Self-harm: from risk management to relational and recovery-oriented care

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Abstract
Purpose – The purpose of this paper is to examine the discourses that shape nurses’ understanding of self-harm and explore strategies for working with people who self-harm in a relational and a recovery-oriented manner.

Design/methodology/approach – Self-harm is a relatively common experience for a cohort of people who present to the mental health services and is, therefore, a phenomenon that mental health nurses will be familiar with. Traditionally, however, mental health nurses’ responses to people who self-harm have been largely framed by a risk adverse and biomedical discourse which positions self-harm as a “symptom” of a diagnosed mental illness, most often borderline personality disorder.

Findings – This has led to the development of largely unhelpful strategies to eliminate self-harm, often in the absence of real therapeutic engagement, which can have negative outcomes for the person. Attitudes towards those who self-harm amongst mental health nurses can also be problematic, particularly when those who hurt themselves are perceived to be attention seeking and beyond help. This, in turn, has a negative impact on treatment outcomes and future help-seeking intentions.

Research limitations/implications – Despite some deficiencies in how mental health nurses respond to people who self-harm, it is widely recognised that they have an important role to play in self-harm prevention reduction and harm minimisation.

Practical implications – By moving the focus of practice away from the traditional concept of “risk” towards co-constructed collaborative safety planning, mental health nurses can respond in a more embodied individualised and sensitive manner to those who self-harm.

Originality/value – This paper adds further knowledge and understanding to assist nurses’ understanding and working with people who self-harm in a relational and a recovery-oriented manner.

Keywords Engagement, Risk, Self-harm, Recovery

Paper type Conceptual paper

Introduction
Contemporary mental health policies articulate the need for services to be driven by the principles of quality and safety (Higgins et al., 2016). In the context of safety and risk, self-harm has become a major health issue and a cause of concern internationally (Fleischmann and Shekhar, 2013). Mental health nurses are at the frontline of service provision and are likely to encounter in almost every practice setting people who may have thoughts of self-harming and/or engaged in self-harming behaviour. They are therefore in a pivotal position to utilise their knowledge and skills to support people who present with self-harm and as such have an important role to play in self-harm prevention, reduction and harm minimisation. People who self-harm experience many needs and challenges related to their emotional distress. A positive and open attitude by nurses is critical, if they are to engage with the person in a manner that supports and promotes the person’s safety and recovery (Morrissey, 2015). However, how nurses conceptualise and think about self-harm strongly influences their action, interactions and the strategies they use to support people (Higgins et al., 2015), which in turn impacts on the person’s treatment, recovery and safety outcomes. This paper aims to examine the discourses that shape nurses’ understanding of self-harm and explores strategies for working with people who self-harm in a relational and recovery-oriented way.
Exploring terminology surrounding self-harm

Language is not a neutral vehicle of expression, but has the potential to shape thoughts, emotions and behaviours and can restrict or expand our understanding of the world (Watts and Higgins, 2017). Over the years, clinicians and researchers have struggled to gain consensus about the language and terminology used to describe self-harm in an effort to be more sensitive to those who engage in self-harming behaviours (Turp, 1999). In some areas of practice and research, different terms to describe self-harm still persist such as deliberate self-harm (DSH), self-injury, non-suicidal self-injury (NSSI) and suicide attempt (Silverman, 2016; Inckle, 2017). However, as understanding around self-harm has gradually increased over the past few decades; the terminology used to describe it has also evolved (Doyle et al., 2017). Terms such as “attempted suicide” and “parasuicide” have been dropped in recognition that many acts of self-harm have little or no suicidal intent (Silverman, 2006). These terms went on to be replaced by “DSH”; however, the use of this term has been criticised for its insensitivity and pejorative, accusatory overtones (Pembroke, 1996; Silverman, 2006; Inckle, 2010). Most current practice and research now focus around two main terms: those of “self-harm” and “NSSI”. The term self-harm is favoured throughout Europe and Australia and is used to describe self-injury that does not lead to death, irrespective of suicidal intent (Silverman, 2016). NSSI is the term favoured in the USA and refers to the direct, intentional destruction of body tissue without intent to die (Nock, 2009). Notwithstanding the different meanings, the terms self-injury and self-harm both share a common connection, that is, they each refer to some degree of harmfulness to the body.

Suicide and self-harm are often conflated in the literature and clinical practice. Although some writers are critical when self-harm and suicidality are considered as merely different points of a continuum of lethality (Turp, 2003; Cutcliffe and Stevenson, 2007), they also acknowledge that the line between suicidal and non-suicidal behaviour is often blurred. Self-harm can have a relationship with suicidal potential, particularly in the context of risk factors. Therefore, knowing the presence or absence of intent to die is essential to distinguish a suicide attempt from self-harm (Ploderl et al., 2011); however, differentiating between forms of self-harm and suicidal behaviour is not always easy as each person may have complex and individual reasons for self-harming and might not always be aware of their reasons for self-harming and be ambivalent about their intent to live/die.

It is important for mental health nurses to reflect on the underlying assumptions and meaning of the language they use to describe self-harm and consider how language shapes thinking and in turn, their behaviour within practice, including their approach to risk. The language used to discuss risk is equally important. While the language of risk, risk assessment and risk management dominates the policy and clinical practice culture, risk language may alienate people who self-harm as many may prefer to speak of personal safety and ways of keeping and promoting their safety (Higgins et al., 2016).

Self-harm

Self-harm is fundamentally an embodied experience; it is physical, psychological, emotional social and symbolic, which has meaning, purpose and function at all of these levels (Inckle, 2017). The act of self-harming may present in various ways ranging from the highly visible and public to the virtually innocuous invisible and private (Turp, 2003). Self-harm methods differ significantly between community populations and what is termed “clinical” populations. In community studies, which are predominately school-based studies of self-harm, cutting is the most common method of self-harm followed by overdose (Madge et al., 2011; Doyle et al., 2015). In “clinical” populations, which are largely measured by assessing those presenting to the emergency department for treatment, there is a reversal of this trend with people who overdose presenting as the main method followed by people who engage in cutting (Hawton et al., 2015; Griffin et al., 2016). The most common forms of self-cutting include cutting the arms and hands, sometimes the legs and less commonly the face. Other ways in which people injure themselves include scratching, biting, picking and occasionally inserting sharp objects under the skin. Less common forms include tying ligatures, pulling out one’s hair and scrubbing oneself so hard (sometimes using cleansers such as bleach) as to cause...
Self-harm – nurses’ responses

Self-harm is multifaceted, complex and emotionally challenging, and produces a wide range of beliefs, feelings and responses from practitioners, which are likely to be present in their therapeutic interactions (Reeves, 2013). Considerable evidence suggests that people who have experience of self-harm often get a mixed response from practitioners (Pembroke, 1996; Shaw and Shaw, 2007; Inckle, 2010), with negative stereotyped attitudes prevailing (Thompson et al., 2008). Consequently, people who seek support report feeling criticised, blamed, rejected or having their self-harm minimised by the use of pejorative terms and labels such as “cutters”, “attention seeking”, “manipulative” or “personality disorder” (Babiker and Arnold, 1997; Inckle, 2017). Negative or hostile responses by mental health nurses can cause the person to feel that the nurse is uncommitted, unsympathetic and uncaring (Thompson et al., 2008). In addition, negative attitudes and stigma associated with self-harm can influence people’s willingness to ask for help or tell people about how they are feeling. Some of these attitudes and response have been shaped by the discourses that have been put forward to explain the aetiology of self-harm. Discourses can be understood as language in action, which provide openings to help us to see and make sense of things (Danaher et al., 2007). Foucault (1975) believed that discursive explanations not only shape our understanding of ourselves, but also affect our views on all things and therefore are impossible to avoid.

Discourses that surround self-harm

In the context of mental health nursing, the biomedical discourse takes a dominant place and shapes how nurses make sense of self-harm and how they respond to and work with people who engage in self-harming behaviour. NSSI is included as a “condition for further study” in the DMS-5 with the potential that it will be considered as a “disorder” in its own right (American Psychiatric Association, 2013). It is also frequently viewed as a symptom of the diagnostic label borderline personality disorder (BPD) (Bowen, 2013). Notwithstanding the possible explanations for this proposed diagnosis, the construction of self-harm as a psychiatric diagnosis and aligned with a diagnosis of BPD raises a number of concerns. First, those who self-harm rarely contextualise their self-harm as a feature of a diagnosed mental illness (Doyle et al., 2017). Second, there is concern at the attempt to classify behaviours as disorders and at the creation of a complete dichotomy between suicidal and NSSI (Kapur et al., 2013). Third, BPD is a diagnosis that has the potential to “alter, damage and even shatter the person’s core sense of self” (Higgins and McBennett, 2007, p. 853). Irrespective of whether nurses view self-harm as a category of mental illness or a symptom of “PD”, by labelling the person, practitioners are stigmatising and marginalising people who self-harm. This is especially problematic when one is endeavouring to encourage people to seek help and support for a behaviour that is usually secretive. Furthermore, by constructing self-harm as a symptom of PD, nurses may view the behaviour through the lens of “attention seeking” and choose to withhold “attention” from people who are in need of attention at critical times in their lives (Carlen and Bengtsson, 2007). Moreover, within an illness model emphasis is placed on the elimination of self-harm behaviours through the use of controlling strategies such as increased surveillance, observation, contracts and behavioural interventions (Cutcliffe and Stevenson, 2007). In keeping with this model of understanding, nurses are positioned as “experts”, who must control the person’s behaviour through risk assessment and risk management strategies. In addition to defining and imposing risk management interventions, they measure outcomes based on the elimination of self-harm behaviours, which may actually result in increased distress for the person involved. Mental health nurses therefore need to examine this discourse and consider how it helps, if at all, with understanding and responding to the person who engages in self-harm.

In challenging the biomedical construction of self-harm, Babiker and Arnold (1997, p. 2) point out that “self-harm is one part of a large repertoire of behaviours that involve the body in the
expression of distress within the individual”. Others point to its complex and multidimensional nature that is imbued with highly personal and purposeful meaning, which may vary at different times and in different contexts (Turp, 2003; Inckle, 2017). There is also a growing body of evidence to suggest that self-harm is associated with a number of traumatic experiences including physical, sexual and emotional abuse, bullying, difficulties in familial relationships, experiencing the self-harm or suicide of others and worries about sexual orientation (Madge et al., 2011; Doyle et al., 2015).

In keeping with the idea of personal meaning, one of the more commonly recognised functions of self-harm is its role in regulating and expressing emotions. This is often framed in terms of providing relief or release of overwhelming or unmanageable feelings (Shore, 1994; Nock and Prinstein, 2005). Allan Shore (1994) proposes the “Self-Regulation Interactive Model” of self-harm, which asserts that the primary, but not only, function of self-harm is regulation of affect. Within this model, people inflict pain on the body in an attempt to emotionally regulate or cope with overwhelming feelings of emotional pain, distress or numbness. Proponents of this view point to the fact that people who self-harm report a range of interpersonal and intrapersonal reasons for the behaviour (Inckle, 2017).

For some, it may help with emotions such as anger, anxiety and frustration by acting as a release for pent up emotional distress and psychological pain (Butler and Malone, 2013). For others, self-harm is a means of coping with a sense of alienation, dissociation or feelings of numbness and emptiness (Turp, 1999, 2003). Self-harm and the associated physical pain can provide psychological relief, albeit temporary, by helping the person to physically feel and give the person a sense of being alive in their body. Moreover, for some people seeing blood being released from the body can also help them to feel calmer, cleansed/purged (Babiker and Arnold, 1997).

Viewed through this discourse, the act of self-harm holds multiple meanings for the person and is a way of coping with intense emotions or feelings of numbness. The person is no longer constructed as a “risk-laden object”, requiring “risk management” strategies but a person in need of sensitive, creative and therapeutic responses (Clancy et al., 2014; Higgins et al., 2016). Rather than withholding attention, the focus is on attending to the person with a view to exploring their story and the meaning they attribute to their self-harm. Emphasis within this view is on relational and personal recovery, a “journey of discovery” where the person develops “personal resourcefulness [...] control, a positive sense of self [...] and rediscovers their voice and a belief in their ability to live a meaningful life, despite the presence of challenges” (Higgins, 2008, p. 7). Thus, mental health nurses move from the position of expert, to collaborator in a quest to explore and co-construct a range of strategies for personal safety and well-being. The focus becomes one of shared responsibility as opposed to compliance and conformity, and the language changes from risk aversion and prevention, to harm minimisation and positive risk taking, which may “[...] involve the person taking on new challenges leading to personal growth and development” (Slade, 2009, p. 177). While recovery is a personal process that belongs to the person who self-harms, practitioners can facilitate that process by providing a recovery relational-oriented approach to care.

A recovery and relational approach to care

A recovery-oriented approach to care has implications for safety planning with people who self-harm. While “risk management” is frequently concerned with restrictions, containment, staff control, organisational protection and taking responsibility for the person, recovery is oriented towards relationships, hope and the provision of opportunities to foster personal control, choice, autonomy and growth (Higgins et al., 2015). Within a recovery approach, safety planning becomes a joint endeavour that requires the nurse to engage in a relational dialogue, and demonstrate a willingness to remain connected with the person “at risk”, while recognising that there are no certainties (Higgins et al., 2015; Reeves, 2015). This next section focuses on guiding principles to help nurses to work with people who self-harm in a more relational manner.

Responding helpfully: relational-based care

A relational approach to care speaks of human engagement and the centrality of the person’s life world in the process of healing and recovery (Higgins and McGowan, 2014). Similar to any
A genuine respectful relationship that is collaborative, compassionate and supportive is essential for working with someone who hurts themselves (Morrissey, 2015). These qualities are essential because for many people who hurt themselves, their formative relationships, as well as previous encounters with practitioners including mental health nurses, may have been negative, damaging and unhelpful; therefore, an extra level of sensitivity is required (Inckle, 2017). The relationship between the person and nurse does not just happen or indeed should not be taken as a given. Instead, it needs to be built with care and “attention” over time, and be based on listening, acceptance, patience and respect. If the nurse wants to develop trust and sustain a supportive and helpful relationship with the person, there is a need for a holistic approach that is underpinned by values of person-centeredness, including collaboration, empowerment and a focus on personal strengths rather than deficits (Davidson et al., 2009).

The person harming themselves needs someone to connect with, particularly at the time when their feelings of distress or alienation are strong. In the context of mental health practice, the person is likely to approach a nurse whom they feel able to connect with. Therefore, providing an open safe and supportive space whereby the person can seek help without fear of judgement or rejection is critical. Each interaction with the person is an opportunity for the nurse to offer support and comfort through skills such as listening, sensitive enquiry and empathy, and a compassionate presence that is respectful of the person’s needs. Moreover, engaging in a supporting relationship requires the nurse to demonstrate a willingness and ability to remain connected with the person throughout the ebb and flow of their distress, self-harming behaviour and recovery.

Carl Rogers’ (1961) person-centred approach believed that if practitioners built relationships based on what he/she referred to as the three core conditions – genuineness, acceptance and empathy, then the people they were attempting to help would begin to understand aspects of themselves that were previously unknown. Consequently, this could help the person become more self-confident and autonomous and better able to cope with their everyday living. Practitioners who are empathic, compassionate and acknowledge and validate the person’s experience and situation are more likely to encourage people who self-harm to disclose more about their concerns, their motivations for harming behaviour, as well as their hopes for the future. Being empathetic requires the nurse to tune into what the person is communicating through their self-harming behaviour and convey their understanding to the person. Notwithstanding this, conveying empathy may be challenging, particularly if the nurse holds negative beliefs and attitudes towards people who self-harm.

Responding helpfully: non-judgemental attitude

Engaging in a discussion about self-harm, risk and safety can be experienced by nurses as challenging and anxiety provoking. Mental health nurses may struggle to understand the reasons underpinning the person’s self-harming behaviour and may find it difficult to respond in a helpful, compassionate and creative way. In addition, witnessing the reoccurrence of self-harm can be very difficult to understand, particularly if the nurse has invested a lot of time with the person and hoped that the self-harming behaviour would cease. Consequently, the practitioner may feel disappointed, frustrated and may find it difficult not to react in a judgemental, critical or even punitive manner. Moreover, in the context of helping, nurses may be exposed to many different beliefs or misconceptions about self-harm, such as self-harm is attention seeking. Such beliefs are often a reflection of a wider societal view and can become embedded within practice. Holding such beliefs is unhelpful and likely to influence how nurses engage and communicate with people who hurt themselves. It is important for nurses to be aware of their own beliefs about self-harm and more importantly, how these beliefs influence their ability to be fully present for the person.

People who self-harm often experience internalised shame and stigma; thus, a key component of a recovery-oriented approach is the constant attention to how self, team and organisational processes can perpetuate stigma. This requires nurses to create a de-stigmatising context by being attentive to the language of self-harm and the manner in which labels and nursing practices may be part of a shaming and stigmatising process. Moving beyond stigmatising labels and behaviours requires the nurse to enquire about the person and their personal story of recovery, separate the person from their behaviour or diagnosis, and create a context wherein the engagement with the person is inclusive.
Responding helpfully: exploring meaning and context

Given that each person’s experience of self-harm and the meaning they ascribe to the action is unique, practitioners require disparate strategies towards assessment as one approach does not fit all. Conducting a risk assessment with the person requires the nurse to be able to demonstrate a willingness and ability to remain connected with the person at risk, while at the same time acknowledge and work with the complexity and non-linearity of the everyday lives of people who self-harm (Reeves, 2015). Traditionally, a technical rational model of risk assessment, underpinned by use of standardised, impersonal questions in the format of a checklist or validated tools have dominated practice. While nominal categories might make for efficiency and provide a paper trail of evidence that a checking process has been carried out, the emphasis on a checklist approach has the potential to erode meaningful engagement with the person who self-harms as well as missing out on the opportunity to help the person to explore his/her experiences and its unique meaning and purpose at that time.

As self-harm is an embodied means of communicating thoughts, feelings and experiences that cannot be represented in any other way (Inckle, 2017), expecting people to relay their distress in a coherent linear narrative that fits neatly within a risk assessment checklist may be counterproductive. Therefore, nurses need to consider the use of more creative and flexible approaches such as writing, art or drama-based strategies to help people explore and express their experiences. Irrespective of what strategies are used, being able to listen with empathy and compassion to people’s experiences is one of the most powerful responses (Morrissey and Callaghan, 2011); yet its therapeutic potency is often undervalued when engaging with people who self-harm. Being listened to and more importantly being heard is an important way of validating the person, particularly given that the person who self-harm often experiences chronic judgemental listening from others (Inckle, 2017). Moreover, by attending to the person’s experiences in the moment, the nurse can create a trusting and supportive context within which the person feels safe to talk about their concerns and explore their personal histories.

In addition to listening, the nurse also needs to be interested in getting to know the person and their unique story of trauma and distress as well as the meaning they attach to their self-harming behaviour. Engaging in a dialogue about self-harm does not reinforce the person’s self-harming behaviour; however, it has the potential to evoke a sense of discomfort or shame within the person when they disclose or talk about their experiences (Sanderson, 2015). Therefore, it is important for nurses to acknowledge this and ensure that each person is allowed the time, space and flexibility they require. Listening and trying to understand the person’s intrapersonal world and experience of self-harm can be emotionally challenging and demanding for nurses. Nurses therefore need to be consistently attentive to the times they may distance themselves from actively engaging in a collaborative dialogue with the person due to compassion fatigue and emotional disengagement. This, in turn, is likely to reduce the quality and efficacy of their relationships, assessment of risk and safety plans.

Responding helpfully: working collaboratively to develop a safety plan

Whilst exploring the meaning and context of self-harm is an important component of safety planning, it is only effective if it is followed by a safety management plan that includes some form of intervention to “reduce, contain or otherwise ameliorate the risk, thus changing the outcome” (Thomas et al., 2009, p. 3; cited in Gerace et al., 2013). Valuing the person’s engagement and input is essential if the safety plan is to be person centred and co-constructed (Higgins et al., 2016). Moreover, collaborative involvement ensures a more accurate assessment of meaning, strengths and coping strategies; better understanding of the person’s perspective on risk and safety; and greater ownership of the process and plan (Higgins et al., 2015). Recovery-oriented safety planning also focuses on recognising and supporting the person to use their personal strengths, skills, resources and capabilities or protective factors which they can use as part of their safety plan (Stickley and Felton, 2006; Boardman and Roberts, 2013). These strengths may be identified by the person themselves or through a collaborative dialogue with the mental health team, family members or carer. Supporting the person to elicit strengths, hopes and goals can help to encourage the person to open up to thinking about new possibilities and solutions to their
problems or concerns. (DeShazer et al., 2007) However, it is crucial that the goal setting with the person is specific and attainable at that particular point in time.

In contrast to a risk preventative approach, a recovery-oriented approach speaks of positive risk taking. Morgan (2004, p. 19) points out “positive risk taking is not negligent abdication of clinical responsibility” or ignoring professional obligations to intervene in certain circumstances “[…] [but] "[[… about making good quality clinical decisions to support and sustain a course of action that will lead to positive benefits and gains for the individual service users". Harm reduction or harm minimisation is an alternative to preventative approaches and accepts that someone may need to self-harm at a given point (Inckle, 2017). Prevention and punitive controlling strategies, such as removing sharp objects, increased surveillance, withdrawing “privileges” meet neither the immediate or long-terms needs of the person. In fact, highly controlling and preventative regimes may increase the intensity and frequency of self-harm and the emotional and psychological distress experienced (Inckle, 2010). In contrast, a harm reduction approach, which was developed in response to failures of traditional risk adverse thinking, asks the nurse to work within an ethos that accepts that self-harming behaviours may be the person’s only means of coping and surviving at a given point in time. Whilst the behaviour may pose a physical risk to the person, harm reduction focuses on making the person as safe as possible, rather than preventing the individual from using their only means of coping that time. All forms of self-harm involve some degree of risk, some forms are very risky and cannot be made safe and will always require medical attention. However, other injuries can be managed so that they do not cause irreversible, unwanted fatal damage. Inckle (2017) suggests that the provision of clear accurate information about anatomical and human physiology can help the person stay safe and avoid causing irreversible or unwanted damage. One of the essential elements of a harm reduction approach is attending to the injuries in a practical and meaningful way. The National Institute for Health and Clinical Excellence (NICE) (2012) Guidelines (UK) recommend that practitioners consider giving advice regarding self-management of superficial injuries including providing tissue adhesives. Helping the person to self-care in a caring and compassionate manner and at the same time to maintain choice and autonomy can have a positive effect on the person’s self-worth and entitlement to care (Inckle, 2017).

The NICE (2012) Guidelines (UK) also include reference to supporting people who repeatedly self-harm to develop alternative coping strategies to regulate distress such as teaching the person breathing techniques, counting aloud or holding an ice cube to reduce intensity of emotion. These strategies need to be discussed when the person is not feeling the need to hurt themselves. The use of advanced directives to facilitate the person to record their wishes for intervention which could be factored into the safety plan has been advocated (NICE, 2012) as well as the use of Wellness Recovery Action Planning as a tool to support safety management (Copeland, 2002).

Responding helpfully: developing reflective practice

Developing a commitment to ongoing reflective practice can help the practitioner to feel more informed and confident to work more collaboratively when supporting and facilitating positive risk taking with people who self-harm. However, nurses face the challenges of reconciling this approach with the current risk assessment and management policies and procedures, driven by concerns about liability, wherein the primary task is to implement defensive risk averse anti-therapeutic strategies (Stickley and Felton, 2006). In addition, working with people who engage in self-harming behaviour means being exposed to a range of intense and extreme emotion; thus, practitioners need to pay attention to their own well-being not only for the sake of themselves but also for the people they work with and their colleagues (Morrissey, 2015). Without ongoing support systems, nurses are likely to have difficulty in offering emotional and psychological support and/or feel supported and contained themselves when working with people with self-harming behaviours. In the context of mental health practice, caring for self while caring for people who self-harm is essential for effective, competent and safe work, as well as for establishing and maintaining good working and personal relationships. Nurses not only have a responsibility for monitoring and assessing the effectiveness of their clinical work in terms of service user outcomes but they also need to “practise reflection” carefully, constructively and
purposely. As a life-long activity, reflecting can be demanding and emotionally challenging. While all of us have the potential to reflect, it is not an innate or tacit ability. As with most acquired skills, developing the ability to become a more reflective practitioner requires time, commitment and the use of different reflective strategies such as reflective diaries/journals, reflective practice groups, clinical supervision. However, for learning to occur, nurses need to be willing to acknowledge their personal beliefs, anxieties and responses towards people who self-harm and examine how such responses might impact on the person and their experience of recovery. Acquiring an increased awareness of one’s responses and learning needs may be challenging and evoke feelings of discomfort, self-doubt and defensiveness. Nonetheless, reflection can help the nurse to gain increased confidence, which in turn can enable the nurse to move from defensive practices to defendable practices and from a position of “responsible for” to “responsible with”.

Conclusion

Mental health nurses have an important role to play in self-harm reduction and harm minimisation. However, given that mental health nursing sits within the biomedical discourse, it is inevitable that defensive risk adverse techniques form the dominant mode of practice. Within this context, practices are not only restrictive in terms of the person’s freedom, but there are few alternative understandings permitted or available to the person presenting with self-harm behaviour. In addition, it fails to promote and value the importance of relational-based care, therapeutic engagement and emotionality beyond the rhetoric. People who self-harm experience many needs and challenges related to their emotional distress and require a different model of understanding and engagement. By embracing the self-regulation model of understanding, there is the potential for nurses to move beyond the clinical meaning of recovery which involves “fixing” and constraining people, to a way of being that embraces relationality and openness. It also offers the potential to create a culture in which self-harm is anticipated as a possible outcome even with excellent standards of care, and wherein staff are supported and encouraged to discuss and reflect on their anxieties while “taking therapeutic risk” and working with people who self-harm as opposed to working on them.

References


Further reading


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