



Working with People who Self-Harm

Information for staff in emergency services

As a staff member with virtually no training in mental health, I really need more information about this I honestly have no idea what to say to someone who has self-harmed”¹

“It makes such a difference when staff treat you like a normal person with real feelings – it really is appreciated”

BACKGROUND

The ‘Better Services for People who Self-Harm’ quality improvement programme recently surveyed over 1,000 members of staff and 500 service users to find out how services could be improved in relation to the first 48-hours of care received. Both groups acknowledged the need for improved information for staff, to help them gain better knowledge and understanding of this complex issue. This leaflet is one way in which staff can find out more about self-harm (for details of other materials, please see the ‘**Further Resources**’ section at the back of this booklet).

WHAT IS SELF-HARM?

The phrase ‘self-harm’ means different things to different people. In this booklet we are talking about something a person does which causes them **physical harm**, but which is actually an expression of their **emotional distress**. This could include cutting or burning oneself, overdosing, jumping from a height, inserting things into one’s body, swallowing something poisonous, self-strangulation, or many other actions.

Of course, many people in society harm themselves to cope with emotional pressures, but in ways which our society finds acceptable – or at least understandable! Drinking to excess is one example. Getting immersed in work to the extent that one’s health suffers is another! This isn’t within the scope of this booklet, but helps put self-harm in context.

Self-harm and attempted suicide are not the same thing – the motivation is different, and self-harm is often a way of trying to survive unbearable feelings. The first few sections of this booklet focus on understanding non-suicidal self-harm, the guidelines about responding to self-harm are relevant regardless of whether or not the person’s intention was suicide.

In the ambulance or emergency department you will treat people who may only self-harm once or twice, perhaps during a **life crisis**. You will see other people who will return many times over a long period, for whom self-harm is an established **coping strategy**, which they may need to use for months or years before finding other ways of coping.

¹ Quotes taken from the ‘Better Services for People who Self-Harm Project’ – Wave 1 audit results.

COMMON MYTHS ABOUT SELF-HARM

Myth	Reality
People who self-harm are attention seeking or manipulative	For many people their self-harm is a very private act. They may have self-harmed for years without telling anyone. For other people self-harm may be the only way of communicating at a time when they are deeply distressed. <i>“I don’t self-harm to annoy staff, but rather because something is very, very wrong inside”</i>
It’s best to ignore someone when they have self-harmed - they are less likely to do it again	Rejection and feeling bad about oneself may be a cause of someone’s self-harm. Further rejection is likely to lead to further self-harm! <i>“People use self-harm as a way of coping with some big s**t - if they (staff) treat you wrong it is like being abused again</i>
If people who self-harm cause themselves pain, they don’t need pain relief when their injuries are being treated	Sometimes people are conscious of pain when they self-harm, at other times they are not. Once the self-harm is over, pain is very much a reality!
Self-harm is failed suicide	Self-harm is often about managing deep emotional pain, and the person is trying to find a way to avoid suicide. However, there are times when the two overlap – e.g. when someone harms themselves badly not caring whether they live or die.
People who self-harm have a borderline personality disorder	Just because self-harm is listed as <u>one</u> of the ‘symptoms’ of borderline personality disorder in the diagnostic manual, does not mean that everyone who self-harms should attract that diagnosis. The reasons for self-harm are many and various, and may or may not be related to a mental health condition.

The quotes above are taken from people who completed the Wave 1 ‘Better Services for People who Self-Harm’ service user survey, April 2006

HOW COMMON IS SELF-HARM?

- The Mental Health Foundation estimates that around **1 in 130 people** (nearly half a million across the UK) self-harm
- Self-harm is one of the **top five causes of acute medical admission** in the UK each year
- Most people who self-harm *do not* attend the Emergency Department (ED), so **hospital admissions do not reflect the true scale of the problem**
- A recent survey of 6,000 15-16 year-olds² found that 11% of females and 3% of males have self-harmed

UNDERSTANDING SELF-HARM

To a person who has never self-harmed, the realisation that people cut and burn themselves, strangle themselves, jump with the intention of injuring themselves, or drink a corrosive substance (to mention just a few methods of self-harm) may be shocking and bewildering.

It becomes easier to understand when one looks at the reasons and context for self-harm. Studies have shown that about **80% of people who self-harm have experienced abuse**, often in childhood, but also as adults. This might be sexual, physical or emotional abuse, which can lead to a person feeling:

- unclean
- unworthy
- guilty
- angry
- trapped
- silenced

When one thinks about these documented effects, one can see how self-harm can be a possible response to this trauma. In the USA and Canada some practitioners see some self-harm as part of 'Complex Post-Traumatic Stress Disorder' – self-harm is therefore understood as an understandable **response to past traumas**.

Of course, not everyone who self harms has experienced abuse, and for every individual there will be a unique and complex mix of issues involved. There are other experiences which are common to some people who harm themselves. **Losing a parent** in early life is one of them, **losing a baby** is another. Some people who self-harm grew up in families or institutions in which there was **no culture or language for expressing feelings**. Later, when life events give rise to strong, but perfectly natural feelings, the person may have no way of communicating what they feel. Another common factor is **pressure to achieve high standards** – a factor for some school and university students. Young people have also talked about harming themselves as a response to being bullied, or in response to problems at home or bereavement.

For some people there are triggers quite apart from life events. Some **people who hear voices** experience their voices telling them to harm themselves, perhaps taunting them if they do not. In a similar way others may have **compulsive thoughts** about self-harm that are so persistent that eventually there is no more energy to fight the impulses.

Not everyone is aware of their own actions in harming themselves. For people who disassociate, i.e. lose touch with themselves and their surroundings, self-harm may be **an unconscious act**.

² By Their Own Young Hand: Deliberate Self-Harm and Suicidal Ideas in Adolescents; Hawton et al (2006)

PEOPLE WHO MAY BE AT A HIGHER RISK OF SELF-HARMING

As mentioned above, **young people**, especially females, are more likely than adults to self-harm.

Cultural factors can sometimes play a part – for example rates of self-harm seem to be higher among South Asian females. A review of recent literature³ suggested that stereotyping, racism, marital and family problems, domestic abuse, isolation, hard-to-meet expectations and the concept of "izzat" (family honour) can all lead to increased mental distress.

Other literature explains that some Asian women find self-harm an acceptable option for dealing with distress because it allows them to privately express their anguish whilst upholding the belief that problems should stay within the family⁴. Research and literature recognises that conflict between different generations within one community can be a cause of self-harm among black and minority ethnic women. At the same time, it is important not to assume this the *only* or main reason for it. Research also indicates that people from black and ethnic minority (BME) groups may be less likely to access services – either because they do not believe that mainstream services can help them, or because they are afraid of the 'community grapevine'.

Studies have shown that for **gay, lesbian, bisexual and transgender people**, the incidence of self-harm is greater than in the general population. In reports on self-harm, gay men were more likely than bisexual men, and lesbians more likely than bisexual women to cite their sexuality as a reason for harming themselves⁵. A study of 200 gay men in Northern Ireland⁶ revealed that a quarter of gay men have attempted suicide, two thirds have considered it and 30% have self-harmed. Recent research into self-harm among young people⁷ suggested that those who were worried about their sexual orientation were more likely than people without such worries to report self-harm. The link between bullying and self-harm can also be a factor.

According to the **Prison Service** Safer Custody Group's Research and Training Unit, a high proportion of people, especially young people under the age of 21, self-harm in custodial settings. Although young women represent only 6% of the prison population, they represented over half of the self-harm incidents reported in 2003.

It is also worth noting that **people with any chronic condition, either physical or psychological**, have an increased risk of self-harm. Self-harm in people with physical conditions can sometimes be overlooked, or disguised, because of the condition and the need to treat it. Some psychiatric and medical studies state that 15% of those with a chronic illness suffer from clinical depression; others place this figure as high as 60%.

Regardless of age, sexuality, ethnicity or anything else, it is important *not to make assumptions* about a person's reasons for self-harm. For each person it will be a complex mix of factors, and the triggers may be different at different times. The most important thing is to start from the service user's frame of reference, be aware of potential factors and keep an open mind.

³ Self-harm in British South Asian women: psychosocial correlates and strategies for prevention
MI Husain, W Waheed and Nusrat Husain (2006)

⁴ Strategic and Local Initiatives undertaken to Tackle Self-harm amongst Young South Asian Women', Kamna Muralidharan, Newham Asian Women's Project, 2005

⁵ Mental health and Social Wellbeing of Gay Men, Lesbians and Bisexuals in England and Wales; Mind 2003

⁶ 'Out on Your Own', conducted by the Rainbow Project

⁷ By Their Own Young Hand: Deliberate Self-Harm and Suicidal Ideas in Adolescents; Hawton et al (2006)

SELF-HARM IS ABOUT.....

I can't cry.

Letting the blood
flow brings relief
**I can't cry.
Letting the blood
flow brings relief**

**Overdosing gives me 'time out' when I can't cope
with the emotional pain any more.**

Self-harm **helps me** not to kill myself.
It brings **just** enough **respite**
to carry on another hour or **another day.**

I go into
'a different world'.
I'm not really aware of
what I'm doing.

It's OK people saying, 'Talk about it', but I would if I could.
I can't get any words out 'till I've got through this pain.

I feel trapped.

I am dirty and evil inside and
need to let the badness out.

**I suppose I'm saying to myself
and others that something is wrong.**

*I'd like to express feelings in other ways,
but I got hit as a kid if I cried or got angry,
and I have lost that part of me.*

HELP!

**Self-harm jolts me out of depression
so that I can get to work**

The pain inside is unbearable.
Physical pain numbs it for a while.

**My voices tell me to
self-harm**

I have these
compulsive thoughts every
minute about harming
myself.

Eventually I'm too
tired to fight them
any more

I'm bad and need to punish myself.

I **don't** understand why I
have harmed myself.

I **don't** understand
what is going on

WHAT HELPS:

“When staff are kind are kind to you it makes all the difference – it makes you feel you are worth bothering with, like there is some hope”

- Showing respect and warmth to the person who has self-harmed – letting the person know they matter
- Acknowledging that the person is distressed
- Asking if they would like anyone to be with them
- Checking if the person has any disability needs which would affect their care
- If possible, offering a quiet, private place to wait, if the person would find this easier than waiting in the main area
- Asking if there is anything you can do to help them feel safe (e.g. removing the sharps bin from the cubicle!)
- Offering pain relief whilst the person is waiting for treatment (if the person is in pain, and provided there is no clinical reason for not giving pain relief at this stage)
- Providing adequate dressings to stem bleeding whilst waiting for treatment
- Being up to date with clinical guidelines (e.g. stomach lavage no longer recommended unless advised by National Poisons Service) – see NICE Guideline
- Balancing clinical guidelines with patient choice e.g. even if cut could be steri-stripped, the patient may prefer it to be stitched if this prevents them cutting deeper into the wound later on – offer choices
- Explaining the nature of the injury or condition, the treatment options and effects
- Passing on information between workers and teams (ambulance, triage, ED doctor, key nurse, mental health practitioner). People will understand that some questions have to be repeated, but being asked 5 times why one has self-harmed is an ordeal!
- Asking the patient’s consent for each procedure – and letting them know they have a choice whether to go ahead or not
- At triage, or ‘meet and treat’, taking into account mental distress as well as physical injury in deciding on urgency of treatment and the treatment plan
- Checking how the person is at regular intervals (e.g. 15-20 mins), asking if they need anything and updating them on progress (even if nothing has changed!)
- Offering an overnight bed if a person would otherwise go back to an empty house in the middle of the night
- Providing a choice in terms of gender of staff. Women may not be comfortable talking about their situation or experience with a male member of staff and vice-versa. The gender of staff may be especially important with regards to privacy around the body.

WHAT DOESN'T HELP?

- Making assumptions. Questions such as 'Why do you want to punish yourself?' is complicated to answer if the self-harm is nothing to do with punishing oneself! A more helpful question is, 'Do you want to talk about harming yourself?' or 'I'd like to try and understand what led you to harm yourself today.'
- Asking the person about their self-harm in a public area – e.g. at the reception desk or in the waiting area.
- Asking young people questions in front of their parents. Often, especially within some BME communities, parents may be unaware that their child is self-harming.
- Telling the person that they are wasting NHS time and resources.
- Carelessness about pain relief/anaesthesia during stitching or other painful procedures
- Comments which reflect one's own cultural or religious beliefs (e.g. a cultural belief that self-harm is evil)
- Discharging the patient whilst they are still physically vulnerable e.g. whilst dizzy and unable to walk steadily after an overdose
- Using language which de-personalises people e.g. "self-harmers", "BPD's", "repeaters, frequent attenders". Use phrases such as "people who attend the ED frequently"

CULTURAL FACTORS TO TAKE INTO ACCOUNT:

- Language barriers. Not only is it bad practice to use relatives or friends of patients as interpreters, it could also have a very negative impact on the patient in question. Issues that may have caused someone to self-harm (for example abuse within the family or community) may continue to be hidden. As one Asian woman told us:

"The patient may have told the person they have come with one story, and attended A & E with the hope that they will be able to disclose to nursing staff the true nature of the problem...the last thing they want is for someone to be making decisions for them or take back a twisted story to the family. 'Psychiatrist' can be a taboo word which will blackmark an individual – let them wait until an interpreter becomes available so they can speak freely".

- Always check if the individual wants to be spoken to in front of whoever they have come with – patient confidentiality is essential.
- If the setting is a local hospital, it is important that staff are aware that patients may be uncomfortable waiting in the waiting room for fear of being seen by someone they know or an Asian doctor – who may be known to the community or family
- Don't assume that a patient from a particular ethnic background would prefer to see someone of the same background – for some people this is their worst nightmare!
- As above, check if the person is comfortable with staff of a specific gender

YOUR RESPONSE AS A WORKER

Treating someone who has self-harmed may prompt feelings which you would not experience if their injury was accidental. Staff members have talked about feeling shock, anger, nausea, and bewilderment. Equally you may feel great sympathy, a strong desire to help, but wonder how best to do that.

Some people who self-harm visit the ED frequently over months or years. One can easily feel helpless and frustrated in this situation. Why do they continue self-harming? Aren't they trying to help themselves? Aren't mental health services doing anything to help? It may be the case that the person is not getting the right sort of help, and it is important to have good referral systems to a range of sources of support (self help groups, helplines, voluntary sector organisations, as well as mental health services).

However, even when the right help is in place, for some people the journey takes months or years - sometimes many years. It is a slow process of resolving past trauma and learning new ways of coping. It may not feel as if what you do can make any difference, but in fact you can have an enormous impact. Surveys of people who self-harm indicate that, although the quality of the medical treatment they receive is very important, it is the attitude of the staff members which is crucial. Negative and judgemental responses from staff can reinforce the trauma, guilt, low self-esteem and other issues which caused the self-harm in the first place. A non-judgemental, accepting response can be a building block in the recovery process. An individual staff member may not see the results of that – but over time it will make a difference.

SUPPORT AND TRAINING FOR STAFF

Many staff have expressed the desire to receive more education and training around mental health in general, and self-harm in particular. If you feel that you would like more support, supervision or training in this area, you should speak to your manager in the first instance. Alternatively, you could discuss your ideas with the person who is your local team lead on the 'Better Services for People who Self-Harm' project (if you do not know who that person is, contact us on the details below).

In the '**Further Resources**' section overleaf, you will find details of some of the many organisations that provide training in this field. The 'Better Services for People who Self-Harm' central project team can also offer a range of services, including slide sets based on this leaflet, telephone conferences, an email discussion group and learning events. These are all available free of charge to participating members – contact us for more details.

CONTACT THE 'BETTER SERVICES FOR PEOPLE WHO SELF-HARM' CENTRAL PROJECT TEAM

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FURTHER RESOURCES

Organisations that provide training / information for staff working with people who self-harm:

- The Royal College of Psychiatrists' Training and Education Unit – service user led training is being developed to commence in 2007.
For more details contact Helen Blackwell on hblackwell@cru.rcpsych.ac.uk from October 2006
- The Newham Asian Women's Project (NAWP) provides a 'skills, education and awareness' training day, for people working with Asian women who self-harm.
Contact Kamna Muralidharan kmuralidharan@nawp.org, Telephone 07961644088
- Mind in Croydon has produced a video and DVD on self-harm
See <http://www.mindincroydon.org.uk/> for more details
- Bristol Crisis Service for Women provide a range of training packages and courses.
See <http://www.users.zetnet.co.uk/BCSW/index.htm> for more information
- The Basement Project produces a range of materials – Telephone: 01873 856524

Further reading on self-harm

- To find out more about the 'Better Services for People who Self-Harm' quality improvement programme, visit www.rcpsych/cru/auditselfharm.htm
- For a range of information leaflets on mental health, visit the Royal College of Psychiatrists' website <http://www.rcpsych.ac.uk/mentalhealthinformation>, or call 020 7235 2351
- National Mind hold information on a range of mental health issues – www.mind.org.uk
- National Self-Harm Network (NSHN) – a user-led organisation www.nshn.co.uk
- National Institute for Clinical Excellence (NICE) – for details of the guideline relating to the care of people who self-harm www.nice.org.uk
- University of Oxford Centre for Suicide Research <http://www.psychiatry.ox.ac.uk/csr/resepsis.html>
- National Enquiry into Young People and Self-Harm <http://www.selfharmuk.org/>

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With thanks to the following for their generous contributions:

Paul Gill, Maureen McGeorge, Kamna Muralidharan, Newham Asian Women's Project, Satveer Nijjar & Richard Pacitti