Self harm on prescription: the lesser of two evils?

This article reports an innovative method of using a diabetic lancet pen to reduce complex self-injurious behaviour and discuss the ethical considerations.

Discussion

Repeated self harm is one of the most challenging and anxiety-provoking behaviours a physician is likely to deal with.

It is reported that 2% of adults have deliberately harmed themselves without suicidal intent (Meltzer et al, 2002) and nearly one-half of patients presenting to an emergency department with deliberate self harm met the criteria for a personality disorder at follow up interview (Haw et al, 2001). It is now customary to consider self injury (intentional cutting, burning or other physical damage) as distinct from self poisoning.

There has been ongoing discussion and debate about how best to deal with those who repeatedly self injure. Guidance on self harm by the National Institute for Clinical Excellence (2004) recommends the consideration of 'advice regarding self-management of superficial injuries, harm minimisation techniques, alternative coping strategies and how best to deal with scarring'. This advice is too vague for clinicans to offer any practical advice and directs them to unspecified voluntary organizations for further details.

Anecdotal reports suggest a variety of methods have been used in the past. These include punching a pillow, 'snapping' wrists with rubber bands, pinching instead of cutting, slamming doors, screaming, squeezing ice and drawing on one's body with red markers or paint to simulate blood (Wester and Trepal, 2005; Pengelly et al, 2008).

The authors felt that the use of the lancet pen was a safer and hygienic alternative which left minimal long-term physical scars or effects. One hypothesis is that this patient's anxiety and distress was reduced by the self-inflicted release of blood, which she was able to do in much smaller quantities with the lancet pen than her previous methods of cutting with razors and knives.

There remains an ongoing ethical debate about whether professionals should be giving advice about alternatives to self injury as this could be misconstrued as colluding with and almost permitting the dysfunctional behaviour to continue. It would be a very challenging position to defend in court. With reference to a legal opinion commenting on the Suicide Act 1961, which makes it a criminal offence to aid, abet, counsel or procure someone else's suicide, 'a practitioner may believe they are assisting someone to harm themselves more safely but the Crown Prosecution Service may see matters differently if professionals are reckless as to whether the patient dies' (Pengelly et al, 2008).

Attempts to develop a staff handbook of harm minimization by Pengelly et al (2008) highlighted the differing ethical views of professionals. These included concerns from a psychotherapist that suggesting alternatives to self injury may be cited as encouraging a patient to injure him-/herself. The General and Community Faculty of the Royal College of Psychiatrists was 'unable to provide an established view concerning harm minimisation'. Surprisingly, the solicitors took a pragmatic approach and allowed the handbook to be approved.

Conclusions

A variety of interventions have been suggested in managing these complex

Figure 1. A lancet pen prescribed as a safer form of self injury.

Case Report

A 28-year-old woman with borderline personality disorder had been engaged with psychiatric services for 5 years. She had a long, complex history of deliberate self harm since the age of 13 years including daily self cutting of arms, legs, groin, genitals, face and stomach, and at one point inscribing the word 'slag' and a crucifix on her forearm. She used cigarette butts to burn her arms and took repeated overdoses. There was extensive preoccupation with self harm and she regularly surfed suicide websites and enjoyed talking about her self harm. She said that her ultimate intention was to join her deceased father 'in heaven'.

Her care was further complicated by extensive substance misuse including amphetamines, benzodiazepine, cannabis and alcohol. She had repeated admissions, including under the Mental Health Act, and ongoing support from psychiatrists, social workers and nurses. Pharmacological treatments included antidepressants, antipsychotics and mood stabilizers which did not significantly reduce self-harm behaviour. Multiple attempts to engage her in psychological therapy had proved unsuccessful.

It was felt an innovative approach was required to manage this challenging behaviour. A lancet pen (*Figure 1*), as used by diabetics for blood monitoring, was supplied to the patient and she was advised to use this in place of razors and knives. A remarkable change in behaviour was observed.

Her self harming reduced considerably for the first time in 15 years and use of the lancet pen also decreased. Her mental state stabilized with less impulsivity, less depressed mood and more confidence in being able to regulate her emotions. There were fewer crisis presentations than previously when she required crisis intervention every few months. This improvement was maintained for over 9 months, with no psychiatric admissions.

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patients, including self-help strategies, psychotherapy and medication (Fagin, 2006), but there remains limited literature identifying safer alternative strategies for minimizing repeated self injury. This report suggests one successful and innovative intervention. BJHM

Fagin L (2006) Repeated self-injury: perspectives from general psychiatry. *Advances in Psychiatric Treatment* **12**(3): 193–201

Haw C, Hawton K, Houston K, Townsend E (2001) Psychiatric and personality disorders in deliberate self-harm patients. *Br J Psychiatry* **178**(1): 48–54

Meltzer H, Lader D, Corbin T (2002) *Non-fatal suicidal behaviour among adults aged 16 to 74.* The Stationery Office, London

National Institute for Clinical Excellence (2004) *Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care.* National Institute for Clinical Excellence, London

Pengelly N, Ford B, Blenkiron P, Reilly S (2008) Harm minimisation after repeated self harm: development of a trust handbook. *Psychiatr Bull R Coll Psychiatr* **32**(2): 60–3

Wester K, Trepal H (2005) Working with clients who self-injure: Providing alternatives. *Journal of College Counselling* **8**(2): 180–9

Traumatic parenchymal laceration in a horseshoe kidney

An 18-year-old man was transferred to the authors' institution after a motor vehicle collision in which he was a restrained front seat passenger. The referring hospital performed contrast-enhanced computed tomography which revealed a previously undiagnosed horseshoe kidney with a laceration of the right lower pole moiety. On transfer, he was pale and mildly tachycardic but normotensive.

Arterial and delayed phase computed tomography was performed to assess for renal pedicle injury. This demonstrated complete transection across the right lower pole moiety of the horseshoe kidney with non-enhancement of the lower pole renal parenchyma (*Figures 1* and *2*). Active contrast extravasation from the right side of the isthmus and inferior aspect of the upper pole moiety was identified along with significant haemoperitoneum.

At the time of scanning, retained contrast from the prior computed tomography was present within the collecting system, opacifying a duplicated system on the right with an apparently intact upper moiety ureter and an avulsed lower moiety ureter, from which contrast extravasation occurred in the excretory phase, consistent with urinoma. The left moiety collecting system had a grossly dilated and clubbed appearance, which was thought to be long-standing. A right nephrectomy was performed via laparotomy. He made a good recovery and was discharged on the seventh postoperative day.

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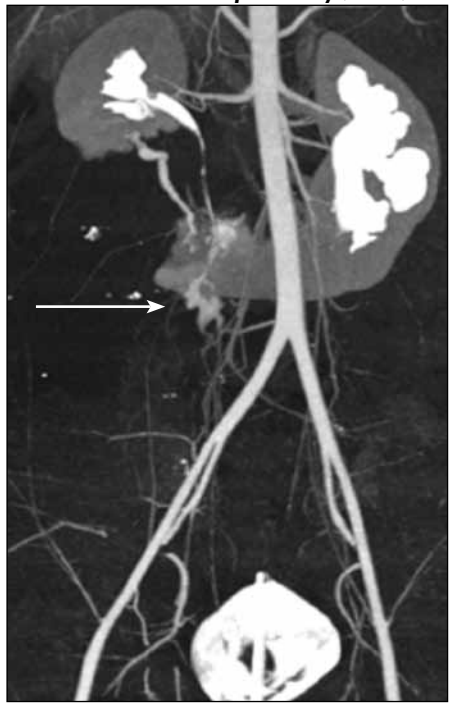
Figure 1. Coronal reformatted image from arterial phase computed tomography renal angiogram demonstrating complete transection of the right lower pole moiety of a horseshoe kidney with non-enhancing renal parenchyma. A duplicated collecting system is present on the right with avulsion of the lower pole ureter, with evidence of urinoma accumulation in the region of the lacerated right side of isthmus and lower pole moiety (arrow).



Discussion

Horseshoe kidney is the most common congenital fusion anomaly, occurring in 1 in every 400 births, twice as commonly in males. The renal parenchyma of a horseshoe kidney is vulnerable to blunt abdominal trauma as a result of its low position and presence of the midline isthmus which is prone to compression across the lower lumbar vertebrae, usually at L4, the maximum point of lordosis. The isthmus varies from a thin fibrous band to a thick mass of functioning parenchyma as in this case, which typically results in a more complex spectrum of injury. BJHM

Figure 2. Coronal reformatted image showing bone detail demonstrates the vulnerability of the midline isthmus to trauma as it becomes compressed across the lower lumbar vertebrae.