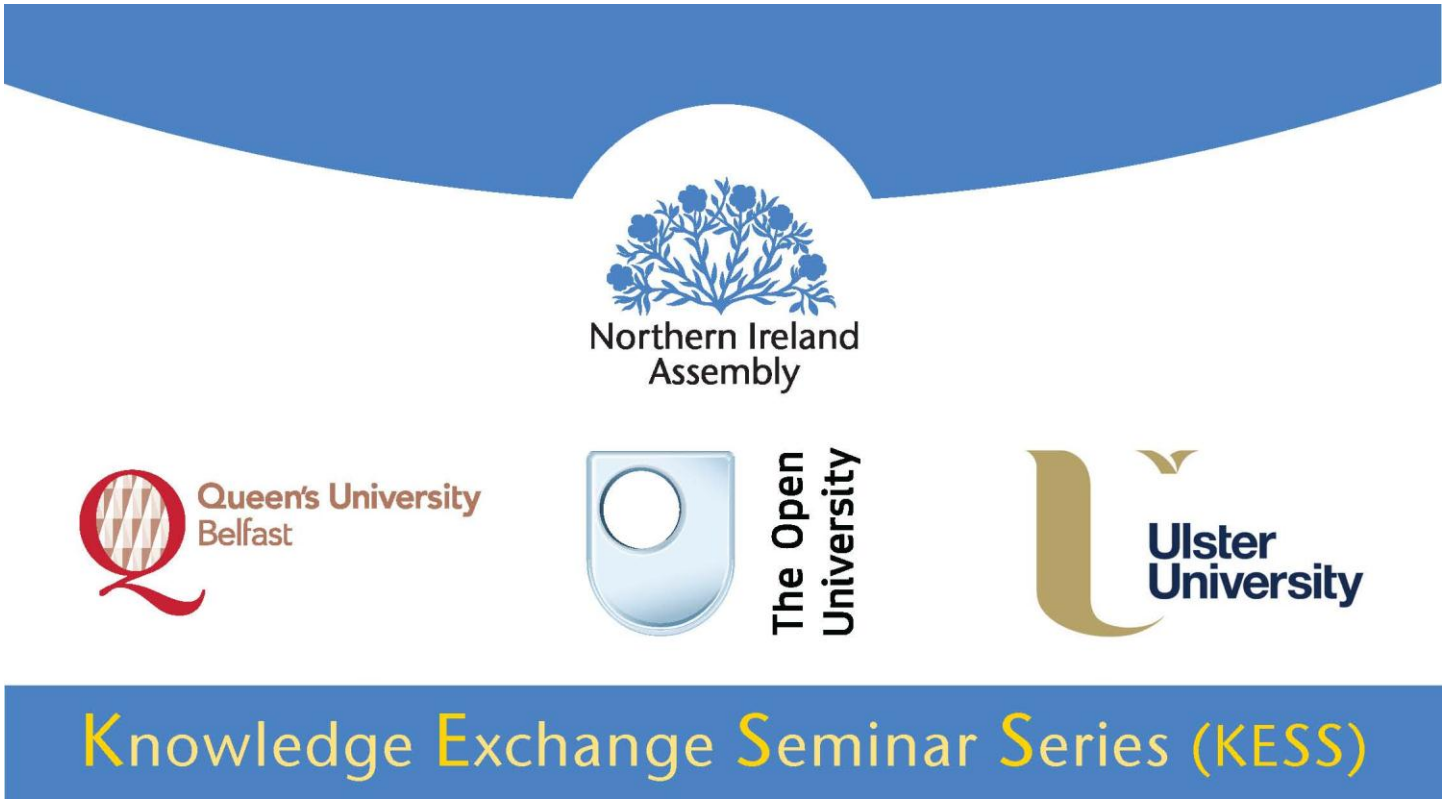

Self-harm and Help Seeking: Service User and Practitioner Perspectives

Dr Maggie Long
Institute for Research in Social Sciences (IRiSS)
Ulster University

1. Introduction

This briefing focuses on help seeking among people who self-harm. Self-harm is a significant public health issue and an important risk factor for suicide, about which there a paucity of Northern Ireland-based research. Self-harm is recognised to be considerably more prevalent than is suggested by reported figures based on hospital Emergency Department (ED) presentations. Self-harm is often a hidden behaviour and thus the extent of the phenomenon is unknown. Help seeking is a crucial factor in suicide intervention yet it is a complex and difficult process for people who self-harm. This briefing provides an overview of the context of self-harm in Northern Ireland (NI). Subsequently, the findings from a piece of qualitative research are outlined, which aimed to understand experiences of self-harm and help seeking from the perspectives of people with a history of self-harm and practitioners experienced in working with the behaviour. The findings focus on data collected from one-to-one interviews with participants (n=30) recruited at a community level, independent of statutory services, to gain insight into hidden self-harm. Key findings are presented, which provide understanding about barriers to help seeking and experiences of help seeking from both informal networks and formal services. The briefing concludes by suggesting practical recommendations to improve understanding of self-harm and enhance service provision.

2. Context of Self-harm in Northern Ireland

Self-harm is a significant public health issue regionally, nationally and internationally. It is widely accepted that self-harm is a major risk factor for suicide. Between 40% and 60% of people who die by suicide have a history of self-harm (Hawton et al., 2006). The Self-harm Registry was established in NI in 2007, initially piloted in the Western Trust area between 2007 and 2009, and subsequently rolled out across the region, as a response to the suicide prevention strategy (Department of Health, Social Services and Public Safety: Northern Ireland (DHSSPSNI), 2006). The Registry measures self-harm ED presentations across NI on an annual basis and is based on the methods used by the National Suicide Research Foundation in the Republic of Ireland (ROI). The most recently published statistics from the NI Registry demonstrate that in 2012/13 there were 8,279 ED presentations involving 5,970 people (DHSSPSNI, 2013). Moreover, comparative research on the Registries used in both NI and the ROI indicates that a higher incidence of self-harm by intentional drug overdose is reported in NI than in the ROI (Griffin et al., 2014).

While the Registry provides important data on the nature of ED presentations, these reported incidents far under-estimate the accurate extent of self-harm in NI. The “iceberg” of suicide and self-harm has been proposed (McMahon et al., 2014), which portrays the tip of the iceberg as the visible though infrequent occurrence of death by suicide, just below the surface and less visible is reported incidence of self-harm captured by the self-harm registry and well below this at the base are the very common, unreported, hidden self-harm behaviours. In the ROI, it has been estimated that there are approximately 60,000 cases of hidden self-harm per year in comparison with the 11,000 hospital ED presentations (National Suicide Research Foundation, 2013). These estimates clearly evidence the extent of the discrepancy between hidden self-harm and reported self-harm. However no comparable evidence exists for NI, which means the nature and extent of hidden self-harm has for the most part fallen beneath the radar of policy makers and service providers.

It has been suggested that school-based and community-based research studies are the most effective methods of gaining insight into the phenomenon of hidden self-harm. In NI, the NI Young Life and Times Survey (Schubotz, 2009) and the NI Lifestyle and Coping Survey (O’Connor, Rasmussen & Hawton, 2014) were carried out with school pupils aged 15-16 years. Both surveys reported that 1 in 10 young people had self-harmed on at least one occasion during their lifetime. While this rate is lower than in England and Scotland, O’Connor et al. (2014) postulate the figure might indicate that young people in NI are less likely to disclose sensitive personal information, a possible intergenerational consequence of the “Troubles” (Muldoon, 2004; Muldoon et al., 2007). Community-based studies on self-harm in NI are scarce. The subject is clearly sensitive and access to community populations who self-harm is difficult. The research on which this briefing is based was designed to make a significant contribution to understanding of hidden self-harm in NI by locating the research at a community level.

Participants were recruited at a community level, outside of statutory services, by advertising in community services and third level education. One-to-one interviews were carried out with 10 people who had a history of self-harm but were no longer engaging in self-harm at the time of research participation. In addition, a further 20 one-to-one interviews were carried out with participants who worked at a community level in a range of roles, to discuss their experiences of responding to self-harm disclosures and working with people who self-harm. It was determined that practitioners from the community sector would have experience of working with a wider range of people who self-harm including those people who never present to hospital.

3. Findings

3.1 Barriers to Help Seeking

Barriers to help seeking included external barriers such as stigma and internal barriers such as fear. Furthermore, the functions of self-harm as a coping mechanism, method of communication or means of control strengthened existing internal barriers to help seeking. The barriers interact in a complex way, whereby a person internalises the external stigma, subsequently leading to a sense of confusion and self-doubt.

Participants highlighted the level of misunderstanding in society about self-harm and the impact this misunderstanding has in preventing people from asking for help:

> People don't understand what self-harm is, they just think it's either a cry for help or just some kind of psychiatric disorder; they don't see it as a manifestation, I suppose, of other things that are going on really. I think really there is an ignorance around it, and that would stop people going for help (Service User).

Participants related that misunderstanding from others when people do seek help or disclose self-harm, can feed into an existent cycle of shame and cause the person to regress further into his or her self-harm. Social stigma leads to self-stigma whereby the person internalises the negative judgments of others and accepts the pejorative view to be legitimate. This finding is particularly damaging for people who self-harm, who are already struggling with issues of self-derogation and shame. These feelings, in turn, can contribute to feelings of fear about help seeking and in particular the reactions of other people.

The findings showed that self-harm enabled the participants to cope with painful life experiences and emotional distress. Self-harm helped when no other outlets were available and accordingly represented a fundamental impediment to seeking external support in foregoing this, albeit maladaptive, coping mechanism.

> I know for myself there was definitely large periods of time where I didn't want help because I didn't want to stop cutting because it, it made things feel better, so why would I stop doing the one thing that made me feel better, and I really resented attempts to get me to stop cutting because I felt like they were taking away the one thing that was a release, an outlet for me and I had no other way (Service User).

Practitioners who worked with people who self-harm suggested that because self-harm is a means of communicating distress for people who struggle to verbally articulate their feelings, which can be a consequence of trauma, it is difficult to seek help because seeking help demands the verbal expression of issues and needs:

> Well I would say the groups that I would work with would be a lot of men, old and young, that I would deal with who have self-harmed. And I think a lot of that comes from "big boys don't cry". They don't know how to express their emotions, they don't know how to talk through things, it's almost like they're imploding on themselves with this self-harming (Counsellor).

Promoting understanding that self-harm communicates severe distress offers the potential to improve responses to self-harm presentations and disclosures in statutory and community services.

3.2 Experiences of Help Seeking

Participants described experiences of help seeking from both formal statutory services and informal support networks. Experiences of formal help seeking included; access to statutory health services for immediate first aid, medical, psychiatric or social care and on-going support. There was a range of motivations for help seeking; some experiences were a deliberate choice initiated by the person the result of an emergency situation or discovery by others. A number of participants sought help only when their self-harm intensified to serious levels and they reached crisis point, either feeling suicidal or making an actual attempt to end their own lives.

> I'm still not sure myself in my head whether it was a suicide attempt or whether it was self-harm . . . and I went out to the kitchen and I slit my wrist, and em, was taken to hospital . . . eh because at that point I did want to die, I wasn't thinking about anything else and I couldn't even feel myself, I couldn't even, it wasn't sore (Service User).

Participants explained that their choice to disclose self-harm was taken carefully. We found that because self-harm is a hidden behaviour, used to cope in difficult circumstances, people often feel reluctant to confide in others. Indeed, the participants reflected on feelings of fear about the repercussions if their private behaviour became public knowledge. We found that friends provided an invaluable source of support in the person's informal social networks and were often confided in more than family, among participants across the age ranges. Moreover, participants indicated that the help-seeking process is more effective if the decision to seek help is taken autonomously. Being obliged to access help before the person is ready was recognised to be counter-productive by service users and practitioners.

Participants reported seeking help from a range of formal, statutory services including; social workers, GPs, health centres and hospital EDs. Some of those who sought help from statutory health services described feeling as though they were treated without compassion or regard for their humanity, "not a person but a case." These findings included reports of delayed treatment and lack of follow-up care, which led to subsequent and more severe episodes of self-harm and even suicide attempts. From personal experiences, one participant concluded that a failure to offer follow-up care means that people are left vulnerable, possibly leading to more serious levels of self-harm or suicide:

> I've been to A&E a few times myself, with things directly related to self-injury and . . . It's sorta like, "aw never mind the underlying problems, stitch you up and you're on your way, see ya later" . . . you get let out into the nowhere . . . and I think that's how a lot of people get into a very bad way, where suicide becomes a very big thing (Service User).

The findings reported that when people present to EDs in a vulnerable mental state, they might not be emotionally equipped to take advantage of the services offered. One service user reflected on her attendance at the local ED following a suicide attempt: "the things that I had said to cover up how I was really feeling, I was suicidal, I did need care." This finding is particularly concerning because people who refuse help following a suicide attempt are at significantly higher risk of subsequent completed suicide. Our findings showed that self-harm often represents a person's efforts to cope rather than an attempt to end his or her life. However, our study has demonstrated that an increase in the intensity of the behavior coupled with a lack of appropriate support from either informal social networks or formal treatment services can lead to suicidal crisis. Thus, we would suggest that a

presentation to ED provides an opportune moment to identify those people who are most vulnerable, in need of immediate psychological support, and in crisis are conducive to change.

4. Conclusions and Recommendations

It has been argued in this seminar series that the recent increase in the suicide rate in NI could be recognised as a public health crisis (Mallon & Galway, 2015). Self-harm is a major risk factor for suicide and as such it is imperative to develop understanding of self-harm and interventions for self-harm in NI. Moreover, the findings of the current study demonstrate that similar to other contexts, service provision could be enhanced to more appropriately respond to the needs of people who self-harm. We propose the following recommendations based on the findings of this research and existing evidence.

There is a need for dedicated self-harm awareness training for staff at all levels, across sectors who respond to self-harm disclosures and presentations. This type of intervention has been proven to be effective in the ROI, whereby self-harm awareness training delivered to front line staff in the Health Service Executive was reported to improve staff attitudes and clinical confidence (National Office for Suicide Prevention, 2012). Training programmes that promote understanding of self-harm could enhance service responses and thus support more effective help seeking behaviours among people who self-harm. Additionally, the findings support a need for emotional support for practitioners working with self-harm on a repeated basis. Reports of service users feeling they are "treated like cases" could be indicative of depersonalisation, which is a sign of burnout. Thus, we suggest that therapeutic supervision could help to mediate the effects of prolonged exposure to crisis including burnout, vicarious trauma and secondary trauma. Both components of this recommendation are supported by a systematic review of staff attitudes towards self-harm, which found that training and support for practitioners working with self-harm could help to improve staff attitudes and patient care (Saunders et al., 2011).

The findings suggest that the provision of pastoral care or emotional support in EDs when a person presents with self-harm or attempted suicide could provide a crucial intervention at the time when the person is most vulnerable. The provision of pastoral care in EDs could be provided by services in the third sector. Furthermore, we suggest that there would be merits to a cross-sector, interdisciplinary approach to follow-up care. Pastoral support in EDs alongside medical treatment and the potential for follow-up care outside of statutory services could enhance the uptake of follow-up care, and thus enable more people who self-harm to have a positive help seeking experience and potentially overcome self-harm. There is evidence that a similar intervention is being implemented in Scotland, in line with the Mental Health Strategy for Scotland 2012-2015. The Distress Brief Intervention (DBI) has been designed for people presenting in distress, who are not at immediate bodily risk but the emotional component of their presentation would indicate the potential for future risk. The DBI is a cross-sector initiative, which involves pro-active follow-up care, led by the third sector.

Lastly, statistics on self-harm in Northern Ireland are limited because they are based more broadly on self-harm hospital presentations, reflecting only reported incidents and thus underestimating the prevalence. Therefore, there is a call for a quantitative study to provide a more accurate estimate of the population prevalence of self-harm in NI to more appropriately inform policy. This type of research could facilitate an evidence-based estimate, similar to that provided by the National Suicide Research Foundation in ROI. Ideas could be derived from population prevalence estimates carried

out in past research on sensitive issues including non-suicidal self-injury (Klonsky et al., 2013) and posttraumatic stress disorder (Muldoon & Downes, 2007).

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