

Intervention strategies for people who self-harm

The Royal College of Psychiatrists (2010) estimates that the incidence of self-harm in the UK has risen over the last 20 years and that the rates among young people are the highest in Europe. Tissue viability practitioners will at some time in their career be expected to plan the care for a person who has self-harmed. However, self-harm is poorly understood by many healthcare professionals. The quality of nursing care depends greatly on the quality of the assessment, therefore an accurate and holistic nursing assessment is crucial to ensure that people who self-harm receive appropriate care.

Karen Ousey, Claire Ousey

KEY WORDS

Self-harm
Wound management
Treatment
Multidisciplinary care

Self-harm is a behaviour, not an illness, and its management is highly dependent on any underlying problems, which could range from an episode of psychosis with intense suicidal urges to an impulsive reaction to a stressful emotional event (Skegg, 2005). The challenge for healthcare professionals is to ensure that effective communication is maintained between the person who has self-harmed and the multidisciplinary team, and that timely and appropriate referrals are made to relevant community agencies.

Karen Ousey is a Research Leader, Department of Podiatry and Clinical Sciences, Centre for Health & Social Care Research, University of Huddersfield, West Yorkshire; Claire Ousey is a Mental Health Practitioner, Nye Bevan House, Heywood, Middleton and Rochdale Primary Care Trust, Rochdale

This paper explores self-harm and examines some of the management strategies that may be used to plan care interventions effectively.

Self-harm

The term self-harm is commonly used to describe a wide range of behaviours and intentions including attempted hanging, impulsive self-poisoning and superficial cutting in response to intolerable tension (Skegg, 2005).

The Royal College of Psychiatrists (2010) states that self-harm covers a wide range of behaviours and may be defined 'as an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent'. The National Institute for Health and Clinical Excellence [NICE] (2004) guidelines use a broader definition of self-harm as 'self-poisoning or self-injury, irrespective of the apparent purpose of the act'.

The Royal College of Psychiatrists (2010) describes self-injury as being commonly caused by cutting, although other methods employed include burning, hitting or mutilating body parts, and attempted hanging or strangulation. Self-harm and injury are leading causes of acute hospital admission, but many of those who self-harm are never admitted. The Royal College of Psychiatrists (2010) estimates that the incidence of self-harm in the UK has risen over the last 20 years

and is now the highest in Europe among young people.

Self-harm can affect people from any age group or background, although socioeconomic deprivation is a predisposing factor. Self-harm is more common in people with mental health problems, those serving a prison term, asylum seekers, armed forces veterans, people bereaved by suicide, and in some ethnic and sexual practice groups (Royal College of Psychiatrists, 2010).

Corser and Ebanks (2004) suggested that people who self-harm most often damage their skin with:

- ▶▶ Razor blades
- ▶▶ Scissors
- ▶▶ Pens
- ▶▶ Lit cigarettes or matches
- ▶▶ Boiling water
- ▶▶ Bleach or peroxide.

Sharman (2007) identified that approximately one in ten young people will self-harm at some point and that the urge can arise at any age, although it is more common in young women than men. However, there is some evidence that self-harm itself is not as predominantly female as has been commonly thought, with physical, emotional or sexual abuse during childhood being a more common indicator (Sharman, 2007). There is also evidence that cutting is repeated more often than other forms of self-harm (Lilley et al, 2008).

Factitious disorders may present in the primary or secondary sector and require intervention from either a tissue viability or dermatology team.

Factitious disorders

Factitious disorders are defined as self-harming behaviours that directly or indirectly cause subjective, clinically relevant harm without being directly linked to suicidal intent, and with the prevalence being highest among dermatology patients (Harth et al, 2010). Self-inflicted dermatosis have been described by Harth et al (2010) as:

- ▶ Dermatitis artefacta syndrome: unconscious self-harm
- ▶ Dermatitis paraartefacta syndrome: impulse control disorders, often manifests as manipulation of existing skin lesions also known as 'skin-picking' syndrome
- ▶ Malingering: defined as wilful deception by feigning injury or disease in order to gain something
- ▶ Gardner-Diamond syndrome: characterised by episodes in which painful blue maculae appear along with various physical and psychological symptoms (Behrendt et al, 2001)
- ▶ Münchhausen syndrome
- ▶ Münchhausen by proxy syndrome.

Referral to the dermatology team is important if a patient presents with a factitious disorder:

The multidisciplinary team

Self-harm is poorly understood by many healthcare staff and dedicated training is often required to improve both their understanding and also the treatment and care they provide. The effective collaboration of all local healthcare organisations is essential to developing properly integrated services (NICE, 2004).

Arbuthnot and Gillespie (2005) state that the provision of evidence-based care following self-harm requires a strong focus on psychological measures. The quality of nursing care also depends on the quality of the nursing assessment, therefore an accurate holistic assessment is crucial (Gillespie and Melby, 2003).

Additionally, understanding the

person's motivation for self-harm will help the healthcare professional to perform an accurate assessment and formulate a care plan. For example, it is important to ascertain whether the self-harm is a result of traumatic experiences or a display of attention-seeking behaviour. The care plan will require a different set of skills depending on the reason for the self-harm. For example, a referral to mental health services for counselling or cognitive behaviour therapies (CBT) may be required if the person has psychological issues that he or she needs to resolve. Healthcare professionals treating the actual wound should also involve mental health staff in any care.

Several studies identified that people who cut or burn themselves find that they are treated with little tolerance, compassion or respect when they seek professional care for their wounds.

Several studies have identified that people who cut or burn themselves find that they are treated with little tolerance, compassion or respect when they seek professional care for their wounds (Reece, 1998; Harris, 2000).

In response, NICE (2004) has produced guidelines that address some of these issues and include the following recommendations:

- ▶ Ensure a full account is taken of the distress experienced by those who self-harm when they present for treatment
- ▶ Ensure sufficient information is made available to allow people who self-harm an informed choice about treatment options
- ▶ Ensure the agreed treatment is provided without unnecessary delay.

NICE (2004) recommend that people who have self-harmed should be treated with the same care, respect and privacy as any other person. They also suggest that healthcare professionals undertaking this work should have

regular clinical supervision in which the emotional impact upon them can be discussed and understood. Wherever possible, people who have self-harmed should be offered the choice of a male or female healthcare professional for both assessment and treatment, as the self-harming behaviours may be related to previous abuse issues. When this is not possible, the reasons should be explained to the person and written in their notes.

Healthcare professionals should involve people who self-harm in any discussions and decisions about their treatment and subsequent care. To do this, healthcare professionals should provide people who self-harm with comprehensive information about the different treatment options available. Furthermore, healthcare professionals need to be educated on the manifestations of self-harm and its various underlying triggers.

Risk assessment

Every person who has self-harmed should have a comprehensive assessment of needs and risk, including a full mental health and social needs assessment with an evaluation of the social, psychological and motivational factors specific to the act of self-harm (NICE, 2004).

To encourage joint clinical decision-making, the person who has self-harmed and the healthcare professional should mutually agree any conclusions/plans and these should be written into the notes. Where there is significant disagreement, the person should be offered the opportunity to document this in the notes.

The assessment should be passed on to the person's GP and to any relevant mental health services as soon as possible to enable follow-up.

Any assessment should include identification of the main clinical, demographic and psychological characteristics known to be associated with risk of further self-harm and/or suicide, in particular depression, hopelessness, and continuing suicidal intent (NICE, 2004). A survey by Meltzer et al

(2000) on non-fatal suicidal behaviour among adults aged 16–74 in Britain identified that the prevalence of self-harm was particularly high in the following groups:

- ▶▶ Those who had run away from home (14%)
- ▶▶ Those who had experienced sexual abuse (14%)
- ▶▶ Those who had been expelled from school (13%)
- ▶▶ The homeless (12%).

Firth (2007) estimates that around 80,000 people who self-harm do not receive either a psychological evaluation or a follow-up appointment. This is despite suicide being 100 times more likely in someone who has recently engaged in self-harm. The Royal College of Psychiatrists (2010) recommend that:

- ▶▶ People attending hospital after an episode of self-harm should receive a bio-psychosocial assessment, which recognises the necessity to adopt a holistic approach to care planning, including physical, psychological and social well-being (Gilbert, 2002). The assessment process should be performed by a healthcare professional with adequate skill and experience and in accordance with NICE (2004) guidelines
- ▶▶ Assessments of risk and need should be closely related. NICE (2004) suggest that following any psychosocial assessment, the decision about referral for further treatment should be based upon a comprehensive psychiatric, psychological and social assessment. This should include a risk assessment and any treatment/referral decisions should not be based solely on the basis of the person having self-harmed.

Wound assessment

Assessment and management of the self-harm wound follow the same principles as those in any other wound, including assessment of the wound site, dimensions, state of the wound bed, amount and colour of exudate, appearance of the surrounding skin, amount and intensity of any pain and treatment options.

Healthcare professionals should attempt to gain a comprehensive history of the wound, including when it was caused, what caused it, whether the person has attempted to clean it and if he or she has a preferred treatment method.

These elements are important as healthcare professionals need to assess whether there is a risk of deliberate wound contamination that requires treatment. Some people may be repeat self-harmers and may have a preferred method of treatment that will require discussion and documentation. Before administering any care, consent must be obtained.

The healthcare professional should attempt to gain a comprehensive history of the wound, including when it was caused, what caused it, whether the person has attempted to clean it and if he or she has a preferred treatment method.

Moffatt (2000) explains some of the difficulties involved in assessing patients who have wounds caused by self-harm. She states that when assessment has ruled out the presence of an organic cause for the wound, the healthcare professional is faced with the dilemma of whether or not to tell the person that self-wounding is suspected. This is a decision that must always be made on an individual basis and with the support and agreement of the multidisciplinary team. It is important that there is well-developed clear communication between mental health staff, psychiatrists, occupational therapists, physiotherapists, pharmacists, counsellors and GPs, as well as the individual and their family/carers if appropriate.

Managing the wound

NICE provides guidance on the management of wounds caused by self-harm, stating that superficial uncomplicated wounds can be closed with tissue adhesive, while more

complicated injuries may need surgical assessment and possibly exploration (NICE, 2004). However, NICE is clear that the person's level of distress should be taken into account and delays in treatment should be avoided.

As stated above, the first recommended line of treatment is the use of tissue adhesive, which is simple and effective on small superficial wounds (NICE, 2004). However, NICE (2004) also states that in the treatment and management of superficial uncomplicated injuries of 5cm length or less, skin closure strips can be offered as an effective alternative if the person expresses a preference.

It should be remembered that the scarring that results from acts of deliberate self-harm can be just as important as the act itself (Babiker and Arnold, 1998). Therefore, effective communication with the person who has self-harmed and ensuring his or her involvement in the treatment plan is essential to promote concordance and to prevent removal of any dressings. Education about how to prevent further episodes of self-harm is important, for example the use of distraction techniques as an alternative method of coping.

Developing therapeutic relationships

Mangnall and Yurkovich (2008) undertook a literature review and identified that people who self-harm often feel that no one is able to provide the emotional support, understanding and affection that they need. In fact, the act of self-harm can itself be seen as a dramatic communication method. Potter (2003) suggests that the body is being used as 'text' and serves to communicate something that is difficult to articulate by conventional means. It is vital that the healthcare professional listens to the person who is self-harming and does not judge their behaviour.

Warm et al (2002) state that avoiding labelling people who self-harm and allowing them to speak freely helps to develop a therapeutic relationship, which can improve self-harming behaviours.

The CARE (containment, awareness, resilience and engagement) framework, as described by Shepperd and McAllister (2003), may be used to empower both the person who self-harms and healthcare professionals, promoting structure and confidence and allowing both parties to fully engage in a care plan.

The CARE framework does not seek to replace the medical model (which can provide important containment and treatment while a patient is ill or in crisis); rather, it focuses on building self-awareness and an appreciation of hidden strengths in the individual so that he or she can move towards the future with optimism (Shepperd and McAllister, 2003).

Shepperd and McAllister (2003) also argue that developing trusting partnerships will increase the motivation of people who self-harm, enabling them to remember past traumatic events, learn new problem-solving skills, dispute self-defeating thoughts and find a sense of meaning in the recovery process.

Manipulative behaviours

Within therapeutic relationships, it is important that healthcare professionals are able to assess effectively whether self-harming behaviours are being used to manipulate situations and/or staff.

This has been explored by Neilson (1991) who states that people who engage in manipulative behaviour may have experienced some level of abuse as children, leading to low self-esteem and poor anger management and impulse control. As a result, manipulative behaviours may be used to elicit rewarding 'emotional' care from healthcare professionals, and ensure that the person who self-harms remains visible to healthcare services.

Conclusion

Self-harm is a behaviour that can result in wounds that require intervention from tissue viability or dermatology services. Timely and appropriate referral to a multidisciplinary team is essential to ensure that the physical and mental health needs of the person who self-harms are met. **WUK**

References

- Arbuthnot L, Gillespie M (2005) Self-harm: reviewing psychological assessment in emergency departments. *Emerg Nurs* 12(10): 20–4
- Babiker G, Arnold L (1998) *The Language of Injury*. BPS Blackwell Books, London
- Behrendt C, Goos M, Thiel H, Hengge UR. (2001) Painful bruising syndrome. *Hautarzt* 52: 634–7
- Corser R, Ebanks L (2004) Introducing a nurse-led clinic for patients who self-harm. *J Wound Care* 13(5): 167–70
- Firth L (2007) *Self-harm*. Independence Educational Publishers, Cambridge
- Gilbert P (2002) Understanding the bio-psychosocial approach: conceptualization. *Clin Psychol* 14: 13–17
- Harris J (2000). Self-harm: cutting the bad out of me. *Qual Health Res* 10(2): 164–73
- Harth W, Taube M K, Gieler U (2010) Factitious disorders in dermatology. *J Dtsch Dermatol Ges* 8: 361–73
- Gillespie M, Melby V (2003) Assessing acute myocardial infarction. *Emerg Nurs* 11(5): 26–30
- Lilley R, Owens D, Horrocks J, et al (2008) Hospital care and repetition following self-harm: multicentre comparison of self-poisoning and self injury. *Br Med J* 192: 440–5
- Mangnall J, Yurkovich E (2008) A literature review of deliberate self-harm. *Perspect Psychiatr Care* 44(3): 175–84
- Meltzer H, Lader D, Corbin T, Singleton N, Jenkins R, Brugha T (2000) *Non-fatal Suicidal Behaviour Among Adults Aged 16 to 74 in Great Britain*. HMSO, London
- Moffatt C (2000) Self-inflicted wounding 2: identification, assessment and management *Br J Comm Nurs* 51: 34–40
- Neilson P (1991) Manipulative and splitting behaviour *Nurs Standard* 6(8): 32–5
- National Institute for Health and Clinical Excellence (2004) *Self-harm. The Short-term Physical and Psychological Management and Secondary Prevention of Self-harm in Primary and Secondary Care*. NICE, London
- Potter N (2003) Commodity/body/sign: borderline personality disorder and the signification of self-injurious behavior. *Philos Psychiatr Psychol* 10(1): 1
- Reece J (1998) Female survivors of abuse attending A&E with self-injury. *Accid Emerg Nurs* 6: 133–8
- Royal College of Psychiatrists (2010) *Self-harm, Suicide and Risk: helping people who self-harm*. Available online at: www.rcpsych.ac.uk/files/pdfversion/CR158.pdf (accessed 28 September, 2010)

Key points

- ▶▶ Self-harm is a behaviour that can result in the formation of a wound which requires intervention from tissue viability or dermatology services.
- ▶▶ The challenge for healthcare professionals is to ensure that effective communication is maintained between the person who has self-harmed and the multidisciplinary team.
- ▶▶ Self-harm can affect people from any age group or background, although socioeconomic deprivation is a predisposing factor.
- ▶▶ Factitious disorders are defined as self-harming behaviours that directly or indirectly cause subjective, clinically-relevant harm, without being directly linked to suicidal intent.
- ▶▶ The National Institute of Health and Clinical Excellence [NICE] provides guidance on the management of wounds caused by self-harm.
- ▶▶ Education about how to prevent wounds is important, for example by using distraction techniques as an alternative method of coping.

Sharman J (2007) *Understanding Self-harm*. Mind, London

Shepperd C, McAllister M (2003) CARE: A framework for responding therapeutically to the client who self-harms. *J Psychiatr Ment Health Nurs* 10(4): 442–7

Skegg K (2005) Self-harm. *Lancet* 366: 1470–83

Warm A, Murray C, Fox J (2002) Who helps? Supporting people who self-harm. *J Ment Health* 11(2): 121–30