Diabetes and self-harm: understanding and addressing the problem

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Singhal et al. have recently reported a retrospective cohort study on self-harm and suicide utilising English Hospital Episode Statistics (HES). Citing a rate ratio (RR) of 1.6, results indicate that episodes of self-harm occur more frequently among people with diabetes when compared with a reference cohort comprised of admission/day-case episodes for predominantly minor medical problems and surgeries. In light of this finding the present paper has three objectives: (i) to discuss the extent of self-harm both generally and in the context of diabetes; (ii) to provide a psychological and contextual understanding of self-harm and its over-representation in diabetes; and (iii) to present, briefly, models of best practice recommending improved integration of psychological support within diabetes health care.

As RR for suicide was not inflated, the issue of suicidality among people with diabetes is not addressed in the present paper. Moreover, Singhal’s paper did not differentiate type 1 and type 2 diabetes and, at some risk of over-simplification, the term diabetes is therefore used throughout in reference to both forms of the condition. In addition, ‘indirect’ self-harm incurred via suboptimal self-care is not the focus for this paper albeit a very significant consideration in the overall delivery of health care to people with diabetes.

Prevalence of self-harm
Self-harm is defined by the UK’s Royal College of Psychiatry as any intentional act of self-poisoning or self-injury irrespective of the motivation or degree of suicidal intent. By no means a rarity self-harm is a major public health challenge and in England each year approximately 200 000 hospital admissions occur as a result. Overall, self-harm is one of the top five causes of acute medical admission for both men and women in the UK and lifetime incident rates identified in the 2007 UK Psychiatric Morbidity Survey were 3.7% and 3.8% respectively.

A biopsychosocial model of self-harm
Self-harm is a feature of both animal and human behaviour. It is an activity observed to occur ubiquitously across cultures and throughout history as a vehicle for healing, religious display, martyrdom, ritual, rite of passage, decoration, and enhancement of social status.

From a singularly rationalist position the act of self-harming suggests a distressing, illogical loss of agency – a problem of impulsivity, of diminished control and of disinhibition. However, reports of many people who self-harm indicate that it is sometimes a premeditated activity, engendering profound, if transient, feelings of emotional release, power, control, and well-being. Klonsky discusses a series of putative biopsychosocial functions served by self-harm and these include: alleviation of negative emotions; cessation of dissociative psychological states – i.e. emotional numbness or detachment; a replacement for suicide; an assertion of one’s own autonomy; a signal for help; a means to express self-directed anger; and to achieve feelings of exhilaration or excitement. Any single episode of self-harm may involve a combination of these and other motivational features and the diversity therein serves as a salutary reminder that no unitary causality or defining core feature exists to define and therefore categorise the ‘self-harmer’. Harris’ quotation from a research participant highlights this complexity and the various co-existing motivations for self-harm, its antecedents, and socio-emotional consequences:

“...the emotional pain became so great that all I wanted to do was end all the pain. I hit the wall in my bedroom, and all the emotional pain just went. For the first time I had found relief from this kind of pain. I found that physical pain or self-harming became a normal part of my life. I found myself at school deliberately hurting myself, falling over in the playground or falling off apparatus in the gym. Doing this I found relieved the emotional pain, and I received the warmth, love and attention that I had been looking for.”

Self-harm and comorbid mental health problems
In seeking to identify those at particular risk of self-harm research consistently indicates the influence of psychopathology – depression, schizophrenia, anxiety, eating disorder, addiction, borderline personality and bipolar disorder. In the aforementioned analysis by Singhal et al. the researchers compared rates of self-harm episodes among those who had registered previous hospital episodes (excluding emergency or primary care) for a range of psychiatric disorders with a reference cohort who had former exposure to minor surgery/illness, e.g. appendectomy, cataract, inguinal hernia repair etc. With RR figures (i.e. rate in psychiatric category/rate in reference cohort) ranging from 6.2 (substance abuse) to 14.1 (depression), the paper demonstrates how a hospital episode arising from a psychiatric diagnosis markedly inflates the subsequent likelihood of an incident of self-harm behaviour.

Self-harm and diabetes
Importantly, and within the same study, Singhal et al. undertook to explore physical comorbidity data and calculated RR across a range of chronic health conditions, including diabetes. Across all ages the study detected 12 433 episodes of self-harm among people with a previous hospital episode for diabetes, yielding an RR of 1.6. This would suggest that for every 10 episodes of self-harm presenting at an English hospital in the reference cohort (i.e. those not exposed to diabetes) 16 episodes would be detected among people presenting...
with prior exposure to diabetes. The authors classified this as a ‘high’ RR and recommended that:

‘It is important for physicians to be aware of the physical disorders that are associated with an increased risk of self-harm so that at-risk individuals may be better identified and can be monitored for psychiatric symptoms and mental distress. This illustrates the need for greater integration of medical and mental health services.’

Diabetes-related self-harm?

What is it about the experience of diabetes, as opposed to minor medical/surgical problems, that subsequently inflicts the probability of people injuring themselves on purpose?

In drawing attention to the innately challenging nature of diabetes Polonsky has coined the terms ‘diabetes distress’, and ‘diabetes burnout’. Capturing the capacity of the condition to exhaust, to worry, to frustrate and to expedite personal crises of both body and mind, these terms provide a welcome focus on the role of diabetes as an inherent source of distress. The daily requirement for continuous, diligent self-care and adoption of watchful dietary habits places a persistent demand on individuals who may already experience stress and a diminished ability to cope for reasons unrelated to their diabetes. Persistent, lingering threat of hypoglycaemia (e.g. Wild et al.), fear regarding self-injection and concerns about diabetes complications can cultivate marked distress among many people living with the condition, and place additional burden on their partners. Indeed, feeling themselves to be a burdensome ‘liability’ for others is a regularly reported concern of people living with diabetes.

Browne et al. provide a number of candid reports from participants in their qualitative study of type 2 diabetes as a source of social stigma – a ‘blame and shame disease’. A 67-year-old male participant stated:

‘I find a lot of people, they like to think of you as the culprit. In fact I actually had one person say, “well you’ve dug your grave with your own teeth.”’

Type 2 ‘diabesity’ regularly attracts a broadly pejorative, strongly caricatured media portrayal. Serving to compound the tendency of people with the disease to experience stigma-related shame, humiliation, a loss of status, and embarrassment, this creates a social and psychological context conducive to self-harm and is becoming an increasingly global matter. This is also fertile ground for reactive depression of at least mild–moderate nature. It may be the case that depression mediates this observed link between diabetes and subsequent self-harm, but as yet this remains an issue of some uncertainty, encumbered with the conventions of a psychiatric terminology that does not indicate the reason for the condition itself. The causal directionality of the diabetes-depression relationship is sometimes a source of debate with evidence to support either position in a complex chicken versus egg co-relationship (e.g. Golden et al., Trento et al.).

Mindful, therefore, of the context in which people living with diabetes find themselves, the role of self-harm emerges as a transient self-therapy, offering a fleeting yet powerful governance of one’s body and emotional state. Self-harm’s various putative functions take on new meaning and relevance when viewed in the context of an uncannily predatory disease that potentially brings with it shame, a threat of limited life and disability, time-consuming daily tasks, and unwelcome health complications.

Health care responses to self-harm

The skill and sensitivity with which self-harm incidents are managed by clinicians vary widely across context. Pejorative views and dismissive, hostile attitudes are sometimes reported by those seeking treatment, as are poor communication and a lack of understanding among staff. Qualitative reports indicate that, in addition to excellent examples of care, service users often report a perceived lack of sympathy, long waiting times and delays in accessing care and pain medication. Particularly when injury is deemed to be socially motivated rather than ‘genuine’ the intentional nature of self-harm can attract stigma and derision in pressurised health care environments where resources are insufficient even to deal with unintentional injury and illness. McCarthy and Gijbels highlight the importance of education for health care staff, particularly with respect to empathy and knowledge concerning self-harm. Clearly, staff education regarding self-harm, including its biopsychosocial context, is an important component of clinical training for medical and nursing staff.

Supporting people with diabetes

Within the UK the National Institute for Health and Care Excellence 2004 guidelines on the management and secondary prevention of self-harm emphasise the importance of dealing with self-harm safely in a spirit of support, understanding, respect and choice. Accordingly, the paper makes recommendation for inclusion of people who self-harm in the development of services. A key recommendation includes universal provision of a detailed, holistic psychosocial assessment with a qualified staff member for all patients presenting with self-harm, an assessment of mental capacity, and full exploration of any ongoing risks. There is much still to be done, however, and, as Cooper et al. point out, the English guidelines developed a decade ago have not been fully realised nor sufficiently widely implemented.

Of relevance also is the 2013 paper published by the UK Royal College of Psychiatry outlining a framework for the development of liaison psychiatry services within acute hospital settings. Given the high proportion of patients who at any time have diabetes within acute hospitals it is clear that liaison roles will be of significant relevance to many people living with diabetes.

The Division of Clinical Psychology in the UK has published a framework for the development of a professional Clinical Health Psychology specialism. With a remit for provision of psychological support and therapy in the context of both acute and chronic illness these roles often involve the assignment of a specialised clinical psychologist within a hospital/community diabetes team. This lends to multidisciplinary working and adoption of an increasingly integrated, holistic care model allowing medical, nursing, dietetic and podiatry staff to access psychologically informed opinion, supervision and guidance. NHS Diabetes and Diabetes UK provide a
range of examples of good practice utilising this and similar models, although provision is inconsistent across the UK.41

**Recommendation**

The conceptualisation and delivery of mental and physical health services as separate entities betrays the reality that health of mind and body are one and the same. It is imperative that, in light of the scale of diabetes as a public health problem, services urgently develop and augment their capacity to provide formal and informal emotional support to people living with diabetes, some of whom will be engaging in self-harm. The Roman poet Juvenal’s words ‘mens sana in corpore sano’ (sound mind, sound body) were mirrored in 1999 by the US Surgeon General who advised there is ‘no health without mental health’. It is vital that diabetes care embraces this same integrative view.

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**Declaration of interests**

There are no conflicts of interest declared.

**References**