Health services, suicide, and self-harm: patient distress and system anxiety

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Patients often become distressed in health settings, and provision of emotional support is a routine part of clinical care. However, in some situations, patient distress can become disturbing to both clinicians and patients, and can affect ordinary therapeutic engagement. We argue that health systems that support people presenting with suicidal acts and self-harm are particularly at risk of providing maladaptive responses, which we have termed dysregulation. If health systems become dysregulated, staff and patients might find it difficult to think clearly and respond adaptively. We describe some common characteristics of dysregulation, including negative feelings about patients, an inappropriately narrow focus on diagnosis and risk assessment, and ad-hoc, abrupt, and inconsistent decision making. These dysregulated responses might impair more adaptive responses such as containment of distress, safety planning, and negotiated responsibility with patients and carers. We discuss the main drivers of dysregulation and the implications for clinical practice in the management of self-harm and suicide risk.

Lancet Psychiatry 2015; 2: 275–80

Published Online February 2, 2015 http://dx.doi.org/10.1016/S2215-0366(15)00051-6

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Organisations and anxiety

The rationale for writing this Personal View began with a hunch: that the response to suicide and self-harm in clinics and hospitals is flawed in some way, and that the key to understanding these flaws lay not only in the relationship between staff and patient, but also between staff and the wider health system. Despite the extensive published work about suicide and self-harm, relatively little has been published about the experience of responding to a suicidal person.[1] Yet that experience can be emotionally disturbing for staff, and its effects can have widespread repercussions.

Prevention of suicide is difficult. Suicide rates vary over time[2] and are strongly affected by clinical, psychological, social, cultural, and economic factors.[3–6] Many risk factors for suicide have been identified, but the causes of suicide remain poorly understood, and evidence of what works to reduce suicide is scarce.[4,7]

Public health interventions, multilevel interventions, improved organisational responses, and drug treatments have been shown to be effective in the prevention of suicide.[7–9] However, interventions have only a slight effect,[10,11] or are sometimes counterproductive—such as admission to an inpatient mental health unit.[12]

Clinical settings are dramatic and emotionally challenging places, an observation not missed by television producers, but one that the system of care itself sometimes overlooks. In a classic study of student nurses working in general hospitals, Menzies Lyth[13] described the ways in which hospitals sought to contain the anxiety of their nurses, often unsuccessfully. She argued that this effort to manage the emotional dynamics of the institution was not a marginal activity, but instead a fundamental responsibility: "the success and viability of a social institution are intimately connected with the techniques it uses to contain anxiety".[13]

Furthermore, a recent report[14] from the UK Department of Health noted that "fear is toxic to both safety and improvement", yet is endemic in some systems: "Time and again, we see the harvest of fear…a vicious cycle of over-riding goals, misallocation of resources, distracted attention, consequent failures and hazards, reproach for goals not met…if the system is unable to be better, because its people lack the capacity or capability to improve, the aim becomes above all to look better, even when truth is the casualty."

When failures in the health system occur, investigations are commissioned to establish the causes of the failure, to identify wrongdoing, and to learn lessons. These investigations are undertaken typically by clinical peers and are often perceived as threatening by staff, which could affect clinical practice. Mattinson and Sinclair[15] observed the ways in which investigations into the deaths of children who died as a result of their parents' behaviour did not address the paradoxes associated with failures in care: "We do not dissent from most of the conclusions of these reports, yet there remains an uneasy feeling that something has been missed. It is clear that the workers missed cues, failed to communicate or failed to communicate what was important. Quite rightly, the reports say this should not have happened. To draw such obvious conclusions, however, does not advance our understanding of why such mistakes continue to be made by intelligent, concerned and frequently well-trained and experienced people."[15]

To understand the causes of such apparent paradoxes needs an understanding of the system in which staff work, and the ways in which that system might respond to the stress and anxiety it encounters. Here, we argue that suicide and self-harm are potent causes of distress and anxiety among staff, and that careful attention should be paid to organisational responses. Unless health systems can respond adaptively to manage this anxiety, substantial problems will emerge.

Responding to a unique health problem

When someone presents to health services with suicidal or other self-harming behaviour, they are often thought of as a needy person seeking help, and are subsequently assessed for their suitability for various forms of care and

treatment. But what if those needs are not health needs at all? What if the assessment itself is ill founded? And what can be done if no effective forms of care and treatment are available? We argue here that the current model of care presents everyday clinical problems in each of these areas.

Self-harm is defined by the National Institute for Health and Care Excellence (NICE) as "any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. This commonly involves self-poisoning with medication or self-injury by cutting."[16] Although the NICE definition of self-harm includes acts with high and low levels of suicidal intent, in this Personal View we use the terms self-harm and suicidal acts separately to reflect their widespread use in clinical practice. All suicidal acts include self-harm of some kind, but self-harm need not be suicidal in intent. For example, one of our patients disclosed that having a razor to self-harm with is the only thing that had stopped the patient from killing themselves.

We recognise that self-harm and suicidal acts are often distinct problems[17] but consider them together in this Personal View for three reasons. First, suicidal acts and self-harm can be hard to distinguish when attempting to clarify suicidal intent; we thought that to acknowledge that uncertainty would be best, rather than to artificially exclude it. Second, both self-harm and suicidal acts share a crucial feature: the person involved is both the cause and the casualty of the harm. This duality conflicts with the conventional, so-called sick role and the behaviour usually associated with it.[18] Third, when self-harm and suicidal acts threaten life, they need an urgent health service response. However, the ambiguities that we have described mean that staff might not know how best to act, beyond dealing with the immediate injury, and the person could try to resist treatment.

When a clinician begins to engage with the problems of a self-harming or suicidal patient, they often feel some sense of responsibility for the outcome of that person's actions, even though they cannot influence those actions directly. This experience of feeling both responsible and powerless is unwanted by clinicians, emotionally difficult to bear, and is likely to affect their relationship with the patient.

Ambiguity around the origins of the problem further exacerbate anxiety. If suicide is regarded as a patient presenting as both cause and victim in a potentially lethal act, then the rights, obligations, and expectations associated with the sick role become complicated. Not only has that person been the proximate cause of their presenting problem (however complex the underlying social and emotional factors might be), but they might or might not have sought help for their disorder, and might or might not follow clinical advice about it.

Situations that combine severe distress, role confusion, uncertainty about responses, and a potentially fatal outcome will be emotionally charged for staff and patients. Although health services typically make huge efforts to save life, some acts of self-harm could result in the patient being discharged from care (eg, when a patient is intoxicated), even when the risk of death is acknowledged. If so, this action could contribute to the recognised risk of repeat self-harm or suicide in the months after discharge from hospital.[19,20]

The emotionally charged situations we have described are unique and unsettling: a person in need who does not behave like a patient, and a health system that feels obliged to intervene, yet isn't always clear how to do so. Such situations could be experienced by a range of clinical staff in various care settings, such as the family doctor's practice, emergency department, and psychiatric ward. These difficult situations often present unexpectedly, and often (although not always) recede quickly.

Here, we refer to these unique situations, in which the usual assumptions and social rules that govern patient–clinician interactions are suspended or unclear, as a dysregulated zone. We use dysregulated here to describe an absence of order, and it suggests a loss of emotional control for the parties involved. Importantly, not all patient–clinician interactions concerning suicide and self-harm will take place in a dysregulated zone.

In some situations, the patient conforms to a sick role, and staff feel confident that their care and treatment is helpful. For example, a mother who becomes depressed with psychotic features after the death of her only child will elicit empathy and care; she is unlikely to experience dysregulated responses. By contrast, an angry and intoxicated young man presenting with his tenth episode of cutting is likely to elicit a dysregulated system response. Furthermore, if staff are over-worked, or distressed by contact with previous suicidal acts, the zone is more likely to become dysregulated. Components of the dysregulated zone are represented in figure 1.

Characteristics of the dysregulated zone

Dysregulated feelings: conflicting emotions about the patient

Patients tend to respond positively to therapeutic engagement:[21] clinical compassion and empathy in response to self-harm are essential therapeutic factors. Yet first-response staff (eg, in emergency departments) sometimes have a negative attitude towards people who self-harm.[22,23] People presenting with self-harm are likely to evoke strong feelings in staff, who might empathise with a vulnerable person, but simultaneously feel angered and repelled by their act of violence against their self.

Staff might respond with several coping strategies. For example, these unsettling, untherapeutic feelings might be disallowed or deemed inappropriate (eg, "I feel angry towards this person, but I can't feel like that about a patient"). Alternatively, staff might complain that suicidal patients waste resources, clog up the system, or are attention seekers whose maladaptive behaviour would

only be encouraged by professional help. Difficult and contradictory feelings risk impairing clinicians' confidence and clinical judgment. Fortunately, negative staff attitudes are amenable to change.[24] To facilitate such change, the health-care system would need to be able to take account of the complex origins of the emotions elicited in staff.

Dysregulated responsibility: avoidance and over-control

Health-care systems seek to impose order on unstructured and distressing situations.[13] When responding to suicide risk and self-harm, the order imposed is often implemented on the basis of diagnosis: people with an illness should be treated within the health service, but those who are not ill should seek alternative forms of help elsewhere. This perspective does not apply to all services, and is more often implicitly recognised than formally expressed in policy.

A key issue for staff working in the health-care system is to establish whether a person's underlying problems have been caused by mental illness, social factors, or other difficulties. The results of that distinction are important: small differences in presentation or interpretation could result in either discharge or compulsory inpatient treatment. Yet the boundaries between illness and so-called problems in living are hard to define. Because psychiatric diagnoses are symptom based, clinicians can have difficulty in distinguishing between symptoms that suggest the presence of a disorder from expected reactions to situational difficulties.[25] Loss, grievance, frustration, humiliation, defeat, entrapment, and childhood adversity are all strongly correlated with suicidality,[26] but none would correspond to a diagnosis of mental illness in its own right. For example, a man presenting with suicidal distress after the break-up of his marriage would be considered more appropriate for National Health Service treatment if his distress was thought to have been so severe as to precipitate a depressive illness. The importance of a mental illness diagnosis in the distinction between illness and distress is summarised in figure 2.

No reliable method to manage these decisions exists and staff often find their way to clinical responses through ad-hoc methods,[27] which can be confused and inconsistent. Those who have dysregulated responses might do some or all of the following: make abrupt decisions, consider binary alternatives, think in stereotypes, create simplistic narratives, and implement solutions before the problem has been identified. If a person has self-harmed and has not been diagnosed as having a mental illness, staff might perceive a moral hazard if they respond empathetically to their distress. To respond in such a way might be thought to encourage similar self-harm in the future, or to unhelpfully capitulate to manipulation by the patient. This sense of compulsion felt by staff has similarities with the sense of entrapment often felt by patients.[26]

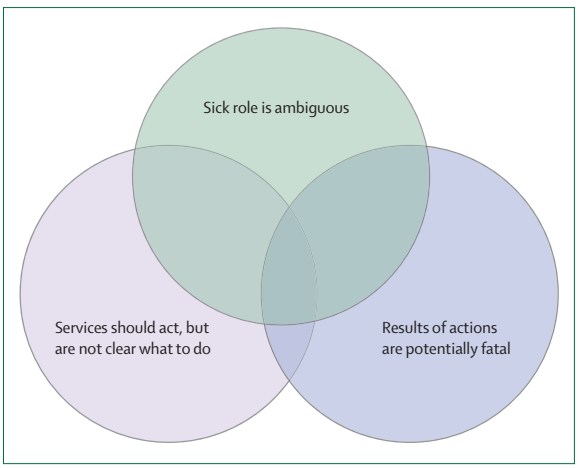

Figure 1: **Factors contributing to dysregulated responses to people presenting with suicidal acts and self-harm**
Three main factors contribute to a dysregulated zone: ambiguity about the sick role; a need to respond, matched by uncertainty about what to do; and potentially fatal outcomes. The greater the overlap between these three factors, the greater the risk of dysregulation. Many other influences affect the dysregulated zone, because the patient, clinician, and system will influence the dynamic of that interaction.

Dysregulated interventions: a therapeutic relationship displaced by risk assessment

Service users appreciate engagement, information, and empathy from staff, but often report that service responses are uncaring,[22] and psychosocial assessments are superficial and rushed.[28]

Conventional risk assessment shows weak evidence of predictive utility,[29] and provides very little information about the potential motivation for suicide or self-harm. Clinical guidelines state that risk assessment should not be used to predict future suicidal acts, or to make decisions about treatment or admission to hospital.[16] Nonetheless, risk assessment has come to dominate other therapeutic tasks and perspectives such as engagement or containment of distress.[23] Reasons for this dependency on risk assessment is understandable. For example, the ability to accurately predict risk would be an immensely useful clinical tool; therefore, risk continues to be assessed in the hope that outcomes can confidently be predicted, even though experience and evidence shows that this prediction is not possible. Additionally, risk assessment provides staff with a clear goal when the appearance of doing nothing would be unacceptable, confers some protection against criticism or medico-legal action, provides structure (albeit inadequate) for communication with patients, and offers a sense of control for service providers in an often chaotic and distressing situation.

Management of emotional engagement with the patient's distress is difficult, and risk assessment can be used to categorise patients to process them through the system (eg, transfer of care, and admission). By contrast, a therapeutic assessment might improve engagement[30] and reduce repetition of self-harm.[31]

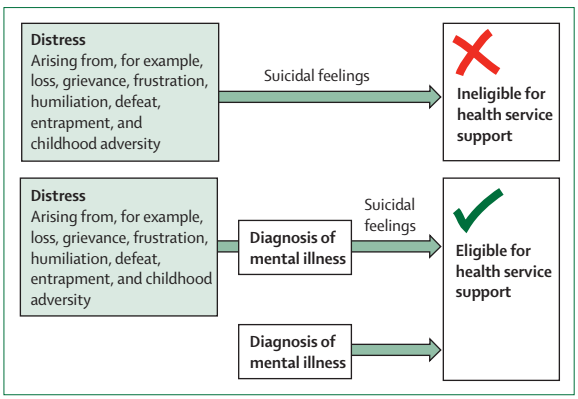

Figure 2: **Distinguishing illness from distress when considering health system support—the importance of a mental illness diagnosis**

Responses: working better in the dysregulated zone

Systems should acknowledge the risk of dysregulation, and seek to recognise it when it occurs

Dysregulation is contagious and can quickly affect everyone in that zone. For that reason, for clinicians to recognise dysregulation as it happens is often difficult, because they are often already involved in it. This irony—that clear thinking is impaired by dysregulation, just at the point when it is most needed—presents a tricky challenge in clinical practice.

The language that is used in the health-care system could be an indicator of dysregulated behaviour, as described by Ruch[32] in a social-work context. Clinicians often feel that they are expected to behave in ways that are rational, straightforward, risk free, and outcome driven. We suggest that such behaviours are not always adaptive. Instead, clinicians should be allowed to acknowledge the subjectivity, complexity, and risk-laden nature of the tasks they are expected to undertake. This kind of approach is difficult or impossible to achieve if the system regards any death by suicide to be a service failure. Some have argued that health services should accept the bold goal of zero suicides among persons receiving care;[33] however, our view is that such an aspiration could adversely affect clinician behaviour by increasing the risk of dysregulation, and that a more realistic goal would be to aim for effective mitigation of suicide risk.[34] In our view, staff appropriately engaged with a goal of mitigating suicide risk are more likely to be successful than staff confronted with the impossible task of eliminating risk altogether. A comparison of staff attitudes and behaviours between settings that have a so-called zero suicide policy and those that do not would test this view.

Staff and the systems in which they work do not find it easy to accept that some suicides will continue to happen. To express such a view could be argued as being complacent in the face of potentially fatal risks, yet to deny it might impose an unfair and disabling burden on clinicians.

Clinicians are perhaps especially prone to imposing unattainable standards on themselves. During an earlier draft of this Personal View, this section opened with the sentence: "At a senior (consultant) level, practitioners need to be able to articulate, understand, and resolve the emotional and interpersonal complexities of care for the suicidal patient." After several revisions, one of us remarked that "this sentence makes me feel scared". The sentence provoked anxiety because it assumed a level of omniscience and authority that no clinician could consistently achieve in practice. In other words, it was showing signs of dysregulation. We removed the sentence, but point it out here as a reminder of the ease with which clinicians might unconsciously seek to regulate themselves against unattainable standards.

Use of diagnosis and risk assessment for guidance rather than as the gateway to help

Repetition of self-harm could be fatal, whether the person is mentally ill or not. A vital task for assessing clinicians should be to explore the context and motivations for suicidal feelings and acts. Whether the person meets criteria for diagnosis, admission, or detention under mental health legislation should not negate the fundamental importance of understanding the patient's situation and building the patient–clinician relationship. Risk assessment is only one part of a comprehensive psychosocial assessment, and should be regarded as the beginning of a mitigation plan rather than an endpoint in itself.

When a patient has suicidal thoughts or self-harms, their risk of further acts is far higher than that of the general population.[3,6] Seeking to refine estimates of that increased risk is unlikely to be productive, particularly because population risks are poorly associated with individual patient needs, and many risk factors—such as age, gender, and past self-harm history—are not amenable to change.

Risk assessment and the identification of care needs should as far as possible involve the full participation of the person in receipt of services and the people close to them so that the risk is understood, responses are negotiated, and responsibilities shared. Several useful interventions that mitigate the risk of suicidal behaviour include the following: immediate (rather than conditional) empathy and engagement, including routine enquiry about suicidal thoughts;[35] containment of distress;[35] implementation of a safety plan;[36] an assessment of the person's response to these interventions, with a step up to more intensive care if needed;[34] and engagement, communication, and support for carers, including professional carers.[37] Promotion of this kind of therapeutic response might foster clinician–patient engagement, by helping them both to feel safer, reassuring patients that their concerns are being addressed, and reassuring staff that by taking action they will have some protection against future criticism or legal action.

Using a relational approach to engagement with the patient

Effective interventions depend on clinician engagement and empathy with the patient. At the first contact with a patient, establishment of a working therapeutic relationship should therefore be prioritised over diagnosis or risk assessment. Specifically, the engagement by a clinician with a suicidal or self-harming patient should begin by asking "what happened to you?", rather than "what's wrong with you?". The former question is non-judgmental, prioritises an understanding of the patient's perspective, and takes special care not to presume that clinicians know the reasons for patient behaviours. In this way, it seeks to foster the core conditions of effective therapeutic relationships, including authenticity, security, understanding, and empathy.[38]

A thoughtful enquiry about patient distress is analogous to the so-called not-knowing standpoint taken towards the patient in mentalisation-based therapy,[39] the curiosity emphasised in attachment-focused parenting,[40] and the acknowledgment of shame and self-criticism emphasised in compassion-focused therapy.[41] Relational thinking keeps the patient's distress at the forefront of attention, rather than thinking of it as an impediment to other actions. A clinician who is sensitively seeking to understand the causes of self-harm and suicidal thoughts is likely to foster empathy, and so help to contain distress.

Relational thinking is easier to describe than to implement in practice, particularly because dysregulated situations tend to generate negative inferences about patients, so-called black and white thinking, and immediate or abrupt responses. Good quality training and supervision is needed to help staff recognise and manage their own emotional response to suicidal or self-harming patients.

Conclusion

Distress is contagious. If clinicians are to engage sympathetically and effectively with a suicidal or self-harming patient, they too will experience some of the turmoil and anguish that led the patient to seek help. The anxiety this engagement generates affects not only patients and staff, but also the health systems themselves. Health services sometimes respond adaptively or unhelpfully to these emotional demands, and their responses will have a profound effect on both staff and patients within the organisation.

We argue that the person presenting with self-harm or suicidal acts makes particular and predictable emotional demands on health services, and we describe three factors that are particularly potent: ambiguity about the sick role, a need to respond matched by uncertainty about what to do, and potentially fatal outcomes, whatever actions are taken.

These three factors could generate dysregulated zones in clinical settings, in which it is temporarily difficult for staff and patients to think clearly and respond adaptively. We have described some common characteristics of dysregulation, including negative feelings about patients, an inappropriately narrow focus on diagnosis and risk assessment, and ad-hoc, abrupt, and inconsistent decision making. These responses might militate against the therapeutic responses that are favoured by patients and shown to be effective: containment of distress, safety planning, and negotiated responsibility with the patient and carers.

These therapeutic responses are sophisticated tasks in a normal environment but much harder to achieve in a dysregulated environment. This achievement is particularly difficult if the system and staff working in it find it hard to accept that not all so-called problems in living can be fixed, or every suicide prevented. More work should be done to develop and test ways to manage clinician anxieties in these situations.

The best of care might need, paradoxically, to aim to be good enough, because this goal might be sufficient to minimise the risk of dysregulation, and improve the chances of a genuinely therapeutic encounter. This aim is not to dismiss the importance of diagnosing illness when it exists, and to manage risk whenever possible, but diagnosis should not be a prerequisite for help, and risk assessment itself does little to improve outcomes. Not all suicides can be prevented, but we shouldn't stop trying.

Contributors

This is a Personal View based on clinical experience, knowledge of published work, and group discussion. All authors contributed equally to the design, analysis, revision, and approval of this report.

Declaration of interests

We declare that we have no competing interests.

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