Caring for self-harming patients in general practice

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ABSTRACT

INTRODUCTION: Intentional self-harm is an international public health issue with high personal, social and financial costs to society. Poor relationship dynamics are known to have a negative influence on the psyche of people who self-harm, and this can increase anxiety and decrease self-esteem, both shown to be significant contributors to self-harm behaviours. Positive and functional social supports have been proposed as a cost-effective and constructive approach in diminishing self-harming behaviours.

AIM: This qualitative study investigated the aspects of professional, social, familial and romantic relationships that people who have self-harmed identified as having a positive and constructive effect on their self-harm behaviour.

METHODS: Twelve participants with a history of self-harming behaviours were recruited through free press advertising in primary care and interviewed. The participants ranged in age from 19 to 70 years, and represented New Zealand (NZ) European and Māori from across the Southern region of NZ.

RESULTS: This study shows that constructive relationships that inhibit self-harm behaviours are characterised by participants' perceptions of authenticity in their relationships, and knowing that other people genuinely care. Feeling cared for within an authentic therapeutic relationship enabled participants to overcome their perception of being damaged selves and gave them the skills and confidence to develop functional relationships within their communities. A relationship-centred care approach may be useful for general practitioners seeking to develop more effective therapeutic relationships with patients who deliberately self-harm.

KEYWORDS: Doctor–patient relationships; primary health care; mental health

Introduction

Self-harm is defined as 'intentional self-inflicted poisoning or injury, which may, or may not have a fatal intent or outcome'.[1] The Royal Australian and New Zealand College of Psychiatrist's clinical practice guideline for the management of deliberate self-harm suggests that published rates are likely to underestimate its prevalence, and that hospitalisations represent a small proportion of community self-harm.[2] In New Zealand (NZ), intentional self-harm accounted for 176.7 hospitalisations per 100,000 population in 2013, with women aged 15–19 years, the most deprived, and Māori over-represented in these data.[2] Most patients who receive hospital treatment for deliberate self-harm injuries do not continue self-harm behaviours.[2] Community prevalence of deliberate self-harm in NZ has been estimated at 0.4%, with lifetime prevalence at 4.5% (twice as high for men as for women).[2] One United Kingdom (UK) study that analysed primary care data suggested a figure as high as 0.4% for women and 0.25% for men,[3] while another suggests a lifetime risk of 10.5% for deliberate self-harm.[4]

Treating and managing patients who self-harm can be challenging for health professionals. When patients present with serious self-induced

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WHAT GAP THIS FILLS

What is already known: Self-harm is a major public health issue affecting women, youth, Māori and socially deprived groups disproportionately. Self-harm prevalence has increased year-on-year, with little understanding as to why. Mental health interventions aimed at reducing self-harm appear to have been largely unsuccessful in their aim. While little is known about the incidence and prevalence of deliberate self-harm in the community, general practitioners are often the first port of call for help.

What this study adds: These findings suggest that health professionals can inhibit their patients' desire to deliberately self-harm by developing therapeutic relationships that are characterised by genuine caring and authenticity. The relationship-centred care approach provides a potentially useful framework that emphasises a values foundation for healthcare work rather than technically appropriate transactions between health practitioners and patients.

injuries, front line doctors and nurses often feel inadequately prepared for dealing with it,[5] and can hold negative and punitive attitudes towards people who self-harm.[6,7] Nurses may find it emotionally frustrating to manage ongoing care relationships with patients who self-harm; and maintaining professional boundaries exhausting.[8]

Patients who regularly self-harm often feel mistreated by healthcare professionals,[4] although counsellors hold a valuable role in their lives.[9] Guidelines indicate pharmacological and psychological treatment strategies for managing deliberate self-harm, sensitive to age, ethnicity, vulnerability and other diagnoses such as Borderline Personality Disorder and depression.[2,4] While there is little evidence regarding effective interventions for deliberate self-harm in primary health care,[2,3] general practitioners (GPs) play a key role in ongoing care following hospital treatment for episodes of deliberate self-harm. Given the furtiveness and shamefulness associated with self-harm, it is important for GPs to maintain a holistic approach with patients in the context of continuity of care and trusting relationships; a strategy that may enable intervention before a crisis.[4]

The impetus for the current study was the lead author's experience in a general practice serving a vulnerable population with many patients who deliberately self-harmed. She became curious about factors that led to recovery and the role that positive social supports might play in managing self-harm behaviours.

Positive social supports, both professional and non-professional, have been identified as a cost-effective and constructive approach in diminishing intentional self-harm.[10,11] The term 'functional social supports' describes the impact of positive social relationships on health.[12] It is reasonable to suppose that positive, supportive interactions might influence the prevalence of intentional self-harm. However, there is little published research on what constitutes functional social support and how this might actually avert self-harm.

The relationship-centred care approach[13] provides a potentially useful framework for theorising functional social supports. It has four key components: (1) recognition of personhood and authenticity; (2) acknowledgement that emotion and empathy are legitimate; (3) healthcare relationships are reciprocal; and (4) relationships in health care are morally valuable because they are honest, allowing patients to assess their impact on clinicians 'rather than being misled by a particularly good performance'.[13] This approach to health care explicitly problematises the wisdom of clinical detachment, and its proponents argue that the relationship-centred care approach has a positive impact on healthcare processes and outcomes.[13]

This article presents the perspectives of people who have self-harmed on the factors that transform their relationships with health professionals into functional social supports, and the impact of these on their desire to self-harm. These findings are relevant to GPs and community nurses and have the potential to result in more effective therapeutic relationships and better outcomes with self-harming patients.

Methods

Because self-harm is a deeply subjective experience, a qualitative interview approach that allows participants to tell their stories and the

interviewer to ask questions about the impact of functional social supports was deemed most appropriate for this study. A free regional newspaper was the primary means of advertising the study. Participants had to be aged >16 years and there had to be an interval of 2 years since the individual had last self-harmed. This was to diminish any potential harm to the participants by reporting their experiences, as well as to facilitate reflections on the personal assessment of usefulness and functionality of support relationships. Mental health status or diagnosis did not exclude participants, as individuals who self-harm are not necessarily mentally unwell, and not all individuals with a mental health diagnosis self-harm. Twelve participants from Otago (Dunedin, New Zealand) with a history of self-harming behaviours were recruited and interviewed. The participants ranged in age from 19 to 70 years. Nine were female, three were male; 11 identified as NZ European and one as Māori.

The same semi-structured interview guide was used for each interview, although the interviewer (JR) was also responsive to the ways participants chose to recount their experiences (Table 1). Each participant was interviewed once. Interviews were transcribed and a thematic analysis was conducted with the assistance of Nvivo (QSR International, Melbourne, Vic., Australia). A template organisation approach was used so that segments of text were coded according to the questions in the interview guide, allowing for *de novo* and unanticipated insights.[14] These codes were then clustered according to likeness under categories such as self-worth, family, counsellor, support. Regular meetings between the authors during this phase established analytical concordance and these discussions developed the emergent themes presented here. Approval for the study was gained from the University of Otago Ethics Committee (H14/118).

Results

Participants recalled accessing health care for self-harm and sequelae from a range of providers, including GPs, emergency departments (EDs), medical and surgical wards, outpatient medical facilities and mental health services. The extent of treatment provided by these health service providers ranged from acute to non-urgent. Many participants had ongoing relationships with mental health services and counsellors in addition to their GP. In talking about the most effective relationships with health professionals in terms of relieving the impulse to self-harm, participants identified several common factors that resulted in the emergent themes detailed below; these themes were 'seeing of me'; authenticity; and relationship-centred care.

'Seeing of me'

Participants described feeling that they often felt categorised and judged by health professionals with whom they interacted.

> 'I think they just looked at me as another number… as soon as you're sitting in front of them telling them about it, it's sort of just like, 'oh she cuts'. So does every other girl in this mental health system.' [Female, 21 years]

In *effective* therapeutic relationships, participants felt accepted as an individual rather than a diagnostic category (ie not just another Borderline Personality Disorder diagnosis). Feeling acknowledged and listened to facilitated and promoted trust in their health professional.

> 'It's important for me to be who I am in the relations with people around me, and [for them to] still love me, still care about me, even if I'm in my pyjamas with my hair wet.' [Female, 33 years]

Table 1. Interview questions

1. What are your first memories of self-harming?
2. Can you tell me about the reasons you began to self-harm?
3. Can you tell me about the support you received [if any] before starting to self-harm?
4. Can you tell me of any changes to the relationships you had once you started to self-harm?
5. Do you feel you receive enough support to help you manage your self-harm urges?
6. How would you describe a positive relationship?
7. What do you believe you need from those around you to help you cope with your self-harm urges?
8. What prevents you from seeking help before you self-harm?
9. Can you describe the difference between times when you seek help and choose not to self-harm and those times when you seek help but do self-harm?

The following excerpt illustrates the negative impact that not being listened to can have on the development of an effective therapeutic relationship.

> 'They did a lot of talking and they never listened, especially my psychiatrist… I can remember many instances where I'd say, 'I feel like this', and she'd go, 'no, no, no you don't, you feel like this'. And completely flip it around because that didn't fit in with her little 15 min slot for me.' [Female, 21 years]

Participants acknowledged that health professionals had distinct roles. While listening was important, so was the need for non-judgmental, compassionate professionalism.

> 'I think it's because it's a different relationship you have with your counsellor than what you have with, say your psychiatrist. You get a lot closer and…. if you want to do the work you have to learn how to trust them. From there you build an amazing relationship. For me, [my counsellor] knows 99% of my life. She's here every week, she cares, yeah.' [Female, 33 years]

As these excerpts illustrate, participants were often ambivalent about their engagement with mental health professionals. The most effective therapeutic relationships they described were the relationships they enjoyed with psychiatric nurses and counsellors. In the quote directly above, this participant knows her counsellor genuinely cares about her as an individual. She also suggests that trust is a prerequisite for 'doing the work'. The therapeutic efficacy of counselling was described as variable, and was associated with the level of commitment to the relationship that both participant and counsellor had.

Authenticity

Over and above clinical competence, participants needed the health professionals they interacted with to be authentic. This meant being honest about the impact of providing care to someone who had self-harmed; whether positive or negative. This required that health professionals revealed themselves to participants. Participants indicated that this provided a kind of reality check and was strongly linked to being acknowledged as an individual.

> 'Nurses don't tell you how horrible it was to have to put a femoral line in a girl who had just taken some sort of overdose of 'XYZ'. You know, like you don't get that feedback, because that's not the way that the system works.' [Female, 32 years]

Participants did not expect non-psychiatric health professionals to address their mental health issues. However, they needed all health professionals with whom they interacted to recognise and acknowledge that they were unwell; this acknowledgment was crucial to building relationships in care, and for patients to accept and be comfortable in receiving that care.

Relationship-centred care

Many participants commented on the importance of relationship-centred care, suggesting that this approach made authentic relationships possible with their therapists. Some reflected on the tensions between clinical detachment and their need to be recognised as individuals.

> 'It's so confusing and conflicting because on one hand, it's like I want these professional people to think of me as a person, outside of my own self. On the other hand, I'm like, 'I'm going to come and see you because you are able to think of me objectively, just as my own'. You know?' [Female, 32 years]

As an example of relationship-centred care, participants tended to view their relationships with counsellors as reciprocal, and felt that their counsellors 'cared' about them as individuals. The following quote illustrates the way that being challenged by counsellors is acceptable because it occurs within a genuine caring relationship.

> 'It's just making you talk, and think, and challenge. She [counsellor] challenges very subtly. It's professional, but there is much more of a… yeah, I was going to say caring, nurturing, and caring. There is concern there.' [Male, 66 years]

Participants appreciated the accessibility afforded by the more flexible professional boundaries of their relationships with counsellors, but at the same time being cautious not to abuse or overstep these. This also illustrated the importance of these therapeutic relationships in modelling healthy relationships in general.

> 'If things get really really, 'oh my gosh I can't do this anymore', I can send her [counsellor] a text on her work phone and she will respond within 20 min to half an hour… I understand that there's still boundaries. There is still that counsellor-patient role. But, yeah, she definitely holds a very special place to me, more than just a counsellor would. She's hugely important.' [Female, 33 years]

This participant described drawing on her counsellor's flexible professional boundaries only when she had taxed her own ability to manage herself. She trusted her counsellor would respond because the relationship was authentic and the counsellor genuinely cared for her welfare.

Discussion

Why individuals indulge in self-harm behaviours is a complex problem. There is no 'one-size-fits-all' to explain why people self-harm, just as there is no 'one-size-fits-all' to the solution.[2,4] Turp's description of self-harm as multifaceted and emotionally provocative incorporates elements not usually associated with self-harm because it considers the relationship of the act with the wider social and societal impact, acknowledging that self-harm has a substantial and often sustained impact on people around an individual who self-harms.[15] In relating to others, people who self-harm often demonstrate an expectation that they will be harmed, exploited and let down, and the research indicates they continually observe for evidential signs that they are about to be abused or rejected.[16]

Attitudes held by clinical staff towards people who self-harm are highly likely to influence their clinical practice and the experiences and outcomes of patients.[6,7] In most studies that examined attitudes of staff towards people who self-harm, general hospital staff expressed negative attitudes including irritation and anger.[6] Yet half of all staff in a UK study also reported feelings of sympathy towards self-harm patients,[17] perhaps indicating that as knowledge and understanding of self-harm increases, negativity towards individuals who self-harm decreases, illustrating the importance of training about self-harm for both health professionals and patients.[8]

While there is a role for all levels of emergency and general medical services in the care of people who self-harm, self-harm should be regarded as a long-term health condition with support services and interventions configured from within general practice.[18] GPs and community nurses can use their existing long-term relationships with patients and families to build trust, which our research suggests might be advantageous in managing and inhibiting self-harm behaviours. Our findings also support previous research suggesting that people who self-harm want to be seen by empathic health professionals who are able to listen, be supportive and non-judgmental.[19] While people who self-harm do not expect an ongoing therapeutic relationship with every health professional they encounter, they do want to be treated with respect.

Given the modest scope of our study, we can offer no comment on the utility or efficacy of contemporary approaches to treating and managing deliberate self-harm. However, like previous research,[20] our study indicates that specialist health or mental health services are not perceived as particularly effective in supporting people to cease deliberately self-harming. Our findings support other studies that have found that counsellors are highly valued by people who self-harm, and that once some confidence in the relationship occurred, counsellors were able to challenge their clients' self-harm behaviours.[9] Within these relationships, participants felt acknowledged as individuals, as well as genuinely and authentically cared for.

Relaxation of the professional structured boundaries of access, availability and contact, were beneficial to participants' healing journeys, and were also considered to validate their trust in their health professional. The relaxation of professional boundaries, particularly clinical

detachment, frequently resulted in a therapeutic connection beyond standardised treatment regimens and represented a turning point for many of our participants. The emotional investment made by health professionals in these relationships was empowering for participants because they felt that they really mattered as persons to someone else, and were not alone in their journey. These relationships were viewed as authentic, in that both parties were honest and revealing of themselves; that is, vulnerable to some extent, and perceived as mutually enriching or beneficial.

Therapeutic relationships between patients and health practitioners are bounded to ensure both parties' safety, and to decrease the potential for transference and counter-transference. Within the interpersonal context, boundaries suggest a 'psychological space' or distance between individuals, one that is often used to emphasise the clinician's stance of neutrality and objectivity. Breaching of professional boundaries generally refers to actions by patient, clinician or both, that violate the limits of the therapeutic relationship.[21,22] Carer or compassion fatigue can also result from breaches to the professional boundaries of the therapeutic relationship.[23] However, some have argued that traditional methods of setting limits and defining boundaries in patient care are no longer convincing.[13,16]

How is it possible for GPs and health professionals to balance professional boundaries with the kind of relationship that provides functional social support for people who deliberately self-harm? All health care depends on the quality of relationships between health professionals and their patients, and among health professionals.[13] The relationship-centred care model explicitly acknowledges the centrality and quality of the therapeutic relationship. As a framework, it incorporates elements described by our participants as functional social supports: acknowledging personhood and individuality; being reciprocal in terms of emotional investment, respect, trust and empathy; and based on moral values of partnership, honesty and authenticity. Like other functional and healthy relationships, a relationship-centred approach to care is oriented around clear and open communication and dialogue, where each party is open to the world-view of the other party and able to express themselves.[13] Healthy relationships are safe spaces, free from manipulative or abusive behaviour. Being able to re-negotiate relationship boundaries and to manage conflict are also features of healthy relationships.

We are not advocating for the demolition of professional boundaries, rather that they accommodate relationship-centred care where health professionals can develop therapeutic friendships with patients they believe would benefit from this sort of relationship. Anecdotal evidence suggests that health professionals already enjoy such relationships with patients, particularly in smaller communities. These authentic therapeutic relationships may be the key to more effective management of self-harm patients by community health professionals.

Limitations

The key limitation of our study is its small scope. Our participants were demographically dissimilar, the uniting principle being their history of deliberate self-harm and the fact that they had not self-harmed for at least 2 years before participating in this study. While we are uncertain as to whether we reached data saturation, there was a striking similarity in the stories participants told and in their descriptions of the impact of functional social supports on diminishing their desire to deliberately self-harm. While we make no claim to representativeness and generalisability, our findings contribute to what is already known in the field of self-harm, offering another potentially useful tool to assist in the management of this condition.

Conclusion

Therapeutic relationships are complex and multifaceted, but relationships comprising non-judgmental caring, listening, empathy, authenticity, and equity are beneficial to patients. Our study suggests that functional social supports can inhibit the desire to harm for people who have relied upon self-harm behaviours. People who self-harm need their health professionals to possess appropriate

clinical competencies, while also acknowledging them as individuals and being authentic. This may require health professionals to practice relationship-centred care with patients who self-harm. This is particularly relevant to GPs and community health professionals who have long-term relationships with their patients.

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COMPETING INTERESTS
The authors declare no competing interests.