for an affective disorder have 30 times the risk of suicide than the general population, and overall 15% of depressives will commit suicide. Also note that suicide in depression often occurs during early recovery when energy and motivation have returned, but hopelessness continues. Other important psychiatric diagnoses include alcoholism (around 15% of suicides), antisocial personality disorder, drug misuse, early dementia, and schizophrenia. Schizophrenics make up a small number of suicides, although their lifetime risk is around 10%. Most schizophrenic suicides are young men early in the course of their illness, particularly if there are depressive symptoms. Note that only in a small minority suicide was a 'rational' or 'existential' act.

**Other Correlates:** These include immigrant status, social isolation, previous episodes of DSH, family history of psychiatric illness, recent loss (bereavement, separation, redundancy), chronic physical illness.

## Assessment

To do this direct but tactful questions need to be asked (these do **not** increase the risk of suicide) with reference to epidemiological risk factors (see above). In particular consider:

- A direct statement of intent.
- Presence of psychiatric illness, particularly depression.
- Previous suicidal attempts.
- Feelings of hopelessness.

Also beware social isolation, elderly, males, chronic painful illnesses, misuse of alcohol, and bereavement. Find out not only reasons why suicide is being considered, but also reasons to hold back (e.g. religion, family). If suicidal thoughts are expressed, have plans been made, and if so what are they?

## Prevention and Management

There is an "urban myth" that people who are seriously considering suicide do not talk about their feelings or intentions. Nothing could be further from the truth suicidal ideas are expressed by 68% before they act and 67% visit their GP in previous month, 40% in the previous week. Also remember that 25% are currently psychiatric out-patients.

The most important aspect of management is recognition of suicidal risk (see above).

Any psychiatric illness present needs to be adequately treated. This might entail admission to hospital (perhaps under the terms of the Mental Health Act), with high levels of observation by hospital staff.

Effective follow-up with social and psychological support is essential for patients who have had contact with psychiatric services.

In addition to the psychiatric services, voluntary organisations, such as the Samaritans, may also help to prevent suicide.

**N.B.** Despite all efforts suicides do occur, and in these circumstances support for relatives, **and** staff, is vital.

## *Deliberate Self Harm*

### Overview

Deliberate Self Harm (DSH) can be defined as a self-initiated act in which the patient injures themselves, or takes a substance in greater quantities than the therapeutic dose or the level which they are habituated to, that does not result in death.

DSH patients are clearly a heterogeneous group comprising those who have 'failed' to complete suicide, those with rather ambivalent feeling about death, and those whose intention is not to die. The evidence for this is as much as anything the striking difference in the epidemiology of DSH from suicide. There are extremely high rates with up to 1 in 100 young

women being admitted at least once with DSH, and it is the commonest single cause of acute medical admission to hospital for women, and second only to ischaemic heart disease in men.

Around 90% of DSH acts are drug overdoses, most commonly with NSAIDs, anxiolytics, and antidepressants (in that order). Around 80% use prescription drugs (70% their own, 10% other people's). 50% of men and 25-45% of women have taken alcohol within the last 6 hours. Of non-overdose DSH, self-laceration is the most common, otherwise it tends to comprise failed violent suicide attempts.

## Self-laceration

This can be of three forms:

Deep and dangerous wound with high suicidal intent.

Self-mutilation e.g. by schizophrenic in response to psychotic symptomatology.

Superficial wounds. This third group is the most common, and represent an important subgroup of DSH that can be extremely difficult to manage. They are mostly young women with severe personality disorders characterised by low self-esteem, impulsivity, unstable moods, difficulty with interpersonal relationships, and a tendency to abuse alcohol and drugs. They sometimes fit the criteria for borderline personality disorder. High rates of childhood sexual abuse have also been reported. Multiple lacerations seem to relieve increasing tension, appear to be associated with little pain, and are followed by feelings of shame and guilt. The behaviour can occur as an imitation of others in psychiatric in-patients.

## Epidemiology

Rates of DSH appeared to increase substantially in the 1960's and 70's, although they may have been stabilising or falling since then.

**Age & Sex:** DSH is more common in the young than the old. Peak age for men is between 20 and 24, and for women between 15 and 19. Women > men (c.f. suicide) up to around 50 years of age, and then similar rates between the sexes are seen.

**Marital Status:** Divorced, and single people, plus those who married young are more at likely to self-harm.

**Social Class:** DSH increases dramatically with decreasing social class (c.f. suicide).

**Employment:** Unemployed rates are much higher than for the employed.

**Psychiatric Illness:** 15-20% of DSH is in those with psychiatric illness (c.f. suicide). Of these 50% depression, 30% personality disorders, 15% alcoholism.

**Other Correlates:** The majority of those who self-harm have experienced major life events, also disruption in interpersonal relationships, broken homes, criminal records, suffered child abuse, social isolation, anxiety over job/ housing etc. (c.f. suicide).

**Motivation:** Most commonly DSH is impulsive following a situational crisis. Serious suicidal intent is present in 5-15% of those who self-harm. Reasons given include:

- 'cry for help'
- 'escape from intolerable situation'
- 'relief from state of mind'
- 'attempt to influence others'
- 'testing the benevolence of fate'.

## Assessment

Because of the considerable overlap between DSH and suicide, plus the significant rates of psychiatric illness in DSH patients, DSH should never be underestimated. 1 to 2% of DSH kill themselves within 1 to 2 years. An episode of DSH increases the risk of death in that person by 50 to 100 times.

Following an episode of DSH the first task is to assess the degree of suicidal intent. This may be suggested by:

- A clear intention to die, and remorse for having failed.
- Planning of the episode in advance.
- Steps taken to avoid discovery.
- No attempt made to obtain help afterwards.
- Using violent methods.
- Undertaking 'final acts' e.g. leaving a note, paying off bills, writing will.

This then needs to be followed by a general psychiatric assessment and an assessment of suicidal risk (see above). Note that there is **no** correlation between the medical seriousness of the DSH and the risk of suicide in the future.

The overall risk of repetition of DSH is 15 to 25% in the year following the episode. The best predictors of DSH repetition include:

- Previous history of DSH.
- Psychiatric treatment.
- Criminal record.
- Personality disorder.

Other predictors include being separated, low social class, drug or alcohol problems, early separation from mother, the episode not being precipitated by a situational crisis.

## Prevention and Management

It is worthwhile noting that 1/3 of all patients who self-harm attend their GP for relief of emotional symptoms and 1/4 are recurrent psychiatric attendees. This implies that prevention should in theory be possible, and entails treatment of any psychiatric illness, social intervention, and family and individual counselling.

Following an episode, precedence should be given to medical treatment of the episode. Management may then follow the lines described above for suicide (see above).

First ever episodes respond best to intervention.

There are high rates of default from psychiatric clinics in DSH patients that are referred.