Top tips: skin and tissue trauma caused by self-harm

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Patients who deliberately self-harm and cause skin and tissue trauma are increasing in number across primary and secondary care settings (Nice, 2011b). Self-harm has often been considered a taboo subject and an unnecessary burden to the NHS (Kilroy-Findley and Bateman, 2016). Despite the growing need for effective care, services for assessment, diagnosis and intervention are often overstretched and unable to meet the holistic needs of patients who self-harm (National Institute for Health and Care Excellence [NICE], 2011a; Mind, 2013).

Patients who present with self-harm injuries require understanding, supportive consultations, timely diagnosis, signposting to further help, education and promotion of self-care, as well as wound care, if we are to be reassured that the best standard of care is delivered (Hunt, 2016a). Education and awareness of self-harm for all clinicians is essential if we are to understand the physical and psychological effect on people and achieve the best outcomes and reduce the risk of infection, scarring and reattendance in healthcare services (Kilroy-Findley, 2015; Hunt, 2017). This paper aims to share some tips to guide clinicians who care for patients who self-harm resulting in skin and tissue trauma.

Sutton (2007) and Dallam (1997) both acknowledge the concept of self-harm as 'a complex group of behaviours resulting in the deliberate destruction of body tissue without conscious suicidal intent, with a pattern of a period of pent-up negative feelings resulting in individual depersonalisation, followed by relaxation and repersonalisation post self-harm activity' (Dallam, 1997). Kilroy-Findley (2015) argues that despite progress in healthcare for this patient group over the past 20 years, self-harm remains a largely taboo subject with lack of understanding and intolerance from the wider public and some healthcare providers. Determining the exact number of cases is almost impossible due to complex psychological, social and physical issues, the varying results of skin and tissue destruction, how and where patients present alongside misdiagnosis and under-reporting of injuries (World Health Organization [WHO], 2017; Dallam, 1997). Recent figures (WHO, 2017) state that one in ten people will at some time carry out some form of self-harm, including cutting, hanging and poisoning and there has been a rise in admission to hospital, quadrupling with a particular increase in under-18s over the past 10 years.

WHO states that 1 in 10 (10%) per 100,000 population will self harm at some stage of their life (including drug abuse, food abuse etc). In under-18s, there has been a 70% increase in the past two years with 19,000 A+E reports from NHS Trust data of attendances with self-harm behaviours (WHO, 2017).

Cutting has increased by 285% in girls and women and 186% in boys and men in this period, with many requiring antibiotics, surgical interventions and inpatient care as a result of their injuries (WHO, 2017). SelfharmUK (2016) suggests that as many as 13% of 11–16 year olds self-harm annually, with an increase of 70% in 10–14 year olds attending emergency departments in the UK for self-harm injuries compared with 2015. Women and girls are more likely to self-harm than men and boys, but Mind (2010) suggests that this may be an assumed fact, as males are more likely to act out more 'accepted' behaviours, such as punching walls, which is not always recognised as self-harm.

NICE (2011b) estimates that self-harm can cost the NHS £204 to £4,231 per patient who self-harms, depending on the level of injury and complications. It is clear that the trend to self-harm is increasing, so intervention and supportive services need to review current provisions and adapt to this growing need if we are to maintain the safety of patients in a cost-effective and clinically effective way.

1 **Understand the concept of self-harm:** Self-harm is complex and personal to the patient and involves layers of emotions, social stressors, mental health issues, substance abuse and harmful coping mechanisms (Sutton, 2007). The standard definition of self-harm is varied and can be confusing to the novice practitioner when attempting to apply the concept in day-to-day practice.

Mind (2010) suggests it is a 'way of expressing very deep distress, a means of communicating feelings that cannot be put into words', while WHO (2017) implies that it is an expression of 'serious psychological distress'. These negative feelings often relate to anger, guilt, frustration, hopelessness and self-hatred, says Mind (2010).

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Box 1. The signs of self-harm. Adapted from NHS Choices, 2015.

- Unexplained cuts, bruises or cigarette burns, usually to wrists, arms, thighs and chest
- Keeping areas of skin covered at all times, even in hot weather
- Signs of depressive illness, such as low mood, tearfulness or lack of motivation and interest in normal activities
- Self-loathing and expressing a wish to punish themselves
- Suicidal thoughts and not wanting to go on
- Becoming withdrawn and not speaking to others; isolating themselves
- Changes in eating habits, being secretive about eating with unusual weight gain or loss
- Signs of low self-esteem, blaming themselves for any problems or thinking they are not good enough for something
- Signs of pulling out hair, skin conditions to the scalp, thinning of hair, bald patches
- Signs of alcohol and/or drug abuse.

It is clear that general descriptors and statements are often difficult to adequately define this population because of their personal life experiences, coping skills and support networks (Kilroy-Findley, 2015). There are many different ways that a person can harm themselves intentionally: cutting or burning their skin; punching or hitting themselves; poisoning with toxic chemicals or medication; misusing alcohol and drugs, starving themselves, binge eating and excessive exercising (NHS Choices, 2015). See *Box 1* for signs of self-harm.

Guidelines are available to aid understanding of self-harm in the healthcare setting (NICE, 2004; 2011b) *[Box 2]*. These documents attempt to educate clinicians and ensure that patients who contact healthcare services are not judged and they are given timely support within a 48-hour period with signposting to appropriate specialist services so that care is ongoing as needed. People often try to keep self-harm secret due to either shame or fear of discovery. It is usually close friends, family, staff at walk-in centres and GPs who notice when people are self-harming, and it is pertinent to note that people who self-harm will often choose to seek healthcare from places where there are short consultation times and they can feel 'anonymous'. These departments often do not have the designated resources for psychological, social and financial support and very few staff are trained in mental health or wound care specialties. A 'revolving door' service is thus perpetuated (Hunt, 2017). There is an ongoing stigma attached to patients who self-harm with assumptions relating to those seeking 'drugs' for perceived pain higher than that assessed by the clinician, wasters of NHS funds and resources and the most common assumption that patients are self-harming as a 'cry for help' (McDougall and Brophy, 2006; Mind, 2010; 2013; WHO, 2017). Patients who self-harm are often in an emotional state when they seek help and we need to be sensitive to this, patients may have a heightened state of mind, deteriorating mental health or a complete lack of insight into their actions and providing a caring, trusting environment wherever the patient presents for health care is essential (Kilroy-Findley, 2015)

Box 2. Expected standards for care providers when caring for patients who have self-harmed (adapted from NICE, 2011b).

People who have self-harmed should:

- Be cared for with compassion and the same respect and dignity as any service user
- Have an initial assessment of physical health, mental state with consideration of safeguarding concerns, social circumstances and risks of repetition or suicide
- Receive a comprehensive psychosocial assessment
- Receive the monitoring they need while in the healthcare setting, in order to reduce the risk of further self-harm
- Be cared for in a safe physical environment while in the healthcare setting to reduce the risk of further self-harm
- Receive continuing support for self-harm and have a collaborative risk management plan
- Have a discussion with their lead healthcare professional about the potential benefits of psychological interventions specifically structured for people who self-harm
- Have a collaboratively developed plan describing how support will be provided during any transition between mental health services.

2 **Who self-harms and why:** Although self-harm occurs in all age groups, in all levels of society and across all demographics (NICE, 2011a; WHO, 2017), it is more prevalent in younger people with no association with ethnicity, social status or gender (National Self-harm Network [NSHN], 2009). The Royal College of Psychiatrists (RCP, 2014) suggests that self-harm occurs more in people with mental illness, ex-servicemen and women, asylum seekers and those in prison settings as these people have less control over their situations or environment.

People often self-harm as a way of coping with overwhelming emotional issues caused by social problems, such as bullying, difficult

relationships, trauma, physical or sexual abuse, bereavement or as a result of psychological illness, such as personality disorders, bipolar disorder, depressive illness and schizophrenia. Self-harm occurs when emotional feelings and sensations escalate and the person is unable to cope or deal with their experience. Harming their body helps to release stored-up feelings.

Self-harm can be divided into two categories: non-direct self-harm, such as substance misuse, gambling, over- or under-exercising, promiscuity, staying in violent relationships (Sutton, 2007; Self-harm UK, 2016) or direct self-harm, which is severe enough to result in superficial, moderate or severe tissue damage producing a wound that is at risk of infection and scarring (Hunt, 2017). The act can be compulsive, with detailed planning and skin aftercare. The individual may experience a strong urge or craving to inflict injury, often feeling they have no other choice. Relief follows the act of tissue injury, but often the need reoccurs resulting in a vicious cycle of tissue healing and reopening. Impulsive self-harm is carried out spontaneously with little if any planning or aftercare and may be associated with alcohol or drug intake or a psychological crisis. This patient group often presents with infected, deep-seated wound damage that needs antimicrobial cleansing, suturing or intense surgical intervention (Kilroy-Findley and Bateman, 2016). Sutton (2007) suggests that in some cases people can demonstrate both compulsive and impulsive behaviours.

Box 4. Implements commonly used in self-harm (with % internet respondents) (Sutton, 2007).

The study had 4,000 respondents from both primary and secondary care that attended a healthcare facility with diagnosed self-harm behaviours in 2006. Here is a breakdown of the implements used:

- Razor blades (89%)
- Knives (81%)
- Shards of glass (59%)
- Needles (56%)
- Scissors (54%)
- Lit cigarettes (44%)
- Cigarette lighter (43%)
- Fingernails (31%)
- Boiling water (20%)
- Nails (13%)
- Hammer (13%)
- Iron (11%)
- Safety pins (9%)
- Baseball bat (7%)
- Hotplate/oven (6%).

Box 3. Methods used to self-harm (Sutton, 2007; NHS Choices, 2015).

- Skin cutting, slashing, carving — sometimes carving words, symbols, designs or dates into the skin
- Skin burning, scalding and erasing (by rubbing off layers of skin)
- Compulsive skin picking, also called neurotic excoriation and dermatillomania
- Excessive scratching causing bleeding and scarring
- Inserting objects into the anus, penis, urethra or vagina with the purpose of causing tissue damage and without sexual intent
- Self-punching, hitting, slapping, biting or bruising causing skin damage
- Stabbing with sharp objects, such as pins, needles, nails, compasses, scalpels or fingernails
- Head banging
- Hair pulling from the scalp, eyelashes and eyebrows, known as trichotillomania
- Interfering with damaged wound tissue and dressings to obstruct healing
- Inserting needles under the skin and into veins
- Pulling off skin and nails
- Swallowing foreign objects resulting in internal tissue damage
- Breaking bones.

3 **Methods of self-harm:** There are many different ways that a person can harm themselves intentionally with resulting tissue damage, infection and scarring (NHS Choices, 2015) *[Box 3]* using a wide range of implements *[Box 4]*. The locations of injury highlighted by Sutton (2007) suggest common locations are those that the patient can quickly hide from other people (Mind, 2013).

4 **How to recognise self-harm:** recognising that self-harm has occurred at the onset of a consultation is important if we are to begin to manage the holistic needs of the patient. It is important to take a detailed history including information about medications, clinical examination of any wounds, investigations into any remaining foreign bodies or possible infection (Kilroy-Findley and Bateman, 2016). Asking the patient in an understanding, non-judgmental manner 'Have you self-harmed since our last meeting?' can be uncomfortable for the clinician and the patient, but has a positive outcome of getting the issue

out in the open and allowing self-harm to be addressed (Hunt, 2016a). Referral to other specialists, such as plastic surgery or tissue viability teams. Identifying further harm to the patient or to others if there is an immediate risk needs urgent involvement with mental health teams, such as crisis (Broadbent, 2011).

5 Promotion of self-care: Encouraging patients to participate in their own health care is key to managing ever-increasing NHS costs according to While (2016). Self-care has been defined by the The Proprietary Association of Great Britain (2011) as 'the agreed care taken by individuals towards their own health, promotion of safety and wellbeing' (www.pagb.co.uk). The concept is broad and fully encompasses all aspects of patients improving and maintaining their health, adopting positive lifestyle choices and reducing activities that are harmful, such as smoking and alcohol intake. It also emphasises the importance of patients being educated and taught skills to enable self-management of illness and the avoidance of deterioration where possible. Bateman (2014) emphasises that self-care is viable, achievable and a productive way forward for people who self-harm and that providing written information and self-care packs is an important part of the care package. Communication, education, observational support, clear objectives in care plans and reassurance alongside care innovation are required to ensure successful outcomes of care delivery. Dowsett (2015) and Bateman (2014) encourage the use of therapies that are easy and simple to use when promoting self-care in patients with wounds, such as wound care, self meditation, self exercise, self healthy diet life changes etc, as this will improves patient confidence and ownership of care and reduce their reliance upon the clinician. We must also recognise that self-care is not going to be undertaken by all patients who self-harm.

6 Use of self-care rescue packs: The aim of a self-care rescue pack is to implement early patient-led intervention to prevent physical deterioration of self-inflicted wounds. This is intended to empower the patient and encourage them to take control of their condition to maintain their safety and overall wellbeing. Self-care and timely intervention have been shown to also reduce the individual's attendance at urgent care centres, walk-in centres and the need for hospital admission which has a direct cost saving to the healthcare provider allowing resources to be used appropriately (Ryan et al, 2009). Work by Hunt (2016a&b; 2017) in regards to self-care in relation to self-harm has demonstrated the positive use of rescue packs in regards to patients' ability to manage their wounds pre- and post-injury and eliminating the need for hospital admission. This allows the focus of care to be on their emotional and psychological wellbeing rather than the physical consequences of self-harm.

The rescue pack needs to be simple. It must fit in with local formulary guidance and be easy for the patient to use and to understand its benefits. The key is to have the pack available and accessible before the self-harm activity occurs, usually at the patient's home or work setting. It is essential for those patients who impulsively damage their skin but also important for those who to compulsively plan their self-harming. Ensure the patient has a complete pack at the first review and they should be instructed to use it when they next self-harm. It should be stressed that rescue packs are to promote skin protection and healing and are not a substitute for referral and review by skin and wound specialists.

A self-care rescue pack would typically include:

- A sterile dressing pack with gloves
- Gauze to clean and mop up body fluids
- An appropriate antimicrobial product, such as irrigator, gel or wipe
- An appropriate topical secondary dressing that is atraumatic, absorptive for low to moderate fluids, adhesive and has a long wear time
- Product information leaflet
- Wound care management leaflet detailing red flags, such as erythema, excessive bleeding, increased pain, discharge, that should be monitored, as well as directions of who to contact with concerns.

7 Practical tips when managing patients with a self-harm injury

- Know your patient and let them get to know you
- Build a non-judgmental, supportive and trusting relationship
- Ask them 'Are you self-harming?'; and do not avoid the issue
- Explore the patient's rationale, how they self-harm and why
- Know what tools the patient is using, this will

Box 6. Support services (list not exhaustive).

- GPs
- General advanced nurse practitioner/ practice nurse
- Community mental health team (CMHT)
- Community psychiatric nurses
- Crisis team
- Acute inpatient psychiatry
- Tertiary psychiatric services
- Prison mental health services
- Early intervention services for psychosis
- Clinical psychologist
- Mental health social worker
- Talking treatments/therapies
- Counselling services specialist in cognitive behavioral therapy
- Counselling and psychotherapy
- SelfharmUK
- Mind.

direct your wound care

- Review any tissue injury — assess, diagnose and select appropriate dressings
- Carry out appropriate cleansing, debridement and update their wound care plan
- Discuss self-care, keeping safe and self-care pack concepts
- Provide a self-care pack that meets the patients wound care needs (if appropriate, i.e. in those patients that consent to take on own care, that can understand instruction and use the equipment and are able to report use of the pack for ongoing care management)
- Ensure that information and instructions for self-care packs are given verbally and in writing

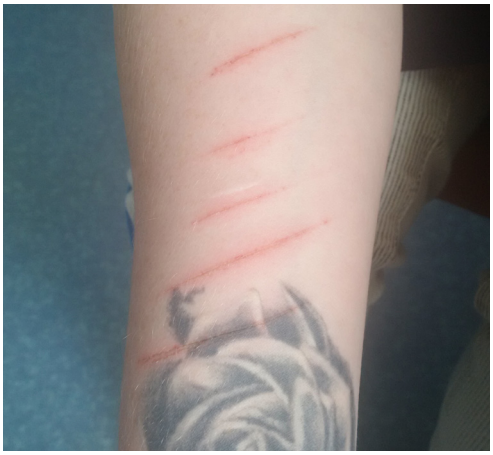

Figure 1. Case study 1. Superficial cutting with razor at first consultation.

- Ensure that the patient is clear about the contents of self-care pack and how to use the products
- Ensure that the patient is aware of red flags that may indicate they need to seek professional advice
- Ensure contact details of other relevant health service are included in the pack
- Ensure that the patient knows how to obtain a replacement pack
- Reassure the patient that they are not being told to stop self-harming, but they are being encouraged to remain safe when they do self-harm
- Refer to appropriate specialists regarding emotional, psychological and social needs so that a holistic care package is in place.

8 **Making a referral:** There are many support groups in both primary and acute care that patients can access for help for self-harming behaviour *[Box 6]*. These services not only provide social, psychological and physical help, but importantly provide wound care advice. Some of the key drivers of support groups are to allow people to be listened to and not judged, promoting self-care for wounds, as well as help for the underlying emotional causes (Kilroy-Findley, 2015).

9 **Case study 1:** A 33-year-old male was diagnosed with severe anxiety and depressive illness, from a dysfunctional family set up, exposed to drugs and an unsociable behavioural environment since the age of 4. He lives with his partner. He has symptoms that include: anger, agitation, low mood and panic attacks almost daily. He is concordant with medication and is currently undertaking cognitive behavioural therapy.

He presented with self-harm superficial injuries to his right inner forearm, his usual place of choice to self-harm, using a razor he keeps specifically for this purpose, which he keeps clean and self-cares for his skin before and after the injury is inflicted. There was no suicidal ideation or intent at the time of assessment. He cleaned the wound with antimicrobial irrigation, dressed with a soft silicone adhesive dressing, and the patient used a rescue pack that he keep at home. He was advised to always use clean tools for cutting to reduce risk of infection. Contact has been made with the Community Mental Health Team for continuing support. The patient already has a community psychiatric

nurse who he sees every 2 weeks, he has appropriate medication, appropriate wound care, and has self harmed for many years despite the education, and information etc. This is a classic case of a patient who will self harm when he feels the need to manage his symptoms. He is undertaking cognitive behavioural therapy and has had counselling previously — he is not a serious risk to himself or others.

Conclusion

This article introduces the clinician to the basic underlying principles of self-harm and its effect upon healthcare services. It highlights the need for timely holistic assessment, diagnosis, management and signposting to appropriate services to ensure patient safety is optimised and that ongoing supportive care is delivered. Patient self-care and involvement with care is paramount for ensuring active participation and ownership of health problems if any success in resolving issues is to occur. Awareness, understanding and education from all clinicians and allied care workers is key to ensuring a caring, supportive environment is promoted allowing patients to feel safe, believed and respected. WINT

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