An exploratory study into the factors which influence nursing staff's attributions, beliefs and behaviour towards individuals who self-harm

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Abstract

Previous research into self-harm suggests that nurses frequently hold negative views about individuals who self-harm. In addition there is little consensus in the literature on definitions and causes of self-harm, or the impact of nurses' beliefs on their care giving to this group. This study aimed to explore nurses' attributions, beliefs and behaviour towards self-harm and to identify the impact of this work on nurses.

Q Sort methodology was used in this study to investigate the attitudes and self reported behaviour of a group of nurses towards people who self-harm. Participants also completed a standardised measure of burnout.

Factor analysis of Q sort responses resulted in eight factors reflecting mainly positive attitudes but some struggling to understand the individual who self-harms. Analysis yielded no differences between short and longer term working but nurses' personal accomplishment increased from training which discussed self-harm. Implications for theory, clinical practice and service delivery are discussed.

'Look at the individual, not the harm. Look at the person beyond the scars.' (Sadler, 2002).

This quote encapsulates this research on self-harm. Societal views of self-harm have been likened to the position of child abuse twenty years ago where people had just begun acknowledging that it occurred (Sadler, 2002). The author was questioned during the course of this research why the author would want 'to bother' researching self-harm. Through undertaking this research the author wanted to try to understand how nursing staff view individuals who self-harm, as the majority of contact with services is through nurses. Additionally, the author was interested in the impact these beliefs or attitudes may have on provision of treatment and how holding these views and working with individuals who self-harm impacts on staff. The impact on staff is important as nurses as a professional group have been identified as experiencing high levels of burnout (Kanste, Kyngas & Nikkila, 2007; Maslach, Jackson & Leiter, 1996).

The economic, physical and emotional costs associated with an individual who self-harms are large (Crawford, 2001). Self-harm can result in long term physical health problems as permanent damage to tendons and nerves can occur as well as scarring, leading to disfigurement. Individuals who repeatedly self-harm and attend Accident and Emergency (A&E) services use a substantial amount of service provision. It is suggested that they account for 150,000 – 170,000 attendances at A&E every year with self-harm resulting in 68,716 hospital admissions in England and Wales in 2001/2002 (Department of Health, 2003). Self-harm is one of the top five causes of acute medical admissions in the United Kingdom (Hawton & Fagg,

1992) (as cited in National Institute for Health and Clinical Excellence (NICE), 2004). In addition, self-harm causes strain on the individuals' family and social network (NICE, 2004).

In a reaction to the growing political awareness and high personal and economic costs of self-harm there is growing interest in self-harm as an area of research, with research varying from; trying to define self-harm (Matsumoto, Azekawa, Yamaguchi, Asami & Iseki, 2004; McAllister, 2003; Owens, Horrocks & House, 2002); to exploring its prevalence (Horrocks, Price & House, 2003; Moore, 2005); to providing explanations for the behaviour (Himber, 1994; Lindgren, Wilstrand, Gilje & Olofsson 2004; Lindley-Starr, 2004; NSHN, 2006; Sadler, 2002). Other research focuses on associations between self-harm and other difficulties, such as domestic violence (Boyle, Jones & Lloyd, 2006) and suicide (Cooper, Kapur & Webb, 2005; Gairin, House & Owens, 2003; Hawton, Harriss & Zahl, 2006). Types of individuals who self-harm have also been considered, such as young people and adolescents, individuals with learning disabilities, men versus women and older people (Anderson, 1999; Derouin & Bravender, 2004; Eddleston, Dissanayake, Sheriff, Warrell & Gunnell, 2006; Hurry & Storey, 2000; Murray, 2003; Taylor, 2003; Webb, 2002).

Other research has focused on health professionals' understanding of self-harm, as well as accounts from individuals who self-harm (Jeffery & Warm, 2002). Staff perceptions of care and individuals' perceptions of treatment received has also been investigated. Despite the growing awareness of self-harm, it is claimed that individuals are still met with negative perceptions when they seek support and their experiences of services are reported to be poor (Holley, 2007; Huband & Tantum,

2004; NICE, 2004; Slaven & Kisely, 2002). Self-harm continues to be misunderstood. It generates fear and suspicion in staff (Rayner & Warner, 2003). Repulsion at the act, difficulty sympathising, ignorance, punitive consequences and an inability to be non-judgemental are all common staff opinions (NICE, 2004; Sadler, 2002). This explains why it is likely that it will continue to be a 'secret' coping strategy and hidden health problem for years to come (McAllister, Creedy, Moyle, Farrugia, 2002a). Research needs to clarify what perceptions are held, the impact of these attitudes on service provision and the impact on staff of working with self-harm.

Definitions

Menninger in the 1930s described the 'wrist cutting syndrome' and concluded that self-harm was an attempt to 'self heal' or as 'self preservation' (Simpson, 2006). Since this early definition there have been multiple attempts to define self-harm, but the literature lacks agreement on a single definition.

Pattison & Kahan (1983) (as cited in Matsumoto *et al.* 2004) proposed the 'deliberate self-harm syndrome' which was defined as a triad of self-mutilation, eating disorder and substance misuse. This narrow co-morbid definition of self-harm is limited as many individuals who self-harm would not meet the criteria for inclusion for this syndrome, as not all individuals who self-harm misuse substances or have an eating disorder.

Poustie & Neville (2004) proposed that self-harm should be considered as a 'long-term health condition,' with service provision acknowledging that self-harm is a

recurring difficulty. The idea of 'condition' suggests that self-harm is not controlled by the individual and that there is something intrinsically wrong or defective with the individual.

Deliberate self-harm is a further term which has been used to describe self-harm. NICE (2004) guidelines acknowledge that for some individuals self-harm can occur in dissociative states where the self-harm may appear to be out of the person's control or awareness. They have therefore specifically omitted the word 'deliberate' in the definition. However, it can also be suggested that the removal of the term 'deliberate' was because of its perceived connotations to blame (Taylor, 2003).

McAllister (2003) described her view of self-harm as "intentional damage to one's own body, apparently without a conscious intent to die."(p.178). Intent of the individual is key in self-harm, distinguishing self-harm both from suicide and also from unintended harm (Taylor, 2003).

Types of self-harm and difference to suicide

The issue of intent in self-harm, along with the lack of a uniform definition on what types of behaviour constitute self-harm, are key issues in the literature. Self-harm has been used to describe a wide range of behaviour, such as cutting of various parts of the body with a variety of implements versus behaviours which can cause harm, such as binge drinking of alcohol, smoking, eating disorders, body piercing, tattoos, exercising excessively and drug misuse. The issue is that some behaviours are deemed socially acceptable by some societies and cultures (Himber, 1994). The use of symbolism to represent blood, bleeding and cutting appear in virtually all

cultures and can have a powerful symbolic meaning for the social group following that religion or belief, such as the Sacrament of Holy Communion (Himber, 1994). However, cutting in self-harm is viewed as an individual experiencing significant psychological distress. Cutting is where razor blades, knives, broken glass or any object which when applied to the skin with sufficient pressure, causes an open wound (Woldorf, 2005).

Horrocks *et al.* (2003) conducted a clinical database study where 5066 attendances for self-harm were identified by 3239 individuals over an 18 month period. Recorded methods of self-harm were: cutting (72%), punching walls and banging heads (8.6%), swallowing objects (2.3%), stabbing self (1.9%), traffic related (1.5%), burning self (0.9%) and other (3.1%). They account for 90.3% of the data for individuals presenting with self-harm. However, the remaining 9.7% of the data were hanging (4.7%), jumping off building / out of window (2.0%), carbon monoxide poisoning (1.5%) and drowning (1.1%) and could be defined as attempted suicide. This study is an example of how the terms 'self-harm' and 'suicide' have been used interchangeably in the research.

Lindgren *et al.* (2004) proposed that the aim of self-harm is not to die, but to feel better. However, the rate of suicide in an individual who self-harms is suggested to increase to between 50 and 100 times that of the general population (Hawton *et al.* 2002) (as cited in NICE, 2004). In the year after an act of self-harm 20% are suggested to repeat the act, with 1% dying from suicide (Crawford, 2001). Crawford (2001) proposes that if a high standard of care was provided to individuals after harming themselves, this would reduce suicide rates. This is supported by studies

suggesting in 8% to 25% of all suicides, the individual had presented at A&E after self-harm in the year prior to their death (Owens *et al.* 2002; Gairin *et al.* 2003). The NICE guidelines (2004) specifically for self-harm were developed following political agendas focused on reducing suicide rates. The Department of Health (2002) and the Scottish Executive (2002) both developed strategies making the assessment and treatment of self-harm in A&E a national priority, as a way to reduce suicide rates.

In addition to increased risk of suicide it is reported that individuals who self-harm are at increased risk of dying from other physical illnesses, such as lung disease, gastrointestinal ulcers and acquired immunodeficiency syndrome (AIDS) (Hawton *et al.* 2006). An explanation for this finding could be that individuals who self-harm often engage in other activities and behaviours, such as alcohol misuse and risk taking, which can increase the chances of developing a physical illness. However, the presence of chronic illness may also lead to a lowering of an individual's mood, which in turn is known to increase self-harming behaviour in individuals where self-harm is a coping strategy for emotional regulation (Hawton *et al.* 2006).

The definition of self-harm used in this study followed the NICE (2004) guidelines omitting the use of 'deliberate'. For the purposes of this study, self-harm is the act of harm to oneself which can include: scratching of one's skin, burning the skin, pinching and bruising the skin, cutting the skin (with various implements), picking scabs or interfering with wound healing, hitting one's head, infecting oneself, breaking bones, punching oneself, inserting sharp objects into body orifices and hair pulling (Holley, 2007; Lindley Starr, 2004; Poustie *et al.* 2004; Taylor, 2003). This can be summarised as 'the intentional infliction of physical damage upon one's

body,' (Woldorf, 2005). Other forms of self-harm, such as overdoses, hangings and poisoning were excluded, as these were considered in many studies to be attempts at suicide.

Prevalence

Self-harm is suggested to be on the increase (Ridley, 2002). However, it is difficult to operationalise the actual and estimated numbers of individuals who self-harm, given its 'private' nature. Prevalence rates are also skewed by repetition of self-harm. When prevalence figures change within the literature, consideration needs to focus on: societal changes and discussion of certain topics which were previously taboo; availability and resources of services: and increases in media coverage which can raise awareness, increase familiarity and thus in turn increase its use as a coping strategy due to its increased profile (Jeffrey *et al.* 2002).

Meltzer, Jenkins, & Singleton (2002) (as cited in NICE, 2004) suggested that between 4.6% and 6.6% of people have self-harmed in Britain. Incidents of self-harm have ranged from 750 per 100,000 population per year (Haines, Williams, Brain & Wilson, 1995) to propositions that self-harm accounts for more than 100,000 of A & E attendances and hospital admissions per annum in England and Wales (Poustie *et al.* 2004) to approximately 140,000 presentations of individuals who self-harm (Mitchell & Dennis, 2006). The WHO multicentre study (1997) (as cited in Boyce, 2003) on hospital based self-harm in 16 European countries identified the UK as having 632 per 100,000 cases of self-harm. These rates were twice the size of Australia at 276 per 100,000 and over five times the size of Spain at 118 per 100,000. The inconsistencies in reporting are a consequence of varying and vague

definitions, misdiagnosis, under-reporting, particularly because most self-harmers are aware of how socially stigmatising it is, as well as the problems with data records and collection (Taylor, 2003).

Self-harm is carried out by a wide age range of individuals, from children to the older person. In older people, it is reported (Eddleston *et al.* 2006) that self-harm is more likely to be fatal due to their physical vulnerabilities owing to chronic illness, frailty and social isolation. Boyle *et al.* (2006) suggested that self-harm was prevalent in individuals who were also suffering domestic violence. Individuals who are disadvantaged socio-economically, live alone, are divorced or a single parent, suffering from physical illnesses, debt, conflict and loss in their interpersonal relationships or lacking in social support are all at increased risk of self-harm (NICE, 2004).

In sum, prevalence rates in the literature are inconclusive due to varying and vague definitions, misdiagnosis and under-reporting.

Why do Individuals Self-harm?

There have been multiple attempts in the literature to explain why individuals self-harm. It has been necessary to be selective in detailing the theories of self-harm in this study, however other research can be accessed which has focused specifically on reviewing the theories of self-harm (Lindley Starr, 2004; McAllister, 2003; Raynor *et al.* 2003; Raynor, Allen & Johnston, 2004; Simpson, 2006; Webb, 2002).

The lack of clear theoretical consensus on why people self-harm evidenced in the literature means that staff may find it more difficult to work with individuals who have self-harmed. Different theories have been proposed to provide explanations for self-harm behaviour. These include: biological, behavioural, cognitive, social, biosocial disorder, cultural and psychodynamic theories (Lindley Starr, 2004; McAllister, 2003, Raynor & Warner, 2003; Simpson, 2006) However, these explanations are distinct and isolated from each other and, although they provide explanations for aspects of self-harm, there does not appear to be a model for understanding self-harm which is able to bring all these factors together to provide a comprehensive understanding of why individuals harm themselves.

In order to structure these factors and theories for self-harm the author found it helpful to group the research into three areas: internal factors, external factors and self-harm as a coping strategy. Internal factors refer to internal aspects of individuals and consider self-harm as impacted by things which are occurring within the individual, such as the presence of mental illness. External factors, such as exposure to difficult life events and interpersonal relationships, are factors which are external to the individual. The presence of internal and / or external factors does not immediately equate to self-harm behaviour in all individuals. There is a third dimension, as for some individuals self-harm can be viewed as a way of coping with these internal or external factors. In this way self-harm can be conceptualised as 'a temporary solution to a permanent problem' (Woldorf, 2005, p.197). The permanent problems could refer to internal or external aspects of an individual. If either of these factors are present self-harm may then be used as a way to cope with the impact of these in some people.

The Impact of Internal Factors

There is an assumption in the literature that poor mental health underlies why individuals self-harm (Barr, Leitner & Thomas, 2004). Barr *et al.* (2004) reported that 64% of individuals who self-harm had mental health difficulties. This data was obtained from a total of 4329 presentations of individuals to hospital after an act of self-harm over a four year period (1996 – 2000). Surprisingly, the study includes in its analysis multiple presentations by the same individual. Out of the 4329 presentations only 2417 different people presented during that time. This suggests that 64% could be an elevated figure within the sample as the figures are skewed by repeat attendances. Also a history of substance misuse in individuals was used to identify mental health difficulties. Although it is likely that many individuals who misuse substances would meet criteria for a diagnosis of a mental health problem it is a problematic to use this as a sole indicator of mental illness.

Other studies supported Barr *et al's.* (2004) view of high levels of mental illness, depression and borderline personality disorder (BPD) were proposed as commonly present in those who self-harm (Haw *et al.* 2001; NICE, 2004; Simpson, 2006). McAllister (2003) attributes the use of the BPD diagnosis with individuals who self-harm as a contributing factor to why staff perceptions can be negative towards individuals who self-harm.

Additionally, there are biological reasons which predispose individuals to harm themselves. Decreased serotonergic activity and receptor binding index is suggested in individuals who self-harm (Dallam, 1997). This suggests that self-harm self soothes the individual through activating the endogenous opiate system. This means

that the act of self-harm may release neurotransmitters in the body which can be experienced as pain relieving, mood enhancing and arousal reducing (Dallam, 1997). Heightened sensitivity to emotion, increased emotional intensity and a longer return to emotional baseline have also been suggested (Linehan, 1993; Cited in McAllister, 2003). The difficulty with these ideas are that only some individuals report positive feelings after self-harm and there is very little research in this area. It is also difficult to establish these factors as sole reasons why an individual self-harms.

Derouin *et al.* (2004) proposes deficits in cognitive and emotional skills needed to cope with day-to-day life as explanations why an individual self-harms. This idea is supported by the Objects Relation Theory which establishes that during childhood individuals develop internal representations of themselves (Lindley Starr, 2004). In individuals who have been abused or who have experienced other negative life events it is more likely that their internal representation of themselves will be negative. The effects of having a negative internal sense of self are that it is more difficult to self-soothe and the person may adopt other ways to manage their emotions (Lindley Starr, 2004). This idea also acknowledges the importance of the social environment, such as life events, the current environment and coping skills as other factors to explain why individuals self-harm.

In sum, internal factors, such as mental illness are suggested to explain why individuals self-harm. However, these internal factors cannot alone explain why individuals self-harm and other factors are proposed to have an impact on whether an individual self-harms.

The Impact of External Factors

The impact of life events on an individual's behaviour can not be underestimated. Examples of significant life events can be wide ranging but some examples are sexual, physical or emotional abuse, loss or separation, poor parental physical health problems or communication, and loss of or inability to have a child (Smith, 2002).

A life experience which has been discussed in numerous studies is sexual abuse (Hawton, Rodham & Evans, 2002; Lindley Starr, 2004; Matsumoto *et al.* 2004; Murray, 2003). Abuse can leave an individual with an unclear sense of self, issues relating to intimacy and privacy, guilt, fear of being alone and self punishment. Associated losses of abuse, such as loss of a relationship are particularly difficult if the abuser was a family member, and also being disbelieved or ostracised by family are other difficulties that may increase the likelihood of an individual self-harming. Individuals' coping strategies can also become invalidated by abuse and can lead to emotional dysregulation. This idea of emotional invalidation is also proposed by Poustie *et al.* (2004) who suggest that continued emotional invalidation could lead to chronic and multiple health problems and so self-harm should be considered a long term health problem. However, these propositions require further research before they can be accepted and validated as explanations for why individuals self-harm.

Dissociation is a strategy often utilised by individuals who have been abused and is also associated with self-harm (Himber, 1994; Schoppman, Schrock, Schnepp & Buscher, 2007). Matsumoto *et al.* (2004) described how dissociation is often present at a high level prior to self-harm, which explains the absence of pain reported by

many individuals who self-harm. Additionally this helps others to understand how an individual can experience feelings of release after the self-harm, as this could be the change from the dissociative state to one where they are bought back to the 'here and now' and current situation.

Webb (2002) conducted a systematic literature review of factors associated with self-harm, identifying psychosocial and psychological factors as explanations for self-harm. However, the focus of this literature review was adolescents so it could be argued that generalisability of these findings are limited. Also, the systematic review was limited to 11 studies in a ten year period of 1990-2000. Psychosocial factors identified were; family dysfunction with difficulties, such as poor family communication and relating; and social worries, such as interpersonal relationship difficulties, sexuality and career pressures. Psychological factors were highlighted as depression and hopelessness.

External factors, such as difficulties in interpersonal relationships, can impact on an individual's feeling of self worth and can be a key factor in why people self-harm (Finch & Pozanski, 1971 as cited in Anderson, 1999; Mitchell *et al.* 2006; Pembroke & Smith, 1998; Simpson, 2006). A grounded theory study by Simpson (2006) provided an explanation for how interpersonal difficulties impacted on self-harm by increasing a person's level of emotional distress due to loneliness and feelings of powerlessness to effect change in their interpersonal network. Often when an individual self-harms the situation is perceived as being insolvable (Mitchell *et al.* 2006). Self-harm is then viewed as a metaphor for loss but also as a way to gain a solution to the individual's difficulties (Anderson, 1999).

Young, Van Beinum, Sweeting & West's (2007) population based survey of 1258 20-28 year olds identified that employment and stress in the workplace affected the severity of the self-harm and the starting motivation for harming but also coincided with the individual stopping self-harming. Limitations of this study were that participants were provided with a list of options to answer from rather than the provision of open ended questions. Additionally there were only 20 out of the 1258 currently self-harming. This small sample size prevents these claims from being substantiated and generalised.

In sum, external factors, such as traumatic life events can provide explanations for why individuals self-harm. However, the presence of internal and external factors in individuals does not always lead to an individual harming themselves. It is therefore important to consider why self-harm is utilised by some individuals as a strategy to cope with these factors.

Self-Harm as a Way of Coping

The literature on self-harm describes internal and external reasons why individuals self-harm. Self-harm can therefore be described as a way to manage and cope with resultant feelings and emotions from these internal and external factors.

Self-harm has been described as a way to cope and survive, diversion from suicide, communication, regulation of distress and anxiety, dealing with anger and distraction (Derouin *et al.* 2004; McAllister, 2003; Smith, 2002). Gratz (2006) suggested emotional inexpressivity, past experience of maltreatment and lower levels of positive affect intensity/reactivity as explanations for why individuals self-harm. The

function of self-harm is self preserving in the absence of other more adaptive strategies (Connors, (1996) as cited in Lindley Starr, 2004; Pattison *et al.* 1983 as cited in Matsumoto *et al.* 2004). Self-harm can therefore be conceptualised as self restraint to suicidal feelings as the self-harm represents the least possible damage and thus reduces the overwhelming feelings which may lead an individual to commit suicide. (NSHN, 2006). In this way self-harm can be understood as a method of coping over the longer term, which explains the high repetition rates in self-harm (Jeffrey *et al.* 2002; Matsumoto *et al.* 2004).

Self harm is an example of a behaviour that can elicit both positive and negative reactions. Seeking support or the 'attention seeking' label are positive reasons given why individuals would harm themselves (Pembroke, 2006). Behaviour can have many functions and can be used to achieve objects or to gain the support or attention of another person. In this way the consequences to behaviour can increase the likelihood of reoccurrence. However, in contrast, consequences to behaviours can differ depending on the context in which the behaviour is performed and the differing reactions from individuals. A negative reaction is where individuals who self-harm are ostracised by their family, social network and professionals when they continue to self-harm.

Increased tension, difficulty inhibiting need to harm, premeditation, identification with past events and situations which previously triggered harm, involuntary action and rumination were all themes identified as reasons for self-harm (Huband *et al.* 2004). In this study (Huband *et al.* 2004) feelings associated with self-harm were categorised as; powerlessness, uncared for, shame, anger, ignored, reticence,

mistrust, and guilt. This study provides important information about the experiences of individuals who self-harm and their perceived helpfulness of interventions. However, the study is limited to the 'cutting' method of self-harm and it was a retrospective self report study with ten participants who were asked to recall their experiences of self-harm over varying time frames. There was also a wide range of numbers of episodes. Even in the infrequent group the mean number of times were 8.7. This suggests that the sample in this study were longer term users of self-harm which limits the results generalisability.

Himber (1994) explored the meaning and function of cutting. The findings of the study highlighted themes of dissociation, suicidality, blood, shame and secrecy, the significance of the first cut for the individual and self cutting in treatment. Self-harm was also identified as the individual's strategy to manage overwhelming feelings of distress. This study had a small sample size of 8, recruited from a locked psychiatric unit which specialised in dissociation, with the main reason for admission being cutting. These factors impact on the generalisability of these findings, as many individuals who self-harm never require psychiatric admission. However, a strength of the study is its use of an open ended, semi-structured interview which allowed greater depth and breadth of information. This study highlights self-harm as an emotional regulation and coping strategy. This can be summarised as 'self-harm is a way to gain control of the body externally when the individual feels out of control within' (Raynor & Warner, 2003, p.309).

Summary of Why Individuals Self-harm

The research can be divided into internal and external factors to provide explanations for why an individual self-harms. These factors alone do not account for all the variance for why individuals self-harm. It therefore is necessary to also understand self-harm as forming part of an individual's coping mechanism. In sum, one useful way to view self-harm is as a coping strategy, although there are multiple accounts in the literature to explain why individuals self-harm.

Assessment

It is estimated that 170,000 people attend A & E services after self-harm (Moore, 2005). However, studies have shown that nearly half of patients who attended hospital after self-harm did not receive a psychosocial assessment (Moore, 2005; Williams, Mitchell, Preston, Augarde, Barber, Catalan & Jones, 1998).

It has been NHS policy for 25 years that everybody who attends hospital after self-harm should receive a psychosocial assessment (NICE, 2004). Suggestions for incomplete or absent psychosocial assessment are staff factors, such as lack of training, negative attitudes and lack of understanding of individuals who self-harm (Clancy, 1997 (as cited in Cook, Clancy & Sanderson, 2004); Haw *et al.* 2003; Himber, 1994, NICE, 2004); and patient differences, such as being older than 65 years, multiple attendances at services, leaving prior to treatment completion, and the use of cutting as the method of harm (Barr *et al.* 2005; Crawford, 2001). It is estimated that half of individuals who attend A&E following self-harm will have consumed alcohol and that rates of substance misuse are estimated at six to ten

times higher than the general population (Anderson, 1999; Haw *et al.* 2001; Horrocks *et al.* 2003)

Comprehensive clinical assessment is considered pivotal to treatment and management of self-harm (Boyce, Oakley-Browne & Hatcher, 2003). The psychosocial assessment should include an assessment of need and risk and are used to form intervention and management plans, and highlight factors which are known to be predictors of poor outcome (NICE, 2004). A psychosocial assessment should explore their social situation, interpersonal relationships, life events (current and past), any substance misuse or psychiatric history and motivation for the act of self-harm. Another key issue to be considered is the person's ability to consent to treatment as well as a person's level of distress and whether they are willing to stay and be assessed and receive additional input. Each act of self-harm needs to be assessed separately as the individual may have had different reasons than before or may have used a different method (NICE, 2004). The meaning, function or intention of self-harm should be explored (NICE, 2004). Assessment can provide an opportunity for intervention with the individual who self-harms (Clarke, Baker, Watts, Williams, Feldman & Sherr, 2002).

There are two clinical questionnaires (to the author's knowledge) which have been devised to aid the assessment process. The Self Injury Questionnaire (SIQ) Mina, Gallop, Links, Pringle, Wekerle, & Grewal (2006) measures the method, frequency, type and function of self-harm and their associations with histories of childhood trauma. There are eight conceptual themes; regulation of feelings, regulation of realness, safety, communication with self, communication with others, fun, social

influence, and regulation of body sensations. This measure demonstrated validity and reliability with a clinical self-harm population however, additional studies will need to use this measure in order for these findings to be considered generalisable. The second is the Risk Assessment Questionnaire McAllister, Creedy, Moyle & Farrugia (2002b) which aims to support and guide nursing assessments of individuals who self-harm. This measure also requires further research in order to establish its reliability and validity.

In sum, given the importance of comprehensive assessment it is essential that further research considers how staff attitudes and lack of understanding impact on assessments of self-harmers.

NICE Guidelines (2004)

These clinical practice guidelines are derived from the best research evidence available at the time they are developed and aim to assist clinicians and patients in making decisions about treatment. They should improve and provide a consistent standard of care, reducing variations between service provision.

Engaging individuals who self-harm is essential, as well as promoting joint working and making decisions based on understanding of their situation (NICE, 2004). The aims are to reduce harm, improve survival and improve the experience of receiving treatment for both individuals who self-harm and their families (NICE, 2004).

The guidelines outline a further 10 aims of treatment:

- Rapid assessment.
- Engagement.

- Minimise pain and discomfort.
- Minimise waiting time for treatment.
- Harm reduction.
- Psychosocial assessment.
- Assessment and referral to additional services if appropriate.
- Prompt Psychological and Psychiatric treatment when necessary.
- Integrated approach and working between organisations.
- Ensure that confidentiality, child protection, consent and competence issues are addressed.

The key recommendations and priorities for implementation were:

- The patient should be respected, attempts made to understand the individual's current situation and circumstances and there should be choices offered to the individual so that they are fully involved in the service and treatment that they receive.
- Staff should be provided with training to help increase understanding into self-harm and the care they provide as well as the provision for staff to receive clinical supervision.
- Activated charcoal at the ready.
- Triage of individuals so that appropriate services can be accessed.
- Treatment of the individual's physical health regardless of whether they are willing to have a psychosocial assessment.
- Assessment of needs.
- Assessment of risk.

- Psychological, psychosocial and pharmacological interventions. Whether any of these interventions is required should be decided after a comprehensive assessment. These interventions should be aimed at treating the underlying difficulties rather than just treating the self-harming behaviour.

The NICE (2004) guidelines concluded that there was insufficient evidence for any specific recommendations regarding interventions, as many showed little positive effect for individuals who self-harm. Interventions reviewed in the NICE guidelines were problem solving therapy, dialectical behaviour therapy, manual assisted cognitive therapy and the use of crisis cards. Any referral for further intervention should focus on the individual as a whole rather than solely on the self-harm and attempts to treat that issue.

Management / Treatment

How to manage individuals who self-harm has been an area of debate for a number of years (Bowers, Gournay & Duffy, 2000; Mitchell *et al.* 2006; Poustie *et al.* 2004). Research on the management of self-harm stresses the importance of engaging the individual (Huband *et al.* 2004). Successful engagement can be achieved if the expectations around confidentiality are clear; the assessment is completed in privacy; the amount of note taking is monitored; resources are used to aid discussion and focus on the self-harm; and consideration is given to the individual's current life circumstances and levels of environmental stress (Clancy, 1997 (as cited in Cook *et al.* 2004); Derouin *et al.* 2004).

Goals of treatment should be mutually agreed with the individual to provide structure, clarity and to reduce inconsistencies and misunderstandings (Slaven *et al.* 2002). Historically, a common goal of treatment of staff working with individuals who self-harm has been to help the person stop self-harming (Bird & Faulkner, 2000) (as cited in NICE, 2004). Although, this may be a long term goal for some individuals, for others it may not be. The important focus of therapy should be in reducing harm and making the self-harm as safe as possible minimising the risks to the individual. In addition, providing support and education to encourage the development of other more adaptive ways of coping with their difficulties could also be explored. If goals of treatment are not mutually agreed it is very likely that the intervention will be unsuccessful as the changes to the individuals' life need to come from the individual themselves in order for change to be effective and to be sustained over the longer term. Interventions are reported as helpful if staff were 'caring, acting competently and promoting autonomy' (Huband *et al.* 2004). One study stated that individuals who self-harm hope to be seen and valued as a human being when they access services and that staff foster hopefulness in the outcome of treatment options they are providing (Lindgren *et al.* 2004).

Specific interventions which have been suggested for individuals who self-harm include: Manualised Assisted Cognitive Therapy (MACT) (Boyce *et al.* 2001; Evans, Tyrer, Catalan, Schmidt, Davidson, Dent, Tata, Thornton, Barber & Thompson, 1999); Solution-Focused Brief Therapy (Lamprecht, Laydon, McQuillan, Wiseman, Williams, Gash & Reilly, 2007); Group Therapy (Wood, Trainor, Rothwell, Moore & Harrington, 2001) (Wood, Trainer & Rothwell, 2007); Psychodynamic Interpersonal Therapy (Guthrie, Kapur, Mackway-Jones, Chew-Graham, Moorey, Mendel, Marino-

Francis, Sanderson, Turpin, Boddy & Tomenson, 2001); and Dialetical Behavioural Therapy (DBT) Linehan *et al.* (1993) (as cited in McAllister, 2003). An intervention suggested by a service user (Pembroke, 2006) was to provide harm reduction. This recommendation has also been described in the literature as harm minimisation i.e. reducing the severity of the harm by teaching individuals how to reduce the risk of harm and providing education about self-harm (O'Donovan, 2007).

Lamprecht *et al.* (2007) used a single session of solution-focused brief therapy incorporated into the existing psychosocial assessment. The most helpful aspect was the shift from problem focused to focusing on strengths and solutions with the patient as the expert in their lives. Further research is needed to establish its validity and generalisability. A similar approach is the CARE framework (Shepperd & McAllister, 2003). This is a tool for responding therapeutically to individuals who self-harm. The framework is divided into four parts: containment (provision of structured support), awareness (goal of increasing understanding by both nurse and patient), resilience (developing positive self-talk) and engagement (considering the use of questioning and allowing the patient to discuss and share at their pace). It is suggested using this framework helps nurses to feel more contained and satisfied in their work and patients are more aware of their own capabilities and strengths (Shepperd *et al.* 2003).

Wood *et al.* (2001) compared group therapy (problem solving, cognitive behavioural interventions, dialetical behaviour therapy and psychodynamic group psychotherapy approaches) with routine care (family intervention or counselling) in adolescents who had harmed themselves. Group therapy reduced the likelihood of repetition of self-

harm in comparison with the routine care approach. However, the study was not able to evidence any change in depression scores. This reduces the efficacy of this study as over the longer term (post seven month follow up) mental health is a risk factor for repetition of self-harm. Coupled with the small sample size, this suggests that this intervention alone would not be sufficient as a comprehensive intervention for self-harm.

Another study by the same research group, Wood *et al.* (2007) considered group treatment (six week structured group then a longer term weekly group) plus routine care versus routine care (family sessions, counselling and medication) in adolescents. Risk of repetition of self-harm was lower in the group treatment plus routine care than routine care alone. However, generalisability of the results are difficult as the length of time in group treatment is not defined nor does there appear to be a limit to the sessions. Also the study does not provide information on how it measured reduced repetition of self-harm. The group treatment plus routine care did not statistically lower depressive and suicidal thinking.

Brief psychodynamic interpersonal therapy has been suggested as effective in reducing feelings of depression and repetition of self-poisoning (Guthrie *et al.* 2001). However, there are a number of methodological limitations to this study as no attempts were made to control other factors which could have contributed to the observed change. For example the increase in nurse input which coincided with the intervention is also likely to have had a positive impact on these outcomes. Additionally, selection was unrepresentative, as half the participants were excluded as the inclusion criteria prevented suicidal individuals from inclusion in the study.

This suggests that participants excluded from the study were individuals who were more depressed.

Manualised Assisted Cognitive Therapy (MACT) is a brief cognitive, problem focused therapy, developed from Dialectical Behaviour Therapy (DBT) which is delivered immediately after an act of self-harm. MACT is manualised in six self-help booklets. Significant reductions in depressive symptoms were recorded (Boyce *et al.* 2001; Evans *et al.* 1999). The POPMACT study (Davidson, Scott, Schmidt, Tata & Thornton, 2004) explored therapist competence in delivering the MACT with individuals who self-harm. The results suggested that the level of therapist competence (as assessed by the level of skill in applying the techniques, their interpersonal effectiveness and their adherence to the therapeutic model) was significantly associated with observed reductions in anxiety, depression and social functioning. However, the study did not demonstrate any changes to the rates of self-harm (Davidson *et al.* 2004).

Finally, Huband *et al.* (2004) sourced opinions of the helpfulness of strategies for managing self-harm. The top five strategies for patients were; long term relationship with one key worker; being encouraged to talk and express feeling from their past; access to a 24 hour emergency contact telephone number; receiving counselling; and taking prescribed medication. However, whilst staff also rated receiving counselling and discussing past experiences in their top five, in contrast, they rated discussions between all staff as helpful, encouraging the patient to care for their own wounds and finally teaching individual relaxation techniques. This latter strategy of relaxation was the least helpful strategy identified by the individual who self-harms.

The reasons given for the unhelpfulness of relaxation was that the relaxation weakened their perceived self-control in resisting the urges to self-harm (Huband *et al.* 2004). It would be helpful for staff to discuss treatment options with patients and a collaborative decision can then be made.

Overall, there is a lack of evidence of effectiveness in this area (NICE, 2004). The evidence base for all treatments is very small and extremely limited as most studies have small sample sizes which makes generalisation very difficult especially given that individuals who self-harm are heterogeneous (NICE, 2004). Additional issues are that a number of the approaches which have been identified as effective in reducing repetition of self-harm require specialist training (Huband *et al.* 2004; Linehan, 1993; Wood *et al.* 2001), and there is uncertainty whether the same approaches should be utilised for individuals who present for the first time versus frequent repeat self-harmers (Lamprecht *et al.* (2007). Additionally, the interventions which have been evidenced to be effective are not globally effective in, for example, reducing repetition of self-harm and treating underlying difficulties, such as depression (NICE, 2004).

Attitudes to Self-harm

Individuals hold beliefs and attitudes about many aspects of life. Both positive and negative life events, such as abuse, loss of significant others, supportive interpersonal relationships and personal accomplishment are thought to impact and shape a person's beliefs about themselves, other people and the world (Hawton, Salkovskis, Kirk & Clark, 2004; Young & Beck, 1982). The beliefs and attitudes held by an individual impact on their thought processes and behaviour. It is therefore

important to consider what beliefs and attitudes are held by staff, as this is likely to affect their behaviour and the way they view individuals who self-harm.

Recent research has focused on the attitudes towards self-harm held by healthcare staff. However, how attitudes and perceptions impact on service provision remains unclear. Self-harm is an emotive issue which evokes a response and opinion in most people (Allen & Beasley, 2001) (as cited in Raynor *et al.* 2005). Murray (2003) acknowledged that historically self-harm has been misunderstood, with suggestions that staff have held views that if they provide a supportive, empathic environment to an individual who self-harms they are reinforcing the self-harming behaviour (Jeffrey *et al.* 2002).

Other research has explored staff attitudes towards individuals with learning disabilities who self-harm (Bell & Espie, 2002; Halliday & Mackrell, 1998; James et al. 2005; Jenkins, Rose & Lovell, 1997; Lovell, 2008; Vaughan, 2003; Whittington & Burns, 2005). There are mixed perspectives highlighted in the literature with the terms challenging behaviour and self-harm being used interchangeably. Studies have included either or both of the terms self-harm or challenging behaviour. The issue of intent in self-harm is also further complicated when considering the function of self-harm for someone with a learning disability as they may or may not be able to communicate this information. The lack of knowledge around intent has been proposed as the reason why the literature discusses behaviours initiated by individuals who have a learning disability as challenging behaviour rather than as self-harm (James *et al.* 2005). Due to these differences between the literature on self-harm in relation to individuals with learning disabilities and individuals without a

learning disability it has not been the focus of this thesis. For further information on this area please refer to Lovell's, (2008) recent review of individuals with a learning disability who self-harm.

Jeffrey *et al.* (2002) explored perceptions held by healthcare staff about individuals who were self-harming. Healthcare staff included were: psychiatrists, psychologists, general practitioners, nurses, social workers and mental health support workers. A questionnaire design containing 20 statements was used to examine perceptions. The results are limited due to: the lack of information about how accurate perceptions from the literature were identified or how the accuracy of these perceptions were verified; the absence of a pilot study; and there were no attempts to establish the validity and reliability of the questionnaire. The results suggested that general practitioners, psychiatrists and nurses have a poorer understanding of self-harm than workers with psychological and social care/community training. The results also support the benefit of training specifically on self-harm to increase staff understanding. Statistical significance was not obtained due to the small sample size and thus limits the applicability of the study to wider populations.

A number of myths dominate any discussion about self-harm. Poustie *et al.* (2004) proposed that the portrayal of an individual who self-harms is as a "chaotic substance misuser". Jeffrey *et al.* (2002) suggests that negative perceptions include, 'Self-harm is a way to manipulate another person's behaviour', 'It's attention seeking', 'Self-harm is not serious as its self-inflicted' and 'Individuals who self-harm are immature' (National Self Harm Network (NSHN), 2006). However, the reality of self-harming is that although there are common themes why individuals self-harm,

self-harm is affected by the individual, their environment and how they are feeling at the time of the act (Jeffrey *et al.* 2002; Kapur, 2005). An explanation for negative attitudes among staff is that staff may assign personal responsibility to themselves if the individual self-harms again (Smith, 2002). Staff may perceive their previous interventions as unsuccessful. This could impact on their treatment of that individual and may affect their decision about whether to refer to a specialist service.

Nurses' Attitudes to Self-harm

Nurses' attitudes to self-harm have been a specific focus of research on self-harm. They are of particular interest due to their high level of contact with individuals who self-harm and their reported negative perceptions towards individuals who self-harm. Two studies (Anderson, 1997; McCann, Clark, McConnachie, & Harvey, 2007) have reported positive attitudes from nurses. However, both these studies were limited by their use of the Suicide Opinion Questionnaire (SOQ) measure as they defined self-harm as having intent to die. Additionally, McCann *et al.* (2007) used hypothetical vignettes which do not necessarily equate to how an individual would respond in an actual situation to an individual who had self-harmed. A further concern raised was at two month follow up, where only 5 of the original 43 staff members were still working in the department. This high turnover of staff could be burnout. It is therefore imperative that research focuses on the impact of working with individuals who self-harm has on nurses.

There are numerous suggestions why self-harm is viewed negatively by nurses. These include the self inflicted nature of the injury, the aversiveness and seriousness of some of the injuries and the repetitiveness of the self-harming behaviour (Mackay

& Barrowclough, 2005; Raynor *et al.* 2004)). Additional difficulties faced by nurses attempting to gain further information and knowledge about self-harm are the inconsistencies in the literature surrounding the definition of self-harm and the intent of individuals who self-harm.

Research has explored different types of nurses' perceptions of self-harm. These include general nurses (Anderson, Standen & Noon, 2003; Huband *et al.* 2000); nurses working in inpatient environments (Bowers *et al.* 2000; Hopkins, 2002; O'Donovan & Gijbels, 2005; Wilstrand, Lindgren, Gilje & Olofsson, 2007); and A&E nurses (Mackay *et al.* 2005; Slaven *et al.* 2002). Additionally, two scales have been developed to explore nurses' perceptions of self-harm (McAllister *et al.* 2002 (paper a); Patterson, Whittington & Bogg, 2007). To the author's knowledge no research has explored community mental health nurses' attitudes to individuals who self-harm.

General Nurses

In a study (Huband *et al.* 2000) of attitudes of clinical staff (n=213), hospital staff were found to perceive individuals who self-harm as difficult, feeling less in control, less empathetic and tolerant during the course of their work than staff working in the community. Overall 75% of staff found working with individuals who self-harm difficult to manage and 65% struggled to develop a relationship (Huband *et al.* 2000). It is not possible to differentiate the general nurses' attitudes from the rest of the staff results.

Inpatient Nurses

One study (O'Donovan *et al.* 2005) used content analysis which identified themes of inpatient wards as stressful for individuals who have self-harmed and that self-harm was viewed as distinct from suicide. A patient centered approach to care and prioritising the value of the therapeutic relationship were also highlighted. This study provided good insight into the views of psychiatric inpatient nurses, although the sample size was small (n=8).

Another qualitative study using narrative interviews identified themes of: being burdened with feelings, fearing for the patients' life threatening actions, feeling overwhelmed by frustration, feeling abandoned by co-workers and management and balancing professional boundaries. These themes all highlight significant emotions and reactions by nurses (Wilstrand *et al.* 2007). An additional study (Hopkins, 2002), which used an ethnographic approach, identified further emotions of frustration and helplessness by nurses. None of these studies have detailed how working with individuals who self-harm impacts on the nurse. Negative emotional reactions have been identified, but no further exploration of how nurses are affected and whether there is an impact on the quality of service provision that they provide.

A&E Nurses

MacKay *et al.* (2005) explored what factors may influence staff judgments of patients presenting following an act of self-harm. Male medical staff expressed less personal optimism, greater irritation and less helping behaviour towards individuals who self-harm. Medical staff also did not perceive that they needed additional training, despite their negative attitudes. Greater attributions of controllability by staff of the patients'

actions decreased staff sympathy towards the patient. However, as in McCann *et al.* (2007) this study was limited by the use of hypothetical scenarios, and the conclusions are not really conclusive given the difficulty in ascertaining whether an individual would react and behave in the same way in actual situations. This study did recommend the need for further research on how attitudes impact on service provision.

Slaven *et al.* (2002) used semi-structured interviews and content analysis to explore A&E nurses' attitudes about self-harm. Nurses identified a lack of confidence, avoidance of working with self-harm, a lack of structured services, lack of priority for repeat attenders and lack of understanding and disagreement with the act of self-harm. These negative attitudes reflect the impact or barriers which individuals who self-harm are presented with when they access services. This study needs to be replicated to clarify whether these findings are generalisable across a wider population, especially as the sample size of nurses in the study was small.

Only two studies (Sidley & Renton, 1996; Anderson *et al.* 2003) have included two types of nurses. Sidley *et al.* (1996) included general and A&E nurses, however, no analysis was conducted to explore whether there were any differences in the two groups. Furthermore, the focus of the study was on drug overdoses rather than multiple forms of self-harm. Anderson *et al.* (2003) utilised a grounded theory approach to explore both doctors' and nurses' (A&E and Mental Health) perceptions of self-harm. The findings raised experiences of frustration in practice, lack of identified specific strategies to use with young people who self-harm, value of life and reflections on own experience. It was suggested that these factors highlight

barriers to developing a relationship and providing a service to individuals who self-harm. In contrast, establishing effective communication with the individual was seen as essential. The limits of the service were also acknowledged as a problem as time available to explore the issues with an individual is scarce (Anderson *et al.* 2003). However, the term suicidal behaviour was intermittently used within the research limiting their generalisability to individuals who self-harm.

To summarise, the research suggests that most types of nurses hold negative perceptions towards self-harm. However, to the author's knowledge community nurses' perceptions of self-harm, comparisons between different types of nurses' attitudes and length of time working's impact on attitudes have yet to be explored. Although these studies contribute to the research base on attitudes towards self-harm, little is known about why individuals have these attitudes nor how holding these attitudes and working with individuals who self-harm impacts on nurses and, finally what impact holding these attitudes have on day-to-day practice.

Scales to Measure Nursing Attitudes to Self-harm

A measure specifically designed for measuring attitudes to self-harm in nurses is the Self-Harm Antipathy Scale (SHAS) (Patterson *et al.* 2007). It was developed to measure the notion of antipathy, which is the idea that nurses hold negative views of self-harm and treat individuals who self-harm as an homogenous group which triggers negative emotions of hostility and rejection. It has six factors of: competence appraisal, care futility, client intent manipulation, acceptance and understanding, rights and responsibilities and needs function. This scale had high internal consistency as demonstrated by high Cronbach alpha (0.89) scores on each

of the factors. The total variance explained by the factors was not provided in this study, but the study did state that each factor had a cumulative variance above 5% and had eigenvalues above 1.0.

Another measure specifically designed to explore A&E nurses' attitudes to self-harm is the Attitudes Towards Deliberate Self-Harm Questionnaire (ADSHQ) (McAllister *et al.* 2002). The 33 item questionnaire explored four factors: perceived confidence in assessment and referral of clients, dealing effectively with clients, empathic approach, and ability to manage effectively with legal and hospital regulations which guide practice. However, only three of the four factors could be interpreted as directly related to attitudes towards self-harm and the scale was limited in its development as the loadings of the statements onto the four factors only accounted for 36% of the total variance. The scale also had a low Cronbach alpha score (0.42) suggesting poor internal consistency. Additionally, the questionnaire evaluation which the scale was developed from only received a 35% response rate which makes generalisability problematic.

These two scales both attempt to explore attitudes to self-harm held by nurses. The SHAS scale appears to be more valid and reliable than the ADSHQ. However, further research is needed before the scales can be used in a wider population.

The Impact of Attitudes on Service Provision

Research suggests that individuals who self-harm have experienced a wide variety of responses from services. Attitudes held by staff have been suggested to impact on the provision of service to individuals who self-harm (Barr *et al.* 2004). Individuals

who self-harm are not viewed as a 'rewarding' group to work with and represent an inappropriate use of staff time taking resources from patients whose injuries are not self-inflicted (McElroy & Sheppard, 1999; Slaven *et al.* 2002).

Service provision has been suggested to be impacted by whether the individual has a mental health diagnosis, if the health professionals believe that the intervention has little likelihood of success and lack of understanding of self-harm (Barr *et al.* 2004, Himber, 1994). It is proposed that the act of self-harm should not precipitate access to additional specialist services but the presence or absence of underlying issues that need addressing. In a study (McAlaney, Fyfe & Dale, 2004) which explored referral rates, only 17% of individuals in A & E were referred to the specialist self-harm service. Explanations for this low rate of referral could be time constraints in making referrals, lack of understanding about what help benefits an individual who has self-harmed, lack of knowledge about services or a reflection of negative attitudes to individuals who self-harm (Moore, 2005). McAlaney *et al.* (2004) reported that 55% of staff stated that self-harm was a form of attention seeking behaviour, with 50% stating that they disliked working with individuals who self-harm. These results suggest that negative attitudes do impact on service provision, in particular on the relationship between the nurse and the individual who self-harms (Raynor *et al.* 2004). Further research is needed to clarify this position.

Poor service provision has also been linked to an increase in likelihood of repeat self-harm (Pembroke, 2006). The estimated rates of repetition are one in six people who attend A&E (Owens *et al.* 2002). However, it has been reported that individuals who self-harm are left feeling rejected, distressed, hopeless and shameful following

a presentation at services as the individuals' negative feelings have been exacerbated by the treatment they have received, if negative, which reduces the likelihood of them seeking future support and treatment (Sadler, 2002; Slaven *et al.* 2002). These experiences of poor treatment can also be defined as retraumatisation for the individuals (Lindley Starr, 2004). These poor experiences of treatment could explain why it is estimated that around 50% of individuals who self-harm do not wait for their treatment to be completed or are not offered a psychosocial assessment (Horrocks *et al.* 2003; McAllister *et al.* 2002).

One of the main difficulties facing nurses is that there are contrasting views on how individuals who self-harm should be managed. Holley (2007) described how polarised views of nurses leads to poor experience of care for both staff and patients, as staff are concerned about whether their actions may breach their professional conduct guidelines. It is proposed that there should be a refocus, attempting to understand what the self-harm is about for the individual, considering their experience of the social world, and as a perceived rational response to life events (Anderson, Woodward & Armstrong, 2004).

A&E services have been defined as 'an important gateway to treatment for deliberate self-harm patients' (McAllister *et al.* 2002b, p.185). A&E services are tailored and developed towards providing an immediate provision of services with nurses having numerous roles, such as providing triage, referral, prompt response to and containment of the problem, first aid, psychosocial support and coordinating discharge or referral to specialist services (McAllister *et al.* 2002). However, despite

this wide role remit, McAllister *et al.* (2002) also identified that, at that time, nurses were receiving no formal training in self-harm.

Roy & House (2003) as cited in NICE (2004) conducted a literature review of service user experiences of self-harm. Nine studies were included in the study from a total of 33. Experiences ranged from 6% being satisfied with the services they received (Arnold, 1995) (as cited in NICE, 2004) to another study finding 44% finding the experience positive (Dorer, 1999) (as cited in NICE, 2004). The main causes for negative experiences were staff attitudes and a poor understanding of self-harm. Negative attitudes were reported to increase distress, lead to more acts of self-harm and/or individuals not accessing services and simply treating their own wounds (NICE, 2004). Being listened to and given time, providing a safe environment, not being treated differently simply because injuries are self-inflicted, being involved in treatment decisions, having carer support and increasing staff knowledge of self-harm are all highlighted by individuals who self-harm as ways to make the experience more positive when accessing services (NICE, 2004). The review also highlighted that repetitive self-harmers are viewed more negatively as well as individuals who have no intention of wanting to die. However, the major criticism and limitation of the studies which were contained in the review was that they all used interviews or methods which directed or structured the responses. The recommendation from the review was that qualitative methods, such as Q sort, should be used to explore nursing staff attitudes to self-harm and their psychological and social origins (NICE, 2004).

To summarise, negative attitudes have been suggested to impact on service provision, but further research is needed to clarify how the negative attitudes impact on the delivery of services.

Nursing, Self-harm and Burnout

The literature on self-harm suggests that working with self-harm is difficult to manage. In one study, 75% of staff working with individuals who self-harm found the work difficult to manage (Huband *et al.* 2000). This suggests that it is likely to have an impact on healthcare professionals who work with this patient group. It is also suggested that, early in careers, there may be individuals who have positive attitudes to self-harm but over time become more negative, when faced with repeated episodes and, in their view, little improvement in the patient (Patterson *et al.* 2007).

The lack of understanding from some health professionals, and in some cases fear and anxiety of working with individuals who self-harm are given as explanations for the attitudes, language and treatment of service users who self-harm (Huband *et al.* 2004; NICE, 2004). These feelings and attitudes suggest that self-harm is likely to be viewed as a treatment resistant behaviour (Huband *et al.* 2004).

Sidley *et al.* (1996) described how nurses have negative personal reactions after working with individuals who self-harm. However, to the author's knowledge, no further studies have specifically explored how self-harm impacts on nurses. McAllister *et al's.* (2002) factor analysis suggested that the more skilled a nurse perceives themself, the more the nurse will feel that their work with individuals who self-harm is worthwhile, and in turn be less likely to hold negative attitudes

(McAllister *et al.* 2002). Linking this idea to the concept of burnout, it could be proposed that if nurses received training this could improve self-rated skills, which may lead to less feelings of burnout in staff and ultimately impact on care giving.

Burnout Syndrome

Definitions and Prevalence

Reports on the prevalence of stress related problems in the workplace vary (Fraise, 1996). In Fraise's (1996) study, 70.3% of his sample of healthcare professionals (N=130) reported that they had felt affected by stress in the past 12 months. The primary source of stress was work in 92.2% of the group. In particular, healthcare professionals appear to have special reasons for being stressed, due to dealing with individuals in distress, working face to face and having a sense of responsibility where errors could result in further suffering or possibly death. These factors have been identified as key factors in 'burnout'.

Burnout is often characterised and assessed using three categories: Emotional Exhaustion, Depersonalisation and reduced Personal Accomplishment (Maslach *et al.* 1996). People who experience all three of these categories have the highest levels of burnout. Emotional exhaustion refers to the feelings of psychological fatigue where an individual feels that they do not have the capacity to give any more of themselves. Depersonalisation refers to the development of negative attitudes and feelings towards an individual so that you reduce the amount of empathy you can provide. Reduced personal accomplishment refers to holding the negative view that you are not as able and successful in your work with patients as you would like to be or used to be (Jansen, Kerkstra, Abu-Saad & Van Der Zee, 1996). Symptoms can

include; tiredness, headaches, eating problems, reduced abilities to empathise, insomnia, and interpersonal difficulties (Whittington, 2002). Ultimately, over the longer term burnout leads to an impact on the quality of service provision provided (Estryn-Behar, Van der Heijden, Oginska, Camerino, Le Nezet, Conway, Fry & Hasselhorn, 2007)

Burnout is most commonly assessed using the Maslach Burnout Inventory (MBI), as its reliability and validity are established within the literature. Many studies have used this measure when exploring the concept of burnout (Demir, Ulusoy & Ulusoy, 2003; Embraico, Papazian, Kentish-Barnes, Pochard & Azoulay, 2007; Hochwalder, 2007; Imai, Nakao, Tsuchiya, Kuroda & Katoh 2004; Kanste, Miettunen & Kyngas, 2006; Jansen *et al.* 1996; Perseius, Kaver, Ekdahl, Asberg & Samuelsson, 2007; Whittington, 2002; Wu, Zhu, Wang, Wang, & Lan, 2007).

Development of Burnout

Burnout is often considered to develop when an individual is expending too much effort at work over a long period of time whilst having too little time to recover (Embriaco *et al.* 2007). Other individual factors which influence the development of burnout are decrease or loss of self confidence, loss of interest in one's profession, feelings of fatigue and hardiness personality traits. Hardy personality was defined as relating to a person's commitment and involvement, a sense of personal influence and control, and an openness to change and problem solving in the workplace. A lack of these factors leads to burnout (Garrosa, Jimenez & Gonzalez, 2006; Simoni & Paterson, 1997). Job related or environmental factors which influence the development of burnout include, providing additional support or doing 'overtime' in

healthcare settings, frustrations with job expectations and realities, lack of supervision, exposure to death and dying, interpersonal conflict and noise pollution (Beckstead, 2002; Demir *et al.* 2003; Garrosa *et al.* 2006). Change is also widely recognised to increase stress levels (Corr, 1999). Examples of change within an organisation such as the NHS can include changes between wards, changes within staff teams, shift work and larger organisational change.

Factors that have been identified as decreasing the likelihood of development of burnout is job selection, level of engagement in a job and occupational commitment (Jepson & Forrest. 2006; Vinje & Mittelmark. 2007). These factors all relate to a theme of control. If a job has been selected by an individual it is suggested that this can help them to cope better with work place demands. Level of engagement in a job and occupational commitment are similar propositions as they both suggest that higher levels of commitment or engagement to a profession can increase an individuals' ability to cope with stress because they are able to acknowledge their value to their profession and are more enthusiastic about their work.

Burnout has also been highlighted as a risk factor for negative work related attitudes (Barnett, Brennan & Gareis, 1999; Demir *et al.* 2003). The negative attitudes suggested can include feeling that they have nothing left to give in their working days, feeling deskilled, and judging that patients deserve their difficulties. These attitudes have a huge effect on the individual and their provision of service to the patients. These attitudes can lead to a deterioration of service quality but also high turnover, absenteeism and low morale in staff (Barnett *et al.* 1999). Changing nurses' views of their work environments is also important as, if they feel more

empowered in their workplace, this will reduce the probability of burnout, which in turn reduces the probability of poor care being received by patients (Hockwalder, 2007). It is imperative therefore that research into negative staff attitudes include burnout measures when they are considering staff attitudes.

Impact on Services

Burnout is a pervasive problem with huge personal and economic costs, not just to the individual and to the provision of care and support to patients, but to the organisation as a whole (Browning & Greenberg, 2003). The organisation struggles to manage the absenteeism, decreased quality of care, and turnover of staff as well as low morale. Burnout has also been associated with physical exhaustion, reduced productivity, illness, increased misuse of illicit substances, marital and family conflict, reduced job satisfaction and psychological problems (Barnett *et al.* 1999; Browning *et al.* 2003; Jansen *et al.* 1996). In one study, burnout was found to be the second highest risk factor for intention to leave their job, with high burnout scores tripling the frequency of intention to leave in some countries included in the study (Estryn-Behar *et al.* 2007).

A wide range of professionals experience burnout. Those most at risk are those who have an intense involvement with people and/or provide assistance to people who are in need or who are distressed (Imai *et al.* 2004). Any professions where individuals work with people in a supportive role are at an increased risk of developing burnout (Kanste *et al.* 2006). When an individual is becoming burnt out, what they may become aware of is a reduced ability to care or offer psychological support to others. This is suggested as a way to protect the self. They will begin to

provide only minimum support and are likely to develop very superficial relationships with their patients in an attempt to avoid further stress (Beckstead, 2002).

Nurses and Burnout

Healthcare professionals and in particular, nurses have been highlighted as a group which is at high risk for developing burnout due to the nature of the work (Embriaco *et al.* 2007; Kanste *et al.* 2007; Maslach *et al.* 1996). In a systematic review of 70 European studies on stress, 21-51% of mental health nurses had high levels of burnout in the exhaustion subscale (Edwards, Burnard, & Owens, 2003 as cited in Perseius, Kaver, Ekdahl, Asberg, & Samuelsson, 2007). Nurses are repeatedly confronted with patient difficulties both physically and emotionally (Kanste *et al.* 2007). Stressful aspects of nursing include: potential for serious injury, staffing shortages, high number of working hours, lack of job control, inadequate rest because of rotating schedules, lack of knowledge, struggles with aches and pains from lifting and pulling patients, providing care to individuals who can be rude and aggressive, role overload, job insecurity, difficulties with other staff or management and organisation restructuring or ongoing changes in the health service (Embriaco *et al.* 2007; Imai *et al.* 2004; Milliken, Clements & Tillman, 2007; Wu *et al.* 2007).

It has been suggested that burnout is affected by the type of education, or more specifically, the differences between the courses which provide training to be a nurse, length of service as a nurse, age, job status, job stressors such as workload role ambiguity, use of short-term coping strategies and hardy personality (Demir *et al.* 2003; Garrosa, *et al.* 2006; Potter, 2006; Simoni *et al.* 1997).

Nurses who have good support, job clarity, empowerment, are younger in age, have more autonomy and lower levels of complexity in their work are suggested to have lower levels of burnout. In addition, if managers have a leadership style which considers the nurses' well being and job satisfaction, these factors also contributed to lower levels of burnout (Hochwalder, 2007; Kanste *et al.* 2007; Wu *et al.* 2007). However, those with high levels of burnout are individually at risk of health related problems, but also at an organisation level the service has problems with productivity, absenteeism, high turnover of staff and poor performance whilst in work. Health problems which are at an increased risk of developing when under pressure and stress include; heart disease, migraines, hypertension, muscular pain, duodenal ulcers, irritable bowel syndrome, and mental health problems such as anxiety and depression and feelings of inadequacy (Milliken *et al.* 2007). For nurses, these factors ultimately mean that individual patients will be affected either by receiving a poorer service from exhausted staff or waiting longer to be seen due to staff absenteeism. In the longer term the heathcare service could be faced with retention and recruitment problems. This is particularly problematic given the current workforce age where it is estimated that approximately a third of the current nursing workforce is over 50 years, as it is clear that the service may be unable to meet the demands left by these individuals when they retire (Milliken *et al.* 2007).

Burnout, Nurses and Self-harm

As already discussed, healthcare professionals, in particular nurses have been shown to experience high levels of burnout (Kanste *et al.* 2007; Maslach *et al.* 1996). One of the difficulties of their work is managing patients who have high levels of distress, such as individuals who are feeling suicidal or who have self-harmed

(Perseius *et al.* 2007). Working with individuals who self-harm is difficult to manage as they are individuals who are distressed and may have experienced difficult life events. However, there is a lack of research which focuses on the impact of working with individuals who self-harm on nurses.

The research suggests that many nurses hold negative views towards individuals who self-harm and this lack of understanding could impact on their perceived ability to provide intervention and treatment (NICE, 2004). They either feel that it is not helpful because the individual will continue to self-harm or they may feel that they are not adequately trained or possess the correct skills to manage these kinds of difficulties. With either of these scenarios the end result for the nurse is feelings that they are not being effective in their work. This is the definition which is often provided for the third component (reduced personal accomplishment) of burnout. It could therefore be proposed that many nurses working with self-harm already meet one of the three criteria for burnout. The lack of research focusing on the impact on staff of working with individuals who self-harm needs to be addressed.

In terms of study design, the research completed historically has employed traditional quantitative research design methodology, although more recently more qualitative research methods have been used. Research recommendations from NICE (2004) suggest that qualitative research methods, such as Q sort could be used to better understand staff attitudes to self-harm.

Q Sort Methodology

Q Sort methodology (James & Warner, 2005; Stephenson, 1953) has been increasingly used over the last fifteen years in health research, such as in measure development (Caspi, 1992; Drew, Muderrisoglu, Fowler, Shedler & Koren, 1997; Westen, 1999), attitudes about health literacy (Logan, 2007) and exploring the use of ideological labels (Zechmeister, 2006). Q methodology has also been used in research focusing on improving care received by patients, whether by exploring patients' views of their treatment (Morecroft, Cantrill & Tully, 2005) or asking individuals' perspectives on their health and rehabilitation when they have been on long term sickness absence (Ockander & Timpka, 2005). Additionally, Q Sort has been used to investigate factors affecting the therapeutic process, for example engagement of clients (Lister & Gardner, 2006) and understanding and acceptance of chronic pain (Risdon, Eccleston, Crombez & McCracken, 2003).

Q sort methodology has been particularly used in nursing research. McKeown, Stowell-Smith & Foley (1999) investigated passivity and militancy in nurses' industrial relations. Thompson, McCaughan, Cullum, Sheldon, Mulhall & Thompson (2001) also used Q sort methodology with nurses focusing on the accessibility of research based knowledge for nurses in acute settings. This study was then followed up by a later study by the same research group (Thompson, McCaughan, Cullum, Sheldon, & Raynor, 2005) where Q sort methodology, was used to define the barriers that are faced by nurses in using evidence based practice in primary care settings. In contrast, Cross (2005), used Q methodology to consider nurses' attitudes towards health promotion.

In relation to the current research area, two studies exploring self-harm have also used Q Sort methodology. Rayner & Warner (2003) explored perceptions of self-harming behaviour in the general population and related this to clinical practice. The Q sort produced seven accounts or ways of understanding self-harm: visual communication/survival, depressed/abused, existential angst/helplessness, depressed and desperate, biological, interpersonal communication and attention seeking/emotional resolution. James & Warner (2005) also utilised Q Sort methodology in their study researching self-harm. They were interested in how women with learning disabilities who self-harmed are understood by professionals and how the women conceptualised their self-harm.

Q Sort "provides an approach in which the person, not the variable, is the focus of the analysis." (Caspi, 1992, p.513). It encourages diversity rather than reducing it (Lister & Gardner, 2006). Q Sort allows the researcher to describe shared perspectives (Zechmeister, 2006). As the end result is a 'sort' that reflects the individuals' views on a subject that the statement cards contain. It is less clear to the participants in a Q Sort what the particular focus of the study is. A general understanding is obtained but the specific constructs to be extracted are not so easily accessible to the participants.

Of interest in the analysis are not the statements *per se* but how they have been placed in relation to each other in the fixed distribution. Factor analysis is often utilised in Q sort studies to explore how perceptions or attitudes are clustered in groups (Logan, 2007). No pre-judgments are made to these groupings in the form of hypotheses as in other studies where factor analysis is employed. The participants

whose sorts highly correlate as identified by the Factor analysis are used to explore areas of similarity and differences between those grouped participants, and what may differentiate them from the other participants. The groupings of the participants are considered to represent those participants holding shared views on an area of focus (Zechmeister, 2006). Also the 'n' in a Q sort study is not the number of participants but instead the number of statements in the Q sort multiplied by the number of participants, for example 50 statements multiplied by 20 participants equals 'n' of 1000 (Logan, 2007).

There are three main sections to Q Sort: generation of the statements, sorting of the statements by the participants and the analysis of the sorts created by the participants. There are variations in how each of these three stages are completed. Table 1 provides a review of studies which have used Q Sort methodology. The differences in the three main sections are outlined. This study aimed to draw on previous researchers' experiences of completing Q Sort methodology.

Table 1: Variations in Q sort methodology between research papers.

Research papers	Section of Q Sort		
	Generation of statements used	Sorting of the statements	Analysis of the statements
Caspi, Block, Block, Klopp, Lynam, Moffitt, Stouthamer-Loeber, (1992)	- Not outlined however, how alterations were made to statements were detailed: Rewriting of wording of statements and establishing readability of statements.	- Completed in person. - Table chart specifying the number of statements per pile.	- Analysis of variance - t-tests - No statistical package mentioned.
Cross, (2005)	- Literature review.	- Completed via mail. - Q Sort response grid (specifying the number of statements per pile)	- Factor Analysis - Varimax Rotation - PQ Method used.
James & Warner, (2005)	- Statements taken from semi- structured interviews conducted with staff and patients	- Completed in person.	- Factor Analysis - Varimax Rotation - P.C.Q Package used.
Lister & Gardner, (2006)	- Literature review - Informal discussions with colleagues - Semi-structured interviews with individual and small groups of clinical	-Completed via mail. - Q Sort response grid (specifying the number of statements per pile)	- Principal Component Analysis - Varimax Rotation - PQ Method used.

	psychologists from a range of specialities.		
Logan(2007)	- Not detailed.	- Completed online.	- Principal Components Analysis - Varimax Rotation - P.C.Q Package used.
McKeown, Stowell-Smith & Foley, (1999)	- Literature Review. - Media Search. - Interviews. - Pilot completed.	- Not detailed.	- Centroid Factor Analysis - Varimax Rotation - P.C.Q Package used.
Morecroft, Cantrill & Tully, (2005)	- Semi-structured interviews with patients and GP.	- Completed via mail.	- Factor Analysis - PQ Method used.
Ockander & Timpka, (2004)	- Interviews.	- Completed via mail.	- Principal Components Analysis - Varimax Rotation - No statistical package mentioned.
Rayner & Warner, (2003)	- Statements taken from semi- structured interviews conducted with participants. They were recruited from work colleagues, friends and family.	-Completed in person or via mail. - Pilot completed first.	-Factor Analysis - P.C.Q Package used.

Risdon, Eccleston, Crombez & McCracken, (2003)	- Interviews with pain clinicians and researchers - Literature review - Database examined of semi-structured interviews with patients - Internet and media searches.	-Completed via mail.	- Factor Analysis – Centroid Method - Varimax Rotation - PQ Method used.
Thompson, McCaughan, Cullum, Sheldon & Raynor, (2005)	- Semi-structured interviews. - Observational material. - Pilot completed.	- Completed via mail.	- Principal Components Analysis - Varimax Rotation - Scatter Plots - PQ Method Used.
Thompson, McCaughan, Cullum, Sheldon, Mulhall & Thompson, (2001)	- Semi-structured interviews. - Observational material.	- Not specified how participants obtained and completed the Q Sort.	- Factor Analysis - Regression Modelling - PQ Method used.
Westen, Muderrisoglu, Fowler, Shedler & Koren, (1997)	- Clinical Experience - Academic Literature - Research Programs - Self report and coping measures	- Completed via mail - Q Sort response grid (specifying the number of statements per pile)	- Factor Analysis -Varimax and Promax Oblique Rotations - No statistical package mentioned.
Westen & Shedler, (1999)	- Clinical Experience - Academic Literature	- Completed via mail - Q Sort response grid (specifying the number	- Principal Components Analysis - Varimax Rotation

	- Research Programs - Self report and coping measures	of statements per pile)	- No statistical package mentioned.
Zechmeister, (2006)	- Not discussed.	- Completed in person.	- Principal Components Analysis - Varimax Rotation - Scree Tests - PQ Method used.

Table 1 showed less variation between the studies on how to collect completed sorts, obtaining them either by meeting the participants in person or by using the postal service to collect data. In some studies (Caspi *et al.* 1992; Cross, 2005; Lister *et al.* 2006; Westen *et al.* 1997; Westen et al. 1999) participants were provided with a record sheet to direct them on the number of statements permitted per category. In the current study the participants were met rather than recruiting via the postal system. This overcame previous studies' difficulties with low response rates or incomplete or incorrectly returned forms. This current study also used a record sheet to promote correct placement and number of statements in the fixed distribution.

Table 1 also evidences variations between types of analysis (Factor analysis, Principal Components Analysis, t-tests and Varimax rotations) and statistical packages utilised (P.C.Q and PQ method). A number of researchers (Cross, 2005; Morecroft *et al.* 2005; Lister *et al.* 2006; Thompson *et al.* 2001; Thompson *et al.* 2005; Risdon *et al.* 2003; Zechminster, 2006) have utilised and extensively documented the use of the PQ Method. The PQ Methods extensive and positive reports of usage was why the package was appropriate for this study. The software is a MS-DOS program adapted for the PC by Schmolck, P. It is available to download free from http://www.rz.unibw-muenchen.de/~p41bsmk/qmethod/.

Why do this study?

This study was completed in a health board where there are three types of nurses who are commonly working with people who self-harm, Accident and Emergency, Community Mental Health, and Psychiatric Liaison Team nurses. Other types of nurses such as district nurses, nursery nurses, general nurses in medical settings,

and primary care nurses working in GP surgeries and other primary care medical settings have not been included. Much of the self-harm research literature has focused on nurses in A&E. A&E nurses are usually the frontline staff receiving individuals who present to services following an act of self-harm. They provide the majority of the medical support, such as suturing wounds. They are also responsible for making referrals to the appropriate individuals for assessment and specialist intervention.

Psychiatric Liaison Nurses assess individuals within acute medical settings, such as A&E departments. This role was created to provide a seamless pathway from hospital to psychiatric services and to reduce readmission to hospital (Callaghan, Eales, Coates, & Bowers, 2003; Ryan, Clemmett & Snelson, 1997). They receive referrals and liaise with A & E staff and endeavour to see the individual whilst they are still in hospital receiving treatment. The team of nurses covers 24 hour periods. Psychiatric Liaision nurses can provide an accurate psychosocial assessment of the pertinent issues and are an essential component of the services provided to an individual who has self-harmed (Sinclair, Hunter, Nelson & Hunt, 2006).

Community nurses work in the community visiting individuals at home or in health centres. They provide ongoing support to individuals who have mental health problems. They work as part of a multi-disciplinary team which usually consists of a Psychiatrist, Clinical Psychologist, Occupational Therapist and Support workers. The length and frequency of time they provide support to an individual varies. As discussed, individuals who self-harm may or may not have a diagnosis of a mental illness. However, if they are being seen by a Community Nurse they are likely to

have a formal diagnosis of a mental health problem. It is important to acknowledge that although an individual may self-harm they may never present at A&E to receive treatment for their injuries.

In summary, self-harm is a widespread problem which often does not come to the attention of services. However, when individuals do present at services it is reported that they are perceived negatively and receive a poor provision of services which is failing to meet their needs (NICE, 2004). The negative attitudes and lack of understanding of self-harm by healthcare staff are likely to reflect the lack of agreement and consensus in the literature around the intent definition of self-harm. Although there have been a number of research studies exploring self-harm and nurse perceptions, very few have compared different types of nurses' perceptions or explored the impact on patients receiving treatment from nurses who hold negative views. Working with individuals who self-harm has been recognised as difficult, however, there has been very little research identified which specifically explores the impact that working with individuals who self-harm has on staff.

This study therefore aims to explore staff's attributions, beliefs and behaviour about self-harm and to identify the kinds of staff emotions which are associated with self-harm.

Research Questions:

1. What beliefs, emotions and attributions do staff experience when working with individuals who have self-harmed?

a. If staff hold negative beliefs about individuals who self-harm, are these to prevent them feeling overwhelmed or helpless as a way to cope with the work?

b. If a person holds negative attributions about individuals who self-harm will it make it difficult for them to develop a relationship with the person when providing treatment?

2. Is working with individuals who self-harm over a longer period associated with higher levels of stress and lower levels of well being?

3. How do nurses benefit from training?

Method

Alternative Methodologies

A number of methodologies were suitable for exploring the research questions in this study. Interviews (structured, semi-structured and unstructured), questionnaires, and Q Sort methodology were all considered.

Questionnaires produce large volumes of quantitative and qualitative data. Their use in research is extensive as they are considered to be a reliable form of gaining perceptions and attitudes to a particular area of interest. The use of open ended questions helps a questionnaire to have depth as well as breadth. The limitations to their use are their reliance on self-report and low response rates.

Interviews in various formats (unstructured to structured) are also widely used in research. Advantages to their use are that they can elicit more information; they allow the flow of information and facilitate a more in depth analysis of a particular area of interest. Disadvantages include: being time consuming and stressful for participants, small sample sizes and the interviewer needing skills in questioning and data analysis.

In comparison, Q Sort methodology enabled the researcher to gain a larger sample than in interviews with a high response rate by meeting with the participants to obtain the data. Both qualitative and quantitative analysis was used and the data had both breadth and depth.

NICE (2004) guidelines have recommended Q Sort methodology as a method for researching beliefs about self-harm. Q Sort methodology is designed to explore subjective understanding of a subject. A Q Sort is a set of items, usually printed on cards, which provide plain English statements (jargon free) regarding a particular area of interest, such as self-harm. Particularly important in statement design is the clarity, comprehensiveness and relevance of the statements to the area of interest. The value of the Q Sort depends entirely on the statements it contains.

Participants

All participants in this study were drawn from one health board in Scotland. There were a total of 39 participants who were all qualified nurses. They were drawn from three areas of nursing: Accident and Emergency (A&E), Psychiatric Liaison and Community Mental Health. Community nurses work within community mental health

teams whereas A&E nurses work in the A&E department within hospitals. Psychiatric Liaison nurses are also based in hospitals and assess individuals' mental health in A&E or shortly after their discharge in a follow up appointment, if appropriate.

An important debate in this study is the issues surrounding researching a sensitive area, such as self-harm with another professional group, which in this study were nurses. In consideration and awareness of these issues and to assess how the potential project would be received preliminary informal discussions occurred with the relevant nursing managers. These discussions were very positive and managers expressed support for this study. Only after this support was gained was this research developed and progressed.

Recruitment was staggered into five stages after ethical approval had been gained. Firstly, managers responsible for each of the nursing groups were identified and contacted via email. These emails introduced the researcher and provided outline details of the study. It also offered the managers the opportunity to meet with the researcher or, if they preferred, for information to be disseminated to them via email or telephone. The first difficulty with recruitment arose during this process of identifying the management structure within the health board. It was a time consuming task and difficult to obtain up-to-date information. The researcher was also aware that it was necessary to ensure that a manager was not excluded as this could have been detrimental to the success of the recruitment procedure if support was not secured in a particular geographical region or nursing speciality. This first difficulty was overcome by thorough liaising and negotiating with the appropriate managers, who all agreed to support the study and for their staff to complete the

study during work hours. Permission was also secured to display recruitment posters in prominent staff working areas for each of the three nursing groups.

The second stage of recruitment occurred following the meetings with managers. A standard email briefly introducing the researcher and the study was created with two attachments (the recruitment poster and the participant information sheet). This was distributed to the managers as they had agreed to forward these documents to their colleagues in their respective teams inviting them to take part in the study. A difficulty which arose at this stage was that A&E nurse's do not all have regular access to email due to their shift patterns and their working environment. To overcome this difficulty the charge nurses within each of the A&E departments were contacted and an agreement was reached that the recruitment poster would be prominently displayed in the nursing station and in the nurses' tea room. If nurses expressed an interest in the study they would then be furnished with the participant information sheet.

The third stage of recruitment consisted of the distribution of the recruitment posters. These posters were displayed in prominent locations within the hospitals and within the community teams. The posters invited interested parties to contact the researcher if they wished to take part.

The fourth stage of the recruitment process was the distribution of the participant information sheet, when requested by participants. It was ensured that there was a minimum of 24 hours between the participants receiving and having the opportunity

to read this information and when they were asked to give informed consent prior to taking part in the study.

The final stage of the recruitment process was scheduling in times and places to meet the participants to complete the study. This provided the researcher with the biggest challenge of the recruitment process. There were various difficulties posed by each of the three respective nursing groups.

Community nurses were difficult to arrange meetings with due to their wide geographical distribution. The researcher therefore had to travel extensively across the health board to meet with, in many cases, only one participant. This slowed the recruitment process as travel and the spread of appointments reduced the researcher's time to see participants. Although the time spent recruiting this group was high, it was necessary to ensure that the sample of nurses in the study were geographically representative of the health board.

In contrast, A&E nurses were difficult to recruit due to the unpredictable and high demand of A&E services. Additionally, they are also required to provide a continuous service and do not manage an appointment schedule as their community colleagues do. This meant that the researcher had to be involved in substantial negotiation with the charge nurses to facilitate and accommodate the requirements of the study. To overcome these difficulties it was agreed with the charge nurses that it was necessary for the researcher to meet with A&E nurses out with standard office working hours of 9am till 5pm. It was also agreed that the researcher would be

available in A&E within agreed time slots so that if service would allow for the release of a nurse to complete the study this could be arranged.

The only recruitment difficulty with psychiatric liaison nurses was their low numbers in the service in comparison, in particular, with community nurses. To overcome this difficulty the researcher was able to secure the opportunity to meet with the psychiatric liaison nurses at their regular area-wide team meeting. This meeting allowed details of the study to be discussed. This meeting was suggested by some of the participants as a reason why they volunteered for the study.

Stimuli and Measures

Q Sort methodology (Stephenson, 1953) (James & Warner, 2005) was used in this study. NICE (2004) guidelines have recommended Q Sort methodology as a method for researching beliefs about self-harm. As outlined earlier, there are various ways that researchers have used Q Sort methodology in their respective studies. Table One outlines the main differences between development of statements, how the Q Sort process is managed and how the data obtained is analysed. Despite the differences outlined in Table One the studies have all completed the following four stages: they have all selected statements; they have all selected participants; all participants have then sorted the statements; and finally the sorts have then been analysed and the results obtained interpreted. In this study all four stages were completed as in the previous studies detailed in Table One. Each stage was selected and completed due to its reliability and validity as demonstrated in the studies in Table One. The style of the selection of the statements was utilised because from the systematic analysis of the studies in Table One it was evidenced that the

reliability and validity of the statements are enhanced when generated from multiple sources.

There is wide variation between the methods used by the researchers to generate the statements. Literature search, interviews, clinicians' views, self report, observations and media searches have all been used. This study used interviews to obtain clinicians' views, and literature and media searches. Self report and observations were not used as the media searches furnished the researcher with service users' perspectives. Observation of individuals who self-harm was not appropriate, particularly if they were harming themselves.

The statements about the area of interest are the essential component of the Q Sort. Both the validity and reliability of this methodology are both affected by the statements. It is essential therefore that the statements are comprehensive, relevant and clear. In order to achieve this, statements were generated from multiple sources:

1. Media sources were searched using the search term 'self-harm' to obtain information on self-harm via an internet meta−search tool). A meta-search tool was used as this searches ten search engines, such as Yahoo, Ask Jeeves and Google. It is important to use multiple search engines as they each have allegiances with different companies to gain revenue. Service users had contributed to some of the material contained in the websites used which provide forums for service users and patients to gain support.
2. A previous qualitative Doctoral Thesis (McGlynn, 2006) which explored nurses' perceptions of self-harm was sourced.
3. A literature review of databases (Ovid and Science Direct) was completed.

4. Two consultation interviews were conducted with health professionals (a Clinical Psychologist and a Consultant Psychiatrist) who have clinical experience of working with individuals who self-harm. The aim of these interviews was to explore their thoughts and experiences of working with individuals who self-harm.
Please see appendix one for a diagrammatic representation of this information as a methodological protocol for this study.

From these multiple sources, a list of statements about self-harm was generated. These statements were then reviewed for face validity by both the researcher and her supervisors. Readability was ascertained using the Crystal Plain English Guidelines.

A pilot Q Sort using the statements was completed with two Clinical Psychologists. Feedback received from this pilot was that both participants found the statements easy to comprehend and free from ambiguity. The process of sorting the statements was reported to be enjoyable and also made the individual reflect on their experiences of working with individuals who self-harm. No recommendations were made for changing the wording of the statements or the format of the instructions given. The pilot data was excluded from the analysis as the participants were Clinical Psychologists and not nurses.

The statements (see appendix two) included factors which are thought to affect people's responses to self-harm, such as statements about their knowledge and beliefs about self-harm, their perceived role in the person's treatment, the relationship with the self-harmer and how they cope with the emotional aspects of

working with someone who self-harms. As well as the statements about self-harm there were also statements about the options of support they can provide to the participants when an individual who has self-harmed presents to services in this health board.

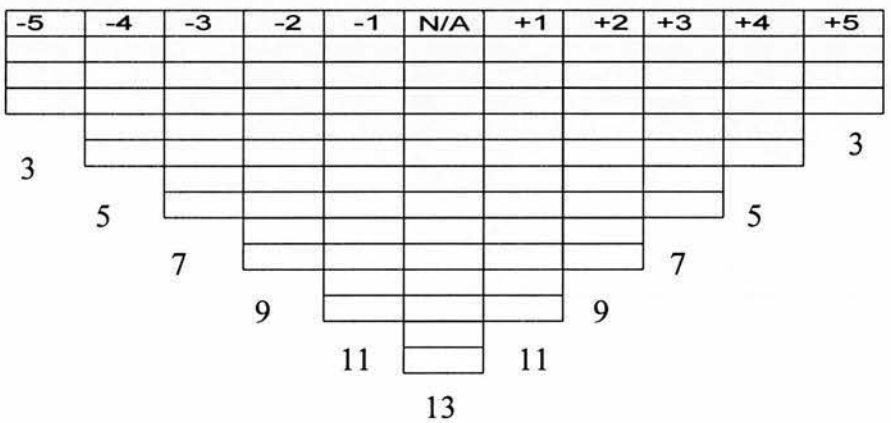
Each statement about self-harm was printed on a separate card. The statements were 'sorted' individually by the participants into a fixed distribution (defined by the number of statements). The distribution of the items was fixed so that the participants were required to assign a certain number of statements to each column. The utilisation of a fixed distribution is important to ensure that measurement error is minimised. A fixed distribution excludes the possibility of differences between the sorting of statements being due to an individual sorting style as opposed to 'real' differences between opinions and views. This is because when individuals were asked to sort statements, if there was no fixed distribution some individuals would sort to the 'extreme' columns whilst others may sort all statements into the 'middle' columns (Drew *et al.* 1999). The use of a fixed distribution in this way reduces measurement error. The fixed distribution also facilitates the ranking of the statements and requires the participants to consider all the statements in relation to one another. This gives a more in depth insight into their perceptions towards self-harm as the level of agreement or disagreement of the statements is not based purely on one statement and the decision of agree or disagree, but rather level of agreement or disagreement in relation to statements already sorted. In this way the strongest level of agreement and disagreement perceptions can be highlighted so it is hoped that a more representative view of an individual's perceptions or contrasting perceptions of self-harm can be obtained.

In this present study, the participants were asked to sort 83 cards with statements typed on about self-harm into one of eleven columns. The columns ranged from 'highly agree' to 'highly disagree' with the middle of these two values being neither agree nor disagree. To help the participants be clear how many statements were required in each column a large grid was provided which indicated how many boxes were available for each column (see figure 1 for grid). The statements were sorted or rank ordered from 'strongly agree' with the phenomenon in question, to 'strongly disagree' with the phenomenon in question with 'neither agree nor disagree or not relevant' in the middle of the distribution. Each statement received an identifying number written on the back of the card unseen by the participants. The pattern of the sorted statements was recorded for each participant. The way the items were sorted provided information about staff attributions, beliefs, emotions and self-reported behaviour towards individuals who self harm.

The participants were also required to complete a demographics questionnaire (including items such as age, gender, years of experience, level of training and job role) and a burnout questionnaire (Maslach Burnout Inventory, 1996). There were two questions about training completed. The first asked whether participants had attended training specifically for self-harm. The second question asked whether the participants had attended any training where self-harm had been discussed, such as training for a therapeutic intervention or for a type of disorder or mental illness. The sorting of the statements and completion of the questionnaires took between 30 to 40 minutes. This information was then collated for analysis.

Figure 1: Fixed Distribution grid used by the participants to provide a guide on the number of cards per column.

Highly Disagree Highly Agree



Maslach Burnout Inventory

The Maslach Burnout Inventory questionnaire (Maslach & Jackson, 1986) contains twenty-two items which are designed to assess how participants feel at work. The concept of burnout is thought to result from experiencing prolonged stress from continuously working with individuals or in situations which are difficult to manage. The items are evaluated in three sections; emotional exhaustion (depleted emotional resources), depersonalisation (negative and cynical attitudes towards others) and reduced personal accomplishment (negative evaluation of one's own work and abilities). This tool was selected for a number of reasons. Its use in the literature is extensive and it has been reported to be the most commonly used measure to assess burnout (Barnett, Brennan & Gareis, 1999). The tool has robust psychometric properties with the Cronbach Alpha coefficients for internal consistency at .90, .71 and .79 respectively, demonstrating high reliability of the items (Maslach & Jackson, 1993). The convergent validity of this measure was established by the use of correlations with independent behavioural ratings and job characteristics (Maslach & Jackson, 1993). The measure has limitations in that it was mainly developed with North American samples which reduced its validity with European samples (Whittington *et al.* 2002). However, it has been demonstrated to be a reliable multidimensional measure as Kanste *et al.* (2007) documented using exploratory factor analysis which supported the construct validity of the measure. Evidence was gained for the three factor structure used in the Maslach tool corresponding to emotional exhaustion, depersonalisation and reduced personal accomplishment. Test-retest reliability, external validity and absence of social desirability have all been demonstrated in relation to this questionnaire (Maslach & Jackson, 1993).

The items are scored via a Likert Scale where the frequency with which the participant experiences the feelings is indicated between 'never' having that feeling to experiencing that feeling 'every day'. There is no combined total score on this measure. A high degree of burnout is reflected in high scores on the sections emotional exhaustion and depersonalisation and a low score on personal accomplishment. Subsequently, a low degree of burnout is reflected in low scores on the sections emotional exhaustion and depersonalisation and a high score on personal accomplishment. An average degree of burnout is reflected in average scores on each of the sections. Table 2 details the cut-offs and degrees of burnout scores for all three subscales.

Table 2: Cut-off and degrees of burnout scores for the Maslach Burnout Inventory

Degree of burnout	Sub-scale score range		
	Emotional Expression	Depersonalisation	Personal Accomplishment
Low	0 – 18	0 – 5	40 +
Moderate	19 – 26	6 – 9	34 - 39
High	27 +	10 +	0 – 33

Design

This exploratory study aims to identify staff attributions, beliefs and behaviour about self-harm and to explore the kinds of staff emotions that are associated with self harm. Q Sort methodology and two questionnaires (Maslach Burnout Inventory and a Demographics questionnaire) were used in this study. Q Sort was chosen over other methodologies, such as individual interviews or questionnaires alone as it was felt that Q Sort is less demanding than individual interviews and more engaging and interesting than questionnaires for the participants. By using this methodology a larger sample size was recruited than individual interviews. Additionally, a more representative sample of the localities was achieved than if questionnaires had been employed, due to the sporadic geographic distribution of returned questionnaires and the low response rate of questionnaire studies.

Ethical Considerations

Full ethical approval was obtained from NHS Research Ethics Committee (NREC) (see appendix three for ethical approval letter). To ensure ethical guidelines were followed all participants were debriefed at the end of the study. This debrief invited the participants to engage in informal discussion about the study. The researcher and the academic supervisors contact details were highlighted to the participants if they required any further information about the study or if they should wish to withdraw their consent from the study at any point in the future. Helpline numbers were included on both the informed consent material and were highlighted during the debriefing discussion. This was included in case any participant was affected by the issues raised, particularly if they have had personal experience of self-harm (known or supported someone) or if they have self-harmed. Confidentiality was ensured for

both groups through the separation of the consent form from the Q Sort record sheet and the completed questionnaires. This was to remove the possibility of personal identification. On separation, the consent form, Q sort record form and questionnaire were all given a unique code. This was necessary to facilitate identification of a participant's data should an individual wish to remove their consent at a later date.

Procedure

The nurses were recruited on a first come first served basis and were provided with the participant information (see appendix four) twenty-four hours prior to giving written consent and taking part in the study. The nurses contacted the researcher either by telephone or through the health boards' global email service. A time, date and place of meeting were arranged which was mutually convenient to both the nurse and the researcher.

As participants contacted the researcher they were self-selected as they chose to participate in the study. To ensure that the participants were representative of the population, the researcher recruited participants evenly from each of the A&E departments as well as equally from each of the community teams. The psychiatric liaison nurses provided an area wide service and so selection due to geographical area was not necessary.

The researcher met each participant individually in a private room at their place of work to make involvement in the study more convenient for the participants. Each participant was thanked for agreeing to be part of the study and was offered the opportunity to ask questions before they were required to sign the consent form. The

researcher ensured that all participants had received and read the participant information sheet prior to signing the consent form. Some participants chose to re-read the participant information sheet as there had been a delay between their initial reading of the information and the meeting to complete the study.

There were three tasks in this study to be completed:

1- The Q sort.

2- The Maslach Burnout Inventory

3- The demographics questionnaire.

All tasks were explained at the beginning of the study. The participants were shown the Maslach Burnout Inventory and were advised that this would be the second task. They were then shown the demographics questionnaire and were told that this would be the last thing that they would be expected to do. All participants were advised that the question on the demographics questionnaire which referred to working hours per week was not their contracted hours but the actual number of hours that they worked. The researcher gave examples of how actual hours and contracted hours may differ. The examples given to participants were whether they arrived at work earlier or stayed later than they were contracted to and also whether they spent additional time working at home. Understanding of this discussion was checked by asking the participant if the instructions for the two questionnaires were clear. The participants were also asked to answer all questions as openly and honestly as possible.

The Q Sort was then discussed. Participants were advised that their first task was a Q Sort. The Q Sort task was fully explained, until the researcher was confident that the participant knew what was required. The researcher had created a large grid containing the fixed distribution columns. This allowed the participant to be visually clear on the numbers of cards which were needed for each column. The participants were advised that they were required to read each statement carefully and place a card into one of the columns according to how much they agreed, disagreed or neither agreed or disagreed with the statement written on the card. It was made clear to the participants that there would be only one card per box and that they were permitted to move the cards as much as they wished until they were happy with the placement of all the cards on the grid. This grid was duplicated on the Q Sort record sheets which the researcher used to record the completed sorts of each participant (See appendix five for the Q sort record sheet). Each card had a number on the back to allow for the recording and analysis of the statements. It was anticipated that providing the large grid for participants on which to place their completed card sorts would enhance and improve the process for participants as it would remove any difficulty trying to establish or remember how many cards were required for each column. The record sheet for the researcher was created to reduce the possibility of recording errors of the cards.

The participants were then given a further opportunity to ask questions prior to starting the study but were informed that they were able to ask questions at any point during the study. Participants were also advised that that they were free to withdraw from the study at any time, even at a later date once data collection has finished. It was highlighted to the participants that no personal information would be stored as

all participants were assigned a number at the beginning of the study to ensure anonymity. Finally, the participants were told that the researcher would remain in the room should they have any questions during the course of completing the tasks asked of them. However, it was made clear to all participants that they would not be observed by the researcher. It was hoped that participants would feel free to assign cards to columns that were most representative of their views. If the participants had been observed it is less likely that this would have occurred as demand characteristics of placing cards where they felt was socially acceptable would be likely to have featured significantly.

After completing the Q sort, Maslach Burnout Inventory and the demographics questionnaire, the participants were debriefed by the researcher through engaging them in a general discussion about the study and allowing them the opportunity to raise any concerns or ask further questions. During the study, the researcher utilised clinical skills, such as being sensitive during interviewing and attempting to minimise stress for the participants. It was hoped that this would then aid them to feel as relaxed as possible within the study. The researcher also highlighted their contact details and the helpline numbers should they feel distressed as a result of taking part in the study. No participant reported the process of completing any of the three tasks as distressing.

Lastly, the participants were also informed that after analysis and write up of the study the author would be contacting nurse managers to provide information about the results of the study either via a report or arranging a time to present the findings to the nurses within all three specialties. The participants were thanked again for

their time and involvement in the study before leaving to resume their work commitments. Average time with each participant was thirty minutes.

Data Analysis

There are a number of components to the analysis within this study. Q Sort methodology uses both quantitative and qualitative approaches within its analysis. The quantitative part of the analysis involves ranking of the statements and their placement in the fixed distribution as well as the factor analysis of the resultant data. The qualitative part of the analysis, in contrast, can be described as the purposive sampling of participants to yield perceptions about a topic of interest. The methodology yields data which is rich in information. The quantitative results are used by going back to the original data and statements and analysing at a level of depth usual for qualitative methods. This means that the factors or accounts from the factor analysis are related back to the statements of the participants and from this interpretation of the accounts the participants' views and perceptions of self-harm are described.

In this study consideration was given to the quantity and quality of the data generated. Multiple sources were consulted (Westen *et al.* 1997) (Risdon *et al.* 2003) (James *et al.* 2005) in order to provide guidelines for how to obtain the required sample size in a Q sort methodological study. From this consultation of published studies which have used Q Sort methodology, the ratio of participants to statements is the significant factor. For example, in Westen *et al's.* (1997) study there were 23 participants sorting 98 statements which when multiplied totalled 2254 items of information for the factor analysis. In Risdon et al's. (2003) study there were 30

participants sorting 80 statements which when multiplied totalled 2400 items of information for the factor analysis. In James *et al's* (2005) study there were 40 participants sorting 47 statements which when multiplied totalled 1880 items of information for the factor analysis. These figures guided the establishment of the minimum requirement for this study which was estimated at 30 participants sorting 80 statements as this far exceeded numbers from previous studies. The final data was collected from 39 participants sorting 83 statements.

Initially, descriptive statistics for the participants were collated and represented. After this was finalised the quantitative and qualitative aspects of the analysis were completed.

For the quantitative part of analysis the Q sorts are analysed using Factor Analysis for intercorrelations between items. Factor Analysis is a statistical technique which aims to describe and summarise groups of variables which are correlated. The variables in this study are the statements. The aim of this analysis is to reduce large numbers of statements to a number of factors or accounts which can provide information about the underlying processes which influence and impact on perceptions of self-harm. Statements can be present and highlighted in more than one factor as it is the relationship between the placement of the statements in the sorts that provides the different accounts or attitudes towards self-harm.

Once the factors have been obtained they are then rotated orthogonally using a varimax procedure. Rotation of the factors occurs to increase interpretability of the results. Rotation adjusts how the factors are defined. Varimax rotation is a variance

maximising procedure. The aim is to make high loadings higher and low loadings lower. A factor is more easily interpreted if the loadings on the factors are high and all factors are uncorrelated to each other (Tabachnick & Fidell, 2000).

The PQ Method statistical package allows a researcher to select Factor Analysis and orthogonal varimax rotation as an option and then performs the analysis on the data indicated by the researcher. The researcher is then able to select how many factors are used. Each account represents a different version of perceptions of self-harm. The 'best estimate' for each factor sort is discussed in Q sort methodology as the factors which are obtained after the rotation. For each factor or 'account' there are a number of participants' sorts who most represent the factor or account. These are known as exemplificatory sorts. If there is just one sort which represents the account or factor best then it is referred to as an 'exemplar' sort for that particular factor or account.

The qualitative part of analysis then uses the exemplars from the factor analysis and takes the analysis back to the level of the raw data. The individual sorts are explored in detail to outline, classify and explain the meaning for each account in relation to an individual's perception of self harm. This process is completed for all of the accounts that have been identified.

There were three research questions in this study. The first research question explored the beliefs, emotions and attributions that staff experience when working with individuals who have self-harmed. This question was explored using the analysis and interpretation of the factors.

There were two additional parts to question one. The first part explored whether negative beliefs are held by staff to prevent them feeling overwhelmed or helpless as a way to cope with the work. The second part explored the impact holding negative attributions about individuals who self-harm have on their ability to develop a relationship with the person when providing treatment. Both parts were explored using the analysis and interpretation of the factors.

The second research question focuses on whether there are higher levels of stress in staff who work with individuals who self-harm over a longer period. A&E and psychiatric liaison nurses both work within the hospital environment and only see patients for a brief, usually one off, period of time. In contrast, community nurses visit patients in their homes on a fortnightly basis over an extended period of time. Although the development of rapport can occur within one session, multiple sessions with an individual who is self-harming will facilitate the sharing of more information and it is likely that community nurses will have the opportunity to consider the individuals wider social context as they visit in the persons home. The analysis explored the differences between whether a nurse works over a short period of time (A&E and PAT nurses) or over the longer term (Community nurse) and their levels of burnout. An Independent Samples t-test was used for this analysis as there were two groups' differences to explore.

The third and final research question was interested in how nurses benefited from training. The analysis explored the relationship between participants who had completed specific self-harm training and training that discussed self-harm and the resultant impact on their levels of burnout. T-tests were used to investigate

differences on the burnout measure between people who had completed specific training on self-harm and those who had completed training that discussed self-harm.

Results

There were 39 completed Q sorts. These were entered into the PQ Method database (Schmolck, 2002). Factor analysis of the Q sorts produced nine factors which explained 67% of the variance with all nine factors having eigenvalues above 1.0. The factor analysis generated loadings and 'clustered' items together. The content of these 'clustered' items was explored in order to highlight what statements were present together. Eight factors were rotated orthogonally using a varimax procedure as this is the limit for the PQ Method package. This resulted in eight factors which explained 66% of the variance (see figure 2). Factors one, two and three accounted for 50% of the variance obtained in this study. The exemplars sorts were identified and included if loaded on one of the factors between ($p > .60$) and ($p < .35$). High loading on a factor means that the participant holds many aspects of that attitude or account towards self-harm. The first two factors (factors one and two) were defined with multiple exemplars. Multiple exemplars are where more than one participant has sorted the statements in a particular way that best represents an attitude towards self-harm. Where more than one participant has highly loaded on a factor this means that there is more than one exemplar sort which can be used to describe how the factor relates back to the statements and what attitude or view it represents. The remaining five factors (factors three to eight) were defined by a single exemplar.

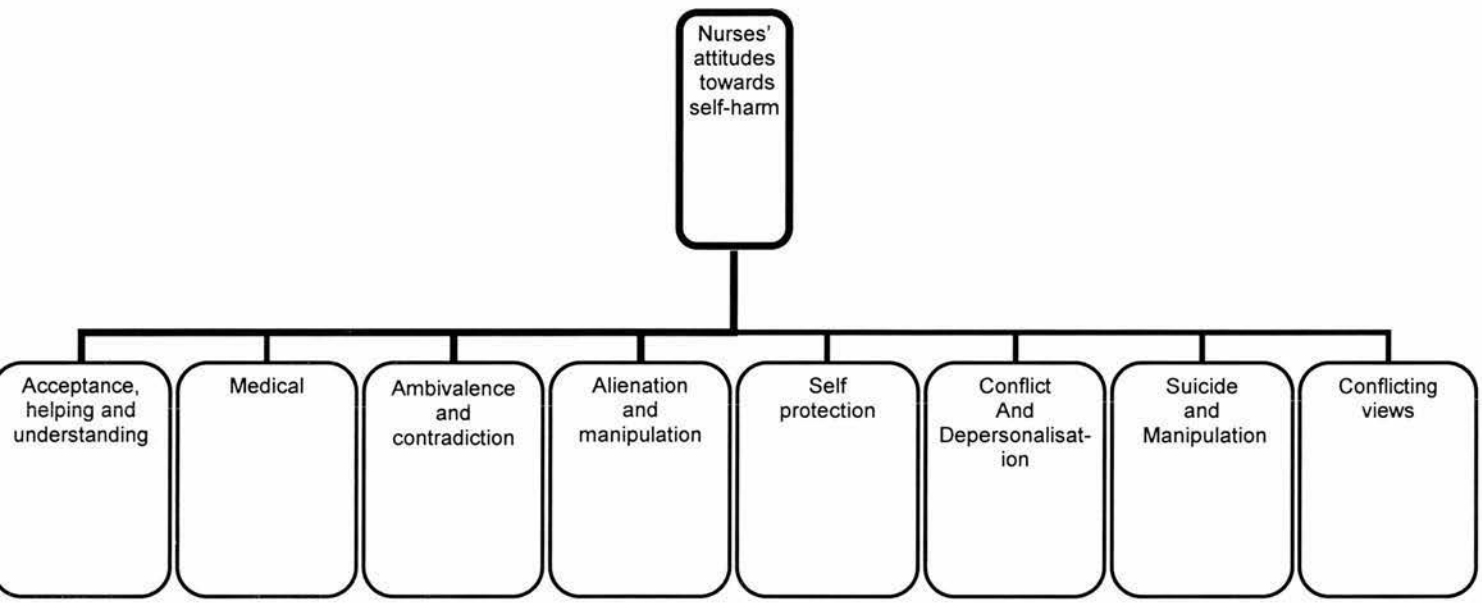


Figure 2: The eight factors representing nurses' attitudes towards self-harm

For each of the factors the Q sorts and their subsequent statements were identified for further analysis. The statements which were placed at either end of the fixed distribution (highly agree and highly disagree) were extracted from each exemplar sort. These were then used to interpret the factors. Independently, both the researcher and the academic supervisor reviewed the factors and achieved 100% agreement on factor interpretation without need for discussion.

The demographic information and the burnout scores were collated for each sort and used to aid interpretation of the factors that account for staff perceptions towards self-harm.

Descriptive Statistics of Demographic Information

There were a total of 39 participants in this study who were all qualified nurses. They were drawn from three areas of nursing; Accident and Emergency (A&E), Psychiatric Liaison or Psychiatric Assessment Team (PAT) and Community within one health board in Scotland. Female nurses accounted for 69% of the sample. Community and A&E nurses each accounted for 44% of the participants in this study with the remaining 12% of participants working as Psychiatric Liaison Nurses.

Figure 3 represents the distribution of ages within the nurse sample. Their ages ranged between groups 21-30 and 51-60. The largest proportion (33%) of participants were in the 41-50 year old group. Nurses who had been qualified for more than 21 years accounted for 41% of the nurses as highlighted in figure 4. In figure 5 it can be observed that over half (54%) the nurses work between 31-40 hours per week. However, 31% of the nurses reported working between 41-50 hours

per week. In table 3 it can be identified that nearly half (44%) of the nurses had discussed self-harm whilst training but just over a third (38%) had received specific training on self-harm.

Open – Ended Questions from Demographic Questionnaire

Training completed specifically on self-harm

15 participants out of 39 reported that they had completed training specifically on self-harm. ASSIST and STORM training on suicide prevention, self-harm, assessment, risk management and relapse prevention were the most attended trainings (ten participants). Three participants reported varied experiences of training from a specific two day training course to ad hoc half day slots on self-harm. Finally, two participants reported self-harm training within their nursing qualification training.

Training which discussed self-harm

12 participants out of 39 reported receiving training which discussed self-harm. Five participants had attended specific therapeutic training or training for specific mental health difficulties which discussed self-harm, such as solution focussed therapy, personality disorder and substance misuse training. Five participants described discussing self-harm as part of their nursing training qualifications. One participant had received information from GASH (group against self-harm) at a mental health open evening. One participant reported that they had discussed self-harm on their in service training within their A & E department. The remaining participants did not provide specific information regarding the training that they attended.

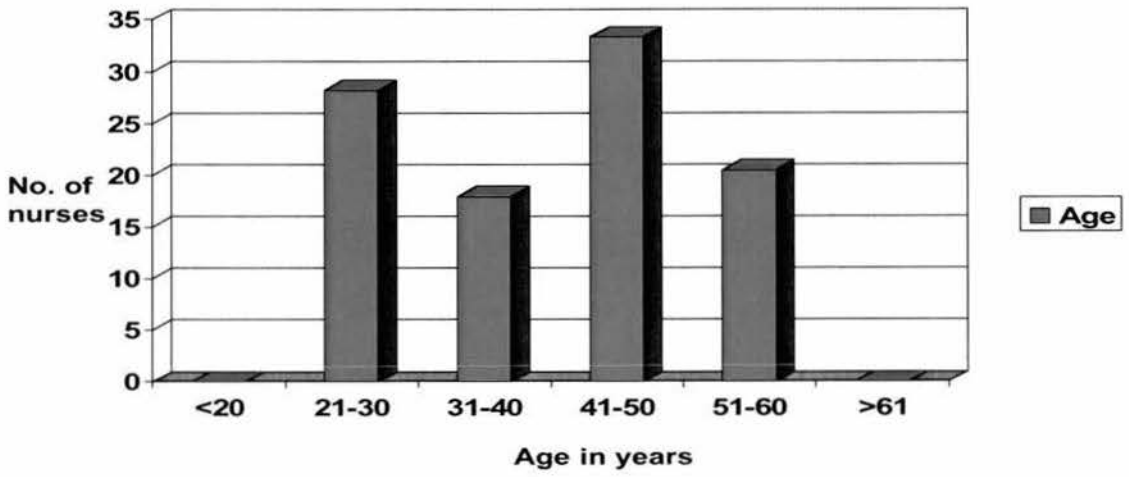


Figure 3: A diagrammatic representation of the age distribution (%) of the Nurses.

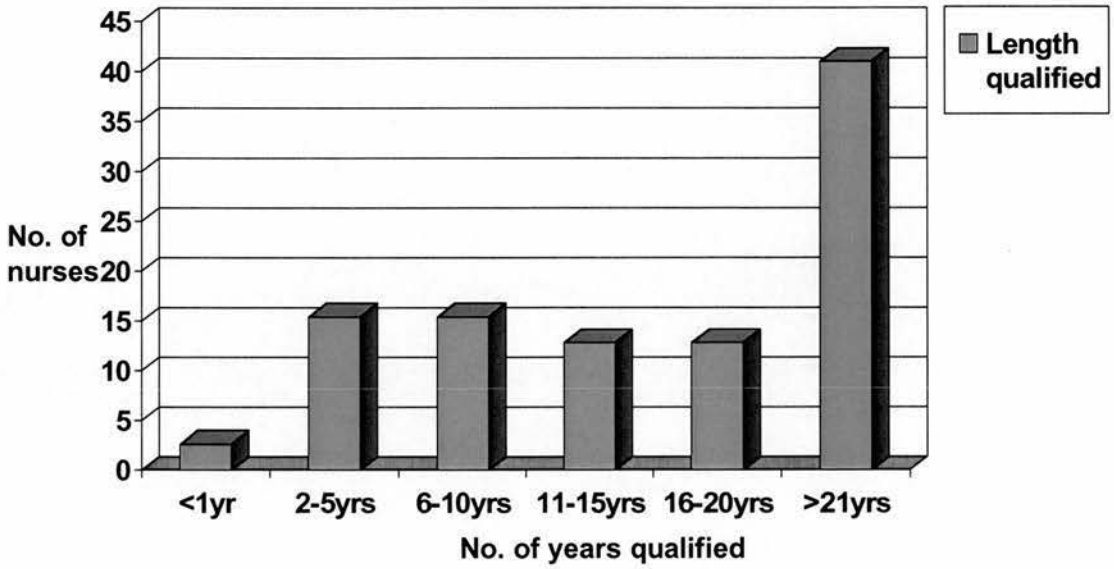


Figure 4: A diagrammatic representation of length of qualification in Nursing of the participants.

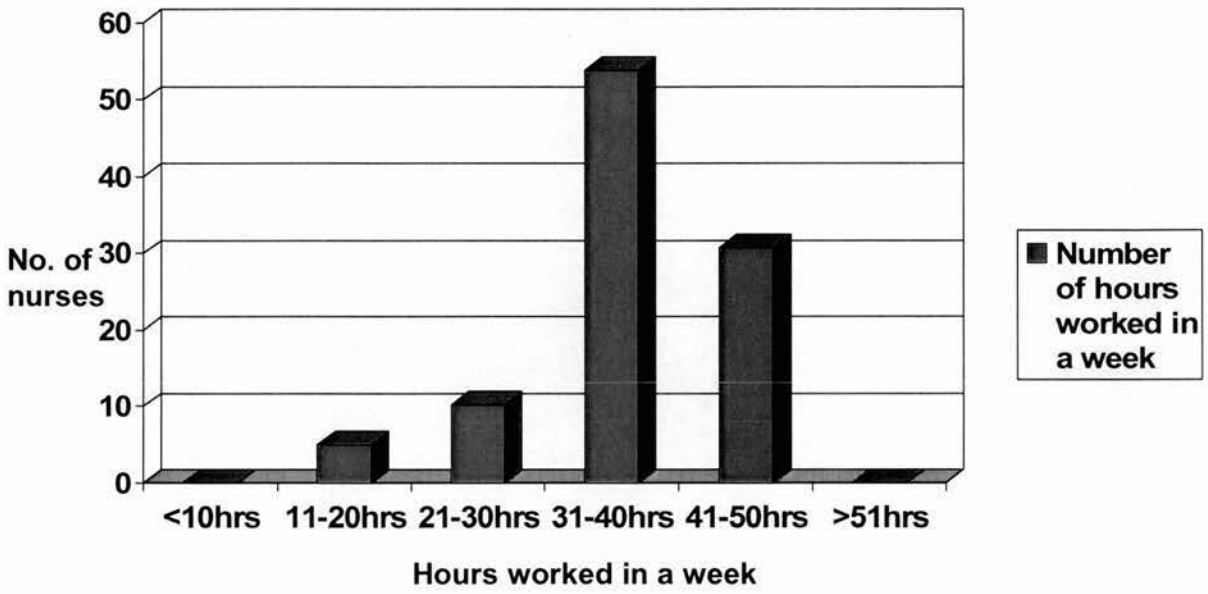


Figure 5: A diagrammatic representation of the actual number of hours worked by the Nurses in an average week.

Table 3: Demonstrates the attendance at self-harm training.

	Attended Training	Percentage that Attended
Self-harm training	Yes	38
	No	62
Training that discussed self-harm	Yes	44
	No	56

Table 4 below shows the percentage of variance each factor accounted for. Factor one, for example, accounts for 41% of the variance and therefore was the most representative factor of attitudes towards self-harm.

Tables 5 and 6 provide additional information about the exemplar participants whose sorts are used to interpret the factors. The age, gender, type of nurse, number of years qualified and number of hours worked in a week were detailed in table 5. In addition, in table 6, the participants scores from the Maslach Burnout scale, whether they have received training on self-harm and, finally, whether they have discussed the issue of self-harm whilst on training are displayed. This additional information is used to aid interpretation as similarities and differences between the exemplar sorts can be identified. Interpretation of the factors was completed by looking back at the pattern of sorted statements from the participants who had exemplar sorts for each factor. The placement of the statements in the highly agree and highly disagree columns were identified and then used along with the demographic information to interpret the factors.

Table 4: Percentage of variance accounted for by each factor.

Factor	Eigenvalues and Variance		
	Eigenvalues	Variance accounted for (%)	Cumulative (%) accounted for
1	16.2792	41.7415	41.7415
2	1.8864	4.8369	46.5784
3	1.5769	4.0433	50.6216
4	1.4173	3.6342	54.2558
5	1.3542	3.4724	57.7281
6	1.1767	3.0172	60.7453
7	1.1178	2.8662	63.6115
8	1.0849	2.7819	66.3934

Table 5: Age, Gender, Nurse Type and Number of Years Qualified for each Participant who had Exemplar Sorts for the Factors.

Factor	Partic-ipant	Loading	Age	Gender	Nurse Type	Years Qualified	Hours Worked
1	33	0.73	41-50	Female	PAT	21+	41-50
	3	0.70	21-30	Male	Community	6-10	41-50
	1	0.67	31-40	Male	Community	11-15	31-40
	6	0.64	41-50	Male	Community	21+	41-50
	27	0.63	31-40	Female	A&E	11-15	31-40
	20	0.62	51-60	Female	A&E	21+	31-40
	21	0.62	41-50	Female	PAT	11-15	41-50
2	29	0.65	21-30	Female	A&E	6-10	31-40
	19	0.64	21-30	Female	A&E	2-5	41-50
	28	0.62	51-60	Female	A&E	21+	21-30

3	11	0.75	41-50	Female	Community	11-15	31-40
4	7	0.79	21-30	Male	Community	6-10	31-40
5	30	0.75	31-40	Female	A&E	11-15	21-30
6	24	0.66	41-50	Female	PAT	21+	31-40
7	12	0.65	41-50	Male	Community	21+	41-50
8	10	0.65	51-60	Female	Community	21^{+}	31-40

Key: PAT = Psychiatric Liaison Nurse; A&E = Accident and Emergency Nurse

Table 6: Burnout Scores and Status of Training Completed for Participants who had Exemplar Sorts for the Factors.

Factor	Participant	Loading	Emotional Exhaustion	Deperson-alisation	Personal Accomplishment	Training in self Harm	Training discussed self-harm
1	33	0.73	High	High	Moderate	Yes	Yes
	3	0.70	Moderate	Moderate	Moderate	No	Yes
	1	0.67	High	High	Moderate	No	Yes
	6	0.64	High	Moderate	Moderate	No	Yes
	27	0.63	Low	Low	Low	No	Yes
	20	0.62	Low	Low	Low	Yes	Yes
	21	0.62	Low	Moderate	Moderate	Yes	Yes
2	29	0.65	Low	Low	Moderate	No	No
	19	0.64	Moderate	High	Moderate	No	Yes
	28	0.62	Low	Low	High	No	No

3	11	0.75	Low	Moderate	High	No	No
4	7	0.79	Low	Low	Moderate	No	Yes
5	30	0.75	Moderate	Moderate	High	No	No
6	24	0.66	Low	High	Low	No	Yes
7	12	0.65	High	High	Moderate	No	Yes
8	10	0.65	Low	Moderate	Moderate	Yes	No

Each factor or account represents different perceptions or attributions, emotions and behaviour towards people who self-harm. Accounts were examined across individuals with common themes and divergences being explored. Participants loading on each factor suggested their level of association with that factor. This loading represents a point of view and their level of association or agreement to this view. For each factor or 'account' there are a number of participants sorts who most represent the factor or account. These exemplar sorts and eight factors are outlined as a way to explore research question one.

Research Question One

What beliefs, emotions and attributions do staff experience when working with individuals who self-harmed?

There were eight factors identified from the analysis. Their exemplar sorts and the corresponding statements are detailed and described below.

Factor One: Taking it Seriously; Acceptance, Helping and Understanding

Seven of the participants' (1, 3, 6, 20, 21, 27, 33) Q sorts exemplify this factor with this factor accounting for 41% of the total variance. These seven participants best represent this factor and so are used as examples to describe and interpret the factor. Statements which were rated with high agreement by the participants are either '+5' or '+4'. Conversely, statements which were rated with low agreement by the participants are either '-5' or '-4'. These numbers are shown in parentheses after the statements.

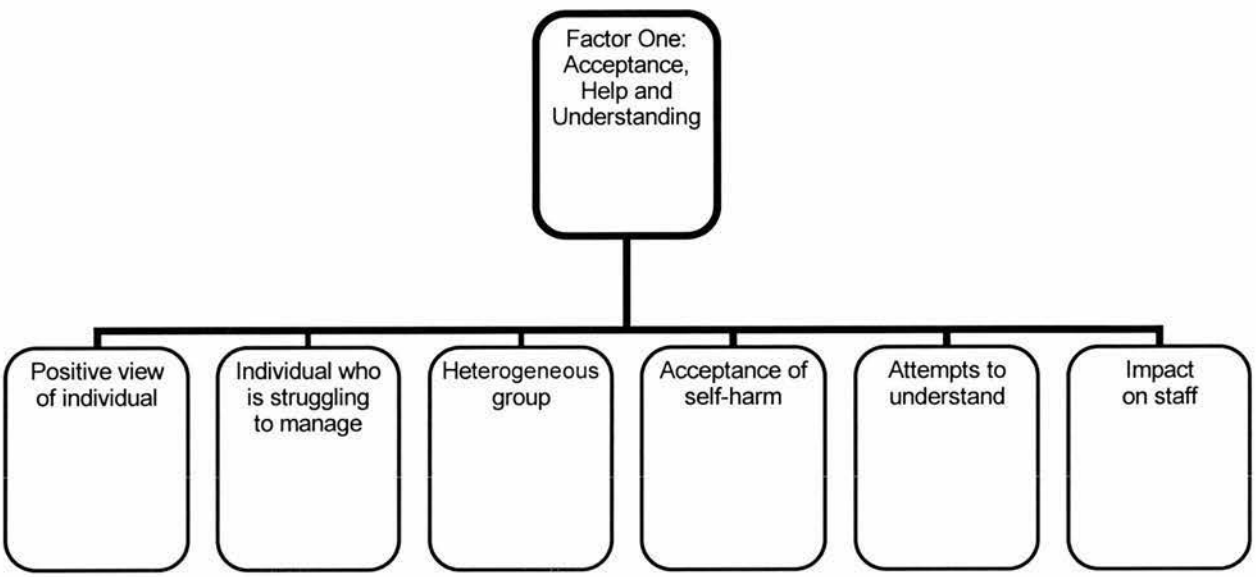


Figure 6: Factor one: Taking it seriously: Acceptance, helping and understanding

This factor represents a very positive view of self-harm by the participants with five out of the seven participants rating *'Individuals who self-harm can be likeable'.* (Participants 6 & 27 rated it (+5), Participants 3, 21 & 33 rated it (+4)). The participants viewed the individual who self-harms as an individual who is struggling to manage. *'People self-harm as they struggle with things that have happened to them in their lives'.* (Participant 1 rated it (+5), Participant 20 rated it (+4)).

This factor also represented the view that individuals who self-harm are a heterogeneous group with different methods of harm *'People who self-harm use a wide range of behaviours'.* (Participants 3 & 20 rated it (+5), Participant 21 rated it (+4)); and have different reasons for harming. *'There are different reasons why males and females self-harm'.* (Participant 6 rated it (+5) Participant 3 rated it (+4)).

There appeared to be acceptance of the self-harm behaviour and attempts to understand self-harm. *'Self-harm communicates emotions and distress'.* (Participants 1, 3 & 20 rated it (+4)). Consideration was also given to the types of individuals who are more at risk of self-harm. *'Young people (below 25 years) are more likely to self-harm'.* (Participants 1 & 21 rated it (+4)) *'Individuals who self-harm have often misused substances'.* (Participants 20 & 21 rated it (+4)) These explanations were external factors to the person, such as their life experiences and relationships and strategies for coping. The self-harm was not viewed in terms of an internal deficit or problem in the individual.

The factor acknowledged the difficulties or impact on staff when working with individuals who self-harm. *'It is difficult to hear someone discussing their self-harm'.*

(Participant 27 rated it (+4)). It raised the emotional impact of working with self-harm, *'Working with self-harm can be anxiety provoking'.* (Participants 3 & 27 rated it (+5)) (Participants 6 & 33 rated it (+4)) as well as concerns from staff about time pressures when working with individuals who self-harm. *'Self-harmers take up a lot of my time'.* (Participants 20 & 21 rated it (+5)) Five out of the seven participants expressed concerns about selecting appropriate interventions. *'Sometimes it's hard to decide what to do with someone who self-harms'.* (Participants 21 & 33 rated it (+5)) (Participants 1, 6 & 27 rated it (+4)). It could be interpreted that these multiple reasons of impact on staff explain proposals for the need for specialist teams *'There should be specialist teams for self-harmers'.* (Participants 3, 6 & 27 rated it (+5)) (Participants 1 rated it (+4)).

This factor also represented views on treatment, service provision and the impact poor experience of treatment can have on individuals' self-harm repetition rates, such as the individual playing an active rather than passive role in treatment, *'The motivation to change of the person effects treatment of self-harm'.* (Participants 1 & 33 rated it (+5)) (Participants 6 & 21 rated it (+4)). This statement also suggested that staff recognised the importance of involvement of the individual in the treatment option selection and that individuals who self-harm have often received negative opinions about their behaviour from others *'People who self-harm are used to receiving negative reactions'.* (Participant 20 rated it (+4)).

The need for consistency of working and experience of staff were also highlighted in this factor. *'When working with individuals who self-harm you need to have a consistent approach'.* (Participants 3, 33 rated it (+4)) *'Over time I have felt better*

about working with people who self-harm'. (Participant 21 rated it (+5)) (Participants 6, 27 & 33 rated it (+4)). This factor also highlights the view that admission into hospital and being assessed by a Psychiatrist are not always necessary. *'After self-harming individuals should be admitted into hospital'.* (Participant 1 rated it (-5)) *'If they won't see a psychiatrist - they don't want to get better'.* (Participant 3 rated it (-5) (Participants 1 & 20 rated it (-4)).

Finally, there is an explicit rejection of notions of uniformity in individuals who self-harm *'Individuals who self-harm are all the same'.* (Participants 3 & 33 rated it (-5)) (Participants 20 & 21 rated it as (-4)); and rejections of labelling and stigmatising *'Individuals who self-harm are bad'.* (Participants 1, 20, 21 & 27 rated it (-5)) (Participant 6 rated it (-4)); *'Individuals who self-harm come from a lower social class'.* (Participant 21 rated it as (-5)) (Participants 1 & 3 rated it (-4)). Punishing approaches *'It doesn't matter if the self-harmer is in pain'.* (Participants 27 & 33 rated it as (-5)) (Participants 3 & 20 rated it (-4)); and rejection or minimising of the behaviour were also not supported by this factor. *'If it's not an artery they don't mean it'.* (Participant 21 rated it as (-5)) (Participants 3 & 27 rated it (-4)).

Interestingly, all participants who had exemplar sorts for this factor had attended training which discussed self-harm. A further three participants had also attended training specifically on self-harm. Six out of the seven participants were older than 30 years of age and all the nurses had been qualified for more than 11 years. There were male and female participants from all three of the different types of nurse included in the study. Two of the participants were nurses from A & E and their pattern of scores for Burnout were the same in all three of the subscales scoring low

on the emotional exhaustion and depersonalisation and low on the personal accomplishment scale. This latter low score, in contrast to the other two subscale scores, is indicative of burnout as it suggests that individuals do not gain satisfaction and a sense of achievement from their work. Three participants out of the seven had high scores on the expressed emotion subscale on the Maslach questionnaire while their overall pattern of scores on the subscales suggested an increased level of burnout.

Summary of Factor One

This factor represented a positive, accepting and understanding view of self-harm. Positive characteristics were attributed to individuals who self-harm and there was recognition that the meaning and function which self-harm serves is complex, multi-faceted and individualised. The emotional impact of working with self-harm was also highlighted as well as concerns about staff abilities to work in this area. Increased insight into the experience of individuals who self-harm appeared to be achieved through years of experience and through the provision of training on self-harm. Finally, there was a rejection of labelling, stigmatising, minimising and punitive consequences for individuals who self-harm.

Factor Two: Taking it Seriously; A Medicalised View

Three of the participants' (19, 28, 29) Q sorts exemplify this factor, accounting for 4% of the variance. These three participants best represent this factor and so are used as examples to describe and interpret the factor. This second factor represented conflicting views on self-harm; a medical understanding of self-harm as an illness *'If you self-harm you are mentally ill'.* (Participant 19 rated it as (+5)) and as an

addiction *'Self-harming is addictive'*. (Participant 29 rated it as (+5)); versus attempts to understand and explain why an individual self-harms *'Self-harm communicates emotions and distress'*. (Participant 19 rated it as (+4)); *'Family and friends can 'wash their hands' of individuals who self-harm'*. (Participant 28 rated it as (+4)).

Additionally, the statements are conflictual as they represented both positive and negative views towards self-harm. *'Interpersonal difficulties can cause someone to self-harm'*. (Participant 28 rated it as (+5)); *'Individuals who self-harm find it difficult to problem solve'*. (Participant 29 rated it as (+4)). The negative statements were labelling, stigmatising and treating individuals who self-harm as a homogenous group. *'Self-harming is attention seeking'*. (Participant 29 rated it as (+4)). *'Self-harm is attempted suicide'*. (Participant 29 rated it as (+5)) (Participants 19 & 28 rated it as (+4)).

However, there were also statements which evidenced a desire to help despite the categorical approach, *'It is necessary to understand why the individual has self-harmed'*. (Participant 29 rated it as (+5)) and to provide support and treatment to individuals who self-harm. *'There should be specialist teams for self-harmers'*. (Participant 28 & 29 rated it as (+4)). Views on treatment differed, which appeared to be the result of the impact on staff of working with individuals who self-harm. *'Individuals who self-harm make me irritated, frustrated or angry'*. (Participant 28 rated it as (+5)); *'The way I treat a person with self-harm affects whether they will self-harm again'*. (Participant 19 rated it as (+4)).

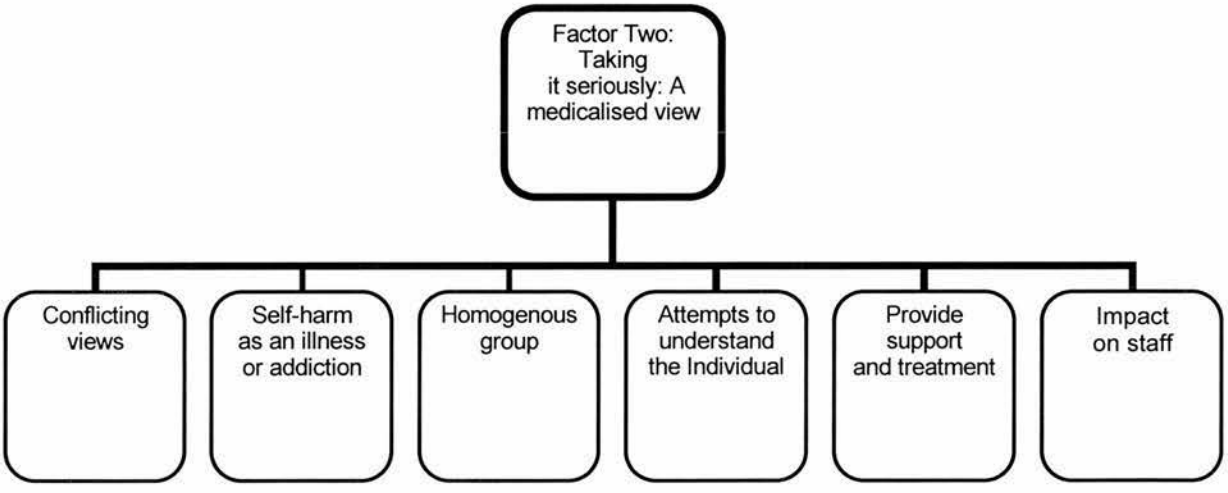


Figure 7: Factor Two: Taking it Seriously; A Medicalised View

The factor rejected nurses' responsibility for an individual who commits suicide *'If an individual who is treated for self-harm went on to kill themselves the health care staff would be responsible'.* (Participant 28 rated it as (-5)) whilst still recognising that they can be efficacious in working with an individual. *'Nothing can be done to prevent someone from self-harming'.* (Participant 19 rated it as (-5)) (Participant 28 rated it as (-4)); *'There is nothing I can do to help someone who self-harms'.* (Participants 19 & 28 rated it as (-4)).

Negative perceptions were also rejected within this factor which stigmatise individuals who self-harm. *'Individuals who self-harm often don't have a job'.* (Participant 28 rated it as (-5)); *'Individuals who self-harm are impulsive'.* (Participants 19 & 28 rated it as (-5)); *'There should be negative consequences for people who self-harm'.* (Participant 19 rated it as (-5)). It also rejects the idea that self-harm is something that people cause and have control over. *'People who self-harm bring bad things on themselves'.* (Participant 28 rated it as (-4)) *'Individuals will grow out of self-harm'.* (Participants 29 rated it as (-4)).

In contrast to factor one only one of the three participants who were exemplar sorts had been on training which discussed self-harm and none of the participants had been on training specifically for self-harm. This is important as it could be suggested that the negative views are a reflection of a need for training on self-harm. All the participants with exemplar sorts in this factor were female and A & E nurses. Two of the participants were in the 21-30 years of age range and had been qualified less than 10 years whereas the other participant was in the 51-60 age range and had been qualified more than 21 years. The burnout subscale scores for this factor also

ranged from moderate or high personal accomplishment to low to moderate emotional exhaustion. Interestingly, it could be suggested that the low to moderate feelings of emotional exhaustion explain why the nurses score well on the subscale considering their level of personal accomplishment, as this is despite the fact that none of the nurses have received training specifically on self-harm.

Summary of Factor Two

This factor contained conflicting views towards self-harm. One perception represented in this factor was a medicalised view adopted where the behaviour is viewed as a manifestation of a mental illness or as a form of addiction. The contrasting perception was where staff appeared to strive to understand the individualised function of the self-harm. Further conflict was present with the desire to support individuals versus the proposition for the need for specialist services. Only one of the staff had received training that discussed self-harm and these conflicts and difficulties managing individuals who self-harm were reflected in their burnout scores. This factor's exemplars were all A & E nurses and could suggest an explanation for the medicalised approach, given the hospital setting in which they work. Despite their lack of training their high levels of personal accomplishment scores could be a coping strategy which is protecting them from emotional exhaustion. However, it is important to consider that staff are likely to achieve personal accomplishment from other aspects of their work, such as work with other patients and peer support.

Factor Three: Struggling to Understand; Ambivalence and Contradiction

One participant's (11) Q sort exemplifies this factor, accounting for 4% of the variance. One participant best represents this factor and so is used as an example to describe and interpret the factor.

This factor represents a difficulty by staff to understand the individual who self-harms. *'I can't understand why someone would want to self-harm'.* (Rated as +5). However, attempts are made to understand the individual. *'Self-harm occurs when a person feels alone'.* (Rated as +4); *'Self-harm is a way to manage difficult feelings'.* (Rated as +4); '*Individuals who self-harm feel hopeless'.* (Rated as +4).

In contrast to the desire to understand there is also a suggestion that staff view individuals who have self-harmed as individuals who have a deficit. *'Individuals who self-harm are impulsive'.* (Rated as +4). In addition the factor also promotes the proposition of negative (possibly punitive) consequences for individuals who self-harm. *'There should be negative consequences for people who self-harm'.* (Rated as +4). This view is likely to affect the service provision provided by staff who hold this view. However, the factor also evidences recognition by staff that individuals need to take responsibility to change. *'The motivation to change of the person effects treatment of self-harm'.* (Rated as +5). Although, given the context of the statements in the factor, this statement could also represent ambivalence by staff to take responsibility for the treatment and intervention they provide.

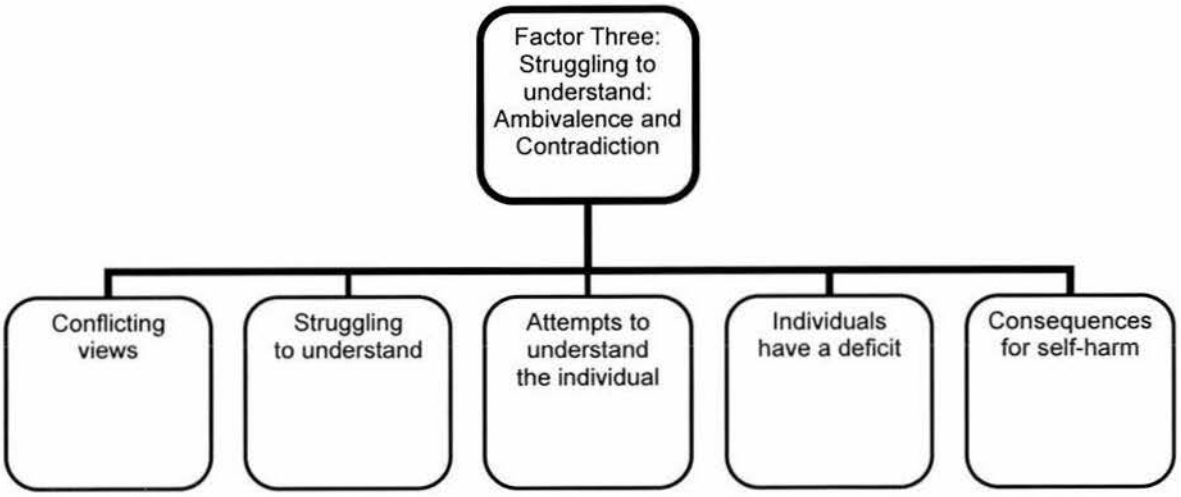


Figure 8: Factor Three: Struggling to Understand; Ambivalence and Contradiction

This factor also represented conflicting views between negative perceptions of self-harm as well as attempts to understand why the individual has self-harmed. Despite some reservations about the reasons behind the actions of individuals who self-harm there is still a rejection of labelling, *'Self-harming is attention seeking'*. (Rated as -4); stigma *'Individuals who self-harm divert resources from those who need them'*. (Rated as -4); *'If they won't see a psychiatrist- they don't want to get better'*. (Rated as -4); and mental illness, *'Self-harmers should always be referred to mental health services'*. (Rated as -5).

For this factor the participant has received no training which either discussed or was specifically for self-harm. There were low levels of emotional exhaustion but moderate levels of depersonalisation and high levels of personal accomplishment. This latter high score could be suggested to provide an explanation for the low emotional exhaustion as if an individual perceives that their work is successful and useful this will provide some protection against difficulties which may arise through the course of their work. The participant was female and worked in the community for 31-40 hours per week, having been qualified for 11-15 years.

Summary of Factor Three

Factor three is represented by ambivalence and contradiction as there is evidence that attempts are made to understand the individual who self-harms but there is also the negative view held that self-harm behaviour represents a deficit in an individual. Ambivalence by staff to take responsibility for their role in treatment is evidenced further by the punitive views of the need for consequences for the individuals who self-harm. However, in contrast, negative views of labelling, stigmatisation and

mental illness are rejected. The participant representing this factor has received no training on self-harm and, as in factor two, has low levels of emotional exhaustion, potentially suggesting that the higher level of personal accomplishment is serving a possible protective function, as in factor two.

The following five factors represent individually between 2% and 3% of the variance, together totalling 16% of the variance. They are also represented by a single exemplar and are therefore described in less detail than factors one to three.

Factor Four: Struggling to Understand; Alienation and Manipulation

One participant's (7) Q sort exemplifies this factor, accounting for 4% of the variance. One participant best represents this factor and so is used as an example to describe and interpret the factor. This factor represents alienation by one nurse to individuals who self-harm, viewing them as being fundamentally different to them. It also represents the view that self-harm serves a function to achieve a desired outcome. Contradictory to these views, this factor also rejected some statements which were labelling and stigmatising to individuals who self-harm. It viewed individuals who self-harm as an homogenous group which is opposite to factor one. However, as in factor two and three there are low emotional exhaustion scores which could be linked to personal accomplishment serving a protective function for staff.

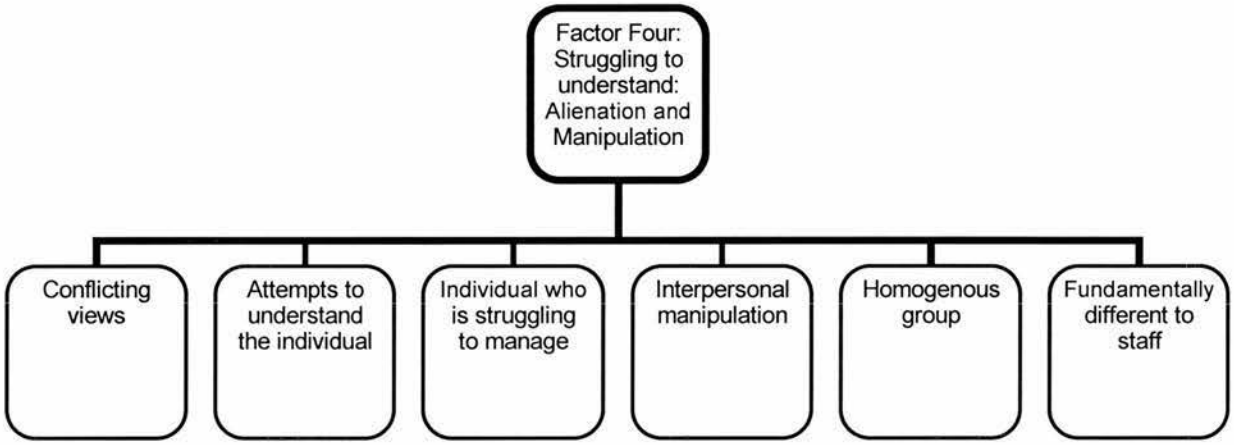


Figure 9: Factor four: Struggling to understand; Alienation and manipulation

Factor Five: Self Protection

One participant's (30) Q sort exemplifies this factor, accounting for 3% of the variance. One participant best represents this factor and so is used as an example to describe and interpret the factor. This factor highlights the negative impact of working with individuals who self-harm and it represents one nurses' view on managing difficulties in the work. The negative impact is reflected in their scores which are within the moderate range for burnout. Staff strategies for managing the negative impact of their work are outlined and this positive identification by staff of strategies to manage were observed in their higher personal accomplishment scores. The participant whose exemplar sort represents this factor works in A & E and had not received training on self-harm. However, despite the recognised impact the work has on them there is still a held view that the individual who self-harms is an individual who needs to be understood. This factor could be linked to factor two as it could be argued that both factors represent ways of conceptualising and managing self-harm.

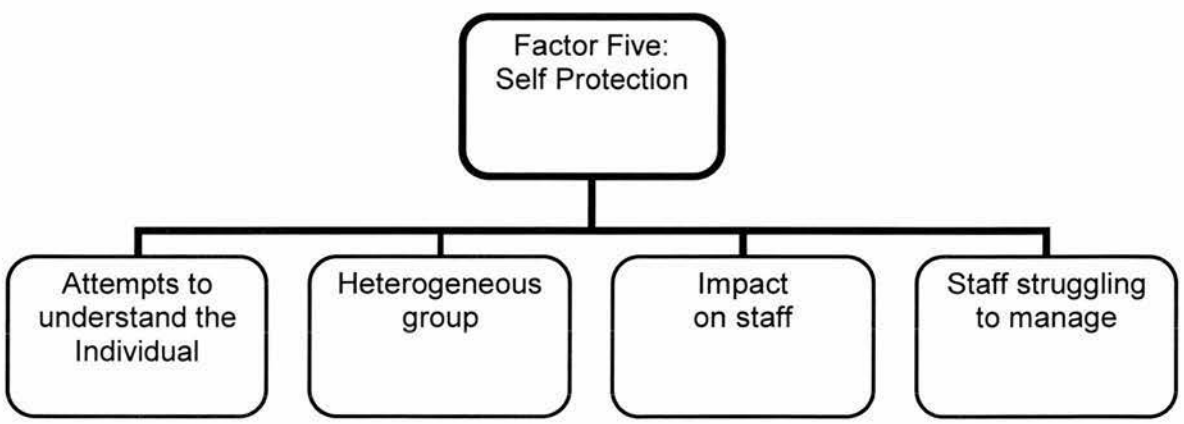


Figure 10: Factor Five: Self Protection

Factor Six: Struggling to Understand; Conflict and Depersonalisation

One participant's (24) Q sort exemplifies this factor, accounting for 3% of the variance. One participant best represents this factor and so is used as an example to describe and interpret the factor. This factor attempts, as other factors, to understand self-harm and rejects labelling, stigmatising and punitive consequences. However, there is conflict within this factor as the factor then proposes that all individuals should be referred to mental health services and specialist teams. This proposition suggests that there is deficit or problem within the individual, although it may also reflect a belief that individuals who self-harm require specialist intervention. This factor is exemplified by a nurse from the psychiatric liaison team and could be a product of their short term assessment work. The assessment allows an individual to focus on facts rather than the individual themselves as they are not working and engaging with the person over a longer period.

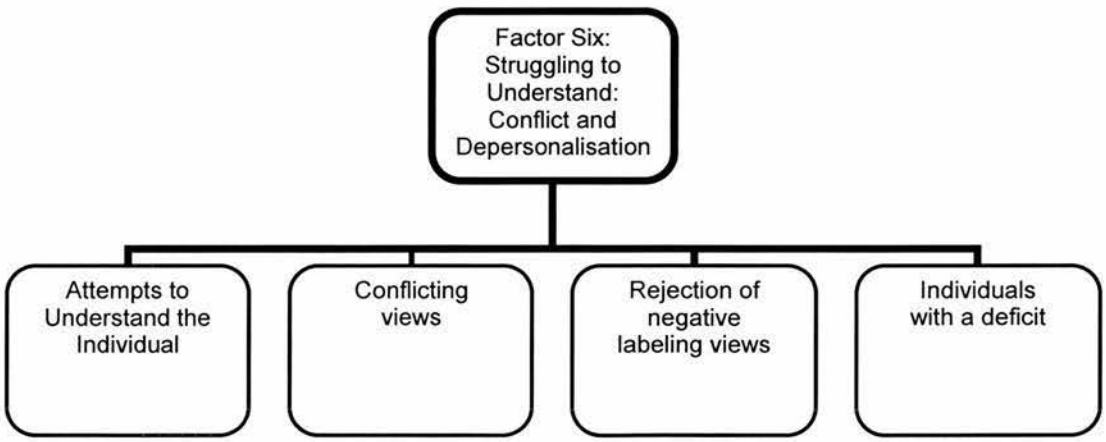


Figure 11: Factor Six: Struggling to understand; Conflict and Depersonalisation

Factor Seven: Suicide and Manipulation

One participant's (12) Q sort exemplifies this factor, accounting for 3% of the variance. One participant best represents this factor and so is used as an example to describe and interpret the factor. This factor represents attempts to individualise and understand but also, in contrast, expresses the view that individuals self-harm to manipulate others and to gain a desired outcome. This latter view is similar to that expressed in factor four. In addition to these views this factor is the only factor which proposes that individuals who self-harm want to take their life. The factor also highlights the impact on staff of working with self-harm, although this participant is also working long hours. The participant whose Q sort represented this factor was a nurse working in the community. Community nurses tend to work with individuals over a longer period and in this case work more hours per week. Combining these two issues with viewing self-harm as a form of suicide and manipulation is likely to lead to difficulties with burnout as the work becomes harder, depersonalised and with only a moderate level of personal accomplishment.

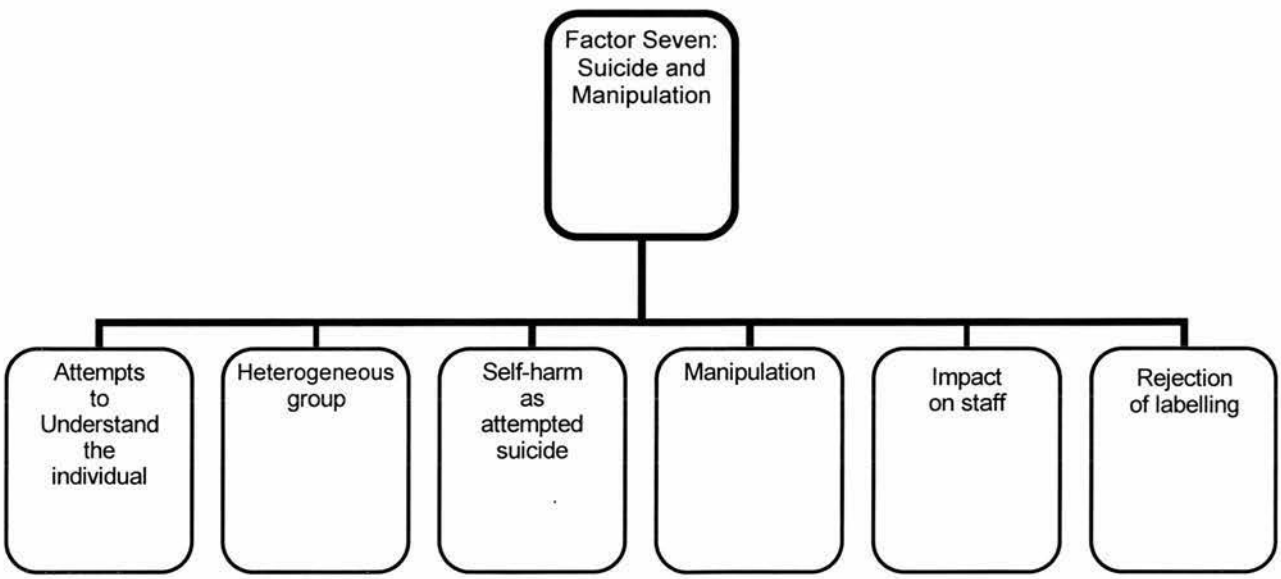


Figure 12: Factor seven: Suicide and Manipulation

Factor Eight: Struggling to understand; Conflicting views

One participants' (10) Q sort exemplifies this factor, accounting for 3% of the variance. One participant best represents this factor and so is used as an example to describe and interpret the factor. Factor eight represents a struggle to understand and conflicting ideas as there are the negative views of their being a deficit or problem with the individual who self-harms, as in factors four and six. However, there is also a proposition of positive attributes to the individual who self-harms, which is similar to factor one and could be impacted by a number of factors, such as training and length of experience of the nurse.

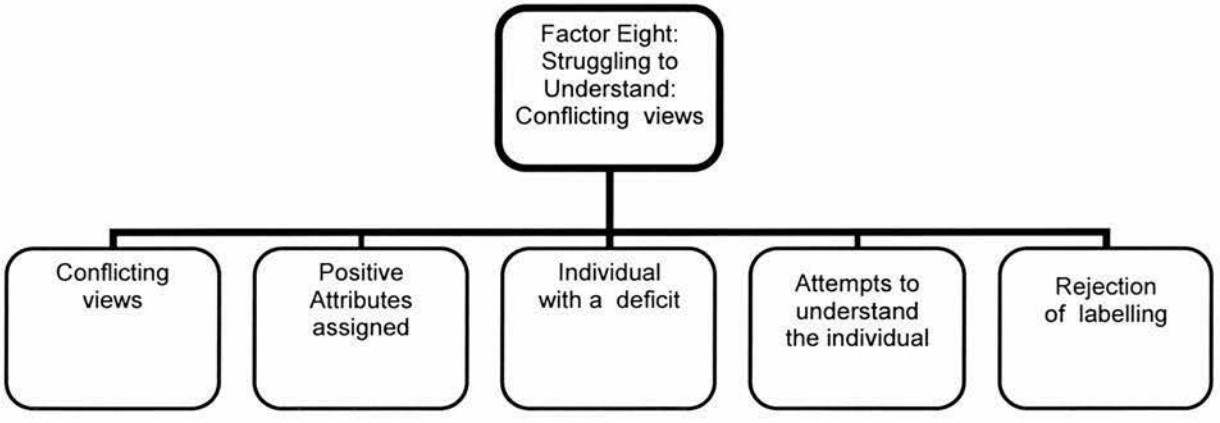


Figure 13: Factor eight: Struggling to understand; Conflicting views

Summary of factors

Overall, these factors represent positive attempts to understand the individual who self-harms. However, this is a struggle and staff attempts to understand are limited by some of the negative views that are held. Two of the factors represent the belief that self-harm is a way to manipulate others. There is also depersonalising of the individual and seeing the individual who self-harms as fundamentally different from themselves. All of these negative views can be perceived as the strategy that staff have utilised to manage their emotions in their work as the factors universally recognised how difficult working with individuals who self-harm is.

Research Question One (a)

If staff hold negative beliefs about individuals who self-harm, are these to prevent them feeling overwhelmed or helpless as a way to cope with the work?

None of the factors represented this view that negative beliefs are held as a way to protect themselves. However, factor five (self protection) has been interpreted to represent how staff try to manage the negative impact of their work on them as individuals. The negative impact is reflected in their scores which are within the moderate range for burnout. The exemplar sorts in factor one are also represented by participants who have high burnout scores. An explanation for these high scores on the burnout indices could be that nurses represented by factor one 'give more of themselves' to their work when they hold positive attitudes and this increases their scores on the emotional exhaustion subscale. However, the factors have not represented the view that if negative views are held it is a way that staff protect themselves from feeling overwhelmed and helpless.

Research Question One (b)

If a person holds negative attributions about individuals who self-harm will it make it difficult for them to develop a relationship with the person when providing treatment?

None of the eight factors represented this view that negative attributions impact on the relationship with the individual who self-harms. If this had been a widely held attribution this would have been represented by one of the factors. However, factors four and seven represent the belief that the act of self-harm is a way to manipulate the behaviour of others. This view could be suggested to impact negatively on the experience of individuals who self-harm due to this view being held by staff. However, this has not been represented in the factors that holding a negative view is associated with difficulty with the relationship with the individual who self-harms or negative treatment of the individual who self-harms.

Research Question Two

Is working with individuals who self-harm over a longer period associated with higher levels of stress and lower levels of well being?

The analysis explored the differences between different types of nurses in this study and levels of burnout on the three burnout subscales. Nurses were grouped by short term work (A&E and PAT) (n = 22) and longer term work (Community) (n = 17). An Independent Samples t-test was used for this. The means and standard deviations for the emotional exhaustion subscale were M = 21.59, SD = 10.11 for short term working and M = 17.59, SD = 11.15 for longer term working. The results of the t-test were not significant (t=-1.172 (d.f.=37) $p>0.05$, d=1.23). The means and standard

deviations for the depersonalisation subscale were M = 7.50, SD = 4.37 for short term working and M = 6.88, SD = 6.01 for longer term working. The results of the t-test were not significant (t=-.372 (d.f.=37) p>0.05, d=0.27). The means and standard deviation for the personal accomplishment subscale were M = 34.09, SD = 7.99 for short term working and M = 36.53, SD = 3.71 for longer term working. The results of the t-test were not significant (t=1.163 (d.f.=37) p>0.05, d=-1.01). For all three subscales there were no significant differences identified between the nurses working in the short term compared to the nurses working over the longer term. This suggests that there were no differences in the levels of burnout experienced whether you work in the short term or over the longer term. Job selection, level of engagement in job and occupational commitment could also have explained the absence of a significant difference in burnout scores in nurses who work over the longer term versus those who work with individuals over the shorter term.

Using the factor interpretations to explore differences between nurses working in the short term versus those working over the longer term it can be observed that there are a number of factors that are represented by either short term working nurses versus others by longer term working nurses. Factors two, five and six are all represented with exemplar sorts from nurses who work in the short term. These factors represent a view of a deficit within the individual who self-harms and that there is a need to protect yourself when working with self-harm are both held. Additionally, factor six expresses that individuals are depersonalised by staff which can be suggested to be a further strategy to manage emotional demands of working with individuals who self-harm.

Factors three, four, seven and eight are all represented by longer term working nurses. Self-harm as a way of manipulating others was raised by two of these factors which is in contrast to the view held by the shorter term staff that self-harm is a deficit in an individual. Interestingly, factor one which is the most positive factor contained a spread of the types of nurses in this study which is likely to explain the non significant result in the correlation.

Research Question Three

How do nurses benefit from training?

Independent Samples t-tests were used to explore whether receiving training specifically on self-harm or that discussed self-harm leads to lower burnout indices. The first group of t-tests explored the relationship between burnout scores and attendance on training specifically for self-harm (see table 7). All three t- tests were not significant (Emotional Exhaustion: $t=-.729$ ($d.f.= 37$) $p>0.05$, $d=-0.77$; Depersonalisation: $t= -1.476$ ($d.f.= 37$) $p>0.05$, $d=-1.11$; Personal Accomplishment: $t= 1.801$ ($d.f.= 37$) $p>0.05$, $d=1.57$) These results show that attendance on a training course specifically for self-harm does not impact on scores on burnout indices.

The second group of t-tests explored the relationship between burnout scores and attendance on training which discussed self-harm (see table 8 below). Two of the results for these t-tests were not significant (Emotional Exhaustion: $t=-.132$ ($d.f.=37$) $p>0.05$, $d=-0.14$; Depersonalisation: $t=.256$ ($d.f.=37$) $p>0.05$, $d=0.19$) and one of the results was significant (Personal Accomplishment: $t=2.381$ ($d.f.=37$) $p< 0.05$, $d=-6.34$). These results show that attendance on a training course that discussed self-

harm does not impact on scores on the emotional exhaustion and depersonalisation subscales for burnout but does have an impact on increasing the level of personal accomplishment.

Overall, these results suggest that training that discussed self-harm has a positive impact on an individual's sense of personal accomplishment.

Table 7: Results of t-tests exploring levels of burnout and attendance at training specifically for self-harm

	N	Mean (M)	Standard Deviation (SD)	Mean Difference	95% Confidence Interval	t Score	d.f. score	Significance (2-tailed)
EE					-9.70 – 4.56	-.729	37	p<.470
Attended Training	15	18.27	12.45	-2.57				
Did not Attend	24	20.83	9.47	-2.57				
DP					-5.77 – .907	-1.476	37	p<.148
Attended Training	15	5.73	4.15	-2.43				
Did not Attend	24	8.17	5.47	-2.43				
PA					-.469 - 7.986	1.801	37	p<.080
Attended Training	15	37.47	4.07	3.76				
Did not Attend	24	33.71	7.39	3.76				

Key: EE = Emotional Exhaustion DP = Depersonalisation PA = Personal Accomplishment

Table 8: Results of t-tests exploring levels of burnout and attendance at training that discussed self-harm

	N	Mean (M)	Standard Deviation (SD)	Mean Difference	95% Confidence Interval	t Score	d.f. score	Significance (2-tailed)
EE				-.457	-7.50 – 6.59	-.132	37	.896
Attended Training	17	19.59	12.65					
Did not Attend	22	20.05	9.07					
DP				.425	-2.94 – 3.79	.256	37	.800
Attended Training	17	7.47	6.53					
Did not Attend	22	7.05	3.77					
PA				4.73	- .704 – 8.76	2.381	37	.023
Attended Training	17	37.82	4.35					
Did not Attend	22	33.09	7.24					

Key: EE = Emotional Exhaustion DP = Depersonalisation PA = Personal Accomplishment

Discussion

This study explored nurses' perceptions of self-harm. Eight accounts of different beliefs and attitudes towards self-harm were obtained through the factor analysis of the Q sort statements. The eight accounts identified in this study do not represent the only attitudes that can be held towards self-harm, but the most dominant attitudes emerging from this study. Three research questions covered; attitudes towards self-harm, negative attitudes as a way of coping, negative attitudes and impact on service provision, short term versus longer term working with individuals who self-harm and impact of training. The research, theoretical, clinical and service implications and methodological issues from the findings are discussed.

Attitudes Towards Self-Harm

The findings in this study suggested that the majority of nurses hold positive views of self-harm, but find it difficult to understand why an individual would harm themself.

Previous research has suggested that negative perceptions are held towards self-harm (Holley, 2007; Huband *et al.* 2004; NICE, 2004; Slaven *et al.* 2002). The views represented by the eight accounts in this study do not wholly support this literature. Overall, the factors represented positive attempts to understand the individual who self-harms. For example, *Factor One: Taking it Seriously: Acceptance, Helping and Understanding* which accounted for the majority of the variance in this study suggested that nurses hold a positive, accepting and understanding view of self-harm. Self-harm was represented as an individual's way of coping with difficulties such as life events and relationships. Interpersonal relationships have previously

been documented as impacting on whether an individual self-harms (Pembroke *et al.* 1998; Simpson, 2006).

Throughout all of the factors there was a theme of struggling to understand self-harm. This struggle to understand is also described in self-harm literature (Raynor *et al.* 2003). Despite attempts to understand the individual who self-harms in all factors, there were also some negative views expressed in the factors. For example, in *Factor Four: Struggling to Understand: Alienation and Manipulation* and in *Factor Seven: Suicide and Manipulation,* self-harm was represented as a way to manipulate others and to gain a desired outcome.

NICE (2004) guidelines recommend that individuals who self-harm should receive a psychosocial assessment of need and risk, where individual reasons why self-harm has occurred are explored. The assessment needs to be completed in a respectful and empathetic manner. Whilst there were positive attempts in the results to understand the individual who self-harms, there were also aspects of the factors which did not support the NICE (2004) recommendations. Negative aspects included depersonalising of the individual *(Factor Six: Struggling to Understand: Conflict and Depersonalisation)*, considering all individuals who self-harm as an homongenous group with a deficit *(Factor Two: Taking it Seriously: A Medicalised View, Factor Three: Struggling to Understand: Ambivalence and Contradiction and Factor Eight: Struggling to understand: Conflicting views),* and that individuals who self-harm are fundamentally different from staff *(Factor Four: Struggling to Understand: Alienation and Manipulation).* Despite these negative views, *Factor Eight: Struggling to*

understand: Conflicting views, also represented attributing positive characteristics to individuals who self-harm.

In terms of defining self-harm, one of the key issues in the literature is the intent of the individual who self-harms. Previous literature has suggested that the aim of self-harm is death. Other studies have included suicide and attempted suicide when exploring the concept of self-harm (Anderson *et al.* 2003; Horrocks *et al.* 2003; McCann *et al.* 2007). In this study only one account(*Factor Seven: Suicide and Manipulation)* represented beliefs that a possible explanation why an individual would self-harm could be death. This account represented a small proportion of the variance in this study, suggesting that the majority of nurses viewed individuals who self-harm as not aiming to die and categorised suicide and self-harm as distinct areas. These findings support previous research which proposes that self-harm is not attempted suicide, but a way of coping, as a self-preserving strategy (Connors, (1996) as cited in Lindley Starr, 2004); Lindgren *et al.* 2004; McAllister, 2003; NSHN, 2006; Taylor, 2003).

Patterson *et al.* (2007) described how earlier in careers attitudes towards self-harm are positive but over time they become more negative when nurses are faced with recurrent episodes from individuals who self-harm. In contrast to Patterson *et al's.* (2007) findings, factor one in this study appeared to represent increased insight into individuals who self-harm as a nurse gained more years of experience. A possible confounding variable to this tentative conclusion is the impact of provision of training on self-harm. Receiving training on self-harm is also likely to impact on a nurse's level of insight into self-harm. Interestingly, the results in this study appear to support

the results of McAllister *et al.* (2002) whose factor analysis suggested that higher skilled nurses feel that their work with individuals who self-harm is more worthwhile, and this positively impacts on their attitudes to self-harm.

In sum, the beliefs and attitudes represented in this study are mainly positive, which contrasts with the majority of previous studies which have evidenced that nurses hold negative attitudes towards individuals who self-harm. However, there is a common theme of struggling to understand. Interestingly, all factors reject labeling, stigma, dehumanising and minimising responses. There are some negative aspects to the accounts of self-harm, which suggest a lack of understanding of self-harm and raise issues around the intent of individuals who self-harms, either by whether they wish to die or whether the aim of the self-harm is to manipulate others. Experience of staff has also been shown to positively impact on views of self-harm, which supports previous findings.

Explanations for Why Individuals Self-harm

There are multiple explanations why individuals self-harm provided in the literature. I found it helpful to group the factors into internal and external factors and self-harm as a way of coping. Internal reasons in the literature why an individual would harm themselves include poor mental health (Barr *et al.* 2004; Haw *et al.* 2001; NICE, 2004; Simpson, 2006) or a biological deficit in an individual (Dallam, 1997; Derouin *et al.* 2004). The findings in this study suggested that some nurses represented (factor two) self-harm as the result of a deficit in the individual, such as a mental illness or an addiction. This supports Barr *et al's.* (2004) propositions that individuals who self-harm have a mental illness. The accounts of attitudes to self-harm also

suggested that individuals who self-harm may have a deficit in their problem solving abilities (factors one, two, six and seven), are impulsive (factor three) and are fundamentally different to staff (factor four). Only one factor (factor eight) raised a possible biological aspect to self-harm in explaining the reason for the act of self-harm being due to enjoying pain.

External reasons provided in the literature why an individual harms themself are life events, such as sexual abuse, difficulties within interpersonal relationships, dissociation, sexuality, occupational pressures and feelings of hopelessness (Hawton *et al.* 2002; Himber, 1994; Lindley Starr, 2004; Matsumoto *et al.* 2004; Murray, 2003; Schoppman *et al.* 2007; Smith, 2002; Webb, 2002). The findings in this study support interpersonal relationship difficulties (factors one, two, five and eight) and struggling to manage difficult events (factors one, four and six) as the dominant explanations why an individual self-harms. In addition, two factors (factors one and three) also suggested financial problems as explanations why an individual self-harms.

Self-harm as a way of coping is represented in many aspects of the research literature (Derouin *et al.* 2004; Gratz, 2006; Jeffrey *et al.* 2002; McAllister, 2003; NSHN, 2006; Smith, 2002). The findings in this study supported these studies expressing self-harm as serving a coping function and was represented in a number of factors. Managing difficult feelings such as hopelessness or shame (all factors except factor seven) was the dominant explanation why individuals self-harm. However, other explanations for self-harm as a form of coping were; to affect change in others behaviour (factors four and seven), as attempted suicide (factors two and

seven), for attention (factor two) and to communicate distress (factor six). Given the high prevalence of self-harm as a way of coping with difficult emotions expressed in all but one of the factors, these findings suggest that self-harm as a way of coping is a widely held view and explanation for this behaviour.

In sum, the findings in this study supported previous research findings of possible explanations of self-harm. Internal factors, such as the presence of an underlying mental illness or biological deficit within the individual, external factors, such as interpersonal relationship difficulties, and struggling to manage difficult events and finally, self-harm as a way of coping with difficult feelings such as hopelessness are all possible explanations. Overall it could be proposed that in order to consider fully why an individual self-harms, staff need to consider the whole person, incorporating the internal and external factors and the strategies utilised to manage difficult events.

Negative Attitudes as a Way of Coping

None of the factors represented the view that negative beliefs are held as a way to protect them self. However, factor five (self protection) has been interpreted to represent how staff try to manage the negative impact that their work has on them as individuals. The negative impact is reflected in their scores which are within the moderate range for burnout. Demir *et al's.* (2003) study identified that as levels of burnout and negative attitudes increased, staff confidence in their abilities to provide an intervention were reduced.

The exemplar sorts in factor one are also represented by participants who have high burnout scores. An explanation for these high scores on the burnout indices could be

that nurses represented by factor one 'give more of themselves' to their work when they hold positive attitudes and this increases their scores on the emotional exhaustion subscale. If this is the case nurses would need to receive more support if they are to continue working over the longer term as high scores on the emotional exhaustion subscale is indicative of higher levels of burnout.

Another variable identified in this study that could have also impacted on nurses' level of burnout is their number of hours working. In this study, 31% of nurses reported working between 41-50 hours per week which is over the average working week of 37.5 hours. Longer working hours are likely to impact on nurses' burnout indices.

In sum, further research is needed to explore whether holding negative attitudes can impact on an individual's level of burnout.

Negative Attitudes and Impact on Service Provision

Previous research (NICE, 2004; Sadler, 2002) has suggested that there are punitive consequences for individuals who self-harm. None of the eight factors represented this view that negative attributions impact on the relationship with the individual who self-harms. However, it is important to consider the concept of social desirability in the nurses' reported responses as these findings could reflect nurses self-reported intentions to provide care and support. Although the nurses using Q Sort may not be aware of the impact of their attitudes on their actual care, at a conscious level their intention is reported. Despite the possible impact of social desirability, this study evidences progression and development of understanding and positive views as

previous studies that have also been subject to the effects of social desirability have still evidenced negative attitudes.

In sum, the results have not highlighted a factor which represented negative views having a negative impact on care-giving behaviour. The findings suggest tentative interpretations that holding some negative views whilst still attempting to understand does not impact on the provision of service. This suggests that further research needs to explore and clarify the relationship between attitudes and provision of services.

Short-Term versus Long-Term Work with Individuals who Self-Harm

Statistical analysis yielded no significant differences between levels of burnout in nurses working in the short term compared to nurses working over the longer term with individuals who self-harm.

Using the factor interpretations to explore differences between short term versus long term working, it was observed that factors two, five and six are all represented with exemplar sorts from nurses who work in the short term (A&E nurses). A previous study (Slaven *et al.* 2002) identified that A&E nurses lacked confidence, struggled with a lack of structure in services, avoided working with individuals who self-harm and found it difficult to understand why an individual would harm them self. Two propositions from Slaven *et al's.* (2002) study were supported in this study. These were; lacking in confidence to work with individuals who self-harm and struggling to understand the individual. Additionally, this study found that short term nurses viewed self-harm as a deficit within the individual, depersonalising the

individual and the need for self protection when working with self-harm. Factors three, four, seven and eight are all represented by longer term working nurses. Self-harm as a way of manipulating others was raised by two of these factors. Interestingly, factor one, which is the most positive factor, contained all of the types of nurses included in this study.

The comparison findings in this study add to the research literature, as only a few studies have focused on different groups of nurses. Sidley *et al.* (1996) included more than one type of nurse (general and A&E nurses) but did not analyse differences and focused on drug overdoses rather than generic self-harm. Anderson *et al.* (2003) did compare nurses (A&E and Mental Health) but intermittently used the term suicidal behaviour in the study. This study overcame both of these difficulties and supported Anderson *et al's.* (2003) findings, as sense of frustration, lack of understanding, importance of the relationship and concerns about the lack of specific strategies to use with individuals who self-harm were all identified.

In sum, although the clustering of statements into factors reveals the above, and that exemplar sorts that embody these attitudes are held by short term nurses, there was no significant differences between the long term and the short term group on standardised measures of burnout. Despite the lack of significance, this study adds to the research literature, as comparisons between nurses working in the short and long term have been made.

Clinical and Service Implications

The findings in this study suggest the majority of nurses hold positive views of self-harm, but that they struggled to understand why an individual would harm themself. The finding of positive attitudes suggest that service users are more likely to report a positive experience of services as attitudes had been reported as a major cause of their negative experience of services (NICE, 2004). However, nurses struggling to understand are also reported by service users to impact on their experience of services. Therefore, this lack of understanding needs to be addressed through training.

The findings highlighted that a greater level of experience in staff was related to more positive attitudes and that increasing understanding impacts on negative attitudes. These findings are important for clinical practice as they highlight areas of good practice within this health board since the majority of staff held positive views towards self-harm. These findings also identify the benefits of having experienced staff within a workforce, as they were more likely to hold positive attitudes. It would be important to utilise this experience of staff in the development of training packages as this would be beneficial for other nurses and would also empower staff who already have experience, knowledge and expertise.

Services need to recognise the impact on staff of working with individuals who self-harm. Information should be provided on alternative and adaptive strategies for managing the impact on them from their work. The impact on the organisation and individual from burnout is high. Various strategies have been proposed to address the levels of stress and burnout in nurses and provide support. They are all aimed at

enhancing the capacity of staff to manage the demands of their jobs. They include; relaxation, time management, assertiveness training, stress inoculation training, rational emotive therapy, meditation, training in interpersonal and social skills and teambuilding (Embriaco *et al.* 2007). Additionally, the quality of the relationships with other staff in teams has also been found to be a protective factor in the development of burnout. Aims should therefore be focused on improving communication and managing conflicts (Embriaco *et al.* 2007). This support should be available not just for managing the issues associated with working with self-harm but for more generic difficulties within the work. Finally, clinical supervision and staff training are also beneficial strategies which could also be utilised by services to improve staff wellbeing, reduce levels of burnout and improve individuals' sense of personal accomplishment.

NICE (2004) guidelines recommend training on self-harm for staff as a priority. The findings from this study suggest that the benefits of training specifically on self-harm and also training which discussed self-harm are beneficial for both staff's levels of personal accomplishment and their attitudes towards individuals who self-harm. Training for staff, therefore, needs to be prioritised.

Impact of Training

Jeffrey *et al.* (2002) proposed that training on self-harm was beneficial for staff as it increased their understanding of individuals who self-harm. NICE (2004) guidelines recommended that staff be provided with training to increase understanding of self-harm. Lack of understanding of self-harm has been suggested as a cause of service users negative experience of services (NICE, 2004). This study's findings supported

Jeffrey *et al's.* (2002) study showing that attending a training course which discussed self-harm does appear to have a positive impact on an individual's sense of personal accomplishment and their attitudes. Positive attitudes were held by nurses in factor one that had all received training that discussed self-harm. However, this study found that training does not impact on scores for the emotional exhaustion and depersonalisation burnout indices.

In contrast, only one of the staff had received training in factor two, and the rest had elevated burnout scores. Therefore, it could be argued that lack of training increased difficulties managing individuals who self-harm, as staff had elevated burnout scores. Interestingly, factor three was represented by a participant who had received no training. Despite their lack of training, their high levels of personal accomplishment scores could be suggested as a coping strategy which is protecting them from emotional exhaustion. Further research is needed to explore what other factors influence staff feelings of personal accomplishment

Training specifically on self-harm did not have a significant impact on scores whereas attendance at training that discussed self-harm did. This interesting finding could be explained by the content of the training being more beneficial in the discussion of self-harm training and that specific skills were obtained that aided management of self-harm. Additionally, whatever the other training focus was could be suggested to have had more impact on general skills and therefore reducing their burnout scores rather than courses specifically tailored for self-harm. Finally, it could also be possible that the courses specifically delivered on self-harm did not contain the necessary material or content or were not as accessible or helpful for nurses.

The findings in this study could be used to aid development of a training package for nurses. Issues raised in this study was a general theme of nurses struggling to understand as well as specific issues, such as depersonalising of the individual and considering individuals who self-harm as an homogenous group, viewing self-harmers as fundamentally different to staff, clarifying definitions (including the issue of intent in self-harm) and types of self-harm, explanations for why individuals self-harm, alternative strategies to self-harm and also ways of coping and burnout of staff.

In sum the findings in this study suggest that training which discussed self-harm benefited the participant's sense of personal accomplishment but further training is needed to promote understanding of individuals who self-harm.

Limitations of this Study and the Use of Q Sort Methodology

There are a number of limitations to this study. Firstly, the selection of statements used in a Q sort study is the responsibility of the researcher, so the effectiveness of the study is dependent on the sampling of the items (Cross, 2005). This limitation was overcome in this study by the use of multiple sources (review of the literature, pilot study, interviews, use of previous doctoral thesis) to develop the statements and eliminate any problems with the procedure and readability of the statements. Future Q sorts could benefit from interviews with a selection of the participants afterwards to clarify the factors or accounts interpreted. Future Q sorts would also benefit from the interviews with staff to be from the same staff group as the participants. In this study a Clinical Psychologist and a Consultant Psychiatrist were interviewed. They were selected for interview because of their knowledge, expertise and experience of

working with individuals who self-harm. It was also hoped that they may provide alternative perspectives to the coverage of the topic area by the statements as the extensive coverage of a topic area is vital for the quality of the statements generated. Although this could be suggested to be a limitation of this study, this study still improved its methodology on previous studies which did not utilise multiple sources to generate the statements for the Q sort.

Secondly, the level of face validity of the statements in this study could be questioned as three Clinical Psychologists not nurses were used to read the final statements. It is possible that these psychologists could have held a shared understanding of self-harm and may not have detected problems with wording due to their over familiarity with the area. This limitation has been raised but the level of impact this may have had on the statements is unclear as the main task of the reading of statements was for readability. This limitation could be overcome in future studies by the use of the target population of participants reading the statements prior to the study. However, in this study it is important to note that no participant reported difficulties with the readability of the statements.

Thirdly, social desirability could have affected the participants' sorts, reflecting how they perceive they should view individuals who self-harm rather than how they actually perceive them (Cross, 2005). The possible impact of social desirability was considered in this study by no direct observation when the participants were completing the study. A further issue in this study was the difference in profession between the participants and the researcher. It could be proposed that this difference could have further impacted on the participants 'actual' versus 'socially desirable'

responses. The researcher was aware of this potential issue and prior to pursuing ethical approval gained nursing management support for the research. The nursing management expressed no concerns about conflicts between professional groups and its impact on the responses of nurses. In addition, no staff reported problems with the completion of the Q sort with the contrary being raised by a number of the participants who reported that they enjoyed completing the study. In addition, Q sort is considered to be a way of obtaining perceptions which is conducive to individuals feeling able to express themselves without fear of negative evaluation, or at least for this fear to be minimised within the approach.

Fourthly, there could be other alternative explanations or interpretations of the factors than the interpretations provided by the researcher (Logan, 2007). This limitation was overcome in this study as the factors were independently interpreted by the researcher and their academic supervisor.

Fifthly, this study did not include measures of levels of engagement in a job, occupational commitment and whether their job was selected by the individual nurses. In any study it is necessary to be selective for areas in which to focus on. However, this study has highlighted these factors as important factors to consider in the future despite their exclusion in this study. Future research is needed to explore whether the presence of these factors moderate levels of burnout in nurses and impact on attitudes and beliefs towards self-harm.

Sixthly, the additional t-tests completed for research questions two and three were underpowered (Cohen, 1992) as the sample sizes were sufficient for Q sort

methodology and the resultant factor analysis but underpowered for the additional analyses. Underpowered tests suggest that the non significant results in all but one of the t-tests could be attributed to being underpowered rather than to an actual non significant result. The effect sizes were calculated for each of the tests as an effect size gives an estimate of the mean difference between the groups. Although five of the tests obtained large effect sizes (Cohen, 1992), the sample size of the groups in the tests where not large enough for this difference to exceed the critical value of t which is influenced by sample size. Despite the tests being underpowered, the large effect sizes suggest that future studies are needed to explore the relationships between length of time working and levels of burnout as well as the impact of training on levels of burnout. The statistical limitation could be overcome in future studies by using a larger sample size to build on the suggested results in this exploratory study. Seventhly, the use of Q sort methodology is not suitable for large scale studies where actual proportions of attitudes are required, as Q sort does not allow the differences between factors and associations to be established as statistically different (Baker *et al.* 2006; Logan, 2007). However, this was not the aim in this exploratory study and therefore Q sort methodology was appropriate in this study.

Eightly, this study did not use a random sample. Morecroft *et al.* (2005) described how the absence of random sampling makes generalisation to wider populations difficult. Random sampling is not required in a Q sort, as participants are selected to be representative of the target population. Participants' loading on each factor suggest their level of association with that factor which is representing a point of view and also the level of association between them and the other participants. Additionally, the goal of Q sort methodology is not to generalise, instead it aims to

identify multiple meaning that individuals might assign to a given concept and how these may differ to other individuals. It also helps us to systematically predict what variation impacts on meaning (Zechmeister, 2006). For this study the variations considered were burnout, length of experience, type of nurse and training.

Ninethly, a further limitation of this study could be the representativeness of its participants to the population of nurses from which it was drawn. Unfortunately, the researcher is unable to establish if this population was fully representative however, a number of steps were taken during the course of the study to attempt to overcome this limitation. This was completed by the researcher ensuring that all areas were represented by the participants. For example, A&E nurses were drawn from all three A&E departments in the health board. In addition, nurses were also drawn from each of the community teams in the health board. This was completed to ensure that the main differences between the areas within the health board, such as in terms of urban and rural, population density, socio-economic levels and health status could be included. A further issue with representativeness is that the participants volunteered for the study. This could suggest that the sample of nurses were different from the nurses who choose not to participate. It could be hypothesised that the nurses who chose not to participate could have held different views to self-harm. However, as this study was an exploratory study, future research is needed to further explore and clarify whether the attitudes in this study are generalisable to wider nurse groups.

Finally, this study focuses on PAT, A&E and community nurses whilst excluding inpatient and general nurses. The conclusions of this study are therefore limited to

these nurses, and the study does not offer us information on these other types of nurses or any information on attitudes held by other professional groups.

Strengths of this Study and Q Sort methodology

This study overcame many previous criticisms leveled at Q sort studies in its procedure; as best practice was established and followed after the review of the literature shown in table one in the methodology section. For example, in this study the researcher met with the participants rather than doing the Q sort via post. This overcame low response rates from previous Q sort research.

Q sort has been described as a less threatening way of addressing and accessing beliefs and thoughts about self-harm, as self-harm is not an area easily discussed. However, Q sort still provides a rich source of information (Raynor & Warner, 2003). Q sort has been suggested to explore and discover perceptions which are not anticipated by the researcher (Logan, 2007). Producing unexpected accounts, as has been done in this study, of positive views to self-harm is unlike other qualitative methods, as the participant controls the classification process rather than the researcher (Baker *et al.* 2006). The individual is able to decide the importance of statements and attributes, rather than discussing what is considered important by the researcher. Q Sort does not shape the participants' responses as, although the range and number of statements are predetermined, where the statements are ultimately placed is wholly decided by the participants (Morecroft *et al.* 2005).

In this study it could be suggested that Q sort methodology, as opposed to interviews, has been beneficial in exploring attitudes to self-harm, as the statements

about self-harm have covered a wider range of attributes which may not have been possible to cover in an interview, or may not have arisen in discussion, as some attitudes may have remained unspoken. The informal comments from the participants reported the process of Q sort as not distressing. In this way, Q sort could be suggested to make participation in research easier and simpler for those individuals who find expressing themselves difficult whilst avoiding excessive interviewer bias (Ockander *et al.* (2004).

Q sort methodology uses quantitative analysis (factor analysis) initially and then uses the yielded results to interpret the factor accounts by going back to the original data and statements in a qualitative way. This use of qualitative and quantitative analysis can be suggested to utilise the best aspects of each type of analysis. The quantitative analysis is necessary and helpful as it provides a simple structure to large quantities of data. However, with the interpretation of the factors considering the placement of statements for exemplar sorts this maintains the personal, rich accounts (Baker *et al.* 2006).

Q Sort methodology was utilised in this study following consideration of alternative methodologies. Q Sort methodology was specifically recommended by the NICE (2004) guidelines as a way to explore perceptions and attitudes to self-harm. There were a number of informal comments received from participants after completing the Q Sorts. One participant reflected on the process of completing the Q Sort. Some of the participants stated that completing the sorting of the statements had made them 'think', reflecting on their feelings towards individuals who self-harm and to consider how they defined self-harm. Specific comments about the practicalities of completing

the sort included difficulties with placing the statements and having mixed feelings about where to place the statements.

This study overcame some of the limitations and criticisms of previous studies exploring attitudes to self-harm by being clear in its usage of terms and definition of self-harm (Anderson *et al.* 2003), by conducting a pilot study (Jeffrey *et al.* 2002), and by having a larger sample size than other qualitative studies (O'Donovan *et al.* 2005; Jeffrey *et al.* 2002; Himber, 1994; Huband *et al.* 2004; Simpson, 2006). The study did not use hypothetical vignettes, as generalisability to actual situations is unclear and therefore results are inconclusive (McCann *et al.* 2007; McKay *et al.* 2005). The use of measures assessing suicidal attitudes was excluded and this overcame the main criticism of previous studies which have also proposed that nurses hold positive attitudes towards individuals who self-harm (Anderson, 1997; McCann *et al.* 2007). This study also had a range of levels of experience of service, age of nurses and a spread of differing types of nurses.

Future Research

This was an exploratory study into the beliefs, attitudes and perceptions of nurses working with individuals who self-harm. As an exploratory study, many questions have arisen through the course of the study which would be beneficial for future research.

Future research would be beneficial to explore whether other studies support the findings in this study of positive beliefs about self-harm in nurses and also comparing differences in types of nurses. This research would be helpful for tailoring training to

nurses' needs and may provide insight into the differences which may emerge due to the impact of different nurses roles on perceptions of self-harm. Further research would also be beneficial in exploring the impact of nurses working with self-harm and what could be provided to staff as a way to reduce their burnout, such as clinical supervision, training or structured peer support.

Theoretically, further research is needed to develop a comprehensive and integrative model and theory of self-harm. The model could incorporate the extensive research literature which provides different explanations for individuals self-harm, such as cognitive, behavioural, biological, psychodynamic and cultural theories.

Development and evaluation of a training package specifically for self-harm would also be useful. It has been suggested that if staff were trained in self-harm in a training package which had been designed with input from service users, this would then impact on the service provision provided by staff (Kapur, 2005). Additionally, the two scales developed for measuring attitudes to self-harm (Self-Harm Antipathy Scale (SHAS) Patterson *et al.* 2007); and (Attitudes Towards Deliberate Self-Harm Questionnaire (ADSHQ) McAllister *et al.* 2002) need further exploration into their reliability and validity. In addition, the data from this Q sort could be used to construct attitudes towards a self-harm questionnaire. This study has highlighted items that are least and most representative of this group of nurses and these could be utilised for a measure of attitudes. Finally, it would be helpful if Q Sort methodology as a research methodology was utilised more in research, as although there are limits to its generalisability and applicability, it has many benefits and participants report their involvement in Q Sort research as a positive experience.

Overall, this study challenges existing research on the pervasive assumption that nurses view individuals who self-harm negatively. Future research is needed to continue to explore this contentious issue. There is also further work to be completed, both clinically and at a service level, to help staff develop further insight into the individual who self-harms. There is a need to provide support, training and clinical supervision to staff in order to reduce their feelings of burnout. It is clear and a reason for hope that the majority of nurses in this study did appear to, '*Look at the individual, not the harm. Look at the person beyond the scars.*' as suggested by Sadler (2002).

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Q Sort Methodology

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Websites

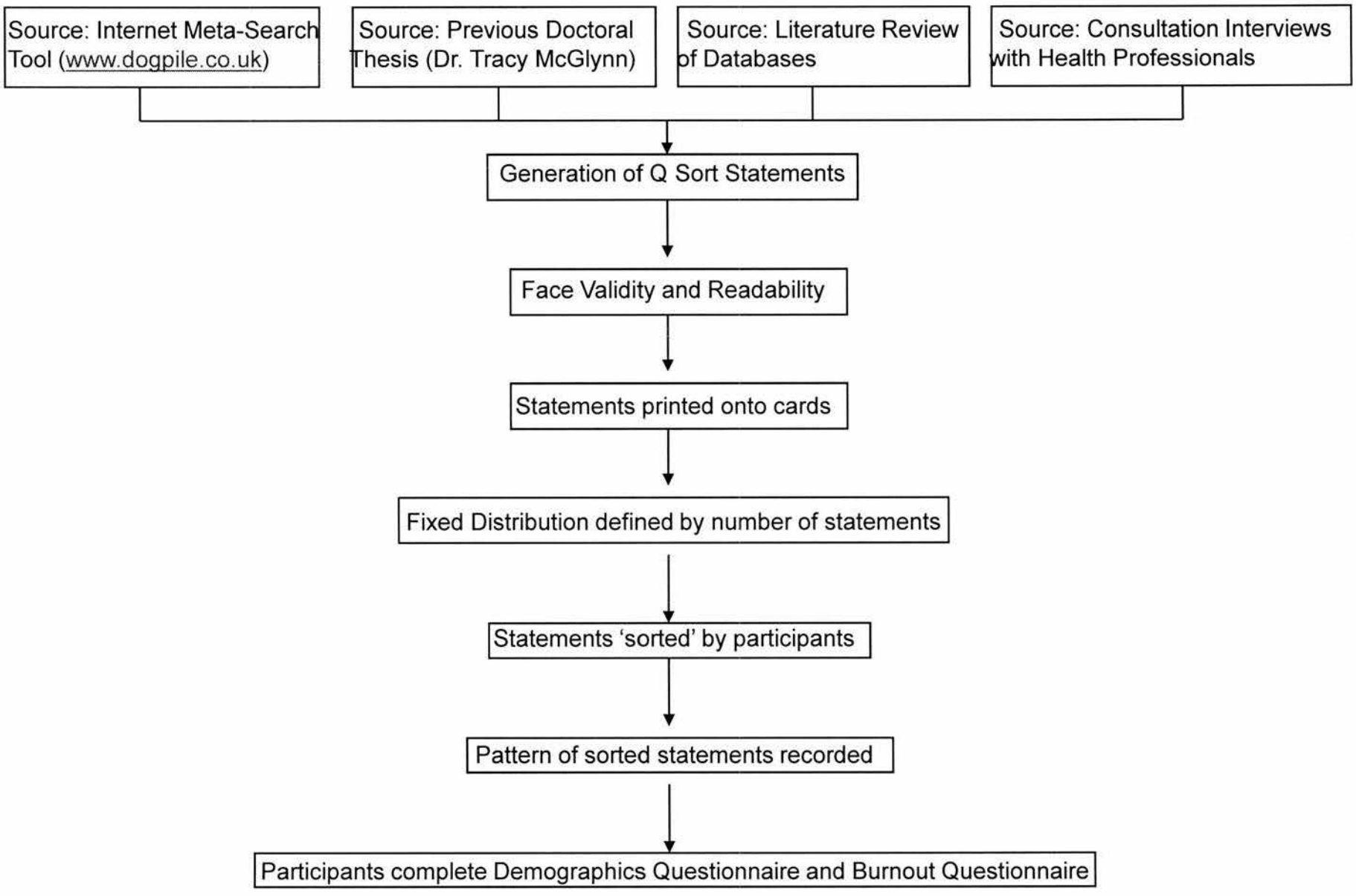
www.dogpile.co.uk

www.nshn.co.uk

Appendices

- 1 – Diagrammatic representation of methodology
- 2 – Self-harm statements
- 3 – Ethics approval letter
- 4 – Participants information sheet
- 5 – Q sort record form
- 6 – Participants consent form
- 7 – Demographics questionnaire
- 8 – Maslach Burnout Inventory

Protocol: Methodology



Q Sort Statements – Self-harm

1. There should be negative consequences for people who self-harm.
2. If they won't see a psychiatrist- they don't want to get better.
3. Individuals who self-harm are bad.
4. I can't make any difference to someone who self-harms.
5. It is difficult to hear someone discussing their self-harm.
6. Having difficulty managing individuals who self-harm means that you are not good at your job.
7. Individuals who self-harm are defective.
8. Family and friends can 'wash their hands' of individuals who self-harm.
9. It doesn't matter if the self-harmer is in pain.
10. Young people (below 25 years) are more likely to self-harm.
11. Self-harming is attention seeking.
12. If it's not an artery they don't mean it.
13. Self-harm is attempted suicide.
14. Self-harmers should always be referred to mental health services.
15. It is necessary to treat all individuals who self-harm in the same way.
16. There are no positive reasons for self-harming.
17. Individuals who self-harm are all the same.
18. Working with individuals who self-harm affects individuals confidence in their ability to do their job.
19. If you self-harm you are mentally ill.
20. There is nothing I can do to help someone who self-harms.
21. It is best to try to avoid working with individuals who self-harm.
22. Self-harmers enjoy pain.
23. Long term working with individuals who self-harm can lead to you feeling burnt out.
24. Self-harmers are unaware how potentially dangerous their actions can be.
25. Family and friends are sympathetic towards individuals who self-harm.
26. Individuals who self-harm make me irritated, frustrated or angry.
27. Individuals who self-harm are often hostile towards staff.
28. It is necessary to seek support from colleagues after working with an individual who has self-harmed.
29. I feel overwhelmed when working with individuals who self-harm.
30. If an individual who is treated for self-harm went on to kill themselves the health care staff would be responsible.
31. Individuals who self-harm often don't have a job.
32. Individuals who self-harm come from a lower social class.
33. Individuals who self-harm have poor physical health.
34. Financial problems can cause someone to self-harm.
35. Individuals who self-harm receive better support if they also have a diagnosed mental health problem.
36. Self-harmers take up a lot of my time.
37. Individuals will grow out of self-harm.
38. Self-harm is self inflicted so it's not serious.
39. Individuals who self-harm are immature.
40. People who self-harm bring bad things on themselves.
41. What the person does immediately after they self-harm tells us whether they were serious or not.

42. There are no similarities between me and a person who self-harms.
43. People self-harm as they struggle with things that have happened to them in their lives.
44. Self-harmers are manipulative.
45. Self-harmers have a personality disorder.
46. There are different reasons why males and females self-harm.
47. Individuals who self-harm live alone.
48. Individuals who self-harm have often misused substances.
49. I feel pressure to make things better for the person who self-harms.
50. People who self-harm use a wide range of behaviours.
51. Self-harm is one way of preventing an actual suicide attempt.
52. People who self-harm cost the NHS lots.
53. Self-harm is a way to affect change in the behaviour of another person.
54. It is necessary to take a break after working with a person who has self-harmed.
55. Individuals who self-harm can be likeable.
56. Working with self-harm can be anxiety provoking.
57. People who self-harm feel shame.
58. Interpersonal difficulties can cause someone to self-harm.
59. Individuals who self-harm feel hopeless.
60. It is never good to harm yourself.
61. Individuals who self-harm find it difficult to problem solve.
62. Individuals who self-harm are impulsive.
63. When working with individuals who self-harm you need to have a consistent approach.
64. People who self-harm are used to receiving negative reactions.
65. I have the skills to work with someone who has self-harmed.
66. Self-harmers dislike themselves.
67. Self-harm occurs when a person feels alone.
68. Individuals who self-harm divert resources from those who need them.
69. It is necessary to understand why the individual has self-harmed.
70. Nothing can be done to prevent someone from self-harming.
71. If I help a self-harmer with treatment following their self-harm it will encourage them to do it again.
72. Suicide is self-harm gone wrong.
73. Self-harm communicates emotions and distress.
74. I can't understand why someone would want to self-harm.
75. Self-harming is addictive.
76. Self-harmers often leave before their treatment is finished or disengage from services.
77. The way I treat a person with self-harm affects whether they will self-harm again.
78. The motivation to change of the person effects treatment of self-harm.
79. There should be specialist teams for self-harmers.
80. Over time I have felt better about working with people who self-harm.
81. Sometimes it's hard to decide what to do with someone who self-harms.
82. Self-harm is a way to manage difficult feelings.
83. After self-harming individuals should be admitted into hospital.

received 23/07/07

Telephone:
Facsimile:

13 July 2007

Trainee Clinical Psychologist

Dear Miss Dewis

Full title of study: **An exploratory study into the factors that influence nursing staffâ€™s attributions, beliefs and behaviour towards individuals who self harm.**

REC reference number: **07/S1001/30**

Thank you for your letter of , responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Application	5.3	30 May 2007

Investigator CV	1	30 May 2007
Protocol	1	30 May 2007
Covering Letter	1	25 May 2007
Summary/Synopsis	1	30 May 2007
Letter from Sponsor	1	30 May 2007
Compensation Arrangements	1	28 July 2006
Questionnaire: Quest	1	30 May 2007
Questionnaire: Quest	1	30 May 2007
Letter of invitation to participant	1	30 May 2007
Participant Information Sheet: PIS	1	30 May 2007
Participant Consent Form: PCF	1	30 May 2007
Response to Request for Further Information		
Postet	1	30 May 2007
Letter	1	25 May 2007
CV	1	30 May 2007

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from http://www.rdforum.nhs.uk/rdform.htm.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Feedback on the application process

Now that you have completed the application process you are invited to give your view of the service you received from the National Research Ethics Service. If you wish to make your views known please use the feedback form available on the NRES website at:

https://www.nresform.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx

We value your views and comments and will use them to inform the operational process and further improve our service.

07/S1001/30	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

SECRETARY TO THE GROUP

Enclosures: *Standard approval conditions [SL-AC1 for CTIMPs, SL-AC2 for other studies]*

Participant Information

My name is Sally Dewis and I am a Trainee Clinical Psychologist currently studying for my Doctorate in Clinical Psychology supervised by xxxxxxxxxxxxxxxx (Clinical Psychologist at the University of Edinburgh) and xxxxxxxxxxxxxx (Clinical Psychologist working in NHS xxxxxxxxxxxx). You are being invited to take part in a study examining Nurse's perceptions of individuals who self harm. Please read the following consent form before deciding if you wish to take part in this study.

Individuals who self harm can be difficult to work with. We are hoping to explore what some of the difficulties are. We are also interested in how working with self harm affects you. We will meet and I will give you information about the study. If you decide to take part in the study you can contact me at xxxxxxxxxxxxx Hospital on Tel: xxxxxxxxxxx and we will arrange a time I can come and meet you. In the study you will be asked to read carefully statements given to you that will be written on cards. You will then sort the cards into categories of how much you agree or disagree with the statements. Finally, I would like you to complete 2 questionnaires, asking about how you feel when you are at work and some general information about you, such as, your age, length of time since qualified and training you have completed. I will not ask your name.

You are free to withdraw from this study at any time if you wish for whatever reason with no detrimental consequences. At the bottom of this sheet are some helpline numbers. The results of the study will be available for you to see if you wish. If you have any questions regarding the study please ask prior to starting or at the end. However, if you have concerns or are distressed about the content of the study, please feel free to speak to the researcher at any time during the study or contact one of the helpline numbers provided if after the study. If you wish to make a complaint about this study you may contact xxxxxxxxxxxxxxx (Consultant Clinical Psychologist and Course Director of the Doctorate in Clinical Psychology at the University of Edinburgh) on xxxxxxxxxxxxx.

All responses that you give are to be kept totally confidential with no individual responses being identified as the records kept will have a code number and not your name. They will only be seen by the researcher for the present purposes of this study. The sorting of the statements and completion of the questionnaires should take approximately 45 minutes. If you are happy to take part in this study please give your consent by signing overleaf.
All cooperation will be greatly appreciated.

Helpline Numbers: **The Samaritans**: 08457 90 90 90; **Breathing Space:** 0800 83 85 87

Participant Number:

-5	-4	-3	-2	-1	N/A	+1	+2	+3	+4	+5
X										X
X										X
X	X								X	X
X	X								X	X
X	X	X						X	X	X
X	X	X						X	X	X
X	X	X	X				X	X	X	X
X	X	X	X				X	X	X	X
X	X	X	X	X		X	X	X	X	X
X	X	X	X	X		X	X	X	X	X
3	5	7	9	11	13	11	9	7	5	3

Participant Consent Form

Thank you for your co-operation with this study.

I agree to take part in this study and fully understand the above:

Signed:_____

Print Name:_____

Demographics Questionnaire

Please circle the most appropriate response.

Age:

Below 20 21-30 31-40 41-50 51-60 61+

Gender:

Female Male

Type of Nurse:

Accident and Emergency Psychiatric Liaison Community/Team

Length of Time Qualified:

Less than 1yr 2-5yrs 6-10yrs 11-15yrs 16-20yrs 21+yrs

Average Number of Hours Worked in One Week:

Less than 10hrs 11-20hrs 21-30hrs 31-40hrs 41-50hrs 50+hrs

Training Completed Specifically on Self-Harm:

Yes No

If yes, please give details

.....
.....

Training Completed That Discussed Self-Harm:

Yes No

If yes, please give details of training

.....
.....

Thank you for your time.

Christina Maslach and Susan E. Jackson

Human Services Survey

The purpose of this survey is to discover how various persons in the human services or helping professions view their jobs and the people with whom they work closely. Because persons in a wide variety of occupations will answer this survey, it uses the terms ***recipients*** to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as the recipients of the service you provide, even though you may use another term in your work.

On the following page there are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about ***your job***. If you have ***never*** had this feeling, write a "0" (zero) before the statement. If you have had this feeling, indicate ***how often*** you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

Example:

HOW OFTEN:	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Never	**A few times a year or less**	**Once a month or less**	**A few times a month**	**Once a week**	**A few times a week**	**Every day**

HOW OFTEN:
0 - 6 **Statement:**

_____ **I feel depressed at work.**

If you ***never*** feel depressed at work, you should write the number "0" (zero) under the heading "HOW OFTEN". If you ***rarely*** feel depressed at work (a few times a year or less), you would write number "1". If your feelings of depression are ***fairly frequent*** (a few times a week, but not daily) you would write a "5".

Human Services Survey

HOW OFTEN:	0 Never	1 A few times a year or less	2 Once a month or less	3 A few times a month	4 Once a week	5 A few times a week	6 Every day

HOW OFTEN 0 – 6	Statements:
1. _____	I feel emotionally drained from my work.
2. _____	I feel used up at the end of the workday.
3. _____	I feel fatigued when I get up in the morning and have to face another day on the job.
4. _____	I can easily understand how my recipients feel about things.
5. _____	I feel I treat some recipients as if they were impersonal objects.
6. _____	Working with people all day is really a strain for me.
7. _____	I deal very effectively with the problems of my recipients.
8. _____	I feel burned out from my work.
9. _____	I feel I am positively influencing other people's lives through my work.
10._____	I'm becoming more callous towards people since I took this job.
11._____	I worry that this job is hardening me emotionally.
12._____	I feel very energetic.
13._____	I feel frustrated by my job.
14._____	I feel I'm working too hard on my job.
15._____	I don't really care what happens to some recipients.
16._____	Working with people directly puts too much stress on me.
17._____	I can easily create a relaxed atmosphere with my recipients.
18._____	I feel exhilarated after working closely with my recipients.
19._____	I have accomplished many worthwhile things in this job.
20._____	I feel like I'm at the end of my rope.
21._____	In my work, I deal with emotional problems very calmly.
22._____	I feel recipients blame me for some of their problems.