Stigma of self-harm in healthcare services

Self-harm – a deliberate attempt to self-poison or self-injure regardless of the incentive or suicidal intent – is a growing problem in the United Kingdom with a heavy burden on health-care systems. Despite this escalating crisis, attitudes from health professionals who treat self-harmers remain negative and the quality of care is deteriorating. The myths of why people self-harm play a substantial role in health professionals' perceptions of self-harmers, which impacts on the efficacy of intervention and recovery rates; however, these myths are far from the reality. This article will reveal the stigma that self-harmers encounter from those at the front-line of our healthcare services and will seek to explain the real reasons behind self-harmful behaviour. By increasing public awareness and educating health professionals on the motives behind self-harmful behaviour, misconceptions and negative attitudes can be diminished.

Studies show that self-harm is a common pattern among adolescents and young adults – 13-25% has reported a history of self-injury. Although many young people only engage in self-harm once or twice, others go on to become chronic self-harmers, with studies evidencing that 6% of the college population do chronically self-harm. Still, these figures may be underestimated as many self-harmers do not seek help. Due to the lack of knowledge and negative misconceptions, those who do seek help report unsatisfactory care from paramedics and emergency staff, who are often the first point of contact. Front-line professionals are in a rare position to interrupt the cycle of self-harm; however, with inadequate rapport between staff and patients, the cycle will continue to have devastating consequences on individuals in need of help. The following misconceptions are put forward.

The first misconception of why people self-harm is the desire to end one's life. In a systematic review of attitudes towards people who self harm, it was found that suicide-risk was a common reason for self-injury as agreed among most clinical staff groups (Saunders, Hawton, Fortune & Farrell, 2012). Whilst self-harm is the biggest predictor of suicidality, those who self-injure do so as a means to manage their distress and cope with negative feelings. The affect regulation model of self-injury proposes that it is a method to relieve acute negative feelings and emotions. It is suggested that early environment may play a role in affect regulation by teaching poor coping strategies to deal with emotional distress. It is also suggested that those with a biological disposition for emotional instability may be more prone to resort to this strategy to manage their emotions. In a systematic review of self-harm (Edmondson, Brennan & House, 2015), affect-regulation was found to be the most common reason for the behaviour. Quantitative studies revealed that the majority of participants (93%) favoured affect-regulation items such as ' to get relief from a terrible state of mind' or ' calming myself down'. This was further supported by qualitative studies which reported that the majority of participants (92%) endorsed in reasons such as ' relieving emotional pain' or ' to calm myself when I'm incredibly emotional or upset'. In further support of the affect-regulation model, research has reported that self-harmers have a poor ability to regulate emotions when experiencing negative affect, as indicated by MRI scans revealing greater amygdala activation (Davis et al., 2014). Consequently, this research shows that self-harm is often carried out for the purpose of reducing negative emotions and to avoid attempting suicide, as opposed to the misconception of health professionals.

The second misconception of why people self-harm is attention-seeking and manipulation. A study which examined nurses' perceptions of self-harmers revealed that labels were used to describe patients such as ' attention seekers' or ' time wasters' (Shaw & Sandy, 2016). Although some self-harmers agree that self-injury is an attention-seeking act, most insist that it is a help-seeking strategy. The interpersonal-influence model argues that self-harm is undertaken as a means of influencing people in the self-harmer's environment. It is argued that self-harm is a cry for help, an avoidance of abandonment or an effort to ensure that they are listened to. To support this, research has found that the second most commonly reported reason for deliberate self-harm is a cry for help motive, including reasons such as ' to show how desperate I was feeling' or ' to hope that others notice something is wrong' (Muehlenkamp, Brausch, Quigley & Whitlock, 2012). In a systematic review (Edmondson et al., 2015), interpersonal influence was a common reason for self-harm. Quantitative studies revealed that a large majority of participants (87%) favoured interpersonal influence items such as ' to seek help from someone' or ' letting others know the extent of my physical pain'. This was further supported by qualitative studies which reported that over half of the participants (56%) supported interpersonal reasons such as ' I received the warmth, love and attention I had been looking for'. Reasons such as ' to frighten someone' or ' to shock or hurt someone' are least commonly endorsed. This research supports the view that self-harm is a call for help, unlike the misconception which suggests that self-harm is an act of manipulation.

A third misconception is that self-harmers can stop if they want to. Although this is true for some, studies have shown that self-harm can become an addiction. In substance addiction, there is a positive reinforcement which is associated with increasing dopamine levels in the brain and negative reinforcement which is associated with relieving negative mood states. Research has found that negative reinforcement plays a part in self-injury. Participants generally experience negative feelings before self-harming, including sadness and frustration but subsequently experience positive feelings after the act, including euphoria and satisfaction (Klonsky, 2009). In a qualitative study, participants compared their self-harm to having a drug addiction (Brown & Kimball, 2012). They declared that self-injury was a reliable ‘ fix’ for overwhelming feelings and they had experienced ‘ highs’ from their self-harming behaviour. Participants also stated that their need to self-harm progressed over time, including the frequency and intensity, and when trying to stop the behaviour they would feel a greater urge to continue. Furthermore, biological research has found that self-harmful behaviour releases endorphins in the brain which produces a euphoric state, reducing pain and alleviating emotional distress (Sher & Stanley, 2009). Therefore, self-harmful behaviour can be overpowering and can be a challenge to cease, unlike the misconception that one can easily stop if they want to.

Although the code of professional conduct states that health professionals should be kind, respectful, compassionate, non-judgemental and show an appreciation of diversity and equality, it appears that many hospital staff are not following this important regime. Whilst these misconceptions are circulating healthcare systems, perceptions and attitudes toward self-

harmers remain unchanged. Discrimination towards those vulnerable can be direct and indirect. Research has revealed that some staff deliberately distant themselves from self-harming patients because they hold feelings of irritation, anger and frustration towards them, especially those who frequently return to hospital (Conlon &Tuathail, 2012). Some health professionals may not be aware of their attitude; however, their demeanour and manner towards patients can appear obvious to the recipient. As a result, self-harming patients become less of a priority compared to those with a physical illness; consequently, influencing their entitlement to care.

Correspondingly, many self-harming patients feel ignored by health professionals and believe that they are perceived as ‘ harder work’ or ‘ time consumers’ (Chapman & Martin, 2014). Research has found that young people who self-harm have reported avoiding the access and emergency department due to their own and others’ previous unsatisfactory experiences. It has been reported that patients have experienced discrimination and have been denied care, such as pain relief, because they have caused their own injuries. Patients were also denied information and were talked about in an ignorant manner. They were also told by health professionals that they were selfish, inconsiderate and were wasting time that could be spent on ‘ real’ patients. Consequently, negative attitudes reinforced the feelings of shame and worthlessness leading to further self-harmful behaviour. This influenced their future decisions to avoid help from health professionals (Owens, Hansford, Sharkey & Ford, 2016).

Although some health professionals can be stigmatizing towards self-harming patients, other professionals such as nurses feel helpless, powerless

and dissatisfied when caring for these patients due to lack of knowledge and training. Nurses feel frustrated as the emergency department is not helpful in treating patients who self-harm – the busy nature of the environment, lack of time, privacy and resources – all of which prevent the development of therapeutic relationships (Martin & Chapman, 2014). Nurses feel that treatments and interventions are insufficient and self-harm patients require specialist treatment which the emergency department cannot provide (Gibb et al., 2010). Research has found a negative relationship between staff member's negative attitudes and knowledge: health professionals who have an accurate knowledge of self-harmful behaviour show a more positive attitude overall and feel more effective at treating patients. Moreover, when nurses are keen to empathise with self-harming patients, the rapport between the nurse and patient is generally more positive (Tzeng, Yang, Tzeng & Chen, 2010). Research has shown that when nurses are provided with mental health training, their attitude changes towards those who self-harm. For example, nurses become more empathetic and patient-orientated. Nurses also described having more confidence to communicate effectively with patients. This positively influenced feedback from patients and the team atmosphere (Karman, Kool, Gamel & Meijel, 2015).

Key findings:

- There are three main misconceptions surrounding the motives and intentions of self-harm – self-harmers are suicidal, attention seeking and/or manipulative, and they have the ability to stop self-harming when they want to.

- Psychological theories (the affect-regulation model, the interpersonal-influence model) and research challenge these misconceptions and claim that people self-injure in order to manage their emotions or to seek help from those around them, and their ability to stop can be hindered by the addictive nature.
- Health professionals' direct and indirect behaviour can influence the care that a self-harming patient receives, potentially increasing the risk of further self-harm.
- Health professionals report feeling powerless when caring for self-harming patients due to the nature of the environment, lack of resources, skills and knowledge.

Self-harming patients are receiving unsatisfactory care which suggests that there is a lack of knowledge and procedure for managing these patients. The national guidelines are designed to influence local and departmental policies to lead front-line staff; however, this system appears to be failing, as the procedure to care for those who self-harm remains ineffective (Rees, Rapport, Thomas, John & Snooks, 2014). Health professions working in the National Health Service are already under strenuous pressure, working long hours and coping with increasing workloads and organisational changes due to the lack of resources and funding. At present, this is an on-going struggle for staff, so with the accumulation of further education and training, this may be seem like an impossible challenge.

Nevertheless, patients are priority in the code of professional conduct and it is an ethical issue if health professionals continue to ignore this code. In any case, there is a strong link between self-harm and suicide, despite many self-

harmers agreeing that suicidality is not a motive. Therefore, these patients should be taken seriously and health professionals should be made aware of the risk of suicide, especially those who are inexperienced.

Consequently, there are many suggestions that can be made in order to reduce stigma and improve healthcare for those who self-injure. First, health professionals should be educated on the motives behind self-harmful behaviour and the context in which it occurs. Education may not work alone; therefore, it may be beneficial if a trainer with personal experiences of self-harm shares their story in order to inform professionals through a traditional-transference approach (Karman, Kool, Gamel & Meijel, 2015). This will provide professionals with a deeper understanding and will help to change perceptions of those who self-harm. They should also be educated on communication and interpersonal skills, which will help to enhance therapeutic relationships between staff members and patients.

In addition to education, on-going training for health professionals should be provided to continuously update their knowledge and skills to care for those with self-injuries. Training should cover knowledge, understanding, attitudes, behaviours, risk assessment and management of self-harming patients. Staff should also be trained to identify risky behaviours and to understand the barriers that self-harmers encounter, as well as understanding their mental health needs and helping them to seek advice and guidance. In addition, refection in practice should be encouraged when caring for people who self-harm.

In short, policy documents, care pathways, protocols and local guidelines should be reviewed and revised so that education and training needs of health professionals are met. This will potentially influence the care that self-harmers receive. Health professionals should treat self-harming patients as any other sick patients on the ward and communicate sensitively. They should aim to develop rapport with patient in order to improve patients' engagement with the services. Nevertheless, health professionals who work on wards where self-harm is severe may also require extra support from colleagues and managers or may require psychological support such as debriefing. If the pressure is too intense for health professionals, a brief screening tool could be introduce to help identify those at risk of suicide. Alternatively, there could be a specialised clinician working on emergency departments supervising front-line staff. Thus, a multi-disciplinary framework may be the ultimate approach to success which will also relieve some pressure off front-line staff.

The context which care is provided to patients and the lack of training and support from managers can challenge professionals' ability to do their job which affects their confidence and increases feelings of frustration and negativity.