The usefulness of self harm

December 13, 2004

Whether it be smoking or cutting oneself, self harm can be an imaginative way to cope with trauma. To avoid shaming people who self harm clinical psychologists should not assume that self harm is wrong, argues *Sam Warner*

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As a teenager I was anti-smoking. I knew it was bad. It smelt and I did not want it around me. I smoked two cigarettes once because I was miserable. It didn't really help, and I didn't rush out and buy more.

No, it wasn't until I was in my 20s, and at university that I started smoking seriously. I've never really stopped.

Yes, I wish I never started. I still know how bad it is for me and for those around me. And one day I'd like to give up.

That smoking will inevitably be banned in (enclosed) public places I accept. However, I'm not sure that such actions will stop the nation smoking. It may help 'social' smokers, but what about us hardened, dedicated smokers?

Let me widen this debate a little bit more. I know cigarettes may be unique in the sense that they are always physically bad for us, but there are other drugs, that whilst not universally bad, are deemed to be bad enough that they are illegal (heroine, cocaine, ecstasy, etc).

Despite this ban, many people use such drugs. Indeed, we take more illegal drugs in this country than anywhere else in Europe. A policy of prohibition does not stop habitual drug users. It criminalises those most in need, shames them and ultimately restricts the ways in which we can support people to manage their (illegal) drug use.

When we don't adopt a policy of prohibition we think the answer is to give people information about the (self) harm caused by the effects of smoking, using alcohol or cutting, for example. Yet, I smoke cigarettes knowing that they are bad for me. People use illegal drugs and other forms of self-harm knowing the damage such actions cause.

Clearly, we need to check that people have basic information about the things they do. However, most habitual self-harmers have detailed knowledge about the negative effects of their actions. When we tell people what they already know we perpetuate a culture of shame. And when we invite people to feel shame about their behaviour we may be complicit in reproducing some of the feelings that underlie the behaviour in the first place. For example, when people tell me that smoking is bad for me it makes me feel stupid, angry and ashamed, and ultimately makes me want to reach for another cigarette.

As clinical psychologists we have a significant role to play in supporting and helping people who self-harm. If we are to be more helpful than harmful we need to reflect on how our attempts to intervene can sometimes exacerbate our clients' felt sense of shame, stupidity and powerlessness: feelings that may underlie self-harm in the first place.

For example, when we suggest our clients have misunderstood their actions (as some cognitive approaches might suggest) or are going to change if we simply stop rewarding them with attention (as some behavioural theories imply) we infer that our clients self-harm because they lack information or imagination. The assumption is that self-harm is an essentially a destructive act that should be stopped.

We make the behaviour the main focus of our concern and sometimes fail to ask, in our fervour to stop it, why people act in the way they do. We fail to integrate different services such that we treat 'symptoms', but never address root causes. For example, women sometimes use alcohol to dissociate from their everyday experiences of domestic abuse. Yet few drug and alcohol services have formalised links with local refuge provision (services in Knowsley, Merseyside, are one exception to this) or routinely concern themselves with matters of abuse.

People self-harm for many reasons: not because they lack information about its negative effects but because they have the imagination to find ways of coping when they feel powerless or trapped. Most people self-harm not because they have a desire to die, but because it helps them stay alive.

If smoking, using drugs and cutting oneself didn't 'work', we wouldn't do it. Self-harm is a trade-off between damage and preservation (cigarettes work like this for me). Sometimes, this trade off stops working when people feel out of control of the things they do. If we are to help people through such times I think we need to stop adding to their felt sense of shame about their actions.

We shame people when we label them as alcoholics or addicts, or when we assume self-harm is a symptom of borderline personality disorder (people get this diagnosis when they cut themselves, which, it can be argued, may be a safer alternative to smoking cigarettes).

When we transform what people do into who we think people are we imply they can never change. Alcoholics may be permanently in recovery, but they can never recover.

One reason people self-harm is because they feel powerless, yet we respond to self-harm with increasingly controlling behaviour. We lock people up when we consider them to be a danger to themselves, and then fail to provide comprehensive mental health services.

The National Service Framework for mental health states that we should adopt a more social, holistic and recovery based approach and move away from a more restricted medical model of distress. Yet, without a diagnosis, in a tier-based system, people cannot get treatment.

Perversely, sometimes getting a diagnosis (of personality disorder) can mean people are refused services (they are hopelessly untreatable). And, treatment often means legal psychiatric drugs, not talking therapies or social support.

If we are to support people who self-harm we need to accept that self-harm (including smoking) is often about self-preservation. If we assume such behaviour is always wrong we can fail to fully explore the underlying issues that bring meaning to such actions and be too quick to restrict our clients' choices.

Most of us self-harm in one form or another (as noted, I smoke). We might not share the same behaviours but we certainly cope with similar feelings sometimes (upset, hurt, shame, anger, boredom, frustration etc). If we are mindful that the feelings are quite ordinary we might not get so worried about behaviour that seems extraordinary. And when we recognise that self-harm can be useful we may then find ways of working that validate rather than undermine our clients. Recovery doesn't always mean changing our coping strategies (although I might, one day).

*** Sam Warner is a consultant clinical psychologist working for Liverpool and Warrington social services, children and families division, and research fellow at Manchester Metropolitan University. She is a member of the Forensic Research Group and the Discourse Unit**

See:
* The government's national service framework for mental health

See also:
August 26, 2004: Psychiatrists rebuke colleagues over remarks on self harming patients - concern after people who self harm described as "wilfully immature"
July 29, 2004: Treat people who self harm with respect, new guideline urges professionals - A&E staff should also receive specialist training, NICE recommends

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Preaching to the converted?

Comment from: Sharif El-Leithy, clinical psychologist,
Traumatic Stress Service, St. Georges Hospital, London
Date: December 13, 2004

As much as I agree with the sentiments of this piece I can't help but feel it is just preaching to the converted. There is nothing new in formulating self-harm as a coping behaviour.

No doubt in presenting it as one option amongst many, and weighing up the relative costs and benefits, clients can be helped in a way that neither minimalises the power of self-harm, nor denies their right to use such methods to cope.

However I am unsure who this piece is trying to convince, as most people reading it would, I think, find it less than challenging to their already held view of the world. Can I suggest that this section [clinical psychology comment] instead be used for considering issues that are contentious, rather than rehashing old ideas."

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No, not everyone is converted...

Comment from: Susanna Reid (not real name), mental health service user, Birmingham
Date: December 14, 2004

I cut when I feel abused by my local mental health service providers. Sometimes when I feel hurt by them, the only person I can lash out at is myself. When people try to stop me, it makes me feel more abused. When they locked me in a psychiatric ward it was the only feeling of control I had over my own body or my own destiny. It was the only little bit of freedom I had.

I don't think that it is a waste of time to write about this because there are still mental health professionals who stick labels on you if you get to the stage of self-harming, and who see you as an attention-seeker instead of understanding that it is a big scream of 'go away, get out of my life'.

I have only ever self-harmed in response to what mental health professionals have done to me. Nothing else in my life has ever driven me to do this.

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Difference between 'drive' to self harm and smoking

Comment from: Phil Barker, professor of health science, Trinity College, Dublin, Ireland.
Date: December 15 , 2004

A typically engaging piece from Sam Warner who is someone who knows a lot about self harm and has the capacity to express it intelligently but also in an interesting fashion.

That said, 'Susanna's' reply puts the whole self-harming scenario into a different context. She noted that: 'I have only ever self-harmed in response to what mental health professionals have done to me. Nothing else in my life has ever driven me to do this.' This seems to be something of a skeleton key.

My experience of people who self harm confirms this 'driving' hypothesis, although what actually does the driving differs from one person to the next.

However, as a former smoker and a fairly active drinker, I think it is fairly uncontentious to say that few people are 'driven' to smoke or drink, whatever they say.

Most of us - like Sam - have to apply ourselves, fairly diligently, to getting over the revulsion and acquiring the taste. Seems quite unlike the lived-experience of self harm in the psychiatric context.

On the NICE (National Institute for Clinical Excellence) side of things, it could ultimately be a blessing in disguise that 'self harming' people find it so difficult to access 'treatment'. What they need is understanding, human support and a bit of acceptance. They are most unlikely to find this in A&E and certainly not in the psychiatric services.

Let us remember that it is the 21st century. Time to do something radically different to help our fellow women and men.

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Since when did smoking keep people alive?

Comment from: Andy Cullen, Bellenden Road, London SE15
Date: December 15, 2004

The comparison between smoking and self-harm does a disservice to both communities. Nobody has died from passive self-harming, but thousands die every year from passive smoking.

A crucial difference between smoking and self-harm is a smoker’s willingness to risk inflicting physical harm on others.

If the author is asking us to accept smoking as a legitimate form of “self-preservation”, are we also expected to tolerate people who cut others as well as themselves?

It simply isn’t true that regarding self-destructive behaviour as 'wrong' precludes a full exploration of the

underlying issues.

' If smoking didn't work, we wouldn't do it…' claims the author, '…self-harm is about self-preservation.'

But 100,000 people die each year in the UK as a result of smoking. Globally, the figure is nearly six million. Is this annual holocaust really a sign that smoking helps people to "stay alive"?

Reaching for a cigarette is not an act of imagination. In the era of the suffragettes, advertisements showed attractive young women smoking cigarettes which were promoted as "Flames of Freedom".

Cigarette companies have always used their immense wealth to impose insidious marketing strategies on young and vulnerable consumers. Smoking has very little to do with individual choice and a great deal to do with corporate power.

Psychiatrists rebuke colleagues over remarks on self harming patients

August 26, 2004
by Adam James

Psychiatrists have criticised colleagues who described self harming patients as "wilfully immature", who "displace more needy patients" and who "seem to thrive on the chaos they cause and attention they receive."

The rebukes were posted on the discussion board of doctors.net.uk, an online resource for psychiatrists and other doctors.

The lively exchange of opinions at the discussion board had followed remarks by a GP, Rachel James. Writing at societyguardian.co.uk she had urged people who self harm: "Please don't lacerate yourself, come to hospital and then complain about it [the service]."

Dr James (a pseudonym) was responding to a National Institute for Clinical Excellence guideline on how accident and emergency (A&E) staff should treat people who self harm. The guideline urged A&E staff - including psychiatrists and mental health nurses - to handle people who self harm with the same respect as they would any other patient.

More than 50 comments to Dr James's article were posted on the discussion board of doctors.net.uk, which more than 103,000 doctors have registered with.

One doctors.net.uk contributor, consultant psychiatrist Dr David Bramble, wrote: "I think she [Rachel James] speaks for many of us who have spent years dealing with these people and, from a psychiatric point of view, getting metaphorically regularly pissed upon by those serial offenders who are not mentally ill but seem to thrive on the chaos they cause and attention they receive.

"In my humble opinion unless there is a robust clinical reason for not doing so. They should be encouraged to apologise for and, perhaps even, pay towards the costs of their wilfully immature behaviour."

Another contributor, Dr Robert Davies, also a consultant psychiatrist, said that most self harming patients "will merely be displacing more needy but less dramatic patients."

Such consultants' views, which appear to contradict NICE's message, may be viewed with concern by many other mental health professionals.

In fact, other psychiatrists on the discussion board voiced disapproval for their colleague's remarks.

A senior house officer, Dr Carolyn Nahman, wrote: "I don't approve of antagonising/being rude/unhelpful to self-harmers - it doesn't help them or the staff dealing with them."

A staff grade psychiatrist, Dr Silke-Yvonne Habel, added: "It's not the patient who is chaotic, but the service. If the service isn't chaotic, then the patient doesn't need to seek attention by creating more chaos. You need to offer separate services and dedicate time."

Dr Robert Davies suggested the guideline increases "the influence of the nanny state, while totally ignoring a fundamental breakdown in the fabric of society."

He said: "They [self-harmers] are an heterogeneous group of patients…This is a fundamental point, and to focus the guideline on a symptom or feature is, to put it bluntly, incompetent. These days, when something goes amiss, it is always the services which have "failed" the individual. The individual is never considered to have

"failed" society.

"Until we get shot of this ludicrous notion, our A&E departments, and wards and clinics will be full of these characters [people who self harm], some of whom have a legitimate place, but most of whom will merely be displacing more needy but less dramatic patients."

Dr Davies went on to suggest that self harming patients be charged £50 for attendance at an A&E ward.

"This could be deductable direct, where necessary, from benefits. I certainly think it would be worth a trial," said Dr Davies.

A third consultant psychiatrist, Dr Robert Gray, said: "Don`t forget these patients are not children and at some point they must take some personal responsibility for their multiple social/relationship/drug/lifestyle/illness problems.

"For many of these patients the solution does not lie with health service professionals but a lot closer to home."

See also:
July 29, 2004: Treat people who self harm with respect, new guideline urges professionals - A&E staff should also receive specialist training, NICE recommends

Treating self harmers like lepers will create more suicides

Comment by: Shaun Williams, vocational worker, Lambeth, London
Date: August 28, 2004

"As an individual who self harmed in the past but overcame this, I find it amazing that certain psychiatrists suggest self harmers should pay in A&E wards. I only self harmed because I felt suicidal, and did not want to die. The act of harming myself prevented my death.

"I would suggest far more time is taken up in A&E wards by people drunk, using drugs etc than people self harming. It is true that indivduals need to control their harming behaviours but treating them like lepers will mean more suicides. I for one have burnt and cut my arms, but never show these off to anyone, so I am certainly not seeking attention and am ashamed I harmed myself in the past, but not ashamed I turned up in hospital for help.

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Outrageous comments...but understandable

Comment by: Wedge Black, director, LifeSIGNS
Date: October 15, 2004

"Such extreme comments are indeed outrageous, but understandable considering the personal confusion and frustration of health care workers who do not understand the syndrome of self injury.

"With awareness training, and a little empathy, health care workers can choose to respond to self harm in a professional manner; considering the whole person, and not simply the ‘damaged tissue’ presented. LifeSIGNS offers free training to health care workers and can be contacted on training@lifesigns.org.uk

"But why did Robert Davies bring up the issue of benefits? There is no rule that people suffering from emotional distress can’t hold professional positions; 1 in 4 people will suffer from some kind of mental distress during their life."

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Training blickers staff to reality of depression

Comment by: Lacuna Lamb (pseudonym), consultant doctor at Lambeth Hospital, Landor Road, London
Date: October 21, 2004

"I have deliberately used a false name to hide my identity. I am not a self-harmer but my husband currently is.

"After over 40 years of mental illness he found that his thoughts drove him to start doing this early this year. He

has done, and is doing, everything in his power to try and stop doing it.

"He knows how much distress it causes me and his young son who, although living with his mother, has become aware that his dad is ill and sometimes hurts himself.

"He cannot say why he does it other than that his thoughts make him do it.

"So far he has not succeeded in getting the help he needs.

"We recognise that this behaviour is a symptom of a problem with very deep roots. He knows that he needs to sort those roots out but also that he is extremely resistant and very untrusting so he has no hope.

"What would the learned Robert Davies suggest for someone in his position?

"My husband is far from immature, not just in age. He is also highly intelligent and very deep thinking. At the moment I consider him to be deeply depressed.

"Regarding depression, I remember a young man who had travelled through the South China Sea by boat to escape an oppressive regime. He was asked which was worse, to be in the boat not knowing what might happen, or depression. He said that the depression was worse because there is no hope. It is a justified truism that no experience is as valid as first hand experience.

" I cannot suggest strongly enough that psychiatric staff spend as much informal time with their patients as possible, among them on the wards, where they still exist. They would learn a lot that their training blinkers them to."

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Doctors should be trained in psychotherapy

Comment by: Michael Russon, GP, Hillswick Health Centre, Shetland
Date: November 17, 2004

"Until psychotherapy becomes a required part of doctors' training, we will continue to have inane comments from colleagues who clearly have no insight into the familial nature of psycopathy and its development."

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Adding psychology to medical science training might help

Comment by: Mustapha Otuyo, staff nurse, Lynfield Mount Hospital, Bradford
Date: April 4, 2005

The unfeeling comments made by some of our eminent psychiatrists towards self harmers further show the bizarre dichotomy between “pure” psychiatry and “pragmatic” psychology.

It is rather sad that the over reliance in medicational therapy as often employed by the psychiatrists would never seem to solve the problems of self-harming. I believe it will be an immature optimism to hope that we can solve the problems of self-harming without demonstrating a little emphathy towards the patient.

My suggestion is that psychology should be added to anatomy, physiology and biochemistry to form the basic medical sciences and clinical psychology to be taught and examined in the final MB.

Treat people who self harm with respect, urges new guideline

July 29, 2004

Professionals should treat people who self harm with the same respect as they would any other patient, a new national guideline has urged.

Around 170,000 people per year attend accident and emergency (A&E) departments after self harming, reveals the guideline published by The National Institute for Clinical Excellence and the National Collaborating Centre for Mental Health (NCCMH)

The guideline, for professionals in England and Wales, recommends that those staff who treat people within 48 hours of them self harming should receive appropriate training.

It also urges that psychosocial assessments of people who self harm should be carried out at the first opportunity.

Other recommendations include that A&E staff involved in the care of people who have self-poisoned should ensure that activated charcoal, which absorbs drugs and poison, is immediately available at all times.

The guideline makes a battery of recommendations for the physical, psychological and social assessment and treatment by primary and secondary care of people in the first 48 hours after having self-harmed.

It covers acts of self-harm that are an expression of distress and where the person directly intends to injure him/herself, for example through cutting or overdosing.

The recommendations include:
* That people who have self-harmed should be treated with the same care, respect and privacy as any patient and that healthcare professionals should take into account the distress associated with self-harm.

* Appropriate training should be provided for staff coming into contact with people who self-harm.

* A&E staff who may be involved in the care of people who have self-poisoned should ensure that activated charcoal is immediately available at all times.

* All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an episode of self-harm. Assessment should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and possible presence of mental illness.

* 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.

* All people who have self-harmed should be assessed for future risk of self-harm and/or suicide and the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent should be identified.

Dr Tim Kendall, consultant psychiatrist and co-director of the NCCMH, said: "170,000 people a year attend emergency departments because they have self-harmed, of those an estimated 80,000 never receive a psychological assessment or follow up even though the risk of committing suicide after self-harming one or more times is 100 times greater than the average risk in the population.

"Self-harm and suicide have now become the third leading cause for life years lost after cancer and heart disease in all age groups. Few people providing care in casualty understand why people self-harm and don't know how to help them effectively.

"There is no one cause for people self-harming, but very often abusive experiences in their past are significant factors. One key recommendation in this guideline is that any staff coming in to contact with people who self-harm in any setting should be provided with appropriate training to help them better understand the problem of self-harm, how best to engage people who have self-harmed and to provide the right assessment treatment and follow up."

The National Institute for Clinical Excellence guideline on the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care (pdf)