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Working with men who self-harm in a learning disability secure unit: Staff perspectives

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Introduction

Men's self-harm is very rarely spoken about. Self-harm is often described in the literature as something that women who have survived traumatic experiences turn to as a method of coping because other methods have been suppressed. This may be down to more frequent disclosure on behalf of women, or services recognising or categorising women's behaviours more accurately as self-harm. However, self-report research from Canada and the US suggests there has been an increase in non-suicidal self-harm among young men (between 36% and 38.7%) (Ross and Heath, 2002, Whitlock and Knox, 2007). There is a small amount of research from the UK, such as Babiker and Arnold (1997) and Taylor (2003), who argue that when men self-harm, generally their injuries are more violent and can be misdiagnosed as accidental.

Because of this obscurity, Green and Jakupcak (2015) suggest that researchers and clinicians may be less likely to assess for or even recognise self-harm in men due to historically gendered views on these behaviours. They conclude that men's self-harm may be overlooked by professionals because 'men's self-damaging behaviours are informed by traditional male gender norms, and as a result, are not adequately represented by current definitions' (Green and Jakupcak, 2015:2).

Claes et al (2007) highlight the minimal research on self-harm in male populations internationally. Their survey of 399 psychiatric inpatients in Belgium found that men's self-harm behaviours can be even more dangerous, and easier to overlook than women's. Indeed, because self-harm is stigmatised for men even more than for women, men feel marginalised by other men and hide their self-harm from family and friends (Babiker and Arnold, 1997). Not seeking support can cause feelings of isolation which in turn can give rise to more self-harm (Taylor, 2003).

Taylor's interviews with five men in a UK mental health drop in centre show that men find it difficult to communicate the need for emotional help. Taylor suggests that the increase in men's self-harm is the result of society becoming less patriarchal, and the resulting feelings of powerlessness in the face of expectations of masculinity. Feelings of disempowerment and lack of control over circumstances are therefore becoming applicable to men as well as women (see Taylor, 2003).

Research in Inpatient services

Self-harm can be brought on by trauma in childhood and during times when dominant forms of coping are taken away yet the person needs to communicate distress. In inpatient services, ordinary coping strategies are limited and people may not feel like revealing their distress as it may lengthen their stay. Furthermore, as a function of masculine gender socialisation, men may be poor reporters of their emotional state. The expectations of normative masculinity allow men to express angry feelings more freely than women in secure care (Fish, 2015), but the pressure on men to be invulnerable and independent constrains their help seeking behaviours and the provision of services for them (Inckle, 2014).

Therefore, gender expectations can get in the way of the recognition of self-harm as well as help-seeking, and detention in inpatient services can exacerbate this. Staff may recognise men's distress but not expect men to self-harm. Gough and Hawkins' (2000) interviews with staff in a forensic psychiatric service in England found that they hold negative or punitive beliefs due to lack of awareness (also described by Moores et al., 2011). Fish and Reid (2011) propose that researchers should consult staff to find out how organisational structure can influence self-harm. They interviewed staff in the UK working with men with learning disabilities who self-harm and found that staff considered men's self-harming to be related to lack of control over their circumstances, and suggested that men were more likely to refuse medication or food, or display more aggressive forms of self-harm such as punching walls. Support workers wanted more skills to help them work with this user group. This suggests that staff do recognise the impact of self-harming behaviours in men and the reasons behind them, but possibly only those traditionally associated with masculine forms of behaviour.

Much of the work on staff working with men's self-harm has taken place in UK prisons. Marzano et al. (2012) interviewed 20 prisoners and found that staff can display hostile attitudes towards their self-harm. Indeed, Ramluggun (2013) interviewed 37 UK prison staff and found that most of them felt ill-equipped and unsupported when dealing with male self-harm. In a later study, Marzano et al (2015) show that male self-harm in prison is increasing, and that prison staff felt they had no practical resources or skills to deal with self-harm. They argue that

there is clear evidence why self-harm should be treated separately to suicide (Marzano et al., 2016).

The existing literature shows the complex nature of men's self-harm, and how certain aspects of life in inpatient services can influence it. The very small body of literature about the changing nature of men's self-harm (Van Camp et al., 2011, Taylor, 2003) flags up the need for more research with men who use services and the staff that work with them. As a starting point, exploring the experiences of staff can provide valuable knowledge into interpersonal experiences and ways of working with this user group. The majority of the literature focussing on men's self-harm comes from work done in psychiatric services or prisons. No studies to date focus solely on men with learning disabilities, who it can be argued are subjected to particular intersectional experiences throughout their lives, marginalisation or discrimination, and furthermore may use inpatient or secure services at some point.

Method

This project was granted ethical approval from the NHS Local Research Ethics Committee and the Lancaster University FASS and LUMS ethics committee. Semi-structured interviews were used to gain the views of nine staff members in a forensic learning disability unit in England, using a qualitative framework. The staff consisted of one psychiatrist, two psychological therapy staff and six direct care staff.

Research questions were as follows:

- What types of male self-harm have staff seen?
- How is the type of self-harm changing with this user group?
- What insights do staff have into the functions of men's self-harm?
- What are the challenges of working with men who self-harm?
- What are good strategies for supporting these men?
- What are staff support needs?

Analysis was performed by applying Hycner's guidance for thematic exploration (Hycner, 1985) and utilising the data management software NVIVO. The following results are arranged into themes which arose directly from the transcripts.

Results

Types of self-harm

Table 1 shows the types of self-harm that staff had seen in men they worked with. More 'masculine' styles of self-harm such as causing fights or tying ligatures were described, as well as other less severe behaviours such as picking and scratching. Swallowing items, a behaviour traditionally associated with women on the unit, was also described by one interviewee.

Table 1: Types of self-harm reported

Tying ligatures	He went through a period of tying ligatures weekly, possibly more than weekly, when he was in crisis and he first moved over to [names service]. (Int 39)
Causing fights	He'd cause fights. He knew he'd lose. He'd stick his head out of the window, [shouting] you effing pervert. . . So next time he come across this effing pervert, he'd get banjoed over big style. (Int 44)
Banging head	The other man that I've worked with, his self-harm tends to be banging his head. He says his head gets full. (Int 39)
Hitting / kicking self	He tends to hit himself, punch himself in his face, which causes bruises, which is difficult for him to hide. (Int 42)
Provoking physical restraint or intervention	And I almost think with a physical intervention, it's a way of self-harm. They provoke staff to physically intervene. You're left with no choice. (Int 44)
Medications	They could quite easily kill themselves. There's people who hoard tablets. (Int 44)
Scratches and scrapes	Two or three recently, just before I retired, were around more superficial self-harm, more scratching, minor cutting. (Int 42)
Interfering with wounds	Basically anything he can do to mess with the wound to stop it healing, he'll do. And that includes rubbing any kind of foreign objects or powders or anything into the wound to prevent that healing. It's ulcerated to the highest degree. It smells, it's that bad. (Int 41)
Inserting	He inserted in his penis, usually pens. Sorry was that too direct? I don't know how he did it sometimes. (Int 51)
Skin picking	The other one, he doesn't recognise himself as self-harming at all. What he tends to do is, he picks. He has an ongoing scar on his forearm and you can see it relates to when he's not very happy. (Int 50)
Eating	And of course, over-eating, not eating, is again a way of self-harm. (Int 44)
Swallowing items	I've worked with a service user who had really really gone out of his way to swallow batteries. You know, and that just wouldn't have been the case years ago. (Int 41)

Is the type of self-harm changing with this user group?

Three participants reported noticing a change in self-harm, both in terms of types and level or frequency of self-harm. This was attributed to culture within units as well as the wider society:

> *What I can see, particularly within high secure locations, is that the profile of self-harm has changed, in my view. So for the male population, that used to be something that may have happened, but it was something that was either hidden or not admitted to, whereas now, it is in the main very open. . . I think, for me just looking round and looking at the groups of service users, there seems to be, there's an acceptance that it's ok. So people don't, they don't seem to feel afraid of coming forward now and saying, I've done this. But I think the scales have just gone up. Whereas one time, you know it might just have been a cut or a graze, or a bruise where someone's rubbed their skin. Now it seems to be you've got to reach for the sky and, you know get something that will kind of really shock, or cause the individual maximum disruption. (Int 41)*

One participant reasoned that the increase in male self-harm was related to individual factors and anxiety due to imminent resettlement:

> *What I have noticed with the two gentlemen I was referring to, is yes I can say for both of them, it is increasing, and it started to increase because resettlement's on the cards now. And I think that's around anxiety levels and they way they're feeling. And I know that because I'm picking it up, because [it's on the reports], so I'm able to pick that up. (Int 42)*

Meanings of self-harm

Table 2 shows staff perceptions of the meanings of self-harm for the men they work with. Some of the perceived functions were relational, a response to bullying or powerlessness. A common thought was that men were using self-harm as a means of communication, or because of difficulties in getting people to understand their distress. Another popular perception was that men self-harmed as a way to bring on or stop ward moves.

Table 2: Meanings of self-harm

Sabotaging family visits	So he was harming his own interests. He'd do something to harm his interest. And as soon as mum turned up with the partner, he'd say something to sabotage the meeting. So he was getting his retaliation first. (Int 44)
To avoid moving	He can walk round the grounds and people will know and talk to him and it's normal here. Whereas in the community, he was very, he was bullied, he was exploited and he was very vulnerable. So for him, the thought of moving on from here is massively unsettling and I think that's partly why he self-harms, to show people that I still need support. To keep the care. (Int 39)
To bring about a	So they can tolerate being in a ward, it might be six months or

move	so, and then they'll request a move, or they'll do something to make a move happen. It might be seriously self-harming or it might be aggression, depending on what they're able to access or what they're able to do. (Int 39)
Turning emotional pain into physical pain	And it's, again perhaps they struggle to put it into words and perhaps it's the emotional pain. They put emotional pain into physical pain. I'm struggling for the words. They're turning one into the other so it's tangible. (Int 44)
Self-care	By physically harming themselves, it gives them a reason for looking after themselves. (Int 44)
Communication	[He self-harms] to ask for help without asking for help, I think. (Int 43)
Reduce stress	It comes in different forms. It's more chronic and that is where they use a de-stress coping strategy. (Int 40)
Control	I think it is about control and taking it to the extreme cases again, those individuals can then be in control of their own treatment regime. Cos quite often what you'll find is, 'I want to dress that myself, I want to it at a specific time, I want to go to the clinic to have that reviewed, but I'll only go in an afternoon.' (Int 41)
Coping	When I understand a little bit about their background, I'm able to say things along the lines of, well this is an effective coping strategy for you, and we explore the relationship with self-harm as a coping strategy, and we look at alternative coping. But it's a very strong coping strategy for people, and it's effective. It does the job. (Int 43)
Copying others' behaviour	[It's] learnt behaviour, without even looking at it. Learnt behaviour. Self-fulfilling prophecy almost. (Int 44)
Manifestation of distress	I can imagine a lot of men in this service saying that self-harm is better than crying. You could see people doing that, that sort of bravado approach. Because you could still have lots of scars and look tough, rather than somebody who's crying. (Int 43)
Response to powerlessness	I think if they feel bullied or powerless, that seems to be a massive trigger for the men I've worked with. So if, yeah if there's a situation on the flat where they've felt that they were threatened or were insulted in a public way, then that can usually, usually comes out in self-harm. (int 39)
Individual diagnosis	Being overwhelmed with worry, that seems to be a link with the men. With the men that I've worked with anyway. I think part of the issue is because people are so different. So we might have somebody there with autism, we might have somebody there with personality disorder. Somebody who's seriously aggressive with somebody who's previously been a victim. And it's just the nature of services, but that contributes to it. (Int 39)

Challenges of working with male self-harm

The major challenges related to the visibility of the self-harm. One of the challenges for staff was getting men to talk about their feelings, to say why they are feeling anxious and why they have self-harmed. Often, staff found it difficult

to see when someone had self-harmed because some of the men tried to hide their wounds. Feelings of frustration and sadness were also discussed.

Table 3: Challenges of working with men who self-harm

Interpreting behaviour	So it's a message of communication. He won't say any of those things, you have to have a conversation with him to work around to, what's the issue. And it does tend to be around some specific things. So once you know him, it's not too difficult. (Int 50)
Dealing with anxiety	It is, I mean the anxiety, there's all the talk about [moving], which has increased anxieties tenfold across the site, not just with these two individuals, cos that's more around resettlement. . . people are anxious of where they're going to end up and what's it going to be like – 'Will I have the staff with me that I know and trust?' (Int 42)
Dealing with aggression	[They] feel unsafe. And it's just that kind of, when they're being aggressive to staff and they're seeing the aggression, but actually it's the anxiety and the feeling unsafe that's causing that, or underlying it. (Int 43)
Frustration	At times it can be frustrating when the patient is unable to communicate their thoughts/feelings verbally. You want to help them but don't know how because you don't know what is wrong. (Int online)
Overwhelmed	Or kind of you come away having absorbed feelings, transference is the word. But you kind of, you take away their feelings, and I've been in sessions where I've come away, I've just felt so cut off. So you end up being a bit dissociative yourself, or overwhelmed. (Int 39)

Strategies for working with men who self-harm

Many of the strategies rested on the maintenance of strong therapeutic relationships, as well as supporting peer and family relationships. Maintaining self-esteem and focussing on men's strengths was another common strategy as described by staff. Art and psychological therapy were seen as extremely successful.

Table 4: Strategies used by staff

Listening to men	We've got to listen. We've got to enable people, as I said earlier, to put what they're feeling into words, and perhaps we need more specialists. More nurse specialists. (Int 44)
Supporting relationships	[We ask them} Do you want me to get in touch with your family? Is there a friend you'd like to talk to, you know, on another ward? (Int 44)
Support self-esteem	So we've got to start with the building blocks of, 'You are a good guy You are a good man.' I often say that to people. You're a good man. I like you. I don't like some of the

	things you do, but I like you. . . And yeah it really is fundamental. (Int 45)
Art therapy	[Art therapy is] about providing a safe space, the same time each week, providing art materials. So sometimes people talk and share their experiences through variable communications, talking therapy. But then other times they might draw or use art materials to provide a visual communication of how they're feeling. Because sometimes they can't find the words to describe their experiences or how it feels. (Int 39)
CBT therapy	Yeh, one of the most useful things with CBT is you teach the service user to become their own therapist. They understand what they do and why they do it and they've got relapse prevention stuff for the future. With PTSD, once the trauma is processed, with physically changed parts of the brain and physically changed where it's stored in the brain, and reoccurrence should be, you know minimal. (Int 43)
Using pictures/diagrams	We do a lot of diagrams, as to what different things might contribute to the self-harm, what the triggers might be, how they feel before, how they feel afterwards. . . It's a catalyst for discussion, and it's not as direct. (Int 39)
Consistency of staff	Cos I think if people are moved around too much, you don't see it, you don't see the patterns as much. You don't pick up on what's going on. And you tend to see the person in crisis. (int 39)
Talking off the wards	They seem to think it's personal to them. It's, so they are making it private, personally I take them out and that's when they can talk to you. If everybody is there, you know. And that's the way that works, once you take them out. (Int 40)
Talking about progress	[We talk about a] ladder, a progress ladder. They say, maybe before you were self-harming ten times a week. All right, now you are self-harming eight times a week. What has changed? (Int 40)
Relational security	I think it's about, it is about supporting those individuals. It's about recognising that that problem exists. It's about making sure that our staff are the best we can have them. I think there's a lot of work been done over the years in regards to that. (Int 41)
Supporting resettlement	It's done over a period of time where the staff team that are identified to be working with them when they move on, will come here and work with them. They'll start visiting the house, the flat, buy in things and eventually our staff will take a back seat and their staff will take sort of over more of the lead. (Int 42)
Talking about strengths	Everybody has his strength and if you promote that strength. . . 'You are very good at organising people. You are very good in making suggestions.' You see, if you keep talking about their strengths, my God, people value it. And I tell you, he will think about the positive things more than the negative. (Int 40)
Finding alternatives	So we look at similar alternative to self-harm such as holding ice cubes and also like, the red ice and that kind of

	thing. Potential those things as a potential alternative. And again it goes back, we start to look at underlying things. But in terms of the self-harm, they do respond well to that. (Int 43)
Engaged staff	Everything being pretty settled. A stable staff team, lots of people who knew him well, lots of people who could notice subtleties about him not being happy, and intervening to address that at an early stage. (Int 50)
Harm minimisation	So I think unconsciously we do a little bit of harm minimisation, because we address, what's the issue rather than just trying to prevent the behaviour occurring. So it's recognizing, you know, he cuts his forearms, we need to get in there on a daily basis before he even cuts. (Int 50)
Engagement while observing	But, you know try to engage is what for me. Cos we see it at a lot of levelling where the staff just sit there like, you know. They are observing, but they don't interact. To me the interaction is a bigger thing than the supervision. (Int 51)
Offering tools	Because when they move somewhere else, they're not going to have the same staff. They're not always going to have somebody with them. So they need to kind of have some internal, self-soothing-. Well that's one of the things that we do in DBT and that's one of the things I do in therapy is kind of developing these self-soothing boxes and kind of having a kit basically, kits of things they can use. (Int 39)

Staff support

Staff valued clinical supervision as well as peer support. Staff used individual strategies to deal with men, such as acknowledging trauma, focussing on positives of the person and distancing themselves a little from the self-harm in order to avoid burnout.

Table 5: Staff support

Clinical supervision	I know in this environment and other environments, there's a lot of clinical supervision delivered, which is a big difference to years ago. So it's recognised that people working with those individuals carry a lot of that round, and need to offload and share it and get support. So I think that's better than it ever was. I don't think you can do too much of that, because I think it's always always needed. (Int 41)
Working in teams	It's more about the containment and the safety. So consistency of staff, consistency of setting, bringing in, having a multi-disciplinary approach, sharing information, having time to reflect with other professionals working with that person. (Int 39)
Involving social workers	For instance a social worker, who should be able to liaise with a community social worker to get information in advance. To get the family involved is important, I would say. (Int 40)

Peer support	I think we've got to give staff the opportunity to say something like, they're doing my bloody head in. And get that out. And without saying, [GASP] oh, you can't say that. Well yes you can because that's how you feel. And if you allow staff to say how they feel and then talk around it, and everybody else is starting to feel the same, so it's what can we do about it, that sort of thing. (Int 42)
Management support	[Making sure] management is watching them, making sure that they're safe and they're well. Because they can't identify burn out, well very rarely can you identify burn out. You just suddenly. Even if you've got training around it, you don't always, well you just don't. (Int 43)
Focussing on positives	But in terms of like applying that to me and service users I'm working with, and the difficulties faced. The positives looking at the progress, looking at, like myself, if I'm becoming overly sort of hung up on something. (int 43)
Distancing self	Maintaining some clinical distancing, although it's a mixed bag. And also I've talked about it to friends of mine in this service about, we all have a therapy mode. We can all go into a therapy mode where we-, and it's kind of like armour that you put a psychological armour type stuff. And that helps. (Int 43)
Taking a trauma approach	I find it helps when taking a trauma informed approach to supporting people who you find challenging. (int Online)
Training	From a personal point of view I would like some training on self-harm and I think this would also benefit the team, particularly for staff who describe it as attention seeking/being needy/manipulative. (Int Online)

Discussion

Van Camp et al (2011) note the changing nature of men's self-harm, that men are beginning to self-harm in ways traditionally considered to be more 'feminine'. This was noticed by some of the participants in the current study, where they described that men they worked with had begun to self-harm in different ways, and agrees with the suggestion by Marzano et al. (2016) that men's self-harm should be looked at separately from suicidality.

A number of the participants suggested that the onset of self-harm was in response to developmental trauma. Knowledge about pathways to self-harm are important for professionals working with people in services, particularly inpatient services and secure units or prisons (Donskoy, 2011). Taylor's (2003) study looking into experiences of five men who self-harm found that men use self-harm as a means to focus away from emotional pain. They often cited rejection as a child as one of the reasons they began self-harming, and cited self-pity, self-hatred, anger and self-punishment as reasons for their continued self-harm. Traumatic experiences

growing up have been often implicated in self-harm research. Gomez et al (2015) attributed self-harm to level of abuse as a child, and argued that this was more a predictor of later self-harm than a person's gender. Marginalised groups such as disabled and gay men report higher levels of self-harm citing high levels of bullying and victimisation as reasons (King et al., 2003).

Communication of distress was a major function, as described in studies with women (Pembroke, 1996). McClintock et al (2003) evidenced that self-harm is highest in people who have no speech. Whittock et al (2011) commented that disclosure of self-harm was low, contributing to the invisibility of male self-harm. This was also acknowledged in the current study, with participants describing men being reluctant to ask for help, and hiding their wounds.

Staff participants in this study describe using a number of strategies to deal with their own feelings. These included distancing themselves somewhat, as well as focussing on positives. This is an encouraging point and contrasts with the studies by Ramluggun (2013) and Marzano and Adler (2007), who report that staff felt they had no resources or skills to deal with men's self harm. Staff valued clinical supervision and peer support as ways to share information and 'offload' their concerns.

This study has gathered valuable information about things that work with men who self-harm. Participants reported the types of therapies that they feel have made a difference, as well as supporting important relationships, including the therapeutic relationship. No other research has detailed this range of perspectives on behalf of staff and further work could explore these in more depth with both service-users and staff.

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Male self-harm is becoming more frequent and life-threatening in secure services. However, to date, the existing literature about men's self-harm comes from psychiatric services or prisons and does not focus on men with learning disabilities. This report details experiences of staff working with learning-disabled men who self-harm in a locked unit, based on a small scale qualitative study in England. A key finding was that the men the staff worked with undertook very distinctive self-harming behaviours, and the perceived functions of self-harm differed from that of women in the same setting.

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