Perspectives of Mental Health Professionals and Patients on Self-Injury in Psychiatry: A Literature Review

Maartje Bosman and Berno van Meijel

Professionals in psychiatry often encounter patients who injure themselves. To explore the perspectives of mental health professionals and patients on self-injurious behavior and treatment, the authors carried out a literature review. The reviewers found little documented data that elucidated or discussed any shared understanding about self-injurious behavior between patients and professionals or between professionals themselves. Many of the problems experienced in relation to self-injury may be due to this lack of a common view. There were few evidence-based strategies for managing self-injury that received any attention in the literature. Future studies should focus on the development and testing of preventative interventions, putting particular emphasis on effective communication between professionals and patients.

MANY NURSES IN psychiatry must deal with patients who injure themselves, but find it difficult to clearly describe their own specific role when working with these patients (O'Donovan & Gijbels, 2006; Smith, 2002).

Little is known about what is effective in dealing with self-injury (Comtois, 2002; Smith, 2002; Vandereycken, 2001). Even so, effective interventions that are available are not used systematically: There is a great deal of variation in the way mental health staff work, and they often respond to self-injury on an ad hoc basis (Bowers, Gourney, & Duffy, 2000; Cook, Clancy, & Sanderson, 2004). There is also some inefficiency in practice: Patients who receive the most intensive care are not the same as those who need the most intensive care (Comtois, 2002). There is a shortage of individualized treatment plans for patients with self-injury (Isacsson & Rich, 2001).

Literature review confirms that nurses find it difficult to build a good working relationship with patients who injure themselves and to give them adequate support (Huband & Tantam, 2000; Loughrey, Jackson, Molla, & Wobbleton, 1997; McAllister, Creedy, Moyle, & Farrugia, 2002). Less than 25% of the patients are satisfied with nursing care (Warm, Murray, & Fox, 2003). Patients are particularly dissatisfied with the attitude of (nursing) staff (Boevink & Escher, 2001; Bywaters & Rolfe, 2002; Lindgren, Wilstrand, Gilje, & Olofsson, 2004). According to Cook et al. (2004), patients "find themselves ignored by health and social care professionals, not just because of negative attitudes towards them but also because they are perceived as difficult to deal with" (p. 43).

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Problems within the relationships between (nursing) staff and patients are related to different perspectives on self-injury and the treatment of self-injurious behavior (Harris, 2000; Reece, 2005).

Therefore, the following questions guided this literature review: What are the perspectives of patients and nurses on self-injury and the treatment of self-injurious behavior? How do these perspectives relate to each other?

METHODS

The authors collected the literature by systematically searching electronic databases (Invert, Cinahl, Cochrane, PsycLit, and PubMed) using the keywords "self-harm," "self-injur*" and "psychiatr*" NOT "suicid*" for the period 1990 to November 2006. The authors restricted their review to literature on adult patients without psychosis. Relevant articles obtained through cross-references were used to supplement the selected sources.

BACKGROUND

Nursing practice hardly distinguishes between "self-harm" and "self-injury": Nurses ascribe different types of behavior to these terms (Bowers et al., 2000; O'Donovan & Gijbels, 2006). Claes, Vandereycken, and Vertommen (2003) define *self-injury* as "a direct, socially unacceptable behaviour that causes minor to moderate physical injury, while the individual is in a psychologically distressed state but is not attempting suicide" (p. 380). The more general term *self-harm* also includes indirect injury, such as excessive doses of pills (Kapur, House, May, & Creed, 2003). In the literature, however, the two terms are used more or less interchangeably.

For ease of reference, the authors will use the terms *self-injury* and *people who injure themselves* throughout this article.

According to Zlotnick, Mattia, and Zimmerman (1999), 33.2% of all patients with psychiatric conditions exhibit self-injuring behavior. Because self-injury is often overlooked in both diagnostics and treatment, its incidence is underestimated (Bohne, Keuthen, & Wilhelm, 2005; Vandereycken, 2001; Zlotnick et al., 1999). Probably patients do not talk about their injurious behavior when not asked directly (Vandereycken, 2001; Zlotnick et al., 1999).

More than half of the patients who injure themselves suffer from one or more psychiatric disorders, the most common of which are depressive disorders, (borderline) personality disorders, eating disorders, posttraumatic stress syndromes, and substance abuse (Barr, Leitner, & Thomas, 2004; Parker et al., 2005; Ruths, Tobiansky, & Blanchard, 2005; Solano, Fernández-Aranda, Aitken, López, & Vallejo, 2005). Recent studies raise doubt about whether self-injury predominantly occurs in patients with borderline personality disorder. Self-injury may well occur separately from borderline personality disorder or prior trauma (Marchetto, 2006; Zlotnick et al., 1999).

People who injure themselves are more inclined to exhibit dissociative symptoms, such as symptoms of depersonalization, derealization, identity entanglement, or loss of control, than patients who do not injure themselves (Bracke, van Leeuwen, & Verhofstadt-Denève, 2001; Noll, Horowitz, Bonnano, Trickett, & Putman, 2003; Zlotnick et al., 1996, 1999). There is a strong association between self-injury and dissociative disorders: 86% of a group of patients with dissociative disorders were found to injure themselves (Saxe, Chaawla, & van der Kolk, 2002).

In terms of gender, Briere and Gil (1998) and Marchetto (2006) found just as many men as women who injure themselves. The idea of self-injury being a problem among women has repeatedly been disproved in recent years (O'Loughlin & Sherwood, 2005; Warm et al., 2003).

The most common type of self-injury involves cutting the arms and hands, but other parts of the body are injured as well (Claes et al., 2003). The reasons for selecting a particular body site include ease of access, desire for secrecy, and negative feelings about that body part (Duffy, 2006, p. 263).

The methods by which patients injure themselves and the seriousness of the injuries inflicted vary greatly, ranging from pathological skin picking, superficial scratches, moderate cuts, deep stab wounds, burns, and swallowing objects, to taking an overdose of medication (Bohne et al., 2005; Deckersbach, Wilhelm, & Keuthen, 2003; O'Loughlin & Sherwood, 2005; Ruths et al., 2005; Taylor, 2003).

Most injuries are inflicted in the evening. This may have to do with specific activities performed at that time of the day that are considered stressful by the patient, such as going to sleep (Evans, Morgan, & Hayward, 2000; Jones, Thomas-Peter, & Unton, 1998). People seldom injure themselves in the

company of others; two thirds of hospitalized patients do so alone, in their own room (Nijman & Campo, 2002).

Individual patterns of self-injurious behavior depend on the psychopathology of the patient, the patient's psychological state at a given point in time, the situation the patient is in, and the purpose of self-injury (Claes, 2004; Osuch, Noll, & Putman, 1999; Schoppmann, 2003).

PERSPECTIVES

Patient Perspective

People who injure themselves often report a history of trauma, such as (sexual) abuse, violence, neglect, abandonment, or the death of a close relative or friend (Gratz, 2003; Hawton, Haw, Houston, & Townsend, 2002; Marchetto, 2006; Rodriquez-Srednicki, 2001; Wiederman, Sansone, & Sansone, 1999). Based on the traumatic experiences, people who injure themselves struggle with problems such as:

- A negatively tinged and vulnerable self-image, little self-esteem, and little confidence in themselves and in others (Boevink & Escher, 2001; McAllister et al., 2001; McAuliffe et al., 2006)
- Negative and distorted image and perception of their body (Noll et al., 2003; Tameling & Sachsse, 1996)
- Difficulties with experiencing, expressing, and regulating thoughts and feelings (Claes, Vandereycken, & Vertommen, 2005; Deiter, Nicholls, & Pearlman, 2000)
- Underdeveloped skills in self-soothing (Gallop, 2002)
- An inability to solve personal problems, leading to a tendency to avoid these as much as possible (McAuliffe et al., 2006).

As a result, people who injure themselves live with a great deal of tension, anxiety, feelings of sadness, hopelessness, insecurity, and loneliness (Claes et al., 2003; McAuliffe et al., 2006; Milnes, Owens, & Blenkiron, 2002; Taylor, 2003; Weber, 2002).

A noticeable similarity among self-injurers is that they experience a certain emotional distance—a feeling of being "cut off" from their feelings, their thoughts, and their body. These experiences of emotional distance also exist toward others and the environment (Boevink & Escher, 2001; Huband & Tantam, 2004; Reece, 2005; Schoppmann, 2003). Schoppmann describes the abovementioned feelings as a sense of "alienation."

Alienation is a gradual process that is triggered by stressful situations. The transition into alienation and the different stages of the process are characterized by specific forms of behavior, physical characteristics, and typical bodily perceptions. For instance, according to Schoppmann (2003), an unmotivated occurrence of laughter is a perceivable sign of a threatening loss of control, which is characteristic of the transition into alienation. The bodily sensations during the experience of alienation are characterized by feelings of coldness, tiredness, and "mist" (Schoppmann, 2003, p. 7). In this state of alienation, patients feel restless and are overcome by an uncontrollable urge to injure themselves. It is no longer possible for them to talk about such behavior, let alone ask directly for help (Pawlicki & Gaumer in Broers & De Lange, 1998; Schoppmann, 2003). Self-injury is inevitable, serving as a kind of "return strategy."

By injuring themselves and by seeing and feeling the warm blood, patients feel that their body is real; they feel alive and demarcated (Claes et al., 2005; Osuch et al., 1999). They regain contact with themselves and with the world around them.

After the injury, patients are freed from the overwhelming emotions and savage tension, even if only for 5 minutes (Bywaters & Rolfe, 2002; Claes et al., 2005; Huband & Tantam, 2004; Kocalevent et al., 2005).

In contrast to the situation just described, in which self-injury serves to eliminate alienation, self-injury may also serve the opposite function of eliciting feelings of alienation; then the behavior is used as a way of releasing oneself from an oppressive situation, stopping unpleasant thoughts or reliving scenes from the past, or making contacts with others that are more manageable (Osuch et al., 1999; Vandereycken, 2001).

Experienced patients sometimes deliberately injure themselves before taking part in social intercourse. They recognize that specific situations, such as going to work or going out with friends, can be very stressful for them. By self-injury, they are able to anticipate these stressful situations. Thanks to the state of alienation, the self-harm evokes, and they can participate in social life: They prefer alienation to social withdrawal (Boevink & Escher, 2001; Schoppmann, 2003). Schoppmann observed

that patients may even develop the capacity to deliberately initiate and terminate alienation without injuring themselves. But if a patient does not have the process of alienation under control, the need to end the alienation through self-injury will arise again, regardless of whether the alienation is a conscious and voluntary state of mind.

Self-injury gives a patient a sense of control, a feeling of security and autonomy. It prevents further alienation, isolation, and suicidal behavior. Patients view their behavior as a form of self-help and self-protection, although they will gradually need to injure themselves more frequently and more seriously to experience any positive effects (Bywaters & Rolfe, 2002; Himber, 1994). For them, it is a form of self-regulating behavior that allows them to manage powerful feelings and dissociative processes (Boevink & Escher, 2001; Claes et al., 2005; Conners in Gallop, 2002; Crowe, 1996; Huband & Tantam, 2004).

The functional nature of self-injury and alienation is not always recognized by nurses. According to patients, nurses tend to see self-injury as a form of irrational and pathological behavior arising from a lack of control, and as something that must be stopped (Harris, 2000; Lindgren et al., 2004). Consequently, patients must interact with nurses who interpret safety and security differently and who allow their professional judgment of the seriousness of a situation to predominate over the patients' experiences and perceptions (Boevink & Escher, 2001; McAllister, 2001). Patients feel that the expectations of nurses are not founded on the actual abilities and preferences of the patients (Deegan, 2003; Harris, 2000; McAndrew & Warne, 2005; Potter, 2003; Smith, 2002). This, in turn, leads to feelings of being misunderstood and to frustration, humiliation, and stigmatization. The gap is widened further because the language used by nurses is poorly attuned to that of patients. This results in misconceptions and misunderstandings, thus increasing the risk of alienation and self-injury even more (Boevink & Escher, 2001; Harris, 2000; Johnstone, 1997; Potter, 2003; Schoppmann, 2003).

Patients want to be approached as normal human beings, with understanding and respect. Being autonomous—a sense of being able to participate actively in their own treatment and having the opportunity to regulate the burdens they bear—is important to patients. Patients also want to feel that nurses show concern. The literature describes interventions and interactions that patients perceive to be helpful (Boevink & Escher, 2001; Corser & Ebanks, 2004; Deegan, 2003; Huband & Tantam, 2004; Lindgren et al., 2004; McAllister et al., 2001; Newton & Parry-Crooke, 2002; Perseius, Öjehagen, & Ekdahl, 2003; Schoppmann, 2003). These interventions nurture hope, self-confidence, and self-esteem (Boevink & Escher, 2001; Lindgren et al., 2004). Patients indicate that these are important aspects if self-injury is to decrease or even stop (Bywaters & Rolfe, 2002; Ettinger in Weber, 2002).

Professional Perspective

Research by Broers and De Lange (1998) shows that when nurses choose interventions, their choices are motivated mainly by the seriousness of the self-injury and by whether the patient is in the midst of a (psychotic) crisis. Nurses tend to give patients greater responsibility if they are confident that patients are in sufficient control of their actions. Health-care workers in an acute setting, more so than their colleagues in an outpatient setting or in day clinics, are sooner of the opinion that patients are in control of their actions (Huband & Tantam, 2000). How professionals define control does not clearly emerge from the literature.

Nurses suggest that they differentiate self-injury without a suicidal attempt from self-injury with a suicidal attempt; however, in their nursing practice, this was not found. Prevention and safety are the key priorities of nurses, who put this into practice (e.g., by removing sharp objects or using no-harm contracts) (O'Donovan & Gijbels, 2006).

The reviewers found several studies that showed the different types of interventions that multidisciplinary health workers considered helpful for self-injuring patients (Antai-Otong, 2003; Broers & De Lange, 1998; Deiter et al., 2000; Gallop, 2002; Huband & Tantam, 1999; McAllister et al., 2001; McAllister, Matarasso, Dixon, & Shepperd, 2004; Perseius et al., 2003; Potter & Dawson, 2001; Smith, 2002). Many of these interventions were designed to increase security and autonomy, to reduce tension and anxiety, and to restore contact with reality. Professionals also attached value to the patients learning how to control their impulses and how to develop alternative behavior in place of self-injury.

In addition to verbal and cognitive interventions, nonverbal interventions such as physical exercise, relaxation, and artistic forms of expression were considered important, with a special focus on reducing tension, restoring contact with the body, learning to sooth oneself, and opening up the patients' own sources and creative talents for them to find alternative ways of expressing their emotions (Batty, 1998; Crowe & Bunclark, 2000; Lindgren et al., 2004; McAllister, 2000, 2001; Richardson, 2004; Schoppmann, 2003).

Huband and Tantam (1999) discovered that as many as 87% of mental health staff believed that encouraging patients to ventilate unexpressed feelings about their past would be the most effective way of reducing or putting an end to self-injury. Nonetheless, patients still encounter nurses who refuse to let them talk about the past (Boevink & Escher, 2001; McAllister, 2001).

Nurses are aware that they spend too little time talking with patients about subjects that are essential to them (Smith, 2002). Professionals put more emphasis on future implications of a damaged body than on exploring a patient's feelings at the specific moment of self-injury (Reece, 2005).

Open discussions about self-injury are even deliberately avoided based on the idea that a patient is not capable of talking about it, or that discussing self-injurious behavior will only reinforce such behavior, or that others might become "infected" (Lindgren et al., 2004). Other reasons put forward for not talking about self-injury include the professionals' workload and their own fears and concerns, such as the fear of hearing grim stories (Schoppmann, 2003).

In addition to these obstacles to communication, the literature lists a number of factors that interfere with the proper treatment and care of patients who injure themselves. Nurses refer to the lack of effective interventions, their own lack of knowledge and personal skills to signal and deal with imminent self-injury, and the lack of practical support in daily practice. Moreover, nurses claim a lack of cooperation and support, information exchange, clarity of policy, and a shared view on self-injury in multidisciplinary treatment teams (Huband & Tantam, 1999, 2000; Loughrey et al., 1997; Reece, 2005; Smith, 2002).

Because of these problems, nurses start to have doubts about their own competencies—feeling uncertain, helpless, frustrated, or angry. Nurses even feel personally rejected, manipulated, looked down on, envied, idealized or maligned, and reviled. They feel that they are caught in a power struggle with the patient, which may eventually lead to a loss of empathy (Reynolds & Scott, 1999). Countertransference, involving feelings of reproach, disgust, and rejection toward the patients, may set in (Antai-Otong, 2003; McAllister et al., 2002; Reece, 2005). These reactions by nursing staff may, in turn, reinforce a patient's need for self-injury. It is important to recognize symptoms of countertransference within a relationship and to make it possible to talk about them (Rayner, Allen, & Johnson, 2005).

Other authors suggest that care and communication be offered from a solution-focused approach (Barker, 2003; McAllister, 2003b). A solution-focused approach is basically future oriented, with a focus on the health, needs, and strengths of patients and their significant others (Iveson, 2002; McAllister, 2003b). Active patient participation is part of this approach. A solution-focused approach not only makes patients feel that they are heard and gives them a sense of control, self-confidence, responsibility, hope, and optimism about the future (Bowles, Mackintosh, & Torn, 2001; Cook, Phillips, & Sadler, 2005) but also lets nurses experience an increased sense of competence and greater self-confidence in working with patients exhibiting self-injuring behavior (Bowles et al., 2001; Webster, Vaugh, & Martinez, 1994).

The literature also emphasizes the importance of nurses and patients sharing ideas and working together. One of the possibilities mentioned in this context was that of setting up an "emergency" group for patients in an imminent crisis, composite of nurses and copatients (Crowe & Bunclark 2000; James, 2003; Smith, 2002). This would trigger collective responsibility and promote equality, with nurses and patients exchanging ideas about possible solutions and learning from one another.

INTERVENTIONS

Scientific research on the effectiveness of interventions used in patients with psychiatric conditions who injure themselves is still in its infancy; it is an underexplored area in psychiatric nursing research (O'Donovan & Gijbels, 2006).

Hawton et al. (2004) analyzed 23 randomized controlled trials carried out in the period up to 1999. As these studies were primarily conducted with

small groups of patients, they had but limited statistical power (Comtois, 2002; Hawton et al., 2004). Most of the trials were conducted among outpatients. Out of the 23 studies, 11 contained no information about diagnoses; the other 12 studies primarily involved patients with (borderline) personality disorders, mood disorders, or both.

Hawton et al. (2004) saw promise in problem-solving therapies, such as help with practical and interpersonal problems. Although five randomized controlled trials showed a reduction in self-injury, the effect was not significant. Nonetheless, there was a significant decrease in depressive symptoms and feelings of hopelessness (Townsend et al., 2001). The use of dialectical behavior therapy and an acceptance-based emotion regulation group intervention with patients suffering from borderline personality disorder led to a decrease in self-injury in a number of studies, but here, too, the effect was not always significant. These forms of therapy did, however, lead to significant declines in complaints of depression, anxiety, and dissociation (Binks et al., 2006; Bohus et al., 2004; Gratz & Gunderson, 2006; Lieb, Zanarini, Linehan, & Bohus, 2004; Linehan in Hawton et al., 2004; Verheul et al., 2003). Application of individual and group psychoanalytic psychotherapies led to a significant decrease in self-injury among patients with borderline personality disorder (Bateman & Fonagy, 1999, 2001).

A striking but nonsignificant trend was observed in cases where patients could make use of an emergency access card. Just having the card caused these patients to injure themselves less (Hawton et al., 2004). Having access to a crisis telephone, however, seemed to lead to even more self-injury (Evans, Morgan, Hayward, & Gunnell, 2000). Notably, only 17% of the patients actually made use of the crisis telephone.

Treatment interventions that proved to have no effect or no consistent effect on self-injury included the following: manually assisted cognitive–behavioral therapy (Goldney, 2004; Tyrer et al., 2003), intensive intervention plus outreach, short-term admission to a general hospital after visiting an emergency room or after having received care from an emergency room nurse (Hawton et al., 2004), (nurse-led) case management (Clarke et al., 2002; Congdon & Clarke, 2005), and general practice-based interventions with outpatients (Bennewith et al., 2002).

For patients who were hospitalized, the risk of self-injury tended to be higher where more restrictive measures were in place (Drew, 2001; Laidlaw Solutions, 2005). Interventions aimed at behavioral change in staff toward a less restrictive approach did result in less frequent use of restrictive measures. The number of self-inflicted injuries also decreased, but not significantly (McCue, Urcuyo, Lilu, Tobias, & Chambers, 2004). Continual care for inpatients provided by the same nurse pointed to the direction of a positive but nonsignificant effect (Drew, 2001).

DISCUSSION AND CONCLUSION

For nursing care in practice, it is important to work based on a common view on self-injury and helpful interventions that can be shared between patients and nurses, and among nurses. The authors conclude from this literature review that much needs to be done before that goal is achieved. There is still a great deal of miscommunication in caring relationships and within multidisciplinary teams, causing nurses and patients to become even further alienated from each other (Deiter et al., 2000; Schoppmann, 2003; Smith, 2002). Part of the problem lies in the way the medical model predominates in today's care (Cresswell, 2005; Harris, 2000; Johnstone, 1997; McAllister, 2003a). This model views self-injury as a pathological behavior that must be stopped as quickly as possible (Stevenson & Fletcher, 2002). This same view is found in nurse–patient relationships in which the issue of self-injury is dominant. It is also found in modern treatment models in which, according to Shaw (2002), the focus still lies primarily on combating symptoms and the use of cognitive–behavioral therapy techniques, medication, and contracts. The one-sided focus on symptom reduction and problem solving, and the technical language this entails, may form "an obstacle in the therapeutic relationship, creating distance and insecurity" (McAllister et al., 2001, p. 28).

The downward spiral described in this article can be stopped by understanding self-injury as a meaningful behavior displayed by patients to regulate emotions and stress (Boevink & Escher, 2001; Isacsson & Rich, 2001; McAllister, 2003a; Shaw, 2002) while also developing a view on caring that can be shared by patients and nurses alike. This requires a shared language (Crowe & Bunclark,

2000; McAllister et al., 2004; Nordby, 2006). A shared view can emerge from an open dialogue embedded in a solution-focused approach, by giving patients a wide scope to express, in their own words, their perceptions, their experiences, and solutions that give meaning to them (Lewis & Osborn, 2004; Potter, 2003; Reece, 2005). However, limited research into the effectiveness of solution-focused interventions has been conducted to date (Lewis & Osborn, 2004; Stalker, Levene, & Coady, 1999), but there are literature sources that show preliminary support for the efficacy of solution-focused care and communication skills (Bowles et al., 2001; Gingerich & Eisengart, 2000; Webster et al., 1994).

Little attention has been paid so far to physical exercise-focused interventions that may reduce anxiety, tension, and alienation and, thus, perhaps also self-injury. This could be caused by the fact that exercise, in general, is a neglected intervention area in mental health care (Callanghan, 2004). There are several studies showing that exercise in psychiatric patients with mood, anxiety, and personality disorders leads to more positive self-image and body perception (Knapen et al., 2003, 2005; van de Vliet et al., 2003). These elements are important in the process of recovery of people who injure themselves. Furthermore, the strategy that patients use to end their sense of alienation also finds its roots in sensitive perceptions and forms of nonverbal expression (Schoppmann, 2003). The authors believe, therefore, that physical interventions are of great importance and should be investigated in future research. Physical exercise-focused interventions are relatively safe and nonexpensive and do not have any adverse effects (Meyer & Broocks, 2000). Mental health nurses "may perform an important role in encouraging physical activity and legitimizing its incorporation within care planning" (Faulkner & Biddle, 2002, p. 659).

Physical interventions and other nonverbal and creative interventions mentioned by both professionals and patients may contribute to identifying which direction is to be taken in improving the quality of care for patients who injure themselves and may also contribute to a broader range of therapeutic approaches that offer more than a symptomatic response. These interventions can also form the basis of innovative research into their effectiveness.

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