

National Self-Injury Awareness Day

March 1, 2002

Information for emergency-room personnel

Emergency-room personnel and self-injury

ER staff often have difficulty understanding self-injurious behavior because they experience it as series of discrete events rather than in the context of the patient's psychological capacities and array of coping mechanisms. Most conditions requiring emergency treatment don't need a great deal of context -- a doctor doesn't need too much background information to treat someone injured in an auto accident, for instance.

In the case of self-inflicted violence, however, effective emergency treatment hinges on understanding the injury as an attempt by the patient to cope with a problem. Self-injury is rarely a random act; people who habitually hurt themselves do it for reasons that make sense to them. Admitting to yourself that you don't understand and allowing the patient to help you gain understanding can be key to providing effective help (Zila & Kiselica, 2001).

Why does it matter that you understand? Lack of understanding often results in harsh or punitive treatment of self-inflicted injuries, eventually leading self-injurers to avoid medical intervention until wounds that might have responded well to immediate treatment become life threatening. People who present at an emergency room with self-inflicted injuries deserve the same level of competent, respectful care provided any other ER patient.

Guiding principles for ER personnel treating repetitive self-injurers

Treating a patient who has harmed himself is frustrating, particularly if you have seen him several times in the past for similar complaints. You may feel helpless because nothing you do seems to prevent recurrences. It doesn't help that you don't have a lot of time, do have to consider legal liability, and may be dealing with a person in crisis who doesn't really understand his behavior, either. On top of that, your patient may have been badly treated in ERs in the past and see you as a potential enemy.

Deiter, Nicholls, & Pearlman (2000) present four guiding principles for emergency workers who treat self-injurers:

1. Return control, as much as possible to the individual
2. Help the patient determine self-capacities (strengths and resources)
3. Help the patient brainstorm short-term coping for the current crisis
4. Link the self-injury to a precipitating event

Return control, as much as possible, to the individual

- Treat the patient with respect. Avoid judgmental attitudes; although it may seem logical that making the ER experience as unpleasant as possible will lead the patient to avoid future self-harm, it is actually likely to result in anger and shame, feelings that in turn can result in more self-harm.
- Give the patient as much information as you can.
 - o Each caregiver should explain who they are, what they are going to do, and why it is necessary.
 - o Offer the patient choices wherever practical.

- o Discuss the patient's beliefs and anxieties about possible outcomes of this ER visit.
- o Talk to the patient about possible consequences of this visit. Listen to her fears and answer questions honestly.
- Check with the patient about her level of comfort with the immediate physical surroundings; if simple changes (a quieter room, more privacy, etc.) would increase her level of security, make them. Some patients may bring an ER checklist with them; try to respect their expressed wishes about their treatment.
- If it is impossible to comply with patient requests, explain why.
- Let the patient know that you are a friendly ally and are trying to act in her best interests. "For example, you might explain that you are acting temporarily as an advocate for the safety of the client's body" (Deiter, Nicholls, & Pearlman 2000).

Help the patient determine his strengths and resources and help him develop options for coping in the current crisis

- Explore support systems and help him evoke images of supportive people or calming objects.
- Help him talk about the feelings behind the self-injurious act and about other ways to cope with those feelings. Self-soothing and tension-reducing strategies may be most helpful in the short term (Deiter, Nicholls, & Pearlman, 2000).
- Brainstorm with the patient about what things he has found soothing or tension-reducing in the past and about what might be helpful now.
 - o Self-soothing techniques might include things like:
 - listening to soothing music
 - taking a hot bath
 - wrapping up tightly in a blanket
 - talking to supportive people
 - sipping hot drinks
 - o Some ideas for tension-reducing activities are:
 - tearing up paper or phone books
 - beating on pillows
 - punching a bag
 - throwing water balloons in the bathtub
 - screaming
 - crying
 - physical exercise
 - tearing up cloth

These techniques are not meant to be long-term solutions to the patient's problems; they are tools for making the present moment bearable. Asking the patient, "what could you have done instead? What might help next time you feel this way?" and brainstorming possible answers helps him realize that harming himself is not his only option for coping with overwhelming feelings. Deiter, Nicholls, & Pearlman observe:

In crisis, the goal is to find some way to feel a little better, even for just a little while. This is a familiar goal for self-injuring individuals. What is unfamiliar is using multiple self-care strategies to achieve it instead of achieving it through self-injury. (2000)

Exploring these strategies with the patient may help him choose other ways of coping in a future crisis.

- Help the patient identify positive things about himself, regardless of how small or insignificant they may seem. Even if it's something as simple as, "I take good care of my

cat," focusing on positives can help the patient see himself as a good, or at least not irredeemably bad, person.

Link the current self-harm to a clear precipitating event

Recognizing the act of self-harm as a choice made in response to specific events (internal or external) provides context and meaning to something the patient might consider crazy or out-of-control. By exploring the antecedents of the self-injurious act, you allow the patient to reclaim it as a coping choice she made. Asking detailed questions about what exactly was going on before the patient hurt herself and when the choice to self-harm became inevitable help her in this task. Even if the client continues to believe that the act had no cause or meaning, it is important to point out that this particular act is different because it led to this encounter (Deiter, Nicholls, & Pearlman, 2000):

The client and provider must take it seriously . . . avoiding the temptation to dismiss it as only part of an ongoing pattern. The client has created a new interpersonal reality, one that allows for the possibility of change.

Suicide and self-harm

Self-injury differs distinctly from attempted suicide, and in fact is often a means of suicide prevention (Zila & Kiselica, 2001; Deiter, Nicholls, & Pearlman, 2000; Connors, 1996; Suyemoto, 1998; Crowe & Bunclark, 2000; Solomon & Farrand, 1996; Guralinik & Simeon, 2001). Many practitioners assume that "the alternative to self-injury is 'acting normally,' but on the contrary [to the self-injurer it is] total loss of control and possibly suicide. [Self-injury] becomes a forced choice from among limited options" (Solomon & Farrand, 1996). At the same time, people who resort to self-harm can be profoundly suicidal. Careful assessment of suicidal risk is crucial. Self-harm by itself is not sufficient cause for admittance to a psychiatric ward; the ER practitioner should perform a careful assessment of suicidal ideation. Can the client articulate the intent of his self-harming action? If he admits to suicidal ideation, does he distinguish the self-injurious behavior from those feelings? These sorts of questions should be considered when determining whether a self-inflicted wound resulted from a desire to die.

Self-care for those who treat self-harming clients

Caring for people who habitually harm themselves can be draining and frustrating. Self-harm often elicits fear, anger, revulsion, disgust, and a host of other negative emotions. As a professional, it is your duty to refrain from expressing these feelings to your patients, but it is important that you find a supportive peer or supervisor with whom you can discuss your reactions to self-injurious behavior. If you are overwhelmed by a specific situation and unable to remain compassionate and nonjudgmental, remove yourself from that situation if at all possible. Educate yourself about self-injury; Deiter, Nicholls, and Pearlman's 2000 paper in the *Journal of Clinical Psychology* is an excellent starting point, and Babiker & Arnold's *The language of Injury* is a valuable sourcebook for clinicians.

When someone presents in your ER with a self-inflicted injury, you have a unique opportunity: you can help her begin to put her self-harming behavior in perspective and to see herself as capable of making other choices. You stand with her at a potential turning point. My hope is that you can use the information here to help make a real and lasting change in her life.

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