Working with Patients Who Self-Harm

Margaret McAllister

Dr. Margaret McAllister is an Associate Professor in Nursing at the School of Health and Sport Sciences, at the University of the Sunshine Coast in Maroochydore, Queensland, Australia. Previously she was faculty in the School of Nursing and Midwifery at Griffith University in Queensland Australia. Dr. McAllister has a certification in psychiatric nursing and particular expertise in therapeutic responses to self-injury and in critical social theory. She reminds us in this chapter that while students or clinicians will use the full range of critical thinking skills in a practice exercise, some of the best teaching sessions are focused in one skill area.

The exercise in this chapter requires students to use the critical thinking skill of analysis, using a rich assortment of teaching methods. Not forgotten are the critical thinking habits of mind that prove so needed for a fair-minded analysis of the problems presenting to patients who self-harm. This is a very rich chapter with at least three creative and well-integrated reasoning exercises that require students to apply mental health content in a clinical relevant context. The connection between using critical thinking skills and making a well-grounded clinical judgment is evident.

Dr. McAllister has also authored a book entitled, “Solution Focused Nursing: Rethinking Practice.” We took a moment to look in to this text and found a treasure that extends to the web based companion text site which coaches novice teachers or those new to this content area to bring this material to students with care to completely engage them in critical thinking pedagogy.

The Session and the Participants
This session is one that I offer to professionals and health science students who are interested in developing their intervention skills when working with individuals who deliberately self-injure. The session participants are typically from a range of disciplinary backgrounds and include: teachers, youth workers, nurses, social workers, psychologists, disability support workers and medical officers.

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The Lesson

This lesson focuses on the practice of clinical problem solving in the context of working with patients who self-harm. My key goals for the class session involve all of the following:

1. emphasizing the importance of a holistic approach to problem solving
2. increasing awareness of the role that solution searching/generating has for clinicians/clients in the problem solving process
3. emphasizing the importance of a balanced appreciation of clients’ vulnerabilities and strengths
4. emphasizing the importance and effects of building a sense of community between clinicians and clients
5. developing skills in working with clients’ strengths, aspirations and solutions

My particular focus for this session is to develop the critical thinking skill of analysis. Participants have an opportunity to examine how dominant ways to problem-solving are enacted in clinical settings. I help them to do this through participating and debriefing a role play and brainstorm exercise.

The critical thinking dispositions of systematicity, open-mindedness and truth-seeking (APA, 1990) are also frequently emphasized as a function of my philosophy of practice and my teaching methods. Finally I try to impress on the participants the value of working with clients to help them problem solve.

This lesson is divided into three main sections: A content loaded slideshow; a role play exercise and a brainstorming exercise. Together they address the following learning outcomes.

The Learning Objectives

Clinicians and other professionals who participate in this session will be able to:

- Critically analyze the dominant ways in which the problem solving process has been used in health services and the impact this can have on patients who self-injure.
- Describe the need for a balanced perspective on clients’ vulnerabilities and strengths. (open-mindedness and truth-seeking) and use this perspective to analyze and draw accurate inferences about a client’s vulnerabilities and strengths, problem identification and solution generation. (analysis, inference).
- Describe the benefits of living in a close community and explain the importance building a sense of community between clinicians and clients (analysis, explanation).

How I teach the lesson

**The slide show:** Thinking well about a problem requires best knowledge of the problem in context so I begin the lesson with a slide show that provides needed content. The slide show also introduces about problem solving and solution searching as well as content about the etiology and incidence of self-harming behavior. Figure 1 is an example slide from that presentation. My slides are visual aids accompanying a short talk on what is known about the problem of
patients who self harm. While the participants view the slides I explain why the problem is so important and that we think we know about intervening.

Here is some of what I tell them (references for this material are included at the end of this chapter). Self-injurers represent nearly one percent of the population, with a higher proportion of females than males. The typical onset of self-harming acts is at puberty. The behaviours often last for five to ten years but can persist much longer without appropriate treatment. It is impossible to know the exact prevalence of self-injury because there is no clear, simple definition, and the act is usually done in secret. We can, however, get an idea of the prevalence from hospital separations, where self-harm occurs in 4% of the Australian population, as well as samples of Australian secondary school students where the prevalence of self-injury has been recorded as 5.1%, 6.2%, and 10.5%. International figures are similar to Australian trends (Berry & Harrison, 2006).

People who self-injure place considerable burden on health care systems. In 1999 suicide and self-inflicted injuries represented 27% of the total injury burden in Australia; equal to road traffic accidents. The annual wider economic burden of self harm is estimated at $160 million and the total health costs of injuries is estimated at $2.6 billion (8.3%) of total health expenditure. The World Health Organization has produced information about ‘at risk’ youth all over the developed world (WHO, 2000). We know they have the following characteristics:

- They live in impoverished, inner city neighbourhoods
- They have many stressors including: prenatal and post natal exposure to drugs, parental depression, abandonment, inconsistent parenting, poverty and hunger, high rates of parental unemployment.
- They exhibit many of all of the following: physical and psychosocial developmental delays, malnutrition, missed schooling, inadequate health care, involvement in crime, drug use, and risky sexual behaviour.

Figure 1: Example content slide for Slide presentation

Small Group Role Play Exercise:
To begin this next part of the session, I divide the participants into groups of three persons each. One person in the group will play the role of the ‘patient’ and I provide them a script to read as they play this role (Figure 2).
Another person in the group plays the ‘clinician’ who is a member of the psychiatric liaison team. I explain to this person that they have been asked to assess the patient. They have the following materials available to assist this process: some brief triage case notes (Figure 3), a Deliberate Self Harm (DSH) Form (Figure 4) and a score on the ‘Sadperson’s Scale’ (Figure 5, Hockberger and Rothstein, 1987). The DSH Form is a pathway form that we have created for our local facility that collects patient intake data on a variety of key variable in order to determine a triage level and risk profile.
I tell the clinician that they are to conduct a health assessment using these standard forms and procedures. The third person in the group plays the ‘critical friend’ to the clinician. I give the critical friend a private message telling that they are to carry out an appraisal of the practice behavior (patient assessment) of their friend the clinician without

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**Deliberate Self Harm (DSH) pathway form**

Intake guideline for the DSH form:

1. Evidence of self harm (Self injury, overdose, both)
2. If medical injury outweighs need for psychiatric assessment institute treatment first: (Record of treatment given)
3. Emotional state (conflict, loss, anger, depression)
4. Suicide related history and current behavior
5. Known psychiatric disease
6. Substance abuse
7. Current Medication
8. Psychosocial assessment (conducted by physician)

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**Sadpersons Scale**

*Note:*

A score of over 6 requires intensive management (which may include hospitalisation).

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Male</td>
</tr>
<tr>
<td>Age</td>
<td>If &lt;19 or &gt;45</td>
</tr>
<tr>
<td>Depression or hopelessness</td>
<td>Admits to depression or decreased concentration, appetite, sleep, libido</td>
</tr>
<tr>
<td>Previous attempts or psychiatric care</td>
<td>Previous in patient or outpatient psychiatric care</td>
</tr>
<tr>
<td>Excessive alcohol or drug use</td>
<td>Stigma of chronic addiction or recent frequent use</td>
</tr>
<tr>
<td>Rational thinking loss</td>
<td>Organic brain syndrome or psychosis</td>
</tr>
<tr>
<td>Separated, divorced or widowed</td>
<td>1</td>
</tr>
<tr>
<td>Organised or serious attempt</td>
<td>Well thought out plan, or “life threatening” presentation</td>
</tr>
<tr>
<td>No social supports</td>
<td>No close family, friends, job or active religious affiliation</td>
</tr>
<tr>
<td>Stated future intent</td>
<td>Determined to repeat attempt or ambivalent</td>
</tr>
</tbody>
</table>

forewarning. They are to assess his/her problem solving and solution searching skills by filling out an Evaluation Form (Figure 6) and they will be discussing their feedback with the group.

**Figure 5**

### Assessing the Clinician’s Response to the Case Study Role Play

Rate the quality of the clinical interaction using the criteria specified. It’s important that you be fair-minded and honest with this evaluation. Be prepared to provide examples for your ratings. (Ask yourself: Why do I think that this interaction was exemplary/adequate/limited/inadequate?)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Degree of Understanding and Clinical Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Exemplary</td>
</tr>
<tr>
<td>Engaging attributes are apparent</td>
<td></td>
</tr>
<tr>
<td>Concerns and issues are considered effectively, safely and thoroughly</td>
<td></td>
</tr>
<tr>
<td>Self-harm understanding is conveyed appropriately to the person</td>
<td></td>
</tr>
<tr>
<td>Future coping and resilience are considered</td>
<td></td>
</tr>
</tbody>
</table>

Describe 3 key strengths (these comments should address more positive ratings)

1. ____________________________________________________________
2. ____________________________________________________________
3. ____________________________________________________________

Describe 3 areas for improvement (these must address all inadequate ratings)

1. ____________________________________________________________
2. ____________________________________________________________
3. ____________________________________________________________

**Figure 6: Evaluation Form to be completed by the Critical Friend**

In order to debrief students in this roleplay, the class is asked to comment on the experience of asking questions and being asked probing questions. Then they are to find common strengths and areas for improvement in their clinical interactions. This helps to move students beyond the clinical context towards future learning experiences.
If time permits, the roles in the group can be shifted and a new patient script (case study) can be provided. This has the advantage of the group working increasingly toward achieving the criteria being evaluated by the critical friend. But in most cases, unless this is a daylong workshop, you will need to move on to the brainstorming exercise.

The Brainstorm -- What is a Healthy Community? Helping youth to find a healthy community is one way to intervene in the problem of self-harm. This part of the session asks participants to turn their minds to thinking about the notion of community. My comments go something like this: “Before we think about a great community, let’s think for a moment about some of the stories in the media that signal to us the breakdown of community.” At this point I again use visual aids to help the participants think about examples of community. I show them eight or ten images that could be analyzed in relationship to the concept of community. For example I might show them the following collection of images: a group of students celebrating their graduation, a child holding an infant in a third world country, two dogs standing together in a metal cylinder, a woman sitting on the sidewalk with a request for food printed on a square of cardboard, neighbors working together on a community project. After giving everyone some time to view the images, to analyze what they represent, what feelings they engender, I ask volunteers to select one image and say why it resonated for them. “What meanings did the image hold, and what effects of community or deficiency in community did you interpret in the image?”

When participants are asked to brainstorm about the attributes of the breakdown of community, they typically generate comments like the following: community’s lack of care, dehumanising each other, failing to act to help others, caring for the self above others, inhumane treatments… leading to demoralization, devaluing self and others, loss of hope, disregard, apathy, competitiveness, ego-centrism, violence…When asked to brainstorm about a good community, or a healthy community, their responses typically include phrases like this: every person is known; each has a role and feels valued; there are rituals that are enriching and rewarding; people are helpful, compassionate, and caring; there is a sense of belonging, fun, achievement; there are celebrations; milestones are marked.

Brainstorming isn’t always reliable so if they fail to mention something important, I add this material myself. To wrap up of the session, I ask participants to relate their insights to how we might support individuals who self harm in the clinical environment if we were to use some of these features of a healthy community.

Assessing learning outcomes in a participant work product

To assess the learning goals students complete the individual work activity. This gives opportunity for students to demonstrate their analytic thinking and creative solution generation skills. It also records evidence of their thinking process (Figure 7).
Figure 7

Individual Activity
Building a healthy sense of self and community with patients

Your task is to devise activities that will help you work with an individual client to build their awareness of their personal strengths and the specific goals they would like to achieve. Use this suggested format to organize and present your ideas. Use all that you have learned in this session to provide your rationale for the activities you suggest.

<table>
<thead>
<tr>
<th>Feature of a healthy Community</th>
<th>Your activity</th>
<th>Patient’s activity</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>People are familiar and known</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sense of purpose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sense of belonging</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Shared places</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Shared ideas</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Shared memories</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

References

Although this series focuses on health science content, the techniques are transferrable to all types of training programs and educational projects.
Download other essays in this series for valuable training techniques that focus student learning of reasoning skills and thinking mindset. See Resources on our website.