

SAMPLE CHAPTER FROM:

Self-Harm

The Short-Term Physical and Psychological Management and Secondary Prevention of Self-Harm in Primary and Secondary Care

ISBN 978-1-85433-409-1
2004

By the National Collaborating Centre for Mental Health (NCCMH)

Co-published by the Royal College of Psychiatrists and the British
Psychological Society

Distributed by RCPsych Publications
(via Turpin Distribution for the trade)

www.rcpsych.ac.uk/publications

(one of a series of complete NICE Mental Health Guidelines)



5 Service user experience of services

5.1 Introduction

'Professionals are often terrified by self-injury. Their normal empathy with others' distress and their confidence and ability to help often desert them when faced with someone who persistently hurts themselves. This problem reflects a serious and widespread lack of understanding of self-injury, which results in great inconsistency and inadequacies in services.' (Arnold, 1995)

There is a rich and well-established service user literature on the subject of self-harm, particularly regarding the acts and meanings of self-harm from the service users' point of view (Harrison, 1995; Arnold, 1995). From this emerges a picture of self-harm as an activity that is usually done in private, and which forms part of an individual's coping mechanisms. However, when the acts are made public, misunderstandings and lack of awareness in clinical practice, both in general medicine and psychiatry, can lead to service responses that are not only unhelpful, but may make matters worse for people who self-harm. This lack of understanding, and the fear thus engendered, can manifest itself in the attitudes, language and treatment of service users who self-harm:

'Carers may relieve their disappointment and frustration with the patient by stigmatising her as bad, attention seeking or manipulative, terms which have no explanatory value but do subtly devalue the patient's distress and can sometimes be used to justify either harsh or indifferent treatment. It is also arguable that apparently therapeutic manoeuvres such as ECT, high-dose medication, or the transfer of care may on occasions be a means of getting rid of a frustrating patient or even punishing her for her refractoriness.' (Tantam & Whittaker, 1992)

Health services aim to minimise harm and therefore try to reduce or prevent self-harm as a priority. Many healthcare professionals view self-harm as attempted suicide, and few healthcare professionals consider or discuss the meaning, function or intention of acts of self-harm, instead assuming that suicide was intended and should be prevented as far as possible. But in attempting to prevent a person from hurting him- or herself, rather than looking at the underlying causes of such behaviour, or indeed the function such behaviour serves a particular individual, services can inadvertently either exacerbate the behaviour or 'drive it underground'. Good practice guidelines developed by users recommend that stopping self-harm should not be a goal of treatment, nor should treatment or care be withheld as a condition of stopping self-harm (Bird & Faulkner, 2000).

Unfortunately, many people who self-harm, especially those who do so repeatedly, feel that healthcare professionals are not willing to listen to them and not interested in reading the wealth of literature regarding self-harm written by service users. This literature not only relates the experience of self-harm and its treatment from the

perspective of service users, it also suggests new practices that would address the problems faced by service users.

Service users often regard themselves as experts by experience, but feel that many healthcare professionals disregard service user literature as somehow lacking authority, a situation that is no longer sustainable in the light of recent policy developments. For example, the Department of Health's expert patient programme (Department of Health, 2001c) acknowledges that in some conditions the patient may understand the condition as well as, or better than, the clinician: 'this knowledge and experience held by the patient has for too long been an untapped resource. It is something that could greatly benefit the quality of patients' care and ultimately their quality of life, but which has been largely ignored in the past' (Department of Health, 2001c). The GDG therefore thought it essential to review the service user literature on self-harm. In addition, the GDG decided to meet and discuss self-harm and the experience of services with service users. Service users were also asked to make their own recommendations as to how the experience of services might be improved. Moreover, given the reports of the often negative attitudes held by some healthcare professionals who offer help for people who self-harm, the GDG also decided to examine what literature was available regarding the attitudes of healthcare professionals to self-harm.

This chapter reviews the service user literature, both that published in the mainstream clinical literature and that published by the voluntary sector, to try to understand service users' experiences of health services, particularly focusing upon the experience of services in the first 48 hours of care after an episode of self-harm. We also present the findings of two focus groups and an individual interview with service users, and the findings of a review of the literature regarding healthcare professionals' attitudes to self-harm (Roy & House, unpublished manuscript, 2003).

It should be emphasised, however, that most of what follows relates to the experience of care for people who self-injure (by cutting) or self-poison, and many of these will be people who have self-harmed repeatedly. This is because most of the accessible literature has been written by this group of people. Although this may limit the interpretation of these findings, there is no reason to believe that the experience of care by those who self-harm by other methods, or by those who harm themselves only once, is necessarily greatly different from that described below.

5.2 Methods

5.2.1 Literature review²

No existing review of this area was available. Therefore, a new review was undertaken, and a total of 2,702 articles were downloaded from a search of the published literature, of which 23 were identified as relevant. A further 186 articles were sourced from a search of a 'grey' literature database (Sigle) of which four³ were considered relevant.

²Details of the search strategy for this and other reviews in the guideline are available in Appendix 7. Information about each study along with an assessment of methodological quality is in Appendix 17, which also contains a list of excluded studies with reasons for exclusions.

³Another four could not be obtained in time for this review (see Appendix 17).

In addition, six⁴ voluntary organisations working with people who self-harm, identified through an internet search and on the advice of the GDG, responded to a request for unpublished primary material, generating a total of 33 studies. Studies were reviewed using predetermined inclusion criteria: 24 studies were therefore excluded, and nine were included in the final review (five sourced from databases of published literature, two from Sigle and two from unpublished reports from voluntary organisations), providing information from 218 participants.

All participants in the included studies had self-harmed, although the method of self-harm varied between studies as follows:

- Self-injury only (ARNOLD1995⁵; BYWATERS2002)
- Self-poisoning ('overdose') only (BURGESS1998; CROCKWELL2001; DORER1999; DUNLEAVEY1992)
- Self-injury and self-poisoning (DUROSE2000)
- Unclear about the method of self-harm (ANON2000; HARRIS2000)

Studies also varied in the following ways:

- Method of data collection

Most studies gathered data using interviews (ANON2000; BURGESS1998; BYWATERS2002; CROCKWELL2001; DUNLEAVEY1992). However, DUROSE2000 used a discussion group and in HARRIS2000 participants gave written accounts. ARNOLD1995 used both interviews and questionnaires.

- Age of participants

Two studies were exclusively of children and young people aged 8 to 17 years (BURGESS1998; DORER1999), while three (BYWATERS2002; CROCKWELL2001; DUNLEAVEY1992) included adolescents in their samples. The remaining studies were of adults. None included elderly people.

- Gender of participants

Three studies were of women only (ARNOLD1995; CROCKWELL2001; HARRIS2000).

- Timing of data collection

Participants in half of the studies were recruited after a particular self-harm episode (ANON2000; BURGESS1998; DORER1999; DUNLEAVEY1992).

⁴These are listed in Appendix 5.

⁵Here and elsewhere in the guideline, each study considered for review is referred to by a 'study ID' made up of first author and publication date in capital letters (unless a study is in press or only submitted for publication, when first author only is used).

5.2.2 Focus groups

Two focus groups were convened, one by the Central London branch of the Samaritans and the other by a self-help group based in Nottingham. Each approached people with a history of self-harm who were in contact with their services, and considered likely to be interested in taking part. People expressing an interest were given further information describing the purpose and methods of the study, the role of participants and the support to be offered for those agreeing to take part. Those who agreed to take part were required to complete a consent form (Appendix 13).

Focus groups were held in May and June 2003, facilitated by members of the GDG or review team (Marcia Kelson, Pamela Blackwood and Rebecca King). Eleven women, aged between 21 and 51 years, took part. One other volunteer agreed to be interviewed on a one-to-one basis.

The facilitators used a semi-structured questionnaire (Appendix 14), designed to help structure initial discussion, but allowing service users to introduce new topics as they wished. Discussions were audio-taped and transcribed for analysis (see below). Anonymised reports of both discussion groups can be seen in Appendix 15.

Service users' recommendations to improve services and treatment for people who have self-harmed were also discussed in the discussion groups and interview; these are presented in the most appropriate category and have been used in generating recommendations by the GDG. These are presented using bullet points. Quotations from the focus group and interview material are referenced 'F'.

5.2.3 Analysis

The material was divided into categories based on the subject matter being discussed. Material from the literature review was combined with that from the focus groups, which also included the recommendations drawn up by each focus group.

5.3 Findings

5.3.1 Overview of the quality of services

In much of the material reviewed, including that from the focus groups, service users reported services to be of variable quality, including both good and bad experiences, although the focus tended to be on poor experiences. This is borne out by those studies where the number of good and bad responses has been quantified. For example, in ARNOLD1995, of those who had used emergency departments, only 6% were satisfied with the service provided, and in DUROSE2000 six of the seven service users questioned found an emergency department to be the least useful source of support. However, DORER1999 found that respondents reported equal numbers of positive, negative and neutral experiences (of hospital services), with about 44% of those admitted to hospital finding the experience positive. In ANON2000, 10 out of 12 rated at least one service [not defined] 'very good' (for 2 people this was a service provided by a voluntary organisation).

5.3.2 Poor staff attitudes

It is clear from both the existing literature and the focus groups that users consider the main cause of their poor experiences of services to be staff attitudes towards people who self-harm and the generally low level of staff understanding of self-harming behaviour. For example, respondents in DUROSE2000 felt that an emergency department was the least useful source of support because staff there have punitive attitudes, lack understanding, and are rude and blaming. They do not treat people who self-harm seriously. This is supported by respondents in other studies:

[The nurse was] *'pretty impatient with me'*. (ANON2000)

'My doctor was not understanding and told me off. He did not try to understand why I cut myself.' (Respondent about GP, DUROSE2000)

'Doesn't treat me like a normal [sic], as if I'm not normal because I self-harm, like there's something wrong with my intelligence or something. Like a retard, I suppose. Because I self-harm, then obviously I'm thick.' (Respondent about his GP, BYWATERS2002)

'Got no help at all. All they wanted to do is pick on me like I was a naughty little girl, and it made me angry, and I couldn't open up at all for how they treated me. I just dreaded going to see them.' (HARRIS2000)

'She said, "you are trying to disgust me".' (F)

'...He doesn't understand and like uses horrible words like "mutilation"'. (F)

Not only do these kinds of attitudes make users' experiences of services unpleasant, but they can also increase service users' levels of distress. Indeed some service users felt these attitudes lead to further self-harm and to people treating their own wounds to avoid attending an emergency department (for example, HARRIS2000). Focus group respondents reported increased distress as a result of the interactions they have had with staff. In particular, they report feelings of isolation and humiliation that encourage them to self-harm again as a way of coping with the distress and to avoid services in future:

' ... it made me even more and more distressed and I've actually felt like leaving the hospital and going and self-harming again because that's the only way I can deal with the distress'. (F)

'... even if my life was in danger ... I'd rather sit at home and sit it out and see whether I'd survived than risk the humiliation.' (F)

Not only are service users critical of emergency department staff, but patients admitted to hospital following self-poisoning also feel isolated, ignored and inhibited by staff (DUNLEAVEY1992). This makes it hard to talk, although they wanted support (ibid.).

In the recommendations drawn up by the focus groups it was suggested that:

- A fast tracking of service users through the system should be considered to minimise harm resulting from their injury and to minimise distress. In all cases staff should provide timely treatment and/or referral.

- Liaison between A&E and psychiatric services should be available 24 hours a day.
- Staff should not 'write off' people who self-harm if they have not been able to meet their needs. It is important to understand that stopping self-harm behaviour is not a 'cure'; exploring and coming to terms with the behaviour may be much more helpful to the individual.

5.3.3 Positive staff attitudes

Service users' experiences of services are much more positive when they encounter staff with non-judgemental attitudes who try to understand self-harm behaviour. For example, the focus group respondents reported that their experiences were greatly improved when healthcare professionals showed them respect and were calm, reassuring and considerate. For example:

'My doctor shows me respect ... the way he talks about me to this other professional ... he is saying this person's ok ... but I'm just so lucky to have a real good GP who can do that.' (F)

Service users appreciate tolerance and understanding, for example:

'He actually spoke to me, rather than talking down to me. He spoke to me like a person, instead of just a silly little girl, who cuts up and all this. He was different. Because a lot of GPs' attitudes are "Oh, it's nothing. You'll get over it." But he wasn't. He was genuinely concerned, for a change, so it was nice'. (Respondent talking about her GP, BYWATERS2002)

'My GP, who has admitted that he does not fully understand what self-harm is about, has however made himself available to me at any time and has been extremely supportive (i.e. I always get the last appointment so that he doesn't have to rush the consultation and we have more time to discuss things)'. (Respondent about GP, DUROSE2000)

5.3.4 Being listened to and given time

Service users also point out the importance of being listened to by staff, even when the interaction is brief or only a single occasion (ARNOLD1995). They also stress the importance of staff paying attention to, or talking about, the particular self-harm episode or suicide attempt, or about the service user's mental state (ANON2000). The focus group respondents said that simply being listened to was important, although in their experience many staff did not listen and appeared to ask questions only to protect themselves in case the service user went on to die by suicide.

Focus group respondents reported that they appreciated healthcare professionals being willing to see them without an appointment and in giving them help, for example:

'... They helped me to write like a note and that to let my parents know what had happened ...' (Respondent about ambulance technician) (F)

5.3.5 Providing a safe environment

The importance of a safe environment is also highlighted: for example, respondents in DORER1999, who had been admitted to a ward after an overdose, appreciated friendly non-judgemental staff and the chance to rest and think things through with pressures removed. This is also borne out by the focus group respondents who said that their experiences of services improved when staff were non-judgemental, calming and able to provide a safe environment. They appreciated being treated with genuine care and respect by staff who tried to understand their behaviour by listening to them.

A safe environment and being listened to is especially important since service users may reveal information about their injuries that makes them feel vulnerable, fearing negative repercussions. This was highlighted by the focus group respondents, who reported feeling unable to be honest about the cause of their injury for fear of a staff member's reaction, for example:

'I would like to go and know that I could be honest, but I wouldn't want that to lead anywhere. It would take a lot of the anxiety away for me to be able to say yes I've done this, please help me sort it out and I'm going away... I know it's a problem because it's gone on so long I don't need to be told that.' (F)

In the recommendations drawn up by the focus groups, respondents suggested that:

- Staff should utilise their communication skills to ensure service users are respectfully listened to and that their needs are met through open and honest discussion
- Staff should be prepared to acknowledge and handle service user distress, calming the situation, and manage their own personal feelings about the situation without compromising their professional role and responsibilities. The degree of injury is not necessarily an indicator of the level of distress the individual may be feeling
- When assessing the service user, staff should not rely solely on risk assessment tools; it is important to ask the individual and to let them explain in their own words
- Acute treatment should be available to service users without any longer-term repercussions
- Staff should recognise that service users may or may not require referral to psychiatric services at the first contact with services following an episode of self-harm
- Staff should be aware that the individual's reasons for self-harming may be different on each occasion and therefore each episode needs to be treated in its own right.

5.3.6 Not being treated differently simply because injuries are self-inflicted

As a result of poor staff attitudes towards people who self-harm, service users feel that they are frequently treated differently compared with service users who have not self-harmed (ANON2000). For example:

'I was told off by nurses and the doctors: I just felt small. They do treat self-harmers different to accident people. We are classed as suicides ... The hospital staff just look at you as though you're wasting time. That's how I felt.' (HARRIS2000)

Being made to wait for longer than service users who had not self-harmed was a particular issue. For example:

'As soon as they find out that I have mental health problems, I have to sit there, for hours sometimes, waiting for someone to look at me. It is horrible.' (F)

'They just say, "have you harmed yourself?" As soon as you mention psychiatrists that's it, they don't want to know. I wait there hours and hours, and then when she comes, she tells them to dress it.' (F)

'People that self-harm, as well, also get left at A&E departments for hours and hours. You could sit there for eight, nine, ten hours for you to see a doctor, because they don't want to waste their time basically that's their attitude' (Respondent about A&E, BYWATERS2002)

Focus group respondents said that they appreciated being seen immediately, including being taken straight to a treatment area. They said that they sometimes find it difficult to wait in a busy environment, for example:

'... and I found it really difficult to be around people and so to be in that environment where there's ... lots of people milling about and there's nurses coming flying and the doctors just walk through.' (F)

In their recommendations they suggested that:

- A quiet place should be available for service users to wait should they wish to do so.

Another issue highlighted by the focus group respondents was that staff should consider the effect of the surroundings in which service users were treated, including being left alone. For example:

'Being left on your own is a dreadful thing.' (F)

'You're left in there [alone] with drawers that say "scalpels" on the outside!' (F)

'When you go into triage the door is always wide open and you've got a great queue of people and obviously they can hear what's being said and you do feel as though you can't say please shut the door.' (F)

'He [consultant in an emergency department] quizzed me quite a lot ... in a cubicle with the curtains open so everybody was like walking past and ... I'd cut myself.' (F)

'[after stitching a wound] one called the other nurse over and said hey come and have a look at this ... job I've done, oh, that's a really good job, but it was really like ... a bit degrading.' (F)

Other areas where service users report inequity of treatment is in receiving unwanted treatment, being stitched without medication, and being refused medical treatment (DUROSE2000). For example:

'I was refused make-up to cover my scars because the doctor said they were self-inflicted.' (DUROSE2000)

'Just wanted to have steristrips but ended up on antibiotics even though I get even more depressed on them and stitches and admitted to hospital'. (DUROSE2000)

Focus group respondents also reported instances where staff coerced them into doing something that they did not want, for example:

'... A&E said they would only treat my injuries if I saw the duty psychiatrist ... after having several hospital admissions over a two-week period I looked like a pin cushion, from various blood tests and drips. I was asked if I was an IV drug user, which I'm not. I wasn't believed and they tested my urine. At the time I didn't know they weren't allowed to just test without my permission.' (DUROSE2000)

They also reported not being given analgesics in situations where other service users would be given them and described occasions where they did not receive adequate anaesthesia or were threatened with suturing without anaesthesia. For example,

'I said it hurts. They said, "well it didn't hurt when you cut it".' (F)

'Obviously you enjoy the pain, you know so so [sic] maybe you need stitching up without it.' (F)

In their recommendations focus group respondents suggested that:

- Service users have the right to be treated with dignity and respect and valued as human beings as do all service users using NHS services. They are therefore entitled to receive the relevant information, be consulted about their care and to be given choices. Staff should offer privacy and maintain confidentiality
- Service users should always be informed of their rights and involved in decisions to detain them
- Under-18s or under-16s: parents may have to be contacted but the young person should be informed of this situation and involved in any decision-making about seeing their parents. On occasion it may be appropriate for staff to ask the service user whether they would like to invite someone other than a parent to provide support

- In wounds where suturing is required, adequate doses of anaesthesia should always be given and reviewed with the service users throughout the treatment process
- Service users should be assisted in making formal complaints in the event that service users or carers are unhappy with the services or treatment they have received.

5.3.7 Being involved in treatment decisions

Focus group respondents reported being coerced into having treatment despite having full capacity to make informed decisions. They were critical of staff not respecting their right to be informed about treatment:

'Maybe if they'd asked me ... um I might even have said yes to a psychiatrist. It's the way it was done.' (F)

Focus group respondents reported that they want to be involved in discussions regarding treatment – for example, the method of suturing used – and reported more positive experiences of wound care when staff had involved them in decision-making. Those who were able to care for their own wounds appreciated being prescribed skin closure strips by their GP. Some reported that a lack of control surrounding their treatment and care resulted in their feeling anxious, panicked and more likely to injure themselves again. For example,

'I need people to work with me ... you know a partnership ... if my rights and everything's taken away then I'm panic [sic] and I'm more likely to injure myself.' (F)

In their recommendations, they suggested that:

- Staff should provide service users with the necessary information about the self-management of their injury/wound and, if prescribed medication, the side effects that they might experience.

Other respondents also highlighted the importance of staff working in partnership with service users in order to take service users' wishes into account. For example:

'The doctor was OK, a reasonable man and the social worker was very good. She understood that I didn't wish to be admitted ... listened to my reasons for ... overdose ... and made effort [successfully] to liase with day centre [which the interviewee was already attending].' (ANON2000)

This was supported by the focus group respondents who said that they found that being referred without having the process explained to them resulted in a negative experience. They also reported that being unable to get appropriate referrals was stressful. In their recommendations they suggested that:

- Service users should be involved in discussions about their experiences and treatment and, in partnership with staff, can come to appropriate decisions if fully informed of the choices available. Choices include consideration of the treatment environment, gender of staff member, wound closure method and follow-up services

- Staff should consult the service user about how she/he wants to be treated, following advanced directives if available
- It is totally unacceptable to use scare tactics (e.g. refusal to use anaesthetic or threaten service users with sectioning) or to 'talk over' the service user to their friends/family members or advocate if the person is conscious and has capacity
- To aid in the smooth referral of service users between services, information gained at A&E should be passed on to the appropriate services to ensure continuity of care and avoid duplication of questions, which may cause additional unnecessary distress to the service user.

5.3.8 Carer support

Focus group respondents who wanted to be accompanied while waiting for treatment and during treatment by a friend, relative or advocate reported negative reactions from staff to their request:

'When I've taken someone ... been told I was "involving them in my self-harm".' (F)

They included in their recommendations:

- Staff should recognise the value for both the service user and staff in enabling friends, loved ones or chaperones to accompany service users to appointments with staff and when receiving treatment. This can reduce the distress experienced by the service user and result in a more useful consultation.

5.3.9 Staff knowledge of self-harm

Respondents find that staff's lack of knowledge about self-harm can lead to their failing to listen to service users or address underlying issues. This can then lead to inappropriate or inadequate treatment (ARNOLD1995). This was supported by focus respondents who also reported frequently encountering staff who presumed they had made a suicide attempt, when they had not. These service users felt that staff lacked knowledge and training about self-harm.

In their recommendations focus group respondents suggested that staff training should include:

- Involvement of service users and local groups that work with them outside of NHS services
- Help for staff in understanding the issues connected to self-harm. This should include the differences between suicide and self-harm, that self-harm is not simply attention seeking, the consequences of labelling and the use of language to describe people who self-harm
- What is expected of staff
- Acknowledgement of the fears and prejudices that some staff may have

- For non-psychiatric staff, guidance in being able to talk about issues with the person who has self-harmed to enable them to make adequate decisions, in conjunction with the service user, about their care
- The fact that individuals can and have made a difference to people who have self-harmed
- Other sources of information for both staff and service users. This may include voluntary organisations.

In addition they suggested that:

- Staff should be trained not to make assumptions about the circumstances surrounding the injury. Questions should be posed in a sensitive manner and can confirm for example whether the episode was an attempted suicide or an episode of self-harm and in the case of self-poisoning what substance was ingested
- Greater awareness and understanding between various services needs to be encouraged and communicated to service users
- People managing services should recognise the need for training, support and supervision for staff who provide services to those who have self-harmed. This should include reception staff and non-psychiatric staff, for example surgical wards that service users may be admitted to. This may mean the need for extra funding.

5.3.10 Summary of findings

Although service users report both good and bad experiences with services, the emphasis is on negative experiences, largely resulting from poor staff attitudes and knowledge of self-harm behaviour. In particular, service users feel that they are not listened to or given time by staff – for example, they would like to be able to explain their injuries without fear of being given, or referred to, treatment they do not want. Also, many would appreciate a safe environment in which to wait for treatment. They would like to be treated with the same respect and dignity given to other service users, for example, by not being made to wait for treatment longer than other users, by being given anaesthetic when being sutured and by being involved in all treatment decisions. They would also like to be consulted about having a relative, friend or advocate with them during treatment. They also made suggestions for staff training in order to help staff understand their needs.

5.4 Health professionals' attitudes to self-harm

Service users are often aware of the negative attitudes held by health professionals towards self-harm. Roy and House (unpublished manuscript) have conducted a systematic review of the English-language literature to identify what is known about the content and origins of these attitudes. Forty papers were identified, describing studies conducted since 1971.

5.4.1 Findings on negative attitudes

- 5.4.1.1 Attitudes to self-harm were more negative than attitudes towards other medical conditions (Barber *et al.*, 1975; Creed & Pfeffer, 1981; Goldney & Bottrill, 1980; Patel, 1975). Patients perceived as being seriously mentally ill and those suffering from painful, chronic illnesses were regarded less negatively, as were patients with high suicidal intent (Rund, 1984).
- 5.4.1.2 Depressive motives were viewed as being more acceptable than 'manipulative' ones (Ramon *et al.*, 1975) and patients who had taken an accidental overdose were regarded more favourably than those who had intended to die by suicide (Ghodse, 1978; Ghodse *et al.*, 1986). Patients perceived as having no intention to die were viewed the most negatively (Ansel & McGee, 1971).
- 5.4.1.3 People who harmed themselves repeatedly were viewed particularly negatively (Alston & Robinson, 1992; Bailey, 1994; Pallikkathayil & Morgan, 1988).
- 5.4.1.4 Several authors commented on the tendency of staff to talk in stereotypes (DeRose & Page, 1985; Jeffrey, 1979; Ramon, 1980). Patients were often thought of in stock categories such as 'genuinely suicidal', 'mad', 'silly girls', 'chronically manipulative' or 'personality disordered'.

5.4.2 Consequences of negative attitudes

Strong emotions in staff may manifest themselves in a variety of ways. Staff anger can be expressed through diminished attention to pain and overall avoidance of self-harm patients. Conversely, some staff can respond with compensatory attentiveness and protection (Antonowicz *et al.*, 1997). When staff try to deal with their negative attitudes to service users, their behaviour can become inconsistent, varying between distancing, irritation, aggression, interest and attempts to understand (Wolk-Wasserman, 1985). Some staff use self-care behaviours (e.g. taking a break, laughing, having a co-worker take over) to protect themselves from emotional turmoil and release tension, and they deal with feelings of anger and judgemental thoughts towards the person who has attempted suicide by behaving in a detached manner (Pallikkathayil & Morgan, 1988).

5.4.3 Reasons for negative attitudes

A suicidal patient may be viewed by staff as a challenge to their professional identity (Wolk-Wasserman, 1985) and as a potential threat to self-esteem, with the fear that subsequent suicide may be taken as an indication of professional incompetence (Ansel & McGee, 1971). Several papers refer to countertransference hate or countertransference crisis (Maltsberger & Buie, 1974; Tabachnick, 1961; Wolk-Wasserman, 1987), suggesting that negative reactions on the part of the health professional may be the result of neurotic conflict leading to rejection of the patient.

5.4.4 Summary

Much of the existing research on staff attitudes to self-harm employs over-structured measures (e.g. semantic differentials, repertory grids and mood adjective checklists), which require respondents to endorse or generate global judgements. Few of the studies

include interviews, and where they do, there is rarely any formal qualitative analysis that would allow more complex themes to emerge. Nevertheless, the research that is available confirms the negative and often punitive attitudes of NHS staff towards people who self-harm, and suggests that there are some fundamental emotional difficulties for staff when faced with such people.

5.5 Clinical practice recommendations

The clinical practice recommendations are ordered according to the 'care pathway' normally experienced in emergency departments. However, most of the recommendations can be applied to any treatment or assessment situation involving a person who has self-harmed.

5.5.1 General principles

- 5.5.1.1 People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm. (GPP)
- 5.5.1.2 Providing treatment and care for people who have self-harmed is emotionally demanding and requires a high level of communication skills and support. All staff undertaking this work should have regular clinical supervision in which the emotional impact upon staff members can be discussed and understood. (GPP)
- 5.5.1.3 Wherever possible, people who have self-harmed should be offered the choice of male or female staff for both assessment and treatment. When this is not possible, the reasons should be explained to the service user and written in their notes. (GPP)
- 5.5.1.4 When caring for people who repeatedly self-harm, healthcare professionals should be aware that the individual's reasons for self-harming may be different on each occasion, and therefore each episode needs to be treated in its own right. (GPP)
- 5.5.1.5 When assessing people who self-harm, healthcare professionals should ask service users to explain their feelings and understanding of their own self-harm in their own words. (GPP)
- 5.5.1.6 Healthcare professionals should involve people who self-harm in all discussions and decision-making about their treatment and subsequent care. To do this, staff should provide the person with full information about the different treatment options available. (GPP)

5.5.2 Relatives or carers

- 5.5.2.1 People who self-harm should be allowed, if they wish, to be accompanied by a family member, friend or advocate during assessment and treatment. However, for the initial psychosocial assessment, the interview should take place with the service user alone to maintain confidentiality, and to allow

discussion about issues that may relate to the relationship between the service user and carers. (GPP)

- 5.5.2.2 Healthcare professionals should provide emotional support and help if necessary to the relatives/carers of people who have self-harmed, as they may also be experiencing high levels of distress and anxiety. (GPP)

5.5.3 Triage

- 5.5.3.1 Emergency department staff responsible for triage should take account of the underlying emotional distress, which may not be outwardly exhibited, as well as the severity of injury when making decisions about priority for treatment. (GPP)

5.5.4 Waiting for treatment

- 5.5.4.1 If a person who has self-harmed has to wait for treatment, he or she should be offered an environment that is safe, supportive and minimises any distress. For many patients, this may be a separate, quiet room with supervision and regular contact with a named and specified member of staff to ensure safety. (GPP)

5.5.5 The physical treatment of self-harm

- 5.5.5.1 People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment. (GPP)
- 5.5.5.2 Adequate anaesthesia and/or analgesia should be offered to people who have self-injured throughout the process of suturing or other painful treatments. (GPP)
- 5.5.5.3 When physical treatment of self-injury is likely to evoke distressing memories of any previous sexual abuse, for example when repairing harm to the genital area, sedation should be offered in advance. (GPP)

5.5.6 Staff training and the organisation of services

- 5.5.6.1 Clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed. (C)
- 5.5.6.2 People who self-harm should be involved in the planning and delivery of training for staff. (GPP)
- 5.5.6.3 Strategic health authorities, Primary Care Trusts (PCTs), acute trusts and mental health trusts should ensure that people who self-harm are involved in the commissioning, planning and evaluation of services for people who self-harm. (GPP)

5.6 Research recommendations

- 5.6.1.1 A study using an appropriate and rigorously applied qualitative methodology should be undertaken to explore user experiences of services.
- 5.6.1.2 Qualitative research methods, such as Q sort and Interpretive Phenomenological Analysis, should be used to better understand staff attitudes to self-harm and their psychological and social origins.