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Deliberate Self-harm: How Do Patients View Their Treatment?

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The opinions of patients who had caused deliberate self-harm about the attitudes of doctors, nurses, families and others towards their acts were studied. Their views of the attitudes of hospital staff were found to be markedly different from attitudes reported elsewhere by staff themselves. There were no differences between the patients' views of their handling by nurses, families, and others towards their acts were studied. Their views of the attitudes of families were unsympathetic. A significant association was found between repetition of an act of deliberate self-harm and the perception of an unsympathetic attitude within the family.

While we have information about the attitudes of doctors and nurses (Patel, 1975; Ramon *et al*, 1975) and of people close to the patient (James & Hawton, 1985) towards cases of deliberate self-harm (DSH), there is little about how the patients themselves view the treatment they are given after their acts of self-harm. It is known for instance that hospital staff have a different attitude towards cases of this kind from that towards patients presenting with physical illnesses (Patel, 1975), but we do not know how much of this is apparent to the patients. There is evidence that nursing and medical staff differ significantly between themselves in their feelings of sympathy towards parasuicidal patients (Patel, 1975; Ramon *et al*, 1975); if patients are aware of these differences, there may well be implications for their assessment and management in hospital.

Significant other persons tend on the whole to be sympathetic in their reactions (James & Hawton, 1985), although Morgan (1979) has described expressed hostility and a definite lack of sympathy in some cases. It is of practical importance to know whether such responses are evident to the patients, and if so, whether these perceived attitudes have any effect on their subsequent behaviour. One could argue that a reaction perceived as hostile might discourage a person from repeating his self-harm, while an over-sympathetic response might even promote such repetition. What advice, therefore, should we give to relatives who find themselves in this dilemma?

This study was designed

(a) to find out how patients view the treatment they have received on general hospital wards after admission for DSH
(b) to relate these views to the actual attitudes of doctors and nurses towards DSH patients, as previously reported
(c) to compare the patients' views of the attitudes of professional staff towards them with their views of the attitudes of their families
(d) to establish whether the patient's view of his treatment by professional staff or by his family is related to the likelihood that he will repeat his DSH.

Method

Patients admitted consecutively to East Glamorgan Hospital for treatment of the effects of DSH were considered for the study, and interviewed as soon as their clinical condition allowed. The interview was a standardised one, used at the hospital for several years, and leads to the measurement of suicidal intent, to a psychiatric evaluation, and to a decision about further management. Patients who were confused or suffering from a psychotic illness were subsequently excluded, as were those unable to provide a significant other person likely to be affected by their action.

At the end of the interview, each patient was asked to give his opinion of the treatment he had received in hospital from the medical and nursing staff in the casualty department and on the ward. He was asked to categorise it as:

(a) definitely sympathetic and helpful
(b) neutral, i.e. neither particularly sympathetic or unsympathetic
(c) definitely unsympathetic and unhelpful.

It was made clear that this opinion was not to be relayed to the staff concerned, and the patient was not asked to complete a form. It was considered that this might be intimidating and thus discourage patients from giving an honest opinion.

He was then asked to provide his opinion of the attitude of his close family or a suitable significant other person to his behaviour, categorised in the same way. If several members of the family were felt to hold varying attitudes, he was asked to report his view either of the overall family attitude or of the attitude of the family member most important to him.

TABLE I
Attitudes of hospital staff: perceived and self-reported

Staff group	*Attitude: % Unsympathetic*	*Neutral*	*Sympathetic*
Senior doctors, self-reported[1]	25	33	42
Patients' view of doctors attitude	12	31	57
Junior doctors, self-reported[1]	44	44	12
Patients' view of nurses' attitude	14	31	55
Nurses, self-reported[1]	40	47	13

1. Figures from Patel (1975)

The patients were followed-up for a year, and a note made of further episodes of DSH leading to hospital treatment. It was not possible to obtain accurate information about episodes treated at home.

The results were analysed using the Spearman rank correlation to measure the degree of agreement between the patient's ratings of doctors, nurses, and families. The Wilcoxon matched pairs test and the Mann-Whitney U test were used to explore the relationships between various subgroups of patients.

Results

One hundred patients were included in the study (37 male, 63 female), and the mean age was 34 years; they were therefore comparable with other reported samples of DSH patients (Birtchnell & Alarcon, 1971; Silver *et al*, 1971). All had been admitted to the hospital via the accident and emergency department, and their mean length of stay in the hospital before interview was a little under 24 hours. All but two were nursed on general medical wards.

Of the total, 55% thought that the nurses had been definitely sympathetic towards them; this was almost exactly the same as the figure of 57% for their view of their treatment by the doctors. Fourteen percent felt that the nurses had handled them unsympathetically, compared with 12% who held the same opinion about the doctors. For the most part, it was the same patients who were unhappy about the attitudes of the different hospital professionals.

The patients' perceptions of the attitudes of both doctors and nurses towards them were markedly different from the attitudes previously reported by hospital staff themselves (Table I).

One-third of the patients believed that their families had been unsympathetic to their action, while 42% felt that they had been helpful; this indicated that the families were regarded as significantly less sympathetic than either nurses or doctors ($P < 0.01$, Wilcoxon matched pairs test). There was no tendency for the same patients to think that both the professionals and their families were unsympathetic. A strong relationship emerged between perceived lack of sympathy on the part of the family and a history of earlier acts of DSH: half of those patients who had harmed themselves previously thought their families unhelpful, and this was significantly different ($P < 0.01$) from the attitude reported by the other patients.

TABLE II
Repetition and perceived attitude of significant other persons

	Perceived attitude: n Unsympathetic	*Sympathetic or neutral*
Repeaters	8	4
Non-repeaters*	25	63
Total	33	67

*$P < 0.02$ (Fisher's Exact test) for repeaters compared with non-repeaters

No relationship was found linking the patient's view of his hospital management with the likelihood of repetition, but a connection did emerge between repetition and his view of the family's feeling towards his behaviour. Among those patients who repeated DSH within the follow-up period, as many as two-thirds had regarded their families as unsympathetic after the index episode (Table II). This is a significantly higher proportion than among the non-repeaters $P < 0.02$). Furthermore, when the 11 patients who had an earlier history of DSH and who considered their familes to be unsympathetic were looked at separately, seven of them repeated DSH during follow-up (64%), compared with 6% for other patients ($P < 0.01$). As expected, there was strong tendency for patients with a history of earlier episodes to repeat during follow-up ($P < 0.001$).

Discussion

The substantial differences between the patients' perceptions of nurses' and doctors' attitudes towards them and the attitudes earlier reported by staff themselves suggested that any lack of sympathy felt by staff treating DSH cases is not readily apparent to their patients. If this is so, the finding must be a

welcome one from the ethical point of view, unless one subscribes to the opinion that some degree of unsympathetic handling may discourage repetition. There is a possibility, however, that the apparent differences in perceptions of patients and staff can be explained by a reduction in the antipathy of doctors and nurses towards self-harming patients brought about by improvements in education and training during the years between Patel's study and ours. An alternative explanation could lie in sampling differences between the two studies, but this seems unlikely, as they were carried out in similar settings, involving unselected cases.

It remained true, however, that one in six patients felt that nurses had not been helpful or sympathetic – perhaps not a surprising finding in the light of the percentage of DSH cases reported to have histories of antisocial behaviour (Morgan *et al*, 1975). who are likely to provoke hostility in all those around them. Yet there was no trend for the same patients to see both families and professional staff as not sympathetic, so that the perceived attitudes may be a true reflection of their handling, rather than simply a mirror of their own personalities.

James & Hawton (1985) have recently shown that 50% of significant other persons express much sympathy after parasuicidal acts, while 3% feel no concern, and 18% show 'little sympathy'. The present study categorised the patients' perceived attitudes of significant others in a different way, but 42% thought that the other person had been definitely sympathetic – a comparable figure to James & Hawton's, suggesting a close correspondence between actual and perceived favourable attitudes of those near to the patient. This is of some interest in view of earlier authors' comments (e.g. Bancroft *et al*, 1977) on faulty or disturbed communications between DSH patients and those important to them.

The finding that one-third of the patients felt that their families had been unsympathetic has implications for the management of DSH cases, but this cannot be divorced from the question of the possible effects of this lack of sympathy. The results show clearly that the perception of a lack of sympathy in the family is associated with repetition. If this link is causal, then efforts should be directed to discovering whether this perception is an accurate one and, if it is, to making an attempt to alter it, in the hope of reducing the repetition rate. It seems probable, however, that any negative attitude in the family is itself closely related to a history of earlier DSH episodes. It may therefore be mainly a reaction to a series of acts perhaps seen as manipulative, and the family's attitude might well not have played any causative role in initiating the patient's repetitious self-harming.

For this reason, it will be important to concentrate attention on 'first ever' episodes in elucidating the different forms that family reaction to DSH can take, and in planning experiments to reduce repetition by modifying family responses which are felt to be inappropriate.

From the behavioural standpoint, it would seem reasonable to expect that a patient's belief that those around him were unsympathetic towards him on account of his act would discourage the idea of repetition, but the findings of this study suggest otherwise. It might be fruitful to continue to study the effects of family and staff attitudes on repetition by carrying out experiments which allow some patients to be treated in a more overtly sympathetic way than others.

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