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Nonprofessional Healthcare Staff Perceptions Regarding Inmate Self-Injury in Georgia

Alisa Adele Harmer
Walden University

Walden University

College of Social and Behavioral Sciences

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Alisa A. Harmer

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Review Committee
Dr. Brandon Cosley, Committee Chairperson, Psychology Faculty
Dr. Sandra Rasmussen, Committee Member, Psychology Faculty
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Chief Academic Officer
Eric Riedel, Ph.D.

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2018

Abstract

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MA, Walden University, 2009

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Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

Health Psychology

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Abstract

Self-injury in correctional facilities is an increasing problem. Healthcare staff are tasked with responding to and treating self-injurious inmates. Research concerning the perceptions of prison self-injury depended on the experiences of professional healthcare staff and showed that specialized training reduced anxiety and altered perceptions. The perceptions of nonprofessional healthcare staff regarding inmate self-injury have not been studied. The purpose of this research was to understand the perceptions of inmate self-injury maintained by untrained healthcare staff through evaluation of their expressed experiences with self-injuring inmates. The research was based on the humanistic nursing theory. A phenomenological approach guided interviews of 8 healthcare staff having direct contact with inmates who self-injure. Participants had a past or present employment status with a State of Georgia Department of Corrections North Region correctional facility. Data were reviewed and coded to best reflect what it means to be a nonprofessionally trained healthcare member responding to inmate self-injury. Nonprofessional healthcare staff perceived that various experiences affected their level of ease and certainty, they operated as preservers of life and active listeners, felt that other healthcare staff held negative opinions, and were very helpful and supporting. Staff perceived that challenges prevented their success in managing self-injury. Last, nonprofessional staff perceived themselves as very helpful and therapeutic. This study promotes social change by encouraging staff to share knowledge, experience, and practical help with each other while building cohesive and collaborative relationships.

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Dedication

This doctoral degree is dedicated to my momma, Caroline Faye Blackmon, whom I am determined to make proud. I did it, Momma. I'm Dr. Harmer now. There has not been a moment since you left this earth that you have not been on my mind. I will forever be appreciative of your love and support. I love and miss you so much.

My entire educational journey is dedicated to my only daughter, Talyah (Rebbie). There has not been a day of your life that I have not been pursuing one of my many degrees. Hands down, you have been my biggest and loudest cheerleader. You pushed me through all the times I yelled, cried, and wanted to quit. You helped me to believe I could during the times I did not think I could. Thank you for your patience every time you had to wait until I answered one more question, read one more article, or posted one more discussion.

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Chapter 1: Introduction to the Study

Introduction

In this study I investigated the perceptions of nonprofessional healthcare workers regarding inmate self-injury in correctional facilities. The purpose of this research was to investigate perceptions of responding to inmate self-injury among a sample of untrained prison healthcare workers. The expectation was that the information produced from this research would present new insights and advise advanced practices. In this study I used qualitative methodology practices to explain the experience under examination. Participants of this study were a purposefully chosen group of healthcare workers who had experience with self-injurious inmates but had not been taught to move away from the biological paradigm of disease, uphold a compassionate presence, guide inmates through the self-harm, or accept, encourage, and have belief in the inmate as an individual.

The Georgia Department of Community Affairs Office of Research (2011) reported Georgia as one of the highest-ranking states for incarcerated persons. Approximately 1 in 36 adults were under correctional supervision at year end 2014 (U.S. Department of Justice, Bureau of Justice Statistics, 2010). With a 34% increase in the number of incarcerated persons between 2009 and November 2016 (Georgia Department of Corrections, 2016), incidents of inmate self-injury are rising rapidly in the state of Georgia. Over 1,000 cases of self-harm occurred between 2010 and 2011 (DeGroot, Cadreche, & Seegert, 2012).

Considered a serious and escalating health concern (World Health Organization, 2009), self-injury can be described as a socially unacceptable behavior causing minor to moderate injury while the individual is in a mentally troubled state but is not attempting suicide. The method by which an individual self-injures and the seriousness of the injury range from cutting, aggravation of chronic wounds, and swallowing or inserting objects into the body. Exclusive to this secure setting, the presence of correctional personnel affects the ability of healthcare staff to provide treatment to the inmate patient. Staff face several challenges in providing treatment in a therapeutic manner that assist the health and healing of inmates. Whether positive or negative, the interaction between the healthcare provider, the patient, and correctional personnel may establish the quality of the treatment that is given to the inmate. Feeling fearful about personal safety may get in the way of a person's capability to care. Having information about inmate offenses might present professional and ethical oppositions when attempting to treat the patient (Weiskopf, 2005). In the correctional setting, healthcare providers' practice involves exhibiting proficiency in an array of clinical skills to attain the best health outcomes for inmates. Healthcare staff must depend on their own medical proficiencies more in a prison setting than in a hospital setting. Studying the nonprofessional healthcare worker is a valued approach of acquiring understanding and awareness concerning individuals who commit their calling to delivering health care to institutionalized populations in prisons.

As the frequency of prison self-injury increases, the number of responses to this behavior may rise. With this increase, unprofessional healthcare staff are expected to respond to and treat inmates in the same way specially prepared healthcare staff provide holistic-based care (Department of Health, 2006). There is little research available on what nonprofessional healthcare staff perceive regarding inmate self-injury. Previous studies suggest that staff feel discouraged (Hopkins, 2002), anxious (Liebling (1990), and frustrated and nervous (Hemmings, 1999).

In this chapter of the dissertation I examined the background that structures perceptions regarding inmate self-injury. Because of the limited research available on this topic, a sample of participants responded to questions regarding what the perceptions are of nonprofessional healthcare staff regarding inmate self-injury. The encounters, as told by nonprofessional healthcare workers, guided the interviews and findings of this phenomenological study. Reflective immersion supported the participants' acknowledgement and interpretation of their presence within a setting helping to shape their perceptions. This research presented an opportunity for healthcare staff to adopt a mentality in which the participant responds to each patient in the same manner regardless of the call. This research also presented an opportunity for social change through empowerment of the staff. Definitions of essential terms used are also located in this chapter.

Background

Self-injurious behavior has received more concentration in research over the years because of the growing number of individuals who self-injure. Research concerning self-injury in the prison system is more available than in previous years and reveals challenges that exist with the relationship between correctional staff and inmates. Existing studies indicate that trained prison healthcare staff working with inmates who self-harm reported reasonable levels of understanding about self-injury, had helpful interactions, felt optimistic about care and outcomes (Gibb, Beautrais, & Surgenor, 2010), and held confident and encouraging perceptions (Suominen, Suokas, & Lonnqvist, 2007; McCann, Clark, McConnachie, & Harvey, 2006). As literature is available discussing the perceptions of professional healthcare staff who are qualified in mental health treatment (Cleary, Horsfall, O'Hara-Aarons, Jackson, & Hunt, 2012; Cleary, Hunt, Horsfall, & Deacon, 2011; Gabbard & Peltz, 2001; Grant & Briscoe, 2002; Josefsson, Aling, Ostin, 2011; Karman, Kool, Gamel, & van Meijel, 2015; Kool, Van Meijel, Koekoek, Van der Bijl, & Kerkhof, 2014), the perceptions of nonprofessionally trained correctional healthcare workers are mostly unknown (Lee, Lin, Liu, & Lin, 2008; Sethi & Upaal, 2006; Srivastava & Tiwari, 2012; Stoppe, Sandholzer, Huppertz, Duwe, & Staedt, 1999).

It is unclear as to what is successful when managing self-injurious behavior (Comtois, 2002; Smith, 2002). Interventions thought to be effective are not used systematically and contain a great deal of variation. Response to these inmates is often

impromptu (Bowers, Gourney, & Duffy, 2000) and display a level of inadequacy in practice. Those receiving the most concentrated treatment are not necessarily those needing the most intensive treatment (Comtois, 2002). Reports indicate that staff find it hard to describe their exact role when treating these individuals (O'Donovan & Gijbels, 2006). Even more so, as the number of known incidents of self-injury in Georgia exceed 1,800 (DeGroot et al., 2012) increasing numbers of untrained healthcare staff act as a first healthcare responder to this population. Unqualified healthcare providers state negativity and apprehension when encountering these inmates (Wheatley & Austin-Payne, 2009) often providing care that is encapsulated in feelings of helplessness, uncertainty, frustration, or anger. Feelings of rejection and disgust toward the inmate may set in (Reece, 2005), which in turn may reinforce the inmates' need for self-injury.

The perceptions of these workers in North Georgia have not been recorded in the literature; therefore, in this study I sought to shed light on understanding their perceptions. A theoretical model that helped to provide a better understanding was the humanistic nursing theory (Paterson & Zderad, 1976). This theory identifies each person as a separate individual having the ability and autonomy to decide how to respond in a situation. A more thorough discussion is offered in Chapter 2.

Statement of Problem

By the end of 2013, over 6 million individuals were under the control or custody of the correctional system (Carson, 2014). In the state of Georgia over 90,000 people were housed in a jail or a prison (Glaze & Kaeble, 2014). Quantitative evidence indicates

that self-injury is evaluated at a greater rate of occurrence than instances of suicide (Silverman, 2009) and happens more among incarcerated populations than those in general settings (Doty, Smith, & Rojek, 2012; McHugh & Snow, 2002). Correctional healthcare staff has the responsibility of providing adequate treatment for self-harming inmates. It appears clear that healthcare workers who have received mental health training in inmate self-injury have a better understanding regarding self-injury and feel more helpful and confident about patient care and outcome (Gibb et al., 2010; Huband & Tantam, 2000; McCann et al., 2006; Sandy, 2013; Suominen et al., 2007). There is limited research available on the perception of healthcare staff who lacks the professional mental health training to respond to inmates who self-injure. Taking the time to listen to the voices of untrained healthcare staff allows other healthcare personnel who respond to self-injury a peek into the world as the untrained staff perceive it. In this study I sought to better appreciate the experience and perception of the nonprofessionally trained healthcare member when encountering inmate self-injury.

Purpose of the Study

With this phenomenological study I aimed to expand the understanding of perceptions nonprofessional healthcare workers had regarding self-injury within the prison system. The purpose of this study was to understand perceptions of self-injurious behaviors held by nonprofessional healthcare staff by examining the effect of the described experience. I used qualitative phenomenological research to communicate the participants' perceptions and interactions about responding to the self-injurious inmate.

Research Questions

This study was focused on assessing the perceptions nonprofessionally trained healthcare workers had regarding inmate self-injury. Using personal interviews with healthcare staff from North Georgia correctional facilities, the primary research question asked:

RQ: What are the perceptions of nonprofessional healthcare staff regarding self-injurious inmates?

In addition, the study obtained answers to the following secondary questions:

SRQ1: What does the nonprofessional healthcare staff think about inmates who self-injure?

SRQ2: What is it like for a nonprofessional healthcare staff member to encounter an inmate who has just self-injured?

SRQ3: What components of holistic healing are evident in the responses of health care staff who encounter the self-injurious inmate?

Theoretical Framework

A theory that provided insight concerning the perception of the nonprofessional healthcare worker regarding inmate self-injury is the humanistic nursing theory (Paterson & Zderad, 1976). This theory asserts that in a situation, individuals have the power and autonomy to decide how to respond to the situation they are facing. Previous experiences are used to gain additional understanding, which is combined with personal beliefs and biases. When staff separate from fixed opinions or expectations, it frees them from

assumptions and negative feelings. When workers are more open and insightful, they can see beyond their biases and become more accepting of the patient and the patient's world. In addition to its use in nursing research (Boykin & Schoenhofer, 2001; Kostovich, 2012), the guidance of Paterson & Zderad's (1976) humanistic nursing theory on perceptions can be seen within clinical practices (Lesniak, 2010; Wu & Volke, 2011) and nursing education (Doane, 2002; Kleiman, Frederickson, & Lundy, 2004). This theory assisted in driving the review of literature and created questions as my study addressed the gap in the literature relating to how inmate self-injury is regarded by this group. This study addressed the significance of phenomenological explanation in humanistic nursing theory. As an approach, Paterson (1966) asserted that phenomenology directs the researcher to study the thing itself (in this study, what the nonprofessional healthcare staff think about inmates who self-injure) as well as facilitate participants in describing what they have come to know or how a situation affects their own existence (i.e., what it is like to encounter an inmate who has just self-injured). Last, Jackson (2004) states that the humanistic nursing theory pulls from the effects of the actions towards the patient (in this study, what components of holistic healing are evident in the responses of health care staff who encounter the self-injurious inmate). Basic concepts of this theory are further detailed in Chapter 2.

Conceptual Framework

A conceptual framework helps to outline and shape a study as well as guide research questions and data collection procedures (Creswell, 2007). In other words, it

dictates how actions are completed. The theoretical framework guiding this research was the humanistic nursing theory. The caregiver must consider how the patient lives and experiences his world in order to attend to the patients' needs. The theory operates as a vehicle for the essential aspects of the nursing experience through probing and describing. Application of this theory is having knowledge of what values, myths, preconceptions, and expectations are brought to the experience. This theory ultimately provides tools for users to move away from intuition to design and assess health behavior and promotion interventions centered on perception of behavior (Croyle, 2005). This view claims that while in a situation, individuals have the power and autonomy to decide how to respond (Paterson & Zderad, 1976).

Central concepts of humanistic nursing theory are: (a) moreness-choice, an individual's preference on how to respond to a situation including the desire for a feeling of "moreness," or helping others; (b) call and response, the relationship between caregiver and patient in the context of the patient calling for help to a specific situation and the caregiver responding in a situation-specific way that delivers quality care to the best of the caregiver's abilities; (c) intersubjective transaction, the process of each individual holding their own "angular" or unique view through which to experience the world, which results in the nurse and the patient each experiencing the transaction—the need for care and delivering care—differently; and (d) uniqueness-otherness, which focuses only on the nurses and encourages reflection on their own feelings and biases and causes them to face some of their own fears, insecurities, and vulnerabilities and may

help them to understand themselves better as caregivers, allowing them to be more effective (Wu & Volker, 2011).

The phenomenological method of inquiry allows for the study of how nurses inspect and comprehend their everyday practice. It allows for insight and identification of the lived nursing act as the point around which all nursing functions revolve. Importance on understanding the perceptions of participants inspired me to use a phenomenological method of inquiry as a lens while supporting and merging theoretical perspectives throughout the process. Humanistic theories emphasize through phenomenological perspectives that our perceptions, whether accurate or not, are our reality. The concept of uniqueness-otherness is essential when examining perceptions regarding inmate self-injury as it aims to bring identification, exploration, classification, judgment, and labeling about perceptions.

The relationship between a healthcare provider and patient affects the well-being of the patient (Hupcey & Miller, 2006). Detached relationships may lead to providers not regarding the patient as a unique person (Lilja, Ordell, Dahl, & Hellzen, 2004) and fostering nontherapeutic relationships (Karman et al., 2015). This means that the correctional healthcare staff, through their perceptions, may be moved emotionally or rationally. Using the information that is contained in the perception may move the individual to separate from any self-interest (Nabert, 1969) while helping others to be as human as possible during particular times in the patient's life (Santos. Pagliuca, & Fernandez, 2007). As perceptions of the individual influence behavior, it is important to

understand the perceptions of the provider of healthcare in the correctional environment. I used Paterson & Zderad's theory and concept of uniqueness-otherness to develop research questions, surveys, and to analyze the data. This is described further in Chapter 2.

Nature of the Study

This study was focused on understanding how nonprofessional healthcare staff process their encounters with self-harming inmates. Phenomenological methods helped to explain these experiences and assigned themes that were reflective of the experience. Reflective immersion supported participants in acknowledging and interpreting their existence in an environment that helped to shape perceptions. Each past and new interaction provides information and insight useful in future actions and interchanges. By way of interviews using open-ended questions and data analysis through identification of meaning units, I became familiar with and translated the perceptions of the nonprofessional healthcare worker. Chapter 3 includes a more detailed explanation of the methodology and approach.

Definitions

Attitudes: This term is used to describe an evaluation of a person, behavior, or idea, which, when considered favorable or unfavorable, creates a reaction in a specific way towards that person, behavior, or idea (Weiss, 2002).

Correctional healthcare worker: This term applies to healthcare staff who deliver healthcare to institutionalized populations in prisons and describes individuals who have training, knowledge, and skills specific to working in a secured environment.

Inmate: This term describes a person convicted of a crime who is under the control and custody of a state correctional facility or mental institution for a time established by the legal system.

Nonprofessional healthcare staff: For the purposes of this study, a nonprofessional healthcare staff member is an individual who holds the basic knowledge and skills necessary to render first aid to the self-injurious inmate during an acute situation but lacks the expertise needed to deliver care that is holistically driven and meets every need the inmate may have.

Perception: This term describes the approach in which there is recognition, observation, and discrimination of objects using the senses (Goldenson,1984) and assists with problem solving and reasoning (Carterette & Friedman,1978). It is the deliberate recognition and interpretation of the stimulus that operate as a foundation for understanding, learning, and knowing or formulating a particular action or reaction (Perception, 2013).

Phenomenology: Phenomenology is a qualitative research method that is used to explain and understand an experience or occurrence by establishing the significance of the experience or occurrence as it is felt or understood by those participating in it (Ary, Jacobs, Razavieh, & Sorensen, 2007).

Professional: A professional is an individual who has been prepared with the knowledge and skills necessary to perform the role of that profession (Professional, 2014).

Qualified mental health worker: Qualified mental health workers are psychologists, psychiatrists, mental health clinicians, registered nurses, and licensed practical nurses who have been prepared with the specific knowledge and skills necessary to assess and manage the incarcerated self-injurious inmate.

Reflective Immersion: This term is used to describe a procedural practice in which individuals are immersed in some type of engaging encounter, and then through reflection and verbal articulation, the individuals can expand the understanding of the issues related to their experience (Shappell, 2010).

Saturation: For this study, saturation was regarded as occurring when no new significant information was revealed (Butterfield, 2003).

Self-injurious behavior: Self-injury is any behavior containing the purposeful infliction of physical harm to a person's own body short of the aim to die as an outcome of the behavior (Simeon & Favazza, 2001).

Assumptions

A self-harming inmate is more challenging and more difficult to care for than other patients. Working with this population creates frustration, helplessness, and doubt for healthcare providers. For this study I chose phenomenology in search of understanding perceptions of healthcare workers. The encounters of participants steered

and informed investigation, findings, and conclusions. One assumption of this study was that participant perceptions regarding inmate self-injury are significant enough to justify further research. Other assumptions were that there were solid rapports established with participants, contributors responded to questions openly and honestly, and that perceptions and views added to the research foundation. These assumptions were essential to this study.

Scope and Delimitations

Purposeful sampling of correctional healthcare staff employed in the North Georgia region who self-identified as an untrained staff member determined participant eligibility. Self-reported responses to a demographic tool identified healthcare staff meeting the inclusion criteria. Correctional healthcare staff who never responded to a self-injurious inmate were excluded. Correctional healthcare staff who reported receiving specialized training concerning inmate self-injury behaviors were excluded. Correctional healthcare staff who identified as participating in suicide awareness or prevention training while employed at a prison were excluded as it was assumed that self-injury was included as a topic. This study also delimited certain geographic conditions; thus, all nonprofessional healthcare workers were not involved in the study as this research scope constrained participants to staff employed in the North Georgia region. In respect to boundaries, outcomes were not an accurate statement of all nonprofessional healthcare staff working in different male correctional facilities throughout the United States. The intent of this research was not to generalize all perceptions but instead offer a rich,

contextualized awareness of some aspect of participants' experience through the concentrated study of the nonprofessional healthcare worker. Detailed descriptions of these perceptions produced potentially transferable results. Assumptions that are central to this research may transfer to another context bearing similarities.

Limitations

This study remained limited as access to correctional healthcare staff working with inmate self-injury was hard to establish. Identifying staff members who lacked specialized training based on self-acknowledgment created a barrier to identifying suitable participants. Limitations existed with the willingness of the nonprofessional healthcare staff member to take part in the study. Suitable nonprofessional healthcare staff members did not want to participant in the study; consequently, a collection of participants was identified with the intent to obtain 12 participants. Using a phenomenological approach, this study's findings were limited to interpretative data analysis. Being aware of any personal presumptions influenced the outcome of the study. Bias refers to any predisposition which blocks impartial thoughts of an inquiry. Bias may have been introduced into this research during the interviewing process. Although I had previous experience working in the environment specific to this research and had worked with some of the participants, it was doubtful that participants associated me with being a current colleague. Because I wanted to understand the participants' perceptions regarding self-injury and create an informative study, participants presented as positive healthcare workers who were helpful in providing treatment to self-injurious inmates. Some used

this time to voice a personal plan regarding the care of these inmates. Because I was seeking transparency from the participants, I understood that there was no way of knowing if perceptions would be mostly positive or negative. I was fortunate in that participants did not appear unconcerned or rude during the interview. Each participant was cooperative in sharing his or her encounters with a self-injuring inmate. I asked interview questions in different ways to obtain deeper accounts of an encounter. As a result, descriptions were more detailed, which produced results that enhanced transferability. Working closely with my peer debriefer afforded me the opportunity to process feelings or reactions I had because of participant responses. In addition, the audit trail and communication transcripts were reviewed by my peer debriefer to ensure my activities met the standards for both credibility and transferability. Being aware of my biases helped me to not surrender to them during data collection and analysis, thus reducing any impact on this study. Last, a bias potentially stemmed from the perception that healthcare staff view inmates in a negative manner.

Significance of Study

The ability to provide quality care and attain positive patient outcomes rests in patients feeling cared for and cared about (Benner & Wrubel, 1989; Parse, 1995; Watson, 1985). Thoughts from healthcare staff about people who self-harm have a significant effect on clinical performances, encounters, and outcomes of the patients to whom they give care (Pompili, Girardi, Ruberto, Kotzalidis, & Tatarelli, 2005). By describing their lived experiences with inmates who self-injure, participants explored and shed light on

how they felt. This raised awareness and laid a foundation for cultivating an unprejudiced opinion of responding to every patient with the same respect despite the medical need. This study presented an opportunity for social change by inspiring workers to make sure they are serving as positive role models and striving for improved patient outcomes. Earlier literature has not studied perceptions of nonprofessional healthcare staff regarding inmate self-injury as it has primarily concentrated on perceptions of qualified workers. This study filled the gap adding to the existing literature on perceptions of inmate self-injury and shined a light on a population not yet reviewed. This research afforded healthcare personnel a systematic approach to altering the influence perceptions contribute to responding to the self-injurious inmate.

Summary

Chapter 1 provided a brief backdrop of the mindset of the nonprofessional healthcare staff when meeting the needs of self-injurious inmates. The research addressed the gap resulting from the small amount of obtainable literature on this topic and added to the development of unprejudiced perceptions of responding to clients in the same manner despite the medical concern. Vital elements establishing this study included the problem faced by nonprofessional correctional healthcare staff, the intended purpose of understanding perceptions of self-injury among healthcare workers in Georgia prisons, and research questions to guide the study. This chapter accentuated the connection of each component to the next. In addition, I explained in the chapter other components including the research approach, assumptions, limitations, significance, and definitions of

key terminology. Chapter 2 is a wide-ranging literature review that examines past inquiries on the nature and functionality of self-injury, models and theories significant to this behavior, the use of labels, feelings that surface in regard to caring for self-injurious inmates, and institutional factors. The chapter also reviews the theoretical framework in which the study was planned. Chapter 3 describes the research technique used, the data collection methods utilized, procedures, and anticipated findings. In addition, this chapter offers a description of the study participants. In Chapter 4, I present the results based on the analysis of the data collected. In Chapter 5, I interpret the findings, discuss the limitations of the study, suggest recommendations for further research, and present implications for social change.

Chapter 2: Literature Review

Introduction

Silverman (2009) found that numerous prevalence rates for self-injury exist depending on the population measured and the definition used. Occurrences of self-injury are approximate as studies manage to be more inclusive with categorizing self-injury under suicide attempts or less inclusive by measuring only certain types of self-harm. Self-harm appears more commonplace in prison or with other confined populations (Matsumoto et al., 2005). Occurrences fluctuate widely depending on the definition and if self-injurious behavior is assessed during incarceration only or over the lifetime of the person (Welsh, 2001). Within the prison walls, self-injurious behavior is even higher (McHugh & Snow, 2002) with occurrences rising more than 25% in the previous year despite a less than five percent population increase ranging from June 2013 to June 2016 (Howard League for Penal Reform, 2016). From 2010 to 2011, over 1,800 incidents of self-injurious behavior were reported in the State of Georgia correctional facilities alone (DeGroot et al., 2012). Specialized mental health training may provide more insight regarding self-injury as well as help to contain any anxieties for correctional workers. Having this training may assist with a changed perception toward self-injurious behaviors (Huband & Tantum, 2000). Studies indicate that when professional qualified staff encounter self-injury, they endorse perceptions that are poised and reassuring (McCann et al., 2006; Suominen et al., 2007).

Several studies have been conducted recording perceptions regarding inmate self-injury. At the present, very little attention has been devoted to understanding the experiences nonprofessional healthcare workers have when encountering inmates who self-injure.

This chapter begins with a review of the literature search strategy that was used to identify relevant articles for the study. The remaining contents of this literature review draw attention to formative inquiries describing the perceptions maintained by healthcare workers regarding inmate self-injury and provide a better understanding of the effects such perceptions have on healthcare encounters. Through a review of the humanistic nursing theory, I attempt to provide insight into the interaction between healthcare worker perceptions and healthcare encounters and healthcare worker perceptions and identifying meaning.

Literature Search Strategy

The research for this literature review was accomplished using numerous information sources involving multidisciplinary online databases, books, professional journals, and periodicals. I initially used Google Scholar linked to Walden University to search "perceptions regarding inmate self-injury". I also conducted a review of related articles on results of interest from Google Scholar. I created multiple alerts as well for sources with the key terms *self-injury, prison, perceptions,* and *humanistic nursing.* I searched common key terms used as a single foundation as well as inclusive of other words through the Thoreau multidatabase. Terms consisted of *self-injury, self-harm,* and

nonsuicidal self-injury. Publication dates for the search began with 2012. Additional terms searched, and combinations of terms included *prisoner, inmate, forensic nurse, mental health nurse, psychiatric nurse, healthcare workers, prison workers, attitudes,* and *perceptions.* I searched for literature on the theory using the terms *humanistic theory, humanistic nursing, caring theory, humanistic nursing research, humanistic phenomenon, descriptive theories,* and *application humanistic nursing.* Publication dates were expanded another 5 years to capture more literature and studies conducted in the United States relevant to the study. Through the Walden online library, I searched Academic Search Complete, Criminal Justice and Forensic Psychology Periodicals, EBSCO, ERIC (Educational Resource Information Center), PsychARTICLES, and Psychology: A SAGE Full Text. A review of references contained in the literature from these research approaches offered extra sources not obtained through the initial search. Throughout the review, I noted important gaps and exclusions of the literature as well as identification of significantly disputed matters or areas.

Theoretical Foundation

My intent for this study was to explore perceptions of self-injurious behavior among nonprofessional healthcare workers using a phenomenological approach. According to Smith, Flowers, and Larkin (2009), phenomenological methods are most appropriate when studying under researched or poorly understood occurrences. This method promotes free flowing understandings and expressions from participants through the eyes of that participant. Sandy (2012) attempted to gain insight regarding workers'

understanding of self-harm as it pertained to secure forensic environments. Sandy (p. 2) agreed that through conversation, implications were created and appreciated (Gadamer, 1996). Meanings of the phenomena are assessed by researcher interpretations of workers' individual realms and the meanings attributed to them. It is this insight and realization that facilitates development of perceptions into self-harm.

The theoretical model guiding the understanding of healthcare workers' perceptions of self-injurious behavior was Paterson and Zderad's (1976) humanistic nursing theory. This theory highlights each person as being a distinctive individual in an existing situation with the ability and autonomy to choose how to respond to a situation they encounter. According to this theory, each human operates as an individual within their circumstances and struggles for survival while seeking validation and understanding. Individuals reflect on past occurrences and use them to gain more insight about themselves. Nurses bring their own perspectives to patient encounters by combining gained insight with any awareness of personal values, beliefs, and biases they hold. This connects to SRQ1: What does the nonprofessional healthcare staff think about inmates who self-injure?). Paterson and Zderad asserted that patients are better understood and more accurately assessed when nurses separate from fixed thoughts or expectancies as it frees caregivers from assumptions and ill-feelings. Being more open, sensitive, investigative, and insightful assists nurses in seeing past their biases and being more accepting of the patients and the worlds in which they exist. This connects to SRQ2: What is it like for a nonprofessional healthcare staff member to encounter an

inmate who has just self-injured?). Through descriptive language, evidence indicates how healthcare workers perceive their personal experience regarding self-injurious inmates.

Although this theory has not been directly applied to healthcare staff perceptions, humanistic nursing theory has been applied to past studies structured around processes or statements of being or becoming (Davis, 2005; Doane, 2002; Cumbie, 2001; Lesniak, 2010; Vassallo, 2001). Kleiman (2010) asserted that by interlocking identity, education, and experiences, individuals generate their own tapestry that unfolds during their response. This connects to SRQ3: What components of holistic healing are evident in the responses of health care staff who encounter the self-injurious inmate?). This tapestry or angular view represents perspectives that consider the "gestalt of unique human experience and involved perception, bias, and prejudice and helps one to be open to the authentic, to the true experience of the other" (Kleiman, 2010, p. 343).

Conceptual Framework

The conceptual framework used in this study was developed by Paterson and Zderad in 1976. Humanistic nursing theory highlights the lived experience of the nurse as a basis of knowledge (McCamant, 2006). This descriptive theory helps others to understand interactions, identify meanings and observations, and describe existing elements such as self-insight, responsibility, self-identify, and the ability to relate to others (Wolf & Bailey, 2013). The theory helps other to consider the core of nursing and integrates the dynamics of being, becoming, and change (Kleiman, 1993). The principles of this theory establish nursing as a "transactional relationship whose meaningfulness

demands conceptualization founded on a nurses' existential awareness of self and of the other" (Paterson & Zderad, 1988, p.3). In this study I sought to identify the perceptions of the nonprofessional healthcare staff regarding inmate self-injury. The analysis of data for this study focuses on Paterson and Zderad's (1976) concept of uniqueness-otherness. Although this conceptual framework has not been applied exclusively to healthcare staff perceptions, this practice assumes an awareness of self and otherness as well as a recognition of each human being as an individual, functioning alone while searching for proof of existence. In view of the uniqueness of the person, the responsibility is placed on the individual to decide how the "himself in the situation" will develop (Paterson & Zderad, 1988, p.4). This is referred to as uniqueness or otherness.

The concept of uniqueness-otherness was conducive in a study on hospice and palliative care (Wu & Volker, 2011). Nurses reflected on feelings and biases and uncovered their own fears, anxieties, and weaknesses. Through interaction with self and awareness on their experiences, participants revealed ways to explore and assign meaning to the encounters.

In another use of this framework, inner attitudes were enhanced through reflection that examined the uniqueness and experiences of the participants (Murphy & Aquino-Russel, 2008). Nurse administrators helped staff to define themselves, their associations, and their clinical practices in circumstances that created anxiety and tension. Vanlaere and Gastmans (2007) suggested that actions rooted in inner attitudes (Atkins, 2006) result in sound nursing care.

The nonprofessional healthcare staff perceptions as explored in this research were based on how staff felt about the situation and about themselves. The prison environment may not be a suitable workplace for them if staff find it challenging to provide care or staff may have mixed feelings about providing care to inmates (Perry, 2001).

Literature Review Related to Key Variables and/or Concepts

Nature of Self-Injury

Statistics reveal self-injury as an unsettling event that manifests as an authentic and existing possibility with vulnerable individuals throughout the world. Research implicated self-harm as both a significant topic and an increasing concern (Bennett & Dyson, 2014), specifically within the forensic system. Although a minute amount of prior studies delved into staff explanations for self-injury in prisons, numerous justifications have been applied. Understanding the exact frequency in which self-harming occurs has been an ongoing problematic issue due to the secrecy that is often associated with this action (Sadler, 2002). Incidents of self-injury appear to occur more because of situations happening within the prison setting, because of other inmates, or both. Healthcare staff referred to remote dynamics such as neglect and abuse. Explanations ranged from hopelessness about the future to undergoing frustration. It is suggested that an inmate's core world causes self-injury. Studies have also associated self-injury with mental illness (Singleton, Meltzer, & Gatward, 1998), drug habits (Maden, Taylor, Brooke, & Gunn, 1996), and increased levels of past violence, rape, and childhood abuse (Corston, 2007).

The custodial milieu and situational concerns as they connected to a feeling of isolation, vulnerability, and control were charged as being prominent elements in this behavior.

Maltreatment

Self-abuse persists in playing a role in self-injury within correctional backgrounds. In a single study of 50 prisoners, 15 revealed that self-injury was a method to discipline or point the finger at themselves (Miller & Fritzon, 2007). Trauma and cruelty encounters influenced psychological processes that predisposed some individuals to self-harming behaviors by intensifying embarrassment and humiliation about the body. Over the years, research instigated childhood occurrences and distress as a menace effecting delayed self-harming behavior (Sakelliadis et al., 2010; Van der Kolk, MacFarlane, & Weisaeth, 1996; Linehan, 1993). Horrocks and House (2010) deduced that exchanges of long-term weaknesses such as childhood experiences and short-term components such as life and employment difficulties provoked occurrences of self-harm. More specific to this study, Carli et al. (2010) and Zlotnick et al. (1996) found links between past sexual or physical abuse and self-injury in offender populations. This study backed findings from Roe-Sepowitz (2007) where sexual abuse was coupled with self-injury in offender samples. Linehan (1993) and Klonsky, Oltmanns, and Turkheimer (2003) hypothesized that rearing in an invaliding setting promoted anger as a factor of self-injury. In a much earlier study, Liebowitz (1987) offered self-injury as an inner-directed anger that accounted for why anger is a precipitant of self-injury.

Abuse, violence, trauma, and disempowerment. For those who participate in this behavior, self-injury has a shielding function. In quite a few studies, a history of abuse, violence, or trauma was a familiar denominator in people who self-injured. Participants for Klonsky and Muehlenkamp (2007) and McAndrew and Warne (2005) admitting to self-injury confessed to childhood physical or sexual abuse. Favazza (1998) reported more than 60% of respondents with a history of abuse as describing miserable childhoods. In studies specific to sexually abused females, self-injury occurred to make their bodies look unappealing as scarring safeguarded them from unwelcomed sexual attention. Babiker and Arnold (1997) added that cutting helped to cleanse the body of mindsets of being dirty, inner hatred and blame, and guilt.

Furthermore, research confirmed that many incarcerated individuals had established histories of childhood trauma and abuse. Jennings (2005) reported abuse and trauma as probable for inmates who struggled with mental health issues. Johnson et al. (2006) harmonized showing that over 55% of incarcerated men in a county jail admitted some type of sexual abuse before age 13. One qualitative study by Short et al. (2009) described healthcare prison staff saying inmates participated in self-harm secondary to imported factors including records of neglect, domestic violence, and sexual abuse. Last, Sandy (2012) communicates that using self-mutilation allows users to return to reality thus stopping current episodes of distress. In one study, self-harm was viewed as a call for assistance in response to a prisoner's situation. Inmates labeled this harm as a way to cope with tough prison situations, especially for those somewhat new to prison lifestyles.

It was implied that prisoners end up in isolated circumstances with no control over domestic or social conditions that they have left behind (Ramluggun, 2013). Additionally, she added that while self-harm is understood to be a result of circumstantial causes, nurses opted to observe intrapersonal influences as the reason of self-harm in prisoners' failure in adapting to living in prison. Short and others (2009) reported that healthcare staff saw the prison setting and stresses it caused as a persuading factor in prisoner self-harm, more precisely, emotional states of disempowerment and isolation initiated by incarceration. Life in secured environments-the regime, staff-inmate relationships, and inmate culture, were identified as likely stressors. Towl and Forbes (2002) shared that negative staff attitudes and responses amplified the probability of prisoner self-harm by aggravating distress and reinforcing feelings of low self-worth, isolation, and loss of control which led to self-harm.

Psychopathology

This study applied self-harm according to the explanation by Patterson, Whittington, and Boggs (2007). They described this behavior as one in which "individuals purposely and consciously engage in harming themselves by employing different methods but where the intended outcome is non-fatal and the individuals understand the meaning and consequences of their actions" (p. 1). The phrase "purposely and consciously" make clear that it disregards those with a severe psychopathology or mental deficiency and thus was not propelled by psychosis or organic impairment, instead a maladaptive coping mechanism (Ramluggun, 2013). There is a high occurrence

of inmates with medical as well as mental health issues (Perry, Bennett, & Lapworth, 2010b). According to Stamler and Yiu (2012), one-tenth of males and one-fifth of females incarcerated battle mental illness. Research on the association between psychopathology and self-harm indicated that 86% of self-injuring inmates had at least one adjustment, anxiety, or mood disorder. Self-harm was frequented with self-reported depressive symptoms with men (Carli et al., 2010) and women (Völlm & Dolan, 2009), psychotic symptoms with women (Marzano, Fazel, Rivlin, & Hawton, 2010; O'Brien, Mortimer, Singleton, & Meltzer, 2003), and impulsivity with men (Carli et al., 2010) and women (Wilkins & Coid, 1991).

***DSM-5* classification and mental illness.** *The Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* offers a universal language by which clinicians and researchers transfer information regarding mental disorders. The *DSM-5* focuses on and incorporates the latest systematic and clinical facts on observed psychiatric disorders. The goal is to ensure the best care and increase usability for clinicians and researchers (Regier, Kuhl, & Kupfer, 2013). It been suggested that self-injury be considered a separate behavioral pattern. Nonsuicidal self-injury (NSSI) has been proposed for inclusion as its own diagnostic category. Under section III of the *DSM-5*, NSSI is listed as a condition for further study. The proposed criteria set require additional evaluation before NSSI becomes a clinical diagnosis (In-Albon, Ruf, & Schmid, 2013). NSSI conditions necessitate at least 5 days of deliberate self-inflicted harm to the outside of the body devoid of suicidal intent within the past 12 months. Additionally, one expectation

from those who self-injure will try to find help from an undesired feeling or mental state, settle a social struggle, or encourage a positive situation. Last, behaviors should be combined with one of the resulting conditions: relational problems or discouraging beliefs and way of thinking, planning, and meditating on self-injury. Those acting out suicidal behaviors within the past 24 months, yet lacking the requirements for other psychiatric disorders, will classify within the proposed diagnosis of suicidal behavior (Stetka & Correll, 2013).

Clinical disorders such as adjustment, anxiety, and mood disorders delivered an increased threat for self-injury in communities (Zlotnick et al., 1999). Leading causes reported were depression, psychiatric disorder, and a lack of coping. One nationwide survey calculated the percentage of self-harming inmates having mental health diagnosis. Just over three percent of the population combined had a diagnosis of mental retardation or pervasive developmental disorder. Seven and a half percent accounted for inmates with a psychotic disorder. Approximately 12.2% had a mixed personality disorder, followed by 15.5% of users diagnosed with a mood disorder, and 52.2% accounting for cluster B personality disorders (Savageau et al., 2015). This conclusion was uniform with Snow's (1997) pilot study where workers classified psychiatric illness and depression third and fourth of nine primary causes for self-harm in prisoners. Several authors have identified issues similar in context related to nursing attitudes towards those who self-harm with a diagnosis of personality disorder. In these studies, authors agreed that nurses needed more training and supervision to foster a more therapeutic rapport with these

individuals (O'Connell & Dowling, 2013; Weight & Kendal, 2013; Westwood & Baker, 2010).

Functionality of Self-Injury

The National Institute of Health and Care Excellence (NICE, 2004) identified self-harm as a "self-poisoning or injury" regardless of the perceived reason behind the act. One reason that explains high incidents of this behavior is inadequate strategies utilized to decrease events (Rickford, 2003; Shaw et al., 2003).

There are many purposes that validate the choice to engage in self-injurious behavior. Found within one of two categories, automatic functions spoke to affect regulation while social functions spoke to the social support of a circumstance or setting (Favazza, 1996). Researchers Herpetz (1995) and Nock and Prinstein (2004) agreed that automatic functions were most endorsed. Rissanen, Kylma, and Laukkanen (2011) shared that self-mutilation relates to oneself or others. Here, individuals helped him or herself through self-harm to let go of internal pain and expose bad feelings. When used to relate to others, self-mutilation was a call for assistance. Although Klonsky (2007) agreed with affect regulation as a familiar reason, he cites self-punishment, attention seeking, reaction to separation, formation of interpersonal boundaries, and replacement or prevention of urges to commit suicide as other meanings of self-injury. While several studies indicated social functions as a functionality of self-injury (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Brown, Comtois, & Linehan, 2002), three studies conducted in the forensic setting named automatic function solely as the functionality of self-injury.

Affect Regulation

According to Klonsky (2007), engaging in self-injurious behaviors helped with temporary management of negative emotions. Suyemoto (1998) illustrated these behaviors as a "need to express or control anger, anxiety, or pain that cannot be expressed verbally or through other means" (p. 537). This act communicates to others the presence of discomfort, concern, or rage and is used as a method to transfer core encounters to the outside world. Pannell, Howell, and Day (2003) listed the release of emotions as the third highest function suggesting that self-harm served as a therapeutic function. In a separate study, healthcare staff reported self-harm as a way to cope and release for prisoners. Self-injury permits users some sense of power over emotions externally due to the inability to control internal feelings. Long and Jenkins (2010) disclosed that self-injurious behavior provided a feeling of relief, release, purging control, and escapism.

Managing emotions. Self-harm drove the need for self-regulation and operated as an approach to stay grounded and manage intense memories and overpowering feelings and experiences. These self-defensive acts assist with warding off feelings of numbness, despair, and re-experienced abuse (Mazelis, 2010). Self-injury helped users to feel better, get a sense of physical boundaries, and have diminished intense emotions. Sakelliadis et al. (2010) identified self-described aggression as a distinctive predictor of self-injury among male inmates. Likewise, Milligan and Andrews (2005) identified shame as a managed emotion in that offenders who participated in self-injury reported more shame than offenders who do not participate in these acts.

Research specific to incarcerated women acknowledged situational and imported factors as functions of self-harm. Situational factors included unpleasant events, changed environments, being relocated within the prison, and being denied a request. Imported factors such as past sexual or physical abuse, mental health issues, and family neglect resulted in vulnerability to self-harm. Internalized feelings transpired when inmates were bullied, punished, treated unfair, or ignored by staff (Kenning et al., 2010).

Models and Theories

Kolinsky's' model shares that those engaging in self-injury believe it serves a boundaries or influence purpose. For some people, it creates a separation between them and others. This interpersonal boundary is based from the objects relations and attachment theory. When insecure attachments occur, individuals set themselves aside from other people. By marking the skin, users separated themselves from the environment and others. This affirmation distinguished between user and others and asserted ones' identity and autonomy. Williams (1983) suggested that inmates self-injure after discovering the influence the actions have on his or her surroundings. Within the interpersonal-influence model or the cry for help model, Klonsky (2007) stated that self-injurious behaviors were manipulative or used to influence other people in the system. In their study, Dear, Thomson, and Hills (2000) gave an account that for participants, any self-harm that worked to change the environment or milieu, attract attention, or achieve a goal was deemed manipulative. Specific to this study, Dixon-Gordon, Harrison, and Roesch (2012) reported that inside correctional facilities, self-injury was interpreted as

manipulative. Many other researchers endorse this view (DeHart, Smith, & Kaminski, 2009; Franklin, 1988; Pattison & Kahan, 1983) with scheming acts of self-injury counting for half of all self-injury in correctional settings. Self-harmers participated to be taken more seriously, to get attention, or to influence the behavior of others.

Soothing sensation. Another function for self-injury is to provide a soothing sensation when an individual is significantly stressed or suffers anger toward him or herself (Klonsky, 2007). Adding to this, Nock (2009) described self-punishment as a behavior acquired from recurring abuse or criticism from others. Sadler (2012) identified cutting as the preferred method utilized in prison. Users identified bleeding as an association to cleansing. Allowing the blood to flow provided a self-cleansing for the user. Secondary to histories of abuse, internalized criticism and self-blame resulted in engagement in self-injury. This sought-after sensation from self-injury produces a feeling of pleasure or increased stimulation for the user comparable to that of jumping from an airplane. Zuckerman (1994) defines this as the pursuing of new, diverse, and powerful feelings combined with the eagerness to take on physical dangers in pursue of these feelings. Having only received minimal attention in empirical literature, even less in theoretical literature, and no attention at all in a forensic setting (Klonsky, 2007), it is not anticipated that the soothing-seeking model will present in this studies' population, it is, however worth mentioning for a few reasons. First, self-injury may function for some participants to produce excitement similar other perilous activities. Next, although physically harmful, these soothing skills are aimed to provide emotional comfort. For

users of self-harm, as the pressure empties out, the individual can manage his or her thoughts and feelings as that moment of danger elapses. Last, although the role of sensation seeking was not indicative of a lifetime use or a specific method its function predicted the practice of additional types of self-harm (Knorr, Jenkins, & Conner, 2013). Research suggested that over 60% of users engage in multiple methods (Glenn & Klonsky, 2010; Gratz, 2001; Pattison & Kahan, 1983).

Labeling of Self-Injury

The use of judgmental expressions and labeling are routine in the correctional arena. According to Liebling (1992), labelling minimizes self-harm. The use of normalizing jargon permits both the user and labeler to avoid confronting the existences of self-harm. Across the literature, the terms genuine and non-genuine are commonplace. Although the perception is that most inmate self-harm is used to manipulate the environment and is less worthy of assistance, results indicated that prison staff differentiated and labeled groups based on the motives for harming and believed motives required a specific type of intervention. When staff felt the self-injury was genuine, inmates required psychiatric follow-up. When self-injurious behaviors appeared less genuine, staff became afraid that rewarding these manipulative behaviors with attention perpetuated the acts. Users considered genuine were believed to suffer mental illness and needed assistance beyond the capabilities of staff.

Genuine Versus Nongenuine

Several researchers documented participants as labeling self-harm as genuine, non-genuine, a trivial act, or attention seeking (Knowles, Townsend, & Anderson, 2012; Short et al., 2009; Liebling, 1992) and agreed that these labels were assigned based on the perceived motivation. Ramlugguns' 2013 study concurred citing a substantial percentage of participants who felt most self-harm was utilized manipulatively thus labeling inmates' behavior as non-genuine. Ireland and Quinn (2007) identified five factors that shaped a distinction in which to label self-harmers as the gender of the user, his or her behavioral characteristics, the severity of the injury, the frequency of use, and the intent or motive behind the use. In addition, Short and others (2009) added that participants viewed non-genuine harm as a learned behavior, particularly in prison, where self-injury achieved results for users and others repeated this behavior in hopes of receiving results. This labeling influenced prison workers' response as these inmates were identified as non-deserving of treatment. Machoian (2001) stressed that despite the motivation or label, it is unsettling when inmates choose to self-harm for attention or validation. She goes on to say that this means of self-harm occurs when communication is unsuccessful. Potter (2003) supported this viewpoint asserting the body becomes an alternate means to communicate when conventional methods have failed. Like Liebling's' research, when self-injurious behaviors were labeled manipulative, inmates were least likely to be treated with respect or value. When users received a stirring response from staff such as hurrying to help or relocate them, the secondary gain of the behavior was reinforced. There is to be

a balance between the identified need and the care that is given. Sun, Long, Boore, and Tsao (2007) noted that nursing staff were most engaging with inmates at risk for self-injurious behaviors when they spent time listening without judging or labeling.

Misunderstandings. The most common misunderstanding is that users are seeking attention. Both Firth (2007) and Mindframe National Media Initiative (2008) answered to this stating individuals perform self-harm alone, secretively, and typically over a span of time. As it becomes habitual, users are no longer aware of the damage to the body (Bird & Faulker, 2000). Although most research available records participants stating that self-harm is used for attention, users reported when staff respond with an uncaring attitude, it often caused users to harm in private. This information helps substantiate the difficulty in collecting data regarding this behavior when it is conducted in secret. Sadler (2002) continues to say that most self-harm is conducted in public and mostly for attention seeking purposes. Another common myth identifies self-harm as a failed suicide attempt. Hicks and Hinck (2008) differentiate self-harm from suicidal acts by stating that with self-harm there is no obsession with death and lacks the intention to take one's life. Reach Out (2015) posits that self-harm is used to cope with feelings that are raw and complex. Sutton (2007) concurs that self-harm is a life saver, not a life taker. Self-harm involves purposeful destruction of tissues with the intention of transferring emotional pain to physical pain. This behavior is considered an upgrade of the users' mental state. According to Mangnall and Yurkovich (2008) to classify an act as self-harm, it must be free of conscious suicidal intent, the direct behavior can only result in

minimal to moderate physical damage, and it must take place outside of psychotic behaviors or organic intellectual impairment. Last, self-injury is believed to serve as practice or training for upcoming suicide attempts (Joiner et al., 2005). Taking into consideration its role placing users at risk for suicide, it is vital that self-injurious behaviors are treated.

With rates as high as 70% (Klonsky & Muehlenkamp, 2007), cutting and scratching the skin was the method most reported (Nock, 2009; Klonsky, 2007; Whitlock, Eckenrode, & Silverman, 2006; Warm, Murray, & Fox, 2003) although banging, hitting, and burning were commonly reported. In addition to these, Klonsky and Oline (2008) identified biting, scratching, and restricting wound healing. Self-injury generally occurred on the arms, wrists, thighs, and stomach (Klonsky & Muehlenkamp, 2007 p. 1046). Whitlock, Eckenrode, and Silverman (2006) and Herpetz (1995) reported that most self-injurers used multiple methods. Contrary to Liebling's' (1992) and Snow's (1997) findings that superficial wounds were not legitimate signs of distress, participants for Pannell, Howell, and Day (2003) felt low severity self-harm was meaningfully related to inmate distress. Lack of knowledge about self-injury not only leads to misconceptions but has been detrimental in the recovery process and even prevented users from accessing medical treatment.

Healthcare Worker Interaction: Being Burdened with Feelings

Registered Nurses with specialist training in psychiatric nursing described fulfilling and unsettled involvements when seeing to individuals who self-injured

(Wilstrand, Lindgren, Gilje, & Olofsson, 2007). Two key premises surfaced: (1) being burdened with feelings, from which the three subthemes appeared were feeling afraid of the patients' life-threatening acts, mental states of frustration, and feeling abandoned; and (2) balancing professional boundaries, from which the three subthemes that appeared were management of individual feelings, upholding a professional association, and a desire for improved care for the patient. In an earlier study, staff reported a feeling of vulnerability (Stern, 1989). Thomas mentioned despair, hopelessness, and anomie as feelings experienced by staff caring for individuals who self-harm. Liebling (1990) discovered in research on staff anxiety levels that suicide attempts and self-harming events were included as one of the most stressful parts of the job. Wilstrand, Lindgren, Gilje, and Olofssons' (2007) qualitative study reported that having a fear regarding a patient's life-threatening act held a weighted emotional response that stimulated uncertainty, powerlessness, and defeat when confronted with treating patients at risk for repetitively injuring themselves. Participants reported being on constant guard, always conscious that this self-harm incident could be fatal. Participants described a fear that users' manipulative acts could be deceiving or misleading. In addition, participants admitted they did not always understand the patients' problems, therefore lacked the ability to care for the seemingly endless difficulties.

Frustration

Specialty trained psychiatric nurses working at an inpatient psychiatric facility identified frustration, irritation, vulnerability (Hemmings, 1999), nervousness, and doubt

when communicating with and caring for individuals who participate in self-harm (Friedman et al., 2006; Bailey, 1994). Healthcare providers considered these patients more challenging and more difficult to care for than other patients (Huband & Tantam, 2000). When nursing staff did not understand reasons for self-harming, they were more inclined to feel discouraged when encountering self-harm (Hopkins, 2002). When confronted with alarming patient circumstances that necessitated care, staff admitted to feeling frustrated. Wilstrand, Lindgren, Gilje, and Olofsson (2007) shared verbal reports from self-harming users who saw workers lose emotional control by raising their voice at patients, gripping the patients arm in a firmer manner, and embarrassing them. Reports of frustration manifested when staff was required to closely monitor these patients while protecting his or her integrity. In addition to this feeling being directed at prisoners, staff reported being frustration with prison systems and practices that wasted time and expenses on manipulators while possibly missing genuine self-harmers.

Managing personal feelings and establishing professional boundaries.

Throughout studies, nurses reported a collection of feelings about self-harming patients'. Nurses expressed experiencing frustration, being angry, feeling helpless (Anderson & Standen, 2003; Hopkins, 2002; Hemmings, 1999), nervousness when communicating with self-injurious patients (Bailey, 1994), and stress (Holdsworth, Belshaw, & Murray, 2001). Nursing providers stated negative mindsets towards patients' who self-harm at times (McAllister, Creedy, Moyle, & Farrugia, 2002; Holdsworth, Belshaw, & Murray, 2001). Other investigations shared nurses' feelings toward the need for additional

knowledge (Clarke & Whittaker, 1998), improving the care provided (Warm, Murray, & Fox, 2002), and overall treatment (Perseius, Ekdahl, Asberg, & Samuelsson**,** 2003). Staff mentioned difficulties and strategies alike when describing personal feelings that erupt when treating self-inflicted wounds, while not giving attention to the self-injurious act itself. Participants admitted shutting off feelings or joking with the patient. Internally, staff felt cold and it necessary to emotionally cut off, as it could be a difficult struggle with feelings during a critical time where you take actions first. It is still unclear the methods health care staff uses to deal with these pressures. Although in scarce amounts, literature on approaching prison work suggested that staff use passive, secondary, and calming coping methods which later became central components within the work culture (Schaufeli & Peters, 2000). Research shares that these methods are ineffective in decreasing work-related stress as well as slow down open and indirect assistance for at risk inmates (Liebling et al., 2005). When healthcare staff laid low, team work was hindered. Socially distancing from inmates proved to be ineffective.

Several strategies exist that assist with balancing professional boundaries. Some include connecting with patients through engagement, establishing structured and direct limits, and putting aside ones' feelings at that moment. Staff should disclose feelings, support each other, and debrief as needed to help balance stressful situations (Wilstrand, Lindgren, Gilje, & Olofsson, 2007). Participants admitted they were often rigid and controlling when faced with self-harm situations. Patients were expected to adhere to instructions or directives given by the nursing staff (Sandy & Shaw, 2012). Nursing staff

also revealed that setting boundaries required an emotional separation from users. This strategy sometimes delayed therapeutic engagement and preserved an increase in self-harm.

Coworkers and Management

Transitioning from novice to qualified or professional nurse is difficult and stressful (Higgins, Spencer, & Kane, 2010; Pellico, Brewer, & Kovner, 2009; Mooney, 2007). Staff verbalized the struggle during this time of change and stated they felt as if they were being 'thrown in the deep end'. Whitehead and Holmes (2011) agreed that while some novice professionals learned to deal with being put in unfamiliar situations, it was not the best way to transition to staff nurse. They added that staff learning needs often were not a priority as the busyness of the workplace took precedence. Doubt, distancing, and disbelief among staff and management were evident in early literature (Stem, 1989; Poole & Regoli, 1980) and displayed the lack of support given by co-workers and management. Healthcare staff reported feeling pressure in situations when they were expected to complete tasks in which they did not feel confident. Higgins, Spencer, and Kane (2010) suggested that newly qualified staff lacked preparation for the realism of prison practice. Participants voiced feeling separated from peers, a lack of staff participation, and not having a voice. Because feelings were so great, and staff was exhausted, they had to take sick leave (Wilstrand, Lindgren, Gilje, & Olofsson, 2007).

Abandonment versus confirmation. Indifference, estrangement, disappointment, distrust, and lack of interest and concern for charges are some feelings

reported by staff stemming from the work environment (Gerstein, Topp, & Correll, 1987). Not being supported, feeling burned out, and not having a clear understanding about the position nurses play increased worry, tiredness, strain, and exhaustion (Posen, 1985; Smith, 1984; Cherniss, 1980). Burnout was a commonly reported theme by Klofas and Toch (1982). They share that staff started professions with optimism and reassurance for the population they serve. After trials and failures, feelings of unconcern and sarcasm to human suffering consumed them. Contrary to feeling alone, some healthcare staff expressed a need to feel backed by co-workers and management. Staff did not feel as if they were alone. Workers shared personal feelings regarding incidents of helping those who self-harm. Peers confirmed healthcare staff. Participants were recorded as feeling good having heard that other staff found it hard and receiving confirmation of a job well done or doing the correct thing (Wilstrand, Lindgren, Gilje, & Olofsson, 2007).

Organizational Issues

Carson (2014) reported over 6 million people being supervised in the correctional system at the end of 2013. Approximately one in every 35 adults in the United States is under correctional control. The State of Georgia ranks fourth having the largest incarcerated population. In 2013, approximately 91,000 individuals were in jail or prison (Glaze & Kaeble, 2014).

Partnership with other disciplines is critical when providing treatment for users of self-harm (Marzano, Ciclitira, K., & Adler, 2012) although departments are not always cooperative (Kenning et al., 2010). Healthcare and prison service workers agreed that

employees should utilize a multiagency structure to manage self-harm. Staff suggested that poor communication between the departments and disciplines stemmed from a lack of clearness of staff functions and tasks and that the need to improve communication is vital. Ramluggun (2013) supplemented that the insufficiency of communication amongst departments regarding the supervision of self-injurious inmates led to staff being infuriated with each other. This deficiency appeared as a combined result of the agency's anticipation and plan, dealing with the risk of self-injury, and healthcare staff's method of working. Fox (2011) also referenced handling the risk regarding the inmates' well-being, being mindful of confidentiality, and staying within the boundaries of the relationship. Last, staff felt the expectation of the agency is to help the inmate cease the harming behavior or at least manage any risks associated with the behaviors.

Prison Environment

Incarceration is a stress as well as a precursor to self-harm (Dear, Thomson, & Hills, 2000). Kilty (2000) cautioned against seeing self-injury as an effect of the pathology of the user. Doing so restricts the position of the behavior to guidelines focused only on punishment and control instead of grasping larger parts of the behavior. One report estimates self-injurious behaviors in prisons as approximately three percent of the population participating in the activity (Schoenly, 2012). Increased incidents of self-harm within the prison indicate that several prison specific factors contribute to this behavior. What remains unclear is whether the environment or the inmates are the more contributing factor. Dear (2006) identified two groups of approaches beneficial for the

deterrence of self-harm in prison. One grouping focused on decreasing ones' psychological vulnerability by offering psychological and encouraging help. The second classification targets environmental interventions that lessen or wipe out situational factors such as disagreements with other prisoners, suitable assignment of inmates in the prison, and improved quality of staff-inmate interface (Ramluggun, 2013). It is well known that prisons handle inmates who are challenged, troubled, and deceptive. The belief that these individuals ruthlessly attempt to have the upper hand within an all controlling system must be acknowledged. Prison workers exhibit frustration from inmates who self-harm manipulatively. Patterson, Whittington, and Bogg (2007) added that self-harm conjured undesirable feelings in staff. Furthermore, behaviors negatively obstructed joint efforts.

Departmental conflict. Conflict continues to exist between care and custody in the prison setting. In addition to punishment and correction, prisons are tasked with the rehabilitation of inmates to the community (Watson, Stimpson, & Hostick, 2004). Conflicting with the aim of healthcare (HMCIP, 1999), the need for safety and correction often minimized the view of prisoners as patients. Oppositions erupted because of prison policy on self-harm and risk management and healthcare staff instituting personal ways of working that is apprised of personal feelings, attitudes, and values toward this behavior (Fox, 2011). More than 50% of staff reported serious communication and cooperation issues. Problems cited were inadequate feedback, hesitancy in accepting at risk inmates, lack of clear instructions about inmates, and minimal information-sharing. In the interest

of the inmate, healthcare staff expressed a need to share medical information to security personnel. Ramluggen (2013) asserted that confidentiality offered ethical and practical challenges stemmed from opposing expectation of the prison setting. Healthcare staff reported role conflict in a security first environment. In addition, staff voiced that institutional facilities should focus more on management approaches as an alternative to depending on healthcare staff or other disciplines in the facility. Because self-injury is a behavioral issue it should be handled by the institution (Ramluggun, 2013).

Healthcare in Prison

Despite literature showing attitudes as negative towards self-harm as common, Karman, Kool, Poslawsky, and van Meijel (2015) report the importance of positive nursing attitudes considering the close contact between provider and user. Not only does the setting influence the attitude of the staff member encountering this user, supervision and support is critical in forming positive attitudes. A positive attitude is desperately needed in providing high quality care. Fan-Ko (2011) stated that the quality of care received by this population was dependent on how they were perceived by mental health professionals treating them. Over the past decade, prison health service assumed the responsibility of providing health care to inmates although some think this responsibility belongs to NHS. As reported by HMPS/NHS prison health services failed to deliver an adequate level of health care calling for the NHS to take over the care in prisons. Noticed is that healthcare workers in prisons were detached and lacked necessary training in comparison to other healthcare professionals. This brought about care that was

insufficient for inmate needs. Due to the impact that prisons have on the inmates' mental well-being, there is a need for increased provision of mental care. The joint Prison Service and National Health Service Executive Working Group combined to formulate measures to improve prison health care services. The working group visited 38 prisons to assess organizational models of health care in use. It was discovered that several significant structural changes and guidelines to counter inconsistencies in health care services were warranted. The major concern was in providing services based on the notion that inmates are allowed equivalent levels of health care as provided to those in the community. In 2000, structure reforms were put in place. The prison health policy unit eliminated the Health Care Officer role within the prisons. Not only did this change help to separate custodial and nursing functions, it favored a more qualifying nursing care.

Care management and delivery. Stamler and Yiu (2012) describe correctional nursing as practicing and delivering nursing care inside the specialized setting of the criminal justice system. The largest group of health care professional within corrections is nurses. Sadly, this role lacks an adequate definition which results in false impressions by medical and security workers alike (Dumpel, 2005). Several authors explored the preparedness of mental health nurses to distribute care that is reliable and empathetic to its users (Rooks & Mutsatsa, 2013; Baker et al., 2012; Hardy, White, Deane, & Gray, 2011). Evidence by Rooks and Mutsatsa (2013) suggested that providing substandard care in the mental health arena is an ongoing issue. Not only is nursing care necessary, it

is also influential and changes the feeling, welfare, and physical condition of patients (Emerson, 2010). Johnson (2004) informed that unhealthy nursing practice often happens. Allen (2008) adds that dishonorable approaches are rooted in practice which in turn endangered patient health through negligent and unpleasant care.

Mental health nursing care should adapt a practice that is positive and stands on user centered values. Education is important in ensuring the attitudes and skills of healthcare staff is appropriate (Department of Health, 2006). Perry, Bennett, and Lapworth (2010a) declared that there is a demand for specialized training, information, and proficiencies when working in the prison setting. Correctional nurses often operate under many dual roles such as practice nurse and custodian (Dumpel, 2005; Willmott, 1997) and mental health provider and practice nurse (Evans, 1999). Research indicated that nurses providing emergency services felt less prepared to deliver adequate care for mentally ill patients (Clarke, Brown, Hughes, & Motluk, 2006; Vahey et al., 2004). McAllister et al. (2002) agreed with these studies and contended that qualified mental health nurses had no formalized training for responding to self-injury. This factor negatively impacted single and group efforts in offering useful and well-timed clinical care and results, which attributed to distress and prompting self-harm. With the increased number of inmates in custody, nurses were further challenged in overseeing as many as 200 inmates per nurse (Stamler & Yiu, 2012). Given that self-injuring inmates are primarily cared for by nursing staff (Condon, Hel, & Harris, 2007) a continuous and ongoing awareness and appreciation of feelings maintained by workers about this

population is of importance to individuals concerned with developing and providing the care (Dickerson & Hurley, 2012). Perceptions and insight regarding self-harm influences readiness and proficiency in delivering care effectively (Anderson, Standen, & Noon, 2003).

It is vital that collaborative efforts exist between inmate and nurse during evaluation, care planning, and distribution of information. Winship (2009) stressed that if healthcare staff is to take on an active role in reaching overall suicide prevention goals and objectives, it is critical to understand the attitude towards this behavior and recognize the need to reassess the attitudes to establish proficient compassionate management of this vulnerable population. Marzano et al. (2012) reports increased anxiety for healthcare workers managing the care. Tension surfaced while providing care under a security-first environment. Difficulties arose when managing the care alongside prison security officers who medicalized the behavior and added pressure to medicate the inmate even when not warranted in hopes to quiet the inmate. This placed staff in compromising clinical positions as well caused them to consider how they would be perceived as a clinician. In addition, healthcare staff agreed that the duty to care placed them in a vulnerable and isolated position as they could be held responsible and accountable for inmate self-harm (Marzano, Adler, & Ciclitira, 2015).

The friction between security and care has not changed much over the years. Norman and Parrish (1999) informed that the strict and disciplined environment restricted healthcare practitioners. One challenge encountered by healthcare providers is the

increasing volume of inmates requiring care. Nearly 10% of the incarcerated people report being sick each day, eight times more than documented in community acute care settings (Wool, 1993). Although some prisoners require primary care from nurses, few are referred to an upper level provider, and many do not warrant treatment. Caring for inmates who repeatedly self-harm was portrayed as problematic and counter-productive. Healthcare staff reported having resisted or resented the expectation of being a caring provider. Staffs developed anger and annoyance with these behaviors led to unprofessional and negligent practices. Marzano et al. (2012) add that in some cases healthcare staff just patched inmates up or extended medication. As time went on, staff became hardened to the beliefs of the inmates and rarely gave them an opportunity to talk which resulted in delayed and less than adequate care on occasion.

Correctional nurses care for a branded and labeled group. Negative attitudes about inmates hinder the nurse-patient relationship. Link and others (1997) shared that healthcare needs were impeded in situations where staff assigned shame, mocking labels, and undesirable approaches concerning some medical conditions, confirming that attitudes impact the type of care received. In addition, fixed views that were nurtured in the work place had an impact on rendered treatment. Healthcare staff should be cognitive of attitudes regarding self-harm as well as approaches aimed at treating these patients as individuals (Jones, Krishna, Rajendra, & Keenan, 2014). According to Peternelj-Taylor (2003), as a more preferred and proper approach to inmates, attitudes should portray “an enduring conviction that caring for these vulnerable groups is the appropriate and decent

thing to do" (p.47). Patterson, Whittington, and Bogg (2007) asserted as less desirable attitudes are noticed and altered, the condition of treatment for self-injuring users ought to improve (Dickerson, & Hurley, 2012). In one study, it was identified that correctional healthcare staff negotiated boundaries between the beliefs of custody and the principles of care. They wrestled with a caring environment within an organization that often lacks a caring value. Weiskopf (2005) added that nurses encountered threats when helping inmates and were required to be cautious and watchful during any health care encounter. No other health care site poses these types of constraints on free demonstration of care and treatment.

Summary and Conclusions

The National Institute of Health and Care Excellence (2004), James and Warner (2005), and Dickerson and Hurley (2012) respectively agree that attitudes are very powerful qualities that can shape interactions. The perception a person holds play an important role in a presented behavior. Actions toward inmate self-injury may be influenced if a perception is changed. Since 1976, it has been known that failure to deliver satisfactory health care to those incarcerated is a violation of prisoners' constitutional rights. Sandy and Shaw (2012) question whether all nurses in prison settings should be required to treat self-harmers or if this duty should be limited to staff with concentrated training. Nonprofessional healthcare workers are a separate group of workers in a correctional setting who encounter and are called to treat self-injury. Organizations who offer concentrated mental health preparation for staff ultimately

empower workers with more understanding about self-injury, thus leading to more confident and positive perceptions as well as providing them with a readiness to deliver effective care. Consequently, where specialized training on self-injury is lacking, attitudes and skills may be inappropriate, substandard, or generate a response in a specific way towards the inmate or the treatment being rendered. When staff feel weighed down or frustrated, develop false impressions, or experience desertion from management or peer perceptions become altered.

The review of the literature presented a background of the study, concentrated on the basis for the research being conducted, and provided a synopsis of the theoretical foundation and earlier works supporting the need to understand healthcare staff perceptions regarding self-injury. Correctional officials are acknowledging the importance of suitable health care in facilities (Glodkuhle, 1999). According to Srivastava and Tiwari (2011) training for non-mental health professionals should be expanded to consider more about the patients' emotional state and less on biological models of illness. Currently, literature on inmate self-injury in Georgia is scarce as most research has been conducted outside of the United States. Studies on prison healthcare workers' perception are not just limited but also uncertain in the cause of these perceptions. The effects of these perceptions on the delivery of treatment are unknown (Kirkham, 1998; Minick & Kee, 1998; Solbery & Brekke, 1997). Furthermore, research on prison healthcare workers and self-injury in Georgia does not exist. Rather than update the previous research existing outside of Georgia, this research uses a qualitative design

to discover new perceptions within the north Georgia region. To understand healthcare staff perceptions, this study discusses staffs' perceptions regarding inmate self-injury. The theoretical framework is discussed in the next chapter. This study offers a chance to increase our understanding of the humanistic nursing theory. If, as the literature suggests, the lived experience of the healthcare provider is a source of knowledge and we are unique beings who have the capacity and freedom to choose how to respond to situations we encounter, this research should find new data about interactions with and perceptions regarding inmate self-injury. Since earlier studies indicated that perceptions have a major effect on clinical performances and outcomes, a belief is that within the self-reflection component of the humanistic nursing theory, individuals think about past experiences and use them to better understand how they interpret the meaning of current experiences. This study provides for this gap concerning nonprofessional healthcare staff working in North Georgia correctional facilities.

This chapter provided a detailed explanation of the literature search strategy utilized, highlighted the necessary components of the theoretical foundation and the conceptual framework, and offered reviews of previous literature as it relates to the key variables of this study. The next chapter presents the exact methods for the study to include the research design and rationale, the role of the researcher, the participant selection logic, instrumentation, and procedures. Chapter 3 also discusses issues of trustworthiness.

Chapter 3: Methods

Introduction

Chapters 1 and 2 provided details supporting the need to understand nonprofessional healthcare staff perceptions regarding inmate self-injury. In addition, the previous chapters identified how personal perceptions may shape interactions between staff and inmates, thus affecting how staff respond to this population. What is not known is how untrained healthcare staff experience responding to inmate self-injury. In earlier chapters I explored the humanistic nursing theory as an avenue that may provide insight into understanding the interaction between perceptions and encounters and assigning meaning. This chapter provides the exact research strategy for this study. A qualitative research method was selected to investigate the existing gap in former studies regarding nonprofessional staff perceptions regarding inmate self-injury. In this chapter I describe the researcher's role, methodology, and issues of trustworthiness.

Research Design and Rationale

The primary question in this study was: What are the perceptions of nonprofessional healthcare staff regarding self-injurious inmates? Self-injury is defined as any behavior intended to cause actual physical harm to a person's body short of the intention to die as an outcome of the action (Simeon & Favazza, 2001). A qualitative research method was most suitable for this research as the study focused on individual perceptions and experience does not readily lend itself to quantitative reviews. Furthermore, there was no effort to obtain statistically significant data and there were no

statements in relation to generalizability. Qualitative research designs have a colorful approach and use the particulars of actual situations to provide insight on the event being explored (Bogdan & Biklen, 2007). Qualitative research characteristics include a relaxed location to meet with participants, a researcher operating as the instrument of data collection, numerous informers of data, a causative data breakdown, emphasis on the participants' meanings, evolving strategies, informative and revealing reviews, and an all-inclusive explanation (Creswell, 2009).

A phenomenological approach was fitting for this inquiry as the aim was to engage with healthcare workers' perceptions regarding inmate self-injury. Although several types of qualitative inquiry exist, phenomenological methods permit an exploratory tactic that seeks to discover how people operate and the significances they assign to the actions (Bachman & Schutt, 2003). According to Smith et al. (2009), phenomenological methodologies are most appropriate when studying under researched or poorly understood occurrences. Studies have had great success with the use of phenomenology. Sandy's (2012) study gained insight regarding a workers' understanding of self-harm as it pertained to secure forensic environments. Sandy (p. 2) agreed that through conversation, implications were created and appreciated (Gadamer, 1996). Meanings of the phenomena are assessed by researcher interpretations of workers' individual realms and the meanings attributed to them. This insight and realization facilitates development of perceptions into self-harm. Jones et al.'s (2015) study adhered specifically to obtaining a descriptive assessment of contributors' encounters and

mindsets when working with clients who had mental health problems and had attempted suicide. In addition, Jones' study was focused on exploring the subjective implication and evaluation of the experience of encountering these patients. These interpretations take into consideration the contributor making sense of their world as well as the researchers attempt to make sense of the contributor making sense of the world.

According to Ary et al. (2007), this type of research is based on actual experiences of members who permit the researcher to translate information while considering the meaning it holds. In-depth interviewing of participants with direct contact with inmates who self-injure was the primary source of information for this qualitative research study. The interviews evinced detailed information in the form of the person's account of a situation or occurrence. Conducting interviews provided a more complete picture of the lived experience the participant was sharing and the tone in which the interview was conducted may have been more relaxed. Reflective immersion also contributed to this research. Through this process participants were immersed in a specific engaging encounter and reflected and articulated about the encounter. Shappell (2010) stated that participants can expand their understanding of the issue related to their experience. During reflective immersion, individuals may acquire a more thorough knowledge of the interconnectedness between their perceptions, the medical treatment provided to the patient, and the ability to be able to interpret his or her existence in the environment (Rhodes, 1997). This integrated process played a key role in changing the way healthcare staffs perceived self-injury in the prison system. By studying the

perceptions of healthcare staff who work with inmates who self-injure, a greater appreciation is gained regarding how providers behave and feel about this population. Awareness relating to the preparedness and desire of staff members to work with this group, the barriers and challenges that occur, and any difficulties that exist when treatment choices are made are disclosed.

Role of the Researcher

In phenomenological research, the researcher is regarded as the instrument for collecting data (Creswell, 2007). In this role, the researcher obtains information directly from the participants through an approach that is attentive, polite, and authentic and in a setting where the real meaning of the lived experience is expressed without judgment. The researcher pursues the real meaning of an encounter of another person by extracting what is hidden deep inside of their thoughts or expressed through their behaviors, yet not easily detected by others. The interviewer/interviewee collaboration influences the quality of the interaction as well as the study's conclusions. Patton (2002) recommended that researchers initiate a self-assessment procedure in which subjectivities that might confuse the study are identified. As the researcher in this study, I needed to identify and accept any biases. The researcher offering personal information and experiences relating to the topic provides valuable information with which readers can reflect on how the researchers' morals or practices guided the data collection and analysis process.

My primary role as student was to learn from each participant as if the participant was my first and only contributor. Moustakas (1994) asserted that researchers should

remain fully engaged in each conversation, remain open to all statements made, assign the same significance to every comment, and foster a graceful movement between researcher and participant that stimulates a complete admission of experience. Participants had the freedom to direct the dialogue with personal or professional information they believed suitable in the moment.

As a child of a parent diagnosed with a mood disorder, I experienced firsthand the challenges and difficulties that stemmed from trying to function in a world that appeared overwhelming and left a feeling of disempowerment. At such a young age, I had a lack of understanding about depressed or manic states. I did not comprehend the idea that close family members could see or hear things that other people did not see or hear, nor the ability to grasp the thought that someone would purposely cause harm to themselves. Over 27 years ago, my journey in healthcare began following the career footsteps of my mother. As a newly licensed practical nurse and while pursuing my associates degree in nursing in 2002, I stumbled into the field of correctional healthcare as an agency nurse administering medication to state inmates. Being a new nurse and new to this setting, personal and professional associations did not exist and thus had no influence on the research. Moving to North Georgia in 2004, I had an opportunity to work in a male prison as a staff registered nurse. Over the years this experience allowed for relationship building with correctional healthcare staff and offered a level of comfort for them as they related to this position.

Being able to talk about like encounters in the correctional environment assisted participants to speak candidly and without restrictions during the interview process. Because I had previous experience working in a correctional facility, it was easy to build a quick rapport with participants. My familiarity of the work environment also helped to put participants at ease while sharing their lived experiences and opinions regarding the work setting and inmate self-injury. Instead of ignoring a researcher's preconceptions, it is important to recognize these presumptions to avoid partiality in the study (McConnell-Henry, Chapman, & Francis, 2009) and to create a plan to reduce bias throughout the research. My experience and daily work paralleling that of other correctional healthcare staff may have been a possible cause of bias stemming from the perception that healthcare staff members may view inmates in a negative manner. In attempt to rise above any such biases, I utilized bracketing while developing the research method and collecting and analyzing the data.

Methods

In this study I used a qualitative research design to explore the perceptions of nonprofessionally trained prison healthcare workers. Through semistructured interviews, I attempted to acquire the opinion of the nonprofessional healthcare workers in efforts to understand their beliefs and feelings and to make available a rich account that stems from their distinctive points of view. Because this study pursued straightforward and honest descriptions of the participants' experiences, a descriptive method was chosen

(Sandelowski, 2000). This type of design assisted me in staying close to the facts and providing a simple portrayal of experiences told by those who have lived them.

Participant Selection Logic

Participants consisted of eight correctional healthcare staff in order to achieve data saturation. Research designs are not universal; therefore, there is no one-size-fits-all way to reach data saturation. Even though when and how data saturation occurs will vary from study to study, there are no set standards as to when it is established. Researchers agree that when there is no new data or themes and the study can be replicated, saturation may have occurred. In addition, depending on the populations sample size, saturation may be reached by as few as six contributors (Guest, Bunce, & Johnson, 2006) if the data is rich in quality and thick in quantity (Dibley, 2011). Selected from a purposeful sampling strategy, participants for this study were chosen deliberately because they had an uniqueness, had been exposed to a certain experience, or maintained a specific level of skill. Purposeful sampling employs the use of a specific population for a study (Creswell, 2007). The participants selected for this research worked, previously or currently, either directly or as a contractor, in a healthcare role of a State of Georgia Department of Corrections North Region correctional facility.

According to Hamilton and Bowers (2006), inclusion and exclusion criteria are beneficial in filtering out participants who may provide untrue or deceitful information. The primary inclusion criteria for this study were that potential participants previously or currently worked in a male prison in the North Georgia region. This was due to the

geographical needs specific to the research. It was vital to this study to identify and recognize that participants were nonprofessionally trained healthcare staff having experience with self-injurious inmates. This secondary inclusion criterion was central to answering research questions.

A research announcement was posted on the Facebook group titled "Georgia Department of Corrections." In the announcement, a link existed that "Friends" of the group could click on that connected them to the Facebook research page containing information about the research study. Selection was based on contacting me, expressing desire to participate, and having the ability to take part in an interview within 1 month from the time of initial contact.

Instrumentation

Before the interview, participants completed a brief demographic form that gathered information about the participants' gender, age, and level of healthcare education. Additional information inquired about the length of time working in the healthcare field, the length of time working in the prison setting, and the length of time he or she provided services to inmates who self-injure. Next, participants responded to statements pertaining to treating self-injury, his or her awareness, feelings, and attitudes toward self-injury, and training, education, and performance. Participants also responded to statements that best corresponded with his or her thoughts about other healthcare staff regarding inmate self-injury. Last, participants had the opportunity to respond to narrative

questions about his or her duties and responsibilities within the correctional setting. A copy of the Demographic Tool is in Appendix B.

Several instruments were used during this study in addition to the consent form. I created the instruments used for this study. The demographic tool (Appendix B) was developed based upon available literature pertaining to prison workers' interactions with inmates who self-injure. Section I of the tool consists of six questions that gathered information about the participants' gender, age, educational level, and years of service. Section II contains 16 statements regarding factors that may influence their perceptions of inmates who self-injure using a 5-point Likert Scale response. Participants rated the statements 1 to 5 according to their agreement with the statement. An assignment of 1 indicated they strongly disagreed, 2 signified disagree, 3 represented neutral or no opinion, 4 indicated agreement, and 5 signified a strong agreement with the statement. Section III consists of five narrative questions with space provided to respond. These questions were used to understand the workday of the participants. If participants did not have experience working with male inmates who self-injure, their responses were not included with the final results. The interview guide (Appendix C) was derived from past qualitative studies that reported negative mindsets (Holdsworth, Belshaw, & Murray, 2001; McAllister, Creedy, Moyle, & Farrugia, 2002) and frustration (Hopkins, 2002; Anderson & Standen, 2003) of healthcare staff regarding self-injury. This assisted with identifying perceptions of healthcare staff regarding self-injury and to answer subresearch question 1. Past qualitative studies on care management and delivery (Rooks & Mutsatsa,

2013; Baker et al., 2012; Hardy, White, Deane, & Gray, 2011; Perry et al., 2010a) helped to develop subresearch question 2. This identified the delivery of care and treatment to the self-injurious inmate. The last researcher developed question was established from past qualitative studies and assisted with reporting any self-identified lack in preparation for prison practice (Higgins, Spencer, & Kane, 2010), departmental conflicts (Ramluggen, 2013), and the labeling of self-harmers (Knowles, Townsend, & Anderson, 2012; Short et al, 2009; Ireland & Quinn, 2007). Subresearch question 3 uncovered particulars about a participant's response when encountering a self-injurious inmate.

Researcher-Developed Instrument

Researcher developed instruments are created when standard instruments are not compatible as instruments for a research and may consist of questionnaires, observation forms, surveys, and interviews. Researchers should conduct a comprehensive search of the literature for a published data collection instrument (Gall, Gall, & Borg, 2003). Researchers are accountable for conducting research of the highest ethical quality which means instruments should be developed in a professional manner.

Published data collection instruments used to assess the perceptions of healthcare staff regarding self-injury varied between studies. Reviewed literature limits the generalizability to relating findings to prison studies outside the United States, perceptions of hospital staff, and professionally trained healthcare staff.

As it is the researchers' responsibility to ensure that "evidence and theory support the interpretations of test scores entailed by the proposed uses of a test" (AERA, APA, &

NCME, 1999, p. 9), results from the instruments cannot be generalized to be the perceptions of all nonprofessional healthcare staff working in Georgia correctional facilities.

I developed two instruments based on trends and reports available from previous studies. It is important to acquire understanding into how nonprofessional healthcare staff process their encounters with inmates who self-injure and recognize themes that may exist within the perceptions of these workers. Reflective immersion provided participants the opportunity to talk about his or her perceptions in dealing with self-injurious inmates (in this study, what does the nonprofessional healthcare staff think about inmates who self-injure?). Reflective immersion provided staff with the opportunity to acknowledge and interpret their existence inside the setting of an environment and helped to shape his or her perceptions. It is these perceptions that help to shape the interactions we share with others (i.e., what components of holistic healing are evident in the responses of health care staff who encounter the self-injurious inmate?).

Procedures

Recruitment. Before data collection began, approval from Walden's Institutional Review Board was obtained. After approval, the recruiting process began. Participants were male and female and contributed on a voluntary basis. No coercion occurred. There are three male facilities in the north Georgia region. Potential participants were invited to take part in this research through an announcement placed on an approved Facebook group account that features a button that automatically forwarded them to the research

account. Information outlining the study's scope and intent and assurance of confidentiality existed on the Facebook research page. In addition, contact information such as my name, my relationship with the university, and a phone number and e-mail address were also available. Interested staff contacted the researcher. After receiving notification of interest, I reached out to each prospective contributor within 24 hours of contact to confirm interest in participation, to answer any questions he or she had concerning the study and to discuss procedures. Participants were selected based on voluntary interest, eligibility conditions, and the ability to take part in an interview within a realistic timeframe. A second phone call was made to individuals meeting the inclusion criteria to schedule a date, time, and location for the interview. Participants had the option of choosing one of three area libraries with quiet rooms preselected by the researcher. The quiet rooms were held by reservation, allowed for privacy, and free from distractions. This gave participants a feeling of control in generating a relaxing milieu to support the promotion of open and honest responses to the questions. A snow ball sampling strategy assisted with acquiring additional participants affiliated with Georgia Department of Corrections but not members of the Facebook group or if recruitment resulted in too few participants. According to Creswell (2007) a snow ball sampling strategy is a method to identify potential participants based on suggestions from those already participating in the research. A tab located on the Facebook page, "people you may know", lists friends of the participants. This tab allowed the researcher to send a friend request to the participants friend. New potential participant had the option of

accepting or ignoring the friend request. Any person "friending" the research page had access to the research and contact information. Interested "friends" were contacted within 24 hours. If they choose to participate, a date, time, and location for the interview was scheduled.

Participation. The chapter 2 literature review highlighted the gap in existing literature and emphasized the need to answer the research questions. The main question of this research concentrated on the perceptions of nonprofessional healthcare staff regarding inmate self-injury. Participants talked about their encounters when working with inmates who self-injure in as much detail as they were comfortable disclosing. It was anticipated that there would be several perceptions regarding this topic and that these interpretations would offer insight into describing how healthcare staff viewed their experiences working with this population.

I pursued the answer using in-person interviews of healthcare staff from north Georgia region prisons using open-ended questions about the key topic. Interviews began by asking basic demographic questions about degrees completed, length of time in corrections, and primary duties. Demographic questions had a twofold purpose: to enter the question and answer session in a smooth manner and for coding. In attempt to produce powerful, concentrated descriptions (Rubin & Rubin, 2005; Moustakas 1994) through flexibility and investigation the necessary questions for this research asked "What are the perceptions of the nonprofessional healthcare staff regarding self-injurious inmates? Additional extensive and open-ended questions were asked to influence this

inquiry. Questions targeted to address participants' perception and experience with inmate self-injury included: Tell me what you think about inmates who self-injure (perception), what is it like when you encounter an inmate who has just self-injured? (perception and experience), describe your response when you encounter a self-injurious inmate (experience). A final interview question allowed participants to share additional information regarding their perception or experience. Interview questions were created by the researcher for the study. As suggested by Rubin and Rubin (2005) probing keys such as continuation, elaboration, and clarification were used throughout the interview to help draw out more information and confirm in-depth interpretation.

Audio taped interviews were conducted with all participants. Facilitating conversations with an interview guide (Appendix C) ensured that relevant areas were included and allowed for flexibility with phrasing and sequencing of the questions. To help build a relationship and decrease any anxiety, each interview opened by establishing a rapport. I discussed the informed consent process. Participants were informed that I would be taking notes and using an audio recording device during the interview. I discussed the voluntary nature of participating, potential risks that may come from discussing perceptions of inmate self-injury, as well as the ability to stop or remove themselves from the research at any time. Participants were informed that the interview would last at least 50 minutes but no more than 120 minutes. Participants had an opportunity to have any questions answered regarding the research before interviewing began. The consent form was signed, and data collection began.

Data collection. Semi-structured interviews were the method for data collection. This method permitted contributors freedom in answering questions frankly. The one on one face to face interview utilized open ended questions asked in a manner personalized to each individual participant and allowed for an audit trailing of nonverbal communication through the interview. When needed, follow up questions were asked to develop and intensify the responses. An audio recording device with MP3 formatting capability was used to interview participants. This type of device allowed for easy transferring onto a computer. Observational field notes taken during interviews as well as reflective journaling notes made after interviews were transcribed at the close of each interview day. Within 24 hours of each interview, the audio recording and audit trail log was transferred to computer file. According to Groenewald (2004) transcription should occur quickly in the event of a malfunction with the device or misinterpretation with written information when transcription is delayed. Participants were assigned and identified by a number that connected their identity to their contact email address. Emails were sent to each participant within 48 hours of transcription asking participants to authenticate the correctness of the transcript. An email requested that participants notify the researcher of inaccurate data within five days of receiving his or her transcript and corrections would be made. Corrections continued in separate emails until the participant declared the transcript to be accurate (Appendix D). A total of four weeks was allocated to complete this phase. Data was coded after the transcripts had been verified for accuracy. To ensure confidentiality, transcribed data was saved to a password protected

folder. Computer files contained individual audio recordings, the transcribed interview, and audit trail records from the interview. Six weeks was allocated for collecting and transcribing data. At the end of the interview, participants had the chance to share any additional information. Although this study would not include the use of deception, I again, gave participants a simple, well defined, and helpful explanation of the rationale for the design and methods used. Participants had an opportunity to have any questions answered. When it was determined that the participant was mentally stable enough to end our time together, I thanked them for their time and reassured them again of the confidentiality. Contributors received a letter of appreciation as well as a copy of the study's findings after final dissertation approval from the university.

Data analysis plan. After the meeting and dictation phase, data was analyzed. This phase consists of working with the information by arranging it and separating it into controllable parts (Bogdan & Biklen, 2007). When conducting data analysis, the researcher makes the effort to understand the experience or occurrence being examined and to obtain an awareness of any associations that may exist amongst the data gathered from the multiple sources (Ary et al., 2006).

Qualitative data analysis involves several steps (Flood, 2010; Creswell, 2007; Rubin & Rubin, 2005). Components of data analysis include recognizing themes, explaining and integrating those themes, expanding on ideas, coding, arranging data and formulating a final synthesis (Rubin & Rubin, 2005). Data was analyzed based on Moustakas Method (1994). After thoroughly reading the entire transcript to gain an

understanding of the content, analysis began with describing the "what?" that each participant shared. Single statements and sections of the text relevant to answering research questions were highlighted. I extracted patterns and categories by looking for relationships or comparisons within the descriptions that helped to identify "who? when? or where?". Categories were linked together to support the conceptual framework that explained the response to the patients request for help from another (describe your response when you encounter a self-injurious inmate). Significant statements were entered in the NVivo software program for coding and developing themes. Through open-ended questions, themes and perceptions were extracted for understanding the research transcripts. Did participants describe their encounter as burdensome or frustrating? Were they faced with organizational, management, or delivery of care issues? In other words, what is it like when you encounter an inmate who just self-injured? Themes provided insight or concepts that address "why"? Statements were entered in the thematic nodes using the NVivo software. Major categories signified the essence of contributors' perceptions of the research topic (what is the nonprofessional healthcare staff perceptions regarding self-injury?). Assigning what it means for each participant is referred to as "individual structural description" (Moustakas, 1994, p.121) and sheds light on the experiences of the participants to comprehend how they faced what they are reporting.

NVivo computer software assisted with organizing and analyzing the data as well as helping to uncover connections and finding additional insights in the transcripts.

Researchers need to make sure that data is not made to match a theory or that unsuitable data is not disregarded. The most important way to safeguard against forced data is to construct research questions that use clear terms, are of the appropriate subject, and causally related. While all data was offered, truly discrepant data was not found. Potential discrepant data was identified and assessed to determine its true plausibility against the conclusion in which it is descript (Wolcott, 1990). Consulting with my peer debriefer, staying consistent, and reporting the discrepant evidence assisted to increase quality of evidence.

Issues of Trustworthiness

Qualitative research differs from quantitative studies in that qualitative studies are subjective and contextual unlike quantitative research that is objective and generalizable (Whittemore, Chase, & Mandle, 2001). In producing a study that is trustworthy, certain qualities should be evident and interwoven into the study. Consideration of credibility, transferability, and dependability is equally important to a qualitative study as validity and reliability are to quantitative studies when defending the trustworthiness of a study and in the foundation of evaluating findings.

Credibility

Qualitative research is grounded on idea that while there is no single collective reality, the social world is complex (Ashworth, 1997) and involves itself with defining, translating, and understanding the meaning people assign to their presence and the world. One way that trustworthiness is assessed is by looking at whether an instrument measures

what it is intended to measure. Qualitative researchers refer to this as credibility and represents whether the conclusions depict what is happening in the situation (Cutcliffe & McKenna, 1999). Guba and Lincoln (1981) state that credibility exists when others can appreciate the encounter after having only read about it and view the findings as significant and relevant.

Member checking. When researchers seek informer opinions of the credibility of the results (Creswell, 1998) they are conducting a member check. Staying in contact with the participant even after the interview to allow for any clarification or expansion of views allows for member checking. Member checking for this study consisted of providing a copy of the participants' transcript back to him or her for review and to confirm that the responses are correctly documented in the manner that they intended to communicate or if there was more they wanted to add.

Saturation. When there are no new data or themes and the study can be duplicated, saturation may have occurred. Contingent on the study's population sample size, saturation may be reached by as few as six participants (Guest et al., 2006). Data should also be rich in quality and thick in quantity (Dibley, 2011). Straightforward and honest accounts of at least eight participants' encounters with inmate self-injury assisted in developing an unprejudiced perception of responding to this population.

Peer debriefing. Peer de-briefers help to ensure credibility by recognizing any biases that after identification and correction help with the accuracy of the study. In addition to the role of mentor, Terri Collins, was selected as my peer de-briefer. She

received her PhD in Health Psychology at Walden University. Dr. Collins is a Licensed Professional Counselor who I have had a professional relationship with and continues to offer feedback on my writing.

As a Walden Alumni who wrote her dissertation on the stress coping abilities and potential violence of male inmates, I believe that she inspected my work through a professional correctional workers' lens. This angle presented awareness regarding information that was necessary to expand this study. Dr. Collins has worked as a senior mental health counselor, assistant mental health director, mental health assistant, and outpatient therapist in the Psychology field for over 15 years, in multiple settings to include state prisons, behavioral hospitals, and county adult detention centers. From the beginning of this study, Dr. Collins has reviewed and presented advice on my study throughout this process. Her in depth constructive comments included personal responses and identification of areas needing additional explaining or clarifying.

Transferability

Another quality interwoven in qualitative studies that measures the trustworthiness of a study is transferability. Transferability signifies whether findings are useful or connected to a similar group of individuals. While qualitative research makes no effort to relate study findings to all populations, this concept speaks to the usefulness of the information about a sample to other people who may profit from learning about this sample or using the results in their lives. Transferability requires information that is full and descriptive so that readers can decide if the findings are applicable and transferable.

According to Creswell (1998) thick description facilitates readers in the process of transferring information to other situations and determining if findings can be shifted based on these mutual features. It is found in research that explains a contributor's demographic circumstance, life experiences, or context in which a meeting occurs. This study utilized case studies framed from interviews to offer thick description and original quotes from participants provided a cross case analysis. The combination of this information should be helpful to readers in determining if a study is significant to them.

Dependability

A study is known to be reliable when the findings can be reproduced. Since qualitative studies delve into the meanings that are assigned by an individual experience, the concept of reliability is problematic. Instead examiners consider the dependability or whether findings are logical based on the information assembled.

Confirmability is a process in which readers can strategically go through the studies data and put together a summation of how the outcomes were attained or assumptions were derived. A useful tool in proving confirmability is an audit trail. An audit trail offers readers the necessary material to confirm the conclusions of the research. Qualitative researchers ensure an audit trail by maintaining a methodological log throughout the duration of the research project tracking information such as underlying principles for any variations, decisions, and directions taken during the development of the study. An audit trail includes pertinent information such as the projects original plan, any records from peer debriefing, primary transcripts, and written data from member

checking. Additionally, an audit trail may include why certain individuals were chosen to be interviewed, any material obtained from that interview, how the information connects with other research reported, or whether data substantiates other collected material.

The audit trail for this study consisted of the original proposal for my study, written comments, feedback, and thoughts from Dr. Collins, my peer de-briefer, a methodological log, and a collection of emails, notes, and communication transcripts that stem from member checking.

Ethical Procedures

This study's success relied on it being conducted in an ethical manner. One function of the Institutional Review Board (IRB) is to ensure that research conforms with ethical standards and regulations. Approval from the IRB was required prior to selecting participants and collecting or analyzing data. "Friending" the research Facebook account named "Georgia Department of Corrections" was required to gain access to potential participants. I took every precaution possible to ensure this study was within the ethical standards set forth by the university. While the wellbeing and privacy of the participants was the major concern, safety measures such as informed consents and authorization to audiotape were incorporated as a standard intervention. Potential participants had the right to refuse to participate and selected participants had the right to withdraw at any time with no consequence. I had exclusive physical access to collected data. Electronic files were maintained on a password protected personal computer and handwritten files

were locked in a storage container. Confidential data will be kept securely at my home for at least five years, after which it will be destroyed.

It is important to mention that although I am not currently employed at a state correctional facility, I worked in a north region state prison for 10 years with healthcare staff that met the inclusion criteria and volunteered to participate. While many were interested and supportive of this study being conducted to increase the awareness, some were concerned that the results would show healthcare staff to be less than proficient in treating inmate self-injury. Assurance was given that the intent of the researcher was to gather information and through the study provide insight regarding the perceptions from staff regarding inmate self-injury as well as support future research on similar topics.

Last, I did not anticipate any harm originating from participation in this study. In the event a participant experienced any distress they were referred to Dr. Terri Collins, an independent professional mental health clinician, for assistance in dealing with emotional distress.

Summary

It is obvious from an assessment of the literature that perceptions encourage behaviors and shape outlooks as well as form attitudes. When perceptions are distorted it can change the way self-injury is seen. As some research is available on perceptions concerning inmate self-injury very little exists surrounding the thoughts from those who have not received specialized training in this area. My most important research question concentrated on perceptions regarding inmate self-injury. The participants involved in

this research are self-acknowledged nonprofessionally trained healthcare workers employed in the north Georgia region.

Chapter 3 explained the methods applied to this study with an emphasis on the research design, researcher role, selection logic, instrumentation, procedures, and trustworthiness. For chapter 4, I chose a descriptive approach to draw out points of view towards caring for this population. Using one-on-one face-to-face interviews as a data collecting tool, information will be gathered and coded. This tool makes certain that contributors' encounters are in depth. Systematic procedural processes for data collection, analysis, and authentication were explained all through the chapter. Issues of trustworthiness, types of methods and reasons for design use, and any biases are also detailed throughout the chapter.

Chapter 4: Results

Introduction

The purpose of this phenomenological study was to understand perceptions regarding male inmate self-injury held by nonprofessional healthcare staff by examining the effect of their experiences during interview sessions. The primary research question was:

RQ: What are the perceptions of nonprofessional healthcare staff regarding self-injurious inmates?

Additionally, secondary research questions included:

SRQ1: What does the nonprofessional healthcare staff think about inmates who self-injure?

SRQ2: What is it like for a nonprofessional healthcare staff member to encounter an inmate who has just self-injured?

SRQ3: What components of holistic healing are evident in the responses of health care staff who encounter the self-injurious inmate?

In this chapter I explain the data gathering process as well as the steps taken to analyze the data. This chapter includes the findings that emerged from the data and the relationship of the findings to the research questions. Finally, I discuss methods used to increase trustworthiness through credibility, transferability, dependability, and confirmability.

Setting

I created a Facebook page to seek participants. After about 4 days, interested persons contacted me through Facebook by sending a message to my inbox or through email. Suitable dates to conduct the interviews were scheduled with the participants. Most participants were available late evenings because many worked during the day, while a few were available early mornings due to working a later or overnight shift. Participants were both happy to participate and excited to share their experiences. A few times participants were unable to meet as arranged. Even though participants suggested all interview times, they would be called in to work, get off later than expected, or have unexpected meetings or emergencies, thus needing to reschedule. One interview session was rescheduled four times. Three interviews were conducted by phone for the participants' convenience. This informal setting of semistructured interviewing allowed for a more open discussion on perceptions regarding inmate self-injury in an environment that fostered confidentiality. This type of setting assisted with discussing issues that participants might not have found as easy to discuss face to face. Telephone interviews created an additional level of anonymity that increased the confidentiality of the study. None of my observations suggested any participant distress that manipulated the study nor did the participants share any stories that suggested they were experiencing any negative feelings that hindered them from recalling or sharing their perceptions regarding inmate self-injury.

Demographics

A total of eight nonprofessional healthcare providers who worked in a north Georgia region male correctional facility participated in this study. Ages ranged from 30 to 57 and participants were either licensed or registered to practice healthcare. Job titles and genders consisted of one female nurse practitioner, one male registered nurse, two female registered nurses, one male licensed practical nurse, and three female licensed practical nurses. Half of the participants held associate's degrees, while two held a practical nursing diploma, one held a bachelor's degree, and one held a master's degree. The participants' combined total of healthcare experience was over 35 years. General participant data are in Table 1.

Table 1

Participant Demographics

Participant	Age	Gender	Education level	Healthcare experience
Interview 1	36	F	Masters	Over 5yrs
Interview 2	45	M	Associates	Over 5yrs
Interview 3	57	F	Practical Nursing Diploma	Over 5yrs
Interview 4	35	F	Associates	Over 5yrs
Interview 5	55	F	Associates	Over 5yrs
Interview 6	30	F	Bachelors	Over 5yrs
Interview 7	49	F	Practical Nursing Diploma	Over 5yrs
Interview 8	55	M	Associates	3 to 5yrs

After it was determined that participants met the inclusion criteria and each participant signed the consent form, I no longer referred to them by their given name.

Participants were assigned a number to follow them throughout the study to keep the identities protected. The data from this study came from three North Georgia region male correctional facilities. The participants combined 25+ years of experience in a correctional setting provided rich details and insights regarding inmate self-injury. Although only six of the participants reported having daily interactions with inmates who self-injured, there was a total of at least 25 years of experience working with self-injurious inmates who offered truthful and impartial data for this study (see Table 2).

Table 2

Participants' Correctional Healthcare Demographics

Participant	Prison experience	Self-injury experience	Daily interactions with self-injury
Interview 1	1-2y11mo	1-2yrs11mo	No
Interview 2	3-5yrs	3-5yrs	Yes
Interview 3	Over 5yrs	3-5yrs	Yes
Interview 4	1-2yrs 11mo	1-2yrs 11mo	No
Interview 5	Over 5yrs	Over 5yrs	Yes
Interview 6	Over 5yrs	Over 5yrs	Yes
Interview 7	Over 5yrs	Over 5yrs	Yes
Interview 8	1 year	1 year	Yes

Data Collection

I was granted IRB approval (09-05-17-0130513) to conduct research on September 5, 2017. Data collection began two weeks later, lasted approximately 3 weeks, and was gathered through eight individual interviews with nonprofessional healthcare staff regarding their perceptions of inmate self-injury. Participants were 30-57 years old,

were licensed or registered in the healthcare field, and previously or currently experienced an encounter with a self-injurious inmate. Potential participants were made aware of the study through a posting placed on a preexisting Facebook page designed for people affiliated with Georgia Department of Corrections. If "friends" of this Facebook page clicked on my posting, they would automatically be taken to the Facebook page created specifically for this study. Interested participants did not need to "friend" me to participant, only to email or message me. A total of 18 interested persons emailed me their contact information. I responded to each notification 24-48 hours of receiving it to explain the reason for conducting the study and to answer questions such as whether I would be using their real names, what type of questions would I be asking, who would see this information, and would anything they say be traced back to them. Each person was assured that all information and identities would be kept confidential and safeguarded. After brief phone conversations, two people were not interested in participating, five people did not meet one or more of the inclusion criteria, one person was never available at the requested interview time despite rescheduling three times, one had a family emergency that took him out of the country unexpectedly, and although one person was willing to discuss her perceptions regarding inmate self-injury over the phone, she did not want to go "on the record" in sharing her experiences. Although I predicted that each interview would take 60-120 minutes to complete, each session was audio recorded and ran between 27-65 minutes.

After discussing the informed consent process, semistructured research questions provided a foundation for participants to reveal their thoughts regarding inmate self-injury. The interviews were conducted in a way to allow conversations to develop from the participants' view and understanding of their experience. Interviews began with participants completing a hand written 27 question Likert-type scale demographic survey that assessed basic information about their education, work experience, and opinions regarding self-injury. Participants were provided with a survey and an ink pen if they did not have one. Surveys took between 10-15 minutes to complete. Before any questions were verbally presented, attempts were made to put the participants at ease by commenting on the weather or asking how their day was going. When participants appeared nervous, I encouraged them to speak generously as if we were just having a conversation. To maintain a genuine presence and provide active listening, I took very few notes. When a participant demonstrated a behavior that could only be visualized and would not be captured as an important nonverbal action or when I needed reminding to ask a follow-up question but did not want to interrupt the participant at that moment, I made a point of taking notes. Within 72 hours of completing an interview, I transcribed it into a Word document, then saved it according to the approach explained in Chapter 3. Individual transcripts were emailed to each participant asking them to review the transcripts for any issues of misinterpretation or need for clarification. Participants were instructed to respond to the email if changes needed to be made. Participants did not need to respond if what they shared was captured correctly. All handwritten surveys were clear

and legible and responses to the open ended questions required brief responses; they therefore did not require clarification. The data collection procedures did not alter much from the methods described in Chapter 3. The data collection process was free of problematic or extraordinary occurrences. Participants were engaged, professional, and supportive throughout the process of sharing their perceptions regarding inmate self-injury.

Data Analysis

To provide an authentic presence during the interviews, I restricted myself to only taking notes when necessary. I identified consistently used words such as *help, manipulative, concerned, scared, communicate, safety, assessment, serious,* and *challenging*. Interview recordings were transferred in the original state from the voice recorder to the computer. There were no changes to affect the quality of the sound. As recordings were transferred to a password protected computer, each was saved and named according to the date and time of the interview. The file name was later updated to include an assigned number that coincided with the order in which it was transcribed. Audio recordings were transcribed word for word as spoken by the participant. Hard copies of the transcripts were filed separately in an accordion style folder and stored securely. Unless it was physically being used, the accordion was kept in a safe location only accessible to the researcher. Handwritten field notes taken at the time of the interview were labeled with the date and time of the interview only and placed in the accordion for safe keeping and referencing. Initially, the program software NVivo was

used to assist with analyzing the data in an attempt to identify the most frequently used words. Although several words were identified, I did not find this software to be very user friendly, felt use of the program was time consuming, and believed that words or groups of words less frequently used were more important in signifying the essence of the participants' perceptions. As a result, searching line by line, I identified and counted regularly occurring key words and phrases. After listening to the audio recordings two additional times, the terms *empathize, judging, training, medically cleared, frustrating, worried,* and *behavior* were familiar across the interviews. These terms were added to the list of words created in the field. I read each transcription several times to identify similar experiences and ideas, to key in on meaningful and relevant information, and to gain more insight and knowledge concerning healthcare staffs' perceptions regarding inmate self-injury. During transcription review, key words and repeated points were circled and cross-referenced with the other transcripts. This process permitted me to concentrate on data related to the RQ and SRQs driving the study. Participant responses were grouped into the following eight evidence supported themes: changes on a continuum, growth, important roles, other healthcare staff, supporting inmates, challenges, understanding needs, and therapeutic approach.

In two cases, I was unable to decipher some of a response. The word inaudible was inserted and surrounded by asterisks with a side note to ask the interviewee for clarification. In both situations the participant provided me with the information needed to completely transcribe the response. Although most participants were excited to share

their experience, some were not very telling, or some included information unrelated to the specific question asked. In these occurrences, the question was rephrased to illicit a more expressive response or participants were redirected back to the original question through gentle probing. Despite the above mentioned scenarios, none of the responses had to be excluded from the analysis.

Evidence of Trustworthiness

The four primary concepts used to increase the trustworthiness of this research were credibility, transferability, dependability, and confirmability. The support as it applies to this study is discussed below.

Credibility

The legitimacy from which this research stands is as discussed in Chapter 3 and was achieved using saturation, member checking, and peer debriefer. Information for this study was collected from eight interviews. Once no new information was shared and there were no new developing themes, the interviews were regarded as being exhausted and indicated saturation had occurred. Member checking assisted in establishing transcript credibility. Participants were asked to confirm that their interview responses were correctly documented on the transcripts in the manner that they wanted to communicate. This process ensured my understanding was accurate as well as decreased the possibility of unplanned biases during the data analysis process. Last, feedback from my peer debriefer, Dr. Terri Collins, further improved the credibility of the collected data

by identifying biases to remove and of the study's findings by pinpointing areas to clarify.

Transferability

The data presented and findings reported were based on participant experiences occurring in male North Georgia correctional facilities and therefore are not transferable to other studies. Nonetheless, the information might be used as inspirational insight for other nonprofessional healthcare staff working with self-injurious inmates. Though the material in this study is exclusive to the population of this study, findings might benefit other researchers in developing a framework for future studies.

Dependability

Each approach, method, and procedure used to collect data for this study are thoroughly explained. By providing the steps taken, other researchers will be able to adopt and replicate the methods to conduct a report like this study.

Confirmability

In addition to using the actual words from the participants and verbatim transcripts from the interviews, an audit trail also assisted with confirmability. I considered the impact of all written comments, notes, summaries, and journaling towards the study outcome as well as took in account the feedback, thoughts and emails from my peer debriefer and participants.

Results

Each participant answered a 27 question Likert type survey prior to his or her sit down interview. Participants were mostly female, had over 5 years healthcare and prison experience, at least 3 years self-injury experience, interacted daily with self-injury, and worked at a North Georgia state prison. Measured on a five-point Likert type scale, participants indicated the extent in which they disagreed or agreed with a statement. Selected from the items strongly disagree, disagree, neutral/no opinion, agree, or strongly agree, the objective of the following tables is to know the alignment of the statement with the participants perception.

The purpose of Tables 3 and 4 is to know if treating inmates who self-injure is a waste of time or a waste of resources. Of the responses from the eight participants on both tables, 62.5% strongly disagree that treating self-injurious inmates is a waste of time and resources, while 12.5% disagreed.

Table 3

Treating Inmates Who Self-Injure Is a Waste of time

	Strongly disagree	Disagree	Neutral/No opinion	Agree	Strongly agree	Total
Number of responses	5	3	0	0	0	8
Percentage of responses	62.5%	37.5%	0%	0%	0%	100%

Table 4

Treating Inmates Who Self-Injure Is a Waste of Resources

	Strongly disagree	Disagree	Neutral/No opinion	Agree	Strongly agree	Total
Number of responses	5	3	0	0	0	8
Percentage of responses	62.5%	37.5%	0	0	0	100%

Figure 1 indicates the perception held regarding wasted time and resources for inmates who self-injure. Of the total eight healthcare staff, five staff members strongly disagreed that time and resources were wasted on this population, whereas three disagreed.

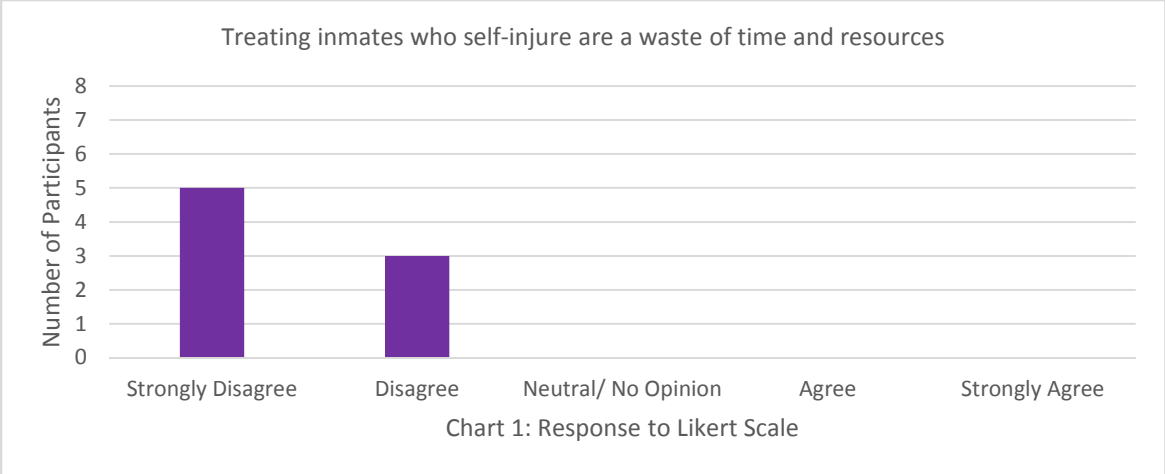

Figure 1. Treating inmates who self-injure are a waste of time and resources.

Offered in Table 5 healthcare staff are aware of how they feel regarding inmate self-injury. Of the eight participants, 75% respondents agree or strongly agree that they are aware of how they feel, 12.5% neither agree nor disagree, and 12.5 % disagree.

Table 5

I Am Aware of How I Feel Regarding Inmate Self-Injury

	Strongly disagree	Disagree	Neutral/No opinion	Agree	Strongly agree	Total
Number of responses	0	1	1	3	3	8
Percentage of responses	0	12.5%	12.5%	37.5%	37.5%	100%

Offered in Figure 2 staff are mostly aware of how they feel regarding self-injury. Six respondents agreed or strongly agreed that they are aware of how they feel, while one had no opinion, and one respondent disagreed.

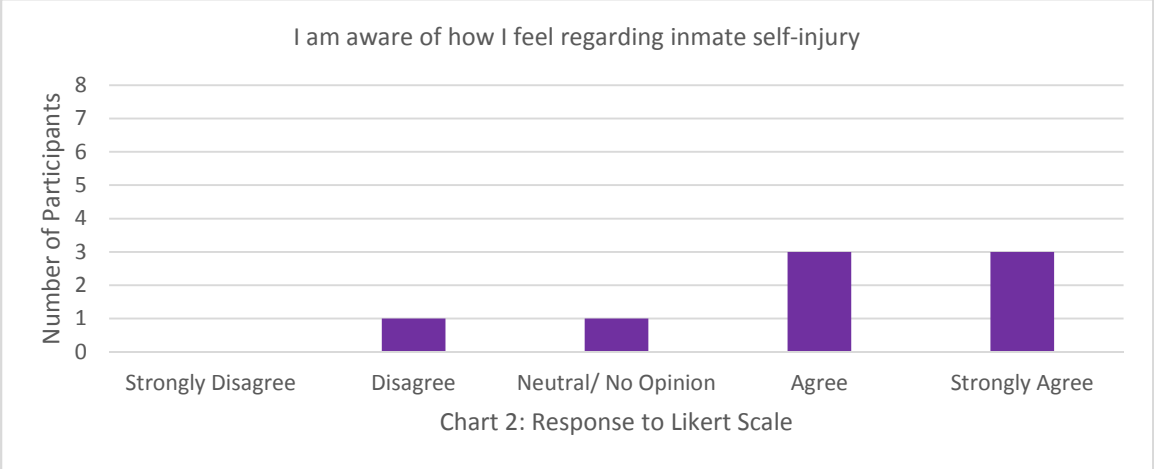

Figure 2. I am aware of how I feel regarding inmate self-injury.

Table 6 shares whether participants' feelings toward self-injurious inmates have changed since the beginning of employment with the correctional facility. 62.5% participants agree or strongly agree that their feelings have changed over time whereas 37.5% disagree or strongly disagree.

Table 6

My Feelings Towards Self-Injurious Inmates Have Changed Since I Began Working with Inmates

	Strongly disagree	Disagree	Neutral/No opinion	Agree	Strongly agree	Total
Number of responses	2	1	0	4	1	8
Percentage of responses	25%	12.5%	0	50%	12.5%	100%

Figure 3 shares that participants feelings toward self-injurious inmates have changed. Of the eight participants, five agreed or strongly agreed that their feelings had changed. The other three either disagreed or strongly disagreed.

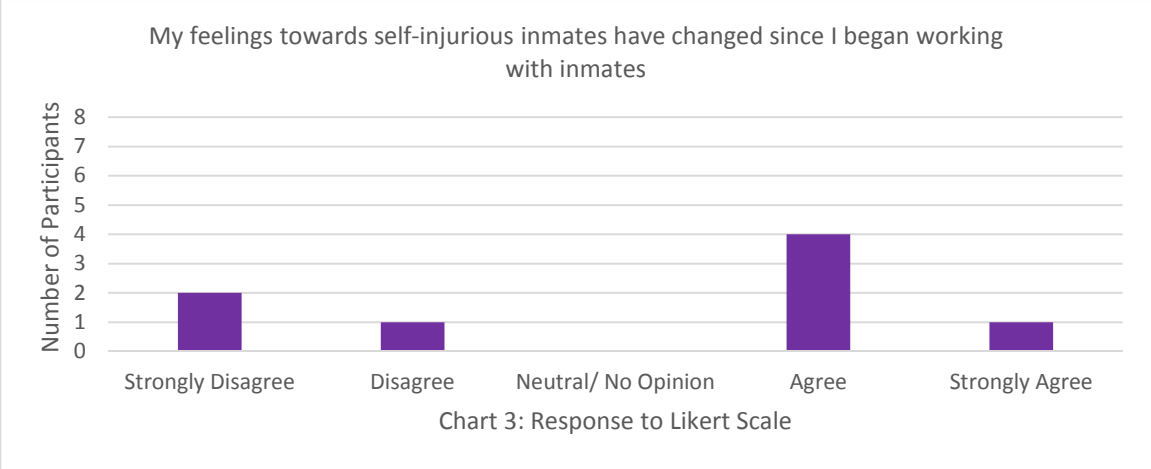

Figure 3. My feelings towards self-injurious inmates have changed since I began working with inmates.

Both Table 7 and Figure 4 show whether attitudes regarding inmates who self-injure are largely positive. 50% of the participants agree or strongly agree that attitudes are positive, 37.5% had no opinion, and 12.5% disagreed.

Table 7

My Attitude Regarding Inmates Who Self-Injure Is Largely Positive

	Strongly disagree	Disagree	Neutral/No opinion	Agree	Strongly agree	Total
Number of responses	0	1	3	3	1	8
Percentage of responses	0	12.5%	37.5%	37.5%	12.5%	100%

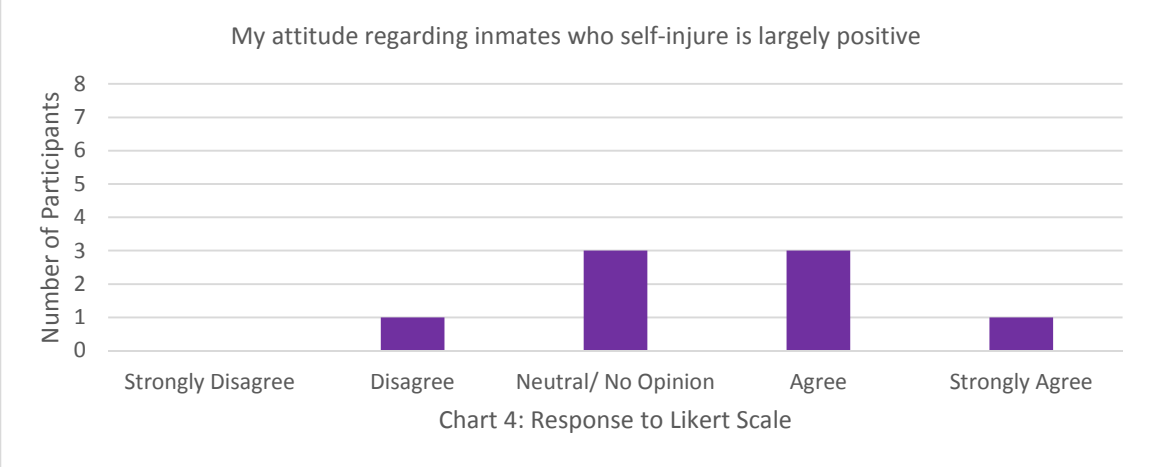

Figure 4. My attitude regarding inmates who self-injure is largely positive.

Table 8 and Figure 5 give information as to whether respondents have heard other healthcare staff say positive things regarding inmate self-injury. Of the combined eight respondents, 37.5% agree that they experienced other staff saying positive things. Equally, 37.5% had no opinion, while 25% of the respondents strongly disagreed with the statement.

Table 8

I Have Heard Other Healthcare Staff Say Positive Things Regarding Inmate Self-Injury

	Strongly disagree	Disagree	Neutral/No opinion	Agree	Strongly agree	Total
Number of responses	2	0	3	3	0	8
Percentage of responses	25%	0	37.5%	37.5%	0	100%

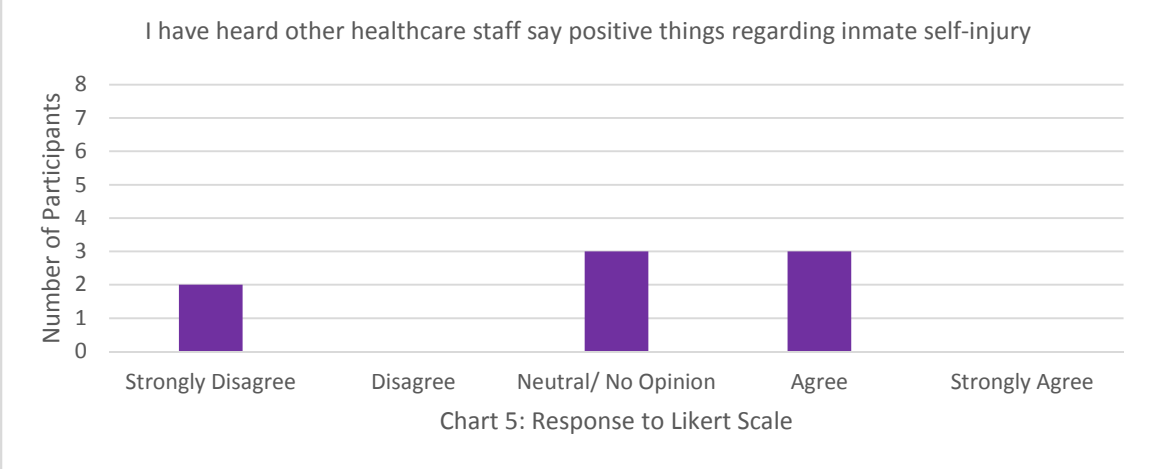

Figure 5. I have heard other healthcare staff say positive things regarding inmate self-injury.

Represented in Table 9, seeing an inmate who has just self-injured is emotional. Of all the eight, 62.5% participants, agree or strongly agree that seeing self-injury is emotional. 37.5% either disagree or strongly disagree.

Table 9

Seeing an Inmate Who Has Just Self-Injured Is Emotional for Me

	Strongly disagree	Disagree	Neutral/No opinion	Agree	Strongly agree	Total
Number of responses	2	1	0	3	2	8
Percentage of responses	25%	12.5%	0	37.5%	25%	100%

Represented in Figure 6 is the claim that seeing an inmate who has just self-injured is emotional. Of the eight participants, five participants agreed or strongly agreed that it is an emotional experience when an inmate self-injures, and three participants disagreed or strongly disagreed.

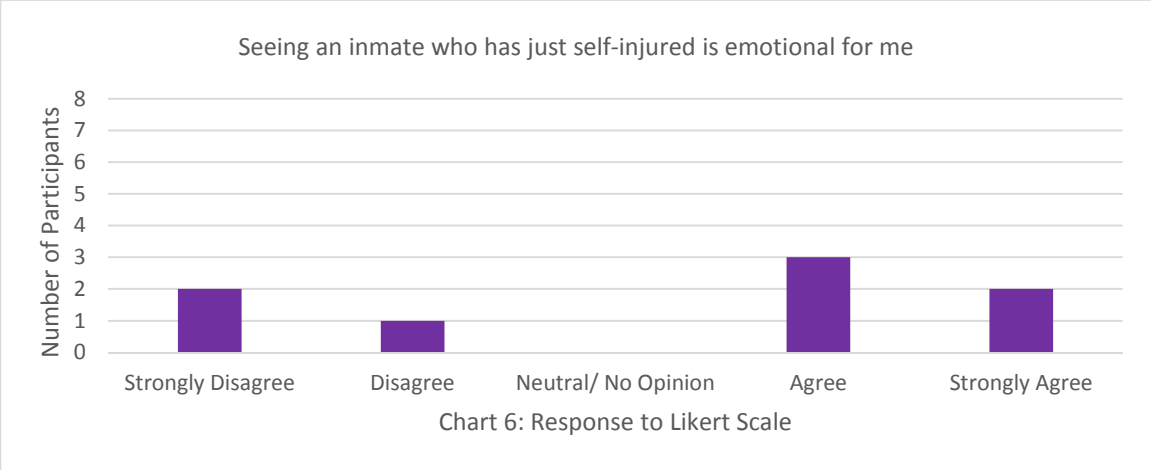

Figure 6. Seeing an inmate who has just self-injured is emotional for me.

Table 10 shows that out of eight respondents, all eight respondents agreed or strongly agreed that their healthcare training needs enhancing regarding inmates who self-injure.

Table 10

My Healthcare Training Needs Enhancing Regarding Inmates Who Self-Injure

	Strongly disagree	Disagree	Neutral/No opinion	Agree	Strongly agree	Total
Number of responses	0	0	0	2	6	8
Percentage of responses	0	0	0	25%	75%	100%

Figure 7 shows that 100% respondents identified needing healthcare training enhancement regarding inmates who self-injure.

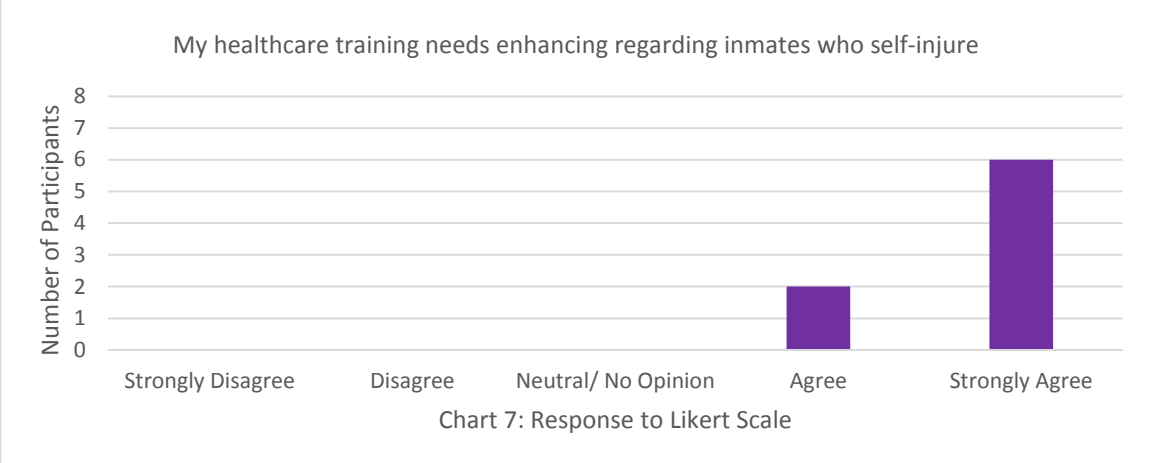

Figure 7. My healthcare training needs enhancing regarding inmates who self-injure.

In Table 11 it is displayed that of eight respondents, six respondents agreed or strongly agreed that further education on inmates with self-harm issues would be helpful. One respondent had no opinion, while one respondent disagreed.

Table 11

Further Education on Inmates with Self-Harm Issues Would Help Me

	Strongly disagree	Disagree	Neutral/No opinion	Agree	Strongly agree	Total
Number of responses	0	1	1	3	3	8
Percentage of responses	0	12.5%	12.5%	37.5%	37.5%	100%

In Figure 8 it is displayed that 75% respondents identified that further education on inmates with self-harm issues would be helpful while a combined 25% either had no opinion or disagreed that further education would be helpful.

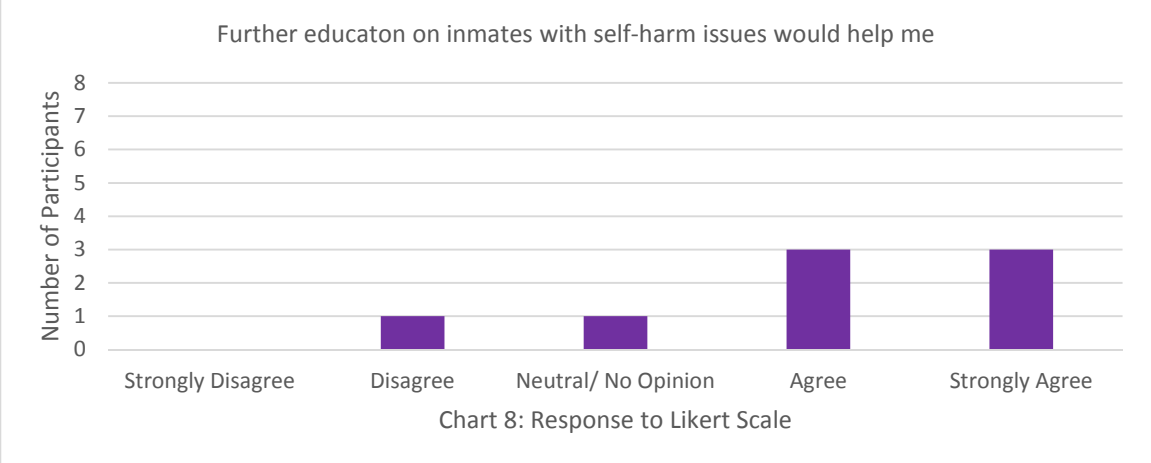

Figure 8. Further education on inmates with self-harm issues would help me.

Table 12 illustrates that there is a great deal of responsibility to help inmates who self-injure as per all eight respondents.

Table 12

I Have a Great Deal of Responsibility to Help Inmates Who Self-Injure

	Strongly disagree	Disagree	Neutral/No opinion	Agree	Strongly agree	Total
Number of responses	0	0	0	2	6	8
Percentage of responses	0	0	0	25%	75%	100%

Figure 9 illustrates that 100% of respondents agree or strongly agree that helping inmates who self-injure comes with a great deal of responsibility.

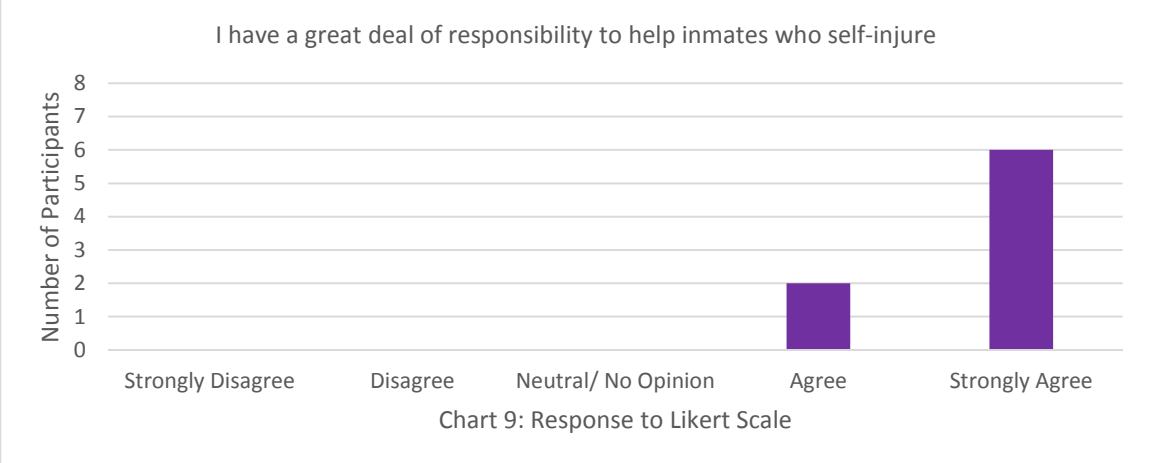

Figure 9. I have a great deal of responsibility to help inmates who self-injure.

Table 13 reveals having the appropriate skill set to help inmates who self-injure. Of the eight participants, six agreed or strongly agreed having the necessary skill set to help inmates and one participant reported not having the skills to help inmates who self-injure.

Table 13

I Have the Appropriate Skill Set to Help Inmates Who Self-Injure

	Strongly disagree	Disagree	Neutral/No opinion	Agree	Strongly agree	Total
Number of responses	0	1	0	4	3	8
Percentage of responses	0	12.5%	0	50%	37.5%	100%

Figure 10 reveals having the appropriate skill set to help inmates who self-injure. Of the eight participants, 75% agreed or strongly agreed having the necessary skill set and 12.5% disagreed with the statement.

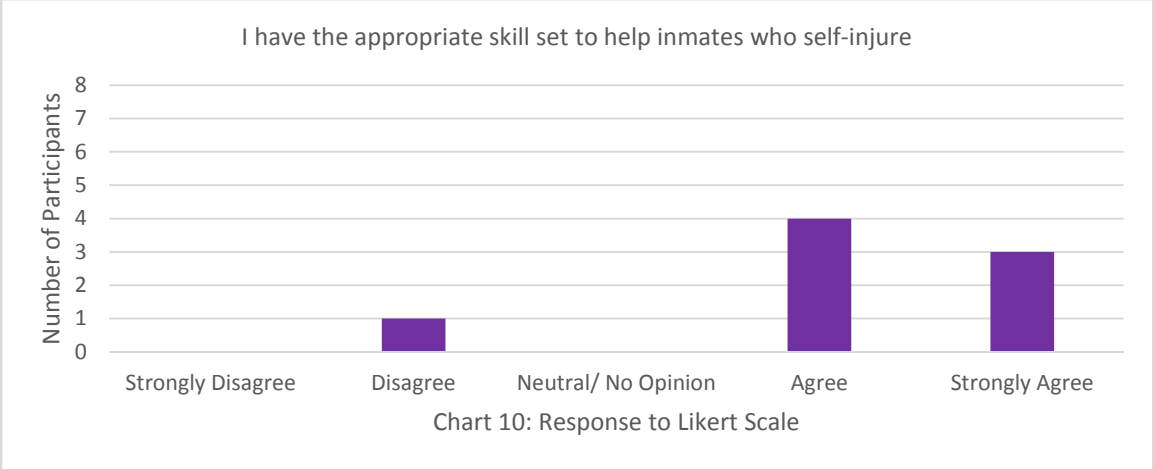

Figure 10. I have the appropriate skill set to help inmates who self-injure.

Six respondents agreed or strongly agreed to being comfortable when responding to an inmate who self-injures and one was neutral whereas one disagreed.

Table 14

I Am Comfortable When Responding to an Inmate Who Self-Injures

	Strongly disagree	Disagree	Neutral/No opinion	Agree	Strongly agree	Total
Number of responses	0	1	1	2	4	8
Percentage of responses	0	12.5%	12.5%	25%	50%	100%

As shown in Figure 11, 75% of respondents considered themselves comfortable when responding to an inmate who self-injures.

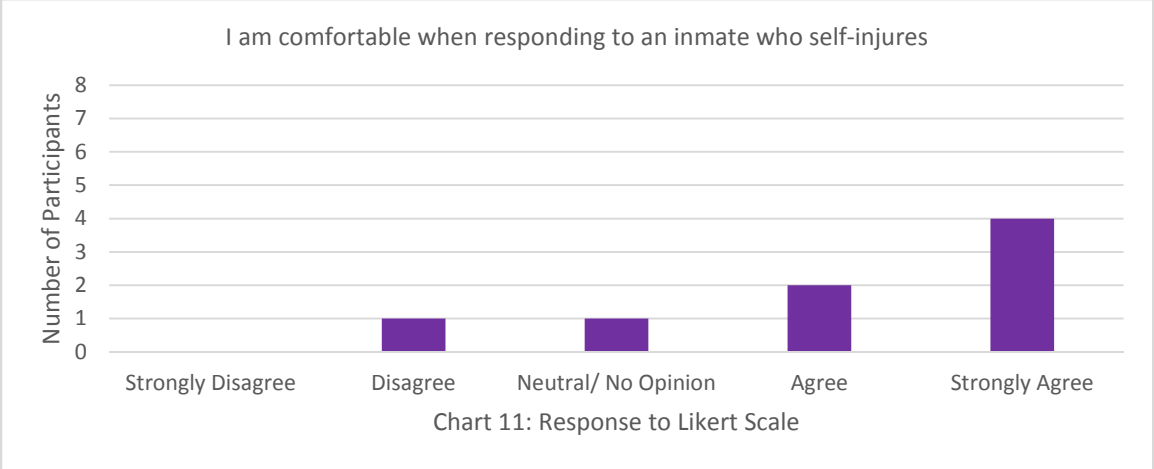

Figure 11. I am comfortable when responding to an inmate who self-injures.

Both Table 15 and Figure 12 illustrate if staff performs well when presented with an inmate who has self-harmed. Of the eight total participants, 75% of the participants agreed or strongly agreed that their performance is good while 25% were neutral or had no opinion. None of the participants disagreed.

Table 15

I Perform Well When Presented With an Inmate Who Has Self-Harmed

	Strongly disagree	Disagree	Neutral/No opinion	Agree	Strongly agree	Total
Number of responses	0	0	2	4	2	8
Percentage of responses	0	0	25%	50%	25%	100%

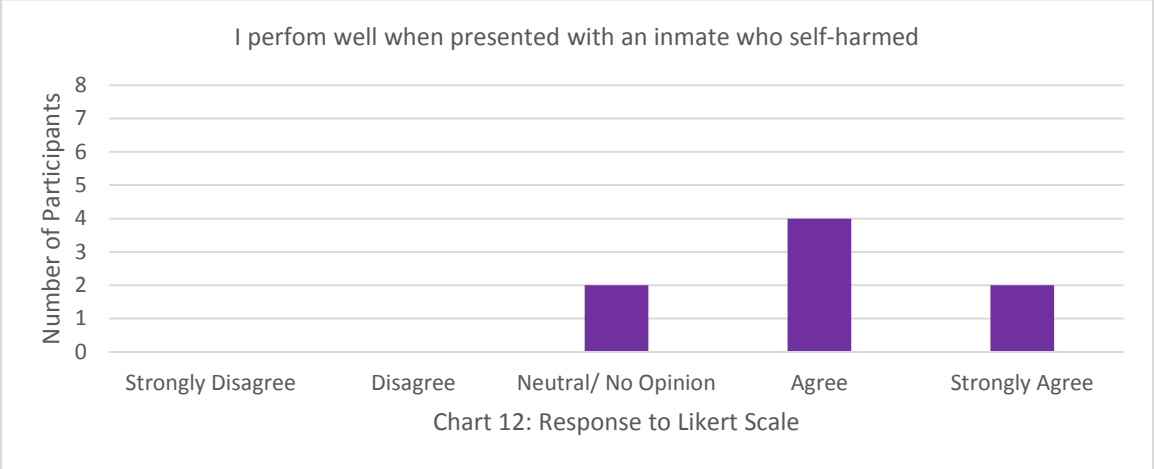

Figure 12. I perform well when presented with an inmate who self-harmed.

Table 16 shows that 75% respondents worked with staff who act professionally towards inmates who self-injure whereas 25% had no opinion.

Table 16

Staff I Work With Act Professionally Towards Inmates Who Self-Injure

	Strongly disagree	Disagree	Neutral/No opinion	Agree	Strongly agree	Total
Number of responses	0	0	2	3	3	8
Percentage of responses	0	0	25%	37.5%	37.5%	100%

Figure 13 confirms six respondents agree or strongly agree that other staff act professionally towards inmates who self-injure, two participants had no opinion, while zero respondents disagreed or strongly disagreed.

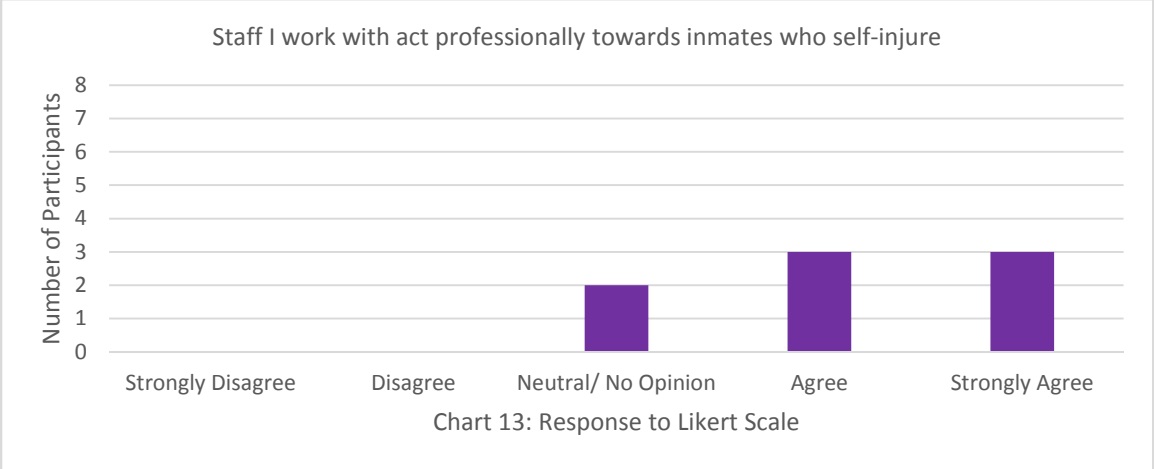

Figure 13. Staff I work with act professionally towards inmates who self-injure.

Table 17 indicates 75% respondents agreed or strongly agreed there are barriers/challenges faced regarding self-injurious inmates, 12.5% disagreed, and 12.5% held no opinion.

Table 17

There Are Barriers/Challenges I Face Regarding Self-Injurious Inmates

	Strongly disagree	Disagree	Neutral/No opinion	Agree	Strongly agree	Total
Number of responses	0	1	1	3	3	8
Percentage of responses	0	12.5%	12.5%	37.5%	37.5%	100%

Figure 14 indicates of the total eight, six respondents agreed or strongly agreed that there are barriers/challenges regarding self-injurious inmates. Only one respondent had no opinion and one respondent disagreed with the statement.

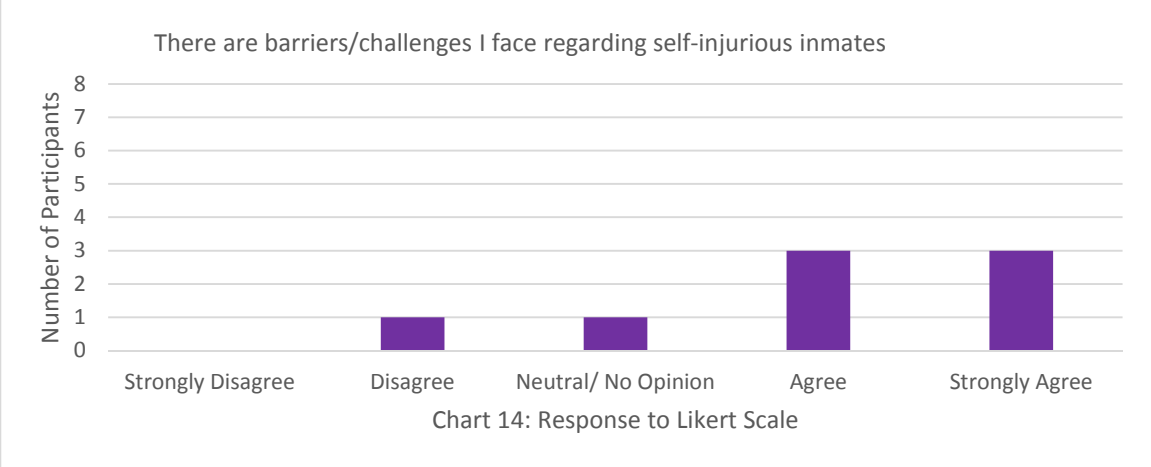

Figure 14. There are barriers/challenges I face regarding self-injurious inmates.

Illustrated in Table 18 and Figure 15 respondents' reply to whether they manage well when barriers/challenges arise from working with this particular group. Of the total eight, 75% or six agreed or strongly agreed they manage well whereas 25% or two respondents held no opinion.

Table 18

I Manage Well When Barriers/Challenges Arise from Working with This Particular Group

	Strongly disagree	Disagree	Neutral/No opinion	Agree	Strongly agree	Total
Number of responses	0	0	2	4	2	8
Percentage of responses	0	0	25%	50%	25%	100%

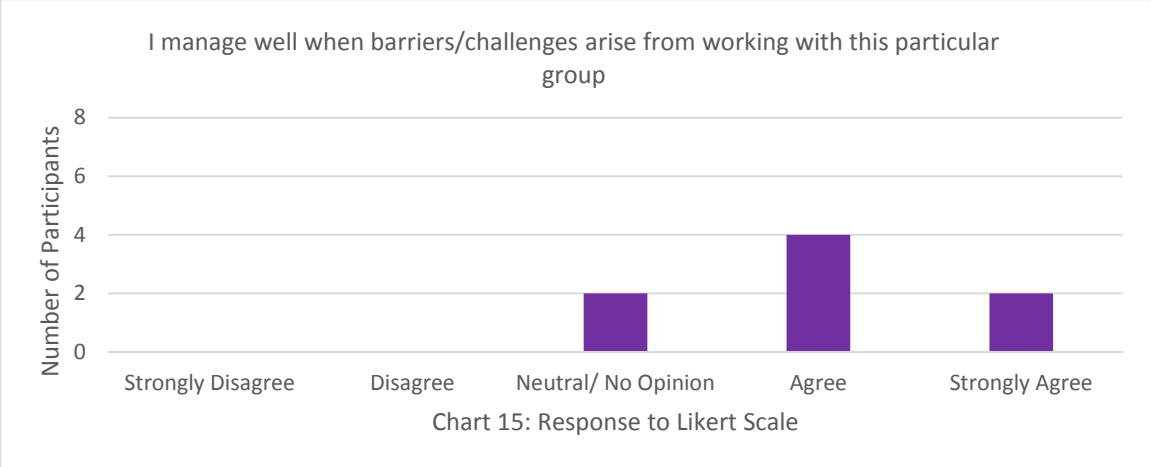

Figure 15. I manage well when barriers/challenges arise from working with this particular group.

While examining nonprofessional healthcare staffs' perception regarding inmate self-injury, eight themes become apparent to answer this study's four essential research questions. The eight themes were: changes on a continuum, growth, other healthcare staff, important roles, supporting inmates, challenges, understanding needs, and

therapeutic approach. The related research question, the major theme, and the related concepts are listed in Table 19. Each theme is discussed below.

Table 19

Major Themes and Related Concepts from Participant Interviews

Research questions	Major themes	Related concepts
RQ: What are the perceptions of nonprofessional healthcare staff regarding self-injurious inmates?	Changes on a continuum	Unfavorable to favorable Fluctuation in comfort level
	Growth	Changes in self Changes in behavior Realizations
SRQ1: What does the nonprofessional healthcare staff think about inmates who self-injure?	Other healthcare staff	Helpful Very professional Uncaring/Disrespecting
	Important roles	Preserve life Active listener Assessment
SRQ2: What is it like for a nonprofessional healthcare staff member to encounter an inmate who has just self-injured?	Supporting inmates	Providing care Emotional support Counselling services
	Challenges	Security environment/Staff Staff members Ineffective communication
SRQ3: What components of holistic healing are evident in the responses of health care staff who encounter the self-injurious inmate?	Understanding needs	Issues with mental processes Deep rooted mental problems Poor coping mechanisms
	Therapeutic approach	Building rapport Being genuine Displaying empathy

Research Question

RQ: What are the perceptions of nonprofessional healthcare staff regarding self-injurious inmates?

The main research topic questioned participants' perceptions concerning self-injurious inmates. Using the insights and opinions shared, the two major themes that were evident were changes on a continuum and growth. These were responses collected from participants throughout the interview sessions:

Theme 1: Changes on a continuum. The major theme that transpired from the main research question was perceptions regarding inmate self-injury fell on a continuum. Two subthemes surfaced from this theme:

1. Participant responses regarding opinions about self-injurious inmates ranged from unfavorable to favorable.
2. The nonprofessional healthcare staffs' level of ease and certainty ranged from high to low.

The second subtheme connects to this research question because participants also described how the experiences influenced their perceived effectiveness or confidence when responding to this population.

Breakdown of the participants' experiences uncovered noteworthy differences in the perceptions of their experiences and ranged from unfavorable to favorable. These continua of changes were based on the participants' perceptions regarding their personal

experiences when responding to inmate self-injury. P1 explained personal experiences with self-injury:

> I think they need proper help. Sometimes it could be manipulative tactic so you're in a catch 22 as well as treat'em, take'em them seriously . . . read between the lines . . . get a good history why this patient is doing what they're doing.

Though perceptions fluctuated from unfavorable to favorable, more perceptions were favorable in the participants experiences:

> Hard to wrap my head around . . . never encountered it. Those that was serious about cutting themselves went way above and beyond really hurting themselves and some would just do the gesture like putting the sheet around their neck and holding it (P4).

P3 also described favorable perceptions when responding to this population:

> They have deep seeded issues that no one knows about, they can't get it out without inflicting pain. It's like I'm confused, don't know why a person would be in so much pain to hurt themselves. Everyday someone is cutting or swallowing something.

Some participants recall their perceptions regarding self-injurious inmates as being less than favorable. Participants reported not enjoying the work, wanting to quit, and dreading the idea of going to work just knowing what they would be facing. One participant stated that initially it was not for him. P4 spoke this way: "Ohh, I didn't really

enjoy it at all . . . Umm, I don't know what to tell you . . . how to answer that, I mean I feel that it's bad that they do that to themselves."

A wide range of perceptions concerning inmate self-injury was noted in the participants experiences. On the unfavorable side of the continuum, participants felt that sometimes they (self-injurious inmates) are going through just to get away from other inmates or trying to get out of something. Providing care, in some situations, was a waste of resources because some of them was faking it, playing around, and not being serious. Providing care, in some situations, was a waste of time because time was taken away from patients that really need and want help. P5 reported, "We put the dressings on and they pull them off, we put in sutures or staple them up and they open the wound up, we send them to the hospital and that costs money and manpower."

Most of the participants in the study used the term frustration when describing an unfavorable perception regarding self-injury. Self-injurious acts were often conducted when inmates were trying to get manipulate or alter a decision or environment. P5 said, "Some do it just to get moved from ACU (Acute Crisis Unit) to CSU (Crisis Stabilization Unit) so they can see everything that's going on . . . that right there gets me." P7 had a similar perception: "I think my thoughts are more negative…the majority, in my opinion do it to be manipulative or secondary gain, to get something else accomplished. I feel negative because I know it's not normal and it's frustrating."

Another unfavorable perception worth mentioning was that the participants perceived difficulty in understanding the inmates act of self-harm. For instance, when

explaining an experience of responding to an inmate who has just self-injured, participants did not understand why someone would self-injure or purposely cut, tie something around his neck, or overdose on medication. One participant did not feel it was logical to hurt yourself to get away from problems.

Participants shared favorable perceptions in that they perceived themselves as helpful and that their work was rewarding. Some felt they did a lot of good and saved a lot of people. Participants reported feeling appreciated and enjoyed the excitement stemming from helping others. Some participants also shared that some inmates were very responsive and apologetic for his behaviors.

Despite the desire to be helpful or effective in caring for this population, participants, at times, felt they were not as helpful or effective as they could have been. In addition, participants felt a lack of control or ability to fix the issue. One participant attributed her lack of effectiveness to not paying attention while in nursing school. A few attributed their ineffectiveness to being new to nursing or correctional nursing while one nurse was transparent in stating she never had an interest in treating mental health patients and felt very helpless when placed in that situation.

Last, participants reported a variety of experiences and perceptions that affected their perceived levels of comfort and confidence in caring for inmates who self-injure. Some responses reported are:

> Like on a scale of 1 to 10, it depends on how bad the injury was. Real deeper cuts I wouldn't feel comfortable with . . . my comfort level is about four or five, the worse the injury, the less confidence I have (P1).
>
> In the beginning, not too comfortable then I got confident. I knew what I had to do to make sure they are medically stable and take it from there (P6).
>
> My comfort level has gotten better. I am not as anxious but you never know what you're going into…I'm not totally comfortable with it but my confidence level has grown in responding (P7).

Theme 2: Growth. The second major theme that emerged related to the main research question included participants experiencing personal growth due to their experiences with this population. Though perceptions ranged from unfavorable to favorable and variables influenced those perceptions, participants felt that their experiences led to growth as it pertained to responding or caring for those who self-injure. The subthemes identified were positive changes in self, positive changes in behavior, and positive realizations.

As for positive changes in self, participants recognized that due to their experiences, they have enriched abilities in themselves that have influenced their perceptions toward those who self-injure. Through the interactions, participants learned their job and how to better recognize the games inmates played.

P2 revealed how personal encounters with self-injurious inmates led to positive talents that can be incorporated into the care of these inmates:

> At first, I thought it was manipulation . . . you did it to yourself then you realize this is the real deal. I feel like I learned something every day…you learn a lot by experience. Every inmate was different.

Likewise, P8 realized some encounters also affected a positive change in self when stating, "We have to deal with the complications. Regardless to if they are level 3 or level 4, I have to have a positive attitude to provide the care they need…it's up to me to provide good nursing care."

Participants revealed that because of their encounters, they now perform, or avoid performing in ways that have affected their perceptions toward self-injuring inmates in favorable ways realizing that feelings must be set aside to find out what's going on with the inmate. To be helpful, participants must talk to inmates and offer other options as ways to deal with whatever he is going through.

Participants also perceived changes through stigmas surrounding self-injury. One participant described that stigma as:

> That's [mental health] a special field different from other fields. They [self-injurious inmates] have issues that they can't get it out without inflicting pain on themselves. They [other staff] had a negative feeling because they don't understand, they thought they were out to get attention . . . there's nothing wrong with him (P3).

Participants also spoke about changes in behavior because of their encounters with inmate self-injury. Aside from the change in being critical, participants stated they

no longer labelled or made excuses for those who self-injured. Working in an all-male prison, participants were taken back by some of the things inmates would say. They [inmates] had these issues that just weren't medically related. Inmates were disrespectful, and participants saw inmates do things like smearing feces, throwing urine, and doing what they had to do to come up to medical from the dorm. P6 added, "They are still human beings . . . don't treat them like inmates . . . not caring and just saying stuff just adds to the issues they already have. I had to adjust to it." P8 shared a similar perception:

> Every day is almost the same with mental health and self-injurious behavior. I know what I'm dealing with. You can't eliminate it because of the mental health. We deal with it. So, we restore lives . . . make sure the inmate is alright.

In addition, participants remarked that experiences led to positive realizations. They acknowledged that because of their encounters, their realizations altered their perceptions toward self-injurious inmates. The following realization was shared by P2:

> Medical takes precedence over mental health. If they ain't alive you can't treat them. You question [yourself], "Is it that bad that you would want to hurt yourself?" [We] weren't used to that . . . you ain't gonna die tonight. I would never want to be in that situation . . . you watch out for them.

Last, participants spoke about their realization regarding the importance of the diagnostic components, therapeutic interactions, and holistic standpoints. Those in the study verbalized responding to calls when inmates self-injured or needed to intervene for a medical issue that was not taken serious by correctional staff. Obtaining a thorough

medical and mental health history were reported as being important components when responding to this population. P1 stated:

> I learned after working with them and I softened up . . . Even the ones who had DSMV diagnosis . . . we had a good idea of what some of mental health challenges were that led to self-injurious behavior, so it really did change me.

Although experiences varied in some way, each participant offered at least one statement indicating a perception that growth had occurred secondary to their unique experience.

Table 20

Summary of Participant Responses Relative to Theme 2: Growth

Area of Growth Change	P1	P2	P3	P4	P5	P6	P7	P8
Self		X		X	X			X
Behavior			X			X	X	
Realization	X	X						

Subresearch Question 1

SRQ1: What does the nonprofessional healthcare staff think about inmates who self-injure?

SRQ1 concentrated on discovering what participants think about inmates who self-injure and led to the major themes: other healthcare staff and important roles.

Theme 3: Other healthcare staff. These are the interview responses from participants regarding other healthcare staff encounters with inmates that self-injure. Everyone in the study talked about how helpful staff appeared to be. One participant simply stated, "we are all jumping in helping." In crisis situations other healthcare staff was readily available to jump in and assist. P5 remembered:

> One person in CSU had cut himself in the stomach, he took out a staple and cut his arms. He was squirting blood everywhere . . . losing lots of blood. He got weak, fell down, and that's when we all went in and tried to control the bleeding. Everybody was there…everybody jumped in to help.

Not all participants thought all staff was praiseworthy and revealed that some encounters were not genuine. Although other staff appeared on the scene ready to physically help address the issue and attend to the wounds, mentally and emotionally, other staff spoke negatively about inmates afterwards. Healthcare staff were known to label self-injurious inmates, discuss the nature of the incarceration, and freely inform others if an inmate was convicted of rape, sodomy, or child molestation. Some participants considered these behaviors unfortunate and felt sadden by them citing that they (other healthcare staff) are there to be nurses first and that inside the prison there is a job to be done without judging.

Still other participants voiced appreciation for healthcare staff that helped and guided them to be successful in a new position. They reported enjoying the co-workers, learning a lot, and working with professional and ethical staff members. Participants

described other staff as sharing, strong, and being a team player. One participant shared her experience with other staff: “That was my first job. I learned a lot…I got to experience a lot and gained lifelong friends as well. I didn’t expect to learn so much as a new nurse. I got to work with some awesome nurses” (P6).

Few participants reported that other healthcare staff verbalized negative comments or behaved negatively toward self-injurious inmates. Inmates were referred to as being crazy or psych patients. Other staff were heard saying that nothing is wrong with him. Being transparent, one participant said, “I think some think how I think, umm.” Another participant said, “they had a negative feeling because they didn’t understand…they (staff) thought they (inmates) were out to get attention.”
While at some point throughout the interview session participants indicated that other healthcare staff held negative opinions regarding inmate self-injury, overall participants felt staff did a good job of helping to meet the needs of the inmate.

Theme 4: Important roles. Participants were asked to discuss their role when presented with an inmate who self-injuries. Referring to the urgent needs of inmate, one participant identified the important role as one that is a preserver of life in terms of talking the inmate out of a situation, preventing further self-harm, and saving the inmates life. Despite the varying differences in the participant responses, others who saw the role of active listener as an important role described tasks such as listening while they vented, effective communication, and providing undivided attention. All participants disclosed

how providing physical and mental health assessments was an important function when encountering self-injury.

Other responses were: “Once you talked to them you really got a feel for what’s going on. You don’t want anyone to hurt themselves but that’s up to that individual, but we are gonna lean toward no one hurting themselves” (P2). P6 stated:

> I have to find out why he did it. Stabilize, assess, and find out the why. Inmates would come up and just want to talk, they would just be pouring their hearts out to me . . . lots of moments like that.

Table 21

Summary of Participant Responses Relative to Theme 3: Other Healthcare Staff

	P1	P2	P3	P4	P5	P6	P7	P8
Supportive Staff		X			X	X	X	X
Less Dedicated Staff	X		X	X				

Subresearch Question 2

SQR2: What is it like for a nonprofessional healthcare staff member to encounter an inmate who has just self-injured?

SRQ2 focused on exploring what it is like when participants encounter an inmate who has just self-injured. Supporting inmates and challenges were the major themes that surfaced based on the interview answers.

Theme 5: Supporting inmates. All responses showed that participants were helpful to the inmates by supporting them in several ways. Some provided hope and direction, some provided emotional strength, while others provided encouragement for the inmates. Participants in the study disclosed perspectives that encapsulated the overall theme discussed within interviews: "[A]lways try to encourage them not to [self-injury]. You're gonna try to protect the inmate. They had an emotional rapport with them, with certain nurses and they would respond to that" (P2). P3 stated:

> In fact, it makes me more eager to take care of them. Get the patient to open up…talk to him, what made him want to hurt himself. I loved being there to get them to help.to keep watch over them (P3).

P6 said, "I try to empathize with them and talk with them about other things to do instead of hurting yourself. I had to put judgment aside and help them, do something now to keep them from doing it again."

Theme 6: Challenges. Participants talked about several challenges they faced while working with and responding to inmates that self-injure. Participants shared how these challenges could have prevented them from being successful in managing the response to the call for intervention.

Several participants felt the nature of the environment created challenges during life threatening times. Working in a security first setting, healthcare staff must wait until the area is secure and safe before providing care to the inmates. P3 recalled more than one situation in which he had to watch an inmate bleed out profusely for several seconds

while correctional staff secured the place and ensured that the inmate did not have anything to use to cause harm to the nurse delaying treatment to the inmate. P6 remembered a situation just a frightening:

> I looked up and there was blood everywhere. I was like oh my God. I didn't know where the blood was coming from and I couldn't react the way I wanted to because of safety. I couldn't do what I needed to do as a nurse because I have to wait until its safe.

Another challenge participants faced involved a lack of available correctional staff. Inmates may need an emergency medication administered, to be secured in physical restraints, or even transported to the hospital. One participant shared a different type of challenge when needing to aid the self-injurious inmate:

> When I go to the location of the injury I don't have security staff available, it takes a few minutes to arrive. It is a major challenge because we cannot go to their side, unit, or dorm without security. Sometimes nobody (P8).

Some expressed challenges related to other factors: "We didn't always grant them with their ultimate goal …them know this isn't how this situation should be appropriately handled so we're gonna, you know, treat our wounds and send you back down to your room" (P1). P4 stated:

> A challenge in knowing what to say to them, how to get them to calm down, explain why they did it . . . maybe if I was more trained, umm but just going in and not knowing anything about inmates.

All participants mentioned difficulties displayed by the inmate ranging from initially refusing to transport to medical to receive care or refusing to allow staff in his cell to provide care, delaying treatment by being uncooperative or in an agitated state, or removing bandages, sutures, or staples after they have been applied. P7 shared this viewpoint:

> He would delay care because he is focused on something else . . . he may be uncooperative with me or angry with me or directing anger towards me while I am trying to treat the injury but to him that's not his priority.

Table 22

Summary of Participant Responses Relative to Theme 6: Challenges

	P1	P2	P3	P4	P5	P6	P7	P8
Security/Environment			X		X	X		X
Other	X	X		X		X	X	

Subresearch Question 3

SRQ3: What components of holistic healing are evident in the responses of health care staff who encounter the self-injurious inmate?

SRQ3 asked participants to reveal the holistic components that are vital to them in responding to the inmate who has self-injured. The data collected guided the formation of the final major themes: understanding needs and therapeutic approach.

Theme 7: Understanding needs. Several of the participants revealed that some of the inmates have real mental health issues while others do not and expressed the significance of understanding the different needs of the inmate. Participants shared that although inmates' self-injury for manipulative or secondary gain reasons, it is equally important to understand the immediate need at that time driving him to engage in acts of self-harm. Each participant individually agreed that there were underlining issues causing the inmate to self-injure and felt that they missed the warning signs leading to the behaviors and acts.

Expressive responses from participants P3, P4, and P5 was:

> Why didn't we catch this? There has to be some tale tell signs . . . he's trying to get this out some kind of way. He's pacing . . . we missed his warning signs. That bothers me. Why didn't I connect the dots? (P3).

> They have some type of underlining problem that needs to be treated. I think it's bad that they do that . . . I feel like some of them have some real type of mental issue as to why they are doing it (P4).

P5 said, "I'm thinking he may be going through a lot of stuff being in prison. There is something he wants . . . give them some more counseling so they can talk and can be safe."

Theme 8: Therapeutic approach. Participants shared the value of having a strong therapeutic style with inmates as an initial component to providing holistic care. Overall, this was one of the most obvious and commonly conceptualized themes

throughout the interviews, suggesting that this may be the foundation for establishing widespread positive regards toward inmate self-injury. Participants spoke about being genuine and caring and how these attributes weigh heavily on the inmates' likelihood to be open to treatment opportunities and interventions. Participants also voiced the importance in understanding the inmates background and how previous experiences cause him to be in that emotional state of mind. Building a rapport was also considered an important therapeutic approach, suggesting that this may be the foundation needed in offering care that is adequate and holistic thus leading to improved patient outcomes.

P5 spoke about her views regarding therapeutic approach:

> I take it all serious…do the best I can. They have triggers . . . when they see that we care, serious, they do better, don't hurt themselves as much. We have to be sincere, do what we can do to help them.

P8 shared views that were similar:

> I have interactions that allow me to contribute my knowledge to help in the restoration of life of those incarcerated. They give me the opportunity to have a good working relationship with them [inmates]. We have to educate them, help them, be caring.

Participants mentioned the need to be genuine with this special population and the need to be available at any time the inmates are in a crisis. P8 shared his thoughts:

> I have to be genuine . . . talk with them about why self-harm is not the right option. I keep it in the right context to help talk them out of self-harm. Because of the environment we have to make ourselves available.

Another participant said, “I feel like I'm genuinely concerned about their well-being, like I do my job to make sure they are stabilized and that they don't suffer any more harm from what they done to themselves,” P1 offered a different type of transparency on this topic, “I did meet some of the patients that were doing it on purpose to be manipulative. That kinda harden me a little bit… kinda made me not take 'em all seriously the way that I should.” Several participants referred to the manipulative mentality of the self-injurious inmate citing the difficulty in determining the difference between a true cry for help and acting out. Regarding this, P1stated:

> It is really sad that dishonest people go that far to get what they want . . . spoil you or harden you from people that really need help, I started wanting to help everybody and then left being paranoid of everyone’s intent.

P1was even more transparent and honest when she reported her final perception that led to her decision to leave the correctional healthcare setting, “I lost my empathy to that… working with this population.

Table 23

Summary of Participant Responses Relative to Theme 8: Therapeutic Approach

Therapeutic approach	I1	I2	I3	I4	I5	I6	I7	I8
Being genuine		X			X	X	X	
Caring	X		X			X		
Establishing a rapport		X	X		X			X
Providing care	X			X			X	X

Summary

In this chapter, I reported the findings of eight nonprofessional healthcare staff perceptions regarding self-injury in male North Georgia correctional facilities. I presented participant demographic information, shared details from the data gathering process as well as presented the approach utilized to analyze the data. Through in-depth interviewing and reflection of participants experiences, the eight themes that emerged included changes on a continuum, growth, other healthcare staff, important roles, supporting inmates, challenges, understanding needs, and therapeutic approach. This chapter also included the process involved in coding the data and a discussion of the evidence of trustworthiness. Findings were presented in a manner that addressed the primary research question and themes for the study. In Chapter 5, I will present the interpretations of the findings, implications for social change, and recommendations for future studies.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative study was to describe nonprofessional healthcare staffs' perceptions regarding inmate self-injury because their unique roles have only been slightly explored. My interest for this research topic originated from distresses surrounding the stigma associated with inmate self-injury. As healthcare workers, staff are called to respond and provide care to all inmates in a manner that is holistic, accommodating, and nonjudgmental, regardless of the inmates' behaviors or diagnoses. Nonetheless, some staff are uncomfortable with their ability to effectively care for patients with this special population (Harms, 2010). Despite the distresses about the perceptions of healthcare staff regarding inmate self-injury, there is a lack of research on the topic. This chapter will include the findings I interpret, a description of the limitations of the study, recommendations for further research, and a discussion of implications for social change.

Interpretation of the Findings

To address the four research questions that guided the study, participants answered a 27 question Likert-type survey prior to their sit down interviews. One-on-one interviews helped to explore and describe the perceptions of nonprofessional healthcare staff regarding inmate self-injury. In this section, I discuss the major findings as they relate to the survey, research questions, previous literature, and the conceptual framework.

Findings for Likert-Type Demographic Survey

Section 1 of a 27-question survey provided six demographic answers concerning age, gender, educational level, healthcare, self-injury experience, and interactions with self-injurious inmates. Demographically, many of the respondents were female having over 5 years of both healthcare and prison experience. Most respondents reported daily interactions with self-injurious inmates as well as having at least 3 years' experience working with this population. Mainly, respondents held associate level degrees and all worked at a North Georgia State Prison.

Section 2 offered 16 Likert-type responses in which participants indicated the extent in which they disagreed or agreed with a statement. Responses to this section pointed out that staff largely agreed or strongly agreed with the given statements revealing that perceptions regarding inmate self-injury were mostly positive. Staff indicated they were aware of how they felt regarding self-injury. Staff felt they were professional, responsible, comfortable, and performed well with inmates who self-injure. Participants self-admitted to having a positive attitude toward this population. Two of the statements yielded disagree or strongly disagree responses; respondents did not feel that time or resources were wasted on inmates who self-injure.

Last, in Section 3, participants responded to 5 open-ended questions asking for brief answers to the participants' interactions with self-injurious inmates. Because there were no guidelines as to how to answer the open-ended questions, the inquiry as to the participants' current job titles yielded nurse practitioner, crisis stabilization unit nurse,

licensed practical nurse, mental health nurse, CSU/ACU nurse, and registered nurse. For question 2, most participants reported assessing and treating inmates as their primary duty in the correctional setting. Few participants reported their primary duty as stabilizing inmates in mental health crises. One participant reported her primary duty as completing physicals and managing inmates' chronic medical conditions such as hypertension, diabetes, and HIV. Replying to question 3, all participants described their days as starting with receiving reports on any new inmates being admitted to the infirmary, the crisis stabilization unit, or acute crisis unit. Most days progressed with completing assessments on the inmates, administering medication, responding to calls regarding inmates who have self-injured, admitting and discharging inmates to and from the crisis unit, and making rounds with or reporting to the doctor on an inmates medical or mental health status. All participants reported their days as ending by providing a complete status report to the oncoming nurse. In response to the fourth question (Have you received specialized training to assist you in working with male inmates?), none of the participants had received specialized training. One participant responded "no" but added that during her clinical rotation she had spent 2 days on a mental health floor in a jail in which the facility provided an hour lecture on games inmates play. Finally, in answer to question 5, participants described their interactions with inmates who self-injure as one in which they assess, stabilize, and medicate as quickly as possible.

Findings for the Research Question

RQ: What are the perceptions of nonprofessional healthcare staff regarding self-injurious inmates?

The major themes that appeared from this question indicated that nonprofessional healthcare staffs' perceptions varied from dislike of the tasks of responding to self-injury to feeling helpful, appreciated, and that the work is rewarding. The staffs' levels of ease and certainty fluctuated from high to low, and staff recognized that having a positive attitude caused them to feel more accomplished in caring for this population, was not hesitant to respond to self-injurious calls, and staff were less critical and stopped name calling. Staff recognized that these changes influenced their perceptions towards inmates who self-injure.

Based on years of different levels of interactions with self-injurious inmates, it was not surprising that healthcare staff described their experience in a manner that set each experience apart from the other. There were no significant findings regarding the perceptions of staff based on the years of experience working in healthcare, working in the prison setting, or working with self-injurious inmates. Unfavorable perceptions were described using words and phrases such as *frustrating, didn't enjoy it, not best for me, stressful, don't understand, taking back, ineffective, feel negative, difficult, nothing good,* and *waste of time.* Favorable perceptions were described as *helpful, rewarding, enjoyable, did a lot of good,* and *effective.* In addition, it was not surprising that staffs level of ease and certainty were most contingent on the presenting condition of the

inmate. In other words, when the inmates' self-injury was considered minor, superficial, or required little to no medical treatment, healthcare staff approached inmates with more ease and were more certain with the treatment they provided. When self-injurious events were more complex, involved arterial lacerations, needed further evaluation off site, or required life-saving techniques, staff perceived themselves to be more anxious and uneasy and uncertain.

Although this study explored perceptions of nonprofessional healthcare staff, this range of described perceptions regarding inmate self-injury reflect findings from another study exploring lived experiences of healthcare staff caring for individuals who self-injured (Wilstrand, Lindgren, Gilje, & Olofsson, 2007). While researchers studied specially trained registered nurses, participants perceived their involvement to be both fulfilling and unsettling and felt both good and frustrated. Nurse participants also expressed less confidence and being afraid when self-injurious acts were life-threatening.

Nonprofessional healthcare staff perceptions regarding inmate self-injury are applicable to the conceptual framework used for this study. Paterson and Zderads (1976) concept of uniqueness-otherness emphasizes that each person is responsible for deciding how to respond in a situation. Participants were encouraged to speak freely regarding their perceptions and encounters with inmates who self-injure. In doing so, healthcare staff revealed that their perceptions not only affected what they thought about themselves but how they engaged self-injurious inmates. Participants reported feeling that the job was not for them and that it was not best for them. One participant stated she almost quit.

They shared that they did a lot of good and saved a lot of people. Healthcare staff also revealed that they were uncomfortable, not confident, and often anxious.

Some degree and type of personal growth was evident for all participants. In the second major theme found, when responding to or caring for self-injurious inmates, staff perceived that changes in self, behavior, and stigmas held influenced the perceptions towards inmates who self-injure. Growth was supported when healthcare staff realized that certain encounters affected their perceptions through self-affirmation. These realizations altered perceptions in ways that were both positive and personal for the participant. Participants identified positive changes in thought about responding to self-injurious inmates. Participants revealed that performance was affected by perceptions toward this population. Some participants felt that encounters led to positive talents that they incorporated into the care they provided inmates. Staff learned their jobs by experience, interacting with the inmates. Last, staff perceptions towards self-injurious inmates did not appear to change based on any shame or humiliation as a result of the self-harm behavior, any name calling or labelling of the inmate, or reasons given in attempt to excuse the behavior. I found that healthcare staff growth largely altered the way inmates who self-injure were perceived.

As discovered in this study, McAllisters' 2002 study found that providers' initially having negative mindsets towards those who self-injure changed to become more positive over changed over time. Staff reported difficulties when initially describing personal feelings. Participants stated they felt cold and confessed the need to emotionally

disassociate themselves from the inmates. Participants admitted to name calling and labelling inmates words such as crazy, cutter, and nut. Staff often joked with the self-injurious inmate during critical times when instead they should have been responding to or caring for the inmate. Lieblings' team of researchers (2005) agreed that socially distancing from inmates proved to be ineffective.

The concept of uniqueness is appropriate for these themes. As applied to the study in 2008, Murphy and Aquino-Russel reported that personal attitudes were enhanced when participants examined and reflected on their experiences. Staff could better define themselves, their associations, and clinical practices under anxious circumstances. Atkins (2006) added to this by saying that actions embedded in inner attitudes result in more reliable nursing care.

Findings for Subresearch Question 1

SRQ1: What does the nonprofessional healthcare staff member think about inmates who self-injure?

Two themes revealed answers to this question. Staffs' perceptions of other healthcare staff varied. While some participants felt other healthcare staff were helpful and professional, some participants felt other healthcare staff were uncaring and disrespecting. Additionally, staff perceived their role as an important one conducting functions such as preserving life, active listening, and assessing the physical and mental health of inmates.

In the first theme that emerged from this question, nonprofessional healthcare staff were encouraged to freely express their perceptions about other healthcare workers. Participants reported that other staff made negative comments or behaved in negative ways while some staff were supportive and confirming, helpful, and proved to be a great resource. Some encounters were not genuine, and staff were judgmental. The use of judgmental expressions and labeling are routine in the correctional arena and may lead to minimizing self-harm. Previous study results indicated that correctional staff differentiated and labeled groups based on the motives for harming (Liebling, 1992). In other literature, staff expressed a need to be backed, whereas others did not feel they were alone and felt confirmed by other healthcare staff. Participants felt good hearing that it was also hard for other staff and appreciated being told they performed well or did the correct thing (Wilstrand et al., 2007).

The findings from this study were similar to findings from several previous works addressing attitudes towards self-injury. Dumpel (2005) stated the healthcare role lacks a satisfactory definition which creates false impressions by medical. Previous studies support that correctional healthcare staff often operate under many dual roles such as practice nurse and custodian (Dumpel, 2005) and mental health provider and practice nurse (Evans, 1999) placing staff in compromising clinical positions that cause them to consider how they would be perceived as a clinician. Healthcare staff participants agreed that this role left them in a vulnerable and isolated position making them both responsible and accountable for inmate self-harm (Marzano et al., 2015). Wilstrand et al.'s (2007)

qualitative study reported that having a fear regarding a patient's life-threatening act held a weighted emotional response that stimulated uncertainty, powerlessness, and defeat when confronted with treating patients at risk for repetitively injuring themselves. Staff reported feeling nervous when communicating with self-injurious patients (Bailey, 1994), and some reported the importance of connecting with patients through engagement. Nonprofessional healthcare participants expressed feeling defeated, frustrated, and unhelpful as a provider whereas other participants felt they performed good works, saved others, conducted thorough and appropriate assessments, and were helpful in de-escalating situations when they took the time to talk to the inmates.

The concept of uniqueness-otherness was supported by the findings of these themes, and the concepts assists with the identification, classification, and judgment about perceptions held. As this concept focuses only on the nurse, it encourages reflection on the nurses' feelings and biases that cause them to face fears, insecurities, and vulnerabilities (Wu & Volker, 2011) as well as demands a "nurses' existential awareness of the other" (Paterson & Zderad, 1988, p.3).

Findings for Subresearch Question 2

SRQ2: What is it like for a nonprofessional healthcare staff member to encounter an inmate who has just self-injured?

In response to this question it was revealed that healthcare staff perceived themselves to be supportive through the care they provide, emotional strength they offer, and through counselling services. Answers to this question pointed out that staff faced

challenges providing care due to the environment, security staff, and ineffective communication.

The theme, supporting inmates, emerged from this question. Participants felt most helpful when providing hope, direction, emotional strength, and encouragement to the inmates. They felt having a good emotional rapport assisted with encouraging inmates to not self-injure. When inmates were willing to open up and talk with healthcare staff, staff were more eager to respond to them and felt more at ease offering direction and hope for the future. Wilstrand et al.'s 2007 research emphasized the importance of connecting with patients through engagement, establishing structured and direct limits, and support as needed to help when providing patient care.

To answer the third research question, I encouraged nonprofessional healthcare staff to talk over challenges faced while working with or responding to inmates that self-injure. The most agreed upon challenge reported by participants dealt with the nature of the environment. During life-threatening times, healthcare staff felt there were delays in accessing the inmate to provide treatment due to the lack of security staff or because the area needed to be secured. Other reported challenges included ineffective communication and uncooperative inmates. Conflict between healthcare and security staff is still ongoing. In Ramluggens' 2013 study, healthcare staff reported role conflict in a security first environment. Despite understanding that safety and security is most important in a correctional facility, nonprofessional healthcare participants report feeling frustrated when treatment was hindered for security reasons. Participants perceive themselves as

being less effective when care is delayed. Additionally, previous literature participant staff reported inadequate feedback and minimal information-sharing as well as communication and cooperation issues from inmates. Participants in this study perceived that other staff was not always forthcoming with information that was vital to responding to the self-injurious inmate. When inmates used self-injury for secondary gain, often other correctional staff was made aware, yet failed to communicate this to appropriate staff for intervention. Participants also perceived themselves as being less successful when presented with self-injurious inmates requiring treatment yet refuse to receive treatment or interfere with the healing process. Opposing the aim of healthcare (HMCIP, 1999), the need for safety and correction often minimizes the image of inmates as patients.

Paterson and Zderads' (1976) Humanistic Nursing Theory facilitates participants in describing what they have come to know or how a situation affects his or her own existence. This strongly reinforced the findings of these themes in which nonprofessional healthcare staff recognized themselves as an individual, functioning alone, while searching for proof of existence. Above all, participants voiced a desire for improved care for the inmate.

Findings for Subresearch Question 3

SRQ3: What components of holistic healing are evident in the response of health care staff who encounter the self-injurious inmate?

Healthcare staff perceive it significant to understand the different needs of the inmate in terms of his mental process, deep rooted issues, and poor coping mechanisms as well as exhibiting a strong therapeutic style that is founded on building a rapport and being genuine and empathetic when responding to an inmate who has self-injured.

All the participants in this study believed that understanding the particular needs of a self-injurious inmate and that exhibiting a strong therapeutic style are crucial when providing holistic health to inmates who self-injury. Mental processes, deep rooted issues, and decreased coping abilities was cited by nonprofessional healthcare staff as important needs of the inmate worth understanding. Staff also agreed that being genuine and empathetic was significant when responding to inmates who self-injure.

Findings from early literature confirm findings from this research. With one-tenth of incarcerated males diagnosed with mental illness (Stamler & Yiu, 2012) and approximately 80% of self-injurious inmates diagnosed with an adjustment, anxiety, or mood disorder, self-injury was noted to co-exist with depressive symptoms and impulsivity (Carli et al., 2010) Williams (1983) suggested that inmates self-injure after discovering the influence the actions have on his surroundings and that for users, any self-harm that worked to change the environment or milieu, attract attention, or achieve a goal was deemed manipulative (Dear, Thomson, & Hills, 2000). Healthcare staff participants for this study shared that although some inmates self-injure for manipulative or secondary gain reasons, some inmates have real psychiatric and psychological issues that needs addressing and consideration.

The final theme developing from this research, therapeutic approach, was one of the most obvious and commonly conceptualized themes throughout the interviews. Literature on healthcare prison work suggested that staff use passive, secondary, and calming coping methods which are central components within the work culture (Schaufeli & Peters, 2000). Strategies useful in assisting with balancing professional boundaries include connecting with patients through engagement, establishing structured and direct limits, and putting aside ones' feelings at that moment. In addition, staff should disclose feelings, support each other, and debrief as needed (Wilstrand et al., 2007). Like this research, building a rapport was considered a foundation needed in offering care that is adequate and holistic thus leading to improved patient outcomes. Several authors agreed that mental health nurses should distribute care that is reliable, empathetic, positive, and stands on user centered values (Rooks & Mutsatsa, 2013; Baker et al., 2012; Hardy, White, Deane, & Gray, 2011). Participants spoke about being genuine and caring and how these attributes weigh heavily on the inmates' likelihood to be open to treatment opportunities and interventions. In other studies, authors have identified similar issues related to nursing attitudes towards those who self-harm with a diagnosis of personality disorder. Authors agreed that nurses should foster a more therapeutic rapport (O'Connell & Dowling, 2013; Weight & Kendal, 2013; Westwood & Baker, 2010). Stated best by Peternelj-Taylor (2003), as a more preferred and proper approach to inmates, attitudes should portray "an enduring conviction that caring for these vulnerable groups is the appropriate and decent thing to do" (p.47).

When healthcare staff participants understood the immediate needs of the inmate, they felt better equipped to help. When participants felt better equipped, actions toward the inmates were more genuine and staff was more empathetic. As a result, participants perceived themselves as more valuable when responding to the self-injurious inmate. The findings from this study confirmed Paterson and Zderads' (1976) theoretical framework explained by Jackson (2004) when stated that the Humanistic nursing theory pulls from the effects of the actions towards the patient and described by Croyle (2005) when emphasized that this theory offers tools for users to move away from intuition to purpose and assess health behavior and promotion interventions centered on perception of behavior. Last, Kleiman (2010) asserts that by interlocking identity and experiences, individuals create their own tapestry which unfolds during their response. This tapestry signifies views that consider the "gestalt of unique human experience and involved perception, bias, and prejudice and helps one to be open to the authentic, to the true experience of the other" (p. 343).

Limitations of the Study

This research was designed as a basis in acquiring valuable information about how nonprofessional healthcare staff perceive inmate self-injury. Participant involvement was voluntary. Although it was assumed that participants answered openly and honestly, one limitation of this research is the trustworthiness of the data, which are based on his or her reported explanation of any personal experience and less on actual facts. The findings are significant to this study as obtaining the perceptions, feelings, and challenges of an

experience is the purpose of phenomenological research. This study also encountered limitations surrounding the sample. Since this study only used participants previously or currently employed in male correctional facilities within the north Georgia region, there was a small number of participants. This research relied on the memory and self-report of practicing healthcare staff and assumed that staff had self-injurious inmates in their care. Because it was not known how many or how often healthcare staff responded to and treated this population, this may have limited the exposure and familiarity with self-injuring inmates and his specific medical needs. The results of this study are only unique to nonprofessional healthcare staff responding to inmate self-injury in male correctional facilities in the north Georgia region. Therefore, findings cannot be generalized to other populations of healthcare staff who may have had different experiences or outcomes in other regions of Georgia or with female inmates. Further research on healthcare staff perceptions regarding self-harm in female correctional facilities is warranted.

Recommendations

The increased occurrences of inmate self-injury have made the traditional types of job orientation, training, and clinical learning out of date for several reasons. First, larger numbers of individuals are incarcerated in prison with less serious charges for longer periods of time. Second, the importance on self-injury response has changed from episodic treatment to a concept of holistic care with a strong focus on continuity and improved patient outcomes. Third, the concept of intradisciplinary health care implies that a group of providers are working together to meet the needs of the self-injurious

inmate and that departmental relationships will improve thus decreasing any existing barriers to care and treatment for this population. With continued increase in inmate self-injury, the demand for professional healthcare staff will increase. Modifications are needed in curriculums to provide instruction that is more consistent with responding to inmates who self-injure. Educational preparation is important to the success of the individual healthcare staff member and the survival in this new role in the correctional setting. This study's findings indicated that participants perceived that the traditional training curriculum, with its focus on safety and security and prison health service, is not adequate to prepare healthcare staff for practice in today's correctional setting. This study explored nonprofessional healthcare staffs' perceptions regarding inmate self-injury as well as examined the effect of the described experience. I learned that these perceptions are on a continuum and that staffs' personal growth as it pertained to his or her experiences responding to those who self-injure are influenced by these perceptions. I noticed that nonprofessional healthcare staff approached self-injurious inmates in a timid and unsure manner when they felt less comfortable, helpful, or confident. These findings support the need to know, from healthcare staff, what is needed to enhance their medical care to inmates with self-harm issues. Despite the different admitted levels of comfort, helpfulness, and confidence, each person referenced the need for more training. Nonprofessional healthcare staff perceived that even with the growing incidence of self-injury in the correctional setting, the amount of training focused on inmate self-injury is lacking. Those invited to contribute in this research were employed from one type of

correctional institutions, prisons. I would recommend exploring perceptions of nonprofessional healthcare staff employed in jails as individual perceptions may vary given inmates may not have not received his sentencing or may be faced with shorter sentencing timeframes. Also, by selecting the prison setting, participants discussed their perceptions as it related to encounters with adult inmates. I recommend that future research in this area include nonprofessional healthcare staff perceptions regarding self-injury in juvenile detention centers. The current study did not address what individuals expected when they chose a career in the correctional setting, what they were told about the specific tasks they would perform as a correctional healthcare staff member, and whether pre-determined expectations differed from the realities of caring for and responding to self-injurious inmates. Researchers can explore those considerations to uncover any impacts it would have on the nonprofessional healthcare staffs' perception regarding self-injury. Correctional healthcare staff are identified as an appropriate source to provide care and treatment that is appropriate, individualized, and holistic. As such, it is expected that healthcare staff have a positive attitude and practice that is centered on values and approaches aimed at helping the inmate. Although somewhat alike in staff type, research participants were largely female. Another recommendation is that a more gendered combination of participants is included to explore the influence of gender norms toward perceptions. Lastly, recommendations for future research would be replicating this study using a larger number of participants as well as studying perceptions of correctional healthcare staff responding to female self-injurers.

Implications

This phenomenological study seeks to expand the understanding of perceptions nonprofessional healthcare workers have regarding self-injury within the prison system. This research confirmed a need for change in the nonprofessional healthcare staffs' perception regarding inmate self-injury. This study has noteworthy social change implications. It introduces matters about nonprofessional healthcare staffs' perceptions that have not been known. As anticipated, the nonprofessional healthcare staff in this study expressed their perceptions regarding inmate self-injury, explored their thoughts about inmates who self-injure, described their experiences with inmates who self-injure, and explained components of holistic healing critical to responding to self-injury. In addition, staff in this study expressed how attitudes of other staff affect their attitude toward inmate self-injury. Social change supports through practices in which approaches expanded participants' individual value and growth. In doing so, contributing healthcare staff develop an awareness of their perceptions regarding inmate self-injury and in turn alter the influence the perception contributes to responding to the self-injurious inmate. Research findings indicated that perceptions regarding self-injury varied on a continuum. Findings promote positive social change since, contributing healthcare staff and those reading it, have or will acquire an increased awareness of their perceptions regarding inmates who self-injure and the effect the experience may have on their confidence when responding to this population. Because of this research, healthcare staff are empowered, understood, and encouraged to offer care and treatment that is adequate and holistic and

leads to improved inmate outcomes. Findings from this research will contribute to the body of knowledge specific to healthcare staff. Through empowerment, staff become advocates and inspire others to serve as positive role models by acquiring a nonjudgmental attitude towards responding to all inmates with the same interests, regardless of the diagnosis as well as encourage others to gain the self-confidence essential to meeting the holistic needs of all inmates within their care. As mentioned, change is needed. The results of such transformations will affect the outcome of treatment to self-injuring inmates by facilitating better perceptions of nonprofessional healthcare staff without role stress. Staff will make more fitting decisions regarding physical and mental health care services. This study backs nonprofessional healthcare staff and urges other healthcare staff and organizations to do the same. With the rapid and steady increase in inmate self-injury, the role of the nonprofessional healthcare staff has become more important than ever. This study explores how nonprofessional healthcare staff perceives aspects of inmate self-injury.

Conclusions

Studies on perceptions of healthcare staff responding to self-injury tend to focus on trained healthcare staff working in mental health or hospital settings. With over 90,000 people in custody in the state of Georgia (Glaze & Kaeble, 2014), the number of known incidents of self-injury is well over 1,800 (DeGroot et al., 2012). The perceptions of the untrained correctional healthcare staff acting as the first healthcare responder to inmate self-injury are mostly unknown (Srivastava & Tiwari, 2012; Lee et al., 2008;

Sethi & Upaal, 2006; Stoppe et al., 1999). Past studies determined that staff was apprehensive and perceived themselves to be helpless, frustrated, and unsure. This phenomenological study explored perceptions of nonprofessional healthcare staff regarding inmate self-injury. The eight major themes identified in this study, along with other studies, provided a chance to gain awareness regarding these perceptions. As found in this research, perceptions held by healthcare staff impact the response to and the treatment toward the self-injurious inmate. Overall, perceptions ranged from unfavorable to favorable. Nonprofessional healthcare staff perceived that factors specific to the individual affected their level of ease and certainty. Staff perceived themselves as a preserver of life and active listener. Staff perceived other healthcare staff as both holding negative opinions and being very helpful and supporting. Staff perceived that challenges prevented them from being successful in the management of self-injury. Last, nonprofessional staff perceived themselves as very helpful and therapeutic.

This research adds to the expansion of concepts, delivered an understanding in areas that could not be explored by quantitative methods, suggests a unique contribution to social change, and implies a basis for future research.

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Appendix A: Demographic Tool

Section I

1. What is your gender? _____ Male _____ Female

2. What is your age? _____

3. What is the highest level of healthcare education that you have completed?

_____ Up to but not including a Bachelor's Degree

_____ Bachelor's Degree or higher

4. How long have you been providing services in the healthcare field?

_____ 0 - 11 months

_____ 1 - 2 years 11 months

_____ 3 - 5 years

_____ Over 5 years

5. How long have you been providing services in the prison setting?

_____ 0 - 11 months

_____ 1 - 2 years 11 months

_____ 3 - 5 years

_____ Over 5 years

6. How long have you been providing services to inmates who self-harm?

_____ 0 - 11 months

_____ 1 - 2 years 11 months

_____ 3 - 5 years

_____ Over 5 years

Section II

Indicate the extent to which you agree or disagree with the statement. Circle the number that corresponds best with your perception.

Statement	Strongly Disagree	Disagree	Neutral/No Opinion	Agree	Strongly Agree
1. Treating inmates who self-injure is a waste of time.	1	2	3	4	5
2. Treating inmates who self-injure is a waste of resources.	1	2	3	4	5

3. I am aware of how I feel regarding inmate self-injury.	1	2	3	4	5
4. My feelings towards self-injurious inmates have changed since I began working with inmates.	1	2	3	4	5
5. My attitude regarding inmates who self-injure is largely positive.	1	2	3	4	5

6. I have heard other healthcare staff say positive things regarding inmate self-injury.	1	2	3	4	5
7. Seeing an inmate who has just self-injured is emotional for me.	1	2	3	4	5
8. My healthcare training needs enhancing regarding	1	2	3	4	5

inmates who self-injure.					
9. Further education on inmates with self-harm issues would help me.	1	2	3	4	5
10. I have a great deal of responsibility to help inmates who self-injure.	1	2	3	4	5
11. I have the appropriate skill set to help	1	2	3	4	5

inmates who self-injure.					
12. I am comfortable when responding to an inmate who self-injures.	1	2	3	4	5
13. I perform well when presented with an inmate who has self-harmed.	1	2	3	4	5
14. Staff I work with act professionally towards inmates who self-injure.	1	2	3	4	5

15. There are barriers/challenges I face regarding self-injurious inmates.	1	2	3	4	5
16. I manage well when barriers/challenges arise from working with this particular group.	1	2	3	4	5

Section III

1. What is your current job title? _____

2. What is your primary duty in the correctional setting? _____

3. Describe your typical day at work. _____

4. Have you received specialized training to assist you in working with male inmates?

_____

5. What are your interactions with inmates who self-injure? _____

Appendix B: Interview Guide

Demographic

What is your highest professional degree completed? _____

What are your primary responsibilities in the correctional setting? _____

How long have you worked in a correctional setting? _____

At the time of hire, how long was your orientation/training period? _____

Have you ever received specialized training to assist you in working with male inmates?

If yes, please describe the type of training you received. _____

Describe your typical day at work. _____

What do you enjoy the most about your job? _____

What do you enjoy the least about your job? _____

1. Tell me what you think about inmates who self-injure.

Please describe your interactions with inmates who self-injure. _____

Do you feel that treating inmates who self-injure is a waste of time? If yes, please explain. _____

Do you feel the treatment of inmates who self-injure is a waste of resources? If yes, please explain. _____

Do you think your feelings toward self-injurious inmates have changed since you began working here? If so, please explain why. _____

What do you think (positive/negative) about inmates who self-injure? _____

Do you think your attitude is largely positive or negative? _____

What do you think other nonprofessional healthcare staff in your department think or feel (positive/negative) about inmates who self-injure? _____

Without using any names, what have you heard other healthcare staff say?

_____

2. Would you tell me what it is like when you encounter an inmate who has just self-injured?

Do you feel as though you have the appropriate skill set to help inmates who self-injure? If no, please explain. _____

Describe your current/past experiences working with inmates in your prison who self-injure. _____

Explain barriers/challenges you face regarding self-injurious inmates. _____

How do staff you work with behave towards inmates who self-injure? _____

How do you do when presented with an inmate who has self-harmed? _____

In the context of the last SIB that you managed, can you tell me about the events leading up to arriving at the location of the inmate? _____

How did the event end? _____

Tell me about the process of reporting the event. _____

Tell me about policies, training, or other safeguards in place to address or monitor self-injury. _____

How well do you think that nonprofessional healthcare staff manages the barriers/challenges that arise from working with this group? _____

3. Would you describe in a little more detail your response when you encounter a self-injurious inmate?

How much contact do you have with inmates who self-injure? _____

Describe your comfort level when responding to an inmate who self-injuries. _____

What factors do you feel are important when responding to an inmate who has just self-injured? _____

What thoughts do you have when you see an inmate who has just self-injured? _____

Does seeing an inmate who has just self-injured make you feel anything/bring up any emotions for you? _____

Do you get any supervision/an opportunity to debrief after an encounter with an inmate who has just self-injured? _____

You are the expert on this experience and so if you had one piece of advice for how correctional healthcare staff could help inmates who self-injure, what would it be?

_____

What do you need to enhance your nursing care to inmates with self-harm issues?

_____

Would further education on inmates with self-harm issues help you? If yes, explain why.

_____

What level of responsibility do you have to help inmates who self-injure? _____

Is there anything else you would like to talk about? _____

Is there anything more about this subject that you think I should know? _____