Youth Self-harm and Suicide Awareness

A reflective practice guide for staff working with children and young people

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Pavilion In Practice

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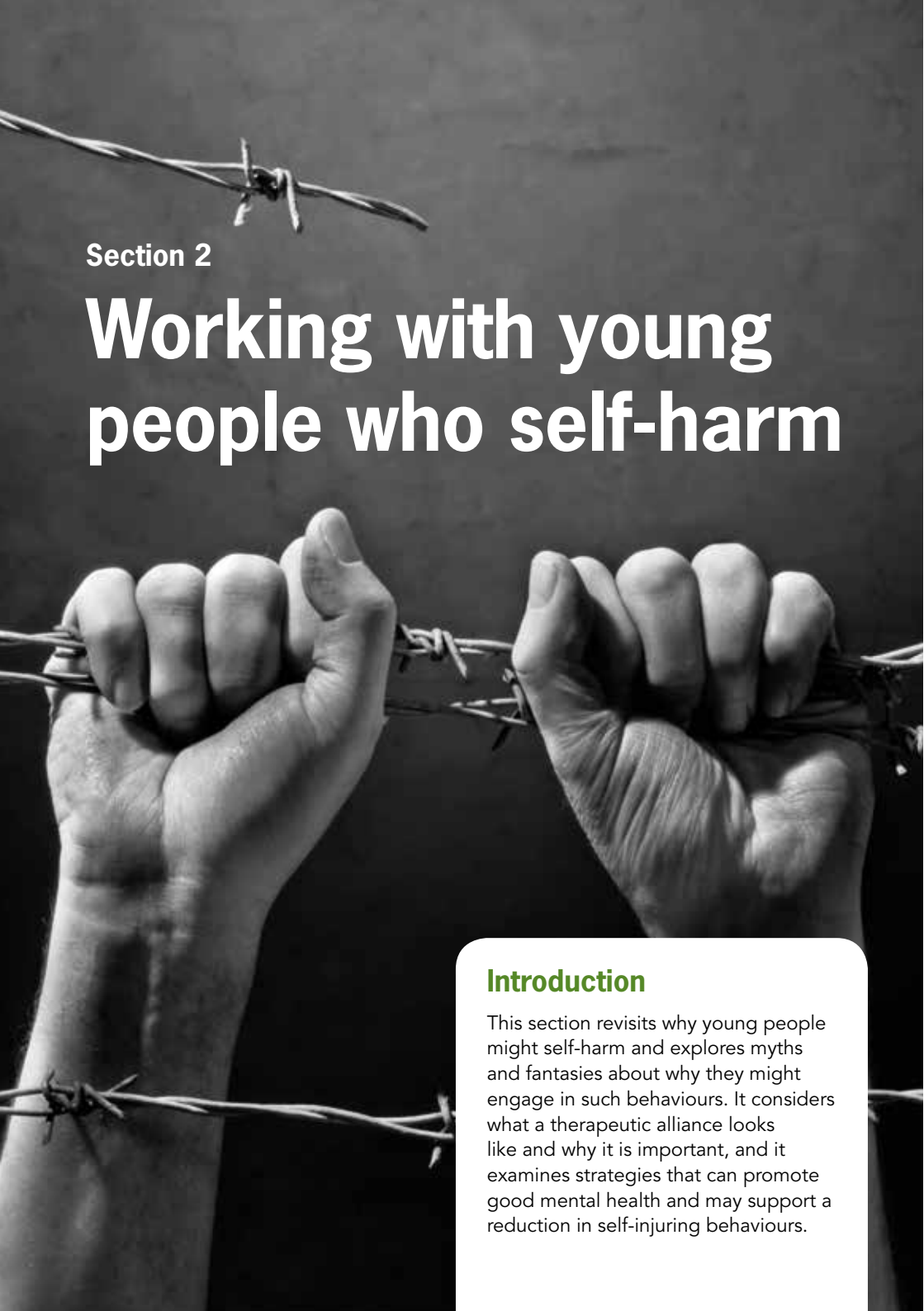

Section 2

Working with young people who self-harm

Introduction

This section revisits why young people might self-harm and explores myths and fantasies about why they might engage in such behaviours. It considers what a therapeutic alliance looks like and why it is important, and it examines strategies that can promote good mental health and may support a reduction in self-injuring behaviours.

Why do people self-harm?

The importance of cultivating an enquiring mind and undertaking self-reflection cannot be overemphasised since this is where the power of learning takes place, transforming information into action learning.

Reflection

Based on your learning and reflection so far, why do you think people self-harm? You may wish to ask others for their thoughts to compare them with yours.

Activity: Self-harm 'role play'

The aim of this activity is to 'get into the skin' of a person who self-harms. Choose one of the following characters:

- *a 20-year-old woman who hears voices telling her to cut herself*
- *an 18-year-old young man who sets fire to his trousers when skateboarding*
- *a 24-year-old woman who puts bleach in her cuts.*

Take two to three minutes to make up a back story detailing a rationale for your chosen character's self-harming behaviour. Get into the character's role and write or record this rationale, as if you were explaining it to someone else.

Then 'de-role' by saying aloud your name, profession, where you work and why you are working through this guide. Look through what you have written or listen to what you have recorded.

- *How does it inform a definition of self-harm?*
- *Are there differences between definitions by a professional and by a service user?*

Self-harm 'role play'

As a result of the role play activity, you may have come to some of the following conclusions:

- Definitions differ; those completed when in character are frequently more personal and there is less use of medical language. This is in contrast to the more objective language used by professionals.
- The need to see service users as individuals becomes clearer.
- Those readers who took the role of the male service user may assume that the act of self-harm was done to impress and/or was part of male peer group activity when in fact it could have been done in isolation. This encourages participants to challenge their assumptions about a person who self-harms.
- Some readers will share the experience of not being able to communicate their character's feelings verbally.
- The use of the body as an external landscape and the way in which people care for bodies, or not, can be statements about their internal landscape.
- The importance of not focusing continually on the act of self-injury when developing a relationship with a young person who self-harms. This can lead to the worker colluding with the way the young person remains invisible ie. they and others focus on the young person's external landscape. There is an opportunity to make some parallels to working with people with eating disorders. (A useful reference here is *Internal Landscapes and Foreign Bodies: Eating disorders and other pathologies* (Williams, 2002)).

Finally, consider the National Institute of Health and Care Excellence (2011) definition of self-harm: 'Any act of self-poisoning with medication or self-injury by cutting'.

Listening to young people's experiences

Watch the 15-minute film Sh! which is included on the enclosed DVD. Consider each young person's story and complete each column of the table, as shown in the example.

Common points raised in undertaking this activity include:

- An acknowledgement that some young people do not know why they started self-harming. Part of the focus of an assessment could be to engage the child in a conversation about the reasons why they self-harm.
- Staying with the young person's pace of change can be frustrating, so what support do staff need?
- In the film, the young person's experience of A & E is positive, however this is frequently not the case for many young people. It can raise complex issues for a nurse to support a person who chooses to injure and this can, for some, fuel anger towards the young person.
- The use of razor blades and other cutting implements is raised and how taking these away can increase

Activity: Sh! Young people's stories

Triggers	Action taken	Type of self-harm	Function/ purpose	What responses were not helpful?	What responses were helpful?
Forced sexual encounter	School nurse reference	Cut fingers/ arms	To make them feel better	Patronised	Positive treatment at A & E

the young person's feelings of distress and, in turn, increase the need to self-injure, yet we need to ensure we keep the child safe, so how do we achieve our safeguarding obligation?

- When working with a young person who does not and cannot stop self-harming, does this have an impact on how the worker takes care of themselves and the feelings that are provoked in them? (This links back to Section 1.)
- Self-harming is not about attention seeking, or is it? At this point, it is important to point out that we all seek attention from the moment we get up regarding our choices in clothing, shoes, where we socialise etc. If a young person chooses to show the marks, scars, cuts on their body this will bring attention, as within our society such marks are not condoned, but this does not mean the young person deserves any less attention than the young person who does not harm themselves in that way.
- The main challenge for the support worker is not be encouraged by the young person to be continually drawn back to focusing the conversation on self-injury. The function of self-harm is not only a way of managing the person's feelings, but frequently of keeping an emotional distance from others.

The function of self-harm

The purpose of this sub-section is to explore the function self-harm may serve in someone's life and increase professionals' understanding of its potential function and their responses to it. What might hinder and what might be helpful? Professionals may assume that they have the answers to these questions, but they frequently and inadvertently make assumptions. The reflection questions on page 47 may help you to step back and consider your own experiences, as well as focus on the task of supporting a young person.

A note from the author

When I am training I have been known to walk around the room dragging an empty chair. I ask participants what they see and what, if I had arrived this morning and had been pulling the chair around beside me all day, would they be tempted to focus upon? More often than not, they answer: the chair. Working with someone who self-harms can be one of the most difficult things a practitioner can do, as the invitation by the young person, in their need to protect themselves, is to encourage them to focus on the chair. This is because, despite some of the negative and dysfunctional outcomes of living with self-harm, it also serves the young person well. So why would they not bring the chair into the room?

Look at the boxed summary about myths and fantasies about self-injury and as you do, consider the impact of myths and fantasies about self-injury on the therapeutic alliance.

Reflective questions

Revisit your learning from Section 1:

- What does self-harm/injury invite you to focus upon in our work/support with an individual?
- What function can this serve to the young person who self-harms?
- What function can it serve for you?

Myths and fantasies about self-injury

Arnold (1995) prompts us to dispel the following common myths, which are unhelpful beliefs when providing care for people who self-injure as they mediate against the development and maintenance of a therapeutic alliance. This means examining the importance of staff taking time out before and after they meet with a young person to examine and reflect on the emotions that are provoked in them. Participants may understand that this is good practice, but may not have explicit routines for reflection after contact with a young person. Self-harm can provoke strong emotional responses from staff and some of these can be fuelled by the myths and fantasies they hold. Many such myths and fantasies are present within the environments that staff work and live in (the language used by work colleagues, such as 'cutters', 'bingers' and 'attention seekers'), so although attending training courses can raise staff awareness, it can be difficult not to be influenced by the more common judgements and assertions made by mainstream working and living environments.

- Self-injury is a sign of madness or deep mental disturbance.
- People who self-injure are trying to kill themselves.
- People who injure themselves are a danger to others.
- Self-injury is about 'attention seeking'.
- Self-injury is used to manipulate others.
- Self-injury is just a habit to be stopped.
- People who self-injure enjoy or do not feel physical pain.

(Arnold,1995)

Below is a list of possible meanings and functions of self-injury for young people.

- A response to sexual/physical abuse
- To feel real
- High levels of dissociation
- Connect back to here and now
- Surviving
- Cope with and find relief from unbearable feelings eg. rage, guilt, frustration or anxiety
- Means of self-punishment
- Physical scars enable person to show internal scars
- Endorphin release
- Increased experience of parental deprivation

An article by Hadfield *et al* (2009) – 'Analysis of accident and emergency doctors' responses to treating people who self-harm' – explores how doctors working in A & E responded when treating people who were admitted with self-harm injuries. The main themes of the article are treating the body, silencing the self, and mirroring cultural and societal responses to self-harm. The article identifies helpful and unhelpful aspects of relationships between people who self-harm and the A & E doctors who treated them. The authors consider the clinical implications of these findings within the context of A & E doctors having limited opportunities to address the relational nature of the care they offer to this group.

Assessments and the therapeutic alliance

Assessments should be completed regarding **need** and **risk**.

Important points to practice include the following:

- consider the full list of functions of self-harm
- there is always a need to check whether judgements are informed by myth or fact
- remember to gather information and make recommendations with the young person.

Routinely revisiting the purpose of the assessment is part of the process. Here is a checklist of questions to help clarify what you are assessing with the client.

- Is it about risk of suicide?
- Is it about function of self-injury?
- Is it the impact on the person's capacity to form relationships, and the type of relationships they want?
- Is it about immediate risk of harm?
- Is it about your own needs?
- Is it about where the client places us?

Each time you meet with a young person you are reassessing what you as a professional need to assess and what both you and the young person need to complete the assessment ie. sharing your view with the young person. The professional's understanding and capacity to develop a therapeutic alliance is crucial.

The service user and the professional's working relationship is complex because there is a third party – they both have a relationship with self-harm.

However, the service user remains at the centre of decision making and person-centred care is at the heart of the assessment process (NICE, 2011).

Maintaining your sense of self during an assessment requires the practitioner to have the following skills:

- interpersonal
- listening
- questioning
- observation.

There can be an invitation to join in a relationship with self-injury rather than with the individual.

Reflection

Consider the complexity of completing an assessment in a person-centred way when some young people do not want to be engaged. What issues might need to be addressed?

Activity: Therapeutic alliance

Read the following text adapted from Burke et al (2008). Research shows that what people who self-injure find most helpful is a relationship in which they are listened to and supported, not judged, where boundaries are clear and the relationship can support them over a long period (Arnold, 1995; Connors, 1996a/1996b; Warm et al, 2002).

- *The challenge for staff is to be a friendly professional and not a professional friend.*
- *The task in establishing and maintaining a helpful therapeutic alliance with a person who self-injures is to ensure that staff remain mindful and aware of their own emotional and intellectual responses. This will guard against the possibility of professionals inadvertently repeating earlier abusive relationships and experiences.*
- *It is imperative that when life appears incredibly bleak for the person who self-injures, professional carers remain hopeful and sustained by therapeutic optimism.*

See also Managing Self-harm in Young People (2014) available at: http://www.rcpsych.ac.uk/files/pdfversion/CR192.pdf

Discuss with a colleague what a therapeutic alliance offers both a professional and their client.

General interventions when supporting a young person who self-harms

In considering general interventions when supporting a young person who self-harms, you may wish to revisit NICE guidance regarding risk assessments on page 37, as well as facts and figures about self-harm on page 31.

Sensitive wound care

Individuals should be dealt with compassionately and their level of distress should be taken into account. Injuries should be dealt with swiftly and delays in treatment should be avoided. Treatment methods should be discussed with the individual. Further information is available from NICE's *Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care* (NICE, 2004). (You may wish to return to the findings in the article on A & E on page 48.)

The Recovery Approach

In 2005 the National Institute for Mental Health in England recommended that

Activity: Thinking about interventions

Write down what you know and have used in relation to the following interventions:

- *Sensitive wound care*
- *Recovery approach*
- *Therapeutic relationships*
- *Developing alternatives*

all interventions for self-injury should be informed by the Recovery Approach.

The Recovery Approach has 12 guiding principles.

1. The user of services decides if and when to begin the recovery process.
2. All services must be aware of the risk of service user dependency.
3. Users of services are able to recover more quickly when their:
   - hope is encouraged
   - life roles with respect to work and meaningful activities are defined
   - spirituality is considered
   - culture is understood
   - educational needs are identified
   - socialisation needs are identified
   - they are supported to achieve their goals.
4. Individual differences are considered and valued across the lifespan.
5. Recovery is more effective when a holistic approach is considered.
6. In order to reflect current best practices there is a need for an integrated approach to treatment and care that includes medical, biological, psychological, social values based and recovery approaches.
7. There needs to be an initial emphasis on hope and the ability to develop trusting relationships.
8. Care should operate from a strengths and assets model.
9. Service users should collaboratively develop recovery management or wellness recovery action plans.
10. The involvement of a person's family, partners and friends may enhance the recovery process.
11. Mental health services (equally applicable to children's services) are most effective when delivery is within the context of service users locality and cultural context.
12. Community involvement as defined by the user of service is central to the recovery process.

(NIMHE, 2005)

These principles are very useful to share when working with a young person. They were designed with adult mental health service users in mind; however they can be equally useful when working with a young person. They can be used to develop a contract which will support the therapeutic alliance that a professional and the young person are seeking to achieve.

Therapeutic relationships

Arnold (1995) talks of the importance of therapeutic relationships throughout her work. She argues that it is a relationship that offers containment for a person's anxiety and mental distress. The containment in turn offers a place for the person who self-injures to recover.

The following quotes are from research carried out in primary care, although they are relevant to work with young people who self-injure, who are frequently in contact with services within primary care.

'Building relationships is central to nursing work and communication skills

can be improved by avoiding jargon and ensuring patients are not labelled' (Collins, 2009).

Good communication helps to build a therapeutic relationship.

'…More recently, a leading primary care academic has presented evidence, drawing on some 50 primary studies and systematic reviews, that a good-quality therapeutic relationship (mostly measured in terms of the popular construct 'patient-centredness') improves patient satisfaction and professional fulfilment, saves time, increases compliance with prescribed medication, and greatly reduces the chance of the practitioner being sued (Stewart, 2005 in Greenhalgh & Heath, 2010)

The latter part of this quote could be viewed as contentious, but there is a reality that workers need to offer services which enhance the quality of the work for both the service user's experience as well as the worker.

Greenhalgh & Heath (2010) conclude:

'In summary, the socio-technical dimension of the therapeutic relationship – in other words, the extent to which it follows the 'logic of care' – might be addressed via the three questions, for the purposes of this exercise the questions have been adapted to support our work with young people who self-harm, to help a worker in their own work to review the function and role they are serving in their relationship with the young person:

To what extent is the clinical relationship continuous, adaptive and sensitive to the nature and context of the self-harm?

To what extent does the clinician acknowledge, understand and seek to optimise the patient's position within a wider socio-technical care network?

To what extent is the network of therapeutic relationships supporting the service user stable and mutually adaptive as opposed to unstable and conflict-ridden?'

Developing alternatives

This refers to harm minimisation, the use of diaries and the self-harm vs. self-nurturing scales tool etc. In supporting a young person, you will need to ensure that the use of any alternative is written into the young person's care plan.

Specialist interventions when supporting a young person who self-harms

There are a number of specific therapies that are beneficial for people who self-injure and these are briefly described next. These interventions should be delivered by appropriately trained and supervised staff and research has proven that the interventions listed have long-term efficacy.

'In the majority of cases people who self-injure will have some significant personality difficulties, whether diagnosed or not, and again the research emphasises the importance of engaging in interventions into the longer term.' (Alwyn *et al*, 2006)

Psychodynamic psychotherapy

Treatment approaches that are based in the here-and-now relationship between client and therapist have been shown to be beneficial.

Mentalisation-based treatment

Mentalisation-based treatment focuses on enabling a person to understand their own thoughts and feelings and the thoughts and feelings of others.

Group therapy

Research supports the value of group psychotherapy for people who self-injure. Groups must be carefully managed to ensure that therapy does not trigger self-harm behaviours and to prevent a culture developing where self-injury equates to status.

Developmental group psychotherapy

Many young people want to belong to a group and group treatment can be a way to facilitate growth for individual members. Being part of a group may help young people to feel included and less isolated.

Dialectic behaviour therapy (DBT)

DBT is a three-stage treatment approach developed by Marsha Linehan. The first stage sees the therapist preparing for the therapeutic relationship by recognising their own prejudices and concerns which may influence treatment with a client.

The second stage sees the therapist helping the client to understand the reasons and functions of self-injury, and the third stage is about the client acquiring and practising skills such as emotional regulation.

Creative therapies

Creative therapies such as art therapy, psychodrama and dramatherapy may help a person who has difficulty articulating their feelings to access their emotions.

The following activity returns to the concept of general interventions (see page 50).

The activity on the next page raises the need to consider and take care of your own needs ie. self-care. It highlights the importance of self-care being at the forefront of your work with young people who self-harm, to encourage and not lose sight of the young person's capacity to self-care, and the need for the person offering support/working with the young person who self-harms to also self-care.

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NICE (2004) Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care (CG16) [online]. Available at: http://www.nice.org.uk/guidance/cg16 (accessed January 2015).

Reflective practice activity

Reflect on the content of Section 2 and the issues it has raised for you on both personal and professional levels.

- What are key learning points for you?
- What aspects of your learning have you (or will you) put into practice?
- What needs for continuing professional development have you identified, if any?

NICE (2011) *Guidelines Self-harm: Longer term management (Clinical Guideline 133)* [online]. Available at: http://www.nice.org.uk/guidance/cg133 (accessed January 2015).

Activity: The self-harm and self-nurturing spectrum

Below is a list of activities/areas of life. This is a useful tool to promote conversation and learn more about the person you are working with. Try completing it yourself – remember to be honest! Score yourself between 0–20 (20 being the highest self-nurturing, 0 being the highest self-harm).

Eating	*0* ⟷	*20*
Sleeping	*0* ⟷	*20*
Working	*0* ⟷	*20*
Exercise	*0* ⟷	*20*
Leisure/relaxing	*0* ⟷	*20*
Partner/sexual relationships	*0* ⟷	*20*
Friendships	*0* ⟷	*20*
Family relationships	*0* ⟷	*20*
Alcohol/drugs	*0* ⟷	*20*
Spending	*0* ⟷	*20*

NIMHE (2005) *NIMHE Guiding Statement on Recovery* [online]. Available at: http://178.79.149.115/wp-content/uploads/2012/01/NIMHE_Guiding_Statement_on_Recovery.pdf (accessed January 2015).

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