22 The person who self-harms

JANE BUNCLARK AND LOUISE STONE

LEARNING OUTCOMES

- To understand a definition of self-harm and its complexities.
- To understand why some harm themselves, the associated factors and the methods used.
- To be aware of experience-based considerations in engaging and supporting this client group.
- To appreciate the key considerations of therapeutic interventions, in a multidisciplinary environment.
- To be aware of evidence-based guidance.
- To be familiar with service users' perspectives on interventions that are helpful or otherwise.

SUMMARY OF KEY POINTS

- Self-harm is complex to understand and define. Its motivation and purpose need to be understood.
- Self-harm arises from unmanageable emotions or memories and may be a means of coping.
- Factors associated with self-harm are broad, varied and individual, often with multiple causation.
- Self-harm is a symptom, not an illness, and is always symbolic.
- Understanding the function of self-harm guides nurses to support individuals in finding alternatives.
- Supervision and reflective practice help the worker to identify and address any re-enactments or other difficulties that might arise in the relationship with someone who self-harms.
- Nurses take the lead in maintaining boundaries for consistency in therapeutic engagement.
- The nursing task is to support individuals in developing understanding and healthier coping mechanisms.
- Risk assessment is fundamental and needs to include the service user and carers.
- Risk assessment needs to sit alongside therapeutic risk taking.

INTRODUCTION

For most people, at both an individual and a societal level, self-harm is a complex and difficult phenomenon to understand – why someone inflicts pain, wounding or scarring when we try to avoid such damage. Self-harm is poorly understood and prompts ambivalent feeling in clinicians. However, nurses encounter individuals who self-harm in most settings. Often we are more sympathetic if someone states that they were attempting suicide rather than self-harming. Barker[1] frequently stresses that the focus of nursing is the craft of caring – that which helps bring together knowledge and aesthetics. For those who self-harm, the nurse's craft is to alleviate distress and to enable reparation, resolution and recovery.

Inflicting damage upon oneself is not a new phenomenon. Self-injury is a long and universal practice, and ceremonies involving blood, cutting and body modification appear in most cultures and religions. The use of pain and blood-loss often serve some social function at times of loss or bereavement. With a 3,000-year history, bloodletting, including through the use of leeches to cure physical and psychological conditions, has recently re-emerged, with research illustrating its usefulness in plastic surgery. Frequently blood, sacrifice and mutilation were found at the core of religion, for atonement of sin, spiritual advancement or purity. The Bible[2] documents rituals in which those who worshipped false gods slashed themselves with swords and spears; and self-cutting was associated with those possessed by demons.[3] Flagellation was a common practice in the thirteenth and fourteenth centuries among the fervently religious for penance and piety, and castration for religious purposes has been recorded over the centuries. The Hindu festival of Thaipusam involves sacrifice, including carrying *weighty* spikes inserted into the body or piercing with hooks and spears. Outside religious contexts, the history of punishment and torture is long and bloody, with mutilation and eventual death occurring throughout the centuries. Trephination, the ancient practice of making an opening in the skull to allow the escape or entrance of spirits, continues to be practised in parts of Africa, South America and Melanesia. At a more subtle level, the use of the skin as a tension reliever and a locus of healing takes many forms, including scratching and skin debridement.

The complexity of why individuals self-harm, and whether or not it is considered self-harm within their society, is confused by an array of terminology and lack of breadth in definition. Terminology includes self-injury, mutilation, para-suicide and deliberate self-harm. 'Self-harm' is currently most generally accepted, with the word 'deliberate' no longer preferred because many, including service users, considered it to be judgemental, ignoring the dilemmas that self-harm is not always 'deliberate' or 'intentional' – for example, if inflicted during dissociation. In terms of definition, the National Institute for Health and Care Excellence (NICE)[4] uses 'any act of self-poisoning or self-injury carried out by an individual irrespective of motivation' (p.5), which is somewhat more encompassing than their earlier[5] definition, with 'act' (p.21) amended to 'motivation'. This is a positive step, as 'act' is a poor determiner: many behaviours generally considered as 'suicidal' fall within the parameters of self-harm. A non-specific definition of motivation is helpful, as some experience interplay of both conscious and unconscious motivation. On the basis of my experience of nursing this group of individuals, I consider the NICE definition of self-poisoning or self-injury as still being too narrowly defined, as it excludes acts of omission of care (such as mismanagement of physical health), failure to protect oneself or gaining harm from others, and the interplay with eating disorders and substance misuse. I therefore suggest a more encompassing definition: 'an act to damage yourself without intending to die. This varies according to the situation and the individual carrying out the act and is a means of getting away from intolerable thoughts or feelings'[6] (p.7).

SERVICE USER'S PERSPECTIVE

I agree that having a broad, encompassing definition of self-harm is helpful, particularly in recovery. It is vital to remember when defining self-harm that self-harm is not the issue in itself – it is a behaviour used to express or serve some other need. As a behaviour that serves a purpose, more 'typical' self-harming behaviours, such as cutting, burning or overdosing, can be all too easily replaced by something else that is equally harmful to the individual. For me, what really helped in my recovery was being supported to be mindful around how I was behaving, and what purpose that behaviour was serving or what need it was meeting. At the time when I was unwell, staying up late and not eating properly were meeting a similar need for me as cutting, and being aware of that was important to my ultimately having a full recovery.

METHODS

A fundamental principle of understanding is having an *inclusive* definition of what might constitute self-harm. In taking a longitudinal history, it may seem there were periods when a person abstained from cutting, etc., but

with inclusivity it could be revealed that in these periods the person was either at low weight or involved in unhealthy or abusive relationships. Thus the damage and maladaptive behaviours were constant.

Table 22.1 categorizes some methods of self-harm. However, there is some crossover between categories.

REFLECTION

Do you think you have missed ways in which your service users have damaged themselves?

PREVALENCE

Self-harm is common in young people, with recently rising rates,[7–10] and in college students.[11–13] The peak onset corresponds with pubescence[14] and about 10 per cent of adolescents report self-harm.[15,16] However, longitudinal studies indicate 90 per cent of adolescents cease self-harm on entering adulthood.[17] The adult population reports approximately 4 per cent[18] engaged in self-harm; and it is more frequently found in women, and among lesbian, gay, bisexual, transgender groups,[19,20] those with socio-economic deprivation[21] and those identifying with 'Gothic/Emo' groups.[8,22] In the UK, Asian women are at higher risk compared to their white counterparts, but there are few studies comparing rates in other Black and Minority Ethnic groups.

Self-harm in the UK is one of the most common reasons for acute hospital admissions,[23] accounting for 200,000 hospital attendances annually,[24] with 40–50 per cent being repeat attendances,[25] the majority of which are

Table 22.1 Some methods of self-harm

Epithelial	Cutting Burning Scratching Abrasion Inserting objects under the skin Biting Hitting/punching self Pulling out hair Carving words on skin
Internal	Overdosing Substance misuse Ingestion of objects/caustic substances
Harm from others	Eliciting criticism or rejection Involvement in fights Contact sports Seeking attack, assault (physical, emotional, sexual) Abusive relationships Sex working Seeking physical restraint in hospital Refusing analgesia, including during suturing
Mind-altering methods	Blood-letting Overdosing Hanging Suffocation Substance misuse Purging
Omission	Failure to take prescribed physical medication Allowing wound infections Sleeping rough Poor hygiene/nutrition Deliberate recklessness

due to overdoses.[26] Deaths worldwide in 2001 from self-inflicted injuries totalled approximately 800,000.[27] While being aware that self-harm is often not about committing suicide, clinicians need to recognize that these individuals are at greater risk of death, either intentionally or accidentally. However, a narrow definition does limit the accuracy of statistics.

WHAT MAKES PEOPLE SELF-HARM?

Individuals self-harm for many reasons; there is no single explanation that fits all, just as the initial trigger for the behavioural pattern is unique. Often someone may have an accidental injury and the relief they experience is such that when distressed they recall the relief and self-harm. The need to self-harm usually arises from emotions that are difficult to manage, with self-harm often being an outward demonstration of inner turmoil, trauma or crisis. Research and individual accounts show that many individuals struggle with intolerable distress or unbearable situations for some time before they self-harm.

SERVICE USER'S PERSPECTIVE

I started self-harming at a very young age and initially it was due to an accidental injury that I aggravated. For me, it wasn't a behaviour that was there all the time but something that became more prevalent during my teenage years. In actual fact, my most damaging self-harming behaviour began when I was admitted to an acute ward in a psychiatric hospital following an overdose (which I would consider a suicide attempt rather than self-harm). I think that this was due both to a pathologizing of the behaviour, rather than consideration of the underlying issues, and a lack of control, as staff struggled to manage my behaviour, rather than supporting me to manage it myself.

Pathologizing my behaviour, by which more than anything I probably mean giving me a label, is an interesting conundrum. At the time, I really wanted to be given a label – for someone to tell me that I had depression or something, because that would explain why I felt like this and why I needed to self-harm. I think that during my time in an acute setting, many professionals felt the need to give me a label, because if I had an illness then they could fix me, and 'fixing' me generally seemed to mean stopping me from self-harming, not teaching me to tolerate and express the distressing emotions that I was managing through self-harm. The self-harm became the 'illness', and I think because of that it became part of my identity. At a time when I was struggling with low self-esteem and poor sense of self, I became defined by self-harming, which I think caused me to self-harm more.

Due to staff anxiety on the acute ward, many steps were taken to control me, and most of these were extremely unhelpful. Putting someone who self-harms on 1:1 observations around the clock might seem like a really logical idea – if you're watching them, then they can't self-harm. However, for me self-harm was a physical mechanism I used to control distressing emotions, so taking away that control wasn't helpful. It left me frustrated and constantly trying to work out how to get my control back in a constant battle with staff. This only left them and me frustrated, and the lengths that they would have to go to in order to keep me 'safe' would escalate to physical restraint and forced medication. I felt like the staff hated me. Ultimately giving me my control back – letting me take ownership of keeping myself safe – was far more useful.

(See chapter 55 for more information on the observation of people at risk.)

REFLECTION

What do you think of the service user's account? Can you think of occasions on which you have unknowingly entered a battle for control?

FACTORS ASSOCIATED WITH SELF-HARM

Abuse

Many individuals have experienced abuse in their early lives – physical, emotional or sexual. This can leave them feeling that they are 'to blame', guilty, in need of punishment or other unmanageable emotions.

Rape

The feelings described above might also arise from unwanted sexual experiences or rape. Some who experienced sexual abuse may believe that they deserve no better treatment and thus encounter further unwarranted sexual attacks.

Being bullied

Many individuals describe experiences of bullying at school, within social groups or at work. Often their experiences have been minimized or ignored by authority figures, leaving them unprotected and alone.

Difficult relationships within families

Some individuals come from divided, critical or violent environments, in which support for emotional development is absent. They might have lived in permanent fear, describing feeling as though they 'walk on eggshells'.

Parental separation

While parental separation is not necessarily harmful, the manner in which attention was given to young people's understanding of why this occurred and the impact on their attachments can hinder the development of a healthy sense of self. Young people may blame themselves, or think they need to 'side' with one parent over another. Similarly, parents' new partners and children may impact on the young person's place within the family, potentially leaving them feeling cast aside and powerless.

Bereavement

Bereavement is a period in which someone without inner coping resources may resort to self-harm. It is not only the loss that causes this reaction, but the lack of support or healthier coping skills to survive strong emotions.

Growing up

Adolescence is a time of turmoil for the healthiest of us; managing transitions, joining peer groups, emerging sexuality, and so on. However, for those without a supportive and enabling structure, it may be a time of isolation, self-doubt and confusion, and they may resort to self-harm.

Entering care

For some, entering care can be a relief from dysfunction or abusive families. For others, it may reinforce their belief that they are 'too hot to handle' and this may be cemented by multiple placements and associated broken attachments.

Problems with race, ethnicity, religion, sexuality, disability

As in the case of adolescence, individuals coping with and managing difference require supportive others. If these are absent, then self-harm may result.

High parental expectations

Some feel valued by their families only on the basis of their achievements, and as a mechanism for giving their family kudos. Perfectionist striving may leave them feeling that they are not good enough, as they are not accepted or loved for themselves.

Emotional neglect, lack of care or nurturing

Neglect, especially emotional/psychological, is hard to define and is frequently unseen or unacknowledged. However, growing up feeling unwanted or unloved, or that siblings are preferred, has profound effects. The belief that you are overlooked or unlovable is internalized, leading to poor ego strength. This dilemma occurs for many who self-harm; they find it hard to understand why they feel 'different'.

SERVICE USER'S PERSPECTIVE

When my self-harming became severe, I started reading about it. What I can remember from that time is that much of the literature seemed to suggest that someone who self-harmed would have been sexually abused or have borderline personality disorder. For me, neither was the case. In fact, as I saw it, I didn't really have any dark issues in my past that would have caused me to end up in a psychiatric hospital. In some ways this made it more difficult – I felt like my 'stuff' wasn't good enough (or rather bad enough!) and for this reason I didn't really talk about it. It's really important to recognize that people self-harm for all kinds of reasons and the 'stuff' that has caused them to come on that particular journey can be wide and varied, but equally valid.

FUNCTIONS OF SELF-HARM

When nursing someone who self-harms, it is vital to explore the function their damage serves. Most individuals have a couple of 'preferred' methods, the choice of damage being dependent on what function or state of mind they are attempting to relieve. Self-harm is individual and personal, yet there are common themes expressed.

Destroying the body or making it less attractive

Scars, odours from burns, excessive obesity, and so on, can be used to make others 'back off' from unwanted sexual attraction, relationships or closeness, or communicate the disgust they feel for their physical self.

Regulation of distress/anxiety

Self-harm can be a 'knee jerk' reaction in which the body is used to release distress, anxiety or other unbearable emotions.

Distraction

Many who self-harm talk about how inflicting pain distracts them from their internal, unseen pain, almost as escapism, giving them a different locus of concentration.

Coping/survival

Many describe self-harm as a way of surviving unbearable memories or feelings, helping them cope with overpowering distress. It is thereby anti-suicidal.

Increased control

For some, self-harm provides a sense of control or mastery; of being in charge of one's life and what damage occurs. The damage is inflicted by them, not by others who may have inflicted damage before.

To feel real/ownership

Some individuals feel detached, like they are not 'living' in their bodies. This may previously have served some protective factor from traumatic experiences. Self-harm, pain or the sight of blood can act as a 'shock' into the here and now. Some speak of the reassurance gained from looking into lacerations and seeing bodily structures.

Testimony

Self-harm and scarification can offer a testament to what has been inflicted on bodies. Individuals speak of their scars showing something of their life story and struggles – almost as if their skin is a canvas, pointing to specific scars that relate to particular events.

Punishment of self or others

Early traumatic experiences can result in individuals feeling bad, contaminated or evil, and self-harm may be intended as either atonement or punishment. There is a perception of deserving punishment or a complex belief that they can punish others, often their abuser, through self-harm.

Cleansing

For some, self-harm serves the function of temporarily cleaning or purifying. Their sense of badness, evil, dirt, traumatic memories or unwanted feelings is evacuated thorough bloodletting. This is exemplified by those who eliminate their contamination into toilets, sinks, etc. For others, the use of bleaches and caustic substances hints at their sense of contamination.

To influence others

Some individuals have had repeated experiences of not being listen to or noticed, with protective figures perceived as 'turning a blind eye'. They might believe that communications via their body, if sufficiently severe, may elicit protection.

Communication

Self-harm is always a communication, either to self or to others, especially at times when people are unable to verbalize their emotions or their need for help. Self-harm could be viewed as a call for help, a hope that someone will notice and contain the emotions.

Re-enactment

While not universally acknowledged, self-harm can be seen as a replication of abusive experiences, with perhaps an unconscious hope that resolution or punishment will occur. The sense of breathlessness from ligature use or suffocation might be akin to a hand held over someone's face to quieten them. Re-enactment within self-harm might be represented in repeated attacks on particular parts of the body associated with particular memories of contamination; for example, insertion of blades vaginally.

Connection with inner world

However much damage an individual inflicts, it is only a glimpse of their internal damage. Attacks on their bodies can serve the function of making connections from their inner world to their physical self, showing others something of their damage.

Testing fate

Some individuals self-harm to test out whether they should live or die, almost as 'Russian roulette'. This is frequently

seen in overdosing: at the point of ingesting the tablets, they want to die, but may subsequently alert others and receive treatment as their intent has altered.

Enacting the caregiver role

Paradoxically, self-harm may provide opportunities for individuals to self-care (or have nurses provide care) following injury. Many individuals have had difficult early attachment relationships with emotionally 'needy' parents, which may have involved lack of consistency in caregiving. Self-harm provides a mechanism for re-enacting and controlling the abuse/neglect and managing subsequent care and healing following injury.

SERVICE USER'S PERSPECTIVE

For me, understanding the functions of my self-harm was absolutely crucial to my recovery. It was understanding what I was *really* doing when I self-harmed that gave me the insight to address the more difficult emotional and relational issues. For example, I came to realize that I often used self-harm as a way of communicating, and that this in turn would often have the result of influencing the behaviour of others. In these instances I was frequently using self-harm as a substitute for talking about the way I was feeling. By identifying, this I felt more empowered to speak and explore my feelings verbally. Similarly, I would use self-harm as an emotional outlet, giving me control over what felt like overwhelming and uncontrollable emotions. The realization of this gave me the courage to start to sit with my feelings and understand that difficult emotions don't last forever.

CHALLENGES OF NURSING INDIVIDUALS WHO SELF-HARM

Nurses have a key role in the care of individuals who self-harm, as they are uniquely placed by caring for the individual's bodily wounds as well as their minds, and will often have intense contact. Nurses are able to offer therapeutic relationships with patients, using the relationship for recovery and the hope of change. Nurses are able to model boundaries within relationships, and healthy ways of coping, while understanding the damage these individuals have encountered and replay upon their bodies – all within a compassionate and caring, yet challenging, encounter. Mental health nurses should be adept at balancing the dilemmas of risk management versus therapeutic risk taking. As discussed, the core concept in nursing this client group is that self-harm is a *symptom*, not the real problem. Just as individuals use their bodies as canvases for emotional management and expression, as nurses we can also be 'caught up' in providing interventions only at skin-level, thus ignoring the site of real damage – the individual's inner belief about themselves and their relationships.

In this work, anxiety will be ever present. Service users are frequently unable to manage their anxieties (intrusive thoughts or memories, overwhelming emotions, or 'split off' parts of themselves experienced as critical, challenging voices), and these are communicated either overtly or subtly to nurses. Attention to containing anxiety is vital for the nurse to function, for the service user's containment and for the system to operate. For a nurse, engagement with someone who self-harms is difficult. Nurses may feel anxious, de-skilled, impotent, hopeless and responsible, perhaps similar to the way the service user feels. Winnicott[28] suggests that workers 'cannot avoid hating them and fearing them, the better he knows this the less will hate and fear be the motives determining what he does to his patients' (p.195).

This anxiety in clinicians manifests in various ways, sometimes in the involvement of multiple workers, each sharing part of the burden and thus making it harder to maintain a consistent, balanced approach. Nurses can be presented with the dilemma of being told secrets or receiving privileged information that is not to be shared with others; this is unhelpful to both colleagues and service users. Alternatively the individual might be judged as challenging, manipulative or otherwise negatively, and discharged from services. Sometimes nurses are so distanced from involvement that they ignore the distress as 'just another crisis' in order to protect themselves. The relationship 'may be driven by the patients' and staff's wishes to deny feelings of pain, anxiety and despair about the level of pathology and disturbance'[29] (p.207). Service users find this neglectful and risk may escalate as they, perhaps unconsciously, battle to make nurses notice their distress through projection.[30] Organizations can become caught up in the same state of mind as service users, with nurses feeling criticized if someone self-harms or if self-harm is promoted as acceptable. 'Unless anxieties can be identified, addressed and contained within the system, it is likely that the system itself will produce defences that actively hinder rather than help therapeutic intervention'[31] (p.77).

In this work, nurses may encounter service users' desperate need for reparative relationships, driven by their lack of early parenting or containment. The nurse may find that relationships come to symbolize more than professional contact, due to the service user's need for reparation; this can result in it being impossible to fulfil their internal void, and thus whatever is offered is not good enough. Their desire for more time, more contact, and so on, will remain insatiable.

REFLECTION

- Looking at the quotation below, do you think you may have 'slipped' into this dynamic?
- 'Nurses … became either the punitive aggressors, who could not see her pain, or, if they could, blamed her for it, or the un-protective mothers who could be vigilant *only after* their child was hurt'.[32] (p.159)

NURSING APPROACHES TO WORKING THERAPEUTICALLY

Since, as already discussed, bodies are canvases of communication, nurses need to ensure that communication is at a verbal level. While service users repeat perverse damage on their bodies, practitioners should not repeat unhelpful, sadistic or ignoring responses. Instead they should offer supportive interventions, aimed at addressing the fundamental problem, rather than its outward manifestation. Nursing individuals who self-harm requires thoughtfulness, resilience, mindfulness and maintenance of a therapeutic stance. Training, in whichever modality, supports nurses in conceptualizing dynamics, gaining knowledge and seeking meaning; without this, any understanding will be limited and symptom-focused, ignoring underlying difficulties and the healthier functions of service users. Nurses should be part of multi-professional teams, and should use collective thinking and reflective team discussions.

Regular, robust clinical supervision is essential to examine the quality of relationships, to understand when re-enactments occur, to discuss anxieties, and to provide support for nurses hearing details of self-harm. Self-harm is always symbolic of other damage, and the more detail discussed, the less it will need to be enacted. Learning about repugnant details of what someone does with their blood, fat cells, and so on, will add to the risk assessment and will enable the individual to be understood at a deeper level. Supervision enables the dynamics around abuse to be addressed, as individuals who have experienced trauma may have learned to view life as offering only two roles – the abused or the abuser. This dynamic enters relationships, and nurses may be experienced as abusive or neglectful or feel abused or punished, through witnessing horrific wounds, rejections of help and crippling anxiety.

Consistent and standardized local protocols are necessary in all settings, with boundaries being set from the outset to manage expectations and provide safety for service users. This prevents the service-user from being reconfirmed as 'special' or encountering a variety of anxiety-driven responses. 'The sufferer who frustrates a keen therapist, by failing to improve, is always in danger of meeting primitive human behaviour disguised as treatment'[33] (p.129). Protocols should be organizationally supported, such that nurses have a clear sense of their primary task, be it to support individuals to learn healthier coping techniques or to extinguish self-harm totally.

Risk assessment is fundamental, yet this service user group has additional complexities, and joint assessment by nurses and service users, including families/carers, is recommended. Joint risk discussions may enable the service user to consider their dangerousness, rather than being dismissive. It is important to note that risk is individual, that it cannot be totally eliminated and that assessment needs to sit alongside therapeutic risk taking. Nurses may wish to be helpful, but this distorts the responsibility boundary. The temptation to be risk-averse or over-protective, or not to allow service users to take responsibility for their behaviours and actions, must be resisted.

(See chapter 54.)

REFLECTION

In supervisions and other reflective spaces, do you examine the quality of your relationship with service users and your valency[34] (that is, your own capacity for patterns of behaviour in relationships) for particular roles?

BOUNDARIES – A FUNDAMENTAL CONCEPT IN CARING

Work with individuals who self-harm is based upon boundary maintenance. The transgression of boundaries in earlier life contributes to poor boundary recognition, such that fundamental boundaries of self/non-self are damaged and individuals have a desperate need to know the limits within relationships. Individuals who self-harm not only attack the boundaries within relationships, but also their primary boundary (their skin). The dilemma of re-enactment of boundary transgression is 'on offer' in contact, and the boundaries must be thoughtfully but not harshly

maintained. The formation and maintenance of seamless boundaries and containing anxieties form the web that creates an environment that is sufficiently containing, such that engagement and difficulties can be addressed. Nurses are responsible for taking the lead in maintaining therapeutic relationships, neither offering friendship/parenting, nor being an inhuman, cold contact. Growth of the service user's insight and ability to hold responsibility occurs within boundaries, which need to be like skin: sufficiently flexible that cracks do not emerge, but with sufficient rigidity that therapeutic space is offered.

A multidisciplinary approach enables consistency for service users, ensures various disciplines are not 'split off', and precludes futile discussions about conceptual models or who holds more anxiety. Collectively the team can address dilemmas such as unwillingness to engage, criticism of care coordinators or responses to requests to change primary nurses. Negotiating team differences enables service users to witness the nurse tolerating and embracing difference and a consistent authority response. The team should not be thought of as knowing all the answers, but supporting service users to seek their own solutions. The most fundamental boundary is that of safety relating to self-harm – when to trust your service user to self-manage and when intervention is required – and therapeutic challenges test the permeability of this. Containment is 'The need for a vessel in terms of the community and the worker to be able to not only hold onto the disturbance but digest and process it'[35] (p.145). Nurses are therefore tasked not only to manage self-harm, but to translate and share its meaning with service users to aid recovery; in essence, the craft of caring.

SERVICE USER'S PERSPECTIVE

My experience with many nurses was that they were very 'unboundaried' and I think that in the vast majority of cases this was with the very best of intentions, maybe because nurses simply didn't know what to do with me. What I needed more than anything at that point was for nurses to be clear and consistent in their responses to me, both individually and across the team. A lack of consistent boundaries across the team could result in patterns of behaviour emerging with different individual staff; for example, 'kicking off' when a particular nurse was on duty because I knew that her response was likely to be to have me physically restrained and injected rather than supporting me to find alternatives to regulate my emotions, or cutting when an especially sympathetic nurse was on duty because I knew that she would be more likely to spend time with me during her shift.

SUGGESTED INTERVENTION: 'SAFETY PLANNING'

Many individuals use self-harm to manage unbearable emotions due to a lack of opportunities to learn healthier coping strategies. Safety planning is a brief intervention to support individuals in searching for alternative coping strategies. The aims of safety planning are:

1. Dispelling secrets

A dilemma in nursing this client group is the secretive nature of self-harm. Safety planning provides an opportunity to request help and involve others in an adult way, and it also supports the expectation that nurses (authority figures) will help protect. In practice, this may be that individuals inform nurses of their self-harm, such that risks and alternatives are considered.

2. Communication

Through safety planning, self-harm and underlying distress is moved from behavioural into verbal communication before self-harm occurs.

3. Reducing impulsiveness

Self-harm can be impulsive, a sudden reaction. Safety planning can break this pattern, providing a time-delay from impulse to consideration of what they might 'do' to survive, thereby acknowledging other possibilities, reducing impulsiveness and increasing healthy control.

4. Tolerating emotions

Safety planning can produce relief from difficulties of tolerating distress, by providing space before self-harm to identify and label emotions and support distress tolerance. This allows individuals to experience the shift and reduction of distressing feelings without the need to evacuate via self-harm.

5. Responsibility through self-direction

Ultimately, safety planning should become increasingly self-directed, with individuals using this technique without nurses' assistance.

6. Choice

Often the impulse to self-harm removes choice from the individual and the only answer is self-harm – almost as if self-harm has its own personality. The thinking space of safety planning provides opportunities for individuals to gain ownership of their actions, rather than automatically self-harming. Some speak of self-harm being their *only* choice, ever-present, under their control and a 'constant companion'. By verbally informing the nurse of the impulse

to self-harm, the sometimes 'incestuous' relationship with self-harm is triangulated. The third person (the nurse) enters the dyadic relationship between the self-harm and the individual, to raise the notion of self-harm as a false solution. This poem by C (ex-service user) demonstrates the phenomenon:

Dear Self-harm,

Goodbye my lover, goodbye my friend, on you I'm no longer depend. You've comforted me in my darkest hour; you've made me strong through your supposed power. I'll take some of you with me, your source and your marks, but I won't take the control you had over me – that I'm leaving behind. F** you, you b** you've robbed me of friends and hope. You were never truthful, never really helped, in fact you never really existed, I gave you power you didn't deserve.

SERVICE USER'S PERSPECTIVE

For me, safety planning was an incredibly helpful mechanism in reducing and subsequently eliminating my self-harming. Over the years, I have been exposed to a variety of efforts by professionals to stop me self-harming, including being on close observation, physical restraint, room searches and forcible medication. However, not one of these methods allowed me to stop *me* self-harming. Having the opportunity to choose to safety plan for five to ten minutes allowed me a safe space to work through the methods I was going to use to avoid or delay self-harming. If I did self-harm after safety planning, there was no failure attached, on either my part or the part of the professional.

The physical treatment of self-harm is really important, and again I have experienced various versions of treatment. At one end of the spectrum, I would be given steri-strips and bandages and told to go and sort myself out; at the other end the practitioner would use that period of time when treating my injuries to try and talk to me about how I was feeling and why I had done it. For me, neither approach was helpful. The former approach has left me with some of the worst scars, mainly because trying to steri-strip your own arm is pretty impractical; the latter has both timing issues and huge potential for manipulation – learning that self-harming is going to result in an opportunity to talk after the event could encourage self-harm rather than talking about the feelings ahead of time. By far the most helpful response to my injuries was for a nurse to treat the wounds with care, calm and quietness – not asking why I had done it or whether it hurt, but simply and competently dealing with the injury at hand. I knew that I had the opportunity to talk prior to the injury (safety planning) and during my next 1:1 session.

REFLECTION

Are your conversations with service users only about why they self-harm, or also about the meaning for them?

WHAT TREATMENTS ARE KNOWN TO HELP?

NICE,[36] while noting there are no proven effective treatments for recurrent self-harm, states that the key aims and objectives of treatment should include the underlying principle of prompt, supportive assessment of psychological and physical difficulties, including pain management. There should be consideration of referral for further psychological, social and/or psychiatric assessment or treatment when necessary, which may include provision of 3 to 12 sessions of psychological intervention specifically structured for those who self-harm, aimed at self-harm reduction. A planned approach is recommended to include the service user, families and carers, with teams considering the issue of effective engagement, including discussion of harm-reduction strategies and the provision of information on long-term treatment, management and associated risks. For individuals with associated conditions, psychological, pharmacological and psychosocial interventions should be initiated.

Table 22.2 Psychological interventions for self-harm

Dialectical behaviour therapy (DBT)[37]	A multi-modal, psychological treatment, combining individual therapy, psycho-educational and skills group training. Includes a combination of cognitive-behavioural techniques for emotion regulation (distress tolerance, acceptance, and mindfulness) and is particularly effective for women with borderline personality disorder (BPD).
Mentalization-based treatment (MBT)	A complex psychological intervention (group/individual therapy) for individuals with BPD,[38] designed to increase individuals' ability to self-reflect. Based on the rationale that BPD is a developmental disorder of attachment, in which there is a failure to mentalize (ability to understand one's own and others' mental states).
Problem-solving therapy	There is supporting evidence that psychological treatments enhancing problem-solving skills may serve as a protective factor for individuals who repeatedly self-harm.[39]
Cognitive behaviour therapy (CBT)[40]	Structured, time-limited, individual therapy focused on problems concerning dysfunctional emotions, behaviours and cognitions. This has been adapted for recurrent self-harm.[36,41] A systematic review examining the effectiveness of CBT to reduce self-harm found some evidence of short-term reduction.

Psychological interventions

NICE recognizes that self-harm is driven by emotional difficulties and individuals' lack of skills to cope, and therefore interventions are aimed at reducing behaviours and enabling the individual to understand their unique contributing factors. The psychological interventions listed in Table 22.2 may be beneficial.

SERVICE USER'S PERSPECTIVE

In my personal journey, I found some of the therapeutic interventions mentioned in Table 22.2 extremely useful, particularly DBT. However, there were other experiences in a therapeutic setting which were equally valuable to me, including art therapy, creative writing, narrative telling and movement/dance therapy. All of these activities added a dimension beyond verbal expression or the use of bodily damage to communicate with others.

CO-PRODUCTION AND COLLABORATION

On reflection, this chapter symbolizes the essence of therapeutic engagement for nurses with those that self-harm. A nurse, asked to write about the issue, was tempted to be the 'knowing expert' based on clinical experience. Involving service users required renegotiating boundaries, and I was anxious about re-establishing contact as their lives have moved on to a journey of health, successful relationships, employment and 'normality'.

However, taking advice from colleagues (multidisciplinary engagement), I approached Louise and negotiated the boundaries of what we might say collectively – not without anxiety regarding contact, responsibility and level of familiarity. These concerns were echoed by Louise, but nevertheless negotiation occurred through expressing anxieties and re-setting boundaries. The resulting chapter is a co-production of working, thinking, insight and sharing. Neither the professional nor the recovered service user was the driver, for both parties brought insight, experience and wisdom. Our skills were different and the project moved from the professional being the leader, to the insights that Louise brought, the better writer and complete finisher leading our direction. In clinical settings, service users should also increasingly take the lead. I initially worried about whether Louise would be 'stirred up' by speaking about her experiences, but again I needed to remember to trust her self-management. In essence, the experience of writing about self-harm and the art of engagement was manifest in collaboratively presenting this chapter to you. We hope you enjoy the co-production, as we did.

CONCLUSION

Self-harm is complex to understand and define: anything can be interpreted as self-harm and no specific method should be viewed as only suicidal. It is not about the behaviour – rather about motivation and purpose (conscious and unconscious). Individuals self-harm because of unmanageable emotions or memories, and factors associated with self-harm are broad, varied and individual, often with multiple causation. It is important to understand that self-harm is not an illness and is always symbolic. Self-harm by omission needs to be recognized by nurses, in addition to more obvious methods. Many individuals have a 'preferred', method and through unpicking the functions of each method, nurses will be guided to support individuals in finding alternatives.

This is not an easy group of individuals to nurse, and the process can leave nurses feeling anxious and disempowered, yet responsible. To address this, supervision and reflective practice is vital to prevent re-enactments or other harmful relationships from occurring.

Nurses are responsible for maintaining boundaries to support the individual in developing understanding and healthier coping mechanisms. Consistent, boundaried attachments are a vital element for therapeutic engagement. Holding secrets undermines your work, is detrimental to your colleagues and perverts relationships from being based on boundaried engagement. Risk assessment is fundamental, and it is vital to use the multidisciplinary team, the service user and families as integral in planning. Risk assessment needs to sit alongside therapeutic risk taking. The use of local protocols based on NICE guidelines is recommended.

Reference list

1. Barker P (ed.). *Psychiatric and mental health nursing: the craft of caring*. London: Hodder Arnold, 2008.
2. Bible, First Kings 18:24–9.
3. Bible, Mark 5:2–5.
4. NICE (National Institute for Health and Care Excellence). *Self-harm: longer-term management*. National Clinical Guideline 133. London: NICE, 2011.
5. NICE (National Institute for Health and Care Excellence). *Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*. Clinical Guideline. London: NICE, 2004.
6. HOTUSH (Helping others to understand self-harm) Crisis Recovery Unit, 2008 (unpublished).
7. Hawton K, Townsend E, Arensman E, Gunnell DJ, Hazell P, House A, et al. Psychosocial and pharmacological treatments for deliberate self harm. *Cochrane Database of Systematic Reviews* 1999; **4**: CD001764.
8. Young R, Sweeting H, West P. Prevalence of deliberate self harm and attempted suicide within contemporary Goth youth subculture: longitudinal cohort study. *British Medical Journal* 2006; **332**: 1058–61.
9. Plener PL, Libal G, Keller F, Fegert JM, Muehlenkamp JJ. An international comparison of adolescent nonsuicidal self-injury (NSSI) and suicide attempts: Germany and the USA. *Psychological Medicine* 2009; **39**: 1549–58.
10. Ross S, Heath N. A study of the frequency of self-mutilation in a community sample of adolescents. *Journal of Youth and Adolescence* 2002; **31**: 67–77.
11. Favazza AR, DeRosear L, Conterio K. Self-mutilation and eating disorders. *Suicide and Life-Threatening Behavior* 1989; **19**: 352–61.
12. Whitlock J, Eckenrode J, Silverman D. Self-injurious behaviors in a college population. *Pediatrics* 2006; **117**(6): 1939–48.
13. Gratz KL. Measurement of deliberate self-harm: preliminary data on the Deliberate Self-Harm Inventory. *Journal of Psychopathology and Behavioral Assessment* 2001; **23**(4): 253–63.
14. Patton G, Hemphill SA, Beyers JM, Bond L, Toumbourou JW, McMorris BJ, et al. Pubertal stage and deliberate self-harm in adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry* 2007; **46**(4): 508–14.
15. Hawton K, Saunders KEA, O'Connor RC. Self-harm and suicide in adolescents. *Lancet* 2012; **379**: 2373–82.
16. Lloyd-Richardson EE, Perrine N, Dierker L, Kelley ML. Characteristics and functions of nonsuicidal self-injury in a community sample of adolescents. *Psychological Medicine* 2007; **37**: 1183–92.
17. Moran P, Coffey C, Romaniuk H, Olsson C, Borschmann R, Carlin JB, et al. The natural history of self-harm during adolescence and young adulthood: population-based cohort study. *Lancet* 2011; DOI:10.1016/S0140-6736(11)61141-0.
18. Briere J, Gil E. Self-mutilation in clinical and general population samples: prevalence, correlates, and functions. *American Journal of Orthopsychiatry* 1998; **68**: 609–20.
19. Skegg K. Self-harm. *Lancet* 2005; **366**: 1471–83.
20. Deliberto TL, Nock MK. An exploratory study of correlates, onset, and offset of non-suicidal self-injury. *Archives of Suicide Research* 2008; **12**(3): 219–31.
21. Hawton K, Harriss L, Hodder K, Simkin S, Gunnell D. The influence of the economic and social environment on deliberate self-harm and suicide: an ecological and person-based study. *Psychological Medicine* 2001; **31**: 827–36.
22. Moorey S. Managing the unmanageable: cognitive behaviour therapy for deliberate self-harm. *Psychoanalytic Psychotherapy* 2010; **24**(2): 135–49.
23. Evans MO, Morgan HG, Hayward A, Gunnell DJ. Crisis telephone consultation for deliberate self-harm patients: effects on repetition. *British Journal of Psychiatry* 1999; **175**: 23–7.
24. Hawton K, Bergen H, Casey P, Simkin S, Palmer B, Cooper J, et al. Self-harm in England: a tale of three cities. Multicentre study of self-harm. *Social Psychiatry and Psychiatric Epidemiology* 2007; **42**(7): 513–21.
25. Platt S, Hawton K, Kreitman N, Fagg J, Foster J. Recent clinical and epidemiological trends in parasuicide in Edinburgh and Oxford: a tale of two cities. *Psychological Medicine* 1988; **18**: 405–18.
26. O'Connor RC, Sheehy NP, O'Connor DB. Fifty cases of general hospital suicide. *British Journal of Health Psychology* 2000; **5**: 83–95.
27. WHO (World Health Organization). *Health-for-all targets. The health policy for Europe. Summary of the updated edition (EUR ICP HSC 013)*. Copenhagen: WHO, 1992.
28. Winnicott DW. Hate in the counter-transference. *International Journal of Psychoanalysis* 1949; **30**; 69–74.
29. Evans M. Problems in management of borderline patients. In: Jacob C, Adshead G (eds). *Personality disorders: the definitive reader*. London: Jessica Kingsley, 1998.
30. Klein M. Notes on some schizoid mechanisms. In: Money-Kyle R (ed.). *The writings of Melanie Klein*. Vol. 3, *Envy and gratitude*. London: Hogarth, 1946: 1–24.

31. Menzies Lyth I. The function of social systems as a defence against anxiety. In: *Selected essays, vol. 1*. London: Free Association Books, 1970.
32. Motz A. *The psychology of female violence: crimes against the body*. Abingdon: Taylor & Francis, 2008.
33. Main TF. The ailment. *British Journal of Medical Psychology* 1957; **30**(3): 129–45.
34. Bion WR. *Second thoughts: selected papers on psychoanalysis*. London: Heinemann, 1967.
35. Navarro T. Beyond keyworking. In: Foster A, Zagier Roberts V (eds). *Managing mental health in the community: chaos and containment*. London: Routledge, 1990: chapter 12.
36. NICE (National Institute for Health and Care Excellence). *Borderline personality disorder: treatment and management*. NICE Clinical Guideline 78. London: NICE, 2009.
37. Linehan MM, Armstrong HE, Suarez A, Allmon D, Heard HL. Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry* 1991; **48**: 1060–4.
38. Bateman A, Fonagy P. Mentalization-based treatment of BPD. *Journal of Personality Disorders* 2004; **18**(1): 36–51.
39. McLeavey BC, Daly RJ, Ludgate JW, Murray CM. Interpersonal problem solving skills training in the treatment of self-poisoning patients: a qualitative exploration of service-users' views. *BMC Public Health* 2007; **7**: 9–17.
40. Butler AC, Chapman JE, Forman EM, Beck AT. The empirical status of cognitive behavioral therapy: a review of meta-analyses. *Clinical Psychology Review* 2006; **26**(1):17–31.
41. Arntz A. Treatment of borderline personality disorder: a challenge for cognitive-behavioural therapy. *Behaviour Research and Therapy* 1994; **32**(4): 419–30.

Further reading

Babiker G, Arnold L. *The language of injury: comprehending self-mutilation*. Leicester: BPS Books, 1997.
Gardiner F. *Self-harm; a psychotherapeutic approach*. London: Brunner-Routledge, 2001.
Motz A. *The psychology of female violence: crimes against the body*. Philadelphia, PA: Brunner-Routledge, 2001.
Turp M. *Hidden self-harm: narratives from psychotherapy*. London: Jessica Kingsley, 2003.

Relevant web pages

Mental Health Foundation. The truth about self-harm. https://www.mentalhealth.org.uk/publications/truth-about-self-harm
MIND. Self-harm. http://www.mind.org.uk/information-support/types-of-mental-health-problems/self-harm/
The Mix. Why do people self-harm? http://www.thesite.org/mental-health/self-harm/why-do-people-self-harm-5680.html
The Mix. Self-harm. http://www.getconnected.org.uk/get-help/harming-yourself/self-harm/
NSHN (National Self-Harm Network). http://www.nshn.co.uk/
Recover Your Life. http://www.recoveryourlife.com/
Royal College of Psychiatrists. Self-harm. http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/depression/self-harm.aspx
Self-Injury Support. http://www.selfinjurysupport.org.uk/home
This is a UK charity that offers support to people who self-harm, as well as resources and publications for professionals.

Time to Change. Blogs and stories about self-harm. http://www.time-to-change.org.uk/category/blog/self-harm
This website contains blogs and stories from people with lived experience of self-harm.

YoungMinds. Self-harm. http://www.youngminds.org.uk/for_parents/whats_worrying_you_about_your_child/self-harm
This charity provides short films, publications and digital resource packs about self-harm.