
CHILD & ADOLESCENT MENTAL HEALTH COLUMN

Looking In, Looking Out—Increasing Awareness of Intentional Self-Harm in Community Populations

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INENTIONAL SELF-HARM without intent to die involves complex health, psychological, and social behaviors. Over many years, an attempt to explain these behaviors has ranged from the supernatural with demonic possession to multiple explanations through psychiatry and psychology (Favazza, 1996). At one time, self-harm was believed to exist primarily in patients with mental illness. In modern society, self-harm without intent to die has come into the main stream through the Internet, music, and movies and is now reported in various community populations. Approximately 1% to 4% of adults and 13% to 23% of adolescents report a history of self-harm without intent to die (Jacobson & Gould, 2007). Other community populations where self-harming behavior has been reported is 4% among military recruits (Klonsky, Oltmanns, & Turkheimer, 2003) to up to 38% among college students (Brown, Williams, & Collins, 2007; Favazza, DeRosear, & Conterio, 1989; Gratz, Conrad, & Roemer, 2002). People with a history of self-harm were found to have an

elevated lifetime risk for suicide (deMoore & Robertson, 1998; Hawton, Zahl, & Weatherall, 2003; Zahl & Hawton, 2004). Self-harm is an international phenomenon as well with care being reported by researchers from England, India, and Norway (Klonsky, 2007).

Advanced practice nurses (APNs), especially the psychiatric nurse practitioner and the pediatric nurse practitioner working with adolescents, are in key positions to screen for self-harming behavior. In a recently published study of Ohio APN's screening for self-harm (Tusaie, Acierto, Murray, Fitzgerald, & Chiu, 2009), psychiatric nurse practitioners reported to be the only group of APNs to screen 100% of their patients. However, APNs from other specialties did not respond to the survey question in such a uniform fashion. For instance, about 64% of pediatric nurse practitioners reported to screen for self-harm. Although there were only seven psychiatric nurse practitioners in this study who responded to the survey, this response makes one wonder, does this reflect the historical pattern of intentional self-harm being linked to mental illness? One can argue that the higher awareness seen in psychiatric nurse practitioners could be due to the fact that psychiatric nurses see patients with evidence of self-harm in their clinical practice. Importantly, the acute awareness by the psychiatric APN, that self-harming behavior is a coping mechanism, may lead the psychiatric APN to pursue this behavior with their patients and why it may be occurring. The secretive nature and related shame of self-harm by

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the patient may reflect less uniform responses seen by the other APN specialties in the survey. Those APNs who do screen may represent the recent increase in discussion, documentation, and awareness of intentional self-harm in community populations during the past decade(s).

It is difficult to determine if discussion, documentation, and/or awareness in lay as well as the professional literature reflect an acute increase in the prevalence of intentional self-harm for several reasons. First, intentional self-harm is not unidimensional. There are multiple behaviors by the self-harmer that result in intentional self-harm. Examples of these behaviors include overdosing, poisoning, cutting, burning, scratching, biting, hitting, hanging, and jumping from high places (Greydanus & Shek, 2009). Second, there is ambiguity around the assessment process. The literature discusses several screening tools, but there is no standard tool for use in the outpatient clinical domain; therefore, screening tools are not routinely used. Because of the hidden nature of self-harming, there may be multiple episodes preceding the actual visible injury. In the Ohio survey of APNs, only one nurse practitioner mentioned using a standardized screening tool. Nixon and Heath (2009) indicate that instrument development for self-harm is in its early stage. Several researchers also pointed out the inadequacy of a screening tool to assess for self-harm.

The “don’t ask, don’t tell” approach may be used by APNs in regard to self-harm. The Ohio survey found more than 75% of the APNs desired more education on self-harming behaviors and most did not receive education on self-harm in their graduate education. For this reason, APNs, other than psychiatric APNs, appear to screen for self-harm only when they saw tangible evidence of self-harming behaviors. Although this is the reality, holding the “don’t ask, don’t tell” approach may result in missed opportunity to identify adolescents with self-harming behaviors.

It is clear from the literature that APNs in clinical practice and nurse researchers face similar dilemma; there is no standard screening tool for self-harm. The first step in future research is to further develop and validate screening instruments to use in clinical practice for community-based clients who may be engaged in self-harm. In the mean time, skilled APNs with their keen ability to assess the patient and the patient’s psychosocial needs must be encouraged to use their clinical judgment

and be vigilant in screening patients for signs of self-harming behaviors as discussed in Greydanus and Shek (2009). In other words, APNs from all specialties need to adapt a more proactive approach in identifying patients for self-harm. The skilled psychiatric nurse practitioners, with their education and experience in dealing with self-harm, can be a resource and mentor to APNs in other specialties on intentional self-harm. Together, we can promote more healthy coping strategies for our patients and their families.

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