Working with people who self-harm: what does the service user need?

Self-harm is a way of responding to lived experiences, either to relieve the intense pain and distress, and/or as a coping strategy that keeps a person alive, a difficult concept and phenomenon. The point when a person who has self-harmed attends A&E is crucial and can influence further contacts with healthcare professionals. This paper is for those who wish to offer effective wound care treatment and understanding from a service user's perspective, whose needs and desired outcomes may differ from those of the clinician. For the purpose of this article, the manner in which the wound occurred is irrelevant; the setting is in an A&E department.

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KEY WORDS
Self-harm
Reflection
Value-based practice
Social phenomena
Service user story

Self-harm is a way of expressing deep distress. Often, people do not know why they self-harm. It is a means of communicating what cannot be put into words or even into thoughts and has been described as an inner scream (www.firststeps-surrey.nhs.uk; www.barnardos.org.uk). Afterwards, people feel better and are able, for a while, to cope with life again (Mind, 2011, www.mind.org.uk).

Self-harm is seen as a spectrum, with suicide at one end and 'normal behaviour' at the other, whatever normal behaviour is (Rethink, www.rethink.org/living). In between are varying degrees of serious and minor self-harm. This article relates to acts of self-harm which are considered by the service user to be separate from acts of attempted suicide, requiring a different motivation. Someone who attempts suicide may be motivated by the desire to end pain and their life completely, whereas someone who self-harms is trying to make themselves feel better (Rethink, 2011).

People who have been sexually, emotionally and physically abused, experience feelings of loss and separation, which are examples of internal and external forces that become so difficult to cope with that self-harm seems the only option (Piaget, 1954).

In the author's opinion, some people harm themselves in less obvious but still serious ways. Their actions may suggest that they do not care whether they live or die, i.e. taking drugs recklessly, having unsafe sex, smoking, or binge drinking (Royal College of Psychiatrists). Who can define what self-harm is? The person who is experiencing it may be the best to offer an opinion.

People of all ages behave and live their lives in a way that does not always fit with what may be called the norm, and behaviour changes according to internal and external sources. It is important to understand why people self-harm, and what experiences they have had. People who have been sexually, emotionally and physically abused, experience feelings of loss and separation, which are examples of internal and external forces that become so difficult to cope with that self-harm seems the only option (Piaget, 1954).

It is the author's experience that, on occasions, clinicians struggle to understand why a person self-harms. The art of reflection may offer the clinician the opportunity to explore their own perspective, and new ideas can be formulated via the process of 'pulling apart' and discussing experiences in clinical supervision. The author suggests that there is an art to 'abstracting' or 'pulling apart' by delving deeper into the many layers involved in reflection and gaining insight into what has occurred, as Boud et al (1985) state:

> *Reflection in the context of learning is a generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understandings and appreciations.*

Race (2007: 223) explores reflection and asks, 'what is reflecting and how do I go about it?' He suggests that:

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We therefore need to capture our thoughts — in other words to furnish evidence of our reflections. This is ideally achieved by putting pen to paper or fingers to key-board.

The author supports this process as transforming experiences into words can make the understanding clearer. As Race (2007: 223) explains:

Reflection deepens learning and enhances practice. The art of reflecting is one which causes us to make sense of what we've learned, why we learned it, and how that particular increment of learning took place.

The art of reflexivity 'refers to the process of critical self-reflection on one's biases, theoretical predispositions, preferences, and so forth... a very important procedure for establishing validity of accounts of social phenomenon' (Schwandt, 2001: 225).

The author has found that social phenomena may give an insight into self-harm. Social phenomena include all behaviours which influence or are influenced by organisms sufficiently alive to respond to one another (dictionary.alot.com, 2011). To expand, social phenomena apply especially to people, attitudes and events particular to a group which may have effects beyond the group, and either be adapted by the larger society, or seen as aberrant, being punished or shunned. For example, people who self-harm can be seen by the larger society to be a 'group' that behave in an unacceptable way.

Is the person who self-harms responding to external and internal influences? Individual experiences make us who we are and enable us to make sense of the world. Learning and development is dependent on our understanding of the environment and our experiences. If these experiences have caused trauma, this accumulation of distress eventually causes such a degree of cognitive disequilibrium that thought structures may require reorganising (Piaget, 1953).

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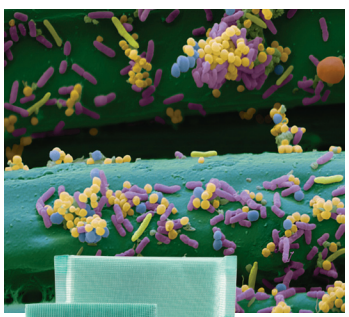

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There remains a general lack of consensus as to how to define self-harm, and it remains a clinical construct with no standardised, empirically validated measure, making it difficult for research in this area to advance.

Research on self-harm has focused on clinical and forensic populations. Studying only these populations, which typically have serious psychopathology, may lead to inflated estimates of the association between self-harm and psychiatric disorder (Klonsky et al, 2003).

Background

According to the Mental Health Foundation (2010, www.mentalhealth.org.uk) 142,000 patients present themselves at hospital due to self-harm in one year. However, there may be a greater number of people who harm without seeking medical attention; it is one of the top five causes of acute medical admission (www.mentalhealth.org.uk).

Clinicians working with people who self-harm should provide the opportunity, if appropriate, to explore the service user's story and discuss options, e.g. referral to counselling, support groups and actively to seek and engage with diversity (i.e. people with identifiable differences in their backgrounds/lifestyles and use of coping mechanisms), leading the way for constructive exploration of self-harm.

However, the clinician should be mindful that the service user may decline any 'talking' intervention, but just want their wound treated and to go home. Some may have care plans in place and or have a mental health care coordinator (Department of Health [DH], 2008).

The Care Programme Approach (CPA) was introduced by the DH in 1991 to provide a framework for effective mental health care. It is at the centre of the personalisation focus, supporting individuals with severe mental illness to ensure that their needs and choices remain pivotal in what are often complex systems of care. In the author's experience, it provides an excellent framework, the principles of which can be supported by all clinicians.

Care coordination is predicated on the principle that people, however vulnerable, should share in decision-making, be knowledgeable about themselves and the effect that their condition may have on their lives, and feel empowered and enabled to inform their own recovery.

Clinician/service user relationship

Perhaps the dilemma faced by clinicians when working in A&E is how to achieve a balance between giving the 'correct' treatment as specified by the National Institute for Health and Clinical Excellence guidelines for a wound (NICE, 2004), and accepting that the service user's views may differ. For example, X has a laceration to their wrist which requires sutures, the person has had a bad experience in the past when sutures were needed and has on this occasion stated that they will only accept steri-strips and a dry dressing.

... people, however vulnerable, should share in decision-making, be knowledgeable about themselves and the effect that their condition may have on their lives, and feel empowered and enabled to inform their own recovery.

Clinicians want to provide security and the best treatment, so when this appears not possible the 'dilemma' occurs. Health organisations live in a world that is target driven and can be seen to be litigious, which, in the author's opinion, might hinder the relationship between clinicians and service users.

The service user/clinician relationship is at the heart of any intervention. Treatment research views the quality of the therapeutic relationship as predictive and fundamental to positive treatment outcome (Horvath and Greenberg, 1994; Horvath and Bedi, 2002).

Listen to the service user's voice and agree a mutually accepted care plan that identifies real and potential risks, including any risks that could compromise the clinician's practice.

Be mindful that some service users do not want to go through a full comprehensive assessment and the purpose of their visit to A&E is to have the wound treated in a non-judgemental way and then be discharged.

For quality care delivery, it is important that the clinician understands their particular or preferred method of communication and how to best meet the needs of the service user. In the author's clinical experience, once you have unlocked your style, it is surprising how well you can flourish, even in areas that you previously found difficult. This can be done in supervision sessions on an individual basis, or in a group, analysing how the clinician's communication style may affect how the service user responds to you.

Clinicians must be caring, show respect and be supportive and non-judgemental and always show human responses as this has the greatest impact of all (anon, service user).

Risk assessment

Assessment and management of risk should be ongoing, taking into account best practice (DH, 2007) and demonstrating a clear understanding and formulation of risks and support for positive risk-taking.

Morgan (2010: 21) explores the concept of positive risk-taking which can be used to provide a better and more innovative service to mental health service users and others:

Positive risk-taking is weighing up the potential benefits and harms of exercising one choice of action over another. This means identifying the potential risks involved, and developing plans and actions that reflect the positive potentials and

stated priorities of the service user. It involves using available resources and support to achieve desired outcomes, and to minimise potential harmful outcomes.

For example, a service user in A&E positively assures the clinician that they have no further intent of self-harm at that time, want to go home and will attend their appointment with the mental health doctor as planned the day after. Clinicians can empower service users by promoting choice and not to allow the service user to be discharged may cause other problems/risks, for example, agitation/aggression.

The most effective organisations are those with good systems in place to support positive approaches rather than defensive ones (DH, 2007).

There will be occasions when a service user may disclose information that cannot be 'held' within the remit of confidentiality and specialist intervention may be needed. For example, if a service user discloses that a child is being sexually abused, the clinician must report this to the appropriage authority (HM Government, 2006).

From 12 October 2009 the Protection of Vulnerable Adults (or POVA) scheme has been replaced by the Vetting and Barring Scheme (2010). Clinicians should be aware of policy, and every NHS organisation should have a, 'vulnerable adults' policy that is applicable for anyone over the age of 18. A vulnerable adult is defined as anyone aged 18 years or over who may need help because of physical or mental illness, or may be unable to care for themselves, or protect themselves from significant harm or exploitation. In these cases, staff should seek further advice from the specialist adviser for vulnerable adults in the trust, or from the local authority safeguarding lead.

Self-harm is not an attempt at suicide. People who harm themselves are often unaware of the dangers of what they are doing and do not intend to kill themselves. Their actions can be attempts at communication,

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psychological or physical relief, or punishment, but should be considered distinct from attempts to end their life entirely. Despite this, someone who self-harms is 50–100 times more likely to attempt suicide than someone who does not (Mental Health Foundation, 2010; www.mentalhealth.org.uk/).

Completing a risk assessment with the service user should be used as an enabler to aid the relationship, rather than a hindrance or a purely legislative process.

The depth of information that can be gleaned from a risk assessment tool can be immense. It will not only offer a common talking point and provide the necessary NHS data, but will also show the service user that the clinician gathers information for a purpose rather than simply to collect statistics. It serves as a means by which the clinician can really begin to 'listen' to the person's individual story, and should be completed in an open and honest way.

Risk assessment can be seen in two stages:

- Immediate risk: is the service user 'safe' for the next 24 hours when they leave A&E?
- Long-term risk: what are the agreed plans in place after the first 24-hour period?

A person who has self-harmed rarely wants to discuss the reasons and A&E is not the best place. Discussions about short-term risk and support plans may, however, be welcomed.

Guidelines

NICE have produced clinical practice guidelines which are, 'systematically developed statements that assist clinicians and patients in making decisions about appropriate treatment for specific conditions' (DH, 1996). Assessment and management of a wound following self-harm is exactly the same as for any other wound. NICE (2004) provides the clinician with guidance for wound care and also state that the service user's treatment preference must be taken into account. However, guidelines are not a substitute for professional knowledge and clinical judgement. If guidelines are not followed as a consequence of an agreement made with a service user, for example, to have steri-strips instead of sutures, the clinician should document why they have not been followed. In using guidelines, it is important to remember that the absence of empirical evidence for the effectiveness of a particular intervention is not the same as evidence for ineffectiveness. In mental health, evidence-based treatments are often delivered within the context of an overall treatment programme incorporated into a care plan, including a range of activities such as art classes to help the service user explore their experiences, as some may find it hard to talk but can express themselves via art work. The purpose is to help engage the patient and provide an appropriate context for the delivery of specific interventions.

It is important to maintain and enhance the service context, i.e. the correct environment to enable a positive service user/clinician relationship, in which interventions can be delivered, otherwise the specific benefits of effective interventions will be lost. Indeed, the importance of organising care that supports and encourages a good therapeutic relationship is, at times, more important than the treatments offered (NICE, 2004).

Collaboration

Clinicians must work to certain principles and values based on collaborative working. The Equality Act 2010 provides a new cross-cutting legislative framework to protect the rights of individuals and advance equality of opportunity for all. The aim is to enable healthcare staff to deliver a simple, modern and accessible framework of discrimination law which protects individuals from unfair treatment and promotes a more equal society.

The wishes of the service user should always be respected, unless issues of risk are considered to override them. For example, if the Mental Health Act (2007) has to be used to section a patient and admit them to a mental health unit.

People who self-harm are 'people' who have feelings, emotions and real experiences. The ability to 'walk in the shoes' of those who self-harm will enable the clinician to see things differently. Providing care that maintains professional and quality standards, while accepting that some service users are experts in their own care and really do know what works best for them is the challenge.

Tate (2010: 32–33) provides a personal account and awarded three gold stars during a positive visit to an A&E department, when she was treated with care and respect. In this article, a long-term service user described how she was pleasantly surprised by the attitudes of the emergency nurses and doctors who cared for her after she had self-harmed:

> *I am rarely able do more than answer questions in these circumstances, but at this time, as the nurse chatted to me, I found myself able to chat back.*

She concluded that the experience would remain with her for a long time.

Discussion

Joint discussions about risk and safety should be an integral part of the assessment, although it should be remembered that any risk assessment is only valid for the time it is made. Both parties must be honest and, if needed, negotiate options and look to agree on short and long-term plans. For example, in the short term, X agrees that when discharged from A&E they will not to harm themselves, and in the long-term will attend a previously booked appointment with their counsellor.

Listen to the words people use. Personal construct theory (PCT) gives one of the richest possible accounts of a person's cognitive processes (Kelly, 1955). Its essence is that personal identity is defined by the way we construe or 'understand' our personal worlds.

Take note of non-verbal communication and document it, for example, a person who gives little eye contact may indicate a low mood or lack of motivation, while too much eye contact could be seen as aggressive. Patton (2002; p243) states:

The quality of the information obtained depends on the interviewer/ clinician's skills.

The clinician should observe their own and the service user's body language, e.g. gestures, eye contact, and pay attention to words used. For example: 'Do you hear/see/feel what you are saying' .Tune into the types of words used and respond accordingly with the same, 'Yes I hear/see/feel what you are saying'.

Establishing a rapport with the service user is one of the most important features or characteristics of subconscious communication. In the author's clinical experience, being 'in sync' with, or being 'on the same wavelength' as the person who presents with a wound as a result of self-harm is important for a positive outcome. A number of techniques are beneficial in building rapport, such as matching your body language (i.e. posture, gesture, etc), maintaining eye contact, and matching breathing rhythm. Some of these techniques are exploited in neuro-linguistic programming (NLP) (Bandler and Grinder, 1981).

NLP is an approach to psychotherapy based on interpersonal communication concerned with the relationship between successful patterns of behaviour and the subjective experiences, e.g. patterns of thought underlying them. Bandler and Grinder believed that there was a connection between neurological processes ('neuro'), language ('linguistic') and behavioural patterns that have been learned through experience ('programming') and can be organised to achieve specific goals in life.

As a clinician, the best you can give a service user is your time and genuine regard and understanding. NLP

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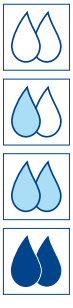

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Key points

- What assumptions do we make: are we really aware of the impact our assumptions on people who use our services have?
- Be mindful of appearances as opposed to reality: look beyond the 'wound'.
- What can I personally do to enhance the service user experience?
- Follow principle-driven treatment: based on principles that tell you how to figure out what to do underpinned by protocols.

techniques can enhance the relationship between the service user and clinician. By listening to the service user's voice, noting the types of words used and making the connection between the spoken words and the service user's experience, the clinician may be able to appreciate that self-harm is not about manipulation, but more a way of expressing what is unbearable and painful (Pembroke, 2000).

Value-based practice

Value based practice (VBP) is the theory and skills base for health-related decision-making where legitimately different, and hence potentially conflicting, values are implicated (Smith, 2010).

VBP is key when working in partnership to identify possible solutions to issues and is something the clinician needs to analyse and understand. For example, how do your personal values affect decision-making and, as a consequence, are there any implications for your practice?

VBP can contribute to improved experiences and outcomes for service users, as it is based on the premise that any decision made is done so with respect for their values and beliefs, combined with current evidence-based practice. Most of us make decisions based on personal values and experiences, which are more likely to be personally owned and acted upon.

Conclusion

Learning about various communication/interpersonal skill models can allow the clinician to make a judgement about the most appropriate (helpful and empathetic) response. When managing and treating patients with wounds as a result of self-harm, it is important that the clinician listens and hears the person's individual story, and is mindful of their own verbal and non-verbal communication. Sensitive listening and active observing, as well as clarifying and double checking what the patient has said to show your understanding, are essential components in developing a good relationship between the clinician and service user (Hawkins and Foster, 2005), as well as spending the time to listen. WUK

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