Summary and General Discussion
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In this final chapter, we summarize and discuss the main findings and propose a number of directions for clinical practice and research.

Summary of the main findings

We have characterized self-harming behaviour as complex in nature, with different functions for the patient. We have also pointed out how the perspectives of patients and healthcare providers differ, often leading to unsatisfactory therapeutic relationships and ultimately resulting in inappropriate care. The main aim of this thesis has been to study whether care for patients who self-harm can be improved through targeted improvement of the attitudes and self-efficacy of healthcare providers.

In the introductory Chapter 1, we defined self-harm, described differences in the perspectives of both patients and mental healthcare staff towards self-harm, and identified the consequences of these different perspectives for the therapeutic alliance and treatment outcomes.

In Chapter 2 we concluded, based on scientific literature, that nurses have both positive and negative attitudes towards patients who self-harm, but that – unfortunately – negative attitudes prevail. Professional caregivers may experience feelings of irritation, frustration, anger and personal incompetence. Compared with other healthcare professionals, mental health nurses make relatively frequent mention of the need for supervision and support by management and colleagues. Three factors appear to increase the risk of a negative attitude towards patients who self-harm: a low educational level of nurses, working in large hospitals, and working in general healthcare. Their attitude can be improved by educating them about self-harm and by upgrading the working conditions in nursing practice. On the basis of our literature review, we concluded that education should consist of reflective and interactive elements supporting the active nature of learning. Beneficial conditions for nursing practice should include enough time to offer intensive care to patients in crisis and who are at risk of harming themselves, adequate resources (such as the availability of effective intervention strategies) for providing care, supervision, a
structured and coordinated approach towards self-harm within the work setting, and support from management and colleagues.

Chapter 3 evaluated the effects of a training programme on the attitude and self-efficacy of healthcare providers who care for self-harm patients. The basic principle of the programme was that healthcare staff need to understand the relationship between intensive and unbearable emotions and self-harming behaviour, and the difficulty self-harm patients have in dealing with these emotions. The second basic principle of the training programme was that staff also need a good understanding of their own feelings and perceptions about self-harm and how these influence their reactions to the patient. Lay experts played an important role in the development and implementation of the programme. We found significant improvements in healthcare providers’ attitude towards self-harm patients, as well as improved self-efficacy in caring for patients who self-harm. We also found that healthcare providers developed closer relationships with their patients.

Chapter 4 describes the development and validation of the Self-Efficacy in Dealing with Self-Harm Questionnaire (SEDSHQ). The questionnaire is based on the literature about self-harm and self-efficacy. The items are related to communication (with the patient, family and friends, and colleagues) in specific situations concerning self-harm, identification of stress factors and the early signs of imminent self-harm, and preventive and curative interventions carried out in specific situations related to self-harm. We tested the questionnaire’s feasibility, test-retest reliability, internal consistency, content validity, construct validity (factor analysis and convergent validity) and sensitivity to change. The SEDSHQ is a 32-item instrument with a single factor explaining 45% of the variance. Testing revealed high content validity, a significant correlation with a subscale of the Attitude Towards Deliberate Self-Harm Questionnaire (ADSHQ), satisfactory test-retest correlation, a Cronbach’s alpha of .95, and sensitivity to change. We concluded that the Self-Efficacy in Dealing with Self-Harm Questionnaire is a valid and reliable instrument for assessing the level of self-efficacy.
In Chapter 5 we investigated the psychometric properties of the Dutch version of the Attitude Towards Deliberate Self-Harm Questionnaire (ADSHQ). The ADSHQ was originally developed to measure the attitude of emergency department nurses in Australia towards patients who self-harm. It consists of 33 items and has four factors: perceived confidence in assessment and referral of self-harm patients, dealing effectively with self-harm patients, empathic approach, and ability to cope effectively with legal and hospital regulations that guide practice. We tested construct validity (factor analysis), test-retest reliability, internal consistency, content validity, and sensitivity to change. Factor analysis revealed four factors explaining 33% of the variance. Cronbach’s alpha values ranged between .585 and .809, with an alpha of .637 for the total scale. Test-retest reliability revealed that the questionnaire was stable over time with the exception of factor 3. The questionnaire was sensitive to change, showing significant increases between pre-test and post-test measurements in the total score and in three of the four factors, as obtained from the intervention study described in Chapter 3 of this thesis. We concluded that the Dutch version of the ADSHQ possesses adequate psychometric properties and is a valuable instrument for measuring the attitude of nurses and healthcare staff towards patients who self-harm in Dutch-speaking countries.

In Chapter 6 we presented the characteristics and treatment outcomes of a specialist inpatient treatment programme for patients who are considered extremely difficult to treat because of the disruptive nature of their relationships with treatment staff. Self-harm is a common behaviour in these patients. The main treatment method consists of providing safety, structure and cooperation. The basic attitude of staff is non-vindictive, with adequate communication with the patient. Guidance and investment in staff are important ingredients of this treatment programme. To evaluate the treatment within this facility, we used Routine Outcome Measurement (ROM) data as well as data collected with a self-constructed instrument on 108 patients. Pre-test/post-test measurements showed statistically significant improvements between admission and discharge on all questionnaires. We concluded that these patients can be treated successfully and that their functioning can be improved by taking the staff-patient relationship as the primary focus of treatment.
Chapter 7 reports on a qualitative study of the process of recovery of twelve patients with severe self-harming behaviour who had successfully stopped harming themselves. Six phases could be identified in their recovery processes: (1) limit setting and connecting, (2) self-esteem, (3) learning to understand, (4) autonomy, (5) stopping self-harm and learning new strategies, and (6) maintenance. Connection was found as the key concept influencing the entire process of recovery: both the lack of and the presence of a close, intense connection provided a reason for self-harm. Learning how to cope with their inner selves and others was an important skill for reducing and stopping self-harm, which was made possible by their having a positive connection with their healthcare providers.

General discussion
The motivation for this dissertation is rooted in daily practice: in many cases the care provided in our healthcare system does not match the needs and preferences of patients who self-harm. The negative attitude of many healthcare providers and their lack of knowledge about self-harm is a particular focus of attention because it aggravates patients’ already disturbed emotions and thoughts, increasing the risk of self-harm. The negative attitude of healthcare providers aggravates feelings of shame and guilt but also the patient’s failure beliefs [1]. The professionals’ lack of understanding and empathy, as perceived by patients, causes the latter to believe that staff operate on the basis of misconceptions about self-harm [2]. This combination of negative attitude and lack of knowledge leads to a tendency among patients to distance themselves from treatment, as we explained in Chapter 1.

When viewed from the professionals’ perspective, it becomes clear that they have difficulties dealing effectively with patients who self-harm. This is confirmed by our systematic review (Chapter 2) as well as other reviews [3, 4]. All reviews mention that a lack of knowledge and skills leads to a negative attitude towards patients who self-harm. Indeed, in our study of the effects of the training programme [5], we found an alarmingly low percentage of experienced healthcare providers who had had previous specialised training in the field of self-harm (four per cent). And despite the growing list of scientific publications regarding self-harm, Saunders et al. [3] found hardly any difference between
older and newer studies in healthcare staff’s attitude, indicating that this is a persistent problem.

Healthcare providers want to provide good care. Good care is based on doing good and on preventing damage, on showing respect and on making no distinction between people [6]. Patients appeal to healthcare providers to give them good care that best meets their experiences and preferences. This “moral appeal” often meets with no response as soon as patients harm themselves. One key question for discussion is why the provision of good care is compromised for patients who self-harm.

In fact, the feelings provoked by the confrontation with self-harm – disbelief and disgust, anger, frustration and betrayal, disappointment, the burden of responsibility, and powerlessness (see Chapter 1) – may create collective anxiety among healthcare providers, leading to intense feelings of countertransference to the patient. The fact that people are able to harm themselves, to destroy their body, evokes existential questions about the purpose and vulnerability of life, as well its finiteness. This is particularly the case when self-harm is used as a survival mechanism for the unbearable pain of mental suffering. In addition, self-harm also raises questions about the potential (limited) influence one may have as a healthcare provider: not being able to influence your patient’s behaviour and emotions, despite all your knowledge, expertise and good will, is a threat to the professional’s competence. To cope with these confrontations, professionals create distance to prevent themselves from being affected too intensively by patients who self-harm. They often use rationalizations such as “because the self-harming behaviour cannot be influenced, it is a waste of time that can be better used elsewhere for patients whose problems can be solved”, and “it is her own choice to harm herself, so it is her responsibility”, and “she must be using her self-harming behaviour to manipulate me and this situation in order to achieve her (pathological) goals”, thus legitimizing their rejection of patients who self-harm. But by creating this distance, it is no longer possible for the professional to see the persons behind the (self-harming) behaviour, with their own stories, and their cries for help. Their attitude deprives them of any opportunity to provide help at all.
There are healthcare professionals who are able to provide good care for patients who self-harm, however, as we have shown in our studies of the specialist inpatient treatment programme [7] and the process of recovery from severe self-harming behaviour [8]. These studies show that staff are able to approach patients who self-harm non-judgmentally and communicate adequately with them. This non-judgmental response is essential in the interaction with patients who self-harm, contributing to a safe and respectful working alliance with the patient in which he or she feels secure and valued [9], with the therapist being genuinely concerned about the patient’s situation and emotions [10]. Only then can the patient open up and talk about his or her self-harm and the underlying motives. It is encouraging that recovery is at least partly possible when these conditions are met. The experience and knowledge gained in these best practice situations should be used as role models within healthcare.

In our study of the training programme, we saw that trainees were eager to take the programme, indicating that healthcare providers do want to learn more about self-harm and to improve their skills. The effects of our training also show that it is possible to improve professionals’ attitude and self-efficacy concerning patients who self-harm [5], something that has been found in other studies as well [11-13]. Important ingredients of such training are reflection on professionals’ own way of offering care and treatment, on their interaction with the patient, family and colleagues, and on their basic knowledge about the backgrounds of self-harm and effective treatment strategies. Training should also include reflection on their own thoughts, emotions and behaviour, followed by the development of an adequate and non-judgmental attitude and approach to the patient. Lay experts who harm or have harmed themselves should play an important role in training. Having these people explain the motives and functions of self-harm is a powerful way of delivering not only basic knowledge but also insights concerning the underlying mechanisms of self-harm. This form of training makes it possible for patients and staff to share experiences. In evaluating our training programme, the participants gave the combination of a lay expert trainer and a professional trainer the highest score, and many trainees mentioned that they learned the most from the personal stories of the lay expert
These accounts significantly increased their understanding of the meaning of self-harm for the patient.

So far, there is no consensus concerning what constitutes good care for patients who self-harm. This needs to be established and elaborated in a multidisciplinary guideline. It is of major importance for patients to be involved in developing this guideline: their experiences and needs are required to optimize the quality of care for this patient group. This multidisciplinary guideline should be appropriate for all different healthcare settings. Although this thesis focused on patients in mental healthcare, we have to be aware that many patients who self-harm have their first experience with treatment and care in general healthcare, e.g. a general practitioner or (in most cases) the emergency room of a general hospital. As this is their first experience with healthcare, it is extremely important for patients to receive the right treatment and to feel valued and respected, as this will make them more willing to accept the further treatment they need. However, McHale and Felton [4], Saunders and colleagues [3] and Karman et al. (2014, see Chapter 2) all found that the attitude of staff in general healthcare towards self-harm was even more negative, underlining the need for a guideline that provides an integrated pathway through all healthcare settings.

Different parties in healthcare are necessary to improve the care for patients who self-harm.

A. The development of the multidisciplinary guideline should be initiated by the professional associations. These associations play an important role as the guardians of the quality of care delivered by the profession they represent, and of the conditions required to deliver such quality. The development of the guideline should include an implementation plan for its dissemination throughout the healthcare setting in the Netherlands and the scientific evaluation of this guideline.

B. Government should make financial resources available to develop the multidisciplinary guideline, and the healthcare inspectorate should monitor compliance with these standards.
C. Basic nursing, social work, medical and psychological training should include lessons about self-harm. Such instruction should provide at least a basic knowledge of self-harm, teach communication skills with self-harm patients, and cover ethical issues concerning self-harm. Lay-experts should play an important role in this education.

D. Healthcare institutions should offer their employees training concerning self-harm based on explicit quality standards. These standards should be based on best practice situations and research until the multidisciplinary guideline has been developed. Healthcare settings could initiate quality projects to improve the quality of care for patients who self-harm, with training, coaching and quality measurements being important elements of these projects. Discussions of the moral and ethical issues involved in treating self-harm could support such innovations in clinical practice. The same goes for the discussion of difficult and challenging cases involving patients who self-harm, with the aim of explicating common problems regarding such difficult cases and exploring suitable approaches and interventions. It would be interesting to involve the patient actively in these discussions in order to identify common solutions for the relevant problems.

E. Managers should play an active role in improving the quality of care for patients who self-harm on their ward. They should realize that most of these patients can recover with the right treatment and treatment conditions (e.g. enough time available for challenging cases and sufficiently skilled staff). The managers should also be aware of the impact of self-harm on staff and the burden it places on them. This means that – besides proper training – they have to offer all staff members the possibility of supervision and peer review.

F. Individual healthcare professionals should be aware that they are extremely important in the care provided for patients who self-harm. The quality of the interaction between the individual professional and the patient, his attitude towards a patient who self-harms, determines whether a patient feels respected and valued. This interaction can lead them to develop the working alliance that they need to discover together the functions of self-harm for the patient and to find ways to handle the underlying emotions. The individual healthcare provider has to search for the best treatment and care for his patient and if he has doubts about his competencies, he must insist on
education or training. The individual professional should evaluate the care he is giving his patients regularly by asking them (i.e. his self-harming patients) for feedback on his attitude and treatment, in order to improve that care.

Limitations and recommendations for further study
In this thesis, we have not addressed the role of family and friends in the delivery of proper care to patients who self-harm. In their close relationship with the patient, they can supply inside information about a patient who self-harms. They can help provide a better picture of the problems underlying the self-harming behaviour and assist in finding ways to handle these problems. They can recognize stress situations leading to imminent self-harm and signs of imminent self-harm. They can also offer help in preventing self-harm and be of great support to the patient. Family and friends are also impacted by their loved one’s self-harm and deserve respect and support from healthcare providers. If a patient agrees, family and friends should be involved in the treatment of self-harm, as several guidelines already advise [14, 15].

Treatment was not the primary focus of this thesis. The existing evidence-based interventions for the treatment of self-harming behaviour are mostly based on cognitive behavioural therapy and emotion regulation. The focus of these treatments is mainly on the underlying process of self-harm and how to cope with burdensome feelings and thoughts. This approach is necessary for delivering high-quality care for patients who self-harm and should be included in the proposed multidisciplinary guideline. Also, the intervention programme used in our training offers interventions for the communication with patients who self-harm, the early signalling of imminent self-harm, and how to intervene. What is lacking, however, are guidelines for handling actual self-harming behaviour if self-harm can no longer be prevented and the contact with the patient is lost, as well as self-harm in specific situations, such as self-harm and command auditory hallucinations. The multidisciplinary guideline should include interventions for these situations as well.
Although we found significant improvements after training in the attitude and self-efficacy of healthcare providers regarding patients who self-harm, we did not measure the effects of these improvements on the actual behaviour of the professionals and the patients. Future studies should examine the effects of training on the actual self-harming behaviour of patients, as well as patients’ satisfaction with the care they receive.

To summarize and conclude: we have shown that the management of self-harm in psychiatry can improve if healthcare providers receive specialised training. This training should focus on the communication with the patient, which requires the right attitude and knowledge about self-harm. To understand self-harm, the deployment of lay experts is crucial. Further improvement of the management of self-harm requires a multidisciplinary guideline for the treatment of patients who self-harm and for mental and general healthcare. We recommend the development of such a guideline, quality standards based on this guideline and regular evaluation of the quality of care.
References
