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## **Compassion Focused Nursing with people who self-harm**

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### **Overall aim**

To provide insight into what is meant by compassion focussed nursing and how to achieve it when working with people who self-harm.

### **Learning Outcomes**

After reading this article and completing the time out activities you should be able to:

- Define what is meant by Compassion Focussed Nursing (CFN)
- Apply the principles of Compassion Focussed Therapy (CPT) to your practice as a mental health nurse working with people who self-harm
- Offer CFN approaches when working with a person who self-harms.

### **Why you should read this article**

Reading a CPD article and completing the 'time out' activities can count towards revalidation as part of the required 35 hours of CPD (for UK readers)

or contribute towards professional development and local registration renewal requirements (for non-UK readers).

### **Introduction**

In many ways, we take for it granted that nurses will be compassionate, as nurses 'care' and are therefore vehicles for compassion. Indeed, 'Compassion' as one of the 'C's' (Cummings and Bennett, 2012), is central to the value of nursing and effectively mandated within the NHS Safeguarding policy (National Health Service England, 2015), in our role to care for the most vulnerable in society. Compassion is essential to nursing practice (Straughair, 2012). As Wright et al, 2018: 684 wrote, *'Simply caring is not enough'*. Nurses need to care with compassion. Since the context of care and treatment is pivotal to the facilitation of the provision of evidence-based care, the delivery of that care, and the person's acceptance of care is very clearly interwoven with compassionate practice. Nurses are the catalyst that enable compassion focussed care to be accepted by the person; that is, they use themselves as catalysts for care, as described by Travelbee (1971). In order to use themselves in this way nurses need to express compassion to others but also have self-compassion. Indeed, compassionate practice can be challenging when working with people who self-harm. On some occasions nurses expressing compassion may be rejected by the person as they don't think they are "good enough" to receive this. It is important here that nurses do not immediately jump to criticising themselves but consider how receiving compassionate care may be complicated for some people. This article considers how nurses provide 'compassion focussed nursing' for people who self-harm, to aid their journey of recovery through interventions informed by Compassion Focussed Therapy (CFT) (Gilbert, 2009) which acknowledges the multi-faceted nature of their experience.

### **Compassion Focused Nursing**

The principle that nurses are compassionate and have a duty to care for those who are sick and vulnerable is a central tenet within the professional code (Nursing Midwifery Council (NMC), 2018). Nurses aim to provide person-centred care and have moved away from task focussed models of practice (Hem and Heggen, 2004). 'Compassionate care requires kindness, respect and collaboration'

(Wright et al, 2018), which are all essential elements of care for people who self-harm, but have been cited as absent in the care received by people presenting at emergency department and in-patient units (Pembroke 2005). Recent research also continues to highlight the need to build on nurses' knowledge around the functions of self-harm and how to respond and intervene in an informed way (Rayner et al, 2018; Rayner et al, 2019).

This paper presents a model of nursing which encompasses elements of CFT to augment nursing care for those who self-harm and ask for our help, and hence, we refer to the as 'Compassion Focussed Nursing'. First, this paper provides an overview of what is understood by the term 'self-harm' followed by an outline of the use of the term 'Compassion Focussed Nursing' as influenced by CFT, and its relevance for nursing people who self-harm.

## **Self-harm**

Nurses have come a long way since inspirational organisations such as 'Bristol Crisis for Women' and 'Survivors Speak Out', amongst others, raised the lid on the experience of self-harm and the care and treatment received by individuals seeking help, many years ago (Cresswell, 2005). In 2013 The National Institute for Health and Care Excellence (NICE) stated that:

*'The term self-harm is used ... to refer to any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting. Self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.'* (NICE, 2013:6)

Further developments in the field, and the publication of Diagnostic and Statistical Manual 5 (DSM-5) (APA, 2013) have created a more universal term of 'Non-Suicidal Self-Injury' (NSSI) which clearly differentiates between inflicted harm which was intended to be fatal, and injury which is intended as a coping strategy, effectively to survive, rather than die. Hence, more contemporary definitions, such as that used by Hooley et al (2020) refine the NICE definition to one that clearly states that NSSI is without suicidal intent: *Non-suicidal self-injury (NSSI) involves deliberate and intentional injury to body tissue that occurs in the absence of suicidal intent*, (Hooley et al, 2020: 101). This paper has continued to use the term self-harm to refer to NSSI to connect to the NICE guidelines in the United Kingdom.

## **Assessment and formulation**

### **Nursing assessment**

Several assessments exist to quantify the severity and impact on self-harm. These include the SAD PERSON scale which considers both Psychosocial and risk factors (Patterson et al, 1983), The Deliberate Self-Harm Inventory and the Self-Harm Behavior Questionnaire (Gutierrez, 2001), whilst these are important tools nurses need to remember to assess NEEDS, using a psychosocial model, as well as measuring RISK, (NICE, 2011/2013)

### **Formulation**

Formulation is a term used in psychotherapy as a psychologically informed explanation of a person's presenting issues and can be used to enhance understanding and inform decisions about how to help or change things (Corrie et al, 2016). It may give a visual map of how events and experiences connect together and helps the client to understand their presenting and past experiences and issues using a specific theoretical model. This paper will be using a Cognitive Behavioural Therapy (CBT) formulation using a five areas model (Greenberger and Padesky, 1995), which is also commonly used in nursing. This connects behaviours, physiological responses (or bodily reactions), emotions and cognitions. Figure 1 below relates this to Angela.

There are many reasons why people self-harm. In this paper, the authors focus on self-harm that has a function of helping the person gain relief from distress. This is because enabling compassion and self-soothing can make a real difference to the person with a view to reducing or coping with distress (Rayner et al, 2022). There are many reasons why people self-harm/injure (Nock, 2009). Sometimes people don't know why they do it until they think about this. It's not unusual for people to think "I just do it". However, it's important to attempt to understand this more with the person and consider how does the self-harm help them? and how does it make things worse?

As people use self-harm for many different reasons, and have different experiences of it, we present 'Angela' (a pseudonym)

### **Case study:**

Angela was interviewed about her personal experiences of interpersonal processes and self-injury (Rayner and Warne, 2016). Written consent was given by them for publication and education purposes.

Angela had been self-harming by cutting, burning, and inserting objects into her skin for about 20 years and had become stuck in this daily behaviour with their self-harm escalating for stressful periods. At the interview they were invited to discuss her experiences before, during and after the most recent incident of self-harm. A CBT formulation diagram was used to write this down after the interview.

<<Insert figure 1: Angela's formulation>>

### **Time out Activity 1: Take some time to reflect and write down the answers to these questions.**

- 1) What happened to Angela?
- 2) How did self-harm help?
- 3) How did it make things worse?
- 4) Which emotions and thoughts stand out to you?
- 5) What else may have helped?
- 6) How else could Angela cope with her emotions?
- 7) What else could Angela do about the situation at a later date?

As self-harm is such an individual behaviour it may be useful to consider the person's experiences of self-harm personalising the formulation above and then move towards considering how the local and national guidelines would influence your care.

### **Working within national guidelines (NICE)**

NICE (2013: 8) lists 8 quality statement that nurses are advised to adhere to when providing care and treatment for someone who self-harms. It is worthy of note that statement 1 asks that staff should offer the same level of care and compassion as that provided for any service user, inadvertently revealing that such parity of care had not been the norm at the time of its publication:

*Statement 1. People who have self-harmed are cared for with compassion and the same respect and dignity as any service user.*

*Statement 2. People who have self-harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide.*

*Statement 3. People who have self-harmed receive a comprehensive psychosocial assessment.*

*Statement 4. People who have self-harmed receive the monitoring they need while in the healthcare setting, in order to reduce the risk of further self-harm.*

*Statement 5. People who have self-harmed are cared for in a safe physical environment while in the healthcare setting, in order to reduce the risk of further self-harm.*

*Statement 6. People receiving continuing support for self-harm have a collaboratively developed risk management plan.*

*Statement 7. People receiving continuing support for self-harm have a discussion with their lead healthcare professional about the potential benefits of psychological interventions specifically structured for people who self-harm.*

*Statement 8. People receiving continuing support for self-harm and moving between mental health services have a collaboratively developed plan describing how support will be provided during the transition.*

Statement 7 asks that psychological interventions are provided, and later in the document, NICE suggest that 'the intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements' (NICE, 2013: 31). The approach in this paper is based upon an integration of Cognitive Behavioural Therapy (CBT) and Compassion Focused Therapy (CFT) (Gilbert, 2009). This is specifically created for people who self-harm, based on best available evidence (Rayner et al 2022). It has been piloted in a psychotherapy group and also a guided self-help online resource.

Angela had care and treatment that did comply with the statements above. The one statement not fully achieved was statement 1. Angela didn't always experience compassion, respect, and dignity. They stated that health care settings had improved over the years, but they still expected rejecting and judgemental responses from staff based on previous experiences and sometimes this still happened when they presented for help.

### **Time out Activity 2: Reflection on NICE's quality statements**

Take some time to reflect on the 8 quality statements promoted in the NICE guidance and consider which ones you meet in your own practice, and in your service. Consider examples of this.

### **Compassion Focused Therapy (Gilbert, 2009)**

Compassion focused therapy (CFT) is a type of therapy increasingly used in mental health settings and is especially helpful when working with people who experience shame and guilt. It is a transdiagnostic approach that targets compassion and has been found to be useful for a variety of severe and complex mental health issues (Gilbert, 2014). Evidence is suggesting CFT is as effective as other interventions or more effective (Craig et al, 2020) and that it not only increases self-compassion but seems to lead to a reduction in mental health symptoms, even with people who have more long term and complex mental health issues. Craig et al (2020) in their systematic review found that there was some evidence in randomised controlled trials supporting the use of CFT with people who have a diagnosis of Borderline Personality Disorder (BPD), eating disorders, depression, psychosis, post-traumatic stress disorder and illicit substance use. CFT was used in a variety of forms in these studies ranging from 2 to 16 weekly sessions. Feliu-Soler et al (2017) found that group CFT was superior to a mindfulness group in reducing BPD symptoms. Effectiveness of individual therapy has also been demonstrated when integrating CBT and CFT for trauma (Beaumont et al, 2012; Beaumont et al, 2016). The people in Beaumont's studies reported improvement in self-compassion and also reduced symptoms of trauma. However larger randomised trails are needed to

demonstrate effectiveness in group and individual therapy, especially against other approaches such as CBT.

Shame has an important part to play in the maintenance cycle of self-harm or Non-Suicidal Self-Injury (NSSI), indeed Rayner and Warne (2016) wrote about a cycle of shame in their qualitative research study on interpersonal issues and self-injury. This study considers how CFT principles and tools can be helpful for self-practice and also to use when working with people who self-harm when practicing compassionate nursing. Gilbert also uses the term compassionate mind training to refer to the training and practice of compassion within CFT but also for professional and personal training that may be used outside of a therapy environment.

Gilbert (2009) defines compassion as a sensitivity to suffering in self and others, with a commitment to alleviate and prevent this. So, nurses need certain qualities of mind to do this (Irons and Beaumont, 2017). Nurses need the ability to turn towards things that are difficult, without avoiding this. This practice is within the self and also towards others. Compassion to others is often the focus in nursing but in order to practice, this paper argues that nurses need to have compassion directed to the self as well. The second quality of mind is wisdom when being caring and helpful by using variety of skills with nurses and others when suffering. Compassionate mind training can help with inner self-criticism experienced by nurses (Durkin et al, 2016) and also for the self-criticism experienced by people who self-injure when they are ill or experiencing difficulties or suffering.

Gilbert (2009) considers compassion in the form of three flows: compassion for others, compassion from others and self-compassion.

#### <<Insert figure 2 : Compassionate flow>>

Here we can see the relationship between self-compassion, receiving compassion and expressing compassion to others (Cummings and Bennett, 2012). Indeed, nurses are 'professionally socialised' (NMC, 2018) into practising compassion towards others. Gilbert (2009) takes this a step further by recognising a personal role in receiving compassion and practicing self-compassion. Nurses tend to focus on expressing compassion to others but may have difficulties receiving compassion or being self-compassionate. This in turn may lead to "compassion fatigue" or "burn out" (Durkin et al, 2016).

#### Time out Activity 3: Applying the principles of CFT to Nursing

Take some time out to reflect on your ability to be compassionate. Rate yourself on a scale of 0-10 on the following three flows of compassion

- 1) Compassion to others
- 2) Receiving compassion
- 3) Self-compassion

What have you noticed about your scores? Which is the highest and lowest? What does that tell you? How can you enhance this?

#### Surf the urge

Urge surfing is a technique used in Dialectical Behavioural Therapy (DBT) (Linehan, 1993). This is a CBT based approach designed for women with BPD that also integrated mindfulness techniques. Urge surfing is a mindfulness-based technique that can be useful when people self-harm.

Often when people get an urge, it's like an itch they need to scratch. What they don't usually do is focus on the urge, accept it with compassion and see how long it takes to pass. They scratch the itch and it goes. For self-harm, nurses can think of an urge as an impulse to engage in an old habit. This may have a physical sensation in the body.

Urges are like waves, they rise in intensity, peak and eventually crash.

#### Time out Activity 4: Let's have a go at 'surfing the urge'

- Get a feather or something soft that will tickle your hand.
- Then tickle your hand with it
- Think about your urge to scratch to stop this, but don't do it
- Notice the sensations in a compassionate mindful way using all your senses as they awaken.
- Notice how these sensations change over time if you don't scratch or stop them
- What happens to them?
- Focus on your breath to ride the wave like you are on a surfboard.

Then reflect on this activity and write down

*What happened to the urge?*

*How long did the urge continue for?*

*What was urge surfing like?*

*Would you try this again?*

Urges usually pass between 20-30mins. Try not to battle or be self-critical when you urge surf e.g. "I can't stand this, I have to get rid of it right now, I'm rubbish at this". Just notice these thoughts and go back to focusing on the urge. These thoughts will also pass.

Keep recognising opportunities to practice this skill if you have an urge to do something. Make a note of your thoughts and emotions and how long the urge takes to go. This can then all be used as a helpful thought next time an urge comes. You can think "it took 30 mins to go last time, I'll give urge surfing a go, I'll notice the urge and the experience and breathe through this on my surfboard..."

This is a technique that can be used when working with people who self-harm. Get them to practise first on the "tickle" above and then other urges such as to self-harm or get drunk or take drugs for example. It is quite a simple practice but does need repeating frequently as skills improve over time.

#### **Making a compassionate kit bag** (adapted from Irons and Beaumont, 2017)

When people are distressed or experiencing very intense emotions, it can be difficult to think clearly and make decisions about how best to support ourselves. At these times nurses can resort to using harmful behaviours. Whilst these can feel helpful in the moment the benefits are usually only short term and can lead to the development of unhelpful long-term patterns. In the same way that most homes have a first aid kit, a 'compassionate kit bag' can be useful to manage overwhelming emotions. It is useful as self-care for most people.

#### Time out Activity 5: Creating your own 'kit bag':

The compassionate kit bag is a container filled with any manner of items that can help you to safely manage your emotions (for example items which can help ground you, distract, comfort or soothe you) during times of distress.

- Find a box, bag or container and consider which things to include that can help to shift your focus outwards rather than inwards.
- Think about items which can pull your attention using a whole range of different senses, including things you can feel, smell, touch, taste, hear or look at (for example, a smell that you find soothing or comforting, or that reminds you of a safe or happy time, a soft blanket that you can wrap round you, a picture of a time when

you felt relaxed and calm, your favourite thing to taste or a song which you associate with feeling safe or uplifted).

- Add things that have been useful in the past and new ones you want to try.
- Keep adding to this kit when you find things useful in this resource. Consider having a portable smaller kit, maybe in a small bag or pencil case to carry around with you.

As well as your physical kit build yourself a digital soothe kit that you can access on the go, possible on your phone or portable device. It can be helpful to have your kit in an easily accessible or handy place so that when you experience high levels of emotions you can access it and find something that may help you feel or cope better. You can use anything you like to create this, perhaps a bag or box that you can design, customise, or decorate in any way you like.

Your personalized compassionate kit bag can be used for self-care when you are stressed or emotional. It is also a great way to encourage people who self-harm to make their own to use when they have an urge to self-harm as a method of increasing self-compassion or distraction. This can also be useful to increase self-compassion after they have self-harmed and may be more self-critical.

### **Compassionate wound care**

It is important to be compassionate towards people who self-harm when nurses dress wounds or teach the person to care for their own wounds (Rayner et al, 2018). Sometimes people may think they do not deserve a caring compassionate response due to their own beliefs about themselves, or that they don't deserve to be compassionate to themselves. Nurses can demonstrate compassion, that in turn can be internalised by the person and they can move towards receiving compassion from you and then experience self-compassion during wound care. Your expression of compassionate wound care can then be practised on themselves.

### **Time out Activity 6: Reflect on your own wound-care practice**

Think about the last time you dressed a wound for a person who had self-harmed. Reflect and write down your answers to the questions below:

- Was this difficult for you?
- How did you cope with your emotions and thoughts about the person?
- What thoughts helped you continue to be compassionate towards them?
- Were you able to convey compassion towards them?
- How did you do it?

### **Conclusion**

This paper has taken you through the principles of compassionate focussed nursing for working with people who self-harm. It has provided the evidence behind the practice, reinforced the 6 C's of nursing and aligned with the Nursing and Midwifery Code of Practice. Compassion to self and others is fundamental to nursing and this paper has provided tools to facilitate compassionate through therapeutic interventions tailored specifically for working with people who self-harm. This work has been based on compassion focused therapy with a focus on expressing compassion to others, receiving compassion and self-compassion in order to maintain the flow of compassion to relieve suffering.

### Standard time out activities

- 1) Take some time to Identify how this paper has influenced your practice when working with people who self-injure
- 2) Please write a reflective account of why your practice will change and action plan what you will do

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## Figures

Figure 1 : Angela's formulation (based on Greenberger and Padesky, 1995)

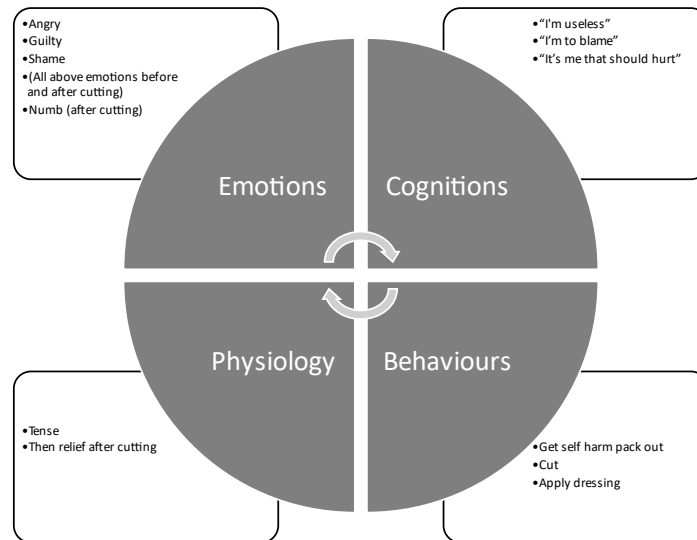


Figure 2 : Compassionate flow (Based on Gilbert, 2009)



