

Understanding Psychiatric Nursing Care with Nonsuicidal Self-Harming Patients in Acute Psychiatric Admission Units: The Views of Psychiatric Nurses

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Self-harm in the absence of suicidal intent is an underexplored area in psychiatric nursing research. This article reports on findings of a study undertaken in two acute psychiatric admission units in Ireland. The purpose of this study was to gain an understanding of the practices of psychiatric nurses in relation to people who self-harm but who are not considered suicidal. Semistructured interviews were held with eight psychiatric nurses. Content analysis revealed several themes, some of which will be presented and discussed in this article, namely, the participants' understanding of self-harm, their approach to care, and factors in the acute psychiatric admission setting, which impacted on their care. Recommendations for further research are offered.

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THE FINDINGS OF a study that explored the practices of psychiatric nurses with nonsuicidal self-harming patients in the acute psychiatric admission setting are presented in this article. Self-harm in the absence of suicidal intent is an underexplored area in psychiatric nursing research. Harris (2000) argued that it is a distinct field that needed to be separated from parasuicide and suicide. Various definitions of self-harm exist, many of which are adopted by professionals in an attempt to categorize and label those who engage in self-harm. Although epidemiological trends in relation to suicide and parasuicide are available, there has been a failure to separate self-harm in the absence of suicidal intent from these categories. A number of studies have explored psychiatric nurses' and patients' views of the

nursing care provided to suicidal individuals; however, only a few studies have focused on self-harm. Little is therefore known about the way psychiatric nurses engage in care with nonsuicidal self-harming patients. The nursing literature examined in this article has come mainly from sources in the United Kingdom, Sweden, and Australia. It is acknowledged that there is a paucity of self-harm nursing literature in both Ireland and the United States. The purpose of this qualitative descriptive study was to gain an understanding of the practices of psychiatric nurses working with nonsuicidal self-harming patients in acute psychiatric admission units. For this study, self-harm was defined as self-harming behavior that involved bodily injury, including cutting, burning, hitting oneself, inserting sharp objects into oneself, and the pulling out of body hair (Gallop & Tully, 2003), undertaken in the absence of suicidal intent.

DEFINING SELF-HARM

Attempting to define self-harm is a difficult task. Numerous terms are used interchangeably to define self-harm or a similar occurrence, such as deliberate self-harm, self-injury, parasuicide, self-mutilation, self-poisoning, self-cutting, overdose, self-directed

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violence, and attempted suicide. The most frequently used terms (self-harm, deliberate self-harm, and parasuicide) are briefly explored in this article.

SELF-HARM

The term self-harm has been defined in many different ways. Broad definitions such as “any self-induced act that results in personal harm” (Greenwood & Bradley, 1997, p. 134) have been offered, as have narrow definitions, such as the “full and conscious intention by the individual to cause injury, completed in a limited period of time resulting in tissue damage that leads to scarring” (The National Inquiry into Self Harm Among Young People, 2004; www.selfharmuk.org/defs.asp). Pembroke (1998), who herself engages in self-harm and who has written extensively about self-harm from a lay perspective, observed that clinical descriptions of self-harm have been in contrast to those written by survivors. Indeed, people who self-harm have been labeled as having a mental illness, locating the problem in pathology and preventing practitioners from seeing people who self-harm as individuals (McAllister, 2003). This claim is supported in a study by Bywaters and Rolfe (2002), which found that adolescents who self-harm believed that those without personal experience cannot fully understand the self-harming experience and that professionals need to listen to understand the meaning of self-harm from their perspective, rather than make their own assumptions.

Within a medical context, attempts have been made to classify self-harm, with the ICD-10 (World Health Organization [WHO], 1992) classifying it under external cause of morbidity and mortality (V01–Y98). Here, each type of self-harm is prefixed by “intentional” and given a classification code; for example, X78 is “intentional self-harm by sharp object” and X79 is “intentional self-harm by blunt object” (WHO, 1992, p. 305). The *DSM-IV* places self-harm as a criterion for the diagnosis of borderline personality disorder (American Psychiatric Association, 1994). However, Pembroke (1998) suggested that self-harm is not a classifiable disorder and does not fit the narrow bands of labels defined as illness. Indeed, Pembroke (1996) has argued that self-harm is a sane response when people are gagged to maintain social order. She proposed that there are two categories of self-harm: self-harm with suicidal intent and self-harm without suicidal intent. She further suggested that there are socially acceptable and unacceptable types of

self-harm. Socially acceptable types include excessive smoking, drinking, exercise, liposuction, bikini-line waxing, wearing high heels, and body piercing, whereas socially unacceptable types include “cutting, burning and smashing bones” (Pembroke, 1996, p. 2).

DELIBERATE SELF-HARM

Self-harm is often prefixed by the term “deliberate.” Morgan (1975) defined deliberate self-harm as a deliberate nonfatal act done in the knowledge that it is potentially harmful, including physical harm, drug overdose, and poisoning. Deliberate is defined as “done consciously and intentionally, carefully and unhurried” (Oxford English Dictionary, 2003, p. 286). This definition implies that self-harm is never impulsive and is always fully thought out; however, McAllister (2003) suggested that self-harm may be accidental, impulsive, “committed” through ignorance, apathy, or poor judgment (p. 178). Pembroke (1996) argued that deliberate self-harm is not a term that is used by those who engage in self-harm and suggested that self-harm does not need qualifying with the term deliberate.

PARASUICIDE

Parasuicide was a term coined in the late 1960s to describe a behavior associated with suicide, which does not have an orientation toward death (Kreitman, Philip, Greer, & Bagley, 1969). Parasuicide has since become a term that is globally used. WHO (2004) defined it as

“an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage and which is aimed at realizing changes that the person desires via the actual or expected physical consequences” (p. 5).

Two concerns have been highlighted in relation to this definition. Firstly, the word “parasuicide” includes the term “suicide,” which has the potential to be misleading, as it is widely accepted that those who self-harm do not necessarily want to die (Cook, 1999). Secondly, the definition cannot be used to describe self-harm, as self-harm is quite often a repetitive act (Batt et al. 1998).

Although the various definitions have many commonalities, such as they all recognize self-harm

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