CHAPTER ONE

INTRODUCTION

1.1: Layout of Study

"Behaviour is a mirror in which everyone shows his or her image" (Goethe, 1749-1832).

It seems fitting and proper to start a discussion on self-harm with a famous quotation on behaviour arising out of the 17th Century by a famous German philosopher, Johann Wolfgang Von Goethe (1749-1832). These words of Goethe, which are not exclusive to psychological and sociological academe, are reminders to all mankind that every behaviour has an underlining meaning, which is implicitly and sometimes explicitly communicated to others. Reiterating this, many people including the researcher of this study believe that some human behaviours tend to speak of distress (Favazza, 1996). It is noteworthy that self-harm is one such behaviour which provides expression of ulterior feelings both to oneself and others of unbearable experiences (Babiker and Arnold, 1997). Even though this assertion is at odds with the view of some clinicians, it is important to emphasise that the sources of these experiences are wide ranging.

Self-harm is sometimes claimed to be a function of unpleasant physical and sexual abuse encounters during childhood. On exploring the literature, one distinct pervasive feature of abuse is the demand for secrecy and silence (Bywaters and Rolfe, 2000). Explicitly, victims of abuse who wish to be heard are forbidden by abusers from speaking or telling of their experiences. Taking a psychodynamic stance, such forbiddance is a sufficient condition for generating anxiety; an anxiety that requires safe expression for mental health promotion. Self-harm is considered by people who engage in it as a safe means of expressing anxiety and telling an unspeakable secret or story (Pembroke, 1998; Sadler, 2002). People who self-harm and receive psychiatric care are referred to in this thesis as service users.

Today, the concept of attitude is one of the focuses of attention in clinical settings in explaining human behaviour. While there is a paucity of studies on attitudes and self-harm, noted in some of these studies is a degree of association between these two phenomena. Hemmings (1999) reinforces this view by asserting that healthcare professionals` negative attitudes, which are sometimes expressed towards service users, are considered as significant

contributory factors for the initiation and repetition of self-harming behaviours. The use of the term healthcare professional in this thesis mainly relates to psychiatric nurses in close contact with service users in the context of care provision.

From a service user's perspective negative attitudes serve as reminders of past abusive experiences, which generate anxiety that can sometimes be expressed using self-harm as a safe outlet (Harrison, 1995; Pembroke, 1998). Negative attitudes are not uncommon among healthcare professionals in secure settings, a setting where service users with mental disorders and criminal histories are cared for. This seems to explain the increase in incidence and prevalence of self-harm in these settings. Despite this, only very few studies have explored the relationship between self-harm and healthcare professionals` attitudes. This study therefore aims to examine this relationship in secure settings using a multi-method phenomenological methodology.

Paradoxically, given the increasing familiarity of self-harm among clinicians and researchers, one would assume the existence of a universally accepted definition of this concept. Apparently, this is not the case. It is therefore not surprising that researchers and clinicians have over the years used a plethora of terminologies, such as deliberate self-harm, self-mutilation, parasuicide and attempted suicide, in describing self-harming behaviour. This use of different terminologies not only causes confusion for service users but also for clinicians and researchers alike.

Linked to this terminological confusion, a number of researchers have described self-harm as a complex behaviour, with its variants existing on a self-harm-suicide continuum (Stanley *et al*. 1992). This complexity does not only promote the use of different terms (mentioned above) in referring to the same or different acts of self-harm, but it also seems to contribute to the difficulty in formulating a universally recognised definition of this concept. To minimise conceptual confusion and to enhance healthcare professionals' and researchers` insight into self-harm, it is important, although seemingly difficult, to develop a universal definition of this phenomenon, taking into consideration its essential feature of intent. This assertion raises an important question that requires a response. How, without an accepted conceptualisation of self-harm, can researchers and clinicians be sure that they are examining the same phenomenon? Even though a response to this question is beyond the remit of this research study, one would highlight that it has been a bone of contention for researchers and

clinicians, as acts of self-harm differ, sometimes significantly from one another. While it is not the purpose of this study to put forward an all round definition of self-harm to encompass all its variants, it is essential to provide an operational definition that will create a clear sense of direction for the entire research study. To do this, a number of extant definitions are examined. Starting with Favazza`s (1989:137) definition, which considers self-harm to be:

> *The deliberate destruction or alteration of body tissues without conscious suicidal intent… and if habitual, may best be thought of as a purposeful, if morbid, act of self-help.*

Although intent seems to be central to this definition, it excludes self-poisoning, which is sometimes considered by some researchers, such as McKinley *et al* (2001) and Haw *et al* (2007:108), as a separate self-harming category. They refer to it as:

> *The intentional ingestion of a substance in excess of the recommended dose either through accident or with the goal of deliberate self-harm.*

Even though healthcare professionals and service users give importance to the intentions of the acts of self-harm, some definitions are in the main descriptive of the behaviours they define. For example, Babiker and Arnold (1997:2) refer to self-harm as *an act of deliberately inflicting pain or injury to one's body, but without suicidal intent.*

While this definition appears to be a deliberate attempt to exclude suicidal intent when referring to self-harm, it is broad as it seems to include a range of self-harming behaviours, such as cutting, insertion of objects and self-poisoning. Such an attempt to exclude suicidal intent renders this definition limited. It is based on the difficulties of establishing intention, a subjective context-specific concept, which is often not expressed by service users within secure settings even when engaged in severely dangerous behaviours (Livingstone, 1997*).* Dangerous behaviours may include cutting delicate parts of the body, such as the neck. Acknowledging this difficulty of establishing intentions and the lack of uniformity of definitions, this study employs Beasley's (1999/2000:21) definition as it seems to encompass a wide spectrum of self-harming behaviours. It states:

> *Self-harm is any behaviour, initiated by an individual, regardless of intent, which directly results in harm to any part of the body of that individual.*

Interestingly, the use of the phrase "regardless of suicidal intent" in this definition enables it to bridge the gap between self-harm and suicide. Taking this stance enables it to encompass a broad spectrum of self-harming behaviours, including self-mutilation,

which is commonly noted in secure environments. Although self-mutilation is the most common approach used by service users to self-harm in secure settings, this study adopts a generic approach of exploring attitudes towards all acts of self-harm in these settings. Hence, Beasley's (1999/2000) definition is therefore considered the most appropriate for the study, as it includes its essential characteristics. Discussions of these characteristics ensuing from the study are included in the following chapters. The chapters of this thesis are divided into two complementary parts that takes readers on a journey from the point the researcher decided to undertake the study to its results and discussion.

Part 1: This section is made up of four chapters. Chapter two sets the scene for discussion by providing a background to the study and a rationale for undertaking the same. The issues outlined in this are expanded on in chapter three, the literature review. It begins by offering an historical perspective of self-harm, including comparative views of past and present acts of this behaviour and attitudes towards it. Self-harming behaviours are sometimes very difficult to separate from suicide attempts. The literature review chapter thus includes a self-harm-suicide debate section, which includes discursive attempts to distinguish between these two phenomena. The chapter then focuses on a discussion of the incidence, prevalence and repetition of self-harm before concentrating on examining the characteristics of service users who self-harm and the reasons or motivations for their behaviour. This is then followed by an exploration of the impact of self-harm on both service users and healthcare professionals. Explanations for the occurrence of self-harming behaviours need to be presented. In light of this, the literature review chapter includes an examination of the possible theoretical explanations of self-harm. This chapter is drawn to a close with an exploration of the concept of attitude, attitude formation, theoretical frameworks underpinning the study, and an examination of the differing perspectives of service users and healthcare professionals about self-harming behaviour.

Chapter four illustrates the methodological issues relevant to the study. It includes a summary of the quantitative-qualitative paradigm debate, including discussions that influenced the decision of opting for the methodology of this inquiry; phenomenology. Following this is an overview of phenomenological methodology with a clear illustration of a rationale for choosing this tradition for the study. The chapter also includes a discussion of the rationale for multi-methods. It concludes with discussions of the

designated data collection strategies, individual and focus group interviews, employed within the chosen methodology.

Chapter five focuses on the processes of data collection and how the data were analysed. Self-harm is an emotive subject. Discussing it at interviews may distress participants. So, ethical considerations, such as informed consent, accessing participants and issues around providing psychological support to participants when indicated, are offered. The sampling procedure within the data collection process is debated. This is to offer insight into both its strengths and weaknesses. Closely linked with this is a discussion of the utilisation of key informants to inform and assist with the development of possible themes for the inquiry. The thesis then offers an examination of the conduct of the pilot interviews. These interviews were undertaken to refine the themes for the inquiry and to enhance the researcher's interviewing skills. Following this is a close examination of the main interviews. The chapter concludes with discussions of data analysis, which includes an illustration of the transcription process and a presentation of a rationale and structure of the analytical framework, Interpretative Phenomenological Analysis (IPA), adopted in this inquiry. Following this is a clear demonstration of the application of this analytical process to both the individual and focus group interviews` data using the IPA framework.

Part 2: This section concerns the findings of the study and their interpretations. It consists of five chapters. The first four chapters, six to nine, focus on the results or findings. The findings are set out in sufficient detail to reflect the study methodology. These include detailed descriptive extracts from transcripts that illustrate the views of participants. Such presentation hopes to ensure adequate understanding of the context from which the data are generated. Chapter ten is an expansion of the result chapters. It is mainly a discussion of the analysed individual and focus group data. Included in this chapter is also a discussion on anxiety and organisational structures. Chapter eleven, which is the final element of this section, examines relevant factors that illustrate the rigour and credibility of the study data and its interpretation. Among other things, the chapter also serves to highlight the implications of study outcomes for practice, both for service users and healthcare professionals. The researcher believes that some of these implications may have negative effects on service users and healthcare professionals in clinical practice. Such implications therefore need good practice recommendations to

address them. The recommendations for good practice and conclusion are therefore set out in this chapter. What are also included in this chapter are the unique contributions made by the study to this research area; self-harm.

With regard to the conclusion, it commences with a presentation of generic summaries relating to the appropriateness and efficacy of the study methodology, including methods of data collection and the IPA framework for analysis. A resume of participants` perceptions or attitudes towards self-harm is then offered. This, in essence, relates to their views of self-harm and their likely responses to self-harming behaviours.

PART ONE: CONCEPTS, CONTEXT AND CONDUCT OF THE STUDY

CHAPTER TWO

SETTING THE SCENE

2.1: Introduction

There are presently growing concerns among clinicians, researchers, carers and service users about the increasing incidence of self-harming behaviour. These concerns have resulted in the generation and publication of both professional and non-professional material on the subject. The process of examining this material for the purposes of this research project serves to underline the diversity of available literature and the complex nature of self-harm. The intention is to create a context from which the researcher hopes to develop strategies for exploring attitudes of psychiatric nurses in secure settings towards self-harm. This chapter thus starts with the provision of a background to the study, which is simply a resume of the circumstances that led to its development. Following this is a detailed discussion of uniqueness of the study and the reasons for undertaking the same.

2.2: Background to the Study

The behaviour of self-harm has occurred throughout recorded history and has been noted to be a significant universal feature of human societies, which has had important functions for groups and societies throughout all eras (Cook *et al*. 2004). In other words, the concept of self-harm is a world-wide phenomenon, serving important functions, such as expression of distress. In the past and even today, individuals who self-harm usually experience some degree of distress (Cutcliffe and Stevenson, 2007). These individuals tend to draw on a repertoire of human behaviour and experiences in their search for ways of relieving and resolving their difficulties or distress (Fish, 2000). Self-harm is one such multifunctional behaviour used by individuals in creating psychological safety, relieving psychological pain and for punishment and preservation of self (Babiker and Arnold, 1997). Yet, it is often associated with negative connotations by those who do not engage in it. They tend to describe it as incomprehensible, loathsome, frightening and shocking (Favazza, 1987; Crawford *et al.* 2003). Succinctly, there is a differential perception of self-harming behaviour between those who self-harm and those who do not, with the former having positive views about it, purely because of its useful functions, and the latter considering it to be a negative human activity.

Self-harm is now recognised in the United Kingdom (UK) and other parts of the world as a significant and preventable behaviour (Clarke *et al*. 2002). It is a behaviour that is found to be highly contagious among service users, particularly in ward-based clinical settings (Hawton *et al,* 1997). It is therefore not surprising that self-harming behaviour exhibited by service users may persist over many years. This view is reiterated by Arnold (1995), who noted in one of her studies that this behaviour tends to be a periodic feature of women's lives for very substantial periods.

It is highlighted in a wide range of studies that approximately 4% of the United Kingdom general population engage in some form of self-harm, a behaviour which is now noted to be one of the commonest causes of admission for both adults and adolescents to general and psychiatric hospitals (Wilhelm *et al.* 2000; Jeffrey and Warm, 2002). While the incidence of self-harm is observed to have been steadily increasing in recent years in the UK, with an estimated rate of 170000 presentations per year, it is also observed to be the highest in Europe (Hawton *et al.* 1997; NHS Centre for Reviews and Dissemination, 1998). Arguably, self-harm is becoming a common behaviour in both general and clinical populations, with the latter experiencing a higher incidence of the same. In secure settings, for example, self-harm is increasing and most of the incidents of self-harm are attributable to a small number of service users (Beasley, 1999/2000). The statistics indicating this increase are likely to be an underestimate, as most acts of self-harm take place in private and are never brought to the attention of social and health services (Bywaters and Rolfe, 2002). This could be attributable to service provision concentrating on physical injury rather than the underlying distress that motivated the behaviour in the first place.

The focus on physical injuries does not only seem to reflect the anxieties and distress that healthcare professionals experience in managing self-harming service users, but it also indicates, as stated by United Kingdom Royal College of Psychiatrists(RCP) (1994; 2004), their misunderstanding of this behaviour and / or lack of specialised knowledge to manage the same. Clark (2002) and Tantam and Huband (2009) confirm this by claiming that self-harm is sometimes misunderstood by healthcare staff despite its increasing familiarity and the provision of guidance for its management. As a consequence, the services provided to service users experiencing this behaviour can be inadequate and sometimes inappropriate. McAllister *et al* (2003), in their study reiterate this view by articulating that service users tend to perceive in clinicians an absence of empathy, rejection and hopelessness. Such

experiences of healthcare can be traumatic and invalidating for service users and may even precipitate the need for further self-harm.

Varying attitudes have been observed among healthcare staff in relation to the different self-harming approaches used by service users. They are generally more sympathetic to service users who take overdoses, especially when seen as attempted suicide, than to those who cut themselves (Clarke and Whittaker, 1998). Thus, service users are more likely to receive positive responses from healthcare staff when they openly declare their behaviours as suicide attempts. This indicates the existence of a gap between service users` and healthcare professionals` perceptions of self-harm. Put in another way, the issues that may be perceived to be important by service users may not be considered to be so by healthcare professionals. To bridge this gap, more work needs to be done to improve healthcare professionals` understanding of self-harm and its management.

Differential attitudes towards self-harm have also been noted to exist among healthcare professional groups. Nurses are generally more willing to provide help to self-harming service users than are doctors (Ramon *et al*. 1975). This can be encouraging for service users as nurses are the largest health professional group providing more service user-care time. Self-harming behaviours are not just a function of negative attitudes of healthcare staff, but are also sometimes psychotically motivated and are associated with a wide range of psychiatric disorders, including depression and personality disorder (Camilla *et al.* 2001). However, in secure environments, service users with personality disorder tend to engage in self-harming behaviour more than those in other diagnostic categories (Camilla *et al*. 2001). Although it is traditionally believed to be a female dominated activity (Sidley and Renton, 1996), there is growing evidence to suggest that it is equally prevalent in both sexes diagnosed with personality disorder (Clarke and Whittaker, 1998). Additionally, a number of research studies highlight that self-harm predominantly occurs in younger service users, who have a high probability of repeatedly engaging in this behaviour (Warm *et al.* 2002).

A number of follow-up studies indicate that up to a quarter of service users who self-harm repeat their behaviour in the year following the index episode, a repetition which tends to increase the risk of further self-harm (Owens *et al*, 2002; Hawton *et al*. 2004) and eventual suicide (Hawton and Fagg, 1988; Tejedor *et al*. 1999; Hawton *et al*. 2003). Reflecting on clinical experience and actuarial variables implicated in suicidal behaviour, it is worth

mentioning that the strongest predictor of suicide is previous self-harm. This view is echoed in Foster *el al`s (*1997) study, which identified self-harm behaviour in 40-60% of suicides. Thankfully, self-harm is not always associated with suicide, but this percentage of self-harm implicated in suicides is quite significant. It is worth indicating that there is an apparent overall decrease in the suicide rate in the UK (Appleby *et al.* 2003). Although this is the case, the rate of suicide is still significant in specific populations, including adolescents and older persons (McAlaney *et al*. 2004). Relatively, the suicide rate is particularly high among service users in secure environments (Gough, 2005). Undoubtedly, this is a major concern not only for healthcare professionals but also for service users` families, members of the public and researchers. It is therefore worthwhile to contemplate the exploration of self-harm in secure environments.

Intrinsic to the investigation of risk factors for self-harm is the question of prediction. Is it possible to identify service users who are at risk of self-harm? Studies that have endeavoured to do so have grossly contradicted one another. Taking physical and sexual abuse as an example, a study by Van der Kolt *et al* (1991) conclusively asserted that exposure to abuse is a reliable predictor of the frequency and magnitude of cutting. Whilst abuse may seemingly precipitate self-harming behaviour, the converse is not always the case, as some service users who engage in self-harm have no direct experience of abuse. In concurring with this, Brodsky *et al* (1995) purport that abuse as a child is not a marker for self-harm in adulthood. Succinctly, service users` self-harming behaviour is an inter-play between many risk factors, with some factors, depending on the nature of the context at the time, taking a leading role. An excerpt from Linehan`s (1993:402) work, provides a good idea of what these factors are:

> *Communication of private experiences is in clinical settings met by erratic, inappropriate, or extreme responses. In other words the expression of private experiences is not validated; instead it is often punished and or trivialised. The experience of painful emotions is disregarded. The individual's interpretations of her own behaviour, including the experiences of intent and motivations of the behaviour, are dismissed.*

Embedded in this account are constellations of negative attitudes held by healthcare professionals. Although this account refers to the psychological environment created by health carers in people's homes (Linehan, 1993), its characteristics also prevail among staff in secure environments, with criticism and failing relationships with self-harming service users being common features. From a service user perspective, the reasons for self-harm expressed today are generally centred on it serving as a mechanism for communicating

unbearable and uncontrollable feelings (Pembroke, 1998; Sadler, 2002), and as a coping strategy (Murray, 1998). It is these attempts to communicate feelings that are often misinterpreted by healthcare professionals who frequently perceive self-harm as attention seeking, manipulative and time wasting (Gough and Hawkins, 2000), and often respond to this behaviour in a resentful and rejecting manner (Johnstone, 1997; McAllister *et al*. 2002). In other words, healthcare professionals may treat service users with distance and anger whenever they self-harm. This angry reaction is emphasised by Arnold (1995) in one of her studies in an Emergency Department. She noted that service users who deliberately injure themselves are often ignored and their wounds are sometimes stitched without anaesthetic. Service users find these attitudes humiliating, derogatory, traumatic and invalidating, and they serve only to enhance their feelings of worthlessness and treatment fearfulness (Shepperd and McAllister, 2003). These experiences may increase service users` risk for further self-harm and avoidance of health services.

Repetition of self-harming behaviour may impose a significant economic burden on health services. In the United Kingdom for example, Kapur *et al* (2002), in their prospective study of self-poisoning service users, provided an estimated cost of £378 per episode. This figure is greater for drugs of higher lethality, such as tricyclics, which are claimed to have an estimated cost of £634 per episode. From healthcare providers` perspective, attempts to respond therapeutically to service users who self-harm, sometimes repeatedly, can create tension, feelings of hopelessness and helplessness (Loughery *et al*. 1997). This is clearly captured in a statement put forward by Motz (2001:182). It reads:

> *Healthcare workers caring for people who self-harm may feel alternatively drawn towards them in a protective capacity and horrified and repulsed by them as emotions of helplessness, anxiety and incompetence were aroused.*

These experiences of a sense of hopelessness and helplessness may result in the generation of angry and hostile feelings towards service users (Haw *et al*. 2007). These attitudes are not uncommon in today's clinical areas. At this point, it could be asserted that previous attitudes still reverberate, creating in some instances, a clinical atmosphere with pervasive ambivalent echoes of negative and positive attitudes, which can sometimes promote self-harming behaviour. One should underscore the fact that it is not just the service users who are negatively affected by the occurrence self-harm, healthcare professionals themselves are also at risk of developing extreme anxiety, particularly from repeated exposure to the same. It is

therefore advisable for them to regularly seek supervision or support to alleviate the stress they may encounter when caring for this service user group.

Although negative attitudes are becoming increasingly common in clinical encounters, a paradigmatic shift has been seen to occur in the UK`s National Health Service (NHS) towards the care of self-harming service users. The shift or change in care provision has been observed since the introduction of the Suicide Act of 1961. The introduction of this Act led to the decriminalisation and increasing medicalisation of suicidal behaviours (Bradby, 2009). To be more explicit, the 1961 Suicide Act advocated a change in the focus of care from punishing to helping service users who are at risk of engaging in suicidal behaviours. This shift in philosophy gained momentum in the late 20th Century when the use of psychotropic medication led healthcare professionals to consider suicidal behaviour as a disease amenable to treatment (DH, 2001a). Acknowledging this and the devastating psychological and spiritual impact that suicidal behaviours may have on families and other survivors, including healthcare professionals, the Government made suicide prevention one of its health priorities, with a clear focus on risk assessment and management of self-harm (DH, 1999b). This is evidenced by the publication of the Health of The Nation document (DH, 1992) and the National Service Framework for Mental Health (DH, 1999a) with emphasis on the need to drive up quality and reduce unacceptable variations in care provision to service users. The agenda in this context is to drive up mental health promotion activities to help prevent self-harm, or at least, reduce its frequency.

Despite these government initiatives, secure hospitals in the UK and other parts of the world are still proportionally experiencing more self-harming behaviours than other clinical areas (White *et al*. 1999; Hawton *et al.* 2007). This is probably because of the concentration of a large number of people with well-established risk factors and the negative attitudes of care providers in these environments. Previous studies have identified negative attitudes in nursing staff in secure settings, specifically prison and secure hospitals (Beasley, 1999/2000), but ignored the relationship between attitudes held by these staff in relation to service users` self-harming behaviour. It is therefore important to address this knowledge gap. This study intends to contribute to bridging this knowledge gap. Although this forms part of the study rationale, a detailed discussion of why the study is unique deserves some attention.

2.3: The Study: Its Rationale and Uniqueness

In retrospect, the decision to undertake this study on self-harm began over 11 years ago during the researcher's student placement on an acute generic psychiatric ward, where a young male service user was observed to inflict, although superficial, multiple lacerations on his right forearm. The researcher failed to respond because of lack of confidence and fear that his actions might paradoxically generate rather than contain an intense emotional outburst in the service user. Most importantly, the researcher was particularly struck by the frequency with which the service user in question and other service users cut themselves. Although the researcher's knowledge about self-harm and the context in which it occurs was limited at the time, this initial encounter was anxiety provoking and raised many questions about the reactions of nurses to self-harming service users and whether these service users represent a homogenous group with specific characteristics.

A cursory glance at the clinical records revealed that self-harm was a shocking reality that appeared to be unsuspected by the majority of clinical staff, as the severity and depth of misery created by this behaviour was mainly unnoticed. Nursing staff responses to the self-harm were generally unsympathetic and unempathetic, describing the behaviour as manipulative and attention seeking. Acknowledging these upsetting negative responses, which appeared to ignore the service users` miseries, it became apparent at the time that there was a need for clear information about the phenomenon of self-harm, and for awareness to be raised that self-harm is a reflection of multiple psychological difficulties in distressed individuals. Consequently, when an opportunity arose, the concerns were raised with the ward manager who subsequently convened a meeting, which resulted in the decision to devise a strategy for managing this service user group. Implicitly, this seemed to suggest that there was a failure on the nurses` part to provide appropriate and adequate care for self-harming service users. The researcher thought of possible rationales for this failure and it became evident that it was due to the gulf between nurses` and service users` attitudes and understanding of self-harm, which is part of the driving force of this study.

On completion of training, the researcher gained employment in a forensic psychiatric unit, where different methods of and an alarming frequency of self-harming behaviour were encountered. Interestingly, negative attitudes toward self-harm were not uncommon in this unit and were more pervasive relative to the general psychiatric ward. Most of the self-

14

harming behaviour was attributable to a small proportion of service users with a diagnosis of personality disorder and depression, with or without the experiences of childhood physical and sexual abuse. At this point, the researcher began to realise that there are factors within clinical environments, which can be attributable to the initiation and repetition of self-harming behaviour. Negative attitudes of health professionals are one of these factors, which the researcher believed could be changed through knowledge and awareness of the phenomenon of self-harm. In response to this, the researcher sought employment in a training department, which ran workshops on self-harm and suicide prevention for healthcare staff.

Divergent results were observed when the effectiveness of the workshops was evaluated at one-year intervals. During the first year, healthcare professionals were more responsive to service users` needs with emphasis on developing deeper understanding of the meaning of self-harming behaviour. In contrast, a resurgence of unsympathetic responses to self-harming service users was apparent during the second phase of evaluation. Reassuringly, the sudden increase in negative attitudes was due to the large number of newly employed healthcare staff who had not attended the self-harm workshops. Although not conclusive, it was apparent that negative attitudes played a part in service users` self-harming behaviour. As a senior clinician at the time, I engaged in intense discussions with other senior clinicians including charge nurses to address this issue. The outcome of these discussions was impressive. Attendance to the self-harm workshops was made mandatory for all healthcare professionals. Sharing the knowledge gained from the workshops with pre-registration nursing students would be an excellent pathway for propagating positive attitudes towards self-harm. Hence, the researcher sought employment at a university with pre-registration nursing programmes.

In preparation for curriculum delivery, a literature review on self-harm was conducted, revealing very limited work on the associations between attitudes and self-harm in secure settings. Hence, a decision was made to undertake this study. This decision led to an extensive review of the literature, which, in part, involved a search of several electronic databases in preparation of writing a proposal for the research project. A number of interesting findings were identified in the papers reviewed.

The occurrence of self-harm in our society has always been a concern, but its prevalence within institutions responsible for ensuring the safety of offenders whilst they have lost their

liberty, is of particular concern (Gough and Hawkins, 2000). Psychiatric nurses are the healthcare professionals who are usually the first to intervene or are asked for advice on the management of such behaviours in these clinical areas. So, service users seeking and receiving appropriate help from this professional group would be protected against the development of acute forms of suicidality and completion (Kalafat and Elias, 1995; Kalafat, 1997). However, it is widely recognised across the academic literature that service users who self-harm usually negate, refuse or avoid professional help to manage their suicidal thoughts (Cusack *et al*. 2004; Wilson *et al*. 2005). This is probably a function of their negative beliefs and attitudes about the usefulness of interventions, and of prior negative experiences with healthcare professionals, including psychiatric nurses. Thus, the quality of care for self-harming service users would depend, in part, on psychiatric nurses` attitudes.

It is evident in the literature that negative attitudes among nursing staff tend to play a significant role in the initiation and repetition of self-harming behaviours (Hemmings, 1999). Psychiatric nurses' attitudes are therefore crucial in the effective management of service users with this behaviour. Hence, an understanding of psychiatric nurses` attitudes toward this service user group would undoubtedly be helpful in the planning and delivery of care. Surprisingly, very little empirical research has actually been conducted on self-harm in mental health services, particularly in secure hospitals despite its alarming prevalence and dangerousness (Beasley, 1999/2000; Gough and Hawkins, 2000). Among the studies that have been done, most focus on service users. It is important to stress that these studies do not directly explore the perceptions of service users, but instead retrospectively review clinical records and associated incident forms (Low *et al*. 1997; White *et al*. 1999; Jackson, 2000). This is largely a function of ethical and legal issues associated with the recruitment and selection of service users as research participants.

To date, very few published research studies have addressed the associations between healthcare professionals` attitudes and self-harm in secure hospitals. Consequently, self-harm remains a poorly understood behavioural phenomenon in these areas and therefore worthy of comprehensive investigation. Hence, this study, which works toward exploring psychiatric nurses` attitudes towards self-harming service users in secure environments.

It is anticipated that the outcome of the study will be of practical utility to nurse educators and clinical staff in the context of curriculum design and delivery. The study hopes to help

improve the care for self-harming service users by contributing to the development and delivery of a curriculum to pre-registration students with emphasis on both knowledge development and fostering of positive attitudes toward the same. Clinical staff will be furnished with appropriate and accurate information based on empirical evidence about the phenomenon of self-harm. It is apparent that without focused skills and deeper understanding of self-harm, psychiatric nurses are more likely to provide inadequate care to service users. The effects of this are likely to be avoidance by service users of health services and subsequent increase in mortality rates related to untreated self-harm (Ryan *et al*. 1997). The researcher hopes that these consequences will be prevented or at least reduced. This sense of hope is inspired both by the researcher's personal experience of self-harm and the late Kazimierz Dabrowski (1967 in Battaglia, 2002), an English Scholar interested in the suffering and misery of mankind. He wrote:

> *The fact that humanity survives and develops serves as evidence that the advantage is on one side of positive qualities. Man's instinct for development, which in the broadest meaning of the word is a tendency to mental and moral perfection, sooner or later gains power and reinvigorates and enhances the positive values. Even in period of collapse they survive in us in the form of moral readiness and yearning for their revival and full realisation.*

This is a succinct message of hope with an intention to bring meaning to human suffering, in this case, self-harm.

2.4: Summary

This chapter has provided a succinct overview of the discussions presented in subsequent sections of the thesis. Included also are the reasons for conducting the study and discussions of how it differs from previous studies. It is important to note that the chapter provided a clear message of the intention of this study. It hopes to contribute to the understanding of this self-harm, improve care provision and as well serve as a rich resource for future research directions. The researcher believes that an extensive review of the literature is a good starting point for developing such an understanding of what self-harm means to service users, their relatives and healthcare professionals. It is therefore imperative to conduct a literature review on this subject to find out who knows and what they know about it.

CHAPTER THREE

LITERATURE REVIEW

3:1: Introduction

As mentioned in the introductory chapter, self-harm is a complex phenomenon, a puzzle which, despite its ubiquity and the established academe of researchers exploring it, the reasons for its occurrence are still not fully and accurately comprehended by healthcare professionals. This position is succinctly expressed by Favazza (1998). As a psychiatrist with long-standing personal experiences with service users who self-harm, he describes self-harm as a riddle. This is no doubt a confirmation of its complexity and difficulty of understanding it. So, it is not surprising for service users experiencing this behaviour to claim that their needs are usually not effectively met by healthcare professionals. Taking account of this, there is a need to enhance healthcare professionals` knowledge of self-harm with a view of improving the quality of care provided to service users with this behaviour. Although there is a paucity of research to date examining self-harm in secure environments, reviewing existing written information on it serves both as a useful step in understanding the attitudes towards behaviour and as a means of creating a context for the study. Even though this study aims to provide insight into attitudes of psychiatric nurses towards self-harm in secure settings, both professional and service user literature are reviewed, but with emphasis on the former.

This chapter begins with a discussion of the historical perspectives of self-harm. This is undertaken to compare the forms and patterns of self-harm and attitudes towards it in the past with those of today. Following this is the suicide-self-harm debate; an attempt made to separate self-harming behaviour from suicide. It is considered useful to include a discussion of the scale of the problem of self-harm. Within this subsection, the incidence and prevalence of self-harm, its repetition and the characteristics of service users who self-harm are explored. This section also includes a discussion of the reasons for people`s self-harming behaviour and the impact this behaviour on both professionals and service users. The chapter then focuses on the tenets of the major theoretical explanations of self-harm before concentrating on examining the concept of attitude, theoretical frameworks of the study and service users` and healthcare professionals` perspectives of self-harm. The chapter is drawn

to a close with a resume of the literature examined; reiterating the main themes of the researcher's contemporary understanding of self-harm.

3.2: Historical Perspective of Self-Harm

Self-harm is a long-standing and extremely widespread practice, which occurred even before recorded history and occurs at all levels of society in many parts of the world (Favazza, 1998). Hence, one would claim that the behaviour of self-harm is not new to mankind. In support of this, Favazza (1998) provides a vivid description of a self-harming act of a Spartan leader written before Christ in the Sixth Book of History, Herodotus. It states:

> *As soon as the knife was in his hands, Cleomenes began to mutilate himself beginning on his shins. He sliced up to his thighs, hips and belly* (Favazza, 1998:2).

Similar acts of self-harm are well documented in a number of scriptures in the Bible with avoidance, atonement and self-punishment being the most cited reasons for this behaviour. An admonition offered from the book of Mark (9:47) in the New Testament shows this:

> *If your eye is your downfall, tear it out! Better to enter the Kingdom of God with one eye than to be thrown with both eyes into Gehenna (hell), where the worm dies not and the fire is never extinguished.*

In the same New Testament, Mathew (5:28-29) states a similar theme. It reads:
> *What I say to you is: anyone who looks lustfully at a woman has already committed adultery with her in his thoughts. If your right is your trouble, gouge it out and throw it away! Better to lose part of your of body than to have all cast into Gehenna.*

It is probably safe to state at this point that self-mutilation within the Christian faith, particularly in instances where people search for redemption and / repentance, has been granted legitimacy by these admonitions. Favazza (1996) presents an example of self-mutilation that illustrates the relationship of this behaviour with religious beliefs. It relates to the oldest story of eye enucleation that demonstrates obedience to Mathew`s and Mark` prescriptions (A.D, 1300). It is about a Cobbler who scooped out his eye because he experienced lustful thoughts when he saw the legs of a beautiful woman who visited his shop. Such a mutilative act could not be considered deviant, as it was culturally sanctioned at the time.

Other culturally approved behaviours relate to people identifying themselves with religious heroes. It was and still noted today that such links may permit people to engage in rituals that involve self-harming behaviours. The "Ashura", a traditional ceremony that commemorates

the death of Hussein, Prophet Muhammad`s grandson at the massacre of Karbala in AD680, is a good example for demonstrating such an association. On the day of "Ashura" some followers (Shia Muslims) would whip or flagellate their own backs with bunched knives known as Zanjirs (Favazza, 1996). Others would strike their chests frenetically with their hands while reciting the words of Hussein (Grayling, 2008:5).

> *Trial, afflictions, and pains, the thicker they fall on man, the better do they prepare him for his journey heavenward*

Other Muslim groups, such as the Sunnis, perceive these behaviours as barbaric, a perception that is apparently based on the physical pain the victims endure (Grayling, 2008). It is therefore not surprising that they tend to condemn the "Ashura". In contrast, devotees view it as a valuable sacrifice that demonstrates their commitment and readiness for eternal life (Favazza, 1996).

It is critical to state that religiously motivated flagellation is not exclusive to Muslims communities, as it is also noted to be practised by Christians. Jesus Christ allowing himself to be nailed to a cross in order to save people from their sins serves as a significant drive for this practice among Christians (Girard, 1977). The crucifixion itself seems to indicate that people must endure pain to prove their faith as well as to repent for any wrongdoing. It is probably for this reason that some people of this religious background engage in self-mutilative acts.

It is important to note that the idea that any wrongdoing should be punished through the infliction of suffering is not restricted to religious beliefs. Throughout human history, beliefs and practices concerning healing have involved some form of self-harm. In the Middle Ages, for example, groups of priests in Europe engaged in flagellatory acts until lacerations were sustained on their bodies, claiming that these actions would protect their communities from plagues (Babiker and Arnold, 1997). Historically, the use of self-harm for healing extended beyond the Middle Ages. In Morocco, healers of the Hamadsha brotherhood movement slashed their heads with knives or razors during ecstatic trances induced by wild dancing, convinced that their self-harming acts would constrain the spirits responsible for ill health (Crapanzano, 1973). Other Muslim groups considered these rituals extreme.

Although these practices are no longer socially acceptable in many countries, especially in developed ones, similar approaches to healing, despite being rare, are observed in the UK today. Even though it was not a self-harming act, the experience of Victoria Climbie is a classic example of mutilation under the pretext of healing. She sustained multiple wounds after being beaten systematically and repeatedly by relatives, allegedly, *"to get rid of evil spirits."* These acts of mutilation, particularly the healing rationale attributed to them are clearly captured in Favazza`s (1989:142) statement:

> *Self-harm is not alien to the human condition; rather it is culturally and psychologically embedded in the profound, elemental experiences of healing, religion and social amity.*

Succinctly, self-harm was not only performed for healing purposes, but also for social and sexual reasons. The first case of genital self-harm published in 1882, contains an account of a 29-year old farmer who confessed to having removed his testicles, possibly because of uncontrollable sexual desires (Warrington, 1882). Today, the wish to be or fear of being a female are the most cited reasons for genital mutilation (Walsh and Rosen, 1989). A reiteration of this is made by Premand and Eytan (2005) in a case report of premeditated autocastration of a non-psychotic 56-year old man. They highlighted that fantasy for genital change, in this instance, the wish to be a female, was the primary motivating factor for the behaviour.

An examination of the 19th Century academic literature on self-harm, clearly revealed pervasive discussions of eye enucleation and self-castration relative to other self-harming acts (Favazza, 1989). This indicates either an increase in the incidence of these behaviours, which therefore attracted more interest among academics, or that the behaviours just had a high affinity for academics at the time. While eye enucleation and self-castration are rare today, they can sometimes be psychotically motivated and tend to occur particularly in instances where there are specific religious beliefs and / or perceptual difficulties.

Religious delusions have often been noted as being associated with extreme forms of self-harm, such as eye enucleation and autocastration. Literature reviews of incidents of self-harming acts conducted by Clark (1981) and Favazza (1996) reveal the role of Biblical texts in influencing individual to engage in these behaviours. The texts, which are all in the words of Jesus Christ himself, include a specific quotation from Mathew (5:29-30). It reads: *And if thy right eyes offend thee, pluck it out. And if thy right hand offends thee, cut it off*

Jesus Christ was both a priest and a victim of faith as he offered himself willingly to be crucified. His willing self-sacrifice, which is believed to be an act of redemption of love and repentance, provides mankind the opportunity for re-establishing a "good relationship" with God (Clark, 1981). From a theological perspective, the phrase, "good relationship", is a request for individuals to respect and love one another, and to live a life without sin. To enter such a relationship, Favazza (1996) asserted, requires individuals to participate in certain rituals and to obey specific rules. The rules in this case are the words of Jesus Christ offered in Mathew (5:29-30) and Mark (9:43-48), with the latter preaching focusing on both eye enucleation and amputation of limbs. It is this advice from Christ that is usually adhered to by individuals with or without a diagnosis of a psychotic disorder. This is epitomised by a disturbing account presented in Favazza`s (1996) book, "Bodies under Siege". The story relates to a woman who felt that her eyes were sinful because they had looked at worldly things. As result of this, she quietly took out both of her eyes after reading the words in Mathew 5 verses 29 to 30. Following her behaviour, she stated that Jesus Christ had sacrificed his blood and she too must do the same in order to become saintly. The first medical article published in 1846 contains a similar description of self-harm. The article was about a woman who enucleated both of her eyes claiming that shedding blood would make her become saintly (Bergmann, 1846).

It is clear that self-mutilation of some people, including those with mental illness, occur in a context of religious sacrifice. Some individuals may try to emulate the suffering of a holy being or religious leaders. Doing so, like the ladies referred to above, may require them to inflict suffering deliberately on themselves. Taking this argument further, self-harming behaviours are also sometimes considered to be a response to command hallucinations that are embedded with religious connotations. This is particularly true when an individual perceives the voices to be emanating from a heavenly or trusted source (Tantam and Huband, 2009). Service users who find themselves in such a circumstance are more likely to obey a command by sacrificing parts of their bodies as a spiritual show of faith.

It is apparent from these accounts that self-harm is used to alleviate deep-rooted emotional distress. Parallels to this can be made with modern western psychiatric interventions that are underpinned by the medical model, which strongly asserts that self-harm is a symptom of mental illness amenable to specific physical and or psychological interventions (Johnstone, 1997). Physical interventions, such as psychotropic medication, are generally used to provide

short-term relief from emotional pain. In the absence of medication, people use self-harm to manage their recurring emotional pain. Arguably, therefore, people are seemingly right to use self-harm as a short-term measure to cope with emotional problems. However, it is not a sanctioned healthcare approach. This is because of ethical implications associated with it, as it is considered to be an unsafe way to deal with emotional problems.

The 1960s saw an upsurge of mental health professionals` interest on self-harm both in the United States and United Kingdom, but with more emphasis on wrist cutting. It seems likely that the incidence of wrist cutting increased at the time, although no hard data are available to support this impression. Expectedly, the increase in interest on wrist cutting led to a number of studies, which as a whole resulted in the formulation of a distinct description of a typical wrist cutter or slasher that appears to separate it from suicide (Grunebaum and Klerman, 1967; Asch, 1971). A typical wrist cutter was portrayed as young woman with the potential for engaging in acts of indiscriminate and repetitive wrist cutting, achieving emotional relief from this behaviour, but with no intention of committing suicide (Graff and Mallin, 1967). This is a good attempt at distinguishing self-harmers from non-self-harmers and the reference made to a young woman seems to indicate that young people, particularly girls, are more vulnerable to self-harm. This view is reiterated by Favazza (1992), who claims that the majority of those who self-injure are in their teens, 20s and 30s.

Pattison`s and Kahan`s (1983) conceptualisation of a deliberate self-harm syndrome, which includes low lethality self-harming acts with no conscious suicidal intent, appears to be the starting point of an interest of modern psychiatry in self-harm. It is also a significant contributor to the suicide-self-harm debate. Further growth in interest of self-harm was stimulated in the late 1980s by Favazza`s (1987) publication of Bodies Under Siege, reviewed in a wide range of mental health journals. This propulsion of self-harm into the conscious mind of healthcare professionals and service users has created a sense of optimism, as both are now more willing to engage in therapeutic interactions (Favazza, 1996). However, willingness of service users for therapeutic engagement may vary, sometimes influenced by service users` and professionals` perceptions of whether the behaviour of the former is a self-harm or suicide attempt. An agreement with this view is more likely to promote therapeutic discourse between service users and healthcare staff. In contrast, any disagreement in perception between service users and healthcare professionals may result in the former avoiding healthcare provision. One of the aims of healthcare professionals in

helping self-harming service users is to promote therapeutic engagement. In this context, lack of or limited therapeutic interaction can, in part, be attributed to the difficulties in differentiating self-harm from suicide. This has resource implications in making decisions of allocating the appropriate expertise that will effectively address these problems. The researcher of this study believes that a suicide-self-harm debate may help distinguish between the two phenomena. Making such a distinction would not only help in enhancing insight into attitudes towards self-harm, but it would also result in service users presenting with either of these phenomena to be provided with tailor-made services to address their needs. Hence, the need to engage in a suicide-self-harm discourse.

3.3: Differentiating Self-Harm from Suicide: A Debate

Researchers and healthcare professionals have, over a number of decades, invested lots of energy in trying to distinguish self-harm from suicide. This effort is generally influenced by the shared assumption that these two phenomena, although they are conceptually and behaviourally different, are sometimes used interchangeably by healthcare professionals to describe service users who hurt themselves (Stanley *et al.* 1992; 2001). It is worrying to realise that such usage will not only serve to perpetuate conceptual confusion, but it may also lead to service users not receiving appropriate treatment. For example, if a hospitalised service user presents with a cut on a wrist, the treatment response by healthcare professionals if the behaviour is viewed as a suicide attempt is likely to be significantly different when viewed as tension reduction.

On exploring the suicide option, the most likely line of treatment to be adopted will be the use of anti-depressant medication, psychotherapy and protective systems of supportive observation. Concerning the latter view, tension reduction, responses from healthcare professionals could be prescription of benzodiazepines and courses of some form of psychosocial intervention. Clearly, behaviours perceived as suicide attempts tend to receive intense responses, including restrictive interventions of observation. So, perceiving or labeling self-harm as a suicide attempt could result in the application of inappropriate and unnecessary restrictive interventions and stigmatization. An awareness of this, serves as the impetus for this study to engage in discussions to help clearly distinguish between these phenomena, self-harm and suicide.

Several studies have explored specific features that can separate self-harm from suicide (De Leo and Heller, 2004). The intention underpinning the behaviours is a crucial element of these features, as it is considered by many the most important in making this distinction (Holdsworth *et al*. 2001; Ross and Heath, 2002). At this point, it is essential to stress that there are two types of intentions; outcome and behavioural (Fishbein and Ajzen, 1975). In relation to the former, it is simply, a measure of a person`s beliefs or thoughts of achieving something specific if engaged in a certain behaviour (Ajzen and Fishbein, 1980). Behavioural intention, on the other hand, refers to the willingness of a person to perform a given behaviour (Ajzen, 1988). This seems to echo the view that human behaviours are, in the main, under volitional control (Ajzen and Madden, 1986). If this is the case, it could be argued that the best predictor of future behaviour is a measure of an individual's intention to carry out that behaviour. In addition to factors beyond an individual's control that may prevent successful execution of intention, it must be stressed that intention may change over time and any change in the same may impede performance of behaviour (Ajzen, 1985). This indicates the difficulties inherent in determining intention.

Establishing the intention of self-harming service users is a difficult task to accomplish. This assertion is a function of the view that acts of self-harm are usually carried out in private and the intentions relating to these behaviours are also private, and are mainly disclosed to healthcare professionals after the behaviour (Walsh and Rosen1998). However, such disclosure, which heavily relies on memory, may not be accurate descriptions of behavioural motives, as memory is prone to distortion. It is therefore not surprising to find ambiguous results in studies which have attempted to establish intentions underpinning self-harming behaviours. Taking Gardner's and Gardner's (1975) study as an example, a significant proportion of service users cited relief of tension as their principal motive to harm themselves. In contrast, some service users in the same study claimed that suicidal thoughts serve as the driving force for their acts of self-harm. However, further discussions with the service users experiencing suicidal thoughts revealed that death was not their primary motive. Such revelation is replicated in Favazza`s and Conterio`s (1989) study. They noted that service users may sometimes state that they are suicidal when in fact they only wish to hurt themselves. This indicates the changing nature or fluidity of intentions, and hence, the difficulty in measuring or establishing them.

Despite this difficulty, several researchers have reported clearly expressed motives experienced by service users before the acts of self-harm. Service users usually express feelings of happiness, psychological reintegration and relief from some form of tension following an act of self-harming behaviour (Favazza, 1998; Sadler, 2002). These authors add that the intention of service users was not to die, but to achieve transient relief from unbearable feelings. At this point, it could be argued that self-harm seems to be characterised by increasing psychological distress, associated with persistent urges to resolve the same by hurting one's body, but with no intention to end life. Thus, in this case, the intention of service users is to achieve an outcome; alleviation of psychological distress.

In relation to suicide, it is evident in the literature that unbearable psychological pain is also the primary rationale for this behaviour. This is clearly captured in Shneidman `s (1973:124) statement:

> *Suicide is best understood as a combined movement toward cessation of consciousness and as a movement away from intolerable emotion, unendurable pain, and unacceptable anguish.*

It is apparent from this statement that an act of suicide is a conscious attempt or intent to escape an intolerable psychological pain by ending one's life. Although this intention is distinct from that of self-harm in the context of cessation of life, both behaviours share a common experience of psychological pain. With this in mind, the researcher of this study shares the claim made by Linehan (1993) and Stanley *et al* (1992) that self-harm and suicide exist on a continuum of lethality, with some behaviours of the former occupying its lower end and the latter occupying its upper end. Lethality, as used in this thesis, refers to severity of injury caused by an act of self-harm and the probability of dying from the same (Farberow, 1980; Worden, 1980).

Explicitly, the concept of a continuum of lethality indicates the existence of varying levels of severity of self-harming behaviours, with some behaviour occupying a central position. This continuum of lethality seems to indicate changes in the motives for self-harming behaviours from one end of the spectrum with no intention to die, right through ambivalent feelings of life and death, to the other end of the spectrum, with clear intentions of cessation of life. Acknowledging this, one would assert that self-harming and suicidal service users are not heterogeneous groups; they are rather part of a homogeneous group of the same phenomenon, which can be categorised into subgroups

using behavioural intentions. Walsh and Rosen (1988) confirm this by asserting that self-harming service users tend to choose disfigurement or harm over cessation, tension reduction over egression and a temporary relief of pain over permanent escape from unendurable pain.

Clearly, the intended aim of self-harming behaviours is in sharp contrast to that of suicidal acts. Simply, they are dissimilar. A person attempting suicide generally aims to end all feelings, particularly those which are unbearable. Put another way, a suicide attempt is an endeavour to separate an individual from awareness or being. In contrast, a person who self-harms, in the main, seeks to feel better through psychological re-integration that can be accomplished through ventilation of intense feelings of anger, anxiety and or sadness (Favazza, 1998; Deane *et al*. 2001). Although this appears to be the case, it is problematic to assess intentions in a reliable and objective way. Hence, there is a need to compliment the criterion of intention with other criteria in separating self-harming behaviours from suicide attempts.

A measure of harm caused is a reliable way of distinguishing self-harm from suicide. With reference to the literature, this can be determined by using variables such as medical treatment required and severity of harm (Stanley *et al*. 1992). For example, Weissman (1975) noted in her study that the lacerations of self-harming service users were significantly less likely to require medical attention when compared with those of suicide attempters. In a similar vein, Clendenin and Murphy (1971) concluded that lacerations sustained by their sample of self-harming service users were less likely to lead to hospitalization for medical attention relative to those who attempted suicide. So far, research findings seem to indicate that injuries caused by acts of self-harm are generally less severe than those resulting from suicide attempts. It is probably safe to attribute this claim to the methods employed by service users when harming themselves, a view supported by Kahan and Pattison (1980). For instance, jumping in front of a fast moving vehicle would undoubtedly result in serious injuries that may pose a high probability of death. On the other hand, cutting oneself superficially with a razor on the thigh or forearm would result in visible injuries with very little possibility of death. The behavioural intentions of service users engaging in these behaviours are likely to be different. Service users are less likely to carry behavioural intentions of death when they superficially lacerate themselves. In addition to having a high chance of death, jumping

in front of a fast moving vehicle is more likely to be motivated by an intention of cessation of life. Arguably, methods used have a place in determining whether a behaviour is an act of self-harm or suicide attempt.

Associated with methods is the concept of repetition. It is considered to be a core characteristic of self-harming behaviour. It is now evident in the literature that service users who engage in self-harming behaviours tend to repeat their behaviours, sometimes using multiple methods (Walsh and Rosen, 1988). This pattern has now been reported in suicide attempters (Kerkhof *et al.* 1998). The outcomes of a number studies seem to suggest that among suicide attempters, repeaters are more common than *first-evers* (Bille-Brahe and Jassen, 1994; Hawton *et al.* 1999; Sakinofski, 2000) and the mortality by suicide is higher among suicide attempters with previous attempts (Sellar *et al.* 1990). The criterion of repetition is not particularly useful in itself in distinguishing self-harm from suicide. This view is purely based on the fact that service users engaging in these behaviours, suicide attempts and self-harm, tend to repeat them. However, using it in conjunction with lethality of methods may help in distinguishing between these two phenomena.

As already stated, the intention generally underpinning self-harming behaviour is to alleviate tension or effect some interpersonal change. To achieve this, service users may repeat their behaviours using methods of low lethality, such as superficially cutting their wrists. However, in instances where several acts of self-harm fail to alleviate the experiences of tension, service users may become increasingly desperate. Such desperation may sometimes result in suicide attempts with service users using methods of increasing or high lethality. Arguably, individuals` behaviours may escalate over time from acts of self-harm using low lethality methods to suicide attempts employing high lethality approaches. This seems to depict the existence of a continuum of lethality mentioned earlier in this discussion. The study of Hawton and Fagg (1998) supports this. They found that 25% of the 80 individuals who committed suicide in Leeds during the time of their study presented at least once with some form of self-harming behaviour at an Accident and Emergency department.

In summary, self-harm and suicide seem to belong to the same phenomenon. It is therefore not surprising to note that these behaviours are similar in a number of ways. Although

similar in some ways, there are significant differences between these behaviours and these have been noticed when examined using the criteria of intention, physical damage, and methods of hurting oneself.

3.4: Scale of the Problem

It is believed that the act of hurting oneself implicitly represents something unbearable, unspeakable that is communicated in the act. Indeed, self-harm speaks of distress and pain that people experience (Babiker and Arnold, 1997). The incidence of this behaviour is noted in the literature to be growing. Thus, its estimated scale and the distress it indicates therefore deserve exploration.

3.4.1: Incidence and Prevalence of Self-Harm

A major problem facing clinicians, researchers and governments around the world in relation to self-harm is that its incidence is increasing and has been doing so since the late 1960`s (Hawton and Catalan, 1987; Cooper *et al*. 2005). Consistent with this, outcomes of epidemiological studies from a range of countries including Australia, the United Kingdom and the United States, reveal a similar picture; a rising trend in the incidence of self-harming behaviour (Weissman, 1975; Patton *et al*. 1997; Hawton *et al*. 2006). In the United States, Favazza and Rosenthal (1993) highlighted that the incidents of self-injury tend to range from 400 to 1400 per 100,000 of the general population per year. About twelve years later, Sakinofski (2000) rigorously reviewed the work of Favazza (1987) and Walsh and Rosen (1988) and reported a self-harm rate of 300 people per 100, 000 of the general population.

Even though this rate is below the lower end of Favazza`s and Rosenthal's (1993) range, one should consider it to be significant as people who self-harm sometimes resort to committing suicide. Hence, the rate presented indicates a problem of serious consequences. The results of Fanslow`s (1994) study in New Zealand indicated a similar pattern. It highlighted that self-harm is the leading cause of injury among members of the general population requiring medical attention. In relation to the United Kingdom (UK), where this study is taking place, the average rate of admission to a general hospital for self-harming behaviours is 100,000 each year (Evans *et al*. 1999). Following an extensive review of the literature, Kapur *et al* (1998) and Copper *et al* (2005) arrive at a different rate. They claim that self-harm is a major clinical problem, with some 170, 000 admissions per year to UK hospitals. Taking this into

account, Hawton *et al* (2006) believe that the rate of self-harming behaviours and subsequent suicides in the UK are increasing. Similar trends are also observed in the United States, Canada and other European countries. Undoubtedly, this is worrying. It is therefore important to explore the rationale for this pattern of self-harming behaviour

Whilst there is a world-wide increase of self-harming behaviour, estimates of its incidence are noted to vary widely. This variation or diversity of rates is likely to be a function of lack of uniformity of definitions, which reflects differential perceptions of this behaviour by clinicians and researchers. It is important to emphasise that an alarming signal of the incidence of self-harm was observed towards the end of the 1980s. Schmidtke *et al* (1996) reported that the number of individuals self-harming and simultaneously seeking help from generic healthcare services has risen markedly, with rates in the UK being the highest in Europe. In support of this, Williams (1997) stated that self-mutilation alone represents 10% of the population of self-harming service users presenting to Accident and Emergency departments each year in the UK. This marked rise in the rate of self-harm indicated in the literature could partly be a result of increased awareness among clinicians and researchers of this behaviour. This seems to suggest that injuries which were previously considered accidental were today sometimes medicalised by referring to them as self-harm. This is clearly one possible explanation for the increase in self-harming behaviours in both generic and secure psychiatric services.

Secure hospitals are places in which one can find some of the highest incidences of self-harm in both female and male service users (Winchel and Stanley, 1991; Low *et al*. 1997; Gough, 2005). Several reasons have been put forward to explain the high levels of self-injury seen in these environments. Babiker and Arnold (1997) in their review of the literature concluded that environmental restriction, boredom and under-occupation are factors that are crucial in the causation of self-injury behaviours in secure settings. The adoption of restrictive measures, such as close observations and physical restraint on service users who are perceived as likely to self-harm, is a significant element in the risk management or minimisation of this behaviour. Such restrictive measures may paradoxically increase service users` self-harming behaviour, an attribution which is based on their potential for evoking feelings of powerlessness and frustration (Burrow, 1994). A history of childhood abuse is a common background of service users in secure hospitals. Although restrictive approaches may be distressing in themselves to anyone, applying them to service users with this

background may be particularly traumatic, as they may reactivate their unpleasant childhood experiences. Service users may self-injure to cope with these unbearable experiences. It would seem, therefore, that what is desperately needed to help reduce the incidents of self-harm in secure environments, is the employment of interactive observational approaches to service users deemed to be at risk of self-injury.

Now that the incidence and prevalence of self-harm have been explored, it seems timely to pause and reflect on their level of accuracy. Certainly, it is difficult, if not practically impossible to accurately determine the incidence of self-harm. This assertion is purely based on the secrecy surrounding the behaviour. Such a secretive approach indicates huge possibilities of under-reporting. Claims have been made that some service users sometimes hide their injuries from healthcare professionals and even from their families (Vivekananda, 2000). When detected, service users may make or provide excuses, misleading clinicians into believing, for example, that their injuries are the result of accidents or attacks from others (Williams, 1997). Consequently, the estimated incidence presented is an under-estimate and not an accurate reflection of self-harming behaviours. They are, however, reflections of the number of service users who reported their self-harming behaviours and or seek professional help to address the same. Thus, they can only serve as a general indicator regarding the extent or scale of the problem. It is now safe to conclusively state that self-harm is a growing problem. Its rising incidence seems to indicate that it is not a one-off activity, at least, not for some service users. Simply, this means that it is a behaviour that is often repeated. Repetition is clearly a feature that is closely linked with the incidence and prevalence of self-harm. It therefore deserves an indepth discussion.

3.4.2: Repetition of Self-Harm

Repetition is one of the core features of self-harm, which, in addition to signifying persistent or recurrent distress of those experiencing it (Tejedor *et al*.1999), imposes a considerable economic and resource burden on the whole of society, including psychiatric services. Recent epidemiological studies reveal that approximately 16% of service users will re-present with self-injuries to the same hospital within a year and 25% within four years (Owens *et al*. 2002). With regard to the former group of service users (16%), most of the repetitions usually take place within three months (Diekstra, 1993). Although this is apparently the case, it is worth stating that only a small number of service users tend to frequently repeat their

self-harming behaviour. As Bancroft and Marsack (1977) emphasise, such patterns of repetition can be used to categorise self-harming service users. Following a two-year prospective study, they suggested four types of self-harming patterns; chronic, habitual, frequent and one-off. A better understanding of this categorisation can be developed with the help of clinical examples.

In Pattison`s and Kahan`s (1983) study, 73% of 56 participants harmed themselves repeatedly, such that some could not even recall the frequency of this behaviour. Parallel to this, is the outcome of Shearer's retrospective (1994) study. Participants were asked about their self-harming behaviour. A large proportion of them affirmatively agreed that they constantly self-injured. They asserted that, in some instances, their actions continued or progressed in severity until their needs, such as gaining healthcare professionals` attention, were met. The service users described thus far fall within the remit of frequent repeaters of Bancroft's and Marsack`s (1977) classification, which is seemingly congruent with Favazza`s and Rosenthal's (1993) self-harm category of moderate or superficial. These categories refer to low lethality behaviours that are repetitive, episodic and sometimes ritualistic, which on occasions are displayed many times a day. According to Barstow (1995) and Warren (1997), such behaviours include cutting, scratching and burning. Cutting is common in secure environments. In these settings, cutting is sometimes used by service users to influence the course of their treatment and it is also claimed to provide them with stimulation to combat boredom.

Cases of chronic and habitual repeaters are seen in service users suffering from psychotic disorders and learning disabilities, such as autism, Retts disorder and Tourette`s syndrome (Winchel and Stanley, 1991; Favazza, 1996). Service users with these disorders sometimes engage in stereotypic behaviours including constant head banging, chewing fingers and eyeball pressing. Such behavioural descriptors fit very well with the stereotypic self-injury category of Favazza`s and Rosenthal's (1993) classification.

Even though attempts have been made to categorise repeaters of self-injury, predicting when and how frequent service users will hurt themselves, is an uncertain exercise. In other words, the predictability of repeaters is far from satisfactory (Hawton and Fagg, 1995; Zahl and Hawton, 2004). However, this can be improved by taking into consideration the motivations underpinning the behaviours, the context in which they occur, the socio-demographic

characteristics and psychopathology of service users. Owen *et al* (1994) and Scott *et al* (1997) reiterate this view by claiming that socio-demographic and psychological factors tend to contribute immensely to the prediction of the probability of repetition. But, because of the fluidity or changing nature of social factors, they stressed that one must adopt a cautious approach in making predictions. Such a way of working would help minimise the chances of achieving false positive or false negative outcomes. Simply, care must be taken to prevent wrong predictions. Hence, attention must be focused on specific characteristics of self-harming service user groups that may help identify those at risk of self-injury. Identification of these characteristics may help practitioners adopt appropriate and timely interventions to prevent, or, at least reduce or minimise, the incidences of self-harm.

3.4.3:Self-Harm: Characteristics of Service Users

It must be emphasised that self-harm is today observed to be a common experience in psychiatric settings, particularly so in secure environments (Hawton *et al*. 2007). A number of researchers have explored and described the characteristic features of service users who self-injure, with some specifically focusing on those which may lead to frequent repetition (Carter *et al*. 2002). The rationale for this, as previously noted, is to help prevent or at least reduce the frequency of this behaviour. Drug misuse, being a female, being an adolescent and having a mental disorder, such as depression and borderline personality disorder, relationship difficulties and a history childhood deprivation, are among the many characteristics or risk factors identified from research for self-harm. These characteristics play a critical role in helping clinicians and researchers identify people who are at risk of self-injury. Scott *et al* (1997:392) confirm this:

> *It seems that the combination of unhappiness, pessimism about the future, poor problem-solving skills and lack of emotional support at a time of crisis distinguishes those in and at risk population who are most likely to repeat an episode of self-harm from those who do not.*

Inadequate problem-solving ability has been consistently cited in the literature as a contributory factor for self-harm behaviour. Linehan (1993) echoes this by claiming that self-harm is, in part, a function of limited problem-solving skills. Strongly associated with problem-solving are issues of powerlessness, hopelessness and perceived helplessness, which are believed to have the potential of inhibiting service users` abilities of generating solutions for problems experienced (Eidhin *et al*. 2002). This assertion is based on the view that negative thought processes of perceived

helplessness and hopelessness tend to encourage individuals, in the main, to think about past failures (Williams, 2001). Arguably, doing this would distract individuals from focusing on future events and possible positive features associated with the same. Consequently, such individuals may resort to self-destructive behaviours like self-harm.

It is thought that self-harm is a behaviour that is carried out predominantly by females. Even though there is no conclusive evidence to support this claim, attempts are constantly made to justify it. Beasley (1999/2000), for example, in a study of incidents of self-harm in a medium secure unit concludes that service users of female gender were proportionally overrepresented in these acts. In a study of service users in Broadmoor Hospital (a secure setting), detained under Section 3 of the Mental Health Act 1983, it was found that 88% of female service users self-harmed compared to 15% of male service users (Liebling *et al*. 1996; Liebling and Chipchase, 2001). In a retrospective case note study conducted over a six-month period in the same hospital, Burrow (1994) noted that 64% of 475 reported incidents of self-harm were by female service users.

A very similar prevalence rate was declared by Low *et al* (1997) following a 30 -month case note study at Rampton Hospital, another UK secure setting. Given that the expression of anger is one of the most cited rationales for self-harming behaviour (Snow, 2002), the gender differences observed are more likely a reflection of the copying patterns of male and female service users. These patterns of self-harming behaviour support Bliss`s (1980) hypothesis of men being more likely to externalise their anger and women being more likely to do the opposite, internalise their anger. From a sociological perspective, society is generally less accommodative of females externalising their anger, as it is not considered to be a feminine activity (Ross and Heath, 2002). Additionally, many researchers and clinicians tend to believe that females are usually pre-occupied with fears of retaliation when externally expressing angry feelings. It is therefore not surprising to realise that females are more likely to re-direct angry feelings onto themselves, as it is believed to be considered a safe way of expressing the same (Harrison, 1995).

Despite this apparent propensity towards self-harm, one is beginning to think that it is a mistaken belief to continue to believe in the existence of a self-harm rate differential

between males and females. Indeed, apart from men tending to engage in more serious forms of self-harm, the traditional pattern of this behaviour is noted in Oxford and Scotland to have changed (McLoone and Crombie, 1996; Hawton *et al*. 1997). Reiterating the view of these authors, the rate of self-harm in these areas among men is growing at a faster rate than among women. Using Hawton *et al`s* (1997) study, a 62% rise in male self-harm was observed between 1985 and 1995, compared to a 42% rise in females within the same period.

Undoubtedly, such a pattern of self-harm contributes to the narrowing of the self-harm differential gap. Obviously, narrowing this gap may help in eradicating the previously held belief of female dominance; self-harm is more common among females than among men. Although White *et al`s* (1999) study purely focused on the incidence of self-harm in the male population of a medium secure psychiatric unit, they also thought that the self-harm differential between males and females had significantly narrowed. They concluded that male self-harm is more similar to that of females than previously believed. However, the basis of this assertion is not clearly articulated in their study. But it could be assumed that this was based on a comparative analysis of similar studies. This is likely to be true, as a handful of studies conducted in other European countries, such as Hungary, France and Finland, indicated a similar outcome; a narrowing of the female to male self-harm ratio (Cantor *et al*. 2000). Acknowledging this, it could be claimed that the traditionally held gender differential for self-harming behaviour may not be as marked as it appears. It is more than likely a function of the fact that a greater number of females report or seek help for this behaviour.

Irrespective of whether there is a gender difference or not, self-harming behaviour is most commonly seen in younger individuals. Confirming this, findings from a number of studies seem to indicate that the highest rates of this behaviour occur in young men and women (Collins, 1997; Swinton *et al*. 1998; Jackson, 2000). This is particularly true for those with experiences of sexual and or physical abuse. This assertion is supported by White *et al`s* (1999) study, which involves a detailed examination of the clinical notes of 88 male service users. It is evident from their analysis that 22% of self-harming service users had a history of physical abuse and 22% also had a history of sexual abuse. A comparative analysis of the findings from a number of studies indicates that sexual abuse is a significant component of female service users who self-

harm. According to Arnold (1995), 49% of 76 women with a self-harming history studied had experiences of sexual abuse, whilst 25% only reported physical abuse. Although one may question the validity and reliability of this study, purely on the basis of its data source (clinical case notes) and the population examined (female only), its findings reveal that self-harming service users are more likely to have experienced sexual abuse than physical abuse. This view is based on the fact that more than three quarters of the study population reported sexual abuse. Its outcome therefore deserves some attention. The finding of Haw *et al*'s (2007) longitudinal study of a mixed gender population agrees with this. They claim that, for females, childhood sexual abuse is a significant risk factor for repetition of self-harm. Similar outcomes were also noted by Hjelmeland and Polit (1996) and Vajda and Steinbeck (1999).

While these risk factors or characteristics have the potential for providing directions for effective implementation of preventive approaches, their diversity has enabled the researcher of this study to believe that it is difficult if not impossible to have a single approach to self-harm prevention. Thus, what is needed is a coherent, collaborative and well coordinated approach that will utilise the expertise of healthcare professionals, researchers, voluntary agencies and service users themselves. On the basis of this, the UK Government developed a National Suicide Strategy for England with a clear plan for reducing death by suicide and undetermined injuries by 20% by the year 2010 (DH, 2002). Significantly, this strategy pays special attention to the seriousness and scale of the problem of self-harm and therefore calls for the behaviour to be closely monitored. Such a call is responded to by creating a multi-centre monitoring scheme, involving projects based in Leeds, Oxford and Manchester (Hawton *et al*. 2007). The main remit of this monitoring scheme is to identify the patterns of self-harm, its impact, service provision and motivations or reasons for this behaviour.

3.4.4: Reasons for Self-Harm

It is necessary to reiterate the view that self-harm is a complex multidimensional behaviour, and such complexity perhaps indicates a multitude of reasons motivating service users to engage in it. Indeed, a wide range of reasons or explanations for this behaviour is today noted in the literature. Tension release is one of the most commonly cited reasons by service users, as they tend to claim experiences of reduced tension

following acts of self-injury (Simpson, 1976; Favazza and Conterio, 1989; Hartman, 1996). Service users who uses self-harm for this reason are believed to have difficulties with verbal communication (Favazza, 1996). Experiences of reduced tension are in essence feelings of calmness; a reduction of psychological arousal to a bearable level. Outcomes of a number of studies indicate this. In a study conducted by Herpertz (1995), 43 out of 54 participants reported expressions of unbearable feelings as their motivation for self-injury. Barstow (1995) and Beasley (2000) in their studies identified similar motivations for self-harming behaviour. While service users sometimes claim to experience relief after an act of self-injury, it is evident that such a relief is generally not long lasting, as the behaviour is usually repeated (Zahl and Hawton, 2004). Arguably, repetition reflects episodes of built up tension or intense feelings in service users, interspersed by periods of calmness. Acknowledging this, it could be stated that acts of self-harm, used to express unbearable feelings, are in the main functional in temporarily restoring calmness, a state which the researcher of this study believes may negatively reinforce this behaviour.

Apart from acting as a reinforcer, self-harm is a potent medium for the communication of intense emotions, such as anger. Liebling *et al* (1997) agree with this by emphasising that service users, particularly those with a diagnosis of borderline personality disorder have been noted in a range of studies to state that attacks against their bodies can be used to hurt or avenge others. Knowing that anger can be communicated in a multitude of ways including violence and aggression, for these service users, the use of self-harm to ventilate feelings seems to be a preferred option of anger expression. This is probably a function of two distinct reasons. Firstly, it is less likely to generate retaliatory anger and secondly, it is more likely to attract empathy and care from clinicians. If the latter happens, the self-harming behaviour can be positively reinforced. Such reinforcement could result in the repetition of the behaviour.

Focusing on the latter rationale, healthcare professionals, particularly those in secure settings, may find it too hard to ignore a self-harming incident. This assertion is based on their fears of possible complaints and litigation. Thus, apart from the professional demand to provide care, responding to service users serves as a potent means of alleviating fears or anxieties experienced during incidents of self-harm. Healthcare

professionals are therefore more inclined to respond to service users` self-harming behaviours. However, their responses may vary according to the severity of the behaviour. For incidents considered to be of high risk, service users would be observed closely to prevent incidents of harm. This manner of observing individuals with the potential of hurting themselves is what is referred to as *specialing*. It is important to state that this approach could reinforce service users` self-harming behaviour. It is noted in the literature that service users are sometimes described by healthcare professionals as attention seekers and manipulators (Harrison, 1995). While such a response is ethically questionable, it could enhance people`s need to self-harm (Sadler, 2002). Notably, they find these responses insulting and offensive, as they are absolutely different from their behavioural motives (Suyemoto, 1998). This differential is explained by Raine (1982) using the case of woman who severely hurt herself a day before her parents planned to depart for holidays. It must be noted that she was asked by her parents to join them on holidays, but declined the offer. In light of this, her self-harming behaviour was viewed as an attempt to manipulate them and prevent them from going on holiday. The service user attributed her behaviour to fear of abandonment and safety.

A detailed exploration of the issue of safety reveals that self-mutilation, a form of self-harm, can sometimes be used, particularly by females who have been sexually abused, to make their bodies look "ugly" or unattractive. Such unattractiveness, caused by the scars, is believed to protect them from unwanted sexual advances. A quotation by Babiker and Arnold (1997:84) seems to explain this better:

> *I wonder if I'd done this when I was little, maybe my vagina would have stayed safe like children's are supposed to. It brings a sense of calm and rightness for a while. It would be better to keep blades in there all the time, may be to keep me safe always.*

On exploring this statement one may rightly claim that self-harm is a desire to shock and drive away potential sexual abusers. This is apparently true, at least, for some service users. In support of this, Babiker and Arnold (1997) emphasise that service users have on occasions reported using self-mutilation as a means of cleaning themselves of aspects of abusers left inside them. Some of them claim that the blood oozing out of their body when they hurt themselves, in essence, gets rid of some aspects of abusers left inside them (Babiker and Arnold, 1997). Such feelings of dirtiness may develop to feelings of self-hatred, self-blame and guilt. These feelings can be tormenting for service users who

may therefore attempt to alleviate the same by using approaches such as depersonalisation or dissociation (Favazza, 1996). In simple terms, the service users would cut off from reality to avoid torment and painful experiences. This cutting off or dissociation is sometimes experienced as feeling dead or numb in the body (Yates, 2004). Although these dissociative feelings are protective in function in the context of not allowing individuals to face their unbearable experiences, they can also in themselves be very distressing and frightening (Low *et al.* 2000). Arguably, self-mutilation enables service users to return to reality which, in turn, ends the episodes of distressing and frightening experiences.

Lack of freedom, being locked up with many rules and limited dignity can also be very distressing for service users, particularly when they perceive their future to be bleak. Users in these settings usually perceive themselves to lack control and or be out of control of their lives (Dollard *et al.* 1939). Being out control can be frightening for anyone, but it can be particularly worrying for individuals who self-harm (Hale, 1999). It is therefore sensible for users with this behaviour to seek ways of regaining control over their lives. In secure environments, self-harm provides users a sense of having control of something or being in charge of their own lives. For example, participants of Herpertz`s (1995) study identified control as the motivation for their acts of self-harm. Arnold (1995) noted a similar motive in a significant number of her study participants.

Although the issue of self-control is a contributory factor for self-harming behaviour, it must be emphasised that individuals are generally disinclined to injure themselves (Walsh and Rosen, 1988). This is probably because such behaviour is not only considered to be a sign of mental illness, but it is also socially embarrassing and stigmatising. However, in institutional settings where others self-injure, the inhibition against such behaviours may be reduced. This assertion is purely based on the view that service users who self-injure in these settings, in the main, receive solicitous attention. This is likely to make this behaviour more attractive for those service users who are looking forward to similar support.

It is clear at this point that self-harm is a highly functional phenomenon, serving a variety of purposes for individuals. The purposes or rationales provided in this text are not exhaustive of the range of rationales for engaging in self-harming behaviour. However,

irrespective of rationales provided, this behaviour can have a negative impact on both healthcare service recipients and providers. Although they appear to be fairly representative, the reasons provided here do not exhaust all possible rationales for service users engaging in self-harming behaviour. It is therefore important to explore the impact of this behaviour on service users, professionals and service provision.

3.4.5: Impact of Self-Harm

One helpful way of engaging in a discussion of the impact of self-harm is to commence with an examination of the frustration the behaviour causes to service users. Generally, it is believed that service users experience feelings of euphoria and calmness following acts of self-harm (Shearer, 1994; Sadler, 2002). However, the literature seems to reveal that such euphoric states are in the main short lived. Claims have been made by a number of researchers that service users frequently experience feelings of self-hatred, worthlessness and disgust when they retrospectively examine their self-harming acts (Feldman, 1988). These feelings are likely to create psychological tension in people experiencing them. Alleviating such tension is one of their primary motives for users of mental health services to harm themselves (Harrison, 1995). Arguably, acts of self-harm may sometimes have a paradoxical effect on people. In other words, reflecting on the acts of self-harm, they may generate distress instead of alleviating the same. It is therefore not surprising that service users tend to repeat this behaviour in their search for calmness. Hence, it is important explore the root cause of their tormenting experiences.

This distress faced by service users appears to be a function of an ambivalent conflict of whether to continue or not to continue with self-harming behaviours. Such conflict tends to arise when service users realise that injuring themselves does not usually lead to a permanent experience of euphoria or tension relief. Certainly, choosing between two alternatives, whether attractive or not, is a major source of frustration (Miller and Rolnick, 2002). Thus, service users may experience tension when they are faced with the dilemma of whether to harm or not to harm themselves. A tension or frustration of this nature can be alleviated, at least temporary, by choosing one of the alternatives. For some service users, continuing with self-injury is sometimes the preferred approach. Using such an approach to alleviate experiences of tension, may increase the risk of suicide. Estimates suggest that individuals who engage in self-harming behaviour are

100 times more likely to kill themselves than the general population (Williams and Pollock, 1993). This risk is generally increased in individuals with a history of drug abuse and / or affective disorder (Van Heeringen *et al*. 2000). Such histories and repetition of self-harming behaviours are common among service users in secure settings (Penn *et al*. 2003), suggesting that suicide rates are higher in this service user group than other clinical populations.

Acts of suicide can inject considerable distress or shock in healthcare professionals and other observers including service users. According to Tantam and Huband (2009), these emotional reactions are not uncommon among individuals who experience sudden losses, such as death. However, there appears to be a consensus among healthcare professionals that the distress caused by acts of self-harm, particularly when repeated, is more alarming and revolting than that caused by acts of suicide (Burrow, 1994; Favazza, 1998). This is probably because of the human tendency to mollify the impact of suicide by rationalisations such as *"it is God's decision for one to take one's life"*. With regard to self-harm, its impact is generally greatly felt by healthcare staff because of frequent exposure to the same, causing persistent frustration and guilt (McAlaney *et al.* 2004). This assertion is not only based on the perceived "senselessness" of the behaviour, but also based on the view that acts of self-harm are regularly encountered in clinical areas, creating enormous demand on the time of healthcare professionals. The demand on time may be a source of frustration, as it may also interfere with the smooth running of the clinical areas. The regular encounter of self-injurious behaviour itself may remind healthcare professionals` of, and as well as add to, their existing distress and negative feelings about the behaviour. Babiker and Arnold (1997:118) echo this by suggesting that:

> *Staff may experience considerable distress and strain through witnessing repeated incidents of self-injury, attempting to anticipate and control risk, and so on.*

Distress experienced by healthcare professionals can interfere with the development of therapeutic relationships with service users and may also damage existing relationships (Burrow, 1994). Acknowledging this, one needs to explore facets of this behaviour (self-harm) that generate such a tormenting emotional reaction in others. Obviously, as humans, healthcare professionals are expected to feel some degree of discomfort in their interactions with service users who cause themselves concrete physical harm.

Additionally, they would experience shock when treating self-inflicted harm (Favazza, 1998). Arguably, these experiences of shock would be even greater when faced with repeated self-harming behaviours. Such encounters may often leave healthcare professionals feeling betrayed, dejected and incompetent, believing that their efforts to help service users in this context have been futile (Loughery *et al.* 1997). In support of this, Frances (1987: 289), on behalf of healthcare professionals, clearly articulated possible feelings that can be faced in clinical encounters. She states:

> *The typical clinician (myself included) treating a service user who self-mutilates is often left feeling a combination of helpless, horrified, guilty, furious, disgusted and sad.*

Clearly, such encounters seem to confirm Burrow's (1994) view of the power of disturbing emotions in damaging relationships. Favazza (1996) reinforces this view by stating that a regular exposure to a stream of anxiety or distress, generated by acts of self-harm, can lead even very experienced psychotherapists to end up "hating" their service users. Although healthcare professionals should not "hate" their service users, the use of the word "hate" in this context seems to indicate the possibility of a critical change in attitude, which can be experienced by clinicians as they encounter repeated failure in reducing or stopping service users from self-harming. Failing to stop service users from injuring themselves may urge healthcare professionals to explore ways of coping with emotions that may be evoked by these behaviours.

Coping is referred to as a dynamic process that involves a mixture of behavioural and cognitive responses, which are simply outcomes of individuals` assessment or appraisal of an event and emotions associated with it (Lazarus and Folkman, 1984). Basically, it is anything a person does to minimise the impact of either a perceived or actual stressor. Noting that disturbing emotions are usually generated from the assessment of stressful events (Morrison and Bennett, 2009), one may rightly consider the aim of coping to be three fold. The strategies individuals would adopt may focus either on minimising the impact of any distress that may be experienced or alleviating the stressors themselves or tackling both of these issues. If this is the case, it could be safely inferred that the strategies employed in any given situation are generally determined by individuals` coping motives. Arguably, coping is a motivational and transactional process that involves interactions between individuals, their environment, stressors and emotions experienced. This opinion is also echoed by Lazarus (1993). It appears from this

assertion that the ultimate aim of such transactions is to manage stressful or demanding situations with a view of making them less distressing.

One of the strategies used in practice to manage stressful episodes like self-harm is seeking support through formal means, such as supervision. In these forums, practitioners tend to discuss in confidence issues that are negatively impacting upon their clinical performance. Practical solutions to problems may also be examined. Staff meetings and teamworking are also coping approaches adopted in clinical practice. They are consistently identified in the literature as strategies for improving care provision as well as addressing difficulties sometimes experienced by healthcare professionals (Cook *et al*. 2004). It is apparent from this discussion thus far that the motivations for using the approaches identified are to reduce distressing emotions to bearable levels and to prevent or stop the behaviour. They are therefore, according to Lazarus and Folkman (1984), embedded with both problem and emotion focused elements of coping.

Repeated exposure to self-harming behaviors can be very tormenting for healthcare professionals. Emotions associated with such exposure are manifested in a variety of ways in practice. For example, Arnold (1995) in her study reported instances where service users` wounds were stitched without anesthetics.  While this is indicative of angry feelings, it is also suggestive of professionals` limited or lack of knowledge and understanding about self-harm and the underlying motives for the behaviour. It is this limitation that seemed to have led healthcare professionals to acknowledge in a range of studies the need for training on this subject (Clark, 2002). They believe that undertaking specific training would equip them with the necessary skills and attitudes on how to effectively respond to people presenting with this behaviour (Crawford *et al.* 2003).

Despite the occasional in-house training provided, the rate of self-harm is still reported in the literature to be high in mental health services and it is shown to be particularly high in forensic settings (Snow, 2002). These incidents would not only lead to huge demands on care time, they could also generate tension between other service users and healthcare professionals with a clear potential of the former accusing the latter for not spending adequate time with them. If such a tension arises in practice, users with these behaviours are more likely to be blamed for the same. Doing so could result in more self-harming behaviours. Taking this into account and other discussions presented, it is now clear that

healthcare professionals should critically re-examine their treatment approaches and coping strategies with a view of finding out possible explanations for service users` continuing self-harming behaviours. A number of theoretical explanations have been provided by researchers and clinicians, and discussion of these would, no doubt, provide some insight in to why service users engage in self-harming behaviours.

3.5: Theoretical Perspectives of Self-Harm

There has always been a quest to understand the aetiology and meaning of self-harm. In the distant past, the predominant explanation for the behaviour has been demonic possession. Jesus, for example, attributed the repetitive self-harming acts of a man carried out with stones to possession by a demon (Favazza, 1996). With advances in social sciences and psychiatry in particular, supernatural explanations have been in the main discarded and alternative explanations for the aetiology, reasons and treatment of self-harm are now provided (Walsh and Rosen, 1988; Babiker and Arnold, 1997). Based on an excellent review of the literature and extensive and intensive work on the phenomenon of self-harm, Favazza (1996) offered three complementary theoretical explanations which fall under the following subheadings: psychological, sociological and biological. This multiplicity of explanations is a reminder of the complexity of self-harming behaviour itself and the view that no one perspective can fully explain it. It is worthwhile, therefore, to examine each of these perspectives in turn, as a combination of them may provide a reasonably comprehensive picture of self-harm.

3.5.1: Psychological Explanations

Several psychological theories have been posited to provide explanations as to why people self-harm. One that is frequently cited is self-harm as an issue of control. When children are physically and sexually abused, they are usually in a situation of no control as their abusers can hurt them at any time (Shepperd and McAllister, 2003). Therefore, when these children grow into adulthood and encounter stressful situations, there is often an expectation of some sort of pain, purely because of previous associations of pain with stress (Morrison and Bennett, 2009). Adults with these associations often resort to self-harm when exposed to stress, not only because it satisfies the learned desire for pain, but also because it is an experience of pain that can be controlled through physical interventions (Walsh and Rosen, 1988). It seems that self-harm affords a level of control over emotions, as it allows people to vent their anger on their own bodies. This partly explains the increase in incidence of self-

harm in secure environments. Living where behaviour is closely scrutinised by healthcare workers and where basic human activities of work, play and rest are regulated with individuals having little or no recourse to changing them, may not only worsen individual psychopathology, but may also re-activate possible feelings of traumatic childhood experiences (Goffman, 1961; Favazza, 1996). Service users may use self-harm to cope with these feelings, as it is a behaviour over which they have total control.

Secure environments are generally described by service users as demoralising and non-stimulating, partly because of their ongoing monotonous activities. These environments tend to house a large number of people with a diagnosis of borderline personality disorder (Liebling *et al.* 1997). Service users with this diagnosis appear to have an inordinate need for novel experiences, excitement and stimulation (Favazza, 1989). The level of excitement and stimulation required by these service users is usually not achieved in a secure setting, a function of its restrictive, rigid and monotonous regime. Service users may therefore experience excessive mental tensions because of this stimulation gap. In many cases, self-harm serves as a useful function to reduce the mental tension of service users and to provide the extra stimulation they require (Sadler, 2002).

The restrictive nature of secure environments may serve as a reminder of the abusive experiences encountered by service users in childhood. These abusive experiences and their reminders could lead service users to develop negative feelings, such as self-blame, self-hatred and self-punishment about themselves in adulthood, a view acknowledged by Babiker and Anorld (1997). They add that these negative feelings are a result of direct teaching by the abuser that the abused is bad or evil and deserve nothing but punishment. Clarke and Llewelyn (1994:274) support this theoretical position and state:

> *The child learns as a result of being abused, the behaviours and cognitions appropriate for being abused and incidentally for abusing.*

On analysing this account, it could be stressed that self-harm is a learned behaviour and its manifestation in adulthood is an expression of internalised oppression, a process by which individuals take into themselves the hatred and denigration received from others (Bustow, 1992). Acknowledging this, it is apparent that the feelings of self-punishment, self-hatred and self-blame are mediating processes between abuse and self-mutilation, as people with these feelings may turn to self-harm to punish themselves. By doing so, they might even feel

relieved, at least for a while, from the supposed badness and guilt. It is these feelings, which are believed by many to lead to the urge to self-destruct (Suyemoto, 1998; Williams, 1997). The relief that occurs can be reinforcing. This expression of anger is important in another formulation, as in moments of extreme anger. In such instances, adults may express their aggression towards an abuser by mutilating their bodies, which can symbolise the abuser (Stone, 1987). Although some anxiety may be experienced, self-harm is a safer alternative to hurting others.

The role of anxiety, guilt and other negative feelings experienced by individuals who self-mutilate can be explained by utilising Freud's dichotomous theory of death drive (*Thanatos*) and life drive (*Eros*) (Freud, 1923). *Eros* is the life force, which drives us towards survival with a fundamental aim of promoting states of calmness and self-cohesiveness. In contrast, *Thanatos* is the death instinct, which propels us towards a state of non-existence. Put simply, it aims for self-destructiveness. In relation to this theory, Freud proposed that humans are closed energy systems with a constant amount of psychic energy (*libido*) for any given individual, which works towards creating a state of equilibrium between the two opposing forces of *Eros* and *Thanatos (*Carlson *et al*. 2004*).* When an individual experiences threatening thoughts, libidinal energy is used to repress them into the unconscious mind, depleting the energy system of resources for growth and development. Thus, when service users continue to experience anxiety, *Thanatos* would be operationalised, which according to Freud expresses itself either externally as aggression directed towards others or internally as aggression directed towards the self. From a service user's perspective, the latter is the most preferred as it is easier and safer to vent anger on one's body parts. Self-harm is thus an outcome of the struggle between the intrapsychic forces, *Thanatos* and *Eros,* with the former assuming a dominant role, particularly in instances where anxiety is evoked.

Although Freud's theory of death and life instincts has in the main been discarded, there are traces of its application in psychiatry. For example, Menninger (1938) considers self-harm as a form of therapy that prevents an individual from total self-destruction. In fact, Menninger`s (1938) theory is reminiscent of the liturgical advice to cut off an offending limb as it is better to enter the kingdom of God with one limb than to be cast into hell with a whole body. Clearly, self-harm may occur within a religious context, which can be sometimes psychotically motivated. In institutional settings, for example, self-harm has been noted to occur in response to auditory hallucinatory commands, such as the "voices" directing an

individual to slash himself or herself with a sharp object (Favazza, 1996). Resisting these commands may result in service users experiencing intense anxiety, and may therefore feel compelled to carry out the instructions given to them. Arguably, self-harm is an attempt to end service users` frightening anxiety episodes.

In psychiatry, frightening episodes have also been observed in service users suffering from depersonalisation, characterised by obsessive thoughts of being detached from one's mental processes or body (American Psychiatric Association, 2000). Additionally, frightening experiences have also been associated with dissociative disorders, characterised by a cognitive difficulty in recalling important personal information, particularly those of a traumatic or stressful nature (Babiker and Arnold, 1997). Simply, it is an alteration in the perception of self and reality, which is usually a function of intense emotional arousal (Suyemoto, 1998). It is thus a defense mechanism employed by individuals against frightening experiences. Self-harming acts associated with depersonalisation are therefore not suicide attempts, but they are therapeutic and communication attempts to end the unbearable feelings of the disorder. It is important to highlight that self-harm is not only associated with depersonalisation disorders, but has also been linked with negative childhood experiences.

An examination of the literature reveals that lack of secure relationships in childhood can initiate and maintain self-harming behaviour, and people who cannot remember feeling special or loved by anyone as children were least able to control it (Van der Kolt *et al.* 1991). Children in abusive families may constantly experience violation of their physical boundaries and are explicitly expected to suppress their needs and conform to those of their parental figures (Babiker and Arnold, 1997). Children in such situations may experience problems with separation and individuation that may even linger on into adulthood. Problems with separation and individuation are not only associated with abused children, but have also been identified in those from relationships with insufficient nurturance (Walsh and Rosen, 1988). The lack of differentiation and confusion between oneself and one's parental figures may result in intra-personal conflict, a conflict that can re-emerge in adulthood (Carroll *et al.* 1980). In secure environments for example, service users are expected to respond to the needs of the institution with limited allowance provided for self-expression. This restriction may not only replicate the problems of separation-individuation encountered by some service users in childhood, its existence may also hinder the development of their individual

identities (Goffman, 1961; Harrison, 1995). For some service users, especially those with histories of child abuse, these experiences may lead to the development of psychological tension, which require a safety valve for safe expression. Self-harm, a form of psychological surgery, can be used to do this as it may help individuals to re-establish their own physical and self-boundaries. In contrast, it could be argued that self-harm on the part of the individual who has been abused may also serve as means of continuing the abuse on behalf of the parental figures.

In secure hospitals, healthcare professionals, purportedly in the name of therapeutic engagement, constantly violate service users` personal spaces. Service users generally find these environments overpowering, unfair, malevolent and uncaring (Favazza, 1996). Obviously, service users in these settings may experience difficulties forming supportive and intimate relationship with healthcare professionals. This is particularly true for those deprived of these relationships as children (Walsh and Rosen, 1988), as these environments may replicate their unsympathetic and unsupportive childhood experiences. Consistent with this formulation, Burrow (1992) theorises that service users in secure environments are more likely to address their conflicts in isolation rather than in relationships to others, sometimes in ways involving injury to their bodies. Clearly, service users` past negative experiences in the context of relationships may make them distrustful and sceptical regarding human relationships and experience considerable conflict during interactions. Service users-healthcare professionals` interactions in secure settings can be frustrating, especially for the former. This is attributable to the existence of a system of social and psychological apartheid, where service users are exclusively recipients of care, while nurses are prescribers and providers of care (Goffman, 1961). In this way, service users are stripped of their individualities and reduced to numbers or diagnostic labels. The frustrations generated by these binary systems could lead to the expression of aggression. Dollard *et al* (1939) support this view by putting forward the frustration-aggression hypothesis.

This hypothesis suggests that frustration is likely to build up when people suffer at the hands of another; when their liberties are restricted and or when inequalities in treatment are apparent. Additionally, Dollard *et al* (1939) assert that in instances where aggression cannot be directed at the source of frustration, it is usually refocused towards others. These characteristics are present in secure environments and service users may not only find it socially inappropriate to be angry with others, but they may also find it difficult to externalise

their anger against others because of the presence of powerful institutional barriers to do so (Snow, 2002). Expectedly, service users may re-direct their aggression at the self rather than the people who may be at the root of their hostility. Using self-harm in this way, especially in instances where it meets individual personal needs, may not only reinforce the behaviour, but may also evolve into an addiction.

Attempts to explain the rationale for the use of self-harm as a coping strategy reveal that people who self-harm are rigid in their thinking and have a limited repertoire of problem-solving strategies (Neuringer, 1964; Williams and Pollock, 2000). A large number of studies that have explored service users` problem-solving abilities noted differences and deficits in the quality of solutions to problems generated, particularly by self-harming service users (Linehan *et al*. 1987; Orbach *et al*. 1990). These differences in problem-solving abilities are probably influenced by specific service users` characteristics. Williams (1996) claims that successful problem-solving depends largely on the quality of the type of memories individuals are able to retrieve. In the same vein, he emphasised that specific memories are very useful as a resource in solving problems because they provide a large spectrum of cues for potential solutions. Self-harming service users, according to Goddard *et al* (1996), are poor at problem-solving because they generally experience difficulties in accessing their memory banks. Hence, when faced with a crisis, self-harming individuals can only retrieve generic memories which, according to Sidley *et al* (1997) and Williams and Pollock (2000), are not conducive to creative problem-solving, as they only provide few management options to address life difficulties. Self-harm is usually one of these approaches. Thus, one could say that self-harm is a result of inadequate problem-solving, which is sometimes influenced by limited verbal communication strategies. The issue of self-harm as a communication strategy requires further exploration, and because communication is an interpersonal process, it is more appropriate to discuss it in the next section, sociological explanations.

3.5.2: Social Explanations

It is well documented in the literature that self-harm within groups is a primitive method of communicating needs, and people prefer it to verbal expression because they find the latter too dangerous and ineffective in achieving emotional relief (Walsh and Rosen, 1988; Clark, 2002). In support of this, Suyemoto (1998:544-545) comments:

> *If language cannot be used to create distance from feeling and regulate affect, self-harm could be a good substitute. It is used as a primitive evocative symbol that*

discharges feelings, communicates the primary process through evocation, controls the effective experience through distancing and externalising, and protects the self and others from the emotions.

Self-harm is thus a safe, concrete and powerful means of expressing inner discomfort in the hope that someone will indicate willingness to lend a sympathetic and empathetic ear. Interestingly, whilst this is true for some people, others, mainly those with experience of sexual abuse, engage in self-harming behaviours to shock and drive away non-mutilators (Figueroa, 1988; Babiker and Arnold, 1997). It is apparent that the motivation of this group of self-harmers, especially those in clinical settings, is to establish a clear group identity with specific characteristics such as outrageousness and frightfulness. If this is the case, any shocked experience that is expressed by healthcare professionals may reinforce the behaviour and hence, its continuation (Favazza, 1987). It is worth emphasising that the self-harming behaviours may serve as a driving force, at least for some healthcare professionals, in meeting the demands of service users (Babiker and Arnold, 1997). It seems that without this "frightening experience", healthcare professionals may not respond to service users` demands, suggesting that self-harm as a communication strategy fails in its purpose to inform others of unbearable inner discomfort. Collins (1997:467) agrees with this and suggests that:

In the medical model, where the injury is regarded as a symptom, the self-harmer often becomes re-abused by a system that fails to see the injury as a communication of the trauma, but views it instead as manipulative.

Self-harm has been noted to be a manipulative act used by people to gain attention (Bywaters and Rolfe, 2002), and in clinical settings, to obtain some nurturing (Suyemoto, 1998). It is essentially an emotional threat and action that is difficult to ignore, particularly in instances of increased intensity and magnitude of the acts. In secure settings, healthcare professionals are sometimes ambivalent about whether or not to engage in a caring behaviour following a self-harming episode. However, the intensity and frequency of self-harming behaviour may increase irrespective of the action taken. Obviously, responding in a caring manner runs the risk of reinforcing the behaviour and thereby increasing its frequency. From a behavioural perspective, although an ignoring approach is expected to extinguish behaviour, it has been suggested by Offer and Barglow (1960 in Walsh and Rosen, 1988) to increase the frequency and intensity of self-harming behaviours. One plausible explanation for this increase is that service users may perceive an ignoring approach as uncaring and unsympathetic and hence, may continue to self-mutilate to receive attention knowing that healthcare professionals may find it hard to continue ignoring self-harming acts. Embedded in these responses, caring and

ignoring, is the notion of attention seeking provided by healthcare professionals, which partly explains the presence of a contagion of self-harm sometimes observed in psychiatric hospital units.

The concept of contagion in the context of self-harm has been referred to as a pattern of self-harming acts within a specific environment in which service users self-mutilate by imitating the behaviour of another (Kirby and Norris, 1998). In a simple way, it refers to the spread of self-harm from one troubled person to another. Although imitation to gain attention has been provided as a possible reason for self-harm contagion, a number of other reasons have been postulated. Hawton *et al* (1999) cites healthcare professionals` anxiety and peer group competition as factors that may contribute to the increase in frequency of self-mutilation. Given that high status is important to group members, there is pressure to self-harm and it is this pressure that facilitates the contagion phenomenon. In institutional settings in particular, expressions of anger and frustration and an under stimulating environment are frequently cited reasons for self-harm epidemic (Ross and McKay, 1979; Pawlicki and Gaumer, 1995). Females, particularly with abusive experiences, have also attributed their self-mutilative acts to a desire to become unattractive, claiming that being undesirable would avert rape incidents (Babiker and Arnold, 1997). This way of reasoning could result in the development of compulsive eating disorders, which may cause an individual to become obese and thus considered to be outside modern societies` description of attractiveness.

Feelings of anxiety, frustration and anger are usually associated with self-harm and related compulsive behaviours. However, the actual processes or mechanisms causing these feelings are not fully understood, but Collins (1997) claims that they may be biologically based. Explanations of biological processes giving rise to self-harming acts are briefly discussed below.

3.5.3: Biological Explanations

Although many cases of self-harm have been successfully treated using psychological and social approaches (Bowers *et al.* 2000), there are indications of limited successes of these approaches in some clinical encounters. For example, Philips (2004), in a study of rigorous and consistent application of physical restraint on self-mutilating service users, concluded that it did not completely stop the behaviour, but reduced its frequency and severity. This

seems to suggest that biological elements are implicated in the causation and maintenance of self-mutilative behaviour. This appears to be the case, at least for some individuals. Service users have claimed to experience less or no pain when they self-harm (Bohus *et al*. 2000). This surprising claim can be explained by the action of a biological chemical, endorphin that suppresses pain and produces a pleasurable effect akin to exogenously applied opiates (Russ *et al*. 1992; Traskman-Bendz and Mann, 2000). Service users, especially those with psychological difficulties, might therefore use self-harm as an external means of stimulating the release of endorphins to alleviate tension and generate feelings of euphoria. This use of self-harm may lead service users to associate it with euphoric feelings and may resort to its use, sometimes repetitively, when faced with unbearable tension. The repetitive use of self-harm has been attributed to service users being addicted to endorphins for their euphoric effect. In support of this theory, Russ *et al* (1992) claims that tolerance to endorphins, like in opiate addiction, may develop as service users self-mutilate, and may therefore require repetitive mutilative acts to achieve the desired effects and avert withdrawal symptoms. However, a close examination of the literature reveals a lack of clarity in the exact nature of the relationship between self-harm and endorphin release (Winchel and Stanley, 1991). Although this may require further exploration, it is beyond the remit of this thesis.

Another neurotransmitter that is associated with self-harm is serotonin. It has been proposed that low serotonergic activity, especially in individuals with borderline personality disorder, is a correlate of assaultiveness and impulsiveness (Zlotnick *et al*. 1999). In other words, self-harm is an impulsive disorder that can be facilitated by impaired serotonin levels. When the efficacy of medication, such as selective serotonin reuptake inhibitors (SSRIs) that generate brain serotonin were examined, the findings indicate that SSRIs do not treat self-mutilation, but rather treat the impulsivity and compulsivity associated with it (Traskman-Bendz and Mann, 2000). This evidence appears to confirm that self-harm is an impulsive disorder that can be caused by low serotonin levels. Thus, serotonin is a biological trait with behavioural correlates, including self-mutilative acts.

These theoretical explanations put forward by clinicians and researchers aim to help develop a better understanding of self-harm and to provide comprehensive and effective care to sufferers. To date, service users are generally unhappy with the treatment they receive and find the theorising and philosophising of healthcare staff unhelpful (Pembroke, 1994; Harrison, 1995). Therefore, without wishing to discard the numerous biological, social and

psychological explanations provided, it is advisable to consider the theory most central to self-mutilation, service users` explanations of their behaviours and their views about healthcare professionals` attitudes. Clarke and Whittaker (1998:132) succinctly explain this view:

> *We contend that much philosophising about self-harm contributes little to our understanding of it and that we need to turn to self-mutilators themselves.*

Indeed, this is an indication that the healthcare professionals` understanding of self-harm is still limited and one of the best ways of enhancing this understanding of what this behaviour means, is to explore it with people that really matter; service users with experiences of self-harm. Therefore, the attitudes of service users and those of healthcare professionals towards self-harm require an indepth examination, as an initial step for developing a better understanding of the same.

3.6: Attitudes

Attitude is one of the most commonly used terms in our day-to-day interactions. People sometimes refer to one another as having an "attitude" and sometimes as having an "attitude problem". Clearly, the everyday use of term attitude is loose and confusing. Referring to someone as having an "attitude" or "attitude problem" is as though attitude is tangible. Such expressions are not uncommon in healthcare settings. Attitude is an abstract concept, which has been noted to be inconsistently used in the literature. It is useful, therefore, to be clear at this stage of the study what healthcare professionals typically mean by attitude.

3.6.1: Attitude: A Conceptual Discussion

Petty and Cacioppo (1996) refer to attitude as a general and enduring positive or negative feeling about some person, object or issue. Similarly, McGuire (1985:239) considers it as responses that locate objects of thoughts on dimensions of judgments.

These two definitions are similar in the context of their evaluative component, as they are indicative of people's thoughts and feelings about an "object of thought" or attitude referent, which, in this case, is self-harm. It is noteworthy to state that all attitudes have a stimulus object or referent or an "object of thought", which is believed to have the potential of activating the same (Ajzen, 1988). This seems to suggest that the expression

of attitudes (evaluation of attitude object) is an active process that requires some degree of energy. Such expressions could only be inferred from verbal and non-verbal responses, noting that attitude is an abstract construct that is inaccessible to direct observations. Arguably, attitudes do not only include how people think and feel about an object, but it also seems to incorporate people's overt behaviour towards the same. In other words, attitude is about how people respond favourably or unfavourably to an object of thought. This is a reiteration of the focus of this study, an exploration of healthcare professionals` feelings, thoughts, beliefs and behavioural responses to self-harming service users. Taking this into consideration, this study utilises Oppenheim`s (1968:105) tripartite definition of attitude, as it captures the essential elements of its aim. He defines it as:

> *A state of readiness, a tendency to act in a certain manner when confronted with certain stimuli.*

The tripartite aspect of this definition is its recognition of the view that people have a choice of three ways of responding to a stimulus (Oppenheim, 1992). These choices for responding, according to Rosenberg and Hoveland (1960) and Carlson *et al* (2003) are considered to be cognitive, affective and behavioural. With regards to cognitive responses, these are in essence the knowledge and beliefs a person may have about the stimulus object, which, in this study, is self-harm. Affective responses refer to the feelings people may have about the stimulus object, while behavioural responses are overt behaviours individuals may display towards the same. A thorough examination of the attitude components from an intrapersonal perspective reveals that attitudes may exist at different levels of depth and intensity (Oppenheim, 1992). If this is the case, it is important to consider the issues of accessing and activating attitudes.

A number of cognitive psychologists claim that people's attitudes are cognitively represented in their memories (Carlson *et al*. 2003). Such cognitive representations are believed to have a greater influence on behaviour, particularly when they are readily accessible and recallable (Higgins, 1996). Attitude accessibility is considered to be the ease with which a particular attitude may be retrieved from memory (Fazio, 1989). Taking this into account, it is probably safe to conclude that behaviours are greatly influenced by easily accessible and retrievable attitudes, a view also echoed by Fazio and Williams (1986)). In addition to accessibility, another concept that seems to be

influential on behaviour is attitude strength. This concept does not refer to the degree of positivity or negativity in the evaluation of an object of thought, but rather to how frequently and how consistently such an evaluation is expressed (Fazio *et al.* 1986). Strong attitudes are frequently and consistently repeated (Krosnick, 1989), meaning that they can be accessed and activated quite easily. In secure environments, negative attitudes, such as referring to service users who self-harm as attention seekers and manipulators, are commonly expressed by healthcare professionals. The frequency of expression of these attitudes indicates how easy they can be accessed and activated. In Krosnick`s (1989) view, they can be considered to be strong attitudes. Strong attitudes are repeatedly claimed to have a strong influence on the way people behave towards object of thoughts (Fazio *et al.* 1986), which, in this study, is self-harm.

This discourse about the influential nature of attitude on behaviour has been going on for a number of decades. In 1901, for example, attitude was referred to as a readiness for action or action of a definite sort (Baldwin, 1901). By 1962, this assertion was confirmed by some social psychologist, Krech, Cructchfield and Ballachey. They argued that people`s social actions, which could involve religious behaviours, care activities and ways of living, are directed or dictated by their attitudes (Krech *et al*. 1962). Although support of this claim is noted today, the attitude-behaviour relationship presented appears simplistic. Obviously, this is ignoring the multidimensional nature of attitude and multiple variables implicated in its relationship with behaviours (Ajzen, 1991). Clearly, attitude-behaviour relationship is a complex phenomenon, and such complexity can be understood by the use of robust models. Influential in this respect are the Theories of Reason Action and Planned Behaviour, which are noted to have considerable utility in explaining the association between attitude and behaviour (Caperchione and Mummery, 2007).

3.6.2: Theoretical Frameworks: Concepts and Relationships

The processes of this study, particularly the literature review, data collection and analysis, were guided by two underpinning theoretical structures; Theory of Planned Behaviour (Ajzen, 1991) and Social Identity Theory (Tajfel, 1982). It is important to stress that the former structure played a significant role in the developmental stages of this study, which, in essence include the framing of the research idea, articulation of the same in the form of a

project proposal and the execution of an extensive literature review. It therefore makes sense to commence this discussion with the same, Theory of Planned Behaviour. But since this is an improved version of the Theory of Reasoned Action (Fishbein and Ajzen, 1975), the latter is initially briefly discussed, followed by a discussion of its extension. A model of the Theory of Reasoned Action is shown in appendix 1.

The Theory of Reasoned Action assumes that most health-related behaviours are under volitional control, and regards a person's intention to perform behaviour as the immediate determinant and primary predictor of behaviours (Ajzen and Fishbein, 1980). This means that people are more likely to perform behaviours if they are willing to do so or refrain from carrying them out if they decide against the same. Arguably, intention is an indication of the degree of willingness or effort people plan to exert in order to perform behaviours. Thus, for volitional behaviours, people would be expected to do what they intend to do. One would therefore assume that an expression of behavioural intention would provide accurate predictions of willful behaviours, a view also acknowledged by Fishbein and Ajzen (1975). However, caution must be taken when making this claim, as Ajzen and Fishbein (1980) warn that intentions are not always good predictors of behaviour, even for those under volitional control. This assertion is based on the view that intentions can change with time, as they can be influenced by a number of factors. However, because the focus of this study is to understand attitudes expressed towards self-harm, the next step of this discourse needs to identify and explore the determinants of intention.

According to the Theory of Reasoned Action, intentions of people to perform or not to perform behaviours are functions of attitudes toward the behaviours and subjective norms (Ajzen and Fishbein, 1980). Certainly, the influential roles of these factors on intention, and the subsequent execution of corresponding behaviour, deserve some exploration. Starting with attitudes, a person who believes that performing behaviour could result in positive outcomes is most likely to hold favourable attitudes towards the behaviour. It is believed that such attitudes could have a positive impact on individuals` intention or motivation to carry out behaviours. In contrast, individuals with beliefs that engaging in behaviours will not be beneficial for others and / or themselves are more inclined to adopt unfavourable attitudes towards the behaviours, which in turn, could result in the development of negative intentions.

As already mentioned, the second determinant of people`s intentions to carry out behaviours are their subjective norms. According to Ajzen (1988), these are beliefs held by people that specific individuals or groups think they should or should not perform behaviours. In relation to self-harm, they exert considerable pressure on healthcare professionals to engage in care activities, such as attending to the needs of service users with this behaviour, independent of their attitudes towards the same. Generally speaking, people are more likely to carry out behaviour if it is positively evaluated and if they are convinced that significant others in their environment think they should perform it. Consistent with this thought, one would assume that healthcare professionals may willingly engage with self-harming patients if they consider their actions to be appropriate and if they think that their colleagues and regulatory bodies share the same views. It is important to stress that the degree of influence of the subjective norm and attitude on intention to perform behaviour may vary from one healthcare professional to another. It is therefore not surprising to note in clinical areas variations in healthcare professionals` responses to self-harming service users (McKinlay *et al*. 2001). Clearly, these two components, attitude towards behaviour and subjective norm, are assumed to combine to determine behavioural intention, which in turn, influences behavioural responses. However, their relative importance may vary across behaviours and situations. In some cases, the attitudinal component will be more important and in other cases, the normative component will predominate (Ajzen, 1988). Again, this explains the variations in healthcare professionals` responses to self-harming service users.

Some interventions, such as *specialing*, vigilant observation of a service user to prevent harm, carried out by healthcare professionals, are sometimes not willingly implemented (Philips, 2004). This manner of responding is sometimes a function of healthcare professionals` duty of care to provide care and sometimes a normative prescription of their employers and professional regulatory bodies (e.g. Nursing and Midwifery Council), and sometimes social pressure from colleagues. Anecdotal evidence clearly suggests that interventions such as *specialing* are routinely practiced in secure settings. It is important to stress that routine practices are sometimes adhered to without sufficient thought (Langer, 1989). This problem of incomplete volitional control on behaviours is addressed by Ajzen`s (1985) Theory of Planned Behaviour by adding a third independent determinant of intention and behaviour, perceived behavioural control, to the existing two (attitude and subjective norm) of the original version, Theory of Reasoned Action (Ajzen, 1985; Ajzen and Madden, 1986). A structural model of the Theory of Planned Behaviour is shown in appendix 2.

The Theory of Planned Behaviour also regards intention as the primary predictor of behaviour, and maintains that behavioural intentions are influenced by attitudes, subjective norms and perceived behavioural control (Ajzen, 1985). Perceived behavioural control refers to a person's perceived ease of performing behaviour taking into consideration some realistic constraints that may exist (Schifter and Ajzen, 1985). Succinctly, the motivation or intention to perform behaviour is influenced by how difficult the behaviour is perceived to be and the expectations to successfully complete it. Perceived behavioural control is believed to have a direct influence on intention and is not mediated by attitude and subjective norm (Ajzen, 1985). In addition to the influence of significant others (subjective norm), perceived behavioural control tends to play a significant part in influencing attitudes of people towards specific behaviours (Ajzen and Madden, 1986). Thus, the Theory of Planned Behaviour is considered to have considerable utility in explaining attitudes towards behaviours such as self-harm.

This theory has recently been re-conceptualised as a dual-factor model, meaning that the each of the three factors that influence people`s intentions to carry out behaviours are now represented as two components (Ajzen and Fishbein, 2005; Conner and Sparks, 2005). Attitudes, for example, are categorised into affective (e.g. happy-unhappy) and instrumental (e.g. useful-useless) components. Perceived behavioural control is divided into two groups, perceived controllability and self-efficacy with the former referring to the degree or level of control people perceive to have over engaging in behaviours. The category of self-efficacy focuses on people`s confidence of executing behaviours. In other words, it is to do with their perceived ease or difficulty of performing behaviours, a view also echoed by Bandura (1997). With regard to the normative component, research has found only weak support of its role in influencing intentions to perform behaviours. In a study conducted to test the effectiveness of this framework (Theory of Planned Behaviour), Ajzen (1991) noted a non-significant subjective norm-intention link. The same outcomes are reported in similar studies (Terry *et al.* 2000; Armitage and Conner, 2001), and such consistency prompted an intense exploration for a rationale for this.

The lack of or limited predictive power of the subjective norm was attributed to the manner in which it has been operationalised (Armitage and Conner, 2001). It is therefore imperative to re-conceptualise the subjective norm component in line with recent social psychological models of group influence, specifically Social Identity Theory, as this helps preserve a central

role for norms in the study of attitude-behaviour relationships. This suggestion led to the division of the the normative component of the Theory of Planned Behaviour into two categories, injunctive social norms and descriptive social norms (O`Connor *et al.* 2003). The injunctive category is about the role of social approval in promoting or hindering behaviour using reward and punishment respectively. The other category, descriptive social norm, concerns about people`s perception of what others do and the role of this in influencing behaviour. Now that the Theory of Planned Behaviour has been discussed, it is time to turn to the Social Identity Theory and to explore its relationship with the latter.

The Social Identity Theory is a general framework that enables people to develop an in-depth understanding of group processes and intergroup relations (Tajfel and Turner, 1986). Additionally, the same authors believe that it also helps to distinguish interpersonal phenomena from group phenomena. It is assumed within this framework that individuals` self-concepts are made up of multiple identities, which Augoustinos *et al* (2006) claim, are expressed in a range of social groups. It is critical to note that not all of the multiple identities are active or salient at any one point (Ellemers *et al.* 2002). Implicitly, individuals tend to select and express identities that they believe are appropriate for the context in which they find themselves. To develop a better understanding of this notion of multiple identities that people may experience, Turner (1987) provides two broad thematic descriptions of the same, personal identity and social identity.

Starting with personal identity, this relates to an individual`s close interpersonal relationships, idiosyncratic characteristics and qualities that make him or her unique and different from others (Turner, 1987). In contrast, social identity refers to aspects of an individual`s self-concept that emerge from membership of a social group and the value and emotional significance attached to that membership (Tajfel, 1982). Taking this argument of social identity further, it is implicit from the notion of group membership that individuals do not live in isolation; they live in relation to one another. This suggests that people are more likely to categorise themselves into groups and to identify with their respective groups particularly when there are perceived benefits (Hogg and Terry, 2000). One of the many benefits of groups is the opportunity they provide for members to compare and evaluate the appropriateness of their attitudes to those held by similar others (Hogg and Terry, 2000). Arguably, social groups have a role in influencing people`s attitude, its development and enhancement. Festinger (1950) agrees this view by claiming that an attitude is correct, valid

and proper if members of a group with similar beliefs and opinions support it. The manner of attitude development illustrated from a Social Identity Theory perspective is consistent with the injunctive category of the Theory of Planned Behaviour, which stresses on the impact of social approval in attitude acquisition. Taking this into account, it could be asserted that approving or disapproving beliefs held by a member of a group about an "object" of thought could result in the individual adopting favourable or unfavourable responses towards that "object".

Apart from changing attitudes, social groups are believed to exert some influence on the behaviours of their members. However, Hogg and Terry (2000) claim that the degree of influence is dependent on the strength of identification with groups. In support of this, Dutton *et al* (1994) assert that the more a person identifies with a group, the more he or she will behave and make decisions that are congruent with the group`s aims and objectives. Such social influence, described by Social Identity Theorists as group norms, are referred to in the Theory of Planned Behaviour as descriptive norms (O`Connor *et al.* 2006). Generally, these normative descriptions relate to the ways in which the attitudes and behaviours of significant others affect people`s decision to act in certain ways. Simply, this refers to people`s perception of others and the impact of this on their behaviours. One must stress that this influence is distinctively different from the injunctive norm; social pressure from others significant within and without a group to engage in behaviours.

One can rightly state at this point that attitudes are acquired or modified by absorbing or reacting to the attitudes of others and professional stipulations. This process of attitude acquisition, together with the perceptions of healthcare professionals and service users of self-harm, deserve more attention.

3.6.3: Self-harm: Perceptions of Healthcare Professionals

It is consistently mentioned in the literature on self-harm that healthcare professionals often feel torn, during care provision, between focusing on the symptoms (behaviour of self-harm) or the person exhibiting the symptoms (Anderson and Standen, 2007). Such experiences are not only considered to be challenging, but they can also generate intense anxieties, particularly in instances of frequent exposure to the behaviour. Noting that these are unpleasant places to be, healthcare professionals in these circumstances are

more likely to explore strategies for resolving their dilemma. Generally, they frequently adopt a behavioural perspective that considers self-harm as behaviour, habit and addiction that has escaped deliberate control (Tantam and Huband, 2009). Arguably, viewing self-harm as a behaviour would reduce healthcare professionals` emotional engagement with service users presenting with the same, which in turn would help reduce the level of anxiety they experience. Additionally, it is believed that a reduction in emotional engagement would offer professionals more opportunity to deal with service users who harm themselves as though they are victims or objects. Johnstone (1997:24) confirms this.

> *Instead of seeing another human being with all her complicated, distressing but ultimately understandable feelings, and her individual circumstances and ways of making sense of them, the staff would tend to react to a "borderline" or, in less formal language, "a cutter" or "a scratcher", labels which confine the service user to the level of his or her symptoms.*

This tendency to label people does not only pathologise and strip them of their individuality, but it also ignores the possibility that they can change. It is worth reiterating that this stripping process allows healthcare professionals to treat individuals as objects, not as individuals with complex needs and feelings. Ascribing labels or just focusing on the behaviour of self-harm is certainly a reductionist approach that gives no attention to the context in which the behaviour occurs. Undoubtedly, people who engage in this behaviour may consider this approach as inhuman. Thoughts of this nature may perpetuate the need for further self-harm.

The researcher believes that healthcare professionals` perceptions of service users` motivation and control over their self-harming behaviour are significant factors in attitude acquisition. This assertion is consistent with the outcome of Ramon *et al`s* (1975) study of doctors` and nurses` attitudes towards self-harm. It suggests that service users whose motives were attributed to despair were treated with more sympathy and understanding than those whose motives were attributed to manipulation. Although this study was carried out almost three decades ago, it is used in this study to indicate the historical nature of attitudes towards self-harm.

Historically, people who self-harm have been described over the last five decades as problematic, manipulators and attention seekers (Cook *et al*. 2004). These descriptors

are still frequently heard in today's healthcare settings. Bywaters and Rolfe (2002) confirm this by asserting that service users who undertake self-harm are now often cared for by healthcare professionals who perceive them as time wasters and unworthy of treatment. These perceptions can be attributed to healthcare professionals` failure to sometimes understand and acknowledge the reasons underpinning service users` self-harming behaviours. In terms of attempting to manage the care of service users, these negative perceptions (attitudes) will undoubtedly impede effective therapeutic engagement, a view regularly reiterated in the literature (Loughrey *et al*. 1997). However, one must be cautious in making such a generalisation, purely because of limited evidence to support the claim. A broader examination of this issue of therapeutic engagement suggests that healthcare professionals tend to hold attitudes which could affect the type and quality of care they provide to service users. The sources of acquiring these attitudes are wide ranging.

Bailey (1994) argues that negative perceptions are in the main a function of healthcare professionals` limited understanding of self-harming behaviour. While this might be the case, negative attitudes have also been attributed to higher levels of caring responsibilities. Patel's (1975) study of attitudes towards self-poisoning illustrates this. The outcome of this study indicates unfavourable attitude (hostility) by healthcare professionals in frequent close contact with service users with self-harming behaviour. Also noted in the same study is that junior medical staff were hostile towards service users who self-harm, whilst the consultants with very limited contact with these service users, demonstrated sympathy for the same.

Although Patel's (1975) study focuses on nurses and doctors in an Accident and Emergency department, its findings are applicable to secure environments. In fact, similar findings have been noted in forensic psychiatric services. Taking Gough and Hawkin`s (2000) study of attitudes to self-harm and its management in a secure setting as an example, most of their respondents agreed with statements such as "service users who self-harm are often selfish" and "dealing with self-harm wastes valuable staff time". According to Gough and Hawkin (2000), these respondents were often in close contact providing care to service users when they self-harmed. Arguably, negative comments expressed were attributed to the frustration caused by the cumulative effect of caring for a large number of service users presenting with self-injurious behaviour. What seems to

add to the frustration was probably the lack of effective ways of dealing with self-harm, as most of the staff reported little training and understanding of this phenomenon. They therefore lack confidence to address the needs of this user group.

Not surprisingly, the results of Gough and Hawkin`s (2000) study, demonstrate that receiving specific training and greater experience with self-harm may increase staff understanding of the same. It is believed that such understanding may result in the development of positive attitudes towards self-harming user groups. Consistent with this, is the outcome of Huband and Tantum`s (2000) retrospective study on the effect of previous training on attitude. It states that healthcare professionals with training in counseling and psychotherapy tend to accept and consider self-harming service user less demanding than those without either of these qualifications. Thus, one may argue that the factors underlying attitudes are not about prejudice toward service users, but they are rather about deficits in healthcare professionals` own personal and professional resources. In the process of agreeing with this, McAllister *et al* (2002) assert that attitude itself is a complex and multidimensional phenomenon and healthcare professionals who perceive themselves to have the appropriate skills to address self-injury problems, are more likely to hold positive attitudes towards the same.

However, the findings of Turnbull and Chalder`s (1997) survey are in contrast to previously presented cases. They state that training and education would not have an influence on attitude. Although such a claim can be easily discarded because of the failure of the authors to establish the reliability and validity of the questionnaire used, the study does provide important guidance on course design for healthcare educationists. It seems to implicitly state that courses designed to improve attitudes should focus on rewarding aspects of care with specific emphasis on how attitude can influence quality care provision.

Apart from training and education, the notion of experience of caring for self-harming service users appears to be pervasive among healthcare professionals as being a significant contributory factor for attitude change. Although his study was not conducted in secure settings, McLaughlin (1994) reported that attitudes of nurses to service users presenting with self-harm in an Accident and Emergency department were dependent upon their years of experience caring for this service user group. He continues to state

that older and more experienced nurses demonstrated more positive attitudes. This could be related to their personal life experiences, which, in the researcher's opinion, have psychologically prepared them to support service users with self-harming behaviours.

The positive attitudes expressed by older nurses can also be explained using the Social Identity Theory (Tajfel, 1982). In line with this theory, it is assumed that people are always motivated to hold attitudes similar to those they interact with. The attitudes shared by older nurses are also consistent with another claim made by the Social Identity Theory. Within this theory, it assumed that similarity in attitudes can provide the basis for psychological group formation (Tajfel and Turner, 1986). Simply, attitudes shared by people can help in categorising them into distinct groups. There are generally two broad groups of people in all healthcare settings; healthcare professionals and service users. According to the Social Identity Theory, members within each group are expected to share similar attitudes towards an object of thought, which in this case is self-harm. This is because the group norm (descriptive norm), a form of social influence, tends to exert social pressures upon people within groups to act in a certain way (Terry and Hogg, 1996).

The practices of healthcare professionals in mental health settings are in the main guided by the stipulations of the medical model (Ross, 2002). Simply, this professional group is expected to adhere to the guidance provided by this framework. Hence, the negative attitudes of professionals described thus far, are at least in part, a function of practices being based predominantly within the medical model. Johnstone (1997: 29) echoes this by stating that:

> *Despite the best intentions of the majority of professionals, people who self-injure often report experiences of treatment that are profoundly unhelpful. The underlying philosophy of the medically based psychiatric approach can be summarised as tending to remove power and control from the person who self-injures, to deny her feelings, and to ignore the meanings behind the actions. These are the very circumstances which are likely to have led to the need to self-injure in the first place.*

Although this statement appears to be a pessimistic view about the medical model, it does indicate the need to incorporate in care provision the perspectives of service users. Doing so, one believe, would result in meaningful and productive user engagement in

both the planning and implementation stages of their care. It is therefore critical to explore service users` perceptions of their self-harming behaviours.

3.6.3: Self-Harm: Perceptions of Service Users

Service users who self-harm tend to expect quality care when seeking professional help. However, their expectations are not always realised. A huge body of research on service users has highlighted significant dissatisfaction with service provision in relation to self-harm (Hemmings, 1999). Service users claim that healthcare professionals are usually judgmental during service provision and in the main treat them with anger (Crawford *et al*. 2003). For service users, particularly those with histories of sexual and or physical abuse, such experiences can be traumatic; reminding them of their previous traumas. This manner of recalling negative experiences may even trigger further episodes of self-harm.

Service users consistently express concerns about the frequency of repetition of their self-harming behaviour (Hartman, 1996). They sometimes attribute the repetition of this behaviour to healthcare professionals` misconceptions of the same. A qualitative study of service users and healthcare staff by Sadler (2002) reveals two common misconceptions about self-harm held by healthcare professionals. They believe that people who self-harm "posed a danger to others" and they do so to "seek attention". In this study, the main reason for service users engaging in self-harming behaviour was to communicate their distress. Consequently, they found such labels, particularly the attention seeking one, as insulting and wrong (Sadler, 2002). Such descriptors, which are largely encountered in the professional literature, appear to be mainly at odds with the perception of service users who self-harm. Authors such as Pembroke (1994) and Harrison (1995) provide a succinct view of their personal experiences of self-harm, taking into account the experiences of other service users of the same behaviour. They asserted that the issues perceived to be important by people who self-harm are not considered to be so by healthcare professionals. This assertion is epitomised in Pembroke's (1991:30) personal account of treatment. She states:

> *My world view and experience were important. My distress was acknowledged within a medical model framework, which I do not share. My entire life was objectified in a way I found dehumanising. I was never listened to.*

Not listening to service users may result in them feeling that the services they receive are misguided, irrelevant and unhelpful (Harrison, 1995). Such a way of responding may distract professionals from addressing issues such as distress, which are considered to be important

by this user group. Additionally, responses of this nature would hinder service users` help-seeking behaviours, which in turn, may impede their recovery (Steven *et al*. 2008). This is a concern for healthcare professionals interested in promoting the well-being of service users.

In contrast to the negative perceptions discussed so far, outcomes of some studies have indicated positive attitudes towards service provision. For instance, Pierce`s (1986) exploration of the views of service users about their treatment, reveals a mixed picture of positive and negative attitudes, with the former being predominant. According to him, service users viewed nurses and doctors more favourably than how these staff groups regarded themselves. Similar findings are repeated in later studies. Burgess *et al (*1998) and Dorer *et al* (1999) noted in their studies of adolescent service users that this user group feels respected, valued and not judged by healthcare professionals. The same authors went on to state that the adolescents studied expressed satisfaction with the care they received. Clearly, positive attitudes expressed by professionals appear to be associated with service users` satisfaction with service provision. It is also critical to state that these attitudes do enhance service users` self-esteem and ability to cope with distress (Horrocks *et al.* 2005).

More examples of positive attitudes are noted in a study by Talseth *et al* (1999), which explores service users` experiences of care using a hermeneutic phenomenological methodology. Positive attitudes, referred to as confirming in this study, were experienced by service users as healthcare professionals attending to their basic needs, making themselves available, listening and demonstrating unconditional acceptance of them. Negative attitudes (disconfirming), such as not being listened to and communication of hopelessness, were also described by service users. In an earlier study of Treloar and Pinfold (1993), which used a questionnaire survey on 105 self-harming service users, the outcome was slightly different in that the attitudes expressed were in the main positive. Service users perceived nurses to be more helpful and sympathetic than doctors. According to this study, being helpful is more about availability of healthcare staff and feelings of being listened to.

3.7: Summary

People have been noted to self-harm even before the birth of Jesus Christ. During this period, healing and religious reasons were the most commonly cited attributions for the behaviour by those who engaged in it. Today, self-harming behaviours appear to be present in all parts of

the world, pervading all cultures and societies. Interestingly, religious and healing functions are among the many reasons attributed to the growing incidence and prevalence of this behaviour. Again, these reasons, religion and healing were mainly cited by people who self-injure. Acknowledging this, one would rightly state that some of the motivations for self-harming behaviours in modern societies are in part a relic of the past. In addition to this, a cursory glance of the literature written from the 1990s reveals that expression or communication of distress and release of tension are also common motives expressed by service users for their self-harming behaviour. Clearly, there is a multitude of reasons or explanations for self-harming behaviour. This multiplicity of explanations is a reminder of the complexity of the behaviour itself.

Secure environments are places in which one can find some of the highest incidences of self-harm (Gough, 2005). Such rates of self-harming behaviour are mainly a function of environmental restrictions and boredom. Self-harm in secure environments and even in other clinical settings is often repeated by service users. Repetition is noted to increase the chances of suicide. Estimates suggest that individuals who repeatedly engage in self-harming behaviour are more likely than the general population to kill themselves (Carter *et al.* 2002). This risk of taking one's own life is often increased in individuals with a diagnosis of affective disorder and a history of drug abuse (Hawton *et al.* 2003). Service users with these characteristics are common in secure hospitals, suggesting that suicide rates are higher in these settings than in other mental health services. This is apparently the case. Apart from suicide, acts of self-harm tend to have a negative impact on service users. In the literature, service users have frequently expressed feelings of self-hatred and disgust when they deeply reflect on their self-harming behaviours (Feldman, 1988). Similar feelings have been expressed towards them by healthcare professionals. Such feelings from healthcare professionals are claimed to be caused not only by the frustration generally generated by the effects of attending to repeated acts of self-harm, but also by their limited understanding of this phenomenon.

Healthcare professionals` limited understanding of the phenomenon of self-harm is apparently a contributory factor to some of their misconceptions of this behaviour. Today, service users who self-harm in healthcare settings are often referred to as manipulators, attention seekers and time wasters. Service users find such negative perceptions insulting and wrong, as these perceptions are absolutely in contrast to their motives for self-harming.

Healthcare professionals` negative perceptions of self-harming service users may interfere with their approaches to care provision. This is apparently the case, as service users' expectations of quality care when seeking professional help are not always realised. Service users have expressed great dissatisfaction with healthcare and some have in the past even claimed to have been treated with anger. Although this is worrying, such claims are a call for healthcare professionals to commence their journey on the path of change; to start changing any negative attitude or perception they may have about self-harm. A good starting point on this journey of change is to conduct studies exploring healthcare professionals` views or perceptions of self-harm. Because attitudes towards self-harm particularly in secure settings are still not well understood, one needs to commence this exploration with a robust methodology that would ensure rigorous interaction between participants and researchers. This issue is explored more fully in the next chapter.

CHAPTER FOUR

METHODOLOGY

4.1: Introduction

This chapter outlines the methodological issues that underpin the present study. It starts with a presentation of its aims and objectives, followed by a debate on the efficacy of qualitative and quantitative methodologies. This extensive academic debate resulted in the selection of an approach considered by the researcher to be appropriate and effective in exploring the concept of self-harm in secure settings. The chosen methodology, phenomenology, is discussed including a rationale for employing it in this research study. To be more specific, Smith's (1996) interpretative phenomenological analysis is utilised, as it is considered to be the most suitable strategy for investigating self-harm. As with the selection of the research methodology, the researcher, after rigorous deliberation, identified methods that are congruent with the scope of the study as well as having the potential of facilitating the generation of appropriate data. Thus, a detailed discussion of the identified methods is essential at this stage, as the accuracy and dependability of study outcomes depend on the effectiveness of their application. The most appropriate method of data collection for this study that emerged from discussions of the chosen methodology was that of individual one-to-one in-depth interviews. To ensure full coverage or extensive exploration of the study area, these methods are complemented by focus group interviews. This chapter therefore includes a discussion of both individual and focus group interviews and rationales for choosing them. The chapter ends with a summary that highlights key methodological issues.

4.2: Study Aims and Objectives

The impetus of this study stems from the researcher's clinical experiences as a student nurse in a forensic setting. It was apparent at the time that the care provided to service users with self-harming behaviour was mainly from nurses. It was surprising to note that this care was in the main inconsistent, ranging from empathic understanding to that of hostility, with the latter approach indicating disregard for the feelings of service users. This differential way of attempting to meet the needs of service users can generate anger and confusion in the same. Such anger and confusion could result in repetition of self-harming behaviour. From one's clinical experience and that of others, caring for service users who self-harm, particularly those who frequently repeat this behaviour, can be stressful and taxing, consuming a huge amount of nurses` time. Arnold and Babiker (1997) reiterate this by highlighting that attempts to risk assess and manage repeated self-harming behaviour could lead to immense strain and anxiety in healthcare professionals. It is this anxiety that is now believed to frequently lead to the development of negative attitudes towards self-harming service user group (Tantam and Huband, 2009). Today, claims have been made by service users and some researchers that negative attitudes do play an active role in leading to self-harming acts, particularly in instances of repetition (Haw, 2007). Noting that repetition of self-harm is a common phenomenon, addressing negative attitudes of healthcare professionals would undoubtedly benefit service users. Hence, this study, which seeks to

- Examine the attitudes of psychiatric nurses toward service users who self-harm in secure environments.

The specific objectives through which the researcher hopes to achieve this aim are to explore:

- Psychiatric nurses` feelings, thoughts and beliefs of self-harm
- Factors which may influence the care psychiatric nurses provide to self-harming service users
- Psychiatric nurses explanations for service users self-harming behaviour
- Possible relationships between service users` self-harming behaviour and care provided by psychiatric nurses

Generally, researchers are advised to explore a range of methods and methodologies with the view of identifying ones that can best address the aims and objectives of their studies (Creswell, 2009). As part of this exploration, the researcher of this study embarks on an

intense debate of qualitative and quantitative methodologies, which follows in the next section.

4.3: Quantitative and Qualitative Paradigm Debate

The academic discourse between qualitative and quantitative researchers with regard to which methodology is most suitable and appropriate for exploring health related issues has been going on for decades, with discussions mainly focusing on the rigour, reliability, validity and generalisability of research findings (Polit and Beck, 2004; Parahoo,2006). Despite the ongoing debate on methodological suitability, there is a growing view among researchers and clinicians that both approaches have a place in healthcare research (Polit and Beck, 2004; Macnee and McCabe (2008). This is probably the case, as Parahoo (2006) claims that no single methodology is capable of ensuring a comprehensive understanding of today's rapidly changing health problems and associated treatment modalities. Supporting this, Polit and Beck (2008) assert that health problems, by their very complex nature, require the use of qualitative and quantitative approaches to understand their aetiologies and illness processes. Consequently, qualitative and quantitative methodologies should be regarded as complementary rather than competitive. They are like two lenses of equal magnification, designed in such a way that each lens is only capable of examining a specific part of the same object. In the same vein, Denzin and Lincoln (2003) claim that they are just different ways of telling stories about a phenomenon and that no one approach is better or worse than the other. Arguably, qualitative and quantitative methodologies should have an equally respected place in healthcare research. Therefore, discussions in the context of which approach is superior or inferior in investigating a specific health related issue can be unhelpful and unproductive. The impact of such discussion is similar to that relating to the use of the values of one religion to judge the values of another. Religious debates on the appropriateness of values are undoubtedly unhelpful, as they are more likely to fuel ill-feeling between religious groups (Lincoln and Guba, 1985). In the past and even today, unpleasant discussions on the inferiority and superiority of approaches have been noted between qualitative and quantitative researchers (Polit and Beck, 2008). So, researchers` energy should be expended on trying to understand when and why to use either of the approaches, qualitative or quantitative. Although an understanding of their similarities and differences will facilitate this process, it is vital to note that distinguishing between them, with a view to establishing

which approach is appropriate for addressing the problem of attitudes on self-harm, can be problematic.

One of the commonly cited differences between qualitative and quantitative approaches is that the data of the former typically consist of words while the data of the latter are essentially numerical (Flick, 2006). This view is shared by Parahoo (2006) who refers to quantitative research as the numerical presentation of empirical observations, and qualitative research as the non-numerical exploration and interpretation of observations for the purpose of understanding the relationships between emerging themes. While this appears to be a fundamental difference between these approaches, in contrast, some researchers consistently argue that no data are purely quantitative or qualitative (Creswell, 2009). In the context of qualitative research, this is based on the belief that qualitative data can also be assigned meaningful numerical values (Libarkin and Kurdziel, 2002), which may help enhance understanding of study findings. Although numbers seem to have a less prominent place in qualitative research, they are nevertheless useful.

Similarly, numbers in quantitative studies are open to a wide range of interpretations, which are often considered by many as subjective (Lincoln and Guba, 1985). However, it is worth emphasising that individuals should not allow these interpretations to distract them from the quantitative meaning of the data, as numbers in themselves can be explicitly expressive. For example, the relationships between self-harm and specific characteristics of study populations, such as child sexual abuse have been clearly depicted by the use of figures in some studies (Haw *et al.* 2001). Arguably, at the level of data, qualitative and quantitative approaches are tenaciously linked, as qualitative and quantitative data can be presented in numbers and words respectively. Hence, apart from the format in which they are usually presented, there is no apparent significant difference between these sets of data. Therefore any attempt to engage in discussions relating to which data are more valid and or reliable may be ignoring their intimate connectedness and inherent complementary features. Succinctly, the difference between qualitative and quantitative data is less distinct than is sometimes imagined. So, if the difference between qualitative and quantitative approaches is in the main not to do with data, then where is it? Exploring their ontological and epistemological perspectives may help provide useful insights to this question.

There are some noticeable fundamental differences between qualitative and quantitative methodologies, but these lie primarily at the level of their underpinning philosophical views about research, generally referred to as paradigms, rather than at the level of the data. Quantitative research is usually associated with a positivist paradigm, with an ontological assumption that there is a single reality out there that can be studied and known (Polit and Beck, 2004; Parahoo, 2006). Epistemologically, proponents of this research approach claim that this can only be achieved by researchers assuming total objectivity (Cuff *et al*. 1992; Silverman, 2001). This is suggesting for researchers to discard and or actively make effort to prevent their values, beliefs and preconceptions from influencing the research process. While this is believed to be a difficult task to achieve, researchers assuming a positivist stance generally tend to believe that objectivity can be achieved through measurement (Koch, 1995; Corbetta, 2003).

Taking account of the issue of objectivity, a significant task expected of researchers adopting this paradigm is the identification and application of appropriate instruments for the collection of accurate data to facilitate the measurement of reality, a single truth. Taking self-harm as an example, some studies investigating nurses` attitudes towards self-harming service users used questionnaires in exploring this relationship (Sidley and Renton, 1996; McKinley *et al*. 2001; Gough and Hawkins, 2000). The use of questionnaires seems to highlight the reductionistic approach of positivists, as they tend to contain elements of complex phenomena, such as self-harm that can be examined individually and in relation to one another (Polit and Hungler, 1999; Polit and Beck, 2006).

Because of this capability of positivism to guide inquirers in examining concepts of complex phenomena and establishing causal relationships, it seems to be the preferred paradigm for medical and psychological research, particularly those focusing on treatment (Nock, 2005). It is therefore not surprising to find that a significant number of studies investigating self-harm, its treatment and attitudes towards it are carried out by psychiatrists and psychologists. In the main, these studies are quantitatively focused and reductionist in emphasis with an ultimate aim of establishing causal relationships**.**

Another perspective which seems to be increasingly gaining popularity among quantitative researchers is postpositivism. Unlike positivists, postpositivists argue that it is practically impossible to achieve an absolute understanding of reality, but maintain that only an

approximation of the same is feasible (Guba, 1990). In other words, postpositivists claim that the absolute truth or reality of a phenomenon, such as why users self- harm can never be fully understood, as there are always many possible explanations for the occurrence of behaviours (Parahoo, 2006). For instance, a self-inflicted injury by a service user in a ward setting could be a function of depression or anxiety about a pending hospital appointment or an inability to cope with demands of the clinical environment or a mixture of all or some of these attributions.

Taking into consideration the wide spectrum of possible explanations for the occurrence of a phenomenon, there is a generally accepted acknowledgement among researchers adopting a postpositivist paradigm that the relative truth or reality can be achieved by employing multiple complementary data capturing strategies (Denzin and Lincoln, 2003). The same authors believe that adoption of such an approach would ensure comprehensive exploration of phenomena under investigation. Implicitly, the use of multiple data capturing strategies does not only indicate postpositivists` beliefs in the notion of a single truth or reality, a central tenet of positivism, but it also clearly underscores how difficult it is to access the single truth. In line with this view, there is an apparent realisation among postpositivists of the difficulty in providing cause and effect explanations of events, particularly those relating to attitudes and human behaviours. Expectedly, postposivists slightly deviated from the positivists' ideal of cause and effect explanations (determinism), by focusing their energy in establishing relationships or associations between variables (Miller and Rollnick, 2002). At this point, it is perhaps necessary to highlight that, despite some divergent views about the world, postpositivists and positivists share some common epistemological and ontological assumptions. That is, they both hold on to the belief of the existence of a reality that could be accessed through robust methodological approaches. Corbetta (2003) cited in Parahoo (2006:42) echoes this:

> *The new positivism redefines the initial presuppositions and the objectives of social research; but the empirical approach, though much amended and reinterpreted, still utilizes the original observational language, which was founded on the cornerstone of operationalisation, quantification and generalisation.*

Qualitative researchers adopt a different perspective. In contrast to positivist's beliefs, the guiding principle among qualitative researchers in their quest to enhancing knowledge of a phenomenon is to view it in the context in which it takes place (Gray, 2009). This is based on the assumption that human behaviour is always influenced by

the setting in which it occurs and that different individuals may behave differently even in identical settings (Libarkin and Kurdziel, 2002). Hence, for these inquirers, appreciating and understanding the meaning of social interactions is an important facet of research. This view is congruent with nurse-user therapeutic engagement that usually focuses on understanding and meeting the latter's needs. Generally, users find these one-to-one encounters helpful as they serve as forums for safe expression and clarification of concerns (Prever, 2010). Perhaps, it is for this reason that clinical settings, particularly those within mental health services, are increasingly experiencing demands for meaningful user involvement in care provision (Sayce and Measey, 1999).

Similarly, participants` involvement is a significant underlying precept of qualitative approaches. Thus, healthcare professionals, particularly nurses, are increasingly acknowledging qualitative research as the most appropriate approach for getting to know users` perspectives and experiences of care (Munhall, 2007). Like nursing, qualitative research seems to place great emphasis on user-centred, holistic and human aspects of care, which are believed to provide a structured path, as May and Pope (1995:42) explain "*to reach parts other methods cannot reach.*" Such emphasis on interpreting and understanding human experiences precisely captures the concerns of this study.

Explicitly, the philosophical basis of qualitative research is naturalistic or interpretive with inherent elements of humanism and constructivism (Streubert and Carpenter, 1995; Fielding, 2001). It must be noted that the interpretive paradigm has some areas of convergence with positivist and postpositivist paradigms. Like positivists` and postpositivists` concept of objectivity, the notion of *bracketing* pervades the thoughts of some interpretivists, as they tend to expend an enormous amount of energy in preventing their preconceptions, beliefs and prejudices from influencing research processes (Cormack, 2000). Inherently, there are fundamental limitations to these notions of objectivity and *bracketing*, as it is practically impossible for researchers to identify all those beliefs held outside awareness that could be influencing descriptive and interpretive processes (Smith *et al.* 2009). It is therefore advisable for researchers adopting these concepts to engage in bias-reducing activities, such as note taking and audio-recording, when undertaking research (Pope *et al.* 2000). The researcher of this study employs these strategies to minimise the influence of his preconceptions on self-

harm on the interpretation of data, as the decision to undertake the study may in itself be a bias.

Another area of commonality between postpositivists and interpretivists is that of "critical realism", meaning that only approximations of reality and truth can be achieved even with the application of robust research methods (Parahoo, 2006). Interestingly, not all qualitative researchers share this view. For example, qualitative researchers operating within a naturalistic paradigm and those adopting an interpretivist approach with strong elements of constructivism, generally tend to claim that reality is multiple and subjective, mentally constructed by individuals (Polit and Beck, 2004). These multiple versions of the world (reality) are probably a function of the differences in individual life experiences and social interactions. Arguably, all realities or truths are context-related.

Acknowledging the dynamic and changeable nature of human perceptions, experiences and interpretations, even within a specific context, researchers may experience difficulties ascertaining the ultimate truth or falsity of constructions. However, it is believed by many commentators that knowledge about the truth can be maximised by researchers developing trusting relationships with study participants, claiming that it may help elicit their personal experiences (Polit and Beck, 2008). So, conducting research without exploring individual experiences may violate the fundamental views of individuals. A detached stance may not achieve this.

According to qualitative inquirers, one possible way around this problem is to become immersed in the study (Fontana and Frey, 2003; Gubrium and Holstein, 2003). Simply, this is emphasising that inquirers should intimately interact with participants and provide the latter with opportunities to freely talk about the totality of their experiences relating to the study. The researcher is of the opinion that this stance has the potential of inhibiting participants' disclosure of personal and intimate information. It is probably for this reason that Gilbert (2001) and De Poy and Gitlin (1994) put forward a claim made by quantitative inquirers that adoption of an insider perspective is an ingredient for study results to be biased towards researchers` perceptions and values. It is however believed to be a good starting point by the researcher of this study and many others for exploring a phenomenon, particularly in instances where very little is known

about the same (Parahoo, 2006; Smith *et al*. 2009). Because little is known about nurses' attitudes towards self-harming users in forensic psychiatric settings, this study, whilst taking into account the highlighted concerns, adopts the advice for active researcher involvement to help achieve a holistic exploration of self-harm.

Interestingly, this adoption is not unique to this study. Qualitative methods are increasingly utilised by healthcare researchers, particularly by those who believe that an understanding of health and illness behaviour is only complete when it includes the subjective experiences of users (Faulker and Thomas, 2000). They seem to be driven by Polit`s and Beck`s (2008) assertion that there is an objective reality, which can only be identified and known when experienced by ourselves, with "ourselves" referring to researchers and study participants. However**,** there is a widely held consensus among quantitative researchers that the data obtained through active exploration and interpretation of human subjective experiences are imprecise, impartial (not objective) and unreliable (Denzin and Lincoln, 2003).

This criticism is positively received by qualitative researchers as it is acknowledged that any data obtained through the researcher-participant encounter are unique to that encounter, and neither the data nor the encounter are replicable (Silverman, 2006; Grbich, 2007). Additionally, qualitative researchers believe that researcher-participant interaction is the best way to develop a deeper understanding of human experiences as they appear to the individuals affected (Burns and Grove, 1997; Casebeer and Verhoef, 1997). In this way, the data collected, although not replicable as claimed by quantitative researchers, are unique, rich, valid and accurate representation of the views of study participants. It is this uniqueness, and the small unrepresentative samples used in gathering data, that make the findings of qualitative studies non-generalisable to the wider population (LoBiondo and Haber, 1994). However, it is crucial to emphasise that the outcomes of one study could have implications in other areas of study. In essence, the focus of the qualitative researcher is not about generalising findings, but of understanding the meaning of phenomena and generating knowledge or concepts using inductive and dialectic reasoning. Spencer *et al* (2003) reiterate this view by highlighting that the generalisability of qualitative studies is conceptual rather than numerical.

Conversely, quantitative research usually commences with a hypothesis, and researchers adopting this approach use statistical methods to reduce it, collect and organise data with a view of testing the existence of relationships and differences between identified components (Burns and Grove, 1997). Large, random and representative samples are generally used to test hypotheses. Additionally, the findings of the quantitative studies, which are generally outcomes of stringent statistical analysis and deductive reasoning, allow researchers to develop explanatory models that can account for the phenomena explored in similar settings (Creswell, 2009). Implicit in this statement is the assumption that the findings of quantitative research are a reflection of the truth, and are therefore generalisable to the wider populations from which the samples are drawn.

It is apparent that producing reliable and valid data for the purpose of producing generalisable findings is an ultimate aim for quantitative researchers, which, as emphasised by Parahoo (2006), can be achieved through the use of measuring scales. While this is probably true for physical parameters such as weight, obtaining reliable and valid data when measuring attitudinal and behavioural concepts is undoubtedly problematic, as these attributes are malleable, meaning that they can change over time for individuals (Augoustinos *et al.* 2006). Precisely, individuals are not consistent in the way they behave and express evaluations of others. An individual who expresses dislike for self-harming users, for example, may not always dislike members of this user group to the same degree, in the same way, or even at all, in different situations. It is therefore highly unlikely to obtain reliable data of attitudes and behaviours even with the most robust scales. Hence, it is important to highlight at this point that no methodological approach, qualitative or quantitative, can claim superiority over the other in collecting data that is consistently replicable. So, researchers should always endeavour to choose an approach that can best address their research question(s).

In sum, having critically examined qualitative and quantitative methodologies, it is apparent that there are more similarities than there are differences between these approaches. Arguably, it would be more appropriate then to see qualitative and quantitative methodologies as part of a continuum of research strategies, all of which are appropriate and applicable depending on the research questions and objectives. Although this is not applicable to this study, it is important to mention that both

research approaches have strengths and weaknesses, and many commentators believe that combining these approaches (quantitative or qualitative) in a single study may result in the strength of one methodology minimising the weaknesses of the other (Brewer and Hunter, 2006; Green and Thorogood, 2004; 2009). It is anticipated that taking this stance will produce convincing research data.

Thus, rather than discounting either approach for its weakness, researchers should be focusing on the most effective ways of blending approaches in their studies, as this can help provide richer and deeper understanding of study areas than would otherwise be possible. Concurring with this, Creswell and Plano Clark (2007) and Macnee and McCabe (2008) appear to stipulate that health related problems cannot be adequately addressed by the use of one methodological approach. Because little is known about self-harm in secure settings, this study, as a starting point for enhancing understanding of the subject, adopts a qualitative phenomenological approach using a multi-method data collection strategy. It is believed that such an approach would ensure that the data collected are reliable and represent as accurately as possible (validity) the phenomenon studied. The rationale for this approach is discussed in the next section.

4.4: Phenomenological: A Qualitative Methodology

There are numerous and diverse qualitative methodologies available for researchers to choose from when conducting research. Although diverse, some of these methodologies have commonalities, which may create difficulties in selecting or choosing an appropriate one for a study (Creswell, 2007). One way around this constraint, is to compare the methodologies and match each of their foci for agreement with the focus of the current inquiry. By so doing, the researcher identifies three closely related methodologies that appear to fit with the aim of this inquiry. They are ethnography, grounded theory and phenomenology. However, these qualitative methodologies may need further clarification and differentiation to help identify the one that can best explore attitudes of psychiatric nurses towards self-harm.

Starting with ethnography, it is a qualitative design in which researchers describe and interpret the patterns of behaviours, values, beliefs and language of a defined cultural group in a holistic manner (Flick, 2006; 2009). Implicit in this statement is the quest for ethnographers to learn about and understand human cultures. Generally, developing a

holistic understanding of human cultural groups is not an easy task to accomplish. However, an approximation of this is possible if the ethnographer as "an outsider" to the cultural group seeks to obtain "an insider" perspective of the symbolic world in which people live, most often, through participant observation and interviews (Fielding, 2001; Baszanger and Dodier, 2004). This study is about psychiatric nurses` attitudes towards service users who self-harm and not about the culture of this professional group. Additionally, although this group of healthcare professionals in the study site is a cultural group, it is a group that is frequently disrupted by the significant number of members moving between clinical areas. This disruption also makes this study population unsuitable for an ethnographic form of inquiry.

Grounded theory (Glaser, 1992; Charmaz, 2006) is another possible methodology considered to be appropriate for investigating the relationship between attitudes and self-harm. As the name implies, it is about substantive theory development, through a recursive process of data collection and analysis, to provide comprehensive explanations of a phenomenon (Polit and Beck, 2006). This manner of theory development brings the theory closer to reality relative to those derived from concepts, researchers` personal experiences and literature. Glaser, (1998) and Creswell (2007) also share this view and have highlighted the same in a number of discussions relating to grounded theory. Taking this on board, grounded theory would have been appropriate and suitable for this study if its remit were about theory development. Additionally, the recurrent data collection process, which requires repeated researcher-participant contact, renders this methodology unsuitable for exploring the views of healthcare professionals about self-harm. This is because they are usually subjected to busy routines in their respective clinical areas. Anecdotal evidence suggests that such busy routines may lead them to dislike the idea of being subjected to numerous interviews.

Now that ethnography and grounded theory have been eliminated, the focus is on phenomenology. Exploring the literature on methodological cohesion reveals that phenomenology is the most appropriate and suitable tradition for exploring a poorly understood phenomenon, such as self-harm. This decision is a function of the belief that phenomenology is about understanding and interpreting individuals` lived experiences with a specific phenomenon, which can best be communicated to others by those who have experienced it (Titchen and Hobson, 2005). This view seems to suggest that the truth or reality of an event or behaviour is grounded in people's lived experiences of that event or behaviour. If this is the case, researchers` empirical observations are limited in

understanding individuals` perceptions of a phenomenon. One approach that is persistently reiterated in the literature to have the potential for enhancing understanding particularly for an under researched subject, is a phenomenological methodology (Gray, 2004).

This assertion is not only based on the inductive nature of this approach, but researchers adopting it are generally motivated to explore the internal logic or emic perspective of the experience of participants. Schram (2003) and Streubert-Speziale and Rinaldi (2003) refer to the internal logic as the "essence" of a phenomenon; the concepts or characteristics for understanding that phenomenon.   In relation to this study, adopting this stance for understanding the internal logic can enrich the researcher's insight into participants meaning of self-harm.

Developing understanding of any phenomenon, including self-harm, is a complex and dynamic process. It is therefore important for researchers undertaking a project on self-harm to utilise a step-by-step approach in gaining insight into this behaviour. It is for this reason that Langdridge (2007) advices researchers using a phenomenological methodology to focus on people's perceptions of "things in their appearing" (describing the world as it appears to people), as an initial step on the path of insight development. This advice is taken into account by the researcher of this study, purely because of the ontological view that the truth or reality of a phenomenon is embedded in people's descriptions of that phenomenon. Hence, the provision of pure and clear descriptions is undoubtedly a critical stage along the insight development continuum. Clearly, there is a need for researchers to develop strategies that would enable them to move along this continuum with a succinct view of enhancing knowledge and understanding of study areas.

This quest for developing understanding of phenomena has resulted in the development of a number of variants of phenomenology, which can be grouped into two philosophical frameworks, descriptive and interpretive (Polit and Beck, 2006). It is however worth emphasising that these variants of phenomenology, in contrast to quantitative positivist methodologies, share a number of common features. These include their focus on human experience and meaning and the way in which meaning arises in experience (Langdridge, 2007). It is believed that the meaning of experience can emerge when researchers actively engage with study participants (Moran, 2000).   Arguably, researchers adopting phenomenological approaches have an active role in the co-construction of meaning and

understanding of people's experiences of phenomena. Because some discussions on the value of describing experiences have already been presented, it seems fitting to commence the discussion of philosophical frameworks with its descriptive category.

Descriptive phenomenology is concerned with describing phenomena with little attempt to find the underlying causes of the same (Giorgi and Giorgi, 2003). Ontologically, proponents of this variant of phenomenology believe that describing "things in their appearing" and trying hard to make sense of the descriptions are the only possible ways of gaining insight into concepts or subjects of studies (Langdridge, 2007). The provision of description of experiences with the view to understanding meanings of experiences, is consistent with Husserl`s (1982) conceptualisation of phenomenology.

Husserl (1970) considered today as the founder of phenomenology, consistently reiterates in his writings that insights into meanings of experiences can be gained if researchers make conscious efforts to achieve *epoché* (bracketing). While some descriptive phenomenologists acknowledge the difficulties of achieving *epoché,* they are apparently supportive of the view that researchers need to make attempts to bracket off their preconceptions and biases about the phenomena under investigation. It is assumed that making such attempts would reveal, in Husserl`s words, the "essence" of things as they appear to consciousness (Creswell, 2007).

It is important to stress that the notion of bracketing (*epoché)* has huge implications for the researcher of this study. Epistemologically, it is believed that one cannot set oneself apart from the phenomenon under investigation, as one needs to bring all what one knows to the study and selectively and appropriately use this knowledge in the tasks of analysis, interpretation and meaning generation. Van Manen (1990) echoes this perspective by asserting that researchers are in the world, part of the world, using their learning and experiences to interpret it. Taking into consideration the difficulties with achieving bracketing and the focus on describing experiences, the descriptive category of phenomenology is of limited value for this study. This study is about developing an in-depth understanding about self-harm, which is believed can be achieved by the researcher actively engaging with participants`, data and appropriately using preconceptions in making interpretations. These issues led to the adoption of the interpretive category of phenomenology to explore the subject; attitude and self-harm in secure settings.

While the researcher of this study believes in the use of preconceptions in making interpretations, using them inappropriately may distort understanding or at least slow down the process of achieving it. For instance, a researcher believing that self-harm is a manipulative and time wasting act may distract him or her, during data gathering, from exploring issues such as distress, anxiety and other possible causative factors. It is therefore necessary to prevent the possibility of such distraction, or, at least, to reduce its chance of occurring. In line with this, this study employs the term "selective utilisation", proposed by the researcher. It refers to an active process of constant evaluation of prior experiences for their appropriateness and the timely use of the same in enhancing interpretation and understanding of the internal logic of self-harm. In other words, researchers need to explore appropriate times for introducing their personal understandings or viewpoints in studies. At this point, it will suffice to say that interpretive phenomenology is an interactive, dynamic and timely process between the lived experiences of participants and the interpretative act of researchers. Van Manen (1990) shares this view.

Clearly, interpretation of lived experiences is one of the core precepts of interpretative phenomenology or hermeneutics, a framework founded and developed by Heidegger (1962/1927). It is assumed within this methodology that people are inseparable from the world they live in and interact with one another (Storey, 2007). This is what Heidegger (1962/1927) famously refers to as "being in the world with others". On examining this statement including one's personal experiences and the experiences of the research participants evident in the transcribed data, it is probably right and fitting to say that people are inescapable social beings, as they are always interacting with one another. It is through these interactions or discourse, asserted by interpretive phenomenologists (Smith and Eatough, 2006) and the researcher of this study that understanding of meanings given to experiences is manifested. It is therefore not possible to bracket off one's way of seeing and identifying the essence or meanings of self-harm, as Husserl (1982) proposed. This explicitly indicates that the essence or meanings of a phenomenon can be revealed or unconcealed through interactions using one's preconception about that phenomenon. Orne (1995 in Parahoo, 2006:69) confirms this:

> *Meaning, in a hermeneutic sense, refers to how a socially and historically conditioned individual interprets his or her own world within a given context.*

Because of the emphasis on context, such meanings are in the main not taken to be universal or generalisable, but they undoubtedly serve a useful function in providing deeper understandings of specific situations or events (Polit and Beck, 2004). It is for this reason that this study adopts an interpretive phenomenological approach, as the researcher intends to actively engage with participants to understand their meanings of self-harm.

In summation, the above discussion examines a range of qualitative methodologies, resulting in the selection of an approach, interpretative phenomenology, considered to be the most suitable for exploring self-harm. Its ontological and epistemological assumptions, which are consistent with those of the researcher of this study, are discussed. This includes a discussion of the view that the truth or reality of self-harm that is believed to be embedded in participants` talk, can be accessed and obtained with the use of language through active participant-researcher interaction.

As already stated, interpretative phenomenology is a category of phenomenology, which includes a number of methodological approaches. Examples of these are hermeneutic phenomenology (Van Manen, 1990), template analysis (King, 1998) and interpretative phenomenological analysis (Smith, 1996). It must be stressed that following a comparative examination of the literature of these variants of phenomenology, one can openly state that interpretative phenomenological analysis (IPA) is the most suitable perspective for exploring the study subject, self-harm. The discussions so far presented are generic, not focussing on the chosen perspective. To this end, an examination of IPA and the rationale for applying it in this research follows in the next section.

4.5: Interpretative Phenomenological Analysis: A Rationale

As people in the world, both researcher and participants are living within a hermeneutic cycle, attributing meaning to or trying to make sense of the world they live in. Smith (2005) therefore refers to people as "meaning making machines", generating meanings of the world through active engagement. Interpretative phenomenological analysis (IPA) gives prime place to understanding the meanings of experiences, the lived world of individuals. It focuses on individuals` personal perceptions of the world or subject of study that is believed to sit neatly in their talk. Understanding meanings inherent in individuals` or participants` talk therefore occupies a central position in IPA and in the heart of the researcher of this inquiry.

It is epistemologically assumed that access to these meanings can be possible if researchers take, in Conrad's (1987) words, "an insider" perspective. Smith (1994) purports that occupying the position of "an insider" requires researchers to use their preconceptions which, he asserts, would help them make sense of the individuals` personal worlds and the meaning they attribute to it. This dual way of analysis or two-stage interpretation process, which is popularly referred to as double hermeneutic, is emphasised in IPA (Langdridge, 2007). It is for this reason that the approach is used in this study, as it fits in well with the researcher's perception of the nature of truth and how it can be explored.

The double hermeneutic emphasised in IPA is an accurate reflection of the dual role of the researcher of this study. In some instances, the researcher assumes the position of participants, using the thoughts and beliefs they share in making interpretations. In other words, the researcher examines self-harm through the eyes of participants. A detailed IPA analysis also involves the researchers taking a specific stance during interpretation, assuming it to be different from participants` and using their own preconceptions in making sense of the participants` experiences. The use of preconceptions in sense-making activities is consistent with Gadamer`s (1996) view of understanding. He claims that understanding is determined by one`s prejudgments, which, in turn, are influenced by history and culture.

A detailed examination of this dual role of researchers reveals that IPA combines what Ricoeur (1970) refers to as empathic hermeneutics and critical (questioning) hermeneutics. Starting with the former, the underlining assumption is that researchers using IPA are concerned with trying to understand phenomena from the point of view of participants. Practically, it is about researchers bringing their pre-understanding, their way of seeing the world into play, with that which is inherent in transcribed data. For the latter, it is about being curious, trying to understand the meaning "hidden beneath the surface" of the data. The adoption of such curiosity is a function of the ontological assumption that meaning or reality is never immediate and transparent, but instead exists beneath the surface of a phenomenon and in need of unmasking (Ricoeur, 1970).

Epistemologically, this meaning can be revealed by researchers taking up a curious position and asking critical questions of the data. For example, what is the participant trying to say here? Is this different from what is stated earlier? It is important to stress that these styles of interpretation (empathic and critical hermeneutics) are part of sustained qualitative mode of

inquiry. One tends to claim that using both styles would result in a richer analysis, which, in turn, would lead to a better understanding of the study subjects. These modes of interpretation also serve as the impetus to use IPA in this research study.

Effectively, the critical questioning position adapted by researchers using IPA indicates an underlying belief in the existence of a relationship between people's talk, their thoughts and emotional state. Smith *et al* (1997) confirm this by asserting that participants are cognitive, affective and physical beings, whose talk is intricately linked to their emotional states and or cognitive processes. If this is the case, one would safely state that speech or conversation is at the heart of understanding, as it is through conversation that meanings are developed and understood (Gadamer, 1996). This assertion is accepted in this study and by proponents of symbolic interactionism, as they claim that meanings occur and are made sense of in social interactions (Silverman, 2005; Munhall, 2007). This suggests that the meanings attributed to self-harm are generated during participant-participant and participant-researcher interactions. Taking account of this, it is critical to discuss, even if briefly, the connection between people's talk and their emotional and cognitive states.

Strong claims have made by many researchers in cognitive psychology that this relationship is not always straight forward, purely because individuals have been noted to sometimes experience difficulties in expressing their feelings and thoughts (Smith *et al.* 1997). When these difficulties arise, it is believed that the feelings and thoughts of participants can be interpreted from their talk. So, eliciting rich information from participants using individual and focus group interviews may enable the researcher to establish how they think and feel about self-harming behaviour. Practically, this is done in the present study by the researcher interrogating the transcribed data, which are noted to be heavily grounded in participants` own words. So, any analytical account derived from these data can be considered as products of participants' feelings, thoughts and behaviours relating to self-harm.

In analysis, IPA researchers set out to use an idiographic mode of inquiry (Smith *et al.* 1995). This is simply a detailed painstaking case-by-case analysis of transcribed data of individual study participants. The aim of this is to produce a detailed account of participants` perceptions and understanding of study subjects rather making general claims. In time, of course, it is possible for subsequent studies to be conducted with other subjects. Doing so would enable researchers to gradually make general claims, which, of course, would be based

on the outcomes of a set of studies. However, one must highlight that the idiographic way of working or process of interpreting data is inconsistent with the notion of data saturation, which occurs when themes and categories in the data become repetitive even with further data collection (Polit and Beck, 2008).

Sampling in this study like many other qualitative studies is guided by this principle of data saturation (Flick, 2006). This suggests that sampling continued to the point when data analysis did not generate new information, themes and categories related to self-harm. Acknowledging this, one would like to stress that this study utilised a modified version of IPA, as its sample size, data collection and analysis are significantly influenced by the principle of data saturation. Avoiding this principle in healthcare research would be an extremely difficult task to maintain. One would assume that any attempt at avoiding it, is, in fact, one of ignoring the impact of professional socialisation on healthcare professionals. The researcher is acutely aware that healthcare professionals involved in care provision for service users who self-harm tend to share some common views about this subject. These shared views are a function of their previous clinical and educational experiences and professional interaction. It is assumed that these shared perceptions about self-harm would emerge at some point during data analysis as themes and categories. This is apparently observed in this research. Similar themes and categories repeatedly emerged during data analysis, resulting in the termination of sampling and data collection.

Researchers using IPA usually try to find a fairly homogenous sample (Smith *et al.* 2009). This means that they seek out participants who share the experiences of the phenomenon under investigation and, where possible, select those with similar demographic variables. Clearly, the nature of the sample in any IPA research depends not only on the subject being investigated, but also on the interest of the researcher. Apart from being homogenous, sampling in IPA is also purposive because researchers actively identify and select participants from whom rich data can be generated about study subjects. Details of sampling and sample size are explored in subsequent sections of this chapter.

In sum, IPA research is invariably qualitative, designed to understand more about a subject rather that to explain or identify causes for its occurrence. Enhancing understanding of a phenomenon, a view generally emphasised in IPA studies, requires researchers adopting it to actively engage with study data. It is clearly an iterative and interpretative approach and the

analysis itself is, in the main, the researchers` engagement with transcribed data. The transcribed data analysed in this study were collected using a number of methods. The use of multi-methods in a single study is prompted by the complexity of self-harm. An examination of the rationale for multi-methods within an IPA approach deserves exploration and therefore follows in the next section.

4.6: Multi-Methods A rationale

On exploring the literature on mixed methodologies, persistent inconsistencies are apparent in the use of the terms methodology and methods. In other words, they are often used interchangeably, and such usage may create room for confusion, particularly for researchers and healthcare professionals who are novices in the field of research. Clarification of these terminologies is therefore essential at the outset of this discussion. Reiterating Polit`s and Beck`s (2006) views on this matter, methodology is considered to be the strategies and theoretical assumptions underpinning a particular research. Arguably, it is a framework that provides guidance for researchers on how to conduct a study. In contrast, methods are the "doing bits" of a research process, which in the main involve the collection and analysis of data (Gray, 2009). The distinction between these terms is undoubtedly helpful in understanding the meaning and application of related terms, such as multi-methods, mixed methods and mixed methodology that are used in this piece of work in arguing for the need to blend two data collection methods within a qualitative methodology.

It is obvious from the quantitative-qualitative debate that some researchers have strong preferences for either qualitative or quantitative methods and would only explore problems perceived to be well suited to the method(s) of their choice. This is no surprise as people are more likely to use a tool they are familiar with and have skills in using it. Similarly, Trow (1957) asserts that most researchers have their favourite method(s) and would only use their preferred choice to investigate problems.

To date, a significant proportion of studies which investigate the phenomenon of self-harm employ quantitative strategies, and most of these studies are retrospectively conducted using case notes and associated incident forms. However, some studies which explore this phenomenon are qualitatively focussed and, in the main, also adopted case report designs. Very few studies explore healthcare staff perceptions` of self-harm. Even though self-harm

has been explored over many decades using both methodological strategies, it remains a behavioural phenomenon that is not fully understood (Nock and Prinstein, 2005). A statement by a service user echoes this (Babiker and Arnold, 1997: 91):

> *The GP I went to didn't condemn self-injury but just ignored it didn't ask why I did it and didn't offer me anything except anti-depressants, which didn't do anything.*

This manner of responding would not only make service users feel worse about themselves and to continue to self-harm, but it may also discourage them from seeking help. This way of responding is probably a function of the general practitioner's limited or lack of knowledge of self-harm. One of the most commonly reported functions of self-harm is to communicate and regulate distress and anxiety (Haw *et al*. 2001). So, not seeking help may hinder the process of service users tackling the root causes of their distress, which may have led them to self-harm. One of the primary goals of healthcare professionals is to support service users in alleviating their distress and anxiety with a view to eliminating or at least reducing the incidents of self-harming behaviour (Shepperd and McAllister, 2003). To achieve this, healthcare professionals need to develop a better understanding of the concept of self-harm and what it means to service users who engage in it. The question therefore arises, what has delayed this understanding and how could they be helped to enhance it?

The limited understanding of self-harm can most likely be attributed to the methodological approaches used by researchers in exploring the same. As already mentioned, a significant number of studies to date that have investigated self-harm have only used single methods (Nock and Prinstein, 2005). While these studies have used single methods at the level of individual investigators and individual research projects, the sum of these individual efforts would result in a multi-method approach to problems. Despite this strength, data comparison could be problematic due to methodological variations. Additionally, because of the limited understanding of self-harm, it seems that the use of single methods on their own is incapable of ensuring comprehensive understanding of the same. This limitation can be better explained by using an analogy of an individual wearing a tight or loose pair of shoes. Putting on a pair of shoes which does not fit may not only feel uncomfortable, but may also hinder free movement when performing duties.

In the context of self-harm, the notion of a tight or loose pair of shoes refers to the use of single methods in exploring this phenomenon, which, in a way, serves as a barrier to fully

understand the same. Clearly, to develop a comprehensive picture of self-harm attitudes towards it, the researcher needs to select an approach that is fit and appropriate for the problem, with embedded elements of reflexivity that would ensure intense exploration. The only meaningful strategy that can do this, as well as capture participants` experiences of self-harm, is a multi-method research design within an interpretative phenomenological analysis methodology (Brewer and Hunter, 2006). This is based on the assumption that self-harm is a complex phenomenon, whose complexity cannot be successfully unravelled by a single method, a view acknowledged by Barbour (1999).

Individual interviews are one of the specific methods chosen for the study because it is believed that they can enable participants, as they reflect and respond to researchers, to give meanings to their past experiences of self-harm. To further identify the meanings of the complex layers of the experience of this behaviour, the study utilises another data collection source, focus group interviews, which could lead to the production of more elaborated accounts of self-harm than those generated in individual interviews. Separate rationales for the use of these approaches, focus groups and individual interviews, are provided in subsequent sections of this thesis. Before continuing with this discussion, it is important to state that a number of academics do sometimes engage in debates relating to whether focus groups and individual interviews are two distinct methods (Freeman, 2006). It is therefore critical at this stage of the thesis to provide some clarification to this concern, as doing so would help in the articulation of the reasons for their use in the data collection process.

Individual interview is the most commonly used qualitative data collection approach in healthcare research (Nunkoosing, 2005). The frequency of its use in healthcare can be attributed to the assumption that, if used effectively, the words generated would accurately reflect participants` inner experiences. Agreeing to this assumption is ignoring the view that individuals may sometimes withhold certain information during interview encounters (Fielding, 2001). In other words, interviewees may be selective in their disclosure. While this possibility also applies for focus group interviews, it is safe to state that interviews of any kind are forms of interactions that focus on exploring people`s accounts about a phenomenon. The primary aim of these interactions is to develop an in-depth understanding of the underlying structures of subjects explored. Consistent with this, is the role of language in enhancing understanding or insight into phenomena studied.

Language is a significant aspect of focus group and individual interviews. As well as being the tool for data collection, language is the data. It is therefore the route to understanding respondents` or interviewees` perceptions of their world (Kvale, 2009). If this is the case, open questions would be the preferred options for researchers using these data generating approaches. However, this does not mean that closed questions do not have a place in these approaches. If used effectively, they would contribute to enhancing meanings of subjects or behaviours examined.

Irrespective of the questioning stance adopted, the data or languages of individual interviews represent what people say, not how they interact or behave in contexts other than interview encounters. In a study of this nature, the researcher`s interest does not only focus on understanding attitudes towards self-harm, but also focuses on developing a better knowledge about the environment or issues surrounding this behaviour. This shortcoming of individual interviews in this circumstance is in the main addressed by focus groups. In these data collection encounters, researchers are exposed to interactions between participants, as well as between participants and interviewers. Theoretically, they offer a more "naturalistic setting" than individual interviews in the sense that they are similar in many ways to people`s day-to-day interactions (Freeman, 2006).

Acknowledging this, it is probably safe to state that these "naturalistic environments" provide an excellent opportunity for researchers to observe participants` behaviour, as well as to hear the vernacular or colloquial speech they habitually use. Arguably, listening in on focus group discussions would increase researchers` familiarity with participants` typical terminologies, idioms and common language. This is certainly the case in this study, as reflected in the narratives presented in the result sections. Such familiarity, one must highlight, enhances the researcher`s insight into self-harm and attitudes towards it. Agar and MacDonald (1995: 80), in their study of drug use, also experienced this knowledge enhancement function.

> *Through group interactions, we learn that something we hadn`t noticed before is a significant issue for drug-experienced young people. From the way the group takes up the topic and the language the use, it is clear that something significant is going on, something significant to them. A new piece of territory is revealed.*

It is implied from this extract that research using focus groups may result in unexpected insights that are less likely to emerge from individual interviews. Taking this and the accounts presented into consideration, it is now clear that these approaches are distinctly

different in the context of their structures. As the names imply, focus groups adopt a group format interaction, and the individual interviews take the form of a one-to-one interaction. Even though this is the case, these approaches are significantly similar in the sense that they are both forms of conversations or in-ter-views, which use language as a very important data source and data (Adami, 2005). Because of this data source and the interactive nature of individual and focus group interviews, they are considered by some researchers as types or forms of the same research method; which is interview (Kvale, 2009). However, acknowledging their differences, roles and functions in information gathering, and the researcher's epistemological and ontological stance in relation to the same, they are used in this study as two independent qualitative data collection methods. This is what Creswell (2009) refers to as multi-methods, which in essence relates to the use of two or more forms of either qualitative or quantitative data collection sources in a single study. This is different from the concept of mixed-methods. Simply this is an approach to inquiry that combines or associates both qualitative and quantitative methods of gathering information (Creswell and Plano, 2007). The same authors believe that adopting such an approach would increase the overall strength or quality of studies. While this is also generally the case for multi-methods, noted in the literature is an apparent increase in the use of multiple qualitative methods in research studies (Heary and Hennessy (2006)). Relating to focus groups and individual interviews, it must be stressed that many researcher favour the combination of these methods in single studies for a wide range of reasons.

Others and the researcher of this study believe that this approach, the use of individual and focus group interviews, can compliment and expand the contribution of a single method in exploring and understanding complex phenomena like self-harm (Johnstone, 2004; Gilbert, 2006). The combination of methods is expected to strengthen confidence in the study findings. Apart from the added scope of understanding attitudes associated self-harm from differing perspectives, the multi-method approach in a single study will facilitate easier comparison of the strengths and limitations of each method. Although multi-methods has been in use for over three decades, it is today noted in the literature to be gaining popularity among researchers and healthcare professionals (Rolfe, 2006). This popularity could be attributed by the increasing demand of healthcare professionals to base their practice on research evidence (DH, 1998).

Today, healthcare professionals in the UK are required by statute to always engage in quality care provision (DH, 1999). Many researchers believe that this requirement of quality care provision can be achieved in clinical practice, if not in its entirety, at least in part, by the adoption of evidence- based practice (Freshwater, 2003; Macnee and McCabe, 2008). Evidence-based practice is the provision of care, based on scientifically derived findings that are valid and reliable (Kinn and Curzio, 2005). The identification of valid and reliable research evidence can only be possible if healthcare professionals are knowledgeable in research methods and methodologies.

Randomised controlled trials (RCTs) are one of the many quantitative methods that are believed by many researchers and healthcare professionals to be the gold standard for research to produce quality evidence upon which to base care (Gilbert, 2006). However, there is growing realisation that these designs, including other quantitative methods are not panaceas for multidimensional health related problems, such as self-harm (Kinn and Curzio, 2005). Acknowledging this, the researcher of this study believes that understanding of self-harm can best be attained through combined, sustained and complementary use of multi-methods in a single study. Brewer and Hunter (2006) also have similar thoughts. They reiterate that multi-methods are mutually complementary in enhancing understanding. Arguably, the adoption of a multi-method approach would produce with certainty more valid, reliable and trustworthy outcomes, and therefore more confidence in the truth value of the outcomes.

This assertion fits in with the researcher's subjective view of self-harm. It is perceived like a dark bedroom, the contents of which can only be seen if an individual enters it and shines a light. With this in mind, the researcher adopts an involved and immersed stance using focus group and individual interviews to enter the concrete world of participants in order to better understand unarticulated and undisclosed meanings of self-harm. Such a blend may enable researchers to reveal different facets of the same reality. To be more precise, it is believed that the meanings of and attitudes towards self-harm, which reside in research participants (psychiatric nurses), can be accessed through intense participant-researcher discussions in individual and focus group interviews.

Acknowledging this value of multi-methods, it is advisable for researchers to always make an effort to reconcile differences between methods and to exploit the advantages that they might

afford when used in a single study (Creswell, 2009). Implicitly, researchers should always focus on achieving optimum results from their studies. Clearly, this is a call for researchers to select methods that are appropriate to examine research questions, even if it involves oscillating between alternative paradigms (Johnson and Onwuegbuzie, 2004). Selecting an appropriate methodology and methods for a study therefore involves careful considerations.

In choosing the methodological approach for this study, the researcher takes into consideration the purpose of the study, its philosophical assumptions of the nature of reality and how this reality can be best apprehended. The researcher believes that it is impossible to fully comprehend the behaviour of self-harm and attitudes associated with it. This view is purely based on its complex multidimensional nature. With this in mind, this study aims to develop a deeper and comprehensive level of explanation and understanding of attitudes towards self-harm through the identification and interpretation of lived experiences of participants**.**

In eliciting participants` lived experiences at interviews, researchers may unintentionally affect the outcomes of a study. Noting that people`s experiences of a phenomenon are real for them and that this reality may change with time (Smith *et al*. 2009). It is therefore imperative for researchers to engage in activities that are capable of not only identifying changes in reality or truth, but also of minimising the researcher's threat to the validity of studies. Hence, apart from audio-recording all interview encounters, the study will involve a second researcher in the analysis of both the individual and focus group interviews.

In sum, researchers from a wide range of disciplines now advocate the use of multi-methods in providing explanations for phenomena. However, it is erroneous to think that the integration of methods is a universal remedy for all research problems. This is because the knowledge of some research problems cannot be adequately enhanced by the use of multiple methods (Brewer and Hunter, 2006). But if research can be enhanced by using a combination of methods, then such collaboration should be encouraged and supported. People who self-harm surely deserve the best efforts from the research community, as this behaviour and attitudes relating to it, are still poorly understood. So, an arsenal of methods is needed to study it.

4.7: Interviews: Individual and Focus Groups

The researcher of this study, like other qualitative researchers, believes that the truth or reality of a phenomenon is dynamic, and this reality can be fully understood, or, at least in part, by engaging in discursive interactions with research participants (Macnee and McCabe, 2004). It must be stressed that such understanding is context dependent, and any changes in context, even if slight, could lead to a change in understanding. It is difficult to maintain uniformity during data collection, particularly in qualitative research (Gubrium and Holstein, 2003). So, some changes to the data collection process are likely to be encountered by researchers when conducting qualitative studies. Hence, the focus of this mood of inquiry is not to make concrete a variable of interest of a study phenomenon, but it is rather to develop a deeper and more comprehensive understanding of that variable. Observation, document reviews and interviews are examples of meaningful avenues for developing an in-depth understanding of phenomena. There is therefore a need to choose the most appropriate method for this study. This need, which cannot be overemphasised, can only be met by briefly discussing the identified methods in line with the aims of the study and the researcher's epistemological stance.

Observation, as a research method involves viewing peoples` behaviour, recording and interpreting it, purely to increase one's insight into a study phenomenon (Gray, 2004). It is tempting to assume that data collected by direct observation are, in the main, valid. An adherence to this assumption undoubtedly overlooks the chance of researchers` error in analysing and interpreting observational data. While interpretation is a benefit of this method, it is also considered to be one of its greatest drawbacks (Parahoo, 2006). When observing, researchers can only see participants` behaviours and not the meanings which participants attribute to the same. These meanings, which can only be inferred following analysis and interpretation of observational data, can be erroneous as there are possibilities of researchers giving accounts that are different from those of research participants.

This study is about attitudes towards self-harm in secure environments. It is important to reiterate that self-harm is still a poorly understood concept in these environments. Hence, there is a need for detailed exploration of the concepts; attitudes and self-harm in secure settings. Conducting a study using observation would not address this need, as it does not involve active discussions with research participants. Additionally, some aspects of attitudes

such as people`s beliefs in relation to a phenomenon are not directly observable, but can be inferred from observable behaviours and the context in which they occur. Apart from the time constraint involved in using observation, the possibilities of making wrong inferences about these facets of attitudes render this method unsuitable for this inquiry. Incidents of self-harm are generally documented in clinical practice. So, clinical documents could be considered as useful sources of data to understand self-harm and attitudes towards it. They therefore deserve some discussion in this submission.

Documents are things which individuals can read and they, in essence, have the potential of informing us about a phenomenon and about those who produced them (Gilbert, 2001). They are therefore an important research tool in their own right. The documents referred to in this inquiry are service users` case notes, written by members of the multidisciplinary team, including psychiatric nurses, involved in care provision. Clearly, case notes represent a written professional view of service users` illness presentations and treatment. In relation to this study, reviewing them may provide some insight into service users` self-harming behaviour and attitudes of psychiatric nurses. Although the case notes may be authentic, credible (free from error) and representative of the study population, establishing the true meanings of their content can be challenging. Arguably, this difficulty can be attributed to the probable variation in the use of language, as most clinical areas are made up of healthcare professionals from different ethnic backgrounds. This limitation, which could lead to inaccurate interpretations, coupled with the absence of participant-research interaction; make this method of inquiry unsuitable for this study.

Acknowledging the aim of the research and the researcher's belief of the value of entering participants' world with a view to eliciting their meaning of self-harm and associated attitudes, the interview is the method of choice. It is believed that this method, because of its interactive and explorative nature, will make explicit the meaning participants ascribe to self-harm. Arksey and Knight (1999 in Gray, 2004:214) reiterate this:

> *Interview is a powerful way of helping people to make explicit things that have hitherto been implicit to articulate their tacit perceptions, feelings and understandings.*

Embedded in this statement is a conviction that researchers are deeply implicated during interviews in creating meaning that resides in participants. These meanings are not merely generated by researchers adopting a questioning approach, but also through active interaction

between researchers and participants. Arguably then, the interview is an inter-view; a looking together and learning together about something. Rightly, it is a collaborative learning process involving researchers and participants in understanding a phenomenon. Relating to this study, interviews are used by healthcare professionals and researchers to explore and learn together about self-harm and attitudes that are associated with it.

Today, interviews are extensively used. In fact, their extensive use has led many researchers to claim that the world is becoming an interview society (Fontana and Frey, 2003; Silverman, 2006). This seems to suggest that one cannot escape from being interviewed, as interviews are now everywhere, in our homes and in the streets of our towns and cities. They occur in a variety of forms, such as individual interactions, opinion polls and job applications. It is therefore no surprise that interviewing takes many formats, which can be placed under two categories, individual and group interviews. The rationales for the use of specific methods within these categories are now discussed.

4.7.1: Individual Interviews: A Rationale

Individual interviews are forms of conversations that are directed according to the nature of knowledge required and the researchers` ways of establishing this. Britten (1995:253) confirms this by arguing that:

> *An appropriate level of direction depends on the interviewer's knowledge of what she wants to find out, asking the right questions to acquire this information and giving appropriate feedback.*

The degree of direction required at interviews is one criterion for classifying these forms of conversations. On the basis of this, Fielding and Thomas (2001) and Green and Thorogood (2004) identify three types of individual interviews: structured, semi-structured and unstructured. The structured interviews involve the use of specific set of questions in a specific order. The rationale for this is to generate comparable answers from each participant. There is clearly minimal participant-researcher interaction when using this interview format. Although this format has a place in healthcare research, this limitation excludes its use in this inquiry.

With regard to semi-structured interviews, researchers may have a list of questions to explore with participants, but the order of the list may not necessarily be followed (Gray, 2009). Additional questions may also be asked and researchers employing this method can also

probe for more information in instances where it is desirable for participants to elaborate on their views. Probing is a useful strategy for exploring new avenues, which are not originally considered as part of the interview goals (Kvale and Brinkmann, 2009). While such directions imposed by researchers may distract participants from disclosing their perspectives of a study phenomenon, they result in participants articulating the perspectives of the former (Holstein and Gubrium, 2004). This is incongruent with the researcher's epistemological position; allowing free expression of experiences. Hence, this method cannot be employed in this study.

The researcher opted for the last category, unstructured interviews, of Green and Thorogood (2009) typology of individual interviews. Before proceeding with the discussion, one must emphasise that the term unstructured is a misnomer, as it is practically impossible to conduct an interview that is totally unstructured. The mere thought of a question to commence an interview is, in itself, a form of a structure. So, the term open interview is used in this study to describe interviews in which researchers ask broad questions that require participants to freely express their feelings and opinions. The main remit of researchers adopting this method is clarifying any doubtful views expressed by participants and to elicit their understanding of study phenomena (Silverman, 2006). Although free expression of feelings is one of the underpinning beliefs of this study, the researcher will include a minimal amount of direction where necessary to generate data. In doing so, the researcher would take into account that interviews are generally anxiety provoking (Munhall, 2009). Hence, one must be very cautious about imposing controls in interview encounters, as they may evoke defence mechanisms in participants (Kvale, 1996). In other words, controls or structures may impede participants from freely disclosing their feelings at interviews.

One of the goals of the interview encounters of this study is to allow free expression. To do this, Kvale (1996) advises researchers to be "deliberately naïve" in interview encounters. Put in a simple way, researchers should minimise their control and remain open to new and unexpected phenomena when conducting interviews. Although very little direction will be offered in this study, implicit in this assertion is the assumption that researchers are aware of what participants are expected to say at interviews. While this is not the case for the researcher of this inquiry, effort will be made to remain curious and sensitive to what participants say as well as what is not said. Adopting this stance may generate rich data of participants' views of self-harm, as participants are encouraged to dictate the pace of

interviews. Kvale and Brinkmann (2009) share a similar view by claiming that researchers exploring sensitive issues, such as self-harm should ensure a shift in power within participant-researcher relationships, with the former being in control. Such a way of working, may not only enable participants to dictate the pace of interaction, but it may also enable them to feel comfortable with their responses.

At this point, it is clear that open interviews are useful methods for exploring participants` views of a phenomenon, particularly where little is known about the same. Although this is apparently true, they are not devoid of limitations, and such limitations can be explained using the analogy of a ray and beam of light.

If a ray of light is shone on a ball in the dark, only a small proportion of the surface of that ball can be seen. But if a beam of light is shone on the same ball, most of it will be distinctly visible. The ray of light represents open interviews, and it indicates that open interviews can only elicit or illuminate some aspects self-harm. In support of this, it is considered that participants may feel intimidated by researchers during open interviews (Silverman, 2006), and such intimidation may deter the former from disclosing their personal opinions, feelings and beliefs of a phenomenon. Arguably, intimidation forms part of a ray, open interviews, and this may hinder the development of a clearer picture of a complex phenomenon, such as self-harm.

Apart from intimidation, it is possible to note contradictory views between participants of open individual interviews. While a multitude of views could be considered a strength, clarifying them, taking into consideration the nature of this method (one-to-one approach), can be difficult. What is then needed is another method to complement and address all, or, at least, some the limitations of open individual interviews. Such a method is represented in the analogy of "ray and beam of light" as a beam. This is an indication of the significance of the use of different perspectives of people in a group format in discussing self-harm. The researcher of this study and others believe that differential perspectives will generate convincing knowledge about a phenomenon, such as self-harm (Creswell, 2009). Focus groups fit in well with this criterion and will better illuminate the phenomenon of self-harm for both participants and researchers.

4.7.2: Focus Group Interviews: A Rationale

Focus group interviews are dynamic interactive qualitative methods of data collection, which in essence, are discussions of a specific subject or set of issues between one or more researchers and a small group of people (Wilkinson 1998b; Green and Thorogood, 2004). They are clearly planned discussion groups for accessing rich information about participants` perceptions of a subject, with researchers (moderators) assuming a facilitator role in guiding discussions (Flick, 2009). The researchers make use of the different perspectives of participants in discussing a phenomenon. Such an approach will generate rich and convincing data that will create a better understanding of a phenomenon, such as self-harm. From a more practical perspective, researchers' roles do not only include observing group dynamics and encouraging active group participation, but also involve preventing one participant or some participants from dominating interview encounters (Flick, 2006). Acknowledging this, it could be stated that focus groups are collectivistic rather than individualistic research methods, with a focus on listening to and understanding the plural voices of participants. So, an effective performance of researcher functions could result in the generation of rich data from participants within a short time. This advantage is, in part, a function of some participants finding discussion groups gratifying and stimulating (Polit and Beck, 2008). Such stimulation may result in more discussions, which, in turn, could lead to deeper expression of feelings. Focus groups are therefore useful and potent ways of learning from people or participants about specific subjects.

It is sometimes assumed that focus groups can cause some discomfort in participants, particularly when discussing sensitive issues (Parahoo, 2006). Many researchers seem to discard this view by claiming that focus groups are more suited for exploring sensitive issues, as the solidarity of friends or colleagues in group settings will decrease any discomfort that would be experienced (Frith, 2000). Decrease in discomfort could lead to intense discursive interactions and clarification of contradictions between participants. Arguably, group settings tends to facilitate more disclosure, as they provide safe environments for participants to react to and build upon the responses of other group members, creating what Wilkinson (1998a) refers to as "synergistic effect".

This study is about healthcare professionals` attitudes with experience of self-harm. The experience of self-harm is part of healthcare professionals' professional socialisation. The

socialisation process can be influenced by a wide range of factors, including length of clinical experience and academic qualification. Although similarities may exist, psychiatric nurses may have varying accounts of clinical experiences and professional education. Acknowledging this, one would assume that this professional group may have diverging and converging views about self-harm. In group settings, they may make attempts to justify or defend their views, which may result in the production of more elaborated accounts than would be generated in individual interviews (Wilkinson, 1998b). Inherent in group discussions relating to diverging views are issues of quality control; members seeking clarification of the views of others. Patton (2002:386) reiterates:

> *Participants tend to provide checks and balances on each other, which weeds out false or extreme views.*

Focus groups are thus tools for appropriately reconstructing opinions of individual participants. Consensus or synergy reached by participants is an outcome of group dynamics, in particular group pressure, rather than reflecting individual beliefs. This "synergic effect" or "group think", may interfere with individual expressions, a significant disadvantage of focus groups (Wilkinson, 2004). What would also influence group dynamics is the group mix. It is evident in the literature that homogeneous groups may generate more data than heterogeneous groups, as members in the former with similar characteristics may feel more at ease in expressing their views (Polit and Beck, 2004). In quantitative terms, their outcomes are not generalisable to the wider population as the group size is rarely large enough or randomly selected to be representative of the same (Silverman, 2006). However, alongside other methods, such as open interviews, they have a significant role to play in contributing to knowledge. The use of such a mixture of data collection methods may enhance the rigor of the study and generate data that are least biased and most comprehensive.

4.8: Summary

This chapter provides a succinct overview of the aims and objectives of the study. It explores various elements that have been put together to form the basis or philosophical underpinnings of the study. This includes a detailed qualitative-quantitative debate that informs the generic methodology, qualitative, chosen for this study. A range of qualitative methodologies were explored with a view to enabling the researcher to identify a specific research tradition for effectively exploring attitudes and self-harm in secure settings. The researcher opted for Interpretative Phenomenological Analysis (IPA) as it was considered to be the most effective

to gain the view of the world from the perspectives of participants on a subject that is as yet poorly understood. To develop this understanding, the researcher followed the guidance provided by Silverman (2001) and Creswell (2007), which indicate the use of a mixture of approaches and or methods would enhance the effectiveness of the research and well as yield convincing or credible outcomes. A multi-method, focus group and individual interviews, was selected within the framework of IPA as a data collection strategy. A clear rationale for using these methods has been articulated. Having identified the research methods, the next chapter examines the application of the same in the research process.

CHAPTER FIVE

METHODS OF THE STUDY

5.1: Introduction

It is often emphasised in the literature that the conduct of research tends to occur in stages (Creswell and Piano Clark, 2007). One stage that needs detailed examination, purely because of its influence on study outcomes, is that of data collection. This chapter therefore intends to provide a comprehensive description of this stage. Creswell (2007) describes it as a set of interrelated activities that precede and extend beyond the point of collecting data. The interrelated activities, in Creswell`s and Piano Clark's (2007) view, include exploring ethical issues, sampling, data collection and data management. In totality, these activities form part of the methods in research considered to be applicable in this study.

Silverman (2006) asserts that methods are specific techniques or "doing bits" of research studies. He believes that their usefulness depends on their fit with researchers` paradigmatic views. Rightly so, the above methods are employed here because they neatly fit with researcher's ontological and epistemological stance for gaining an authentic insight into participants` experiences of self-harm. It is therefore imperative that full descriptions of these activities outlined above are presented at this point of the study in the order that they are carried out. The aim for this is to communicate actions taken to access the truth or reality of participants` meanings of self-harm.

5.2: Ethical Issues

A range of ethical issues was taken into account when conducting this study. The issues considered are discussed in this chapter to demonstrate the study`s ethical soundness. One of these ethical considerations includes the need to adhere to the guidelines of a nationwide research ethics framework.

5.2.1: Research Governance

Ethics refers to a set of rules designed to protect the rights of people, with the ultimate aim of ensuring their well-being and safety when they take part in research (Flick, 2009). The

question of how this can be ensured has brought research ethics to the fore of disciplines in the UK and abroad (Silverman, 2006). It is probably for this reason that the DH (2001) is today expecting every professional body to assume the responsibility of safeguarding its members from any form of research malpractice (DH, 2001). One must stress that this expectation is not always achieved. Lapses in ethical behaviour have been consistently reported in the literature. For example, Parahoo (2006) following an extensive survey reported that some healthcare organisations in the UK were not fully aware of research activities taking place in their premises. Undoubtedly, this is a concern for healthcare professionals keen to safeguard the well-being of research participants and members of the public from any form of research malpractice. Such a concern is a call for a concerted effort to standardise research practice across UK organisations. Consequently, the government developed a Research Governance Framework for Health and Social Care (DH, 2001).

The established Research Governance Framework became a statute in May 2004 (Parahoo, 2006). Its remit is to enhance standards of research practice and to significantly cut down on and prevent unacceptable variations in the way studies are conducted in health and social care settings (DH, 2001). This is no doubt a huge task to address, as ethical issues can occur in every stage of the research process. Taking this into account, the researcher expects to encounter some difficulties in putting right or rectifying all ethical concerns that could occur during studies. However, because of one's quest to ensure ethical soundness of the study, effort was made to address ethical issues as they arose. A collaborative approach between researchers, funders, health and social care organisations and research ethics committees, is one of the many strategies that can be used to do this. It is important to stress that situations may arise in which the rights of participants and the specific demands of the research project are placed in direct opposition to each other even in instances where collaborative and partnership ways of working are employed. If such a situation is encountered, it would be advisable to refer to the ethical guidance laid down by one's professional body and Research Governance Framework (Royal College of Nursing (RCN), 1998). The process of adhering to this guidance is discussed in the ensuing section. This discussion focuses on seeking ethical committee approval, accessing participants, and informed consent and confidentiality issues.

5.2.2: Research Ethics Committee Approval

The advent of the Research Governance Framework in the UK has led to the centralisation of processing and approving of health and social care related research applications (Parahoo, 2006). The essence of this is to minimise variations in research practice and to thoroughly review research proposals for their ethical soundness (Allmark, 2002). The Central Office for Research Ethics Committees (COREC), now referred to as the National Research Ethics Services (NRES) was set up by the government to ensure this (DH, 2005). Apparently, this body works closely with individual Trust Research Ethics Committees (RECs) in critically examining proposals with the sole aim of upholding the welfare, dignity and rights of research participants (RCN, 2004). It is therefore a legal requirement for individuals undertaking research involving healthcare professionals and or service users in the NHS to submit their proposal to the NRES and their respective RECs for ethical clearance (DH, 2005).

Permission for this study was initially sought from the NRES and research site Ethics Committee. This was done by submitting a completed application form with a detailed study proposal on 12th June 2007. This application for ethical clearance did not receive a favourable response; meaning it was rejected (appendix 3). It was rejected, in the main, on methodological grounds. The members of the Research Ethics Committee felt that the proposed mixed methodology, the use of qualitative and quantitative approaches in a single study, was not appropriate for the intended study. The intention was to commence with a qualitative phase using individual and focus group interviews. The outcomes of these interviews were intended to inform the development of a questionnaire to be used in a quantitative phase, which would have involved a survey of healthcare professionals` attitudes towards self-harm. It was sensed from the discussions during the meeting that the members of the Ethics Committee were unfamiliar with a mixed methodological approach to research. Apparently, this is not an uncommon experience with ethics committees. Flick (2009:40) confirms this by stating that:

> *Proposals are sometimes rejected because they had a methodological background different from that of the applicants.*

Although the rejection of the initial application was initially disruptive in the context that it delayed data collection, it was later positively acknowledged following a careful review of the application by the researcher and his academic supervisors. It became crystal clear

following the review that the intended mixed methodological strategy would have been time-consuming. Hence, a suggestion was made for the researcher to think of an alternative approach. Following a detailed discussion with academic supervisors it was concluded that an Interpretative Phenomenological Analysis (IPA) was an appropriate and suitable methodology.

Using an IPA methodology, a second application for ethical clearance was submitted on 19th December 2007 to the NRES and research site Ethics Committee. Approval to conduct the study was granted this time (appendix 4). Despite this permission, the data collection was not allowed to commence because the study was at the time not supported by the research site Research and Development Centre. According to the Research Governance Framework, researchers would only be allowed to conduct studies when given permission to do so by the research centres of study sites (DH, 2001). It was therefore imperative to gain ethical approval from the study site's Research and Development Centre. An application for ethical clearance was submitted to this Centre on 13th December 2007 (appendix). Approval to conduct the study was granted on 20th March 2008 (appendix). Consequently, the process for accessing participants was subsequently initiated.

5.2.3: Accessing Participants

The initial step in the stages of seeking access to study participants at the research site, is gaining the agreement of individuals in authority, who Creswell (2009) refers to as gatekeepers or key individuals. In this case, these included the senior nurses and directors of nursing services. Obviously, the success of the study in part depended upon winning over the cooperation of these gatekeepers. This involved writing letters to them requesting appropriate time and date to discuss the study. Separate meetings for the directors of nursing and senior nurses were organised.

Detail discussions of the study took place at these meetings. In sum, the issues covered were sampling and sample size, data collection, potential benefit of the project and its purpose. To complement the discussions generated, each gatekeeper was given a copy of the study proposal and an information leaflet containing the researcher's contact details (appendix 6). Such an action was attributed to the view that these documents were potentially valuable points of reference and, if read, would develop people's understanding of the research

project. One must add that all the senior managers and directors were also given the option of contacting the researcher if they required further information and / or to clarify any aspect of the issues discussed.   Although the gatekeepers were generally pleased with the discussions held, they were noted to be happier when provided with the option of contacting the researcher to express any concern they may have. It is worth noting that all questions raised during the meetings concerning the study were adequately answered. The responses provided to the queries raised played a significant part in inspiring the key individuals` confidence in the researcher in the context of the ability for safeguarding the welfare of participants.

The researcher also found the outcomes of these meetings hugely beneficial. The meetings resulted in the senior nurse managers setting up a ward managers` forum, which all ward managers within the forensic directorate, including the researcher attended. At the meeting the researcher gave a detailed presentation of the study and complimented the explanations provided by giving each ward manager, written information which included an information leaflet and consent form. Towards the end of the meeting, all the ward managers expressed their support for the study and promised to discuss the same with their respective nursing teams. This promise was fulfilled in June 2008 and the researcher was informed by all managers about how receptive their nursing teams were of the research study. Such a response served as an additional impetus to continue with the process of accessing potential study participants.

In the months of July and August 2008, the researcher met with the individual nursing teams. The discussions held focused on the study's rationale, potential benefits and general information regarding the research process. Opportunity for potential participants (members of the nursing teams) to ask questions was facilitated. Concerns raised were accurately responded to by the researcher. An information leaflet (appendix 6) and a letter of invitation to participate in the study (appendix 7) were given to each of the members of the nursing teams. Members of these teams were not only encouraged to contact the researcher if they need clarification of any of the issue discussed, but were also encouraged to make contact with the same if they wished to express an interest in taking part in the study.

Towards the end of August 2008, 25 potential participants contacted the researcher on the telephone and clearly expressed their intentions to take part in the research project.   In

September and October 2008, 27 and 28 potential participants respectively made contact with the researcher. However, this time, some did so in writing stating their willingness to participate. One female staff nurse stated in her letter that she would do whatever it would take to raise healthcare professionals` understanding of self-harm. Noting that people's intentions can sometimes change, each of the individuals that made contact was asked to thoroughly read the information sheet given to them, and to contact the researcher again if they still wished to participate in the research. This approach is part of the process of seeking informed consent, a key ethical principle in research (Gray, 2009).

5.2.4: Informed Consent

A close look at the literature on research ethics revealed that the notion of informed consent is an important facet of most ethical guidelines (DH, 2001). Such significance attributed to this concept is based on the ethical principle of self-determination or autonomy, which, in essence, requires researchers to respect participants` ability to make free choices about themselves (Murphy and Dingwall, 2001). In this context, free choices simply refer to researchers empowering participants in making decisions to engage or not to engage in research (RCN, 2004).

It is explicit from this statement that researchers are legally obliged to safeguard the autonomy or self-determination of their participants (DH, 2001). It is therefore imperative that they take the steps that are necessary for ensuring this. A significant part of these steps involves the provision of adequate information to potential participants about studies, as information giving would enable individuals to evaluate the potential risks and benefits of participation (Creswell, 2009).

From the outset, all prospective participants were clearly informed of the aim and nature of the study. The researcher was acutely aware that informed consent of potential participants should be obtained before commencing data collection. This view is reiterated by the RCN (2004) and the British Sociological Association (BSA) (2003) in their codes of ethical standards. Hence, at the time of the interviews, each potential participant was again given an information leaflet, presented in a format, language and style that would ensure comprehension or understanding of the study. Sufficient time was given to each individual to read through the document followed by the researcher testing

for comprehension before deeming them eligible or ineligible for participation. The participants demonstrated understanding of the purpose of the study, its benefits and potential risks. They verbally expressed their willingness for participation. Arguably, such an expressed decision or willingness for participation, in other words, informed consent, was grounded in the information provided. Thus, Polit and Beck (2008) assert that prospective participants should always be provided with full information about a study to enable them to form decisions of whether to participate or not.

To confirm the voluntary nature for participation expressed, each participant was asked to complete a consent form, a condition stipulated by the NRES and Research Governance Framework for gaining ethical approval (DH,2001) (appendix 8). Copies of the consent forms were retained by the researcher. These forms highlighted the options of taking or not taking part in the study, a requirement which all researchers are expected to adhere to when recruiting participants (Flick, 2009).

A fundamental principle which underpins all ethical codes relating to healthcare research is the right of participants to withdraw from studies at any time without incurring adverse consequences (Polit and Beck, 2008). In this case, it was made clear to participants that withdrawal from the study at any stage was legitimate. Additionally, they were advised of their right to withdraw any information or data they have provided including tape recorded responses. This advice is a function of the view that qualitative research is a non-static experience, suggesting that it is difficult to predetermine both the exact nature of data to be collected during a study and the possible risks to participants (Usher and Holmes, 1977; Polit and Beck, 2008).

Acknowledging this possibility of harm, consent in qualitative research, like this one, should be an ongoing interactional process between researchers and participants, rather than a one-off activity (Silverman, 2006). This assertion is based on the possibility of unexpected events or consequences occurring during a study (Munhall, 2007). Acknowledging this, it is important for researchers to always assess the effects of involvement and continually renegotiate with participants or seek new permissions from the same as research progresses. One believes that such interactions would enable participants to make informed decisions regarding continuing participation.

At this point, it could be safely stated that consenting is a dynamic activity involving researchers, information on the aim and purpose of studies and participants. Munhall (2007) and Green and Thorogood, 2009) therefore advocated for the use of the term process consent, instead of informed consent, particularly in qualitative studies, as it fits in well with their dynamic nature. Taking into account the changing nature of peoples` competency to autonomously authorise permission for participation, which can be influenced by their capacity for understanding phenomenon, the researcher would agree with Polit and Beck`s (2008) proposal of the need to regularly renegotiate consent. In this research, consent was obtained regularly by informing and seeking permission from participants during interviews. This manner of seeking consent would further strengthen the relationship between the researcher and participants, which in Munhall's (2007) view would allow participants to freely express themselves.

Fortunately, no participant expressed a desire to withdraw from the research study or to have their recorded responses withdrawn. Although this was the case, the possibility of harm to participants was never taken lightly by the researcher knowing the sensitive nature of the subject investigated. The researcher took all necessary steps to protect participants from any form of harm. The actions taken to achieve this are discussed in the following subsection.

5.2.5: Protecting Welfare of Participants

A significant tenet of ethical principles mentioned in all ethical guidelines, reiterated by committee members during the researcher's ethical clearance meeting, is that of beneficence, which focuses on minimising harm and maximising research benefits (DH, 2001). This principle reminds and encourages researchers to take every reasonable measure to protect participants from physical and / or psychological harm (Flick, 2009). One measure adopted in this study to protect the welfare of participants is that of anticipation; anticipation of potential risks or harm. While this was adopted, it was realised during the course of the study that it is difficult, if not impossible, to foresee every risk (Silverman, 2010). In other words, it was practically impossible to think of and accurately predict the wide range of possible effects of the study on participants. This was because participants not only differ in their personalities, they also differ in their life experiences. One is convinced that such differences in characteristics would enable them

to react differently to the different stages of the research process, a belief also shared by Marvastic (2004).

In this study, all but four participants reacted significantly differently during the course of interviews. The four participants cried as they told their stories. The rest of the participants perceived it as a cathartic and learning experience. It is important to note that delving into peoples` inner worlds or psyches can be perceived as intrusive. Doing so therefore requires delicate handling particularly in instances where emotionally laden issues such as self-harm are discussed.

The researcher was particularly vigilant in anticipating some degree of emotional discomfort in participants. It was believed that emotional distress could be generated by the nature of the inquiry, which involves the use of a questioning approach that could expose in-depth anxieties and fears which participants had previously repressed. It is for this reason that participants were made aware before interviews, and even reiterated during interviews that they should only relate information with which they felt comfortable. They were further reassured that all the information narrated would be coded and securely stored in a locked cupboard in the researcher's place of work. However, it must be stressed that only anonymised data would be made available to supervisors. Despite these reassurances, some of the participants still expressed emotions during the interviews. As stated earlier, four participants cried during the interviews. Actions were taken by the researcher to address and prevent such discomfort.

The participants who cried during the interviews were encouraged to discontinue the same, as this was believed would help minimise distress. While this decision may affect the data gathering process, the issue of minimising harm to participants was a priority for the researcher. This action taken is consistent with two closely related concepts, "duty of care" and "ethical soundness of research". With regard to the former concept, researchers are legally obliged to uphold the welfare of people being investigated (Green and Thorogood, 2009). In a similar vein, the notion of ethical soundness requires researchers to terminate interviews if there is any reason to believe that continuation would result in injury or distress to subjects being studied (Flick, 2009). Participation was always renegotiated. The participants who were distressed expressed their continuing willingness for participation. On the basis of this, the interviews continued.

Clearly, self-harm is an emotionally charged subject that is recognised by the researcher of this study and other healthcare professionals working in the field of mental health (Hogg, 1996). To maintain psychological well-being, support was occasionally sought from academic supervisors throughout the data collection period. The meetings held served as forums to safely disclose or express feelings towards some discussions that arose from the interviews. The need for participants to be provided with similar support system was highlighted in most of our meetings.

Participants were fully debriefed after the interviews to address any questions that they may have had relating to the impact of the study and to also identify, if any, a need for additional support. During debriefing, they were thanked for their contribution to the study and were informed that the end product of the study (thesis) would be available for them to read. In addition to this, they were also encouraged to contact the researcher and or an identified clinical psychologist (name given to them) should they require additional support. No participant made contact with the researcher or the alternative support system (clinical psychologist). This indicates that participants were probably satisfied with the debriefing sessions and the general support provided by the researcher.

Even though participants appeared to appreciate the support provided to alleviate distress during and shortly after interviews, concerns relating to confidentiality were expressed about the safety of the tape recorded responses. Noting that only a brief mention of these concerns has been previously made, it is imperative that they are examined in detail in this thesis. They are therefore discussed in the ensuing section on confidentiality.

5.2.6: Confidentiality

As already stated, confidentiality was one of the main concerns expressed by participants. Undoubtedly, this was also a worry for the researcher of this study, as the data which participants have provided is required by law to be kept in the strictest confidence (International Council of Nurses, 2003). Thus, throughout this study, preservation of participants` confidentiality was considered to be paramount and all identifiable information was anonymised to ensure this.

Anonymity of participants is often a requisite of qualitative approaches (Creswell, 2007). So, participants were informed at the outset that the information they provided would be used only for the research study. They were also reassured that the transcripts of the interviews would be stored securely on the researcher's workplace computer which was password protected in order that access was only possible by the researcher. Additionally, all participants including supervisors for the project were informed that tapes and other data relating to the study were kept securely in a locked cupboard at the researcher's place of work, accessible only to the researcher (Lüders, 2004). They were also reassured that the tapes containing the interview responses would be destroyed at the end of the project. Participants were informed of the above because, as collaborators, they needed to be aware of all actions taken during the study.

In relation to the possibility of publishing the study and or presenting parts of it at conferences, lengthy discussions in the context of confidentiality were held between researcher and participants. This was because it is not easy to foresee the impact of these actions on participants. Acknowledging this, it is crucial to safeguard participants` identities if information relating to them is going to be disseminated in this manner. Simply, this would involve distorting participants` information such that, if published or shared at conferences or seminars, it would not be identifiable as theirs.

Taking this argument of sharing information further, names are used in the findings and discussion sections of this thesis. One must stress that the names used are fictitious. The researcher opted to use names, rather than just providing coding responses, to allow a more person centred impression of the data and to help distinguish the gender of participants. It is important to mention that participants` confidential information was upheld throughout the study. The meaning of confidentiality adopted here appears to be consistent with that of Beauchamp and Childress (1989:331-332). They state:

> *Confidentiality is present when one person discloses information to another whether through words or an examination, and the person to whom the information is disclosed does not divulge that information without the other person's permission.*

Participants voluntarily agreed to take part in this research study, with the primary motive of narrating their stories of self-harm. They therefore expected to be respected throughout the study and for the data they provided to be safeguarded. Respect for participants was

achieved and the promise for data protection was adhered to as the raw data was only accessible to the researcher.

In sum, it became apparent from this discussion that there are many ethical considerations which have to be accommodated to make a study ethically feasible. These include issues such as consent, confidentiality and protecting the welfare of participants. These issues were taken into account in this project. Although they were discussed in a particular sequential order, the decisions made about them were invariably interdependent and this was borne in mind throughout the research study. The reminder of this chapter focuses on sampling, data collection and data management. How these were conducted is now discussed in the order listed.

5.3: Sampling Issues

One major decision that researchers tend to take in conducting research is to decide on the nature of the data and from where they can be obtained, as the sources of data tend to have profound effects on the ultimate quality of studies (Morse, 1998). Such a decision for identifying and selecting sources of data is what Grbich (1999) and Macnee and McCabe (2008) refer to as sampling. To be precise, Davis and Scott (2007) define it as the science and practice of selecting a portion of the population in a manner that allows the entire population to be represented in the same. On examining this definition, it became apparent that a sample is, in essence, a subset of a population. Taking into account the qualitative nature of this study, its sample is not representative of the population of healthcare professionals.

According to Parahoo (2007), a population is the total number of units that researchers are interested in studying. It is from these units or elements that data can potentially be collected (Parahoo, 2007). These units could be events or individuals or organisations to name but a few. In this study, the units of the population are psychiatric nurses working in forensic psychiatric settings, referred to in this thesis as healthcare professionals. The focus of this section of the methods chapter is on the sampling process, which includes discussions on how the sample was identified and selected.

5.3.1: Sample Identification

It is worth noting that a good starting point for selecting samples for a study is to clearly define the target population, which is simply the population of interest to the researcher (Davis and Scott 2007). The population of interest for this project is the total number of healthcare professionals (psychiatric nurses) working in locked environments of the Forensic Directorate of a Trust in London. The study site consisted of 15 locked clinical settings with an average of 22 healthcare professionals working in each area. Taking into account the overarching philosophy of the research project, which focuses on the development of an in-depth understanding of attitudes towards self-harm, it was not appropriate to include the entire population in the study. Munhall (2007) agrees by emphasising that researchers using this mode of inquiry, sample for meaning development rather than for producing generalisable findings. Simply, she is suggesting that qualitative researchers are not required to use large samples, as their ultimate aim is to enhance the understanding of phenomena.

Acknowledging this, it was therefore fitting, as a pre-cursor to sample selection, to carefully identify potential participants from this population. In doing this, one took into consideration specific conditions, which potential participants should meet to make them eligible for partaking in the study. These conditions are what Polit and Beck (2006) refer to as eligibility or inclusion criteria for participation. In this study, they were:

1. Healthcare professionals with two or more years of working and caring for self-harming service users in secure environments of a Mental Health Trust in London.

2. Healthcare professionals who are willing and feel safe to share their experiences and views of self-harm with others

While the delineation of the above conditions would assist in identifying a sample, the researcher also felt the need to define characteristics, which the study potential participants must not possess. Doing this, the researcher believed, would ensure the selection of "appropriate participants". The question now arises, what are "appropriate participants"? According to Munhall (2007), these are individuals who have experienced and / or are experiencing the construct being investigated and who are both willing and able to share

their experiences. The characteristics which participants must not possess are what Polit and Beck (2008) refer to as exclusion criteria, which, for this study, are outlined below:

1. Healthcare professionals with no, or, less than two years, experience of caring for self-harming service users.

2. Healthcare professionals not working in secure environments of the study site.

At this point, it would be safe to state that the use of these sets of criteria was a filtering process for selecting an appropriate sample.

As already stated, the clinical teams of the 15 clinical areas were met one at a time over a period of two months. The discussions during these meetings focused on the nature of the study, its aim, and inclusion and exclusion criteria. Each healthcare professional was given an information leaflet and a letter of invitation to take part in the study. Highlighted in the letter of invitation were the study's aim and inclusion criteria. The primary purpose of these meetings was to access individuals who have relevant knowledge and experience of self-harm, and who are willing and able to communicate them. At the end of the meetings, healthcare professionals present were reminded to carefully read the leaflets given to them, and if they met the eligibility criteria, to contact the researcher either in writing or via telephone if they wished to be interviewed. Towards the end of October 2008, about 80 healthcare professionals (potential participants) made contact with the researcher and expressed their willingness to participate.

5.3.2: Sample Selection

It is consistently highlighted in the literature that qualitative research is concerned with seeking in-depth knowledge of participants` experiences (Polit and Hungler, 1999). Its aim, as Flick (2009) asserts, is not about discovering absolute truths about phenomena of interest, but it is about understanding multiple realities or truths of the same. Thus, it could be argued that the notion of generalisability of research findings across entire target populations is not a guiding principle for sample selection in qualitative studies. Huberman and Miles (1998) reiterate this by stating that the focus of sampling in these

studies is not about producing generalisable findings, but it is to do with developing a deeper understanding of subjects studied.

Clearly, there is a quest for qualitative researchers to develop deeper understanding of phenomena. It is therefore not surprising to realise that researchers, using this mode of inquiry, always strive to search for and select the most content and the most contextually rich sources of data (Green and Thorogood, 2004). It is for this reason that they deliberately seek ways of finding individuals who are deeply involved and knowledgeable about phenomena being explored.

As mentioned earlier, about 80 potential participants made contact with the researcher and clearly expressed their willingness to be interviewed. Most of them made their initial contact via telephone and only a few did so in writing. Volunteers or potential participants who met these criteria were again informed about the nature of the study; some in person and some over the telephone. In addition to this, mutually agreed dates and times were set for the interviews to take place. A follow-up letter (appendix 9) was then sent to each of the volunteers eligible for participation confirming the date and time of the interview and as well as indicating the venue allocated by the Trust for the entire duration of data collection. Luckily, all the 80 volunteers fitted the inclusion criteria for participation, and were therefore eligible to be interviewed.

Starting with the individual interviews, two sampling approaches were used for the same. Initially, individuals made contact with the researcher via telephone and volunteered to take part in the interviews. Presumably, they did so because of a felt need to express their views about self-harm. Individuals volunteering participation, as in this study, are referred to as a volunteer or convenience sample (Green and Thorogood, 2004). Sampling eventually evolved to a purposive sampling strategy (Silverman, 2006). In this case, the researcher deliberately selected among the volunteers, individuals who were most likely to provide the information that was sought. According to Parahoo (2006) and Flick (2009), using volunteers is perhaps the least robust of sampling approaches, as the selection of interviewees is mainly dependent upon people volunteering to take part. Nonetheless, this sampling strategy was considered appropriate, as the issue of generalisation is considered to be less important within a qualitative study of this nature.

A total of 70 individuals, who were easily accessible and knowledgeable about self-harm, were selected from the 80 volunteers for participation in the individual interviews. The selected individuals were considered by the researcher as most appropriate for participation in the interviews. The sample size for the individual interviews was 25, meaning that a total of 25 interviews were conducted. Individuals for these interviews were selected from the sample of 70 participants. Explanation of how this sample size of 25 was reached is provided below. However, it is important to mention that this sample size was considered adequate to achieve effective results. Effectiveness in this case means that a wealth of relevant information that relates to the subject under study was generated. The adequateness of this sample was confirmed by examining some of the suggestions for sample sizes in IPA studies (Smith and Eatough, 2006).

In the main, IPA studies are generally conducted using small sample sizes (Langdridge, 2007). But what is a small sample size? To date, there is apparently no right response to this question. This is probably because sample sizes of these studies were determined by a multiplicity of factors, which tend to lead to a variation of sample sizes from one study to another. In Smith's (2005) view, these influential factors include the richness of data required, researchers` commitment to case level of analysis and thoughts on comparing cases. Although this is not a stipulation, IPA studies which are committed to collecting rich data and deeper level of analysis have been noted to use sample sizes ranging from one to 42 participants, with the norm being towards the lower end (Smith and Eatough, 2006; Smith *et al.* 2009). This suggestion for using smaller sample sizes (less than 42) is a function of the view that large samples sizes could result in researchers being swamped or flooded with data, which, in turn, could lead to superficial qualitative analysis (Smith, 2009). Undoubtedly, such a level of analysis defeats the purpose of this study, which aims to achieve a deeper understanding of the subject investigated.

With respect to the individual interviews, the researcher commenced data collection by interviewing 15 participants from the 70 considered as most suitable for providing relevant, appropriate and detail information about self-harm and attitudes towards it. The interviews were transcribed and analysed as they were conducted. On examining the data, new themes and categories were noted to emerge as the analysis progressed. This suggested the need to involve more participants in the data collection process. Hence, new participants were interviewed and their stories on self-harm were added to the

database until the ongoing analysis revealed no new emerging information. Consequently, the total number of participants eventually interviewed rose to 25. This point in data collection at which data became repetitive and no new information was generated from analysis, is what is referred to in a qualitative inquiry as data saturation (Morse, 2002; Polit and Beck, 2006). Clearly, it is the quest for achieving this that resulted in the increase of the sample size. However, this sample size of 25 is still small relative to those used in quantitative modes of inquiry (Polit and Hungler, 1999). Most importantly, it is appropriate for this study as it allowed the researcher to collect rich data that resulted in an enhanced understanding of the construct investigated. Sampling for the individual interviews was followed by sampling for the focus groups.

The sampling process of the focus group was informed by the researcher's experience with the individual interviews and the outcome of the analysis of the data collected from the same. Again, the sample of the focus group was selected from the 70 healthcare professionals believed to be most appropriate for the provision of rich data on self-harm.

Participants who were not involved in the individual interviews were contacted in writing, providing them general information about the study including times, dates and venue for the interviews. Luckily, all of the individuals contacted confirmed their intentions for participation. Despite this, reminder letters with participants` scheduled date, time and venue were sent three days before interviews. Participants were initially selected for three focus groups. Each focus group was made up of six participants. The analytical pattern applied to the individual interviews was also adopted for the focus groups. Simply, the audio-taped interviews were transcribed and analysed in the sequence they were carried out. Notably, new themes and categories were noted to emerge as the analysis of the first three interviews progressed. Acknowledging the desire to achieve data saturation, the emergent of new themes is an indication of the need to recruit additional participants and to conduct more focus groups. As a result, sampling process continued until the sixth group. The sixth group, as Polit and Beck (2008) put it, was the point of data saturation. This also means that a total of 36 healthcare professionals were recruited to and participated actively in the focus group interviews. It is also important to state that all the 25 healthcare professionals who took part in the individual interviews were not engaged in the focus groups.

The information provided by participants in both sets of interviews, focus group and individual, enhanced the researcher`s insight into the subject of self-harm. Such an outcome is believed to be a function of the recruitment and selection process. This process for recruiting individuals into studies is clearly articulated by Denzin and Lincoln (1994) by stating that researchers using qualitative modes of inquiry usually seek out groups, individuals and settings where the processes being studied are most likely to occur. Now that identification and selection of participants have been discussed, it is now time to explore the data collection process.

5.4: Interviews

Interviews are essential parts of many types of qualitative research. This is a qualitative study that utilised interviews as conversations between the researcher and participants. The primary purpose for this was to facilitate interactions between these two parties with the view of enabling the latter to freely express their views in relation to the subject studied. Free expression was achieved and the information generated from the conversations form the bulk of the data of the study. This section examines how these conversations (interviews) were used as data collection methods. It commences with a discussion on the development of an interview schedule followed by an examination of how it was tested. The discussions then led to a presentation of a detailed explanation of how the main interviews, individual and focus groups were conducted.

5.4.1: Interview Schedule

Even though each individual interview is unique in its own right, it is essential to conduct them in a manner that would ensure that their outcomes reflect the social world or phenomena being studied (Flick, 2009). Taking this advice into account, the researcher of this study employed the use of an interview schedule to make sure that the key issues (such as reasons and care provision) in relation to attitude and self-harm were discussed. Arguably, this structure would ensure some degree of consistency across interviews. This is partly because they tend to contain a set of questions which are asked of participants. However, it must be stressed that these questions in the main act as a guide for the interviews rather than dictating the course of the interview (Gray, 2009). According to Smith and Eatough (2006), the questions are usually set out in a sequence considered by researchers to be appropriate and effective for achieving the study aims.

However, in instances of in-depth open interviews, some researchers like Smith *et al* (2009) suggest that interviewers do not necessarily have to follow the order of question, nor does every question have to be asked in exactly the same way of each participant. They advise that the sequence in which the questions are posed should be dictated by the responses of participants (Smith *et al.* 2009).

Implicit in this assertion is that the order of asking questions laid out in schedules is less important, a view also shared by Kvale and Brinkmann (2009). What is important, particularly for an exploratory study of this nature, is for researchers to explore issues of interest relevant to a study that may arise during interviews even if they are not part of a schedule (Breakwell, 2006). If this is the case, why are schedules used.

With regard to this study, developing the schedule enabled the researcher to think in advance about possible areas for exploration. Its preparation also led to the identification of a range of likely difficulties that could be encountered during and after interviews. For example, a participant may demonstrate some degree of hesitation in responding to questions. Participants may also complain of feeling distressed following interviews. Strategies for addressing these likely difficulties were also thought of. At this point, it could be safe to state that a schedule is a form of support system that researchers can refer to if the need arises. So, developing a schedule was important. It helped lessen the anxieties experienced, which in turn enabled one to be more engaged, attentive and flexible. Smith and Eatough (2006) also share similar views about interview schedules. Additionally, they believe that such structures, if well prepared and used effectively, would result in friendly researcher-participant interactions. Such interactions would enable the latter to freely express himself or herself (Smith and Eatough, 2006).

Generation of detailed accounts of participants` views of self-harm is a key issue for this study. Thus, the schedule was prepared to include mainly open questions with the intention of encouraging participants to freely tell their stories (appendix10). It was realised that some of the open questions could be perceived ambiguous by some participants. It was therefore considered necessary to formulate prompts for some questions, which one thought could cause some difficulty with comprehension. Hence, the prompts were explicitly framed. This was done to help guide the interview encounters and to engage in intense exploration of emerging issues with participants. The prompts and list of questions on the schedule

developed were discussed with my supervisors. Feedback was provided and the schedule was re-drafted to accommodate the comments made about the questions. Now that the interview schedule had been prepared, it was time to test it. Initially, this was carried out within a framework of pilot interviews and subsequently in the main body of interviews.

5.4.2: Pilot interviews

It is always a good practice for researchers to undertake a small-scale trial run of methods of data collection especially when newly developed (Parahoo, 2006). The essence of this is to gather evaluative information that would enhance their feasibility and efficacy (Polit and Beck, 2008). Hence, the interview schedule developed was tested to find out whether it would ensure a comprehensive exploration of participants' views or experiences of the phenomena of self-harm and attitude.

Two pilot individual interviews were undertaken with two volunteers who are employees of the study site and as well as noted to be knowledgeable on self-harm. An open individual interview format was chosen for testing the schedule. It allowed the interviewees to offer their experiences whilst a sense of direction was still maintained towards the subject being investigated. The ability of the schedule to maintain this sense of direction was closely examined.

The interviews were conducted in a specific room provided by the Director of Nursing of the study site. As stated on the schedule, each interview commenced with the researcher providing explanations of its purpose and process. Getting the explanations for the interview right at the outset was fundamentally important. This is because the provision of clear information would influence the quality of data and participants` willingness to participate. To maintain willingness to be interviewed, the significance of the research, confidentiality of all data and the possibility of withdrawing from the study at any point was emphasised. Participants were also asked to express any doubts or queries they may have about the interview.

The interviews were tape recorded and consent to do so was sought from participants as stipulated in the schedule. It must be emphasised that a short trial run of the recorder was conducted just before commencing the interviews. Doing so did not only enable the

participants to hear their voices on tape, but it also reassured the researcher that the equipment was operational. On establishing this, the researcher commenced the interviews by asking participants the first question on the schedule. The order in which the questions were asked was influenced by the responses provided. At the end of the interviews, participants were asked about their comprehension of the questions and claimed that the questions were clear and the prompts used made them clearer and facilitated the generation of rich data. It would have been impossible for the researcher to achieve this understanding without pilot work.

The data collected from the pilot interviews addressed the main research issues; healthcare professionals` perceptions of self-harm. This seems to indicate that the schedule adopted facilitated the intended direction of the research. Although the interview process generally proceeded as planned, the researcher is convinced that there was a vast amount of information that was not captured by the recorder. This included participants' behaviour and non-verbal interactions that took place between the researcher and participants. It was believed that such information would add to the meaning of data recorded. Therefore it was imperative to set aside some time at the end of interviews to make notes of the context and impressions formed of the non-verbal interactions. Consequently, the schedule was amended accordingly to create opportunities or spaces for reflection at the end of the main body of interviews. The initial part of the reflection or debriefing would be researcher-participant discussions about the interviews. At this stage, the recorder would be turned off to allow participants to talk about issues that they would probably feel anxious to talk about if the recorder is on. The second stage of the reflection would only involve the researcher thinking about and making notes of non-verbal interactions, and where possible, establishing links with comments expressed. Not taking into consideration the behaviour of participants during interviews could result in researchers losing significant aspects of the meaning of data collected (Kvale and Brinkmann, 2009). Consequently, note making was included in the schedule for the main body of interviews.

5.4.3: Main Body of Interviews: Individual and Focus Group

It must be emphasised that the discussions presented in this section are generic in the context that they are related to both sets of interviews; individual and focus groups. However, distinctions between them are made in a number of places with the use of operational

instances that are specific to each set of interviews. Practically, the data collection started with individual interviews, which were subsequently followed by focus group interviews. Both sets of interviews were guided by the interview schedule.

From a critical realist paradigm perspective, the primary purpose of interviews is to achieve insight into participants` own understanding of phenomena investigated (Sayer, 2002). It is regularly reiterated in the literature that participants have experiential expertise of issues explored. So, to achieve understanding of these issues, it is critical for researchers as co-participants to actively listen to participants` stories during interview encounters. It is worth mentioning that people are generally reluctant to tell their personal stories especially those that are related to emotionally laden subjects like self-harm (Miller and Glassner, 2004). They are however more likely to do so within a psychologically safe environment; an environment where there is an established trust between the parties involved (Parahoo, 2006). It is therefore crucial to commence interviews with rapport or trusting building activities.

To this end, about ten minutes was allocated for social interaction between researcher and participants before commencing the tape recorded part of the interview process. This activity involve the provision of personal information with the view of enabling participants to feel relaxed and to perceive the researcher as trustworthy, non-threatening and one who respected and valued people. It also included discussions relating to how participants were feeling on the day and whether they were happy to talk at that time. The researcher is acutely aware that relaxed participants are more likely to give detailed accounts of their experiences (Phoenix, 1994). Hence, the issue of enabling participants to feel relaxed was taken seriously. In relation to this, seating arrangements and the position of the tape recorder were discussed. The recorder was positioned closed to participants such that they could turn it off if they wanted to. This action was to enable participants to feel relaxed. In fact, interviews were only conducted when participants were noted to be comfortable and relaxed.

As in the pilot interviews, the main body of interviews was audio taped to ensure accurate and complete data. Forty five minutes was allocated for each interview. These (interviews) were commenced with explanations of their purpose and process. Understanding of this information was sought from participants. On confirming comprehension, participants were asked the first question on the schedule. Participants were given time to give as full an answer as possible to questions asked, and prompts were used when they were perceived to

encounter some difficulties with responding. Probes were also used in some instances to find out more about important and interesting issues raised. But care was taken not to interrupt the flow of thought. So, mental notes were sometimes made of issues or subjects raised that one need to follow up at the end of a response to a question. Hence, as a participant got naturally to the end of a turn, the researcher sometimes brought up issues that required exploration. For example, the issue of "sterile environment" was raised with one participant of the individual interviews. She was asked to provide explanations of what she meant by this term.

This sort of probing approach employed would ensure detailed exploration of participants investigated and would also suggest to participants the level and depth of information required at interviews (Smith *et al.* 2009). Acknowledging this, it could be argued that using probes at the beginning of interviews would result in the researcher needing to probe less as they progress. This was noted in this study.

In addition to the use of probes, the presence of a second researcher at the focus group interviews helped in the generation of data. For instance, he assisted in making notes of the non-verbal interactions during interviews. This additional data source can be a useful resource for subsequent contextualisation and development of the analysis of audio recorded data. All the recorded tapes were listened to and transcribed fully. A detailed discussion of the process of transcribing these tapes is presented in the analysis section of this chapter.

5.5: Analysis

The researcher is cognisant that analysing the audio recorded data and the notes taken at the end of the interviews can be challenging. The mere thought of engaging in the analytical process was overwhelming. It was therefore crucial to conduct analysis in stages with a view to assuming control over this aspect of the research process. Noting that the audio recorded information constituted most of the data of the study, it was necessary to transform the oral interview conversations to a written text in the form of transcripts. For this reason, transcription was the first stage of analysis considered. Hence, the initial discussion presented here is the transcription process. This is followed by discussions of IPA as an analytical tool and the application of the same on the transcribed data and notes taken.

5.5.1: Transcription Process

Transcription is an iterative interpretative process that involves the conversion of conversational interactions between two or more physically present people into fixed written forms (Kvale and Brinkmann, 2009). Arguably, it is a translation of oral discourse into a written narrative mode. Such translations could result in loss of vital information as it can be difficult if not impossible to include, for instance, people's tone of voice and intonation in transcribed data. Loosing such data could have a significant impact on people`s understanding of the meanings of issues under discussion. Bourdieu *et al* (1999) reiterate this view by stating that intonations are almost certainly lost in transcription. If this is the case, transcripts could be considered, for example, in the context of intonations, as impoverished portraits of face-to-face interview conversations. To be more explicit, the intonations and body language that are observable during interviews are usually not accessible to readers of transcripts. Even though this is generally the case, transcription and the transcripts that are generated from it, are important facets of the process of analysis. They were therefore taken seriously in this study. This was demonstrated by painstakingly selecting a transcription process that fits well with the researcher`s epistemological and ontological beliefs, and method of analysis adopted (IPA).

Transcription can take two different forms; verbatim and selective (Silverman, 2001). The researcher of this study and IPA require a verbatim record of all data collection activities. The essence of this is to enhance the effectiveness of the study, as discarding some points could result in the loss of relevant information. Hence, verbatim transcription was opted for because it offers the advantage of making all information collected during interviews available for subsequent analysis (Kvale and Brinkmann, 2009). Although this is an achievable exercise, it must be stressed that the process of doing so can be laborious and time-consuming (Potter, 2003). There is therefore a need to lessen some of the pressures involved in transcription. As a result, the researcher did not take the route of providing a record of the exact length of pauses and detailed non-verbal utterances of participants. IPA tends to adopt this stance.

The primary aim of this tool of analysis (IPA) is to interpret the meanings of participants` narratives. So, it does not really require the more detailed prosodic aspects of participants` talk that are required in conversational analysis (Drew, 2003). It however requires a semantic

record of the interviews. This means that the all spoken words at interview, Smith *et al* (2009) asserted, should be included in the transcripts. Hence, the term verbatim transcription, as used in this study, refers to the provision of a text of the spoken words of both participants and researcher expressed during interviews.

Tapes were listened to, on average, twice by the researcher on the day of the interview or that following it. They were fully transcribed and all identifying features were removed to ensure confidentiality and anonymity. Participants were referred to by pseudonym. It took an average of three hours to transcribe the 45 minutes interviews conducted. The transcripts were presented in a form amenable to closer analysis using IPA. A discussion of this analytical tool is now presented.

5.5.2: IPA: A Framework for Analysis

Analysis in qualitative modes of inquiry is an iterative process that involves researchers actively engaging with transcribed data (Smith and Osborn, 2003). In doing so, they are required to be creative, innovative and flexible (Gray, 2009). While this is the case, the process of qualitative analysis can be confusing, off-putting and anxiety provoking, particularly for those who are new to it (Creswell, 2007). This risk of experiencing feelings of anxiety and confusion can be alleviated or at least minimised by adopting a structured approach to analysis (Silverman, 2001). It was partly for this reason that IPA was utilised in this study. It is a stage-by-stage approach that places cognition in a central position of the analytical process. In addition to enhancing the effectiveness of analysis and the confidence of researchers, claims are repeatedly made in the literature that the analytical stages of IPA can make the analytical process more manageable (Smith, 1996; Smith *et al.* 2009). They therefore deserve some degree of discussion.

5.5.3: Application of IPA

Analysing data in any shape or form is a complex process. The impact of such complexity can be minimised if researchers are clear about what they intend to do. The intention of researchers using IPA is usually very clear; generation of accounts of what researchers think participants are thinking of subjects investigated (Smith, 2007). The focus of this study is to provide evidence of participants` thoughts about attitudes towards self-harm and to provide one`s own impression of participants` accounts or stories about the same.

This is what is referred to as double hermeneutic (Smith and Osborn, 2003). Acknowledging this, it could be safely stated that the outcomes of an IPA analysis are based on subjective decisions, but such decisions are arrived at following a systematic and sustained engagement with transcribed data (Smith *et al*. 1997; 1999).

Data of this study were obtained from both individual and focus group interviews. The transcript of each individual and focus group interviews is referred to as a case. The analysis commenced with the cases of the individual interviews. Noting that the researcher of this study is committed to an idiographic approach to analysis, the analysis specifically commenced with the first case (transcript of the first interview), followed by the second case, and then moving on to the third, and so on. Similar analytical approach was adopted for the focus group interviews. Generally, the analyses of the cases were conducted through a number of stages. Discussions of the analytical stages are presented and illustrated with the first case.

The first stage of analysis involves reading the transcript. Each transcript was read and re-read to completeness two times. The essence of this was to gain a high level of familiarity with the account presented. Although care was taken not to engage in any form interpretative activity at this stage, each reading had the potential for generating new insights.

The second level of analysis was the "initial note making" stage. Spaces are needed to insert comments or notes on the transcript. So, researchers using IPA are encouraged by proponents of this approach to have wide enough margins on both sides of their transcribed scripts for note making (Smith *et al.* 1995). The analysis at this stage was detailed and time-consuming because it involved a close examination of the semantic content, the order and manner in which the words were expressed. When reading through transcripts, researchers are advised to maintain an open mind and to note down anything that strikes them as interesting or significant about participants` talk (Smith *et al*. 1999). Responding to this advice, the transcript was read twice and the left-hand margin was used to annotate issues which were considered important. This process continued for the whole of the transcript. The annotations at this stage assume an exploratory stance. In the researcher`s view and that of others, these annotations can be categorised into descriptive, linguistic and conceptual comments, and each category has specific functions (Langdridge, 2007).

Starting with descriptive exploratory commenting, it is just about describing participants` talk within the transcript. In contrast, linguistic commenting focuses on the use of language, metaphor, repetitions, pauses, tone of voice, degree of fluency and so on. The final category of comments, conceptual, takes both the forms of an empathic hermeneutic and hermeneutic of questioning, with the latter being more interrogative (Langdridge, 2007). Taking this notion of interrogation further, researchers using IPA are encouraged to ask critical questions of the data (Smith, 1999). For example, what does the participant mean by a controlled environment? Does staff training have an impact on service users` self-harming behaviour? These questions were asked of the data of the first transcript. Such an analytical dialogue was implemented with each transcript and sometimes involved asking questions of what a word or phrase meant to oneself and to participants. Like multi-methods, the combined use of exploratory comments on the same transcript and the adoption of such a critical questioning stance would ensure richer and deeper analysis. Arguably, the resultant analytical account is a joint product of the participant`s and researcher`s reflection. This stage of analysis is illustrated below in table 1, which contains a short extract from a transcript of an interview with the first participant of the study.

Table 1: Initial Noting

Exploratory Comments	Original Transcript
Secure environments are basically controlled environments. High levels of supervision in these environments help reduce self-harm rates. <u>Do the service users` intention for self-harm changed by these settings?</u> <u>Controlled environment. What does this mean to the participant and myself?</u> Controlling addresses some risk factors such as preventing self-harming behaviour. But does not address the intention to self-harm. Therapeutic input addresses intention, help service users grow. <u>What sort of therapeutic approaches?</u> Controlled environment has limitations Not listening to service user, coping	R: Do you think secure environments play a part in patient self harm behaviour? P: Secure environment is basically a controlled environment. In this setting, most service users are detained under the MHA and they tend to require high level of supervision. So, in these environments, self-harm rates are reduced. The environments do have a positive impact on service user in relation to self-harm. R: Will control environment reduce the incident of self harm? P: To some extent, yes. Controlling in terms of search will help address a lot of risk factors of self-harm. But if there is no therapeutic intervention within the control environment, then one would fail to achieve his aim; prevention of self-harm. You therefore need to have some therapeutic input to help the service users grow. Control alone is not good. R: Why is self harm increasing in secure environments? P: A lot of things---, the media have a part to play, lack of coping ability of people, not being able to express themselves. The reason why it is increasing,..erm...it is an easy way for them to cope with their problems. They often feel that nobody is there to listen to them or care for them

At the end of this stage of analysis, the researcher was faced with a large data set, the original transcript and initial exploratory annotations. It was this volume of data that formed the basis of the next stage of analysis, development of emergent themes. At this stage, the researcher was required to return to the beginning of the transcript to commence theme identification. The initial annotations and what was learnt from making them were used to form the themes. This process of transformation, which was applied to the entire transcript, also involved the use of some theoretical concepts such as Social Identity Theory (Taifel and Turner, 1986), subjective norm and perceived behavioural control (Ajzen, 1985). The essence of this was to make maximum psychological sense of the data. Given the careful approach taken to make the initial comments, the researcher would argue that the themes which were generated or

identified from them are grounded in the participant`s talk and reflect important elements of the data. The identified themes, sometimes referred to as "meaning units", are in essence essentially key words or phrases that describe and / or interpret aspects of the phenomenon found in the text (Creswell, 2007). These themes were annotated in the right-hand margin of the documentation format used. This stage of the analytical process is illustrated in table 2, which presents the initial notes and emergent themes from the extract of the transcript in table 1.

Table 2: Development of Emergent Themes

Exploratory Comments	Original Transcript	Emergent Themes
Secure environments are basically controlled environments. High levels of supervision in these environments help reduce self-harm rates. <u>Do the service users` intention for self-harm changed by these settings?</u> <u>Controlled environment. What does this mean to the participant and myself?</u> Controlling addresses some risk factors such as preventing self-harming behaviour. But does not address the intention to self-harm. Therapeutic input addresses intention, help service users grow. <u>What sort of therapeutic approaches?</u> Not listening to service user, coping	R: Do you think secure environments play a part in patient self harm behaviour? P: Secure environment is basically a controlled environment. In this setting, most service users are detained under the MHA and they tend to require high level of supervision. So, in these environments, self-harm rates are reduced. The environments do have a positive impact on service user in relation to self-harm. R: Will control environment reduce the incident of self harm? P: To some extent, yes. Controlling in terms of search will help address a lot of risk factors of self-harm. But if there is no therapeutic intervention within the control environment, then one would fail to achieve his aim; prevention of self-harm. You therefore need to have some therapeutic input to help the service users grow. Control alone is not good. R: Why is self harm increasing in secure environments? P: A lot of things---, the media have a part to play, lack of coping ability of people, not being able to express themselves. The reason why it is increasing,..erm...it is an easy way for them to cope with their problems. They often feel that nobody is there to listen to them or care for them	Controlled environment Therapeutic approaches Reasons for increasing in self-harm in secure settings

It is important to stress that the themes identified at this point are not definitive outcomes, but they are certainly true reflections of the quality of what participants say in the text (Storey, 2007). So, extreme care was taken not to omit any aspect of the transcripts at this stage, as doing so may distract researchers from understanding significant facets of the study phenomenon. In view of this, the researcher treated the transcripts as whole potential sources of data.

Now that themes have been identified, the next stage of analysis is searching for connections across the emergent themes and clustering them appropriately. To do this effectively, the researcher initially word processed a list of the emergent themes in a sequence that reflected the order in which they appeared in the transcript (first case). The compilation of the list is usually followed by what Smith and Osborn (2003) refer to as theoretical ordering. Essentially, this notion requires researchers to closely examine the list of themes with a view to establishing connections or relationships between them. On applying theoretical ordering to the data, some of the themes were observed to cluster together. The themes which formed the clusters are called sub-themes. While each cluster is assigned a specific title, they are generically referred to as super-ordinate or master themes.

The clusters of themes were checked for their connections or relationships with the primary source of data; participant`s talk embedded in the transcript. Relationships between the themes were also explored. Clearly, this approach to analysis is a close interaction between the researcher and the transcript, which helps one not only to develop a deeper understanding of participant`s responses, but also assists in clarifying one`s own thoughts of these responses. This understanding can be enhanced by introducing strategies to complement or bolster the clustering process. An appropriate approach thought of is compilation of a master directory of participants` phrases that support or match related themes. This was formed by initially developing a directory for each transcript. These directories contain phrases or statements that capture the meaning of identified themes. An extract of interview one directory is illustrated in table 3.

Table 3: Directory of Participant's Phrases or Statements

Super-ordinate theme: meaning of self-harm (sub-theme: maladaptive behaviour)
1. It means injuring yourself, having to harm oneself.
2. It is way of calling for help or crying for help for those who cannot verbally express themselves.
3. The problem is erm erm; it is a cry for help in a maladaptive way

Forms of Self-harm (cutting)
1. This manner of calling for help, takes different forms, such as cutting.

Super-ordinate theme :explanations for self-harming (sub-theme :reasons, gender difference)

1 There is usually underlining reasons for their behaviour. It could be sexual abuse or something that has happened in their lives they find uncomfortable with. They self-harm to cope with these problems
2 There is generally a lack of trust on the part of the service users. So, they are usually hesitant of verbally expressing themselves. So, they do so physically. It is a very common thing with woman rather than men

Once the directory has been developed, it was necessary to provide a graphic representation of the structure of emergent themes. This was done through the creation of a table of super-ordinate themes together with their constituent sub-themes. Identifiers were added to each sub-theme to facilitate analysis and to help locate their exact source in the transcripts. Each of the themes was annotated with interview and page numbers, and key words that would assist in locating their exact position in the transcribed data. Some themes were dropped during this process of assigning identifiers. This was applicable to those which were neither rich in evidence within the transcript nor fitted in well with the emergent structure. The resultant structure is called a table of master themes. Arguably, the final table of themes is an outcome of an iterative process that has preserved the integrity of the participants` account. Table 4, an extract from a table of master themes of interview one, illustrates this.

Table 4: Master Table of Themes of Interview 1

Super-ordinate Themes	Sub-themes	Keywords	Interview and Page Number
Meaning of self-harm	Maladaptive behaviour	Injuring self. Cry for help	1,1 1,2; 1,3
Forms of Self-harm	Cutting	Cutting	1,1
Explanations for self-harming	Reasons Gender difference	Coping Women	1,2; 1,3
Repetition of self-harm	Service users` perception of healthcare staff. Responses to repetition Loss of hope	Not helping them. Feel disappointed Wasting nurse`s time	1,1 1,3 1,1

The analysis thus far discussed focuses on the first transcript. This study involves 25 individual and six focus group interviews and each case was analysed in a similar way to the first case in the sequence the interviews were conducted. Figure 1.0 shows the analytical journey from the transcripts to the master table of themes.

Figure 1: Analytical Steps from Transcript to Master Tables of Themes

Stage 1: Reading and reading the transcript

Stage 2: Initial note making

Stage 3: Development of emergent themes: looking for themes

Stage 4: Searching for connections across the emergent themes

Stage 5: Development of a master table of themes

Stage 6: Development of a consolidated list of master themes
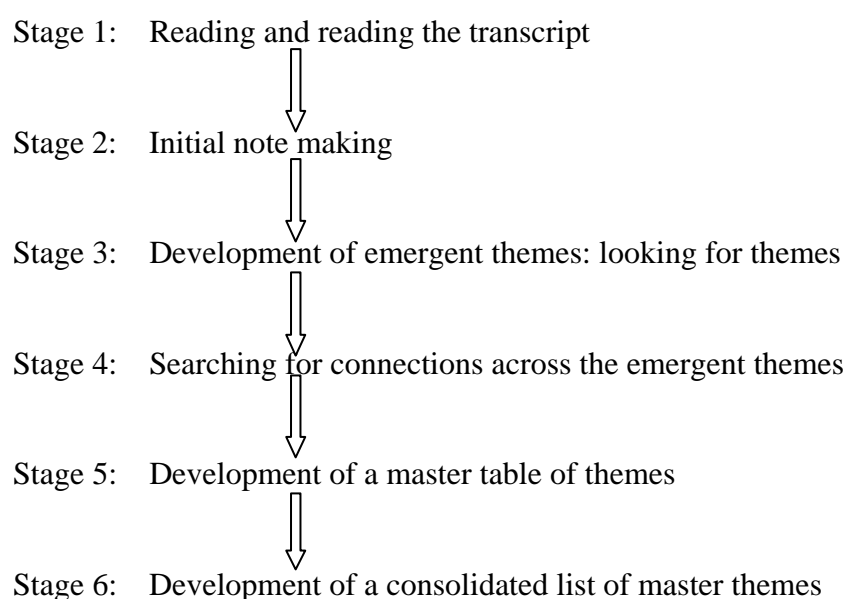
All the transcripts were analysed through stages one to four outlined above. A master list was produced for each transcript. These master lists were then subjected to the final stage of analysis, which, in essence, involved reading and comparing them. Associations between and across themes were noted. It also became clear that many individual phrases and statements were not exclusively located within one single sub-theme, but were rather situated within several different themes. Such positioning of statements within themes reflects natural interactions between people. This suggests that talk does not confine itself exclusively to topics or subjects that people discuss, but it sometimes includes discussions of ideas and meanings from other areas of existence (Munhall, 2009).

However, it is important to note that the outcome of the comparison of the master table of themes was a consolidated list of master themes with related sub-themes and key words to illustrate statements and or phrases within the data. Details of the master tables are shown in the results chapters of this work.

5.6: Summary

In sum, this chapter outlined the processes followed throughout the study. It provided discussions of the ethical issues of the study and examined sampling issues, which include sample identification and selection. Included in this chapter are also discussions on how the interview schedule was developed, piloted and used in the main body of interviews. The process of transcribing the interview data is also explained.

It has been acknowledged that doing qualitative analysis can be a daunting exercise; a challenging one. IPA has been illustrated as a tool that can help the researcher to address this challenge. Its use in analysing textual accounts presented by participants has been clearly demonstrated. Analysing data using IPA involves a number of stages. This chapter has discussed the application of these stages and illustrated them with the transcribed data of the first interview. The outcomes or results of the analytical process were super-ordinate and sub-ordinate themes. These themes are presented in the following chapter with examples of participants` responses.

PART TWO

RESULTS AND DISCUSSION

Introduction

This part of the thesis is made up of six chapters. The first four chapters illustrate the findings or themes which emerged from the data analysis discussed in the previous chapter. The fifth chapter offers a discussion of the findings of the study. These findings are illustrated in the results chapters in the form of abbreviated tables of super-ordinate and sub-themes that capture and represent participants` narratives of their meanings of, and attitudes towards self-harm. As part of the sense-making process of the participants` lived experiences of the study phenomenon, a summary of each super-ordinate theme is presented under the heading of "theme descriptor". Simply, these are overviews of the meanings of the super-ordinate themes and their respective sub-themes. It is believed that the provision of such descriptions would enable the reader, and certainly the researcher, to develop some degree of insight into the study outcomes.

Similar themes were generated from the data of both the focus group and individual interviews. In other words, the findings of these sets of interviews were noted to be similar in the context of the emergent themes. However, significant differences in relation to the depth and breadth of discussions of some of these themes were apparent. Generally, the narratives of the focus groups were much more discursive than those of the individual interviews. These similarities and differences and the reasons for the same, are articulated in the discussion chapter. Since the emergent themes from both sources of data are the same, it makes sense to present the study findings in a single abbreviated table of themes. To help the reader develop a better understanding of the results, this information is complemented with comprehensive tables of themes for individual and focus groups data (appendixes 11 and 12).

A detailed examination of the results reveals that no theme was identified in isolation. Rather, relationships between themes were evident and are illustrated as appropriate. With the help of the literature reviewed earlier, excerpts from participants` narratives of both focus group and individual interviews are used to support the discussions of identified themes. The initials, "Fg" and "In", which stand for focus group and individual interviews respectively,

are used at the end of each excerpt to identify their source. These initials are also followed by numbers, for example, (2, 1) with "2" representing the number of either the focus group or individual interview and "1" indicating the page number of the transcript from which the excerpt was obtained. It is important to stress that some of excerpts are used in more than one section to assist the researcher support themes. While such usage is an indication of the inter-relationships between themes, it also highlights the nature of human discourse.

The first chapter of this part of the thesis examines the visibility of the behaviour of self-harm and participants` explanations of why service users harm themselves. As stated in the literature review, self-harm sometimes evokes negative experience on healthcare professionals. Examples of these may include feelings of anxiety, sense of failure and loss of hope. Chapter Seven focuses on the impact of these experiences and similar encounters on participants. It also illustrates strategies for coping with the impact of self-harm. Chapter Eight relates to the attitudes towards self-harm and factors which may contribute towards attitude development. Chapter Nine, the final part of the result chapters, concerns with how service users who self-harm are cared for in clinical practice. Chapter Ten is a discussion of the findings as they relate to the extant literature. It also includes discussions of anxiety and organizational structures. Chapter Eleven focus on the rigour of the study, implications of findings for healthcare practice, and recommendations for future research, practice and education. It also includes a discussion of the contribution, which the study has made to the body of knowledge of self-harm.

CHAPTER SIX

SELF-HARM: BEHAVIOUR AND MOTIVES

6.1: Introduction

"The act of harming oneself embodies literally an implicit connotation of something unbearable and unutterable ..." (Babiker and Arnold, 1997:1).

One finds it useful to start discussions of this nature with a phrase, frequently repeated in the literature of self-harm that reflects the underlying reasons why people hurt themselves. Undoubtedly, the above quotation illustrates a fundamental meaning and function of self-harm; communication of distress. However, it fails to indicate the source and degree of distress that would enable an individual to hurt himself or herself. Certainly, this researcher and many others believe that factors, which could cause an individual to feel distress and to subsequently hurt himself or herself, are idiosyncratic, as they tend to vary from person to person (Beasley, 1999/2000; Crawford *et al*. 2003). Taking account of this, it could be argued that the behaviour of self-harm does not have fixed causes rather it has multiple causes which may result in unbearable and uncomfortable experiences unique to individuals. This chapter seeks to examine participants` explanations of these unique experiences of service users that may sometimes lead to self-harming acts. It starts with a presentation of a table of themes (table 5.0), followed by an examination of the super-ordinate and sub-themes.

6.2: Table of Themes

Table 5.0: Table of Themes for Individual and Focus Group Interviews

Super-Ordinate Themes	Sub-Themes
Explanations of Self-Harming Behaviour	Visibility of self-harm Private self-harm Public self-harm Type of self-harm Active Passive Internally motivated functions Communication and regulation of distress Habitual behaviour Cleansing Regaining control Externally Motivated Functions Punishment: self and others Influence others Seeking attention Averting death Detention and institutional related issues Controlled environment: Strict rules and limited freedom Depletion of coping skills Stigmatisation Passivity Response to psychiatric symptoms Interpersonal Failure to address service users` needs Feelings of abandonment and not being loved

6.3: Theme Descriptor: Explanations of Self-Harming Behaviour

This theme focuses on healthcare professionals` attempts to explain the reasons for self-harm using their clinical experiences. A significant part of the reasons of this behaviour are the functions which it serves in the lives and relationships of service users. They are presented in this chapter from the perspectives of healthcare professionals. Included in this theme are also

issues to do with the "where" and "how" service users harm themselves. These are now presented below.

6.3.1: Visibility of Self-Harm

This theme is divided into two subcategories, private and public self-harm. They relate to the locations where the acts of harm are carried out in the clinical areas of healthcare professionals` interviewed. These sub-categories are examined here in the order in which they emerged from the study data.

6.3.1.1: Private Self-Harm

This refers to the secrecy associated with the behaviour. Secrecy was noted to be a recurring issue for some participants. They claimed that self-harm in secure settings is a solitary and secretive affair that is usually hidden from others. Others in this case refer to healthcare professionals and service users who do not self-harm. Some comments expressed by participants indicate disapproval of the behaviour. One claimed to have openly expressed disapproval of a particular service user`s self-harming behaviour. When speaking about this encounter, he provided a rationale for his action:

> *I have found this particular service user I am talking about to do it several times. He keeps hiding, but for whatever reason I always catch him. I am not angry with him, but his behaviour... erm... hurting himself all the time makes me feel anxious. He needs to stop. So, I have no option but to tell him that I don`t like what he is doing. He is wasting our time* (Ram, In: 22, 1).

Similar discussions of the private nature of this behaviour were held in the focus groups. In some instances, great concerns were expressed about the secretiveness of self-harm. A participant of one focus group made a good attempt to articulate the same.

> *Encouraging secretiveness of this behaviour can be dangerous ... the secrecy gives them the freedom to inflict harm. You know... this may lead to death or something very serious* (Ade, Fg; 4, 1).

Discussions also focused on concerns about possible causes of the secretiveness of self-harm. Negative attitude of healthcare professionals towards the behaviour featured strongly in opinions about its role in causing self-harm in a number of transcripts. Some participants were of the view that it is the "uncaring manner" in which they respond to service users that sometimes make the latter to harm themselves in private. This was highlighted by a participant of an individual interview:

I must say that most of the service users cut themselves in their bedrooms...erm, but some do so in the toilets. They do not want us to see them because we give them all sort of names. So, they hide when doing so (Adam, In: 1, 1).

One participant drew specific attention to the fact that private self-harm is not just a function of negative attitudes, but its occurrence can also be attributed to some treatment approaches, such as contracts used in clinical practice. Pippa spoke of her experience of secrecy with a specific service user:

One service user I have been nursing for years said to me that the agreement (contract) we made together prevents *him sometimes to talk to me about his problems. It makes him... erm...to hide and hurt himself when he feels bad about his problems. He was sexually abused by his mother, kept this to himself for years, disclosed this when admitted to hospital* (Pippa, In: 2, 1).

When asked to elaborate on the nature of the contract, she simply stated that:

Service users are expected not to hurt themselves when they sign it, as doing so could result in some form of repercussion, such as not being allowed to go out in the hospital grounds (Pippa, In: 2, 1).

Intense discussions related to secrecy by members of a focus group resulted in a very interesting conclusion. They claimed that service users harmed themselves in private because of their perceived necessity for secretiveness learned over the years. This point is reiterated by one of its members.

A female service user I nursed in one of the acute wards told me that she was sexually abused by her dad so many years ago. Erm... she harmed herself a lot in the toilet and kept this in the dark for a long time. This is because of what people say to others who do the same thing. They called them attention seekers. In fact she told me that one of us found her doing it and referred to her as a timewaster (Sam, Fg:2,1).

Identified in this excerpt and other excerpts presented thus far, are factors such as negative attitudes, stigma, fear of repercussion and sexual abuse that participants believed would contribute to and reinforce secretive self-harming acts. Having identified some of these contributory and reinforcing factors, it is now necessary to report on the public nature of this behaviour.

6.3.1.2: Public Self-Harm

A number of participants of both sources of data, individual and focus group interviews, stated that service users sometimes self-injure in communal areas of their respective clinical settings. One participant of a focus group confirmed this:

Some service users hurt themselves openly in the day area. But...erm...I think they do it for attention (Angella, Fg: 2, 1).

When this view of attention seeking was explored further, another member in the same group, in a somewhat angry tone, asserted that:

Harming themselves in front of us is nothing to do with seeking attention. As you know, we don`t always spend time with them. What we do most of the time is to ignore them...not listening to them (Mariko, Fg: 2, 1).

Further debate of the impact of ignoring service users revealed its role in increasing self-harm rates and it`s part in enabling service users to occasionally harm themselves in the presence of others. A reflection account provided by participant clearly illustrates this:

I have to tell you briefly about one service user. She was sexually and physically abused by both of her parents. She has been in the unit for over two years. She regularly cut her forearm...but she does so in her bedroom and ...erm... sometimes in the bathroom. No one paid attention to her...I mean in terms of talking to her, but instead she was often placed on observation. Recently, she went to the TV room and deeply cut herself in the presence of others...I mean deeply cut her forearm (Judith, Fg: 2, 1).

The service user cutting herself in the open following numerous episodes of secretive self-harming behaviours appeared to indicate her wish for people to listen and engage with her. As for the depth of the cut, discussions relating to this were prompted by the researcher. Details of these discussions in relation to methods of self-harm are reported in the ensuing theme.

6.3.2: Types of Self-Harm

This theme focuses on the means used by service users to inflict harm on themselves. Participants of both focus groups and individual interviews reported an array of these methods. Examples reported include burning, overdose, hair pulling, not eating, stabbing, cutting, hanging, strangulation and head banging. Cutting was the most frequently cited means of harm and was identified by some participants as the most commonly encountered in secure services. Although the other methods reported were familiar to participants, they are claimed to be relatively rare in clinical populations of secure mental health settings. A participant clarified this point by stating that:

On my ward and even the wards I sometimes go to offer help, what I have seen is mainly cutting. On most occasions, they use blades. In this unit ...erm... you would hardly come across overdose, head banging and things like hair pulling. I tell

you...most of the service users believe in making a point. They let the blood flow (Sasch, In: 4, 1).

Sasch failed to elaborate on what he meant by "they let the blood flow" even when prompted by the researcher. Thus, a follow-up of this was made in another interview encounter. A participant was asked to talk about her experiences of service users` cutting themselves in clinical practice. In response to this, she asserted that:

> *In my view cutting using blades, for example, serves many purposes for service users. Some of them say letting blood out gets rid of the bad person and dirt. But...erm...although the dirt is sometime taken out, loss of blood can lead to serious consequences, such as death* (Judith, In: 6, 2).

In this extract, Judith highlighted that self-injury could result in near fatal or fatal outcomes. Acknowledging this, types of self-harm are essentially the methods used by service users who hurt themselves, and are categorised in this thesis using the terms active and passive. The researcher made use of these to reflect the level of lethality associated with methods utilised by service users to self-injure. Lethality, as employed here, refers to the potential a method has for causing or not causing death.

6.3.2.1: Active Self-Harm

Claims were noted in the data that some means used by service users carry a serious risk of causing death. According to some participants, examples of these include, severe head banging, suffocation, deep cuts and hanging. An emphasis was made in a focus group that hanging is the most likely to do so. A female member of the group recounted her experience to illustrate this point.

> *Whilst doing my routine checks one Monday morning, I found one female service user, with bed linen tied around her neck, hanging from her bedroom window. I activated the alarm immediately to call for support. When the support team arrived...we brought her down but realised that she was dead* (Mary, Fg: 5, 1).

Murmurs of agreement of this level of lethality for hanging were noted from group members. When asked how this experience can be prevented. Difficulties of doing so were expressed. Although this was the case, participants claimed that being vigilant and engaging service users in some forms of meaningful activities are possible solutions. This view is echoed in the following reflective account:

> *A service user told me that he planned to kill himself some time ago. Recently, he told me that he is no longer going to do it. This is because of what we are doing for him; listening and talking to him and not judging him. But he mentioned in one of our one-*

to-one meetings that he sometimes scratches his forearm with a blade just to express his feelings (Julie, Fg: 5, 1).

Illustrated above is the important role of activities in preventing risk of death. They have successfully changed the service user`s intention of ending his life to mere expression of emotions through superficial injuries. Such a means of harm fits in neatly in the next category of methods, passive self-harm.

6.3.2.2: Passive Self-Harm

This theme concerns self-hamming methods that are unlikely to cause death. Generally, most of the self-harm acts reported by participants did not result in fatal outcomes. Although this was the case, some participants expressed difficulties establishing service users` intentions or motives, as depicted in the narrative below:

> *No one really knows the intentions of these users. They sometimes tell us that their motive is not to kill themselves. But on some occasions, the same service users would say that they want to kill themselves because of things that are happening to them* (Usha, Fg: 5, 1).

Indicated in this narrative is that service users` intentions tend to vary and can be influenced by multiple factors, which participants of this group have failed to explore. However, there seemed to be an agreement among some participants regarding the relationships between methods of harm and intentions. This was explicitly stated by a participant of another group:

> *Service users who want to kill themselves badly use dangerous or violent methods* (Olu, In: 3, 1).

It appears from the above account that methods and motivation may vary from person to person. A consensus view of a focus group expressed by one of its members supports this:

> *Service users with the motivation of not wanting to end their lives are more likely to use low-risk methods, such as scratches, superficial cuts and taking few tablets* (Abiola, Fg: 5, 1).

This participant and many others interviewed believed that these methods are unlikely to result in the cessation of life. Nevertheless, regardless of the methods used, be it low or high lethality, participants felt that service users self-harm for specific reasons. Notably, claims were made by some participants that self-harm can be prevented, or at least reduce its frequency, if healthcare professionals make an attempt to understand the motivations for it.

> *The term self-harm could be seen as simple and straight forward, but it actually refers to a complex behaviour that is difficult to understand. This is because it means*

different things for different people and the reasons or motives for it may vary from one individual to another. If we... erm ... know why people do it, we can help them, work with them to prevent or cut it down (Petrolina, Fg: 5, 1).

6.3.3: Internally Motivated Functions

A close examination of the transcripts revealed a wide range of purposes or functions which self-harm may serve. Some of the functions were claimed to be generated from within service users and the most commonly cited among these was that of communication and regulation of distress.

6.3.3.1: Communication and Regulation of Distress

A commonly reported opinion of participants, irrespective of the methods of self-harm, is that this behaviour is mainly used to express feelings. Service users harming themselves, asserted by some participants, often result in them achieving some degree of emotional release; feeling calmer following the act. In agreement with this idea of emotional release, participants repeatedly mentioned that service users tend to engage in self-harming acts when their feelings become unbearable. A participant made an attempt to explain this by asserting that *"service users do it out of frustration"* (Mariko, In: 5, 1).

When prompted to expand on this notion of frustration, she stated:

> *Frustration could come from staff denying service users from going out on leave. Erm... it could be due to basic things like not giving them their "p.r.n" medication. You know, injuring themselves is a way of communicating to others about their level of unhappiness and distress. They usually feel good and relieved after the act* (Mariko, In: 5, 1).

Like Mariko, some participants spoke of frustration as an outcome of an accumulation of angry feelings over a period of time. They claimed that service users in clinical practice tend to bottle-up their distress and, on most occasions, use self-harm as a channel to release the same. For these service users, some participants stressed that they lacked the ability to verbally express their emotions. The comment below illustrates this:

> *A service user I nursed on this ward told me that she gets frustrated by the locked doors and many rules. Not getting on with her peers also adds to the frustration. The problem is that ... erm... she does not know other ways of dealing with her frustration...anger* (Jill, In: 7, 1).

From Jill`s account, self-harming behaviour appears to be a function of limited or lack of other strategies to deal with anger. More comments follow which indicate distress, coping

and role modelling. One of these, which relates to the level of distress experienced by service users, is highlighted below.

> *One service user stated to me that the depth of the cuts he made indicate how angry he was at the time. For him, the deeper the cut, the angrier or distress he was* (Judith, In: 6, 3).

Anger was the emotion most frequently mentioned by participants during interview encounters. For some participants, this is often reported by service users preceding incidents of self-harm. A number of participants of the study spoke of the relationship between anger and self-harm. One participant explained.

> *The service users of this unit sometimes get angry because of the way we treat them. The newly admitted ones...erm...erm, some of them hurt themselves but not as frequently as the old ones. I think, for the old ones, in the process of hurting themselves to cope with anger, they usually become addicted to it. The new ones are taught to use cutting to deal with anger. Cutting is the best way to get their anger out. They always say it* (Judith, In: 6, 2).

From Judith`s account, it is clear that self-harm is a strategy service users sometimes adopt to cope with their tormenting emotions. It is explicit in this account that it is a behaviour, which people can learn and can become habitual and or addictive if used over a period of time.

6.3.3.2: Habitual Behaviour

One issue that was mentioned in almost all the focus groups and in about four individual interview encounters, is that self-harm is a habitual behaviour. In support of this, participants seemed to agree that it is frequently repeated by service users in clinical practice. The statement below echoes this view:

> *For some service users, self-harm has become a habit. They have to do it regularly* (Joe, In: 8, 1).

Repetition is a commonly expressed view by participants who considered self-harm to be a habit. While emphasising repetition, one participant made an attempt to explain the role of reinforcement in habit development. He explained:

> *For some service users, hurting themselves is a habit... they have repeated it so many times that it has become part of them... a big habit that has been reinforced by the benefits they get from it* (Ade, In:18,3).

The role of reinforcement in self-harming behaviours mentioned by Ade was followed up in one focus group. During the discussion, a participant provided a graphic account of how this behaviour can be caused and or maintained by the benefits people get form it.

146

Service users usually have minimal coping skills or problem solving skills. The skills they have were depleted over the years in institutions. Cutting is one skill they use to relieve tension. When tension is experienced and relieved by cutting, service users continue to use it when the tension is repeated. To me cutting is an addictive type of behaviour that is negatively reinforced as it gets rid of the tension experienced (Usha, Fg: 5, 2).

As stated by Usha, self-harm appears to be a strategy that service users adopt in the absence of other approaches, such as verbal communication, to cope with their frustrations, anxieties and anger. It is also suggested in this statement that repetition of this behaviour is attributable to its addictive potential. The following extract of a specific clinical case from a transcript supports this.

This is about a young girl who tends to set fire to her body. It was an addictive type of behaviour. So, it was not a one-off act. The particular girl has a lot of scars on her arm that she has to use other parts of her body, like the back of her ankles, to achieve the same thing; relief from psychological pain (Terry, Fg:1,2).

The report presented thus far seems to indicate that service users self-harm for specific or multiple reasons. Taking account of this, one of the many reasons that were noted to be quite significant by participants, particularly for service users who have suffered sexual abuse, is that of self cleansing.

6.3.3.3: Cleansing

As already stated, cutting was repeatedly mentioned during interviews and claims were made by some participants that it is the most common form of self-harm in secure settings. One obvious outcome of cutting reported by participants is bleeding. For the most part, this was noted in participants` narratives to be associated with the notion of cleansing; expulsion of "badness" or "dirtiness" or "contamination" from within. A participant spoke:

From experience most of the service users who harm themselves have been sexually abused. These experiences of sexual abuse make them feel dirty. Cutting themselves and letting the blood flow is self-cleansing (Ade, Fg: 4, 2).

Similarly, another participant explained:

Harming themselves particularly in the form of cutting their body make them feel clean. Blood oozing is getting or draining the dirt out of their system...hurting themselves is getting the abuser out that is inside their body (William, In: 11, 1).

From the narratives examined, there seemed to be an agreement between some participants that the use of cutting for cleansing purposes is employed by service users who have

experienced sexual abuse. A participant confirmed this when responding to the question, what does the term self-harm mean?

> *I suppose it speaks for itself, doing harm to yourself...inflicting harm to yourself. This is done ...erm.. according to one service user to get rid of her dad who abused her couple of years ago. What she does is to cut herself. The blood oozing out represents him going out of her body. This way she cuts to clean herself up* (Mike, Fg: 2, 1).

While some participants continue to make links between sexual abuse and self-harm, they also considered cutting and its outcome, bleeding, as forms of emotional expression. The emotions referred to here were anxiety and anger, with the latter directed against abusers.

> *A service user told me that she feels purified the more she cuts. The blood oozing out is taking the "nasty man" out of her. Cutting, she emphasised, is sometimes hurting the man, the nasty man she talked about* (Bola, In: 20, 1).

Bleeding was described by Bola as a cleansing process and cutting was considered to be a medium for inflicting pain on abusers. It is clear from this account that people self-harm for several reasons. Some participants supported this assertion by stating that the scars which subsequently develop when people wound themselves have a role in preventing future abuse. This view is reiterated in the following extract.

> *Most people I cared for have been abused in the past. They cut themselves to look ugly. Ugliness drives abusers away...it makes them feel safe* (William, In: 11, 1).

In a similar vein, another participant commented

> *Destroying the body through cutting would push away future abusers as scars on the body would make people look ugly* (Ade, Fg: 4, 2).

While this extract does explicitly indicate a positive aspect of scars, prevention of abuse, it covertly demonstrates participants` perceptions of self-harm as a means for individuals to regain control over their body.

6.3.3.4: Regaining Control

This theme focuses on participants` perception of the relationship between self-harm and feelings of loss or lack of control. With regard to the issue of control, two facets of this were revealed following a close examination of the narratives. These were control of external factors (such as the physical environment and restrictive clinical approaches) and control of internal factors, which in essence refers to people`s emotional states. These issues are made clearer here using extracts from participants` narrative. Starting with the latter, emotional

state, a participant provided a succinct reflective account of a service user`s quest for assuming ownership of his body.

> *Service users who self-harm in this unit have been abused. I am talking about sexual abused... some abused by their dads and some by other people close to them. Sometimes their lives are taking over by these tormenting and distressing thoughts of abuse. Hurting themselves distracts them from their distress, creates a feeling of being in control* (Roland, Fg: 3, 2).

In the above extract, Roland highlighted the impact of sexual abuse; generation of distressing feeling. These feelings are claimed to result in service users experiencing thoughts of powerlessness and loss of control to change their circumstances. The experience of such an emotional state, as reported by Roland, appears to be related to service users` self-image and subsequent self-harming behaviour. Like Roland, some participants also believed that self-harm helps service users to manage and regain control of their emotional states. In relation to this, Roland stated that:

> *One service user told me that whenever he hurts or cuts himself, other thoughts, such as being nasty inside go away and he feels in charge of his body* (Roland, Fg:3,2).

Similarly, another participant commented on how self-harm helps control emotional states:

> *Some ... when they do it, they get the taste of being in control of their lives. One service user said that she feels happy whenever she hurts herself* (Peter, In: 13, 1).

When asked to elaborate on this comment, his response was that:

> *The service user in question was abused. She was abused by her step-father... erm... hurting herself is like hurting her step-father. So, there is that feeling of relief from angry emotions when she does it* (Peter, In: 13, 1).

In contrast to this way of coping, participants indicated that service users sometimes try to manage their traumatic experiences, which are claimed to have a negative impact on their day-to-day functioning, by detaching themselves from the situations. This is an aspect of dissociation and it is made clearer in the following excerpt.

> *Most of the service users in our unit have been molested sexually, raped by strangers or abused by someone close to them. The thoughts of these experiences can be traumatic for them and may make attempts to protect themselves from these by saying... it is my body that is molested... not really me* (Loveness, Fg: 6, 2).

Events of dissociation were described by participants mainly in terms of service users` inability to feel emotionally or physically. According to one participant of a focus group, the latter (physical numbness) was related to the absence of physical pain at the times of self-

injury. He stated that *"You know, they don`t feel pain when cutting themselves"* (Roland, Fg: 3, 2).

An in-depth exploration of this issue of physical numbness in another group revealed that:

> *Cutting keeps them alive, keeps them awake and makes them to physically and emotionally feel that they have a body...erm... a flesh like other humans* (Mary,Fg:6,2).

These issues of being unable to feel physically and or emotionally associated with dissociation would lead people to question their sense of reality. Self-harm, specifically cutting, as illustrated by Mary, can be used to restore a sense of reality. Additionally, this way of coping with disturbing events was considered by participants as both a difficult and temporary approach. The temporality of this approach was explained.

> *......it is a way of coming back to reality. Some people try to escape problems of life, but such an escape can be tormenting. People use self-harm to come out of that hiding place to face reality and to feel real (Mary, Fg: 5, 2).*

Mary`s response led to further exploration of dissociation in another group. This time participants were asked to provide specific clinical examples.

> *A lot of service users tend to isolate themselves from the rest of the ward community when they feel helpless, tormented and distressed. To them, physical isolation is not sufficient to sort out the problems they are facing. They therefore compliment this isolation by cutting off from this world as though they are dead. But this is just for a very short time... they would come out of the trap by cutting* (Abiola, Fg: 6, 3).

The excerpts presented so far illustrate participants` descriptions of loss of control over internal factors in relation to self-harm. As already stated, these internal factors refer to people`s emotional states. Feelings of anger, distress and torment were the emotions considered by participants to precede the urge to self-injure. According to participants, these emotions are usually generated when people recollect traumatic experiences, such as rape and sexual abuse. What was also reported during interviews that are associated with self-harm were service users` feeling out of control of, and quest to control, external situations. Examples of these situations, presented in detail under theme of externally motivated factors, include abusive encounters and service users` requests for therapeutic engagement.

6.3.4: Externally Motivated Functions

This theme focuses on extrinsic factors that could lead service users to engage in self-harming acts. Implicated in this discussion are feelings of loss of control of external situations. Examples of such situations commonly noted in the transcripts are rape and

sexual abuse. According to participants, such external events would give rise to a state of high emotional arousal, which they consider to be associate with a range of emotional responses. Such responses may include feelings of guilt, being blamed, self-blame, self-hatred, being evil and bad. Participants believed that a mixture of these feelings would increase people`s chance of self-harming. This assertion is based on their potential for leading to an unbearable overwhelming emotional state. Acknowledging this, it is therefore important to examine the relationships between emotional reactions, factors that may generate the same and people`s self-harming behaviour.

6.3.4.1: Punishment- Self and Others

Some participants seemed to claim that the behaviour of self-harm is a re-enactment of traumatic experiences like rape and sexual abuse. Notably, one participant asserted that service users who have been subjected to such encounters are more likely to feel evil, bad and guilty. It is this cocktail of emotions, as indicated in the narrative below that sometimes leads to self-injury.

> *Generally, service users who self-harm have had bad experiences such as being sexually and physically abused. Erm...they often feel guilty, bad and sometimes have feelings of lack of control over their lives. They self-harm to release badness within them and to regain control over their bodies* (Sasch, In: 4, 1).

When Sasch was asked to explain his meaning of lack of control, his response was that:

> *One service user categorically told me that she was overpowered by her abuser when it happened. She was unable to drive him away and he did what he did. She now told me that she feels compelled to hurt herself. She acts on these urges to alleviate the guilt, tension and feelings of self-hatred she developed over the years* (Sasch, In: 4, 1).

In spite of the fact that the abuse was not her fault, the service user had feelings of guilt and self-hatred for being a victim and for not being able to protect herself against such an act. In contrast, some participants do believe that people sometimes expose themselves to abusive situations. An attempt is made by one participant to explain this:

> *This is what I was told by one of my service users. She was visited by a male friend in her flat somewhere in London and was subjected to a form of sexual act. Erm...erm... penetration took place. She claimed that what ensued might not strictly be rape, but might be a sort of rape. She is now subjected to terrible flashbacks of that event...feeling guilty, blaming herself and claimed that she deserved to be blamed and punished for letting it happen. She tends to express self-hatred and on most occasions, cuts herself when she feels this way* (Joy, In: 9, 2).

Although nobody deserves to be subjected to any form of abuse, there was a degree of agreement among some participants that, under the circumstances highlighted, experiences of self-hatred and guilt feelings are not uncommon. It was noted from the extract that guilt on its own did not result in self-harm, but appeared to have played a significant contributory role when experienced together with other emotions like self-blame and self-hatred. What was not indicated in Joy's reflection, and acknowledged by some participants, is the function of self-harm that relates to punishing or expression of hatred for others. A participant`s comment, previously used to illustrate the cleansing function of self-harm, also clearly demonstrates anger. It reads:

> *A service user told me that she feels purified the more she cuts. The blood oozing out is taking the "nasty man" out of her. Cutting, she emphasised, is sometimes hurting the man, the nasty man she talked about* (Bola, In: 20, 1).

The emotion implicated in Bola`s comments, is anger; the service user expressed angry feelings towards an abuser by hurting her body. Similarly, a participant spoke of how the feelings of punishing others are associated with self-injury.

> *When service users self-harm, they also think of how to relieve their psychological pain. The pain is caused by the abuses they suffered. Sometimes there is that anger to get at those who abused them. They cut themselves as though they are cutting the abuser. Their bodies represent the abusers. This is why some don`t feel the pain when cutting* (Ram, Fg: 4, 2).

Ram was referring to sexual abuse. A number of participants were of the opinion that abuses of a sexual nature are common experiences for service users in secure settings who harm themselves occasionally and / or frequently. Although this is the case, as reflected in the narratives, self-harm was not only related to anger expressed towards abusers, it was also described by participants to be a function of the manner in which healthcare professionals respond to the needs of service users. The following extract echoes this:

> *Service users harm themselves because of their anger about staff. It is to do with the way we treat them, we talk to them... sometimes not nice. So, they would like to hurt staff. But because of fear of repercussion, they hurt themselves as it is safe to do so. When they hurt themselves in this way, we have no option but to care for them* (Sasch, Fg: 4, 3).

This illustration reiterates the multiple functions of self-harm. According to Sasch, service users would sometimes harm themselves with the intention of hurting others with whom they feel angry. In the process of hurting themselves, participants believed that they would receive care from healthcare professionals who may feel obliged to fulfil their professional responsibility. Thus, this behaviour may influence the way healthcare professionals respond

to service users. A participant confirmed this point when asked to explain what he meant by putting feelings aside. He stated that:

> *I mean sometimes... you may feel like they are manipulating the system, which can be quite frustrating really. But however, you know... you have people who are harming themselves. This is key to me...erm...I have to be a professional. I have a duty of care. So, I must make sure that they do not continue to harm themselves. So, I tend to engage them in something* (Terry, In: 24, 2).

6.3.4.2: Influence Others

Some participants of both focus groups and individual interviews communicated a shared opinion about self-harm. They believed that self-injury of any kind, particularly cutting, does have a significant influence on how healthcare professionals may react to service users. In highlighting this view, one participant reported that:

> *Service users usually feel good, relieved after the act. They hurt themselves usually to express their feelings. They do not necessarily want to die, but feel that hurting themselves would make people listen to and help them* (Mariko, In:5,1).

This influential function of self-harm was confirmed in a later interview by another participant when asked to provide possible reasons for this behaviour.

> *Some service users harm to manipulate their care. There are many of them here on this ward that tend to harm particularly when the team is reluctant or refusing to meet their needs. When they do it...I tell you, we rush to talk to them* (Terry, In: 24, 1).

Self-harm is not just a function of healthcare professionals` reluctance or refusal to provide care, it is sometimes, some participants asserted, due to service users inability to ask for help. A participant reiterated this view by stating that:

> *Their behaviours change the way we care. One service user told me that he does not know how to ask for help. According to him cutting has helped him a lot and he gets nurtured when he cuts. In his words, he stated that when I cut they come to me, they nurture me* (Joy, In: 9, 3).

Lengthy discussions of the reasons for self-harm took place in focus groups. Ignoring and not responding to the needs of service users are cited as some of the reasons for this behaviour. The significance of this is emphaised in the extract below:

> *Ignoring service users is not helpful; it is not a professional way of doing things. Nobody in his or her right mind would cut himself or herself for nothing. They must have good reasons for doing so. For those in this unit, most of them have not experienced caring and loving relationships... and erm we ignore them. They harm to feel cared for. It is an opportunity for someone to come closer to them* (Abiola, Fg: 5, 3).

While Abiola and other participants like Paul (Fg: 4, 2) acknowledged that self-harm can be used as a means for "attracting care", other interviewees put forward a contrasting and interesting reason. They stressed that service users sometimes harm to shock or drive people away from them. The excerpt below is a clear illustration of this view:

> *As for the service users in this place, some of them liked to be left alone when hurting themselves. They feel disturbed when we intervene. One in particular told me that she sometimes cut deep to express distress and to push us away. She feels that her deep cuts would make us feel disgusted. She believes that making us to feel this way would make us not to attend to her* (Petrolina, Fg: 6, 2).

Petrolina`s account reflects a fundamental function of self-harm; expression of emotions. Additionally, it indicates the service user`s quest for the chance or opportunity to achieve emotional expression. With respect to this, participants of both sets of interview encounters unanimously refer to self-harm as a strategy for coping with enormous psychological distress. Although it could sometimes lead to accidental death, some participants strongly considered this way of coping as a life-saving exercise rather than a self-destructive one. To be precise, self-harm was referred to as a suicide aversion approach.

6.3.4.3: Averting Death

Although not explicit in some cases, some participants stated that people who have been exposed to traumatic events, on occasions, do experience mounting internal tensions. This internal tension is described by participants as a heightened emotional state, composed of an unpleasant mixture of emotions like feelings of depression, anxiety, anger, guilt and self-hatred. Some respondents claimed that self-injury can offer a massive reduction in such internal tension, which could lead to fatal outcomes or at least suicide attempts, if allowed to grow. A participant reflected on a clinical scenario to explain this survival function.

> *Some service users claimed that they cannot do without cutting. One particular female service user told me that each and every scar on her body represents a period of time she escaped death. She sometimes gets very tormented by the thoughts of her ordeal; the abuse she went through. She was badly raped. She could have killed herself by now, but cutting has helped... erm... prevented her* (Zainab, Fg: 6, 1).

Even though cutting has helped the service user to reduce her level distress to a degree that prevented her from taking her life, it does not get rid of the thoughts of abuse. Taking this discussion further, a statement made by another participant of the same focus provided a precise explanation of the usefulness of self-harm in suicide prevention. It reads:

> *From experience, cutting does not really take away the pressures. Service users still get the occasional torment from the thoughts of their negative experiences. But not to a*

level that warrants them to take their own lives. So, cutting prevents suicide and also helps them to regulate and cope with their emotions (Mary, Fg: 6,1).

Even though this is not an ideal coping approach for healthcare professionals, the act of self-harm, as reflected in Mary`s account, helps service users to deal with distressing emotions. It facilitates emotional release, which in some instances prevents or at least delays suicide attempts. Such affect regulatory and survival functions were not only considered by participants to be beneficial for service users, but they were also believed to act as reinforcers for self-harming behaviour. While self-harm was reported to play a part in reducing emotional distress, there are other factors within secure clinical settings that would, as highlighted by participants, contribute to and maintain service users` distress. Examples of these factors include detention in an institution and exposure to rigid or restrictive treatment approaches.

6.3.5: Detention and Institutional Related Issues

It was indicated at interviews that some service users begin to hurt themselves only when admitted to secure environments. Some participants attributed this to feelings of anxiety, distress, powerlessness and being confined in a controlled setting. In addition to such feelings of being trapped, the mere thoughts of being hospitalised and the loss associated with lack of control of over their (service users) lives, participants asserted, would make self-harm more likely to occur. These factors are now addressed in the order in which they were revealed during interviews.

6.3.5.1: Controlled Environment

Attempts were made during interviews to clarify the meaning of a controlled environment. Some participants referred to it as a setting in which service users are being locked, closely observed, monitored and engaged in treatment. Some members of a focus group thought of it as a setting that enables service users to reminisce about abuses they suffered during childhood. One participant spoke:

> *Service users who are at risk of killing themselves are usually placed on continuous observation. Sometimes... erm... we even enter the toilets and bathrooms without warning even when they are taking care of their needs. This means of control reminds them of their past trauma of abuse. This makes them hurt themselves* (Loveness, Fg: 6, 2).

Being subjected to such forms of observation would be tormenting and distressing to anyone. It would be even more distressing or traumatic for someone who has been exposed to abusive encounters in the past. In Loveness` account, self-harm is a way of coping with trauma re-experienced in institutional settings. In the same focus group, some participants claimed that it is the confinement, not the observation and searches that tends to play a significant part in causing self-harm. One participant spoke of it as the *sine qua non* of controlled environments.

> *One service user mainly lacerates his body to cope with the feelings of being locked up and the many rigid rules that goes with it. They have no control of these issues. I tell you... we are also not consulted in making these rules* (Abiola, Fg: 6, 2).

From Abiola`s reflective account, service users self-harm not only because of confinement, but also because they are expected to follow rules which they have little or no chance of changing. Abiola also reflected on the issue of lack of involvement of frontline healthcare professionals in formulating rules that they were expected to enforce. According to some participants, these rules, which require service users, for instance, to go to bed, eat and attend activities at specific times, do in the main have a negative impact on the same. A participant provided examples of the possible effects of rules when explaining what a controlled environment means.

> *It is one that would not help people to grow because they just have to listen and do exactly what they are told. One that would not facilitate the establishment of trust and engagement with service users because we have specific times to do specific things* (Adam, In: 1, 5).

Adam later explained what "not helping people to grow" means:

> *Talking of this unit in particular, users are not involved in decision making. We tend to do a lot for them, think for them and give them ideas for sorting out their own problems. This is not good... because... with time they would lose even the basic skills to deal with personal problems* (Adam, In: 1, 5).

Clearly, a controlled environment, as described in the above extract can have a disempowering effect on service users in the context of it hindering growth or depleting their problem-solving ability. According to Adam, this is a function of lack of or limited involvement in decision making.

6.3.5.2: Depletion of Coping Skills

A depletion in coping skills was reported by just a handful of participants in their efforts to explain its association with self-harm. They claimed that service users are generally

dependent or reliant on them to address their problems. This was perceived by participants to be more of a problem for those service users who self-harm. They described this user group as more passive with a tendency to depend more on healthcare professionals. One participant explained this point.

> *What I think is happening in an institution like this is that we tend to make the service users hurt themselves by allowing them to be dependent on us. Some cannot even cope with the slightest pressure. They always hurt themselves to cope with problems...erm...the other ways of coping have gone* (Sasch, In: 4, 1).

Whilst Sasch attributed self-harming behaviour to deficits in problem-solving skills, other participants do believe that it is to do with the ease of accessing or retrieving memories or information to deal with issues. Participants who believed in the latter claimed that the thoughts of self-harm are more easily accessible and service users are more likely to use the same to address their problems. This is essentially the case, as asserted by some healthcare professionals, for those service users in heightened emotional states. A participant articulated this view when asked to provide reasons for self-harming behaviour. He spoke:

> *In a place like this, we do almost everything for service users and they do what we tell them to do. Doing things this way would make them lose their skills. This is the reality for these service users. The best skill they are left with is self-harm. They harm to cope with life difficulties such as abuse and torment of being in hospital. It is their means for solving problems and...erm...it is easily accessible* (Ram, Fg: 4, 3).

Participants expressed difficulties in coming to terms with the use of self-injury as a problem-solving strategy. One participant in particular expressed disbelief through his body language and complimented this with a verbal expression.

> *I find it difficult to understand why people should do this to themselves. I think it is a waste of time and definitely a waste of resources. I know service users will feel humiliated and stigmatised when given these labels, "timewasters and attention seekers" But I still think our time should be spent in a more useful way* (Adam, In: 1, 6).

6.3.5.3: Stigmatisation

The perception of how service users are viewed by healthcare professionals can have implications for both care provision and self-harming acts. The following excerpts illustrate instances of discrimination against service users purely on the basis of their self-harming behaviour.

> *I am referring here to a specific female service user on a Sunday morning shift. She hurt herself three times that morning. This made us ... erm...erm...not to effectively manage the needs of other service users. The ward became chaotic because they became angry. Staff blamed her for this and ignored her for most part of the shift.*

> *Erm...I must...erm...say... she was as a "waster" of resources, a nuisance. She felt stigmatised and guilty for the chaos. These feelings tormented her and harmed later on in the afternoon* (Zainab, Fg: 6, 3).

Zainab`s account indicated an association between being blamed, self-perception and self-harming behaviour. The service user referred to here ultimately hurt herself because she was ignored and blamed for the unsettled state of the ward. She was in this case stigmatised. Further discussions of this notion of enacted stigma, resulted in another member of the group highlighting an example of differential treatment or discriminative practice:

> *In my unit, some of them are no longer taken seriously because they do it all the time. The ones I am talking about are pure attention seekers. Erm...erm...erm...they do it in the day area. I don`t really worry when it happens. I give my time to other service users ...who I think deserve it. But honestly, when you ignore them...they would do it again and again* (Petrolina, Fg: 5, 3).

In the same vein, another group member spoke of her experience of discrimination:

> *I know labelling and blaming are crucial when it comes to self-harm. They would make people to harm more because of the way they would feel. They would feel stigmatised. We blame and label them to cope with what is going on. These give us the chance to keep away from them...at least for a short time* (Julie, Fg: 5, 3).

The impact of labelling in relation to service users` feelings was explored in another focus group. Participants claimed that labels would generate feelings of humiliation and loss of hope, which, in turn, would result in more self-harming acts.

> *One thing that seems to help with self-harm is when they feel stigmatised because of the names or labels we give them. In my opinion, they feel humiliated and loose hope. It is this loss of hope and feelings of humiliation and not being respected that make them harm themselves* (Sasch, Fg: 6, 3).

The above extract is a clear illustration of the relationship between labelling, feeling stigmatised and self-harm. The following excerpt also clearly indicates how feeling stigmatised could lead to self-harm.

> *What sometimes make them to continue to harm is the stigma, the stigma of being in a psychiatric hospital and the stigma of being given horrible descriptions, such as nuisance, attention seekers and so on* (Mariko,In: 5,2).

Apart from feeling and being stigmatised by hospitalisation and labels, claims were made by some participants that service users` experiences of being out of touch with reality are preconditions for self-harm.

6.3.6: Passivity

The role of being out of touch with reality in causing self-harm was mentioned by just a small minority of participants. They asserted that delusional thinking and hallucinatory experiences do play a significant part in self-harming behaviour. With regard to the former, command hallucinations were the most cited symptoms participants reported to be experienced by service users in their clinical areas.

6.3.6.1: Response to Psychiatric Symptoms

According to some participants service users sometimes hear compelling messages that order them to hurt themselves. A participant reflected on the experience of a service user to explain this:

> *Some service users harm in response to command hallucinations, such as cut yourself or otherwise I will kill you. A female service user told me that, she hears terrible voices that tell her to do exactly what she is told...erm...or she will be killed. They sometimes ask her to lacerate her arms. She has no option, but to do so"* (Usha, Fg: 5, 2).

The service user referred to felt powerless to disobey the hallucinated commands. This appears to be purely based on her fear of repercussions. Participants also reported that service users may harm themselves in response to their disordered thought processes. A typical example is provided below.

> *Some service users harm because of their delusional ideas. One in particular poured boiled water on his head in response to a strong belief that the only way he can be born again was to be baptised with hot water. He severely injured himself* (Jill, In: 7, 3).

Responding to delusional beliefs could result in a serious outcome like the one described by Jill. Although this is the case, a participant emphasised that more serious injuries are likely to occur in instances where service users experience both hallucinatory commands and delusional beliefs. Such a mixture of symptoms, asserted by a participant, does serve as a powerful compelling force for self-injury.

> *One male service user has religious delusions of purification because of sexual abuse. He also experience hallucinatory commands. According to him, the voices are asking him to cut his throat. These two experiences have made him to make serious attempts in the past that led to lengthy admissions on the general side* (Loveness, Fg: 6, 3).

Self-harm is not just motivated by delusional and hallucinatory experiences, it was also considered by a couple of participants to be a product of an interaction between people. It is therefore important to examine participants` views of the interpersonal nature of self-harm.

159

6.3.7: Interpersonal Factors

A good therapeutic relationship was proposed as central to effective care provision. According to participants, this is a relationship in which service users are listened to and where their needs are addressed. The opposite of this, some participants claimed, could lead to service users harming themselves, as they may not feel confident to approach healthcare professionals to voice their feelings.

6.3.7.1: Failure to Address Service Users` Needs

A small number of participants offered explanations of an association between not meeting the needs of service users and self-harming behaviour.

> *Service users harm when they don`t get on with their peers and when not given their medication when they needed it* (Jill, In: 7, 1).

Although Jill spoke of a physical need, medication, the discussions under this theme focused on an interpersonal need. A participant made a good attempt to articulate this when asked to provide reasons for self-harming behaviour.

> *It could be because they have been physically and emotionally abused in the past. It could also be because they have been badly treated by staff on the ward; staff not talking to them nicely. This reminds them of their past physical abuse* (Joe, In: 8, 1).

In the same vein, another participant provided a clearer explanation of the impact of interpersonal interactions on service users.

> *Service users harm themselves for many reasons. They do it as a cry for help and because they cannot match up with family expectations. They may also do it because they are maltreated by staff... in other words... not adequately addressing their needs. It is not just to do with their needs not being met; it is mainly to do with how we talk to them, we talk down on them* (Paul, In: 17, 1).

While "talking down" to service users could lead to feelings of rejection and abandonment, it is indicated in the narratives that exposure to such feelings would subsequently lead to experiences of a low self-esteem.

6.3.7.2: Feelings of Abandonment and Rejection

This theme relates to participants` perception of how feeling abandoned and rejected could lead to self-harm. The service users referred to in participants` accounts have hardly had

caring and loving relationships. Their behaviour, as indicated in the narrative, is a quest for acceptance and love. A participant confirmed this but related it more to victims of abuse.

> *I must say it is clear in this unit that we mainly nurse people who have been abused. They have not tasted true love...have not really felt accepted by family members and others. Self-harm is their way of looking for acceptance and love* (Judith, In: 6, 1).

Similarly, another participant spoke about how the absence of a caring relationship could lead to self-harm.

> *Most of the service users I work with have not had a caring and loving relationship. So, they feel empty. Self-injury is a way to fill that gap; the empty space* (Joy, In: 9, 1).

Feelings of abandonment and rejection were also expressed in terms of inadequate care provision and perceived disrespect. This is indicated in a participant`s response to the question; what are the reasons for service users` self-harming behaviour?

> *Not getting what they want in terms of the care they deserve. All service users want to be cared for in a respectful manner. If they don`t perceive respect from us, they would hurt themselves. Some of us sometimes refer to them as attention seekers and manipulators. They don`t like these descriptors...erm... they get angry and injure their body to express their anger* (Peter, Fg: 3, 3).

Negative descriptors were noted to be signs of disrespect. This was clearly articulated by another participant of the same focus group.

> *There are many reasons for service users to self-harm. It could be due to the way staff talk to them. Some staff do not respect them. Erm... they call them names such as attention seekers and time wasters* (Jonathan, Fg: 3, 4).

6.3.8: Summary

This chapter has presented attempts to explain both the secretive and public nature of self-harm. Although the concepts of lethality and intention are considered to be subjective, they were discussed here in the context of the methods of self-harm, with cutting being the most common form cited by participants. The chapter has also explored healthcare professionals` perceptions of the functions self-harm. They claimed that this behaviour serves an array of functions or purposes for service users. An example of these includes communication and regulation of distress. It has been stressed that self-harm helps service users to reduce their emotional distress to a level that sometimes prevents the cessation of life. It was for this reason participants considered it to have a significant role in suicide prevention.

Apart from averting suicide, it has been illustrated that self-harm is used by service users as a means of regaining control over their emotional state. What has also been highlighted in this section in relation to the notion of control was that the behaviour itself, self-harm, is a manifestation of being out of control. This was agreed by participants to be the case in forensic psychiatric settings where service users are confined, subjected to strict rules with their behaviours closely monitored. Admission to these institutions and negative comments (such as attention seekers) used by healthcare professionals to describe service users have been noted to be contributory factors to feelings of stigmatisation experienced by the latter. Participants have described service users as using self-harm to deal with such feelings. Irrespective of its function, this behaviour does create some discomfort in people who witness it. This has also been noted to be case even for those who carry it out.

The following section, chapter seven, focuses on the impact of self-harm on healthcare professionals. Examples of impact include feelings of anxiety, shock and distress. Notably, people do not usually enjoy such feelings and would therefore actively seek strategies to deal with them. Hence, the chapter also explores coping strategies used by healthcare professionals.

CHAPTER SEVEN

SELF-HARM: IT`S IMPACT ON HEALTHCARE PROFESSIONALS AND SERVICE USERS

7.1: Introduction

The previous chapter exposed the forms of self-harm and participants` explanations of the motivations underpinning this behaviour for service users. Cutting was considered to be the most common form of self-harm in secure settings. While this mode of hurting oneself has been illustrated to create a personal sense of calmness, witnessing it can evoke feelings of unbearable intensity, such as disgust, anxiety and anger. In addition to this, it is noted in some of the participants` narratives that the behaviour can sometimes lead to effective engagement. In essence, cutting was also believed to have the potential to generate an urge or feelings to provide care in those witnessing it. This chapter explores this mix of emotions experienced by healthcare professionals. Although this study is about healthcare professionals, during interview encounters participants provided suggestions of the possible effects of self-harm on service users. Hence, the impact of this behaviour on service users is explored. Included in this section is also a discussion of participants` perceptions of how they coped with the behaviour of self-harm in their clinical practice. To ensure a comprehensive understanding of the issues discussed, the chapter starts with a presentation of a table of themes (table 6.0), which is immediately followed by a succinct summary of the super-ordinate theme and an examination of the sub-themes.

7.2: Table of Themes

Table 6.0: Table of Themes for Individual and Focus Group Interviews

Super-Ordinate Themes	Sub-Themes

Impact of Self-Harm and Coping Strategies	Negative impact on healthcare professionals
	    Frustration , anger and distress
	    Loss of hope and feelings of failure
	    Worry about making issues worse
	
	Positive impact on healthcare professionals
	    Evaluation of care and engagement
	
	Negative impact on service users
	    Feelings of embarrassment
	
	Positive impact on service users
	    Opportunity to receive care
	Coping strategies
	    Teamworking
	    Staff meeting
	    Training and education
	    Blaming service users

7.3: Theme Descriptor: Impact of Self-Harm and Coping Strategies

There are two dimensions to this theme; positive and negative impact of self-harm. Starting with the former, it is evident in the data that the act of self-harm, particularly when repeated, can result in healthcare professionals evaluating care provision and making attempts to meet the needs of service users. In contrast, this behaviour is noted in the study to generate a range of negative emotions. Feelings of anger, failure, frustration and disappointment were among the many emotional reactions reported by participants. Similar responses were also reported for service users. Participants clearly stated that service users can sometimes feel distressed and embarrassed following acts of harm. Taking note of this range of emotional reactions, it is imperative that service users are encouraged to safely express their feelings and for healthcare professionals to be given adequate support to cope with this behaviour.

It is obvious in this study that participants did not like the emotional impact of self-harm on them. Certainly, they did not enjoy the negative emotions experienced and therefore took active steps to alleviate their discomfort. The steps taken are what are referred to as coping

strategies. Examples of these include undertaking training, staff meetings and adopting a team approach to care provision. These examples were considered to be helpful strategies, as they may contribute to the development of healthcare professional`s skills and knowledge about self-harm. It was believed that acquisition of such knowledge would enhance their confidence and competence in caring for people who self-harm. In contrast to this, service users were blamed by some participants for their behaviours. Undoubtedly, such a blaming approach was considered to be unhelpful as it may lead healthcare professionals to be angry and punitive towards service users. According to some participants, these ways of responding could lead to more episodes of self-harming behaviour.

7.3.1: Negative Impact on Healthcare Professionals

As already briefly mentioned, a large number of participants of both individual and focus group interviews expressed a range of emotions they encountered when caring for service users who self-harm. Participants' personal experiences of these feelings are now illustrated.

7.3.1.1: Frustration, Anger and Distress

Some participants claimed that feelings of anger, frustration and distress are normal reactions to challenging situations. They stated that caring for self-harming service users is a challenging experience. Acknowledging this, it is not unusual for healthcare professionals to feel anxious and angry with service users who self-harm. Participants stressed that such feelings were in the main generated when the self-harming behaviours are frequently repeated. A typical response from a participant of an individual interview explains this:

> *I think caring for this service user group is a challenging exercise. They can sometimes make you feel angry and frustrated particularly when they keep on repeating their behaviour. Even though you get angry at them, as a professional, one has to do what is expected of us. I am always thankful when they don`t kill themselves. It tells me that we are doing something that prevents death. But we should never be satisfied...erm...we should be doing more to prevent repeats* (Ram, In: 22, 3).

Repetition of self-harm may present particular difficulties for healthcare professionals in terms of the intensity of feelings it evokes. Referring to Ram`s reflective account, self-harm has in the past made him feel frustrated and angry, but stressed the need for continuing professional engagement for service users who repeatedly present with this behaviour. In support of Ram`s views, another participant provided a rationale in favour of the need for professional commitment and engagement with self-harming service users. He stated:

I think everybody has feelings. Yes, it does affect me of course. If you see someone cutting, it would affect you. But as nurses we have to keep on reminding ourselves that we are professionals and we have to act as professionals. People cut themselves for a reason...they have problems that is ... why they are doing it. I don`t like to see blood at all, but I still have to provide care when it happens. If we don`t care for them, they would continue to repeat it (Paul, Fg: 4, 6).

Within the same focus group, another participant explained the impact of self-harm on himself and highlighted contributory factors to the impact.

I sometimes feel angry particularly when the harm is repeated. It is the feeling of failure that tends to get on me most. Sometimes...erm...I feel disappointed when they hurt. This is because of the hard work...erm...the amount of effort I have made. But on reflection, one does not need to be angry. They are service users with problems. They harm because of their problems. One therefore needs to be professional, be committed to help them (Ade, Fg: 4, 6).

Even though Ade`s account is suggesting that healthcare professionals should not be angry at service users, there appears to be some agreement among a few participants that it is a difficult task to achieve. This was noted to be the case particularly in instances of repeated exposure to incidents of self-injury. One participant of a focus group confirmed this by asserting that:

I sometimes feel frustrated and angry towards self-harming service users, as I really sometimes struggle to understand why they continually hurt themselves (Pippa,Fg:1,5).

Repeated incidents of self-harm can cause considerable distress. As indicated in few narratives, distress may sometimes cause individuals to experience some degree of confusion. Pippa`s account illustrated her uncertainty or confusion. She was not sure of the reasons why people should regularly harm themselves. Such bafflement appears to be tinged with feelings of failure and loss of hope.

7.3.1.2: Loss of Hope and Feelings of Failure

Other emotions participants associated with repetition were loss of hope and feelings of failure. On the whole, these emotional reactions were commonly expressed as disappointment and self-blame; an assertion that appears to be captured in the extract below:

These behaviours sometimes cause anxiety in us including other service users and family members. When they are repeated, I sometimes feel sad, betrayed and disappointed especially if it relates to a service user that I have invested huge amount of time in (Spiro, In: 10, 2).

166

Further exploration of the impact of self-harm in subsequent interviews revealed similar expressions of disappointment. One participant confirmed this by noting that:

> *I find it difficult to understand why individuals cut themselves after providing all the help they need. Sometimes you give it your all, but they still do it...erm...cut themselves. This is what I mean, it is really disappointing. It makes me feel as though I have not done enough* (Jonathan, In: 16, 1).

From Jonathan`s reflection, the degree of disappointment experienced appears to be related to two factors; the amount of effort invested in caring for service users and the perception of progress they have made. In an attempt to explain this, a participant specifically described the impact of the thoughts of being a failure and linked it to feelings of disappointment and the level of care provision.

> *I sometimes feel angry particularly when the harm is repeated. It is the feeling of failure that tends to get on me most. Sometimes...erm...I feel disappointed when they hurt. This is because of the hard work...erm...the amount of effort I have made. But on reflection, one does not need to be angry. They are service users with problems. They harm because of their problems. One therefore needs to be professional, be committed to help them* (Ade, Fg: 4, 6).

From the excerpt above, the thought of being a failure is an impact in itself. This thought together with the degree of care provided, referred to as "hard work", contributed to Ade`s feelings of disappointment. The association between feelings of failure, level of care provision and thoughts of disappointment were further explored in a later focus group. Discussions held reveal a similar explanation, as highlighted by a group member.

> *I see myself as a failure when service users harm themselves frequently. I usually have this sense of failure because of the time and energy I expend in trying to help them. This makes me angry sometimes and in turn makes me hard on them. I know being hard is not good, not a professional way of reacting. But I sometimes ...erm...have to do so because I am worried that they may do something serious to themselves* (Petrolina, Fg: 5, 8).

Petrolina`s perceived seriousness of harm does have an influence on the ways she responds to service users. Specific fears for harm and feelings of disappointment, highlighted in the narrative, are expressed as anger. Apparently, such emotions were not exclusive to Petrolina, but were also noted to be presented by other participants. For example, one participant explained:

> *Whenever service users hurt themselves, I tend to blame myself. I see myself as a failure, I have failed them. Erm... I believe self- harm can be prevented. We should always work towards that. The more they do it, the higher the chance of them hurting themselves badly. I get anxious about this* (Mike, Fg: 2, 4).

7.3.1.3: Worry about Making Issues Worse

A specific fear narrated in just one focus group and by some participants of the individual interviews was that of making things worse. This fear or anxiety was in the main associated with the unpredictability of the behaviour of self-harm. Participants expressed concerns of the uncertainty of the behaviour and emphasised the need for adopting a cautious approach, particularly on night duty, when addressing service users` needs. The extract below succinctly reflected the worries presented.

> *At times I dread to speak to them, I feel terrified to talk to them especially at night. Because...erm...erm...you cannot really predict how they would react. The impact of harm is not just on staff, but on service users as well. Some of them also get frightened and worried when they sense the possibility of harm. I have seen this* (Mariko, In: 5, 2).

It is clear from Mariko`s report that it was probably safer for not to intervene at night. A similar thought was echoed by another participant when asked to comment on her relationships with self-harming service users.

> *I think I have a good relationship with them. I try to be honest and get them involved as much as possible. Erm...erm...I tell you honestly, at night I usually abstain from asking them why they self-harm. Because I don`t know what they would do. If they start hurting, I don`t have enough staff to help* (Jill, In: 7, 2).

Jill`s worries about making things worse were in part due to limited resources in terms of not having an adequate number of healthcare professionals to provide support and in part a function of the harm itself. In relation to the latter, participants believed that some forms of harm may cause more fears or worries than others. The following extract is a good attempt at illustrating this distinction.

> *Certainly, seeing blood flowing and the massive cuts they sometimes sustain do have an impact on me. The sight of all these also has an impact on others. They sometimes surprise you when they cut, they can cut anytime. The depth of the cuts are a shock to me, a big worry for me because you sometimes don`t really know how to move them from point A to point B. But I don`t get worried for those who just take two to three tablets or inflict superficial cuts on themselves* (Chez, In:21,3).

Chez clearly expressed his worries. He sees self-harming service users with severe injuries as a user group with specific care needs that are totally outside his capability; his ability to cope. In support of Chez`s attempt to explain the association between impact and methods of self-harm, another participant provided a graphic reflective account of her first encounter with a self-harming service user.

> *I had a very frightening experience when I started on this unit. One Sunday morning I met a service user in her bedroom with a rope tied around her neck. I was shocked, I*

screamed. It was a very difficult experience and I will never forget it. I have to move on. As a professional, I need to do something to care for them effectively (Mary, Fg: 6, 4).

It was the unpredictability of the service user`s behaviour, the surprise element of it that served as the main source of trauma or shock experienced by Mary. Support of this view was expressed in a focus group when its members were asked to discuss their feelings about self-harming service users.

I feel and act differently according to the individual circumstances. Honestly, if someone has a long history of harming himself, I would consider it as a learnt behaviour. My reaction towards him would not be too much of a shock. For those who take one by surprise, it would be a great shock. Erm...I would be very shocked if they surprise me. It has happened to me several times. It is a challenge. So, I now have to find ways of helping myself and service users (Judith, Fg: 2,5).

It is evident from Mary and Judith`s narratives that self-harm can generate both negative and positive effects on healthcare professionals. In relation to the positive effects, participants claimed that it serves as an impetus for healthcare professionals to explore effective ways of responding to service users.

7.3.2: Positive Impact on Healthcare Professionals

Self-harm was perceived by most participants as emotionally draining. They based this assertion on the view that service users engaging in this behaviour require disproportionate amount of care. Despite this, a small minority of participants believed that these service users deserve help and can be helped to prevent their behaviour or at least reduce its frequency. Some participants stressed that one way of doing this is to actively engage them in their care.

7.3.2.1: Evaluation of Care and Engagement

There was consistency in the views of a minority of participants with regard to the relationship between self-harm and the manners in which service users are engaged in clinical settings. They seemed to agree that self-harming behaviour is a reflection of healthcare professionals` responses to the needs of service users. Thus, participants with this belief advise healthcare professionals to evaluate their treatment approaches following acts of self-harm, especially in instances of repetition. A participant of a focus group provided an explanation of this in her response to the question; do you feel frustrated when caring for service users who self-harm?

I don't think one should be frustrated. When they repeat it, it is a call for us to re-visit our strategies and approaches for managing the behaviour (Judith, Fg: 2, 5).

Expressing frustration does not appear to be the focus of Judith. Her aim for this service user group as indicated in the excerpt was to provide effective care; care which addresses the needs of service users. In support of this, a participant of the same focus group commented that:

I would not feel frustrated. It is something they sometimes do. They are not well and I feel sorry for them. So, I get worried about how I could help them...erm...that is my concern (Angella, Fg: 2, 5).

Further examination of this issue of care provision in subsequent focus groups revealed a slight contradiction around the notion of frustration. A participant explained:

Caring for them can be difficult; feelings of frustration and exhaustion do exist. I can remember quite vividly that one service user kept on repeating his self-harming behaviour despite the help we offered him. When this happens, I tend to feel as if I have failed. But I think we should continue to help them, to look for other ways of resolving their problems (Peter, Fg: 3, 7).

The focus of Peter was to explore "better ways" of providing care to service users. A similar emphasis on evaluation of care was made by a participant when asked about factors that would affect her relationships with service users.

I do agree to some degree with my colleagues that repetition of self-harming behaviour do have an impact on relationship building especially... erm...in case where staff and service users have made agreements. Staff would be angry and disappointed when they harm. Erm...erm...because they have failed to adhere or keep to their promises. Taking a specific example, I felt angry when a service user harmed after promising that he was going to keep away from that behaviour. The behaviour also served as a reminder for me to examine my approaches. My approaches might not be appropriate for his needs (Abiola, Fg: 5, 10).

Abiola explained that self-injury was the motivation for her to closely examine the ways she cared for the service user reflected on. She was of the opinion that the treatment strategies used were not effective in meeting the care needs of the service user. Whilst the wounds service users inflict on themselves can be a barrier to communication and engagement for some participants, it was clear to some that they serve as the driving force for effective interaction. Bola for example reported his experience of this.

It is very stressful for nurses to witness it. It can be very frightening when people cut themselves. Unfortunately, this can be a barrier to communication. But on the other hand, it can be a catalyst to commence and enrich engagement (Bola, In: 20, 2).

Bola commented on two issues that relate to the impact of self-harm. Firstly, he stressed the possibility of it being a deterrent for engagement. Secondly, he seemed to believe that it does play a significant part in initiating and promoting therapeutic interactions. Apart from Bola, only a few participants believed in the latter. For these participants, self-harm was considered to be beneficial for service users claiming that it enables them to receive care.

7.3.3: Positive Impact on Service Users

According to some participants, most of the service users in their clinical settings have suffered some form of physical and or sexual abuse. They reported that feelings of rejection and being unloved were not uncommon experiences among self-harming service users. There is therefore a need, asserted by some participants, for service users with these experiences to search for caring and loving relationships. The overarching view was that service users use self-injury as a means of facilitating care.

7.3.3.1: Opportunity to receive care

Claims were made by some participants that service users are generally not consistently provided with the care they deserve. Participants attributed such limited care provision to the busy nature of the clinical areas, which requires them to attend to managerial and administrative duties. It was highlighted in some of the discussions that service users like sharing or talking about their distressing issues. Some participants noted that self-injury serves to bring service users to the attention of healthcare professionals. It does provide them with the opportunity to achieve their need for engagement, as explained by Peter.

> *On our ward service users are encouraged to express themselves. We sometimes do this by sitting and talking to them...erm...listening to what they have to say. Talking to them has helped reduce the rate of self-harm here. I must say we don`t have the time to do it all the time. Service users love talking. They like people who respect them, who are prepared to listen to them. Cutting gives them the chance to talk to staff, the opportunity to talk about things that are distressing them. One told me that he felt cared for the few times he had this chance* (Peter, In: 13, 2).

Although Peter did not explicitly state the "things" that are distressing for service users, the recurrent thoughts of past sexual abuses and lack of caring relationships, reiterated in a number of interviews, were considered to be examples of unpleasant and tormenting experiences. This was substantiated by participant when asked to describe her feelings in relation to care offered to service users who self-harm.

> *The thought of preventing someone from harming himself makes me feel good. But I sometimes think that I have not done enough when they repeat it. That worries me, you*

know. But following the right procedures consoles me. When you read the notes of service users who harm, you would come to realise that most of them have not had a loving and caring relationship. The service user, like other human beings are always looking for some form of care and love. They get this from staff when they cut themselves (Julie, In: 15, 3).

A similar response was noted when the impact of self-harm was explored in a subsequent interview.

Some part of me always tells me that service users do it for a reason. One reason a couple of them have told me is that they want to be cared for well, but hardly get this from some of us. In desperation for this...erm...they cut themselves and they would get us to rush at them. You sometimes see smiling faces when this happens. Smiling, you know, is a sign of happiness (Jonathan, In: 16, 1).

Jonathan provided a specific reason why service users self-harm in clinical practice; search for engagement and care. This rationale was only briefly mentioned in some focus groups. Jackson, for example, stated that:

I feel that people who self-harm do so for specific reasons. They do have issues that torment them. So, they need help, they need care. Self-harm is a way of asking for help (Jackson, Fg: 2, 4).

Even though self-injury has been illustrated to provide service users` temporary relief from a host of ills, some participants believed that it is not a blissful or joyful activity. Claims were made during interviews that service users who engage in this activity sometimes feel miserable and ashamed about their behaviour.

7.3.4: Negative Impact on Service Users

There was a clear indication among some participants that self-harm, particularly cutting, is problematic in every sense. In this perspective, most of the problems described by participants relate to feelings of embarrassment and shame expressed by service users during clinical encounters.

7.3.4.1: Feelings of Embarrassment

These feelings were by and large associated with scars, which are in essence unavoidable side effects of cutting. A participant of an individual interview made an attempt to depict this relationship.

A service user states she feels calm and experiences a sense of relief when she harms herself. Others have expressed a sense of embarrassment for their behaviour and the prospect of scars caused by their injuries (Joe, In: 8, 1).

From the above account, feelings of being ashamed experienced by service users were a consequence of both the act of wounding themselves and the aftermath of the behaviour, the scars that develop. It is implicit in this extract that scars have a derogatory effect on body image and appeared to be considered as signs which people can use to judge others. It was therefore not surprising for some participants to refer to self-harm, with particular reference to cutting, as a maladaptive behaviour.

> *Self-harm means a lot of things to different people. I consider it, especially cutting, as a maladaptive behaviour service users use to cope with their problems. They also sometimes feel very uncomfortable after hurting themselves* (Zainab, Fg: 6, 1).

Along the same lines of argument, another participant of the same group also referred to it as an inappropriate behaviour.

> *I sometimes wonder why they cut themselves, I could not see a good reason for them doing it. It is not a good way to solve their problems. Cutting themselves is just adding more problems. In my opinion, it is not appropriate to do so. When they hurt themselves, it makes me and my colleagues feel anxious. I must say, my colleagues do not like it when they cut themselves* (Loveness, Fg: 6, 1).

Put simply, Loveness does not seem to like it when service users cut themselves. This was also apparently the case for other healthcare professionals, as depicted in the narrative. The dislike for the behaviour was a function of the anxiety it evoked in them, and this is clearly a threat to their professionalism; professional selves. A range of strategies were indentified in the transcripts that participants found useful in protecting or defending their professional selves.

7.3.5: Coping Strategies

As already highlighted, caring for people who self-harm can be a taxing encounter. The behaviour itself was believed by participants to generate very strong emotions such as anger, frustration, feelings of failure and powerlessness. It is therefore not surprising to identify within a number of narratives that participants found it difficult to adequately care for self-harming service users. Such difficulties were noted to be compounded by lack of training, unclear procedures and lack of or limited staff support and teamworking. Thus, addressing these problem areas would enable healthcare professionals to improve on their care approaches for this user group.

7.3.5.1: Teamworking

The need for some degree of support to care for people who self-injure was highlighted by just a small number of participants. They asserted that support should never be counted as a luxury, but it should instead be an integral part of a strategy for effective and professional working with this user group. One useful way participants thought they would feel supported was to work as a team. The importance and efficacy of teamworking were emphasised during interviews. One participant of an individual interview spoke about this when asked to provide a personal response of her feelings about care provision to service users with self-harming behaviour.

> *I feel the care we provide is adequate as it ensures their safety. It also minimises the risk of it happening again; the risk of repetition. What makes this happens is teamwork. We work as a team. It is helpful that problems are shared. This way...erm...less anxiety is noticed on the ward. People tend to pull their weight together, we work consistently and we speak with the same voice. Teamworking should be part of us and we should look for ways of improving it* (Joy, In: 9, 3).

Further exploration of the efficacy of teamworking at another interview uncovered that it is a necessary, but not a sufficient condition for effective working with service users.

> *Caring for service users who self-harm can be a challenging exercise. Erm...but it is an exercise that is rewarding. They can be difficult to look after, but if one is caring and observant, the goal of preventing further self-harm can be achieved. Teamworking within the team is needed to do so. But on its own, it would not do the trick. Consistency is needed to help. Both should be part and parcel of the way we work. This means staff have to meet regularly to discuss and share views and experiences. We need this to care for people who are psychologically distressed. We also need a clear way of working with the service users. Erm...I mean guidelines to help direct the way we care. They help with consistency* (Paul, In: 17, 1).

Although caring for service users who self-harm can threaten healthcare professionals` professionalism, the extracts presented thus far indicate that sharing experiences can prevent this threat or at least minimise its impact. To be more precise, the threat in this case refers to the anxiety and other emotions that are generated by the behaviour of self-harm. The role of teamworking and consistency in preventing or alleviating this threat was also evident in focus group discussions.

> *When staff are not working as a team, it may deter the development of relationships. Certainly, working as a team is helpful for me and my colleagues. It is also helpful for the service users. Working this way helps to know what we are doing and it helps with consistency. The challenges posed by service users are shared. Sharing reduces the anxiety we sometimes experience. In addition to working as a team, we should also meet once a week as a team to discuss our concerns* (Judith, Fg: 2, 7).

Apart from teamworking, this extract also emphasises the importance of team meetings in the context of the same, providing the opportunity for discussing difficult issues and feelings brought up by working with self-harm.

7.3.5.2: Staff Meetings

The need for support was repeatedly mentioned by participants with some being very precise about the nature or form of support needed in clinical areas. A participant for example provided a personal account of a specific support system needed for effective working with people who self-harm.

> *Staff need to work effectively with these service users. We have to remember that they need a great deal of support when dealing with those who hurt themselves. They therefore need to have access to a support system, regular staff meetings to discuss their concerns. They would learn from one another how to work with these service users* (Joe, In: 8, 5).

In addition to practice learning, emotional expression (offloading) was identified as a significant benefit of team meetings. These forums may sometimes lead to healthcare professionals recognising their needs for further support to tackle distress. The extract below is a good example of the use of a staff meeting for off-loading.

> *I do experience a mixture of feelings when I face self-harm. It can be rewarding when you sense that you are achieving something; service users not harming, but engaging more. I find working with people who hurt regularly like some of our service users distressing and frustrating sometimes. Erm...erm...I feel angry towards them, but tend to contain it, not making them know. The anger needs to be expressed. I do so through staff meetings, sometimes informally with my colleagues* (William, Fg: 3, 6).

From the above account, it is clear that staff meetings serve a useful function for healthcare professionals, as they provide them with unprecedented opportunities to safely ventilate their feelings. What was also noted during interviews is the use of staff meetings for identifying healthcare professionals experienced and knowledgeable about self-harm. According to participants, knowing that these resources exist is a valuable opportunity as these professionals can be called upon for advice and guidance by less experienced ones. The latter is more likely to be the larger group in forensic care settings, since claims were consistently made by participants that healthcare workers in these areas are hardly formally trained on how to care for self-harming service users.

7.3.5.3: Training and Education

Part of the reason for the distress and anxiety healthcare professionals experience when dealing with service users with self-harming behaviour is their lack of or limited training in this area of mental health practice. This was evident during the interviews conducted. Some participants requested training claiming that their present level of skills and knowledge were not adequate to effectively care for people who self-harm. An example of such a request is presented below.

> *I personally feel that we cannot really emphasise on the care that has been provided. Although service users seemed to be gaining, care should be provided by staff trained to work with these people. I don`t think the staff in my clinical area have the necessary skills to do so. I think the care should be more of psychological input and not everyone is currently capable of providing it. If you don`t know what you are doing, you may do more harm than good. The service users we are dealing with are quite vulnerable...erm... they are prone to react with a hair-trigger. One therefore needs to be cautious when dealing with them* (Spiro, In: 10, 3).

When Spiro was asked about what can be done since formal training is not easily accessible, he explained that:

> *What is needed here is to develop a mentoring way of doing things. This means...erm...having experienced staff to work with those who are not well experienced to care for service users who self-harm. This way staff would feel supported and would learn the skills and knowledge of how to care for them. This would also help develop their confidence* (Spiro, In: 10, 3).

The need for training was reiterated by another participant when asked to provide an explanation for the increasing self-harming behaviour in secure environments.

> *Most staff are not properly trained to care for service users with this behaviour. So, the attitude they have towards them is most of the time negative; not treating them right, threatening them with medication or some form of restriction. So, we need staff that are trained or otherwise, it would continue to increase* (Peter, In: 13, 5).

Peter`s comment suggests that limited knowledge about self-harm could result in healthcare professionals responding negatively to the needs of service users. Taking this argument further, some participants do believe that it is the feelings of frustration and anger experienced by healthcare professionals that may sometimes lead to the expression of negative attitudes. Claims were further made that these emotions (frustration and anger) are usually triggered by lack of or inadequate knowledge about self-harm. A comment from a participant echoes this:

> *On the general wards there are specialist units and positions for certain disorders. Self-harm is a growing problem in psychiatric settings. We should do the same; create*

units for this problem with staff trained on how to care for this group of service users. I have seen staff frustrated and angry because of limited knowledge of how to care for these service users. Developing skills and knowledge would help to reduce this frustration (Terry, Fg: 1, 3).

Terry acknowledged that self-harming behaviour is a growing problem, which he thinks can be effectively tackled in special units with staff equipped with the right knowledge and skills. Implicit in Terry`s comments is that the frustrations which are encountered by healthcare professionals do have at least some influence on their responses to service users. Thus, the negative attitudes that are sometimes observed in practice when caring for service users who self-harm are a reflection or communication of frustration. A participant of a focus group agreed with this.

Caring for this group of people is a big challenge. Before, I tend to ignore them because I don`t know what to do. I feel frustrated because of this. Now I have learnt a lot. I belief people can change. A belief that people can change and improve helps. It does not really matter whether the change is small or large. Just be prepared to help and be ready and willing to listen to their views is important. This is a good attitude. Having the right skills and knowledge have helped me greatly. I think this is a factor that would help people to work well with these service users (Ade, Fg: 4, 8).

The issue of negative attitudes being an expression of frustration was also repeated by a participant of a focus group during a discussion of what service users would need least in their care.

*I find it difficult sometimes. Some do find it very difficult to care for them. So, the dismissiveness you see in practice, the ignoring you sometimes come across is all to do with not knowing what to do. I find it frustrating when I face these problems, when I come across difficult cases. I cope with these situations by sometimes being dismissive (*Abiola, Fg: 6, 7).

A similar response was also provided by Terry, he stated that:

I must say that some of us find it difficult to manage this group. It is a difficult group of people to deal with. Sometimes we lack knowledge and training and how to deal with them. So, we end up just dismissing them when they approach us with their problems (Terry, In: 24, 4).

The final theme, blaming service users, relates to professionals` attempts of coping with emotions evoked by self-harm.

7.3.5.4: Blaming Service Users

Blaming was an interesting coping method used by just a minority of participants. It is interesting on the basis that it indicates an absolute shift of responsibility to the service users for the "states" of clinical areas. For example, participants reported during interviews that

some service users have been blamed for increasing self-harming behaviours. A participant for instance spoke about this:

> *From experience, one thing that I have noticed in my area of practice is that service users sometimes copy one another. One service user on this ward is the scapegoat, she is the teacher. She is the one to be blamed for all that has been happening here. But I sometimes ask myself, are we doing our jobs properly? We should stop blaming them. Other staff including myself are guilty about this* (Peter, In: 13, 2).

Blaming was illustrated in this extract as an inappropriate way of coping with self-harm. The participant seemed to call for a sharing of responsibility and re-examination of treatment approaches following episodes of self-harming behaviours. Implicit in Peter`s comment is that blaming is a function of frustration. A participant explained this assertion when asked to talk about his feelings relating to self-harm.

> *It can be quite challenging. Sometimes you do your best, but some would still find ways to hurt themselves. As a result, you tend to get this feeling of anger. But as professionals, we should not allow them to see it, we should try to help them at all times* (William, In: 11, 2).

An exploration of how the service users can be helped resulted in the participant stating that:

> *I see self-harm as a way of service users escaping from distress. So, we must always demonstrate sympathy and acceptance of those who do it. Honestly, it can be frustrating to work with them. It can be very stressful sometimes. There is one particular service user...erm...he is responsible for this behaviour on the ward. Others are copying him, he cuts a lot and he gets the attention* (William, In: 11, 2).

Claims were observed within the transcripts that service users do not like to be blamed for their actions. As already briefly mentioned, some participants were in agreement with this. One for instance stated that:

> *You cannot be blaming them for doing what they are doing and you cannot leave them unattended particularly when you know their history. It could be childhood experiences that are causing it. So, as a professional we should show understanding; try to understand why they are doing it* (Bola, In: 19, 3).

The need for demonstrating understanding and avoiding blaming was repeatedly talked about by participants, with the later noted to have huge implications for causing more self-harming acts. A narrative relating to this is presented below. It reads:

> *From experience, some service users cut themselves when they feel angry for things in the past. Blaming them makes them feel worthless and they cut more as a result. For example, we sometimes blame them for the ward not functioning well or the problems we encounter during the shifts. Usually, things become worse when we don`t treat them right; they cut more and more* (Abiola, Fg: 5, 1).

7.4: Summary

This chapter has shown that self-harm has both negative and positive effects on healthcare professionals and service users. With regard to the negative effects, it has the potential to evoke emotions that may threaten healthcare professionals` sense of professionalism. This threat sometimes acts as a "wake-up call" for them to re-examine their reactions to service users. It is this quest for re-examination of treatment approaches that is considered in this thesis as a positive impact of self-harm. The threat which professionals encounter when dealing with self-harm have been presented as a mixture of emotions. Examples of these emotions include feelings of failure, anxiety, incompetence, anger and helplessness. Participants described these emotional experiences as uncomfortable, an unpleasant place to be, and therefore talked about a number of strategies that can be used to alleviate such discomfort. Some examples of the strategies discussed include teamworking, staff meetings, and training and education. The use of such approaches indicates healthcare professionals` acceptance of at least some responsibility for the behaviour. Additionally, their use also suggests an active search for skills and knowledge with the view of improving care provision for these service users. They will therefore be considered and discussed in the discussion chapter as positive coping strategies. The final strategy, blaming the service user, is considered here as a negative coping approach. To be more precise, it is simply a negative attitude. This is because it denotes shifting of responsibility of the behaviour to the service user with healthcare professionals assuming a blameless position. Taking such a stance may have negative impact on service user in that it could lead to more self-injury.

CHAPTER EIGHT

ATTITUDES TOWARDS SELF-HARM AND FACTORS INFLUENCING THEIR FORMATION

8.1: Introduction

The previous chapter examined the impact of self-harm on both service users and healthcare professionals. With regard to the latter, they sometimes encounter traumatic experiences when caring for service users who self-harm. Loughrey *et al* (1997:30) agree with this and offer a clear description of experiences of healthcare professionals in an article entitled "When Nursing Becomes a Nightmare". It reads:

> *Healthcare professionals working with service users who intermittently wound themselves constantly endure feelings of anxiety, conflict and contradictions in personal values. The staff members experience frustration and guilt whenever an injury occurs.*

It is apparent from this extract that repetition of self-harming acts plays a significant role in generating anxiety in healthcare professionals. It is believed by many researchers and the researcher of this study that these emotions, in addition to other issues such as a perceived motivation for harm, do help in shaping professionals` attitudes towards service users who harm themselves (Commons *et al*. 2008). The distress which professionals experience when faced with this behaviour, in the main, tends to dispose them towards an absence of empathy regardless of the need for therapeutic understanding (Vivekananda, 2000). Clearly, this assertion highlights an urgent need for healthcare professionals to engage in activities to prevent or at least reduce the frequency of self-harming acts. Building a strong therapeutic alliance with service users is one approach that would help professionals meet this need (Patterson *et al*. 2007). Thus, developing and maintaining an appropriate professional attitude towards this user group is essential for effective working with the same. This chapter therefore focuses on attitudes towards service users who engage in self-harming behaviour and factors in the clinical setting that may influence its development. It commences with a table of themes (table 7.0), which is immediately followed by a presentation of an overview of the super-ordinate theme. It also includes an examination of each sub-theme presented in the table.

8.2: Table of Themes

Table 7.0: Table of Themes for Individual and Focus Group Interviews

Super-Ordinate Themes	Sub-Themes

Attitudes Towards Self-Harm and Factors Influencing their Formation	Positive Attitudes
	    Readiness, Acceptance and Engagement
	    Optimism
	
	Negative Attitudes
	    Rigid-Authoritative Approach
	    Labelling and Prejudice
	    Blanket Approach
	    Insensitive Expressions
	
	Influences on Attitude Formation
	    Experience, Training and Education
	    Mentoring and Supervision
	    Policies and Procedures
	    Type of Clinical Setting
	    Repetition of Harm and Perceived Cause
	    Perceived Seriousness of Harm
	    Gender

8.3: Theme Descriptor: Attitudes Towards Self-Harm and Factors Influencing their Formation

Attitudes are extremely powerful attributes that can influence relationships between service users and healthcare professionals (Bywaters and Rolfe, 2002). A detailed examination of the study data revealed two sets of attitudes; positive and negative. It is probably obvious to state that positive attitudes in professionals do play a significant role in enhancing their relationships with service users. A large number of participants expressed readiness, acceptance and engagement as essential elements for effective working with service users. Some participants also believe that being hopeful, in the context that service users would one day stop or at least reduce their self-harming rate would enable healthcare professionals to spend more time with the same. Certainly, the adoption of such attitudes by healthcare professionals would help them develop a better understanding of the reasons underpinning service users` behaviour.

With regard to negative attitudes, they are considered by some participants of this study as barriers to effective care provision. In relation to this, some participants of the study were

noted to be in favour of rigid-authoritative approaches, which include telling the service users what to do and making threats to medicate them. Other participants reported distancing themselves emotionally from service users. Some participants claimed that this manner of relating would certainly impede therapeutic engagement, which in turn, would lead service users to engage in more acts of self-harm. One of the primary aims of healthcare professionals in secure settings is to prevent or reduce the rate of self-harm. One way of doing this as reported in this study is to identify and manage factors that may trigger this behaviour. Negative attitudes of healthcare professionals were identified in this study as risk factors for self-harming behaviour. It is therefore critical to look at the factors that may influence attitude development.

A range of factors were identified in the data that can influence the way in which healthcare professionals interact with service users. Gender, training, education and experience were frequently mentioned by participants to have an impact on their relationships with service users. The nature of the ward, its philosophy, resources in terms of staffing levels and time, policies and procedures, perceived cause of self-harm, perceived seriousness of harm and cultural issues were also noted as contributory factors to attitude change and development. As already stated, caring for people who self-injure can generate distressing emotions. Undertaking formal supervision is one means of managing these emotions. Participants claimed that supervision is a both a coping strategy and a forum for developing helpful attitudes towards self-harm. Examples of these attitudes are now illustrated below using extracts from participants` narratives.

8.3.1: Positive Attitudes

A good number of participants expressed a wish to care for service users who harm themselves. Notably, the feelings and behaviours described when faced with members of this user group were generally positive. In fact participants emphasised the importance of adopting a non-judgemental approach when caring for service users. They claimed that doing so would enable professionals to listen to and understand the issues leading to service users` behaviour. The extract below clearly captures this assertion.

> *For me it is imperative that one must not be judgemental. One should try to listen and understand the problems; issues leading to the behaviours. Being a good listener and using appropriate interpersonal skills are very important and essential for understanding self-harm* (Mariko, Fg: 2, 8).

From Mariko`s statement it is clear that demonstrating acceptance of service users is critical for effective therapeutic relationships. Simply, these refer to care exchanges in which the needs of service users are met. This assertion is based on the premise that being accepting and open would provide an opportunity for service users to relate in a more congruent manner. In other words, they would be equally open in their interaction with healthcare professionals, which is believed, as asserted by some participants, to reduce self-harming rates. This relationship between acceptance, readiness to provide care and self-harm, referred to by participants, deserves further exploration.

8.3.1.1: Readiness, Acceptance and Engagement

Demonstration of acceptance and readiness to engage with service users are fundamental attitudes underlying a key principle of counselling referred to as empathy (Miller and Rollnick, 2002; Videbeck, 2006). It is simply a precept that requires all healthcare professionals to show respect for and listen to service users during clinical encounters with a view to trying to understand their narratives. Some participants of this study believed that adopting this approach would help professionals develop better working relationships with service users. A participant articulated this when asked to identify factors that would enable professionals to establish therapeutic relationships with service users.

> *It comes with experience. As a practitioner, I always try to approach service users` issues or situations with an open mind. From my observation, people harm themselves because of something. This could be stress, it could be because of abuse in the past and so on. For whatever reason, it is important that we remain non-judgemental and to try to always listen to them. Being a good listener has helped me immensely; it helped me understand them* (William, Fg: 3, 8).

It is clear from William`s statement that spending time with and listening to service users are critical in relationship building, as doing so conveys respect and positive regard for the same. Taking this argument further, it was indicated during interview encounters that just forming relationships and not improving them are unhelpful approaches for service users particularly for those with distressing experiences. What is therefore required for effective working with self-harming service users, some participants asserted, is maintaining and enhancing relations hips. A participant reiterated this view:

> *I think it is not only forming relationship that matters. What is more important is to improve and maintain working relationships with them. This means trying to understand and trying to make them feel comfortable working with us. Without that I don`t think we can achieve what we set out to do* (Spiro, Fg: 3,8).

When the issue of how to make service users feel comfortable was explored in another focus group, a participant stated that:

> *I know working with people who self-harm can be challenging. I am a professional. So, when I work with them I always bear in mind they have problems and in need of assistance. I do empathise with them; meaning I demonstrate respect for them and listen to their problems. When they sense this, they would fell accepted and this would make them to open up. Showing that you accept them is quiet important because it helps us assess them well which in turn helps to provide care that is appropriate to their needs* (Mary, Fg: 6, 9).

It is implicit from the discussions thus far that demonstration of acceptance does not imply agreement or approval of service users` behaviour, rather it illustrates how professionals view and respond to service users as worthwhile persons regardless of their presentations. A participant agreed with this during discussions of factors that would influence formation of relationships.

> *As you are aware, humans react naturally to care and compassion. Erm...erm...when one acts caringly towards another, there is usually a tendency of clinging towards the source of care. I am naturally a caring person and I act as such. So, I do not have any difficulty forming relationships with my colleagues and service users. My arms are always open for service users and they know this* (Bola, Fg: 4, 7).

Such a way of demonstrating acceptance provides service users with the opportunity to talk about their difficulties. Some participants also tend to claim that showing acceptance in the form of listening and talking indicates healthcare professionals` readiness and willingness to understand and offer help to service users. Embedded in these concepts of readiness and willingness is the notion of hope. Being hopeful in the sense that service users would at some point in their care pathway stop or at least reduce the frequency of their self-harming was considered by participants to play a role in enhancing professionals` commitment for engagement.

8.3.1.2: Optimism

Some participants expressed positive views about service users. They asserted that adoption of a positive stance is a crucial factor for enabling service users to use alternative means other than self-harm to express their feelings. A participant explained:

> *From a practitioner point of view, you obviously have to be optimistic in your approach to these service users. When we do so it averts their self-harming behaviour. I have experienced it several times. So as practitioners we should be hopeful that our interventions would bring about positive outcomes. Basically, to have a positive attitude helps. Such attitudes transcends to service users, which make them cut down on their behaviour* (Joe, In:8,4).

It is useful to stress, as indicated in the above extract that being optimistic enhances service users` motivation for change. Taking this into account, it is clear that what service users particularly those with distressing experiences need is professionals` commitment to offer help with a belief that it would result in helpful outcomes. In relation to this assertion, helpful outcomes mean service users stopping their self-harming behaviour or reducing its frequency. A participant echoed this in his attempt to explain factors that could influence relationship building in therapeutic settings.

> *As said earlier, respect for people is important. Accepting them and being non-judgemental do help a lot in forming relationships. In addition to this, being committed and optimistic about people that they would change and achieve things also help* (Peter, In: 13, 4).

When this participant was prompted to explain what achieving things means, he stated that *"in this case achieving things means stop harming"* (Peter, In: 13, 4).

It is apparent from Peter`s account and from the narratives of other interviews conducted that one of the primary goals of healthcare professionals working in mental health settings is to prevent service users from engaging in self-harming behaviour. Encouraging alternative activities for self-expression, such as talking about distressing issues, were described by participants to have a clinical role of enabling service users to change; stop or reduce self-harming behaviour. Participants also stated that being hopeful that service users would change has been noted in their clinical settings to result in decreasing rates of self-harm. A participant of a focus group confirmed this:

> *I think being hopeful that service users can stop harming themselves one day is the most important thing. If we are hopeful, optimistic, the service users themselves would develop hope that things would change at some point; stop harming or at least reduce rate of harm. One thing that I have realised over the years that service users liked is to involve them in their treatment and to provide them choice of activities* (Abiola,Fg:5,9).

From the discussions held, feelings of hopelessness and helplessness are frequently associated with people who hurt themselves. The role of healthcare professionals is to alleviate these feelings and instil those of hopefulness in service users. Some participants stressed that the provision of choice of activities, professionals` knowledge and optimism that "things would become better" are powerful strategies for instilling hope. In contrast, some participants were of the opinion that service users would never improve; meaning they would continue to hurt themselves. This assertion was particularly attributed to those who

repeatedly self-harm. A participant of a focus group made an attempt to articulate this when explaining what attitude means.

> *It refers to people`s behaviour towards someone. In the case of self-harm, some healthcare professionals don`t bother whether they hurt themselves or not. They even sometimes call them names; attention seekers and timewasters* (Terry, Fg: 1, 9).

Certainly, such responses to service users are unhelpful, serving only to make the individual feel worse about themselves. Feeling this way, some participants claimed, would increase the likelihood of service users to repeat their self-harming behaviour. Additionally, some participants indicated that the expression of this kind of attitudes towards service users in clinical encounters could discourage them from seeking further help. A participant agreed with this by stating that:

> *My colleagues I believe that being negative about service users and their behaviour can be off-putting for them. Erm...erm...I mean off-putting for service users. This tends to drive them away from us.* (Julie, Fg: 5, 10).

Demonstration of reluctance to seek help by service users was noted during interview encounters to be a huge concern for healthcare professionals working in the best interest of the same. Acknowledging that such reluctance could be a function of negative attitudes, it is imperative in this study to explore the relationship between these attitudes and self-harming behaviour.

8.3.2: Negative Attitudes

According to some participants, a large number of service users in the secure settings of the study site have experienced in the past some sort of abuse, which could be of a sexual or physical nature. It was observed during interviews that there are aspects of secure hospital settings that are highly reminiscent to service users of abuses they have suffered in their lives. Labelling and reacting in harsh and discriminatory manner to fit with labels given are some of the many examples that may reflect abusive relationships. In addition to the possibility of evoking feelings of victimisation, engaging in such approaches would interfere with communication, understanding and the development of an alliance with service users. Participants also believed that traumatic experiences can be can be re-stimulated by these approaches and therefore warn healthcare professionals to be cautious when selecting care strategies for working with service users. It is important to mention that body searching and close observation are examples of restrictive care strategies commonly used in forensic clinical practice for addressing the needs of individuals who harm themselves. These

strategies would be distressing in themselves to anyone, but they may be extremely traumatic for people with past abusive encounters (Patterson *et al.* 2007). According to some participants, service users tend to cope with this sort of trauma by engaging in more self-harming behaviour. It is therefore important to illustrate attitudes described by participants and their perceptions of the impact of the same on service users` behaviour.

8.3.2.1: Rigid-Authoritative Approach

Negative attitudes are common themes participants considered to contribute to self-injury. Being rigid and too controlling are examples of these attitudes cited by participants when narrating their stories about self-harm. To be more specific, it could involve healthcare professionals providing instructions to service users and expecting the latter to adhere to the same. A participant explained:

> *Bad attitudes of staff and being locked up play a big part in leading to self-harm. Controlling goes with secure environments. Service users are told what to do. Erm...erm...they don`t have much to say in what goes on in the units. So, self-harming is like trying to assume some form of control* (Ade, In: 18, 3).

The term secure environment highlighted in the above extract is not clearly explained. It therefore requires further exploration. A participant of a previous interview made a succinct attempt to do so. He stated that:

> *A secure environment is basically a controlled environment. In this setting most of the service users are detained under the Mental Health Act, 1983. These service users tend to require high levels of supervision. On the ward I work on, self-harm rates are reduced. But the rate seems to be going up and up on other wards. One thing I can say for my ward is that healthcare professionals are very committed and worked closely with service users. I am really not too sure of what is happening on other wards* (Peter, In: 13, 5).

It is apparent from Peter`s narrative that commitment on the part of healthcare professionals resulted in reduced rates of self-harm in his clinical setting. Peter claimed that similar outcomes can be achieved in other secure settings if healthcare professionals are willing to offer help. He provided a detailed account of how this can be attained when responding to the question; will a controlled environment reduce the incidents of self-harm?

> *This is the case. Because service users are closely observed and objects which they might use to hurt themselves are usually removed. In this environment we conduct regular searches of bedrooms. We even search visitors. These environments work on the here and now to prevent self-harm. Some healthcare professionals in these environments are quite rigid; they tend to impose lots of control on service users with limited therapeutic input* (Peter, In: 13, 5).

While these approaches may be beneficial in cutting down self-harm rates in the short term, in the long run, prolonged exposure to rigid environmental control can be counterproductive, as service users may regard it as unfair and malevolent. Participants asserted that self-harm is used in these circumstances as a means of coping; an expression of self-exoneration. This is a reflection of service users` dislike of rigid approaches. A participant confirmed this:

> *Service users do not want to be locked up. They do not like too many rules. They hated their freedom being restricted. This certainly frustrates them, causing them to self-harm more. So, when observing them we must be mindful not to overdo it. Erm...I mean some degree of freedom must be put in place* (Jonathan, In: 16, 5).

A participant of a focus group agreed with Jonathan`s assertion by stating that:

> *Service users do not like excessive restriction on their freedom. They do not like too much control. They need some degree of freedom to do things on their own. What they also hated is when we belittle them; referring to them as timewasters. This is common in my area of work. It is all of these issues that lead service users to sometimes harm themselves* (Mike, Fg: 2, 9).

Mike`s reflective account seemed to imply that self-harm is a form of protest of and rebellion against control measures and or oppression in clinical settings. It was also considered to be a function of the labels given to them and the felt stigma associated with the same.

8.3.2.2: Labelling and Prejudice

This theme was illustrated by several participants through descriptions of their perceptions of service users. Phrases such as timewasters and attention seekers were noted to be used by participants to describe service users who self-harm. The use of these descriptors and their impact are highlighted in the following extracts.

> *Service users do not like to be shouted at. So, shouting at them is not helpful. It drives them away from us. They do not also like the names we give them; attention seekers, timewasters and so on. From experience, service users find these phrases insulting, which sometimes push them to repeat their behaviours* (Jonathan, In: 16, 5).

Similar explanations were provided by a participant when asked to talk about what service users would need least in practice.

> *Service users hated when healthcare professionals are disrespectful towards them and when they use derogatory comments against them. For example, describing them as nuisance, timewasters and attention seekers. I must admit...erm...erm...I often find those who repeatedly do it as nuisance* (Jill, In: 7, 4).

In contrast, some participants were noted to be positive in their attitudes toward service users. In fact, few of these participants claimed to have expressed anger against their colleagues for

using terms such as timewasters and beyond help to describe service users. A participant agreed with this by stating that:

> *I feel sorry for them and I feel we need to do more to help them. So, I tend to get angry at some of my colleagues` negative attitudes to self-harming service users; referring to them as timewasters and beyond help* (Pippa, In; 2, 5).

The use of these labels is indicative of healthcare professionals` misunderstanding of the motives of service users` self-harming behaviour. The labels ascribed may serve as a deterrent for developing a better understanding of service users. A participant articulated this when asked to explain what attitude means.

> *It is the way you think and the way you relate to others. As a professional, I spend time and listen to them. However, I feel they are often misunderstood and rejected by us as being unworthy of care. Simply, this means they do not deserve professional time. Honestly, it is our thoughts of them as attention seekers that tend to make us misunderstand them* (Bola, Fg: 1, 9).

People`s perceptions may influence the way they respond to others in their surroundings. The misunderstanding alluded to in the above narrative and in the stories presented by other participants help to shape healthcare professionals` reactions to service users. With reference to some participants, such misunderstanding has in part contributed to them treating service users with self-harming behaviours in their clinical areas as a homogeneous group. In other words, common approaches were used to respond to the needs of these service users. Responding to people in this way ignores their individual needs. This is worrying and it therefore deserves further examination.

8.3.2.3: Blanket Approach

The arguments presented above epitomises the differential treatment offered to service users in clinical practice. Notably, care provision of service users with self-harming behaviours was described by participants to be significantly different from other user groups. The extract below is an attempt to illustrate this. It reads:

> *Some healthcare professionals including myself do treat service users who self-harm as a group. This is because they are very similar; similar in a number of ways. Other service users are treated better; respected and listened to. But as professionals, we must realise that people are different; they have individual needs. So, it imperative that care is provided on an individual basis to address individual needs* (Philip, In: 12, 3).

A similar account for differential care was provided by another participant in her attempt to explain what "splitting" means. It states:

There is variation in attitude. Some healthcare professionals treat service users who self-harm as a group; as one. Erm...erm...they treat them differently from others who do not hurt themselves. But I think service users should be treated as individuals not as a group. This is because of their individual needs (Julie, Fg: 5, 12).

It appears that individualising care provision is an important issue for care providers, but it is particularly important for the "cared for"; service users. This is because it creates an opportunity for the latter to be provided with the care they need and deserve. A participant echoed this assertion:

One thing I found amazing is adopting a blanket approach for all user groups. Doing so certainly ignores their individual needs and this in turn would negatively influence relationship building. So, it is crucial for care to be provided on an individual basis (Peter, Fg: 3, 9).

While a good proportion of participants advocated individualised or tailor-made care, some participants were noted to be insensitive in their responses to service users. Being insensitive indicates professionals' attempts to negatively distance themselves from service users. According to some participants, doing so indicates disregard for service users` general feelings and distress. It is believed that not showing respect for or willingness in trying to understand how the service users feel could result in more self-harming acts.

8.3.2.4: Insensitive Expressions

The themes of service users` needs for respect and to be listened to were persistently repeated during interviews. Whilst a large proportion of participants acknowledged the importance of these needs, some reported instances where healthcare professions failed to show respect for service users. A participant for example reflected on her personal experience. She stated:

A lot of people particularly those who self-harm are very sensitive in some respect in the manner we respond to them. Certain colleagues of mine tend to ask service users why they cut yourselves. They do so in a rude way. I have overheard a colleague saying if you want to cut yourself do it when I am not around. One does not need to be harsh. There are ways of telling service users how you feel as a practitioner (Mariko, In: 5, 3).

The phrase, "*do it when I am not around*" illustrates the impact, such as anxiety, which self-harm sometimes generates in healthcare professionals. As noted in previous discussions, caring for people who self-harm, particularly those who repeatedly do so can be both a physical and emotionally draining experience. As a result, attempts may be made by healthcare professionals, as indicated in the above phrase, to avoid these experiences. However, professional responsibilities demand that users with this presentation are provided

with quality care, which in essence involves responding to their self-harming behaviours. This is certainly a source of tension observed in this study that may influence the manner in which service users are cared for or responded to in clinical practice. In addition to this, other factors were indentified during interviews that may affect healthcare professionals` reactions to service users. It is these influences that are now turned to with a view to exploring their role in attitude formation.

8.3.3: Influences on Attitude Formation

Undoubtedly, understanding the determinants of attitudes is crucial for enhancing the quality of care offered to service users. This assertion is based on the researcher`s view that attitudes tend to determine the approaches which people use when working with individuals who self-harm. Other researchers have agreed with this by claiming that healthcare professionals who believe, for instance, that self-harm is a manipulative or attention seeking behaviour, are more likely to respond to it with some degree of anger and rejection rather with acceptance and understanding (Clarke *et al.* 1998). Such responses are noted in this study and in many other studies to trigger further episodes of self-harming behaviours (Tantam and Huband, 2009). This is certainly a concern for people interested in effective care provision to service users with this behaviour. Hence, there is a need to focus at this stage of the thesis on exploring the role which factors, such as experience, training and education, could play in shaping the way healthcare professionals relate to individuals who self-harm.

8.3.3.1: Experience, Training and Education

Taking into account the meanings of some aspects of the narratives presented, the difficulties healthcare professionals sometimes experience when caring for service users are compounded by lack of or limited training and information about self-harm. Most participants of this study agreed with this and supported the need for training on this subject. A participant of a focus group confirmed this when asked to talk about factors that would hinder relationship building.

> *Not knowing what to do and lack of skills and knowledge about self-harm are stumbling blocks. This is a problem for a lot of us, if not all, in this unit. It prevents us from doing what we are meant to be doing* (Julie, Fg: 5, 10).

Another participant of the same focus group echoed Julie`s views.

> *In addition to being overworked, I think, the ward being very busy, not knowing what to do, lack of knowledge about self-harm and how to care for people with this behaviour*

are factors that could prevent relationship development. As you know, people who self-harm deserve better care. From a professional point of view, we should always provide it (Abiola, Fg: 5,11).

The above account is certainly an emphasis on the need for training of professionals on the subject of self-harm. Undertaking such training, some participants asserted, would ensure effective care of service users presenting with these behaviours. A participant made an attempt to explain this by reflecting on a specific clinical scenario when responding to the question of whether attitudes would vary from one healthcare professional to another.

Yes, it would vary from professional to professional. This is because people`s experiences are different. In the past, one of my colleagues told me that he did not feel skilled and competent enough to deal with individuals who self-injure. This realisation made him to undertake a course on self-harm, which he claimed helped him to relate to and care well for service users (Sasch, In: 4, 5).

Similarly, another participant explained in a positive manner how training significantly changed his approaches to service users.

From experience, caring for people with this behaviour can be very challenging and sometimes emotionally upsetting. I must say...erm... I initially found it stressful because of lack of understanding of the reasons behind their behaviours. I used to refer to them as attention seekers. With experience and training around the subject, it became much easier to engage and work effectively with them. I no longer refer to them as such. I have now realised that they do it to express their inner feelings (Ade, In: 18, 2).

An extract from an earlier interview also illustrates a relationship between training, attitude and effective care provision. It reads:

Yeah! Yeah! It would help increase people`s knowledge of self-harm and their competency on how to care for service users with this behaviour. It would enable us to understand their reasons or intentions for self-harm. Knowing this would no doubt enable us to demonstrate acceptance for them, listen to their views and provide support (William, In: 11, 4).

While training was considered a significant contributory factor for positive attitude acquisition, similar significance for attitude development was also noted in the transcripts to be associated with experience of caring for self-harming service users. A participant made a succinct attempt to explain this relationship.

People with no experience working with self-harm tend to have distasteful and judgemental attitudes towards users with this behaviour. This is common in this unit and the experiences of healthcare professionals here vary from no experience through little to very good experience. Professionals like myself who have the right skills and level of familiarity with self-harm tend to be positive in our approaches; showing concern and willingness to offer help. But I also believe that it can be very draining

192

and stressful to care for individuals who hurt themselves particularly those who repeatedly do it (Adam, In: 1, 5).

Even though Adam expressed willingness to provide care, he warned that working with individuals who self-harm can be emotionally and physically exhausting. Thus, in addition to having experience of and knowledge about self-harm, healthcare professionals who engage with users presenting this behaviour may require a supportive space for guidance and reflection (Babiker and Arnold, 1997). Such a space, referred to in this study as mentorship and supervision, would offer them the opportunity to critically examine their feelings and the impact of these on their work with service users.

8.3.3.2: Mentoring and Supervision

It is apparent from the discussions presented thus far that support in the forms of supervision and mentoring was not a luxury in the secure settings studied, but was an integral part of the strategy for effective and professional working. A participant of an individual interview reiterated this view:

> *I have to say that supervision is essential; it helps us to grow in the way we work. So, we should always use it. In fact management should ensure that the policy which relates to its use is always followed. Mentoring should also be part of this support network. New professionals in the clinical areas need to be coached into good ways of working. These two supports constitute forums for learning professional behaviours and to cope and defence against anxiety experienced in practice. I therefore think they should be incorporated in our professional development protocol and nurse training programmes* (Sasch, In: 4, 7).

It is clear from the above excerpt that supervision and mentoring need to be given importance in practice. This assertion is based on their role in enabling practitioners to develop and deliver good practice to service users. Despite the level of significance highlighted, few participants noted that they have not been adequately supported, and they claimed that such limitations have a negative impact on their work with service users. A participant illustrated this difficulty when asked to discuss how attitudes can be changed.

> *Training and education are the main medium used in our area of practice to bring about changes in our attitudes towards service users. I have used these and I benefitted from them. But...erm...what I think we should develop more in this unit are a sort of body system or mentor system and supervision. I have seen mentoring being practiced here; the less experienced work closely with the more experienced practitioner. Some of my colleagues claimed to have gained from this. I have never been mentored. I need one to learn some key issues of how to care for people who hurt themselves* (Philip, In: 12, 5).

A narrative of a latter individual interview provided similar explanations to illustrate the benefits of and .barriers to mentoring. It reads:

> *Training can change attitude if it is done properly. By properly I mean a programme that focus on practical things that matters; how things are done, not too much of theory. What I now believe that would also help are clinical supervision and mentoring. Erm...erm... mentoring involves two practitioners working and learning together, one with more knowledge and experience of caring for people who self-injure. This way of working helps in shaping the manner service users are treated. I was unlucky, as I was not mentored well. Time was a big factor. My mentor was always busy; doing other things with no quality time for me. On most occasions, he was out of the clinical area. So, I learned the hard way* (Chez, In: 21, 4).

Upon examination of Chez`s reflective account, it became evident that time and availability are constraints to these systems of support. However, acknowledging their benefits in the context of both practice and professional development, it is essential for managers of healthcare settings to work around these constraints with a view of ensuring their effectiveness. Precisely how this can be done may vary from area to another. Adoption of clear policies and procedure, as demonstrated by participants of this study, is one way of responding to constraints.

8.3.3.3: Policies and Procedures

Noted in the narratives presented, professionals of the study site are guided by a policy on how to deal with self-harming behaviours. It provides a structure for professionals to manage their anxieties or worries. However, whilst the guidance offered assist in practice development and consistency of approaches, participants still described variations in responses to self-injury between practitioners. The extract below illustrates this.

> *Yes attitudes vary from ward to ward. But this variation is minimised by structures such as policies and procedures. You know, they help us to be consistent in how we respond to service users. What is actually happening is that the policy helps to reduce the level of differences in the way services users are treated* (Sasch, Fg: 4, 10).

A participant of the same focus group took the argument further by highlighting variations in attitudes despite the presence of a policy.

> *Wards consist of practitioners with different personalities and cultures. Attitudes would therefore vary even within the same wards. I do agree that policies and procedures would help with consistency. What they actually do is that they minimise or reduce the degree of variation of attitudes; manner of approaches (Ram, Fg: 4, 10).*

Variations in attitudes and differential application of policies on self-harm could lead to inconsistencies in the treatment offered to service users. A participant agrees with this by stating that:

> *In instances where attitudes vary between practitioners, service users are usually provided with different treatment. Some of them would find this distressing. With regards to using the policy some of us find it difficult to understand. It is this difference in understanding of the policy that sometimes leads to the varied responses (Zainab, Fg: 6, 11).*

Apart from a limited understanding of policies, the disparity in the treatment provision was believed by some participants to be compounded by philosophies adopted in clinical areas.

> *The wards have a range of practitioner with different personalities, experiences and knowledge about self-harm. The structural environment and philosophies are also different. These philosophies have an impact on the care and treatment provided to service users. For instance, some wards would only admit users who are acutely unwell. Treatment of these users would be very different from those who are not acutely ill. These individuals would be...erm...admitted to other clinical settings* (Philip, In: 12, 4).

Similarly, another participant explained:

> *Attitudes vary from ward to ward. Each ward in this forensic unit has different philosophies. Professionals are required to work according to their ward philosophies. Intensive care wards for example would expect all their staff to strictly follow their policies which are closely related to the wards` philosophies. In such clinical areas, professionals may not negotiate with service users when providing care* (Jonathan, In: 16, 6).

The above account seems to indicate that the nature of clinical areas does have a role to play in attitude development. In other words, the type of practice setting may influence professionals` responses to the needs of service users. Taking this into account it is imperative for the potential of this relationship to be explored further.

8.3.3.4: Type of Clinical Setting

A number of researchers of self-harming behaviours including the one of this study believe that attitudes in care settings are very important, as they determine practitioners` reactions to service users (Friedman *et al.* 2006). A common view relating to this was highlighted by some participants of this study. They asserted that attitudes towards self-harm do have an impact on the care and treatment offered to service users. Claims were noted in the transcripts that practitioners` responses to the needs of service users were influenced by multiple factors. One of these factors, which relates to this part of the discussion, is the

nature of practice settings. A participant explained when asked to talk about whether attitudes would vary from one ward to another.

> *Yes it varies. But it depends on the kind of ward. For example, on rehabilitation wards, practitioners' attitudes towards service users are different. You would find more interaction between the two groups. Unlike acute wards, there is usually limited interaction between practitioners and service users. Practitioners are usually busy doing things they consider important; management issues such as paperwork* (Paul, Fg: 4, 10).

It is apparent from this account that the low level of therapeutic engagement in care settings is a function of healthcare professionals` active participation in managerial duties, which could include attending meetings and completion of paperwork. However, it was noted from the discussions held during interviews that it is the acuity of the illness of service users that in fact dictates the degree or level of engagement. A participant echoed this view:

> *Attitudes vary from ward to ward. As a professional my, expectations of service users vary from psychiatric intensive care units (PICU) through acute environments to rehabilitation settings. In PICUs, I expect them to be very disturbed. Hence, more self-harm. The interaction here is more of prevention; use of observation. I expect them to be distressed in acute wards, but with less self-harming behaviours. Again, the focus here is more of prevention; observing them closely. In rehabilitation wards, I will expect them to be much better and therefore more engagement in rehabilitation activities. This is really what is happening in this unit; you can see the level of engagement changing as you move from ward to another* (Terry, Fg: 1, 10).

Even though the use of observation as a preventive strategy has a place in mental health nursing, claims were made by participants that it could lead to repetition of self-harming acts particularly when passively applied. The term passive as used in this case refers to limited or no engagement with service users when being observed. It is apparent in the narratives of some participants that repetition of self-harm and practitioners` perception of its cause are factors which could play a part in people`s attitude development.

8.3.3.5: Repetition of Harm and Perceived Cause

Echoes of negative attitudes and feelings of frustration were heard during interviews when participants spoke about their experiences of frequent exposures to self-harming acts. A participant provided an explanation:

> *I always endeavour to give the best care irrespective of the circumstances. But it is hard to be empathetic with those who repeatedly self-harm. However, they deserve it because they are unwell. For some it is the voices that are telling them to do so. For some they are so distress that they cannot help it...erm...they hurt themselves. So, I always try to get involved with things to help me know what is leading them to do it. But working with these service users is a challenge* (Joe, In: 8, 2).

Another participant provided similar explanations with clear examples when asked to talk about how frustrations can be expressed.

> *Frustration is expressed in a way of burnout. For example, a service user I was a keyworker for harmed himself a lot. Forming a contract, an agreement was one way I used to manage his behaviour. But he sometimes breaks the agreement. This is frustrating because it takes time to form a contract. On one occasion, I poured out my frustration on him, called him names, attention seeker and also ignored him for a while. On realising that it was the voices that sometimes tell him to hurt himself, I calmed down and it made me to take a positive approach for him; to be there for him.* (Bola, In: 19, 2).

Although the repetition of self-harm can be a frustrating experience, it is the cause of the behaviour that seems to dictate practitioners` responses. For service users whose behaviours were believed to be passive, not carried out on their own volition, as exemplified in Bola`s extract, were considered by participants to deserve empathy and care. In contrast, service users with behaviours which were believed to be externally motivated, for example, a desire to be relocated to another unit, were offered negative descriptors like attention seekers and time wasters. The extracts below provide clear illustrations of practitioners` perceptions about this.

> *Sometimes you don't really know what they want. Even if you give them all the time, they will still do it. Talking about one service user in particular, it is not the voices that are making him to cut; he just wants to see people around him. He loves that attention, plus he thinks he will get more attention if moved to the acute ward (Abiola, Fg: 6, 9).*

> *Their behaviours change the way we care. One service user told me that he does not know how to ask for help. According to him cutting has helped him a lot and he gets nurtured when he cuts. In his words, he stated that when I cut they come to me, they nurture me* (Joy, In: 9, 3).

It is noted in Joy`s account that the worries experienced when faced with self-harming behaviours are the driving forces for care provision. Whilst providing an overview of the methods of self-harm, a participant agreed with Joy`s comments and also made an attempt to explain what attention seeking means.

> *Most service users I know who self-harm cut. They do so to release pressure. Some take overdose when they plan to end it all. Some secretly harm for a long time before they are discovered by others. Other forms include starving, banging of head against a wall and pulling of hair. But cutting is common in this unit. Some cut deep while some just do it on the surface. I think those who just cut on the surface are the ones seeking attention. The others are usually serious about it. I get worried when the cuts are deep. My approach in this case is to put them on observation to prevent further cuts* (Jonathan, In: 16, 2).

On exploring the narratives of some participants, it was noted that the perception of the degree of seriousness of harm, as illustrated in the above extract, plays a significant role in deciding on the treatment and care approaches for addressing the needs of service users. Acknowledging this, it is important to explore this association in more detail.

8.3.3.6: Perceived Seriousness of Harm

A participant provided a very good explanation of the relationship between seriousness of harm and care provision when providing possible explanations for the variations of attitudes between practitioners towards self-harm.

> *One service user told me that the depth of the cuts he makes indicates his level of distress. So, I respond to him and others quickly when the cuts are deep. My colleagues also do the same. For him, the deeper the cuts the more distress he was* (Judith, In: 6, 3).

Similar explanations were provided by another participant.

> *Service users use blades to cut themselves. Sometimes the cuts are so deep that I feel angry at them. However, I would still offer them help but in a way that would not reinforce their behaviours. The deep cuts sometimes tell me that they are in need of help. This makes me to engage more with them* (Sasch, In: 4, 2).

This argument on perceived seriousness and attitude development was taken further in focus groups to include discussions relating to the impact of self-harm. A participant provided a detailed account that illustrates this.

> *I think it is the plan of the service users that contributes to this variation of attitudes. We should not forget that healthcare professionals are employed to provide care. They have a duty of care to meet the individual needs of service users. But our attitudes sometimes get on the way. I have observed in the past very disturbing cuts and very superficial ones. A wide range of personal emotions were evoked by these behaviours. But the amount of empathy and concern I personally express usually depend on the seriousness of the cuts* (Pippa, Fg: 1, 10).

Apart from perceived seriousness of harm, differences between male and female participants in the context of their perceptions of self-harming behaviours were noted in the narratives. If there were actual differences in perceptions or attitudes, it would be assumed that there might be gender-specific issues that contributed to the same. It is these contributory factors that are explored in the section below.

8.3.3.7: Gender

A good number of participants felt that the gender of healthcare professionals may influence their interactions with service users. A participant of a focus group made an attempt to explain this difference when asked to talk about attitudes in clinical practice.

> *Yes there are differences in the way professionals behave. In my opinion, service users tend to listen to females more than males. This is because they are approachable and more likely to give them time to converse. Above all, they tend to treat them nicely. This is what all service users like...erm...they want people to show respect and listen to them. As for the males, they are sometimes heavy handed; harsh to the service users, calling them names. For those who have been abused, treating them this way is like slapping them on the face with reminders of past traumatic experiences* (William, Fg:3,12).

Another participant of the same focus group echoed William`s views:

> *Males generally do not show concern. On one particular shift, I overheard a male band six-nurse saying if she want to kill herself let her do it and even laughed when saying so in front of the service user concerned. Unlike females, they will try to show concern, empathise with service users and offer help when necessary and even show readiness to talk* (Philip, Fg:3,12).

Similar perceptions were also expressed during individual interviews. A participant provided a succinct reflective account of gender issues that make female practitioners unique in their engagement with users.

> *Females are motherly. They use their maternal instinct to help people. They show concern, patience and listen to people. Unlike male practitioners, these qualities are usually not expressed* (Jonathan, In: 16, 6).

A contradictory opinion was noted in some of the transcripts. Claims were made that the sex or gender of healthcare professionals does not in any way help in dictating the manner of their responses to service users. Rather it is believed that the differential responses or attitudes expressed can be attributed to the differences in personalities and cultural backgrounds in practice settings. A participant confirms:

> *I don`t think it is do with sex. It is an individual thing. There are some females with bad attitudes and there are some with good ones. For some it is not really bad attitude; it is merely a reflection of their personality and culture. It is just the way they speak and interact* (Jackson, Fg: 2, 11).

A participant reiterates Jackson`s view of no gender influence on attitude development. She states:

> *In my opinion, gender is not an issue. I think the problem lies on the age and experience of practitioners. More experienced practitioners work well with users who self-injure; they are prepared to listen and help them. The less experienced ones are*

usually very anxious and get worked up when they see wounds. This tends to distract them from interactions (Usha, Fg: 5, 15).

The experience of healthcare practitioners has been repeatedly cited as a significant factor in shaping attitudes and has on a few occasions been associated with age. A participant of a focus group reiterates the importance of experience in attitude development.

> *I also think it is to do with age, which I think links well with experience. Older and experienced practitioners do things differently from younger and less experienced ones. Experience working with this user group is the most important. Those who are experienced know what they are doing and therefore respond well to the needs of the users* (Alice, Fg: 5, 15).

8.4: Summary

The discussions presented in this chapter clearly indicate that attitudes held by healthcare professionals towards individuals who undertake self-harming behaviours may interfere with care provision. Thus, understanding professionals` attitudes, as emphasised in the introductory section of this chapter, is crucial for effective working with service users with this behaviour. A mixture of both positive and negative attitudes, identified in the transcripts, has been illustrated in this discussion. With regard to the former, demonstration of respect, acceptance and readiness to engage with service users were considered to be positive attitudes. Claims were made by participants that healthcare professionals can be judgemental in their attitudes. For example, they have been reported here to refer to service users as timewasters, attention seekers and manipulators. Such negative attitudes have the potential to impede the development of trusting relationships.

Apart from the general discussion on types of attitudes presented, this chapter has also clearly explored factors that might influence attitude formation. What now remains to be examined is how practitioners can use the attitudes they developed over the years in caring for or meeting the needs of service users. The following chapter addresses this issue as it includes discussions of care approaches for individuals with self-harming behaviours.

CHAPTER NINE

WORKING WITH SERVICE USERS WHO SELF-HARM

9.1: Introduction

As discussed in the previous chapter, the occurrence of self-harming behaviours in secure environments can be attributed, at least in part, to healthcare professionals` negative attitudes. There is growing evidence to suggest that expressed negative perceptions about self-harm have a direct effect on care provided to users with this behaviour (Commons *et al*. 2008). To be more explicit, such perceptions might distract practitioners from meeting the needs of service users and might also enable the latter not to actively engage in care processes. Certainly, this is worrying. Thus, there is a need for constructive or positive professional attitudes, as these are crucial elements to effective working with this user group. Simply, the adoption of a positive stance would enable practitioners to identify care approaches that are believed to be effective and appropriate for engagement.

To date, there is a range of approaches available for caring for individuals with self-harming behaviours. Examples of such approaches include observation and physical restraint. As noted in the literature, there are some disagreements between healthcare professionals about these approaches in the context of their appropriateness in addressing the needs of users (Babiker and Arnold, 1997). This chapter sets out to discuss care approaches talked about by participants during interviews. It also seeks to explore the application of these approaches and disagreements observed. The chapter commences with a table of themes (table 8.0) that is followed by a presentation of an overview of the super-ordinate theme. It also includes an examination of each sub-theme presented in the table.

9.2: Table of Themes

Table 8.0: Table of Themes for Individual and Focus Group Interviews

Super-Ordinate Themes	Sub-Themes

Approaches to Care	Preventing and Stopping Self-Harm
	    Restrictive Approaches: Searching, Observation, Restraint and Protective Clothing
	    Administration of Medication
	    Risk Assessment
	    Responding to Injuries
	    Self-Harm Unit
	Meaningful User Involvement
	    Provision of Choice and Engagement
	    Enhancing Hope
	Shifting Responsibility
	    Safe Self-Harm: Allowing Self-Harming Behaviour
	    Self-Harm Group

9.3: Theme Descriptor: Approaches to Care

In secure settings, healthcare professionals are particularly concerned about preventing and or stopping self-harming behaviours (Gough, 2005). This concern is more likely to be based on fear of being blamed for possible serious events that may occur when individuals hurt themselves. Examples of these include severe injuries and death. Similar worries were noted in this study and were evident in participants` narratives. It was therefore not surprising to observe during interviews that participants frequently spoke about the use of medication, observation, search and protective clothing when discussing care provision.

This theme focuses on healthcare professionals` perceptions of these approaches in secure environments. They are considered in this study to be controlling and restrictive. Although this is the case, there is an apparent opinion noted in the narratives that they have a role in preventing or stopping self-harm. Some participants highlighted that they are beneficial in the sense that they do contribute to a reduction in self-harming rates. However, contradictory views were also observed following closer inspection of the transcripts. Some participants claimed that restrictive approaches would reinforce the behaviour of self-harm, and such reinforcement, they asserted, would eventually lead to its increase. Acknowledging this, there is a need for healthcare professionals to explore other approaches that would enable service users to express and manage their own feelings and to have more control and choice

over their behaviours. It is believed that strategies with these characteristics would lead to reduced rates of self-harm, a view also echoed by Tatiana *et al* (2009).

Empowering strategies were discussed during the interviews. Issues to do with user involvement with emphasis on choice and engagement were commonly expressed by participants. Some participants made suggestions for the development of self-harm units. Others acknowledged the benefits of self-harm groups in their clinical areas. Although not practiced in the clinical settings of the study site, the benefits of a harm minimisation approach and its role in reducing self-harm rates were emphasised by some participants. Even though service users may benefit from empowering approaches, healthcare professionals in forensic settings are generally worried about the possible dangers that may result when applied. Thus, participants stressed that it is appropriate in secure settings to adopt a model of a mixture of two approaches; restrictive and empowering. Within this model, service users are treated as capable adults with the strategy dominating at any one time to be dictated by the needs and safety of the same. These care strategies are now examined and illustrated below using extracts from participants` narratives.

9.3.1 Preventing and Stopping Self-Harm

There is a natural tendency or desire in people working in healthcare settings to always do things right (Miller and Rolnick, 2002). In secure settings, one of the right things to do, as mentioned by some participants, is to prevent or stop individuals from hurting themselves. Arguably, if a service user is seen to be hurting himself or herself, practitioners would be more inclined or motivated to adopt strategies for stopping the behaviour. Certainly, this is a reactive way of intervening, which is not supported by some participants. There was a perception among some participants that the best way of preventing self-harm is to adopt proactive approaches. One of the approaches that is considered to be an intrinsic component of care provision in mental health services, particularly forensic settings is risk assessment.

9.3.1.1: Risk Assessment

It is practically impossible to conduct a comprehensive risk assessment in the absence of a good relationship. A good relationship in this case means an intense therapeutic rapport that involves interactions with users without expressing inappropriate concerns to the idea of self-injury. Although what is considered to be an appropriate emotional response can be hard to

determine given the individual presentations of service users, it is worth noting that it is advisable to assess risks within the framework of a therapeutic relationship. A rationale for this is given below:

> *What is really required is a thorough initial risk assessment. It should not stop there. Erm...it should be a continuous process. Risk assessment is a complex process and its effectiveness is influenced by how good is the practitioner-user relationship* (Paul, In: 17, 3).

The role of a good working practitioner-user relationship in risk assessment is clearly articulated in the above extract. It is noted in the literature that people who self-harm usually expect to be ignored when their behaviour is exposed (Thomason *et al.* 2008). If this is the case, it could be argued that users with this behaviour are already inclined to withdraw from others, with others meaning healthcare professionals. A participant of a focus group reiterated this view when discussing the nursing care of self-harming service users.

> *There are variations in the way service users are cared for in secure services. But one thing that seems to be common in this unit is risk assessment. This involves exploring the risk of self-harm or suicidality to inform the development of a risk management plan for minimising any identified risk. The assessment sometimes leads to placing a service user on observation. Talking about one service user in particular, he was reluctant to talk to me. He was sort of withdrawn into his own world, ashamed to talk. I later realised that it was because I noticed his cuts* (Julie, Fg: 5, 3).

Being withdrawn or limited participation in risk assessment could result in negative or poor outcomes. Hence, few participants offered advice on how to tackle this problem. They suggested for healthcare professionals to adopt a calm non-judgemental approach and not to express distaste for any identified injury during therapeutic encounters. For these participants, putting this suggestion into operation could lead to better outcomes; retrieval of information and reduced self-harm rates. A participant agreed with this and added that:

> *Conducting risk assessment with respect, with an open mind would help us identify risks. Managing risk makes clinical environments safer and more conducive for care provision. Users benefit from this and practitioners also feel happier for reduced rates* (Chez, Fg: 4, 4).

Apart from the outcome of reduced self-harm rates, effective risk assessment would assist in predicting severity of risk, which is believed, as noted in the narratives, dictates the level of care needed by users.

> *We need to regularly assess their risks. Erm...erm...the assessment will help us determine the level of care they would need* (William, In: 11, 3).

Participants alleged that some of the measures commonly used to control self-harm in hospital based settings can be perceived by service users to be oppressive and restrictive. Examples of these include observation, physical restraint, searching and the use of protective clothing. Participants were also of the opinion that these methods can be damaging in the sense that they may increase rather than decrease self-harming episodes. Others offered different views. They claimed that these methods are beneficial to service users and practitioners, as they can reduce self-harm rates. A detailed discussion of these views is presented below.

9.3.1.2: Restrictive Approaches: Observation, Searching, Protective Clothing and Restraint

These approaches are discussed here in the order in which they are presented. Starting with observation, it was the most commonly cited method amongst participants for preventing self-harming behaviours. It involves the allocation of the care and supervision of a service user to an individual practitioner (Bowers *et al.* 2000). From participants` views, there are apparently different grades or levels of observation. The level used at any one time is generally determined by the acuity of service users` illness and the risk posed (Philips, 2004). A participant confirmed this when asked to describe his own feelings about care provision for individual who hurt themselves.

> *I am very happy with the way we work on this ward. I mean the observations we do. We do them professionally. When a member of the team is allocated to observe, he or she would watch the service user as well as talk to the same. During this interaction, the team would explore reasons for harm and may also explore alternative ways for self-expression. Just watching them would not address their issues. So, in this unit we put two things together, talking and observing. The service users we watch are usually very ill. When they are at this stage of their illness, we place them on continuous observation we call specialling. We do so particularly if they express intentions to harm themselves. This approach also helps us manage or deal with our anxieties. Commitment is key to do it effectively in this acute ward* (Sasch, Fg: 4, 4).

Service users on acute wards and psychiatric intensive care units (PICUs) who are considered to be acutely unwell with a potential of hurting themselves either accidentally or intentionally, are usually in practice subjected to a very high level of observation referred to as "specialing" (Gournay and Bowers, 2000). This mode of observation, which are considered to be beneficial to users, requires designated practitioners to be within arm's reach of same at all times (Philips, 2004). The essence of this is to alleviate all potentials for self-harm. Some participants found the use of this method of observation beneficial, as it has

prevented episodes of violence and self-harm in their clinical practices. The extract below illustrates this:

> *The one-to-one observation, we call here specialing, is quite beneficial. It prevents violence and prevents service users from hurting themselves. To be effective the practitioner should engage the service user. This is what we do here in this unit* (Ram, In: 22:2).

Similarly, another participant provided an explanation of the benefits of observation when discussing the impact of service provision on users:

> *Although we do not use safe self-harm approaches on this ward, if used they would help reduce incidents of harm. The approaches we used have proved to be effective. These include specialling and general observations. In the main they have reduced incidents of harm. Service users have stated that they benefitted from them, as staff interact with them during observation* (Usha, Fg: 5, 5).

Observations are not only of benefit to service users, they are also considered by some participants to have a positive effect on practitioners. The following excerpt indicates an example of a good outcome.

> *The observation provided made the service users to feel that they are accepted and that members of the team care. This made them to co-operate with the care provided; the observation. In fact it made them to harm less. As for practitioners, it helped to reduce the anxiety we tend to experience when the rates of self-harm are high* (Sasch, Fg: 4, 5).

While some participants believed that observation contributes to reduced rates of self-harm in clinical practice, others were opposed to this view. They claimed that observation, particularly "specialling" would enable service users to be become desperate in their attempts to self-harm and such desperation, they asserted, could lead to more complicated or severe injury. A male participant echoes this perception.

> *People generally don`t like their freedom restricted. When users self-harm, we put them on special observations (specialling). Erm...erm...it cuts down on what they can usually do on their own. From experience, most service users do not like to be watched. They want to be free to do things, not for their privacy to be invaded. For example, watching them closely even when they go to the toilet. I think there are ways of ensuring safety. This sort of way of watching over them would make them feel more frustrated. Erm...erm...increase in frustration makes them hurt themselves more and even more seriously. This is because...erm...it is invasive, restrictive and too controlling* (William, In: 11, 3).

Another strategy for addressing this problem of self-harm that is sometimes conducted in practice as part of observation is searching. A participant explained what this means:

> *In our clinical area, we have a generic way of working with service users including those who hurt themselves. We generally audit the ward regularly focusing on isolated*

areas where they may harm themselves and or act violently. This includes, for example, user searches, cupboard searches and general ward searches. Searches are clearly invasive, they violate privacy. We do searches regularly to remove objects they might use to intentionally or accidentally harm themselves. In addition to this, we frequently occupy them on a one-to-one basis. Medication is used only when there are indications of agitation and when the thoughts to hurt themselves are delusional (Ram, Fg: 4, 4).

It is explicit from Ram`s narrative that searches especially the categories that relate to the body and personal belongings can be considered as intrusive. It could be postulated that such approaches can make users feel irresponsible and incapable of taking control of their lives. Despite these possible emotions that may be generated in users, participants were convinced that healthcare professionals are professionally and legally obliged to conduct searches to prevent harm and save lives. However, it is vital to stress that the objects which users might use to harm themselves and the times they might do so are not always obvious. A participant agreed with and stated that:

We don`t sometimes know what they would use to hurt themselves. We don`t always know when they would hurt their bodies. So, we regularly search their rooms looking for things they might use to self-harm. Most of the time they would give us what they intend to use. But some would hide their objects and use them at some point. For these users we place them on a special form of observation called specialling (Jill, In: 7, 2).

In addition to using special observation on users reluctant to hand in objects that they might use to hurt themselves with, it would be appropriate and safer to complement this with a detailed search. A graphic account of how this can be done was provided by a participant in a later interview.

*We don`t know what they would use at times. So, we have to do a search to find out what they are likely to use. If we are lucky, they would give what they have. Sometimes they don`t; they would hide stuff. When we sense this, we usually do a whole search. This involves searching the entire rooms and sometimes making them sterile; creating a sterile environment. This means emptying the rooms; taking all the stuff out. In some instances, depending on the perceived level of risk, the service users would be provided protective clothing; a safe garment. There are usually mixed feeling for the use of this type of clothing; some are happy and some are unhappy using it (*Peter, In: 13, 2).

It is clear from this account that healthcare professionals may on occasion feel uncomfortable and distressed about certain roles they are expected to assume in practice. An example of this is the provision of protective clothing to service users. The question now arises, what is protective clothing? A female participant made an attempt to respond to this:

I do like the way we work in this unit. When service users are admitted, we usually try to prevent them from harming by searching and placing them on observation. These methods have worked but they have not completely prevented harm. There are some

who are desperate to harm themselves and sometimes desperate to even kill themselves. For these users, we dress them in protective clothing. This is a type of garment made from a special type of material they would find very hard to harm themselves with. This is a very intrusive way of doing things. It violates even personal boundaries (Abiola, Fg: 5, 6).

It is very apparent from the discussion so far that the use of protective clothing is an extremely invasive approach. However, it is apparent from the discussion so far presented that it has a place in mental health practice, as it use is considered to be appropriate for service users with a very high risk of self-injury. The following response from a participant of an individual interview is consistent with this assertion.

The ward I presently work on is a psychiatric intensive care setting. All the users here harm themselves one way or the other. This could involve tying up their necks or cutting themselves. I sometimes get worried when coming to work; anxious about the type and seriousness of harm I may face. The users are women and they harm a lot particularly the older ones. Our approach is that we sometimes strip their rooms. The users would be dressed up in protective clothing. They violate privacy, but they help a lot and we should use them (Jill, In: 7, 2).

When Jill was asked to explain what protective clothing means, she provided a good description of what it looks like.

It is a long dress without buttons. It is blue in colour and made from a material that is very safe for users; very minimal risk for anyone. It cannot be used to hurt themselves. This is not always true. One service user continued to bang his head, scratch his body even when in protective clothing (Jill, In: 7, 2).

It seems as if that these strategies were not always successful as users continued to express their desperation to hurt themselves despite their application. According to some participants, it is advisable in such instances for healthcare professionals to explore other alternative means for alleviating the potential for harm. An approach that is occasionally used is physical restraint.

I have used many strategies with service users. I tend to spend time with them exploring the reasons for doing it. Users who harm like it. They like people talking to them. They certainly like people who make attempts to show understanding. Another thing I tend to do is to observe them closely. One thing I occasionally do is to restrain them. I do so only when I have tried everything. I must tell you a little bit of one individual. I restrained him and I ended up giving him medication. He did not like it. It is a kind of abuse. He expressed disapproval of my actions (Roland, Fg: 3, 4).

It was not surprising that for the user in question to express distaste at being restrained since restriction of any kind to people`s freedom is usually not a joyous activity. Acknowledging

this, healthcare professionals may be worried about using physical restraint. This assertion is succinctly captured in the following reflective account.

> *I do not like to use restraint. I used it a couple of times when the risk is high and other means have failed to help; to stop them from harming* (Mary,Fg:6,5).

Even though Mary had a fear of using restraint, she still went on to use it. Such usage was apparently driven by her professional responsibility for preventing harm and perceived level of risk. It was clear from Mary and other participants that there is a continued need and usefulness of restraint in practice. However, they seemed to suggest that it should be used as a last resort only in instances where there is a clearly defined intention of harm and where it is considered the most appropriate approach that can ensure safety.

> *We have to be cautious when using restraint. We use it when we have tried other things like talking, activities and medication. Users are sometimes so keen to harm themselves that we have no option but to hold their hands. We always restrain one user with mild learning disability when he starts banging his head against the wall. Usually, he would not stop even if you spend hours talking or wanting to engage him in activities. So, we use restraint and sometimes together with medication, a sedative like lorazepam. On most occasions, this mixture helped. So, using them is not a bad thing to do* (Philip, In: 12, 2).

Although medication may enhance the effectiveness of other efforts, few participants did not seem to favour its use. Noting this, it is fitting to critically examine the issue of medication further with the underlying notion of developing a better understanding of its role and usefulness in caring of individuals who self-harm.

9.3.1.3: Administration of Medication

Several reasons for the use of medication were noted in participants` narratives. Its calming function was the most cited in the stories presented. The comment below illustrates this:

> *In situations where the possibility for self-injury is high, we always commence the users on close levels of observation to prevent harm and to allow self-expression of feelings. If a user has a history of self-harm, we make sure that we don`t keep things he or she might use to self-inflict injury. We also sometimes use medication alongside observation to calm them down and to help prevent the thoughts of harm* (Angella, Fg: 2, 2).

A explanation akin to Angella`s account was provided by another participant.

> *We prevent self-harm by doing searches and placing them on observation. When acutely unwell, we place them on special observations. I must say that this is not just a physical preventive measure, it also involves talking to the service users, exploring reasons for their behaviours. I do not believe in the use of medication. But we use*

medication for those who are agitated. It relaxes them and may make them feel sleepy, which prevents us from interacting well with them (Pippa, Fg: 5, 6).

Thus far, medication has been described as a supplementary approach rather an alternative to other methods for managing self-harming behaviours. Hence, it might be right to consider it as a strategy with the potential for enhancing the effectiveness of other approaches like observation. A participant seemed to agree with this by commenting that:

Practitioners tend to categorise self-harming behaviours into high, medium and low risks. Depending on the level of risk, some users would be placed on special observation. This applies to those deemed to be in the high risk category. Medication is frequently used to help contain and alleviate risk; self-harm. But service users need more than medication. They need people to empathise with them, to understand the reasons for their behaviour (Bola, Fg: 4, 3).

Although medication does have a valuable part to play in caring for individuals who self-harm, it is not always a strategy of choice for these valuable reasons given by participants.

I sometimes feel frustrated towards self-harming service users. This is because I cannot really understand why they continue to harm. When the behaviour persists, we sometimes use medication to manage it. But...erm...erm...medication sometimes sedate them. This would prevent us from finding out the root causes of their problems (Pippa, In: 2, 2).

A similar rationale for not favouring medication was provided by another participant when discussing what service users with self-harming behaviours would need least in practice.

Service users do not need too much restriction. They do not want to be confined particularly to small environments; spaces. They do not like strict rules. In addition to this, when they harm, we give them medication. We need to move away from this. I don`t think they need medication at that time. What they need is people talking to them about what they do why they are doing it. So respect and giving time for discussion for their injuries are important (Peter, In: 13, 4).

Noted in this extract are crucial professional qualities for effective working with users who self-harm. Willingness and commitment for engagement, creation of opportunities for such engagement, demonstration of respect and acceptance irrespective of behaviours presented are the virtues explicitly stated in the statement. Bearing this in mind, it is important to emphasise that dealing with injuries inflicted by users requires delicate handling. It is also necessary to highlight that responses to injuries may vary from one care setting to another. As this work focuses on secure forensic services of the study site, how injuries of users were responded to by healthcare professionals within these settings was of a significant interest to the researcher. The responses are now discussed as narrated by participants.

9.3.1.4: Responding to Injuries

Showing concern for injuries inflicted was frequently mentioned during interviews to have a paradoxical effect on the rate of self-harm. Simply, participants seemed to believe that concern, in the form of attention from healthcare professionals, can maintain self-harming acts. In other words, there was some agreement among participants that expression of concern can positively reinforce service users` behaviour. It is believed that such social reinforcement can subsequently increase the frequency of behaviour especially in instances where it has been established.

> *You need to let them take responsibility for their actions. Even though they self-harm, as professionals we should always recognise that they have problems and we should therefore not be harsh with them. What we therefore need to always focus on is their needs and how to address them. But we should not do one thing. Erm...erm... that is we should not show too much concern for the wounds. If we do so, it will make them do it more and more* (Bola, In: 19, 2).

A very similar explanation about the relationship between the provision of attention and frequency of behaviour was offered by a participant of a later individual interview. It reads:

> *The least thing that they would need from us is to condone their behaviours. They also don`t like people to be angry with them because of their behaviour; erm...erm...because they cut themselves. Certainly, too much attention does cause a negative impact on them. So, if they cut themselves, we should encourage them to apply dressing on their wounds. We should not concentrate or show too much concern for the wounds. When we do, it is like encouraging them to do it again. From experience, service users tend to do it for the attention we give them* (Petrolina, In: 25, 3).

A participant who was also in agreement with the role of attention in the repetition of self-harming behaviour commented that:

> *One service user who recently wounded herself was taken to the local general hospital where the wound was stitched. It was a serious wound on her stomach. On her return to the ward, she opened it up when her request to go out for fresh air was not met immediately. There is a pattern in her behaviour. She usually hurts herself when she don`t get her way. Other users are copying the way she gets staff`s time; attention* (Angella, Fg: 2, 4).

Acknowledging Angella`s reflective account, it is probably safe to state that self-harming behaviours can occur in a contagious manner. This simply refers to the imitation of the behaviour of one individual by others in the same environment (Walsh and Rosen, 1989). It was probably for this reason that some participants advocated for the creation of self-harm units, which, if set up, would only accommodate individuals with this behaviour.

9.3.1.5: Self-Harm Unit

A small number of participants expressed disapproval of caring for both self-harming and non-self-harming users in the same setting. They attributed their unhappiness to the view that the latter would eventually imitate the behaviours of the former. Apparently, this is what is sometimes noted in practice as explained by a participant.

> *There should be special treatment units to care for people who hurt themselves. I think such units are long overdue. Mixing users of all sorts of behaviours causes problems. You would see the copycat behaviours, one person copying another. Self-harm is one of the behaviours users tend to copy in this ward. In the proposed units I am talking about, self-harm would not spread to people who have not done it to themselves before. These special units should be set up just like eating disorder units set up for people with diagnosis of anorexia and bulimia. Of course, they should be staffed by properly trained and knowledgeable individuals* (Bola, In: 19, 1).

The prevention of contagion was the primary reason for this suggestion, the development of self-harm units. A consensus view relating to these units was noted among participants during interviews. They were certain that such settings would prevent or at least minimise the occurrence of contagion by enabling users to seek alternatives to self-harm and to learn how to tolerate distressing feelings. A participant reiterated this opinion:

> *Self-harm is a complex problem that can be treated by people who are trained, experienced and knowledgeable to do so. To be effective, they need to work in specialist places. Therefore these places, self-harm units, need to be developed purely for users who hurt themselves occasionally and repeatedly. It is like having a chest clinic, a diabetic clinic and so on. Within the units, users would learn how to express themselves using other means other than self-harm* (Abiola, In: 23, 3).

It appears from the discussions thus far that collaborative working with an underpinning empowerment principle is the preferred approach for care provision in self-harm units. Certainly, such an approach has training and knowledge implications. It is therefore a prerequisite for individuals working in such environments, asserted by some participants, to be experienced, trained and knowledgeable about self-harm. Several people including participants of this study tend to believe that individuals who self-harm often feel empty and bored (Mackay and Barrowclough, 2005). They also claim that self-injury is one way these individuals would overcome their unpleasant states of emotional emptiness. Arguably, enabling users to learn how to tolerate boredom and develop useful relationships and as well as engaging them in meaningful activities of their choice would alleviate the problem of self-harm.

9.3.2 Meaningful User Involvement

One of the reasons frequently mentioned by participants for the occurrence of self-harming behaviours is unbearable distressing experiences encountered by individuals. Claims have been made by several workers in the field of mental health nursing and by some participants of this study that these disturbing encounters are unique and known only to the individuals' concerned (Baker, 1988; Stevenson *et al*. 2002). It could therefore be argued that people are leading experts in their lives and life experiences, which are accessible to a collaborative approach of care. A participant agreed with this when discussing the effectiveness of care provision.

> *In terms of the care we provide here, I feel they are effective. This is because they have prevented a number of service users from harming themselves and taking their own lives. Here we engage them in a range of activities such as talking to them about care plans, listening to their views of why they harm, talking about alternatives to this and discussing future plans. Service users I have worked with liked these sorts of things* (Ade, Fg: 4, 5).

It is explicit from the above account that users of mental health services would like to be treated as capable and resourceful people with at least some responsibilities for themselves. Acknowledging this, mental health practice should be about working and caring with rather than working and caring for service users. Some participants were of the opinion that it is only through such partnership that healthcare professionals would explore what service users think, feel and know about themselves and the problems that even brought them to the service. This is certainly the case as explained by this participant.

> *I always want to know more about the service users. So, I work with them rather that telling them what to do. Erm...erm...doing things this way, they open up and this gives me the opportunity to explore their thoughts and feelings. I sometimes use activities of their choice as a platform to facilitate engagement and exploration* (Olu, In: 3, 3).

The provision of choice was acknowledged by Olu as a significant aspect in mental practice for empowering service users. Other participants agreed with this and asserted that individuals who self-harm would need to be allowed informed choice in their care for specific reasons. It is this value of choice and underlying reasons for providing the same in practice that are now explored.

9.3.2.1: Provision of Choice and Engagement

Significant claims were made during interviews by a number of participants. They stressed that some users in mental health settings, particularly those in secure environments, have

been extremely disempowered over the years by a range of mental health practices. Examples of such practices mentioned at interviews include making decisions on behalf of users, providing directives and expecting them to follow the same, and not providing an adequate range of activities for them to choose from. A participant substantiated this view by noting that:

> On this ward, we tend to do a lot for the service users because we want things to be done quickly. We think they would slow us down, waste our time. So, we tell them what to do and most of time, we do things for them. We hardly involve them in decision making. Apart from this, we have specific routines which they are expected to follow. They should eat their meals, retire to bed, take medication and attend to activities at specific times (Loveness, Fg: 6, 8).

Caring this way especially if it takes place over a prolonged period of time can lead to unhelpful dependency in which individuals become reliant on care givers to address their needs. A participant provided explanations of episodes of dependency that relate to a specific user.

> I am a keyworker for a service user on this ward. This man always waits for me and sometimes waits for my colleagues to do even the most basic stuff like going to the shops to buy a can of coke. He has unescorted leave. Erm... erm...this means he can go out on his own; he does not need to be accompanied by any member of the ward team. The problem of going to the shops always happens; happening every week. Another basic issue is that staff have to decide for him what cloths to put on. This seems to be happening every morning. He is certainly capable of making such decisions (Petrolina, Fg: 6, 9).

The behaviours referred to in Petrolina`s narrative indicate that the service user was heavily dependent on his keyworker and other members of the clinical team to meet his needs and wants. It is important to stress at this stage that such a presentation is not apparently consistent with the wishes of other service users. This view is a function of the claim made by most participants that users generally liked to be actively involved in their care and treatment. A participant of a focus group echoed this opinion.

> Service users would like the opportunity to contribute to their care, opportunity to make suggestions. It is all about empowerment. It is about developing a collaborative relationship between us; users and professionals (Philip, Fg: 3, 10).

Similarly, another participant provided explanations of service users` wishes when asked to talk about what individuals who self-harm need most in practice.

> They need determination and commitment from the service providers; people who are ready to listen to and support them. They also need help from family members. What I think is very important is that they would like to get involved and to take some responsibilities in their care (Jackson, Fg: 2, 9).

The discussions so far presented have focused on the importance of user involvement. What is now needed to be examined, even if brief, is how this concept can be operationalised in clinical practice. An attempt to do so was made by a participant in her discussion of factors that would enhance relationships

> *One thing I have recently realised is that service users liked to be involved in their treatment. We involve them here in formulating care plans and setting goals. I do so with my service user. We work together to review his care plans. Erm...erm...and even the goals we set. I also make sure that he is provided a choice of activities. This is important because it keeps him going* (Abiola, Fg: 5, 10).

Even though that the provision of choice is a significant part of the process of empowerment, as it teaches people not just to follow suggestions provided by others and decision making skills, it effectiveness cannot always be guaranteed because of these reasons. Several studies have clearly indicated that users of mental health services, particularly those with self-harming behaviours, are generally unhappy about the way they are treated by healthcare professionals (Tantam and Huband, 2009). This assertion is a function of certain claims made by services users that they are hardly listened to in care settings and feel unsupported by healthcare practitioners (McCann *et al*. 2006). Certainly, such feelings would result in users losing hope and faith in healthcare services. Arguably, such experiences would have a negative impact on people`s help seeking behaviour. In other words, the feelings of loss of hope would distract users from actively engaging with practitioners. To address this problem, it is important that other strategies for enhancing interaction (such as provision of choice) in clinical practice are complemented by those for restoring hope.

9.3.2.2: Enhancing Hope and Motivation for Change

Feelings of hopelessness are frequently associated with individuals of self-harming histories and this is more likely the case for those who have been sexually or physically abused (Babiker and Arnold, 1997). It is noted in the narratives that, most, if not all, users of the study site have suffered some form of abuse in their pasts. They also claimed that these users, in the main, tend to report feelings of confusion; confusion that could be attributable to their distressing and overwhelming histories of abuse. Some participants believe that minimising confusion would enable users to start to regain some faith in services and hope for a better future. There appears to be some agreement between few participants that developing a therapeutic relationship with users, setting achievable and realistic goals or

targets in care settings, are potent means for minimising confusion and instilling hope. A participant explained:

> *You are right that safe self-harm would reduce rates of harm in the long run. But what we should regularly do here is to instil hope in the users; create a feeling in them that things would one day get better. But you know one cannot do so outside a good relationship. We need to form relationships with them, discuss what they enjoy doing and what they hope to achieve in the future. Users who self-harm are usually unclear about these issues. They can be made clearer in relationships. As practitioners we have a big role to play. Most of the service users if not all has lost hope in life. They were abused in the past. Enabling them to be hopeful is important* (Abiola, Fg: 5, 4).

Instilling hope in users who self-harm is certainly a slow and subtle process, particularly when it involves those with negative perceptions of healthcare services. The role of practitioners is therefore of paramount importance in this process with its success dependent on their optimism, knowledge about users and attention to detail. A succinct explanation of this was provided by a participant when discussing poor attitudes.

> *Poor attitudes are when you are judgemental, when you talk down or look down on someone. It also includes calling users names such as timewasters and attention seekers. We sometimes lose hope that we cannot help them stop their behaviours. It is this loss of hope that...erm...erm...leads to this name calling. But as professionals we should always be hopeful and optimistic that they can achieve, stop or reduce their behaviour one day. Service users would sense this optimism and it does help them to cut down on their behaviours. So, if we are not hopeful, they would do it over and over again like a roller coaster* (Peter, In: 13, 4).

The importance of developing an optimistic stance was re-emphasised by another participant, but this time, when talking about positive attitudes.

> *From a practitioner point of view, you have to be optimistic in your approach to help these users avert their behaviours. It is always good to be positive about the outcomes of care. Basically, to have a positive outlook helps and this transcends to service users. People who have suffered abuse need this. Most of them here have lost hope in life and are really not sure about what they want. But being committed and optimistic might help them stop at some point* (Philip, In: 12, 4).

Being optimistic is not just about having faith that service user would at some point in their lives stop or at least reduce the rate of their self-harming behaviour, it is also about believing that they are adults who are capable of managing their own affairs. Acknowledging this notion of capability and the potential of individuals to become autonomous beings if supported, some participants repeatedly spoke of shifting responsibility of care to users as a better approach to service provision. Discussions relating to how this is carried out in practice were examined.

9.3.3: Shifting Responsibility

Differential perceptions with regard to the issue of giving responsibility to service users in secure forensic settings were noted among participants. Participants who were apparently not in favour of this idea generally spoke of the use of observation, restraint, protective clothing and searching as appropriate and better options for meeting the needs of individuals who self-harm. While these approaches may be suitable for service users in the short term, prolonged exposure to these strategies could demotivate them as well as reinforce their behaviours. It was for this reason that some participants advocated alternative approaches that would help service users to express and manage their feelings and assume more control of their behaviours. An example of such approaches is safe self-harm.

9.3.3.1: Safe Self-Harm: Allowing Self-Harming Behaviour

Although this strategy for managing self-harming behaviour is not practiced in the clinical areas of the study site, it was discussed by some participants as illustrated below.

> *I think service users should be provided the opportunity to harm themselves. Of course, we cannot do this for all of them, as it has huge implications. You know some of their behaviours are influenced by the voices. The voices may tell them to hurt themselves. So, one has to be cautious when applying such an approach. Safe self-harm is really about teaching individuals how to harm safely. This is to be done in a controlled environment. They are taught about safe places to hurt themselves. They are also given dressing packs and sterile blades to cut themselves if they feel like doing so and to attend to the wounds themselves. One key thing about safe self-harm is that a care plan has to be made jointly with the user identifying what to and what not to do* (Adam,Fg:1,2).

Implicitly, this approach is suitable for service users whose behaviours are not influenced by hallucinatory and delusional experiences. For this user group, some participants believed that it would allow them to exercise control over their own self-harming behaviours, which, in turn, would result in reduced rates of the same. This view is substantiated in the excerpt that follows.

> *Providing self-harm packs and educating service users where to cut themselves and how to treat the wounds would help reduce self-harm rates. This method should be used selectively; not on all categories of users* (Bola, Fg: 1, 3).

More support for safe self-harm was provided and the rationale for this was articulated by a participant when discussing what service users would need most in care.

> *I think we should sometimes leave them alone; allow them to hurt themselves. Service users have the right for free expression. Not allowing them to do so would lead to, in the long run, more self-harm and possibly serious ones. I must say that restraining and*

observing them only manage the here and now risk of self-injury. What I think we also need here is a self-harm group. It is good and I have seen it somewhere. Users like it (Philip, In: 12, 3).

Apart from safe-self-harm, the value or benefits of establishing a group for users who self-harm was noted in participants` narratives.

9.3.3.2: Self-Harm Group

Many people who self-harm have at times a great need for emotional support. However, because of their past negative experiences, asserted by participants, some find it extremely hard to seek and even accept professional help. Failure to reach out for help could lead to the use of self-harming acts as a means of relieving distressing emotions. This indicates their need to be allowed time to talk in an unpressured way. A self-harm group serves as a forum that would ensure psychological safety for emotional expression. A participant confirmed:

I know that harming oneself is indicative of serious emotional difficulties. So, talking about these difficulties would release some tension. Some users I cared for in the past acknowledged this. They found giving them time and encouraging them to talk helpful. It was even more helpful when allowed to share experiences with people of similar problems. Erm...erm...because they felt free and safe to disclose things; personal issues. They realised that they were not the only people with this problem of self-harm. They became more aware of their issues and behaviour. On my ward, we have a self-harm group recently set up. I always encourage them to attend (Joe, In: 9, 2).

Sharing problems in a group can help people feel less alone. In addition to this, the group setting, as noted in Joe`s reflective account, offered support as it allowed users to express their emotions and in the process enabled them to develop a better understanding of their behaviours. A participant reiterated:

A self-harm group is a sort of a self-help group for people who tend to hurt themselves. The one we have on our ward is usually chaired by a user and attended by just one staff member. It is an open forum and the key issues discussed were self-harm, causes, coping and future plans. One service told me that he has benefited from attending. He learnt a lot about his behaviour and would stop doing it because group members taught him a better way of coping with problems (Zainab, Fg: 6, 5).

9.4: Summary

This chapter has presented a detailed examination of care strategies for individuals who self-harm. It has highlighted that the approaches to care adopted by healthcare professionals in secure forensic settings are influenced by a multitude of factors. Examples of these influences include practitioners` attitudes towards care and the knowledge and skills of the same, and most importantly, service users` presentation. Acknowledging the significance of

developing an understanding of service users` behaviour, it was suggested in the discussion that care provision should always commence with a risk assessment. This was a function of the view that risk assessment would enable practitioners to identify a specific approach or approaches that would help to best address the needs of service users.

Two broad care strategies were identified; restrictive and empowering. With regard to the restrictive approaches, which include observation and restraint, they were noted by participants of this study to be effective only in the short term in stopping or reducing self-harm. In contrast, the empowerment approaches that may include provision of choice, safe self-harm and self-harm groups were considered to have long term benefits for users. In this case, users are enabled to develop an awareness of their behaviour and learn alternative coping strategies other than self-harm for emotional expression. It is important to highlight that both of these strategies have a place in the care and treatment of individuals with self-harming behaviours. The factors which may influence their use are illustrated diagrammatically below in figure two.

Figure 2: Factors Influencing Care Approaches (FICA)
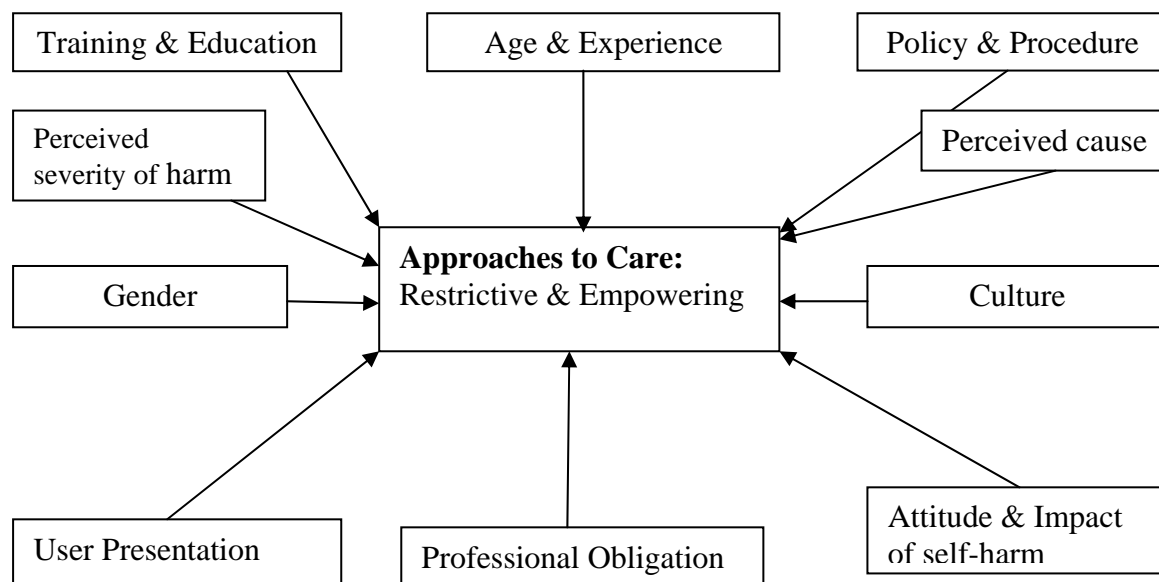
The direction of the arrows is important. Because the sub-themes are seen to influence healthcare professional responses to service users, the arrows are shown to terminate at the theme of approaches to care.

This chapter together with the three preceding ones has presented the results of this thesis. Results are certainly an important part of an IPA study as they are one of the media through which readers can access and begin to understand the lived experience of participants. Hence, from an IPA perspective, they are required to be detailed and discursive, as presented in this work, relative to a typical qualitative study (Smith and Eatough, 2007). Understanding of participants` experiences as reflected in the transcripts needs to be enhanced. To achieve this, a separate section is devoted to examining the results in relation to the extant literature. This is in essence referring to the final discussion chapter that follows.

<h1 style="text-align: center;">CHAPTER TEN</h1>

<h1 style="text-align: center;">DISCUSSION</h1>

10.1: Introduction

As part of the initial processes of conducting this study, a comprehensive literature review was carried out. This revealed a massive disparity between healthcare professionals and users in their understanding of the meaning and functions of self-harm. For the users, it serves as a means of communicating emotions. In contrast, healthcare professionals consider it as a medium that individuals use for seeking attention. Whilst such a differential perception has made users accuse healthcare professionals of having a poor understanding of the important functions of this behaviour, it could also lead to the provision of care that is inadequate and inappropriate. In relation to the latter view, claims have been made in the literature that users have been treated with anger and distance whenever they hurt themselves. It is such attitudes that served as the impetus for this study, which aimed to explore healthcare professionals` feelings and behaviours toward users who self-harm in secure settings.

A wide range of attitudes, care approaches and explanations of self-harm have been identified in this inquiry. While each of the issues is explored here briefly, lengthier discussions relating to them can be found in the Literature Review and Result chapters of the thesis.

The four previous chapters presented the findings of the study. This chapter aims to provide a coherent overview of the findings and how they relate to the existing literature. It commences with a set of conclusions drawn pertaining to factors which may lead individuals to harm themselves. This is followed by a discussion of the impact of this behaviour on healthcare professionals. A wide range of strategies is available in clinical practice for practitioners to use to cope with the impact this behaviour generates. Although these strategies were identified and examined in one of the result chapters, they are discussed here in relation to the existing literature. The chapter concludes with an examination of the attitudes towards self-harm and factors influencing the same.

10.2: Explanations of Self-Harming Behaviour

A broad range of reasons for self-harm has been identified in the literature. Although professionals sometimes attribute attention seeking and manipulation as motivations for this behaviour, the reasons generally mentioned in the literature tend to focus on coping, communication of emotions and control (Sadler, 2002). These reasons are discussed here in relation to those presented in the narratives of participants.

10.2.1: Issues of Control

Several reasons were cited by participants of this study for service users` self-harming behaviours. Issues to do with control, which include feeling out of control, loss of control and the desire to regain control, were frequently discussed during interviews. Clearly, such a multiplicity of reasons is an indication of the complexity of this behaviour. While this is the case, it is necessary to mention that these findings share similarities with previous studies. Taking for example the feelings of being out of control, reports are noted in the literature that children in abusive encounters are believed to have no influence over their abusers, as they can be physically and sexually molested at anytime (Shepperd, 2003). It is the opinion of the researcher of this study that exposure to protracted periods of abuse could result in these children becoming accustomed to the experiences of pain. Arguably, when children who have had such encounters grow to adulthood and are faced with difficult relationships or stressful situations, they are more likely to expect to be maltreated. While this assertion is attributable to their previous associations of pain with stress, it articulates why adults who have been physically or sexually abused tend to resort to self-harming behaviours. Cerdorian (2005) supports this view by claiming that engagement in this behaviour tends to satisfy people`s learned desire for pain; pain that could either be physical or psychological or both.

It is reported by participants of this study that some approaches to care such as observation, restraint, searching and the use of protective clothing remind service users of their past experiences of abuse. While these are recognised practices regularly used in secure mental health settings for preventing or stopping self-harming behaviours, they are described by participants as oppressive, intrusive, controlling and restrictive. The use of such descriptors was based on the notion that these approaches restrict the freedom of users and permit healthcare professionals to invade the privacy of the same. In addition to this, using them indicates healthcare professionals` awareness of the effect on service users of the controlling

and invasive nature of interventions used in the name of safety. Goffman (1961) agrees with this and provides an explanation using the experiences of individuals from abusive families. He asserts that restriction and invasion of privacy do regenerate feelings of traumatic childhood experiences for individuals with histories of abuse. Such feelings, Goffman (1961) claims, could lead to the development of psychological tension that requires a safety valve for safe expression. For users with these experiences, self-harm is a safe medium for emotional expression as it is a behaviour which they have total control of. Arguably, using self-harm in this way could be regarded as a continuation of abuse on behalf of abusers.

Clearly, approaches which restrict service users` freedom have the capability of increasing rather than decreasing self-harm rates, a view also echoed by Gournay and Bowers (2000) and Philips (2004). It is essential to stress that these strategies merely aim to change users' behaviour rather than enabling them to address their emotional needs. This failure to deal with underlying distressing emotional issues in part contributes to self-harm. What is also believed to contribute to self-harming acts in this study is the forceful nature of these treatment approaches. Apart from them enhancing treatment fearfulness, they are believed to be experienced by users as forms of abuse (McAllister *et al*. 2003). Together, these factors may perpetuate the need to injure oneself.
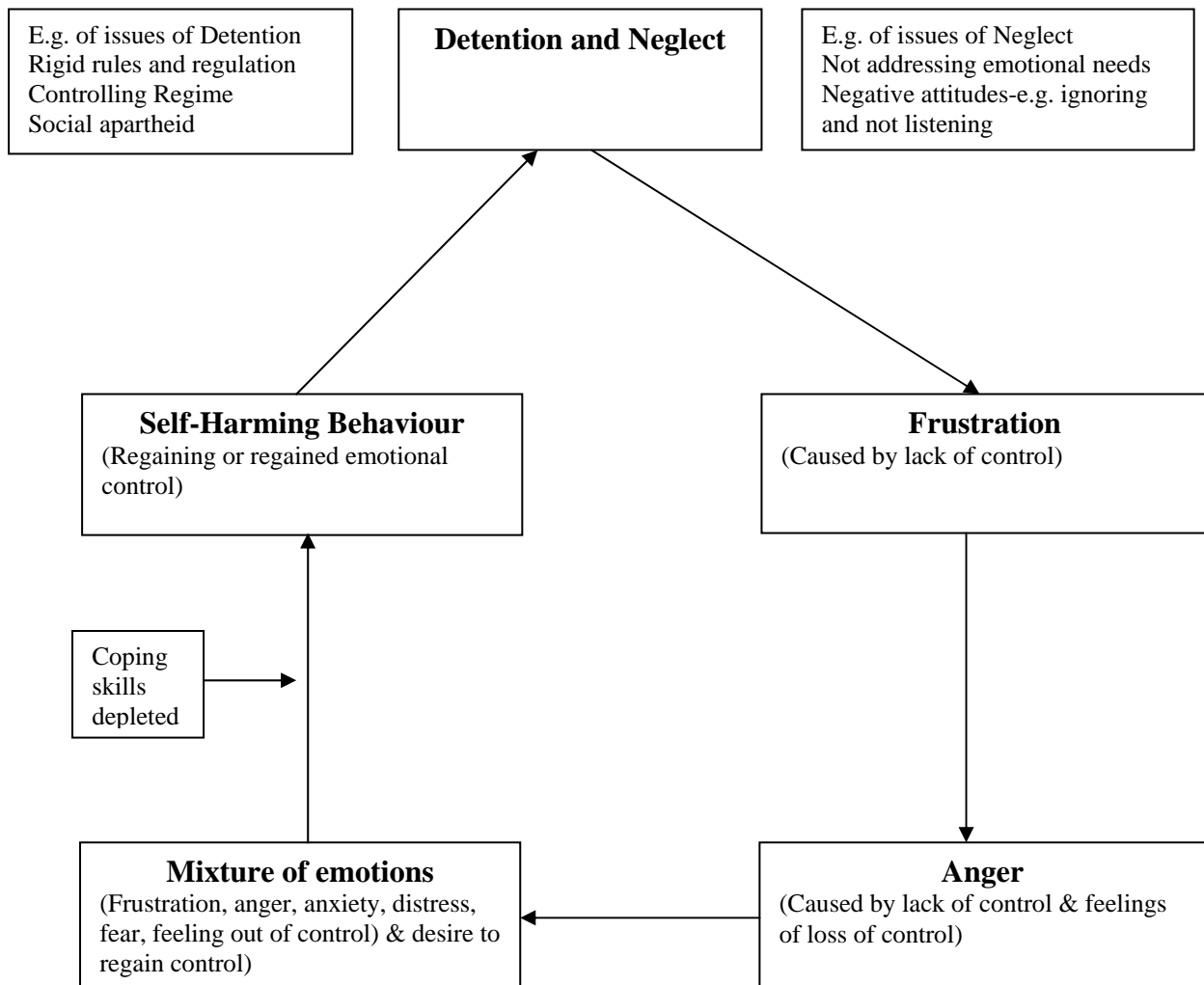
Despite this potential for increasing the occurrence of self-harm, controlling strategies are still used in practice for its prevention. According to participants of this study, such usage is not only influenced by practitioners` professional responsibility, that is the of duty of care to prevent harm, especially in instances where risk is perceived to be high, but their use in forensic settings can also be attributed to fear for litigation. Thus, responding to incidents of self-harm using these approaches helps in alleviating anxieties or worries experienced by healthcare professionals. A cursory glance at the narratives revealed positive outcomes of controlling approaches. It is noted by participants that these strategies helped in their clinical practices to stop and prevent self-harm with their effectiveness being significant in situations of high risk. So, even though they may generate uncomfortable feelings, some participants advocated their use in practice to manage self-harming behaviours.

It is becoming a common knowledge among practitioners that secure environments are hotbeds for self-harming behaviours (Gough, 2005). Similar outcomes are reflected in this study as participants reported that some users only commence acts of harm when detained in

forensic mental health settings. This is certainly not surprising as a number of researchers have consistently cited that being detained and neglected, characteristics which are inherent in secure environments, are significant risk factors for self-harm (Tantam and Huband, 2009). It is essential to state that acts of neglect are manifested in these settings because of a social and psychological gap that exists between users and healthcare professionals (Goffman, 1961). Simply, this means that the latter are providers of care and instructions, whilst the former are expected to comply with rules, regulations and care provided with little or no allowance for self-expression. Not having control in such encounters could result in the users (recipients of care) becoming frustrated, anxious, angry and feeling out of control. Such a cocktail of emotions, which are more likely to be underpinned by strong feelings of being out of control and frightening experiences, would certainly require immediate but safe expression (Dollard *et al.* 1939; Hale, 1999). Self-harm is believed to be the safest channel for venting these emotions, as users may feel uncomfortable to externalise the same against others for fear of repercussions. It certainly plays a part in enabling users to address their desire for regaining emotional control. Feeling in control of ones emotions would enhance individuals` perceptions of safety.

It could be postulated that the provision of care within an atmosphere of a social and psychological apartheid could be disempowering for users. This is apparently the case, as it is reiterated by some participants that care provisions in secure care settings are generally not carried out in partnership with users. This manner of care exchange would certainly over a period of time deplete users of essential life skills including those of problem solving, leaving self-harm as one of the few options for addressing life difficulties (Neuringer, 1971; Pollock, 2000). While this study partially supports this view, there are indications in the narratives that the use of coping skills is situational and it is only in some instances that "normal skills" are hindered; not applied. Examples of these include situations where individuals feel controlled and being out of control. Thus, exposure to such circumstances in practice, coupled with depletion of skills, may result in users utilising self-harm to regain emotional control. The apparent relationship between self-harm, control and depletion of coping skills is illustrated diagrammatically below in figure two. This enables the reader to develop an overview of the context in which self-harm tends to occur. The direction of arrows in the diagram shows the sequence of events which relate to aspects of control that may lead to self-harming behaviours.

Figure 3: Self-Harm Explanatory Model (SEM)

E.g. of issues of Detention Rigid rules and regulation Controlling Regime Social apartheid	**Detention and Neglect**	E.g. of issues of Neglect Not addressing emotional needs Negative attitudes-e.g. ignoring and not listening

Self-Harming Behaviour
(Regaining or regained emotional control)

Frustration
(Caused by lack of control)

Coping skills depleted

Mixture of emotions
(Frustration, anger, anxiety, distress, fear, feeling out of control) & desire to regain control)

Anger
(Caused by lack of control & feelings of loss of control)

As already stated the desire to achieve emotional control is not the only motive for self-harm, individuals also tend to engage in it to attain a state of emotional calmness when distressed. It is this function that is now discussed mainly from the perspective of healthcare professionals.

10.2.2: Emotional Expression

A number of researchers have consistently cited that coping with unbearable feelings is one of the most common motives for self-harming behaviours (Hawton *et al.* 2007). It is also noted in this study and in the literature that this manner of dealing with distress is utilised by people for a range of reasons (Babiker and Arnold, 1997), reasons which are influenced by individual differences in perception of the impact and sources of distress. Perhaps, the most frequently reported purpose, as asserted by Snow (2002), is regulation of distress, a finding

consistent with the views of participants of this study. Some participants claimed that users in their clinical areas usually bottle-up angry emotions that are by and large generated by the overpowering and malevolent nature of secure environments (Favazza, 1996). In these circumstances, individuals will be become stressed and such stress can ultimately lead to anger and frustration if the problems are not addressed. In such a heightened emotional state, customary ways of coping, which include social interaction and activities, are usually ineffective in restoring emotional calmness. Although Eidhin *et al* (2002) support this view in their study that relates to suicidal ideation and problem-solving deficits in offenders, they failed to provide alternative suggestions for tension reduction. This failure is attributable to the focus of the study; exploring the relationship between deficits in problem-solving and self-harming behaviours. However, there appears to be a growing consensus among many researchers that self-harm is an effective means for minimising tension to bearable levels, an opinion also reflected in this inquiry (Hertpertz, 1995; Hartman, 1996). Such usage could negatively reinforce the behaviour when people in heightened emotional states achieve calmness or reduction in tension. Arguably, self-harm can be considered a learned behaviour. This means that people who have maintained a calm emotional state by hurting themselves may continue to do so whenever they encounter unbearable experiences, since unbearable encounters are unpleasant and uncomfortable places to be.

Several studies have shown that negative reinforcement, reduction in tension, maintains self-harming behaviour (Walsh and Rosen, 1989). It is therefore not surprising to note an increase in repetition of this behaviour in clinical practice (Owens *et al*. 2002). Notably, such an increase seems to indicate persistent and re-occurring distress in those repeating the behaviour. It is probably because of repetition that made some participants to regard self-harm as a habitual behaviour.

In clinical practice, repetition of self-harm is mostly associated with service users with a diagnosis of personality disorder (Liebling *et al*. 1997). The emotions commonly observed in this user group particularly in forensic mental health settings are frustration, guilt and anger. It is worth mentioning that users with this diagnosis usually have a history of some form of abuse and the emotions which they express are often in essence relics of their past abusive encounters (Babiker and Anorld, 1997). For these users and perhaps for others, the restrictive and intrusive nature of approaches to care in these environments, purportedly used in the name of therapeutic engagement, are forms of abuse that remind them of their past ill-

226

treatment (McAllister *et al.* 2003). These approaches also bring to the fore the teachings from their abusers that they are bad and deserve nothing but punishment (Babiker and Anorld, 1997). It is these reminders that are believed to enable users with these experiences to develop negative feelings about themselves such as self-hatred, an opinion which appears to be congruent with that of Clarke and Llewelyn (1994:274). It reads:

> *The child learns as a result of being abused, the behaviours and cognitions appropriate for being abused and incidentally for abusing.*

As already stated, it is explicit from the above statement that self-harm is a learned behaviour used by people to express tormenting cognitions and associated emotions. It thus appears to offer people a sense of calm, satisfaction and relief (Harrison, 1995). Acknowledging this, it is regarded in this study as a safer way of alleviating emotions of self-hatred and anger against abusers. Taking this argument of emotional relief further, participants of this study seem to believe that people who have been exposed to distressing events, on occasions, do experience mounting internal tensions with overwhelming thoughts of wanting to kill themselves. Self-harm is used in these extreme cases to facilitate emotional release with a view to relieving affected individuals from emotional distress. Simply, it serves an alternative to suicide in instances where people feel unsafe and being out of control of their emotions. It is therefore a coping strategy considered by participants to offer users a sense of emotional control. A detailed examination of the discussions presented so far reveals the existence of a common motive of suicide aversion between healthcare professionals and users. This assertion is based on the view that the latter (users) are reported by participants to occasionally use self-harm as a strategy for preventing cessation of life. This shared intention has implications for reinforcing the behaviour with the possibility of accidentally or intentionally causing severe acts of harm. It is therefore imperative for healthcare professionals to adopt alternative strategies that would enable users to express their distress as well as tackle its root causes. Doing so, Philips (2004) asserted, would alleviate the behaviour or at least reduce its occurrence.

Self-harm is a coping mechanism for underlying problems, problems which people find difficult to accept and express verbally (Tantam and Huband, 2009). Thus, engaging people in approaches that would enable them to develop the ability to accept their underlying feelings and learning how to express them verbally is considered a valuable step for gradually reducing and subsequently stopping reliance on self-harm. One such strategy proposed by

participants of this study, but which most professionals fear because of the threat of litigation, is safe self-harm (Pembroke, 1998). This approach allows users to harm themselves safely in the presence of practitioners using clean implements provided by the same (Kirby and Norris, 1998). It has been reported in the literature to be successful not only in lowering self-harming rates, but also in stopping the behaviour as well (Fish, 2000). Another approach discussed in this study that appears to offer similar benefits to users, purely because it also promotes therapeutic interaction and learning, is self-harm group. Despite all these efforts to tackle the problem of self-harm, its rate is still noted to be growing even though it is becoming increasingly familiar to healthcare professionals (Cooper *et al*. 2005). This growth could be attributed to the view that it is still poorly understood in mental health practice (Clark, 2002). In view of this, the growing rate is regarded in this study as a call for more time to be created in clinical practice to understand what self-harm really means from the perspective of service users.

10.2.3: The Language of Self-Harm

The relationship between self-harm and difficulties with verbalising emotions is frequently cited in the literature and by some participants of this study. It is thought that individuals who self-harm generally have limited ability to use verbal communication for dealing with distressing feelings (Favazza, 1996). It is worth mentioning that the verbal skills of users are usually depleted in environments, such as secure settings, which discourage individuals` efforts to freely express themselves (Pollock, 2000). Consequently, users who harm themselves in these environments are more likely to be left with a repertoire of self-harming skills if detained over a protracted period of time. Even though they may appear maladaptive to healthcare professionals, for service users, they appear to serve the same function as using a language to communicate feelings, a view reflected in participants` narratives. Noting this, self-harm is therefore regarded in this section of the thesis as a language, with a range of dialects, people sometimes use to express themselves.

This notion of language to some extent contradicts the concept of contagion, which refers to patterns of self-harming acts within specific settings in which people harm themselves by imitating the behaviour of another (Taiminen *et al*. 1998). It must be stated that some participants of this study claimed that service users do sometimes copy the behaviour of others. It is important at this point to re-emphasise that people who self-harm are usually

aware of their emotions and how they intend to express them. They might not be knowledgeable about the motives behind the behaviour (self-harm) of others. Hence, referring to self-harm as a contagion (copycat behaviour) does not only indicate disrespect for the individuals concerned, it also suggests that they have limited knowledge or at worst no knowledge of their actions. The use of the notion of contagion therefore suggests professionals` limited knowledge and poor understanding of self-harm, as individuals are generally clear about the reasons for their behaviour. It is these reasons that users intend to communicate to themselves and others using the language of self-harm, a "language of distress" with many dialects represented by the different methods of self-injury.

As a language, self-harm, particularly self-mutilation (cutting), serves as a physical and concrete form of conveying a message of inner discomfort for individuals deficient in skills of verbal expression. For instance, participants highlighted during interviews that the size and depth of cuts individuals inflict upon themselves often indicate the level of distress that they intend to communicate. Taking this into account, it is imperative for healthcare professionals to work closely with users to explore and learn about the underlying motives for their behaviours. This is because individuals are more likely to give up self-harming when traumatic feelings become understood and accepted as part of the self (Miller and Rolnick, 2002). Development of such understanding would not only result in more respect for the self, it would also enable individuals to adopt alternative means for communicating emotions. The latter would also help to decrease the need to self-injure. Unfortunately, this way of working does not appear to be a priority in secure settings.

Apart from limited training of healthcare professionals about self-harm, the focus in secure settings, as reflected by participants of this study, is risk management. So, the issue of what individuals are attempting to convey is not of immediate concern and are therefore usually ignored. It is fair to state that healthcare professionals do sometimes make attempts to understand the motives underpinning self-harming behaviours. In the main, self-harming acts and intentions behind them are often misunderstood and misinterpreted (Clark, 2002). Such misinterpretation is reflected in the use of negative descriptors, such as manipulation and attention seeking, to describe the behaviours. Similar outcomes are noted in this study as participants clearly refer to users who self-harm as timewasters. This is worrying as such misunderstanding could result in inadequate and inappropriate service provision. It is probably right to state that such professional misunderstanding is not an intentional act; it is a

function of individuals being communicated to in a language they have difficulties comprehending. Certainly, this has an impact on both users and healthcare professionals. For the users, it could enhance their distress, which in turn, may lead to more acts of harm. With regard to healthcare professionals, it could generate a mixture of negative feelings, which could include anger and disappointment particularly if the behaviours are repeated. These issues are explored in more detail in the subsequent section of this chapter.

10.3: Impact of Self-Harm

There is evidence to suggest that mental health settings, particularly secure services, are often highly emotionally charged by the frequent occurrence of self-harming behaviours. In these settings, as indicated by participants of this study, healthcare professionals may experience feelings of frustration, distress and anger, especially when repeatedly exposed to self-harm. McAlaney *et al* (2004) agreed with this and provided a succinct rationale for the presence of this cocktail of emotions. They asserted that such emotional reactions are attributable to the cumulative effect of perceived senselessness of the behaviour and repetition, with the latter creating a huge demand on time for care provision. It is obvious that the emotional reactions experienced by healthcare professionals are directed against service users who self-injure. Undoubtedly, this has implications for practice both in the context of relationship building and care provision.

The researcher of this study believes that anger is part of a normal reaction to difficult circumstances. The literature of self-harm and the narratives of this inquiry clearly indicate that healthcare professionals do perceive caring for individuals with this behaviour to be challenging (Cook *et al*. 2004). It is therefore not uncommon for anger to be expressed towards service users in clinical practice. From experience, this would be more noticeable in circumstances where users are perceived as deterrent of efforts to achieve therapeutic goals. Simply, self-harming behaviour would be perceived extremely frustrating in cases where significant progress is impeded by single or multiple episodes of the same. Barrow (1994) reiterates this claim, but related it to therapeutic engagement. He stated that distressing emotions experienced by healthcare professionals can interfere with the development of therapeutic relationships with service users and may even damage existing ones. While this opinion appears to be consistent with some of the assertions made by some participants in this study, in contrast, other assertions provided gentle reminders of practitioners`

professional responsibility. They appear to stipulate that practitioners should always continue with their professional effort to engage with service users irrespective of feelings evoked by the behaviours of the latter. Not doing so, in other words, adopting an evasive stance would increase the risk for more self-harming behaviours (Owens *et al.* 2002) and eventual suicide (Hawton *et al.* 2003).

The mere thought of these outcomes would be worrying for anyone and it would be even more worrying for healthcare professionals who are committed and willing to offer care to service users with a potential to self-harm. Apart from these issues of commitment and willingness, healthcare professionals in mental health services are sometimes worried about being held accountable for service users` acts of self-harm (McAlaney *et al.* 2004). It is therefore not surprising for practitioners in these areas of practice, to feel vulnerable to blame when incidents of these behaviours are noted to be growing and / or severe. These circumstances are more likely to generate a strong desire for protection. Reports of the use of strategies, such as protective clothing and observation, to alleviate incidents of self-harm were noted in participants' narratives. Interpretation of these reports suggests that the desire to adopt protective approaches was to prevent self-harm and to alleviate practitioners` anxieties evoked by the behaviour. Taking into account the notion of alleviation of anxiety, it is probably right to state that self-harm does negatively reinforce the use of these interventions. Arguably, healthcare professionals would be attracted to use these strategies when faced with self-harm. Motz (2001:182) confirms this:

> *Healthcare workers caring for people who self-harm may feel alternatively drawn towards them in a protective capacity and horrified and repulsed by them as emotions of helplessness, anxiety and incompetence were aroused.*

It appears from Motz`s account that attempts to respond therapeutically to service users who self-harm can create feelings of hopelessness and helplessness. Such feelings are believed to be experienced when self-harming behaviours are repeated against a background of significant efforts to offer help (Loughrey *et al.* 1997). Very similar emotional experiences were reported in this study and examples of these include feelings of failure, loss of hope and fear of making issues worse. Some participants of this study, and researchers on the impact of self-harm, do believe that these feelings can distract healthcare professionals from providing care to service users (Shepperd *et al.* 2003). It could be assumed that such a distraction is a function of limited or lack of confidence and knowledge about self-harm and how to effectively engage with individuals who present with this behaviour. The outcome of

Gough and Hawkin`s (2000) study appears to support this view. They concluded that frustrating experiences that are encountered during care provision are attributable to practitioners` limited training and understanding of the phenomenon of self-harm, a view also echoed by some participants of this study. Thus, receiving specific training and greater experience with self-harm may increase practitioners` understanding of the same. It is believed that such understanding may result in the development of positive attitudes towards this user group. Although participants had no formal training on self-harm, some asserted during interviews that exposure to self-harm should be the catalyst for commencing and enriching engagement. However, there was an apparent agreement among a good number of participants that caring for people who present with this behaviour can be a frustrating and draining experience. It is therefore critical for practitioners working with this user group to find effective ways of managing these emotions to prevent or minimise possible negative effects on the self and care provision.

10.4: Coping with impact of Self-Harm

It is evident in the literature that a good number of researchers have explored the range of emotions which may surface in professionals that work with people who self-harm. Examples of such researchers include Loughery *et al* (1997) and Favazza (1998). Healthcare professionals were noted in these studies to express feelings of discomfort, shock, anger, incompetence and dejection in their interactions with users especially those who cause themselves concrete physical harm. It makes sense to assume that the impact of these emotional reactions would be greater when individuals are repeatedly faced with self-harming behaviours. Frances (1987) agrees with this by stating that healthcare professionals are often left feeling helpless, hopeless, unproductive and disgusted when treating individuals who frequently hurt themselves. Obviously, such a mixture of emotional experiences is an extremely uncomfortable zone for people to find themselves in. People in these situations would earnestly search for strategies that would enable them to effectively manage their emotional state. In other words, individuals in these circumstances would endeavour to find ways of reducing their disturbing feelings to bearable levels. Taking such a stance is what is referred to as coping. In technical terms, it refers to behavioural and cognitive actions individuals adopt to reduce the impact of stressors, such as self-harm (Lazarus and Folkman, 1984).

In this study, participants reported that staff meetings, teamworking and seeking knowledge are some of the approaches healthcare professionals use to cope with the impact of self-harm. Starting with seeking knowledge and skills, some participants of both focus and individual interviews emphasised their need for training on the subject of self-harm. This is suggesting that their present level of skills and knowledge is not adequate for them to effectively care for people with self-harming behaviours. If this is the case, these professionals should not be expected to provide care on their own. In addition to putting users at risk of receiving inadequate care, allowing them to do so might make them feel anxious and incompetent about how to understand and deal with self-harm. One needs to emphasise that this finding is not unique to this study. Apparently, this was the case over a decade ago as a number of researchers reported that many healthcare professionals working in settings where they came into frequent contact with self-harming behaviours have received little or no training on the subject (Babiker and Anorld, 1997; Royal College of Psychiatrists (RCP), 2004). It is therefore believed by the researcher and participants of this study that the provision of specific training self-harm would be beneficial to the latter`s professional practice. Doing so would not only enable them to develop their knowledge, skills and competence, it would also enhance their feelings of effectiveness, which in turn would help them reduce their levels of anxiety when they encounter the behaviour. Taking into consideration the issue of affect regulation and the possibility of stopping or preventing the behaviour, it could be argued that seeking knowledge serves both problem and emotion focused coping functions (Lazarus and Folkman, 1985). While education may help practitioners to achieve these functions, it is necessary to remind them that it may not eliminate the stressor (self-harm), but it would certainly help them to manage the stressor and its associated emotions in different ways. Examples of these include orgrnising meetings and working as a team.

Given the demanding nature of self-harming behaviour, staff meetings and teamworking were considered to be useful approaches for the provision of support. According to participants, these coping methods would enable healthcare professionals to identify ways of reducing the incidence of self-harm as wells as providing them safe and supportive environments for sharing and managing their emotions. Working together this way provides practitioners on-going professional support, a view also echoed by the Healthcare Commission (2004). In addition to agreeing with this assertion, one needs to point out that the simultaneous use of different coping strategies serves as a potent way of managing stressors as each may aim for a different goal. While this is the case, teamworking and staff meetings, as narrated by

participants, aimed at alleviating the problem of self-harm and addressing the emotions of practitioners with the latter appearing to be the main focus. They are therefore considered to be both emotion and problem focused coping strategies.

The final coping method in this thesis discussed by just a minority of participants is blaming. It was considered to be unhelpful because of its potential to enhance service users` feelings of worthlessness that may in turn perpetuate their need for more self-harming behaviours. As noted in the narratives, healthcare professionals are usually subjected to a range of emotions including anxiety, anger and sometimes feelings of hate, when treating people who hurt themselves. The impact of these negative emotional reactions is what Freud referred to in his dichotomous theory as *Thanatos,* the death instinct, which motivates individuals to engage in self-destructive acts (Freud, 1960). Repeated exposure to self-harming behaviours, which evoke these emotions, would weaken the life force, *Eros,* which drives individuals to engage in activities with the view of ensuring stable and calm emotional states (Atkinson *et al*. 1990). Given that these emotions are unbearable and uncomfortable, healthcare professionals would protect themselves against the same using active defence strategies such as blaming service users. Using this technique suggests that service users are bad and therefore blamed for their behaviours and for engendering a mix of tormenting feelings (like anger, hopelessness and worthlessness) in practitioners. This emotional blend may lead healthcare professionals to react negatively to service users. It is therefore necessary to explore how organisations, in this case the study site, contain and modify anxieties experienced by healthcare professionals.

10.4.1: Anxiety and Organisational Structures

A key feature of this study, which has been mentioned in a number of places in this thesis, is that caring for people who self-harm can be a difficult and distressing experience. Associated with this distress is its influence on healthcare professionals` responses to the needs of service users with this behaviour. The major responsibility for care provision of this users who present with self-harming behaviours in the study site`s organisation lies with the nursing staff. They are therefore exposed to the bulk or concentrated impact of the stresses that may arise from therapeutic encounters. Acknowledging the negative impact of stress on people`s well-being and its role in influencing care, this professional group is expected to adopt strategies for preventing or alleviating the same. An approach that is commonly attempted,

as expressed by participants, is to stop or remove the stress or anxiety-provoking stimulus, which in this case, is self-harming behaviour.

It is critical to mention that self-harm is a complex behaviour that forms a vital part of the self or personal identity of individuals. Hence, stopping it could not only be considered to be ethically inappropriate particularly by those who present with this behaviour, but it could also be a very difficult task to achieve. The latter view is echoed in this study in participants` talk, suggesting that healthcare professionals are often, or at least sometimes, exposed to self-harming behaviours they may find tormenting. Such distress is believed by the researcher of this study to be compounded by professionals' feelings of powerlessness generated by their inability to prevent the behaviour (self-harm) and / or their own distress in witnessing it. The cumulative effect of these sources of distress serves as a significant threat to healthcare professionals' professional identity and competency as care providers. Frances (1987) and Motz (2001) agree with this by commenting that healthcare professionals do experience a mixture of negative emotions during therapeutic engagement with users with self-harming behaviours. Claims are made in the literature that these emotions, which can have both internal (unconscious) and external (conscious) origins, often build up to inordinate amounts of anxiety that may threaten to engulf professionals (Menzies, 1988). It is probably for this reason the researcher of this study and McCaffrey (1998) consider anxiety to be the most important unpleasant feeling human beings experience. It is simply a response to perceived danger or "things going wrong". Walsh and Rosen (1989:3) confirm and relate this to self-harm.

> Self-harm is a human behaviour at its worst or it is an example of human beings gone wrong- as wrong is conceivable.

A detailed examination of Walsh and Rosen`s (1989) statement seems to suggest that self-harm is an inappropriate behaviour that deviates from professionals` expectations. Acknowledging its common occurrence in secure settings, healthcare professionals in these environments, especially those who are committed to offer help, have no choice but to frequently witness people "gone wrong". Such exposure to this behaviour often generates anxieties, which in Klein`s (1946) view, are either persecutory or depressive in nature. Although these anxieties are in the main unconsciously motivated, they sometimes take conscious forms. This is evident in instances where healthcare professionals find themselves ruminating over questions such as why is this user doing this to himself? (persecutory

anxiety) and why didn`t I prevent him from hurting himself? (depressive anxiety). Obviously, in the depressive state, healthcare workers, as reflected in some of the narratives of this study, have to work with feelings of guilt for not having done more to prevent the behaviour. The persecutory state relates to healthcare professionals dealing with feelings of being attacked by service users` hurting themselves. Experiencing these forms anxieties clearly indicates rigorous attempts by healthcare professionals to examine incidents of self-harm with the view of identifying where they themselves may have gone wrong. Such attempts can be threatening and may even exacerbate anxieties evoked particularly in instances where there is perceived impotence to control or manage situations.

Another framework that is often used to provide interpretations of the anxieties of healthcare workers and the impact of these on their professional identity and ability to effectively offer care, is Freud`s (1960) theory of death and life instincts, referred to as *Thanatos* and *Eros* respectively. According to this theory, *Thanatos* is the force of negativity and destructiveness that is operationalised when anxiety is evoked. Arguably, exposure to self-harming behaviours would activate *Thanatos*. It is believed that the activation of this death instinct, takes the forms of either sadistic aggression or aggression directed towards the ego (Freud, 1933). It is explicit from this assertion that, any encounter with self-harm may result in healthcare professionals adopting either uncaring attitudes towards users presenting with this behaviour or re-directing emotions, associated with these attitudes, towards themselves. According to Freud (1960), these emotions, as noted in a range of participants` narratives, are experienced as feelings of failure, hopelessness and worries about making issues worse. Such an experience of negative emotions is an uncomfortable place to be. Thus, individuals in these situations are more likely to engage in activities that would help protect them from their own destructiveness. An example of such responses or reactions involves the re-direction of negative emotions towards the sources of anxiety; people who present with self-harm. Certainly, the thought of reactions of this nature would be worrying for both individuals and organisations assigned responsibilities to care for people who self-harm. Hence, irrespective of the mode adapted for manifestation of destructiveness (internally on the self or externally onto people who self-harm), organisations need to develop strategies or structures to effectively deal with anxieties of individuals. Doing so, as asserted by Menzies (1988), would result in effective care provision. Thus, the next aspect of this discussion focuses how healthcare professionals defend themselves from anxieties with what Menzies (1970) called social defence systems or organisational structures.

The core of the anxiety for healthcare professionals lies in their relationships with service users. It is believed that the more intimate professionals are with service users the more the former are likely to experience intense anxiety. The sources of anxiety in this context are attributable to a multitude of factors, which are in the main associated with care provision. An example of the anxiety generating factors, as already mentioned in a number of places in this thesis, is caring for people with challenging behaviours, such as self-harm. Hence, to ensure that tasks are performed with reasonable efficiency, hospital organisations would adopt strategies for preventing healthcare workers from becoming too intimate with their service users. One of these preventive approaches, as noted in some participants` talk, is the movement of professionals from one clinical setting to another. It is believed that this strategy would enable healthcare professionals to refrain from excessive involvement, avoid disturbing identification and enhance their professional practice. Menzies (1970: 53) reiterates this point in some of her work on defence systems against anxiety. In her words, she states:

> *A good nurse doesn`t mind moving. A good nurse is willing and able without disturbance to move from ward to ward or even hospital to hospital at a moment`s notice.*

Whilst this statement seems to emphasise the benefits of clinical movements, embedded in it is an implicit denial of the pain and distress of breaking relationships and the importance of stable and continuing relationships. It is critical to note that the distress of breaking relationships could have a negative effect on the care offered to service users. Hence, this approach requires delicate handling. In other words, it should be adopted with caution.

Consistent exposure to self-harming behaviour and the responsibilities for care and management associated with it can be overwhelming for some if not all healthcare workers. It is therefore not surprising to note in secure settings, environments where these behaviours are frequently manifested, professionals making attempts to quit clinical practice. This view is also acknowledged by McCaffrey (1998). These attempts at deserting practice could be a function of repetition of self-harm being perceived by healthcare professionals as a challenge to their role as healer. Such challenges can evoke immense anxiety. It is therefore critical for individuals experiencing it and the organisations they work for to work towards the effective management of the same. Consistent with this view is Babiker and Arnold`s (1997: 128) assertion.

When encountering people who self-harm, a fundamental issue for healthcare professionals to manage is their own fear, anxiety, frustration, powerlessness and inadequacy.

While these emotions are real and frightening for the individuals concerned, they may have difficulties in articulating the rationales for their subjective experiences. There is therefore a need for organisations to create forums such as mentoring and supervision that would offer psychologically safe environments for the expression of feelings and enhancing understanding of their origins and meanings. Although there is a clear need for these systems of support in this area of work, some participants claimed that they were not adequately supported. Such limitation, they asserted had negative impact on their work with service users.

Role obscurity in the formal distribution of responsibilities is considered by Menzies (1970) and others like the researcher of this study, as a significant factor for generating and enhancing anxieties in the workplace. So, protection from this source of anxiety is necessary for ensuring effective working relationships and provision of care. Simply, this involves creation of clear content and boundaries of roles and responsibilities for all levels of healthcare professionals. Participants of this study acknowledged clarity in their responsibilities, which they claimed is manifested in a range of documents, including procedures and policies. An example of a policy, repeatedly mentioned during interviews is that of engagement and observation. Such repetition could be attributed to its frequent use in mental health settings in the assessment and management of risks.

Associate with the policy of engagement and observation is the notion of delegation. Implicitly, this relates to senior healthcare workers handing over tasks or responsibilities to their subordinates. Doing so would lessen the burden of responsibility on the former, which in turn would reduce the impact of anxieties they may experience. The bulk of the tasks for observing and caring for service users who self-harm are carried out by junior healthcare workers, notably referred to as healthcare assistants. Even though this is the case, senior healthcare professionals maintain general supervisory roles. It must be mentioned that their role is not just to observe from a distance, but they are also professionally required to offer care. They would therefore get personally involved in care provision when necessary. Arguably, delegation serves as way of reducing or managing anxiety, but not its absolute

prevention. In other words, irrespective of their statuses, delegation would not offer healthcare workers total defence against anxiety.

It is clear from the account presented that the structures discussed do play a role in helping individuals avoid the experiences of anxiety. Apart from supervision and mentoring, all the structures referred to appear to focus on eliminating situations or tasks that cause anxiety. Since anxiety is inevitable in clinical areas, what are needed are approaches that would enable individuals to positively confront the anxiety-provoking situations. Adopting this stance would ensure the development of capacities of professionals to tolerate and deal more effectively with anxiety. Failing to do this could result in experiences of overwhelming anxieties, which in turn could lead to negative responses to the needs of service users. A discussion of these responses or attitudes is now presented.

10.5: Attitudes Towards Self-Harm

A number of studies have explored the attitudes of mental health professionals towards people who self-harm. To date, the findings of these attempts made are not only noted to be inconsistent, but they are also observed to vary between and within professional groups (Ramon *et al*. 1975; Patel, 1975; Clarke and Whittaker, 1998). This attitudinal variation could be attributed to the differential definitions of attitudes and different methodologies used to conduct the studies. It could also be a function of the variability in the representativeness of samples and their sizes. Despite the variations noted, it is important to stress that attitudes to self-harm are generally negative and people who hurt themselves repeatedly are viewed particularly negatively (Shepperd *et al*. 2003). A similar conclusion is made in the present study. It is noted that healthcare professionals` attitudes in secure settings were mainly unsympathetic and unempathetic to users who tend to hurt themselves regularly. This assertion is attributed to the frequency with which healthcare professionals ascribe manipulative and attention seeking motives to service users` behaviours. Similar descriptors (timewasters and beyond help) were commented on by Gough and Hawkins (2000) in their report of a study of healthcare professionals` attitudes to self-harm. These utterances are frequently expressed in today`s healthcare settings, a view confirmed by Bywaters and Rolfe (2002) and Starr (2004). They claimed that users who self-harm are often considered by practitioners to be timewasters and unworthy of care. These perceptions about service users are considered in this study to be strong attitudes.

An attitude is considered to be strong if it is frequently and consistently repeated (Krosnick, 1989). The frequency with which the attitudes discussed above were talked about by participants not only indicates their strength, it also shows how easy they can be accessed and activated. Fazio (1989) also shares this view. Acknowledging this, it could be argued that easily accessible and retrievable attitudes or perceptions are believed by the researcher of this study and many others to have a strong influence on people`s responses to self-harming behaviours (Fazio *et al.* 1986). Indeed, this is the case as reported by some participants. They seemed to be convinced that healthcare professionals with a negative perception of self-harm are more likely to reject users with this behaviour as being unworthy of care. Similar findings were reported by McAllister *et al* (2002). They confidently stated that practitioners often respond to this behaviour in a resentful and rejecting manner. But this, they asserted, is mostly the case when it is negatively perceived as time wasting and manipulative. It is believed that these negative comments observed in the literature, which are also persistently expressed by participants of this study, indicate a serious misinterpretation of the motives underpinning service users` behaviour; communication of unbearable emotions (Pembroke, 1998; Sadler, 2002). Additionally, they also seem to denote a communication of frustration, which appears to be compounded by lack of effective ways of dealing with self-harming behaviours. This claim is based on the reports provided by a good number of participants of this inquiry and practitioners cited in previous studies, of their limited understanding of this phenomenon (Tantam and Huband, 2009). It is therefore not surprising to note in this inquiry participants` requests for training on the subject of self-harm, as receiving this, they claim, would enhance their approaches of responding to the needs of service users.

Although discussed by a minority of participants, claims were noted in the narratives that a limited understanding of self-harm could result in healthcare professionals adopting a blanket stance to care provision; meaning using common approaches with a view of addressing the needs of users. Service users may find this blanket way of working humiliating and disrespectful, as it clearly suggests a disregard for their individual needs. These experiences may increase service users` feelings of worthlessness and risk for further self-harm. It is therefore critical, as highlighted by some participants, for care to be individualised.

Parallel views relating to the need to demonstrate respect for and listen to users were repeatedly expressed by participants. Although the importance of this was acknowledged by a large proportion of participants, episodes of disrespect were reported during interviews.

For example, some healthcare professionals were believed to ignore users and to sometimes talk to them in a condescending and controlling manner particularly when they hurt themselves. This way of responding is an expression of anger and frustration. While some healthcare professionals acknowledged the importance of emotional expression, the manner described above was condemned by others out rightly. This seems to serve as a request to explore other ways of responding to service users with a view to alleviating their behaviours.

Demonstration of acceptance, readiness to offer help and adoption of a positive approach to care are crucial elements for effective working with users who self-harm. Miller and Rollnick (2002) agree with this by stating that these are fundamental positive attitudes that require practitioners to respect and actively listen to users during clinical encounters. Adopting these attitudes would encourage users to freely express their feelings, which in turn may enable healthcare professionals to develop a better understanding of the behaviours presented and their underpinning motives. One motive that is frequently cited in practice that is believed to be at odds with service users` perceptions is attention seeking-manipulation. Clarifying this would help enhance insight into self-harming behaviours and associated attitudes.

10.5.1: The Attention Seeking-Manipulation Argument

A closer look at the literature reveals that service users in secure settings usually like healthcare professionals to spend uninterrupted time listening to them (McAlaney *et al.* 2004), as they can be viewed as nurturing and parental figures with possible answers or solutions to their concerns. With these perceptions in mind, it could be stated with certainty that healthcare professionals` attention is very important for users in these care settings. Expectedly, users would adopt a range of strategies to gain the attention of these practitioners. One effective means for intensely engaging practitioners, as reiterated by participants, is self-harm; a behaviour that is very hard to ignore in secure forensic environments. As already stated in a number of instances in this work, these behaviours usually evoke very powerful emotions in practitioners. These may include feelings of nurturance, anger, frustration, guilt and hate. Irrespective of the emotional tone of these reactions, the responses are certainly forms of attention manipulated by self-harming behaviours. It could therefore be argued that the main aim of self-harm is interpersonal as the behaviour is largely motivated by interpersonal issues, such as eliciting care. Given that

service users are adept or skillful at knowing the effects of self-harm on practitioners, it could be inferred from the discussions presented that it is a potent tool for modulating interpersonal closeness.

As illustrated in the narratives of this study, healthcare professionals are sometimes faced with a conflict of ignoring or attending to service users when they self-harm. Starting with the latter part of this tension, being supportive and caring to service users would reinforce the behaviour and thereby enhance the potential of increasing its frequency. Even though it is condemned by some participants on ethical grounds, it is believed that ignoring the behaviour also runs the risk of increasing and escalating its incident and lethality respectively. As implicitly noted in the participants` narratives, service users are generally aware of this conflict facing practitioners. Thus, in their quest for emotional closeness, they may use self-harm as a means for initiating and maintaining contact with practitioners. Using self-harm this way is what could be considered manipulative or attention seeking. Describing the behaviour in this manner is to some degree an indication of disrespect or disregard for the behavioural intentions and a lack of empathy for the individuals concern. It is for this reason that some participants of this study dispel these terminologies. They consider them to be wrong and insulting. Given that self-harm in secure settings and other clinical areas is a private and secretive affair (Sadler, 2002), a view also echoed by participants, the behaviour is certainly not for seeking attention or manipulating professionals. Its primary focus is to communicate emotions.

The attention seeking-manipulation argument also seems to fail when taken into account repetition. People who hurt themselves repeatedly do it in secret and prefer to hide their injuries from others and may only seek help when situations are becoming unbearable or the wound becoming infected (Huband and Tantam, 1999). This finding is reflected in this study as participants claimed that service users tend to hide in the toilets and bedrooms to hurt themselves. Secretly hurting themselves would help them to avoid humiliating comments such as attention seeking and manipulation. Undoubtedly, these terms carry negative connotations and they are believed to play a role in shaping professionals` reactions to service users. It is critical to note that irrespective of whether negative attitudes are covertly or overtly expressed, service users may infer their derogatory or insulting nature through practitioners` demeanor. Making such inferences could activate the need for more self-harming acts (Hemmings, 1999). Clearly, there is a need for practitioners to develop a better

understanding of factors affecting their attitudes to self-harm. These influences are now explored with a view of developing insight into their role in attitude acquisition.

10.5.2: Factors Influencing Attitudes

There is abundant evidence to support the view that individuals who self-harm frequently experience negative attitudes expressed by healthcare professionals (Huband and Tantam, 2009). A range of factors that influence these attitudes has been identified. The multiplicity of these influences makes dealing with self-harm complex and challenging. One such factor that seems to have an impact on attitude development is training. It has been shown to have a significant effect on professionals` attitudes towards people who self-harm. Gough and Hawkin (2000) agree with this by stating that training does help to enhance professionals` optimism, confidence, enthusiasm and positive feelings when working with this service user group. Parallel outcomes were noted in this study as participants insistently claimed that training and education would facilitate the establishment of therapeutic relationships as well as enable professionals to respond confidently in a positive manner, to the needs of service users. It was for this reason that they persistently made requests for training to be provided, given that they had little or no formal education in this subject area. Although specific areas for training were not explicitly identified, some participants still claimed that undertaking training would improve their knowledge and skills on how to deal with individuals who self-harm.

Acquisition of knowledge and skills, as discussed in this study, share similarities with Ajzen`s (1985) concept of perceived behavioural control, which refers to people`s self-belief and confidence to perform a given behaviour. This simply means that individuals who are willing, confident and who feel they are able to carry out a task are more likely to take actions to do the same (Miller and Rollnick, 2002). The ability, willingness and confidence to care for people who hurt themselves can be acquired through training and education, a view clearly captured in this excerpt.

> *Yeah! Yeah! It would help increase people`s knowledge of self-harm and their competency on how to care for service users with this behaviour. It would enable us to understand their reasons or intentions for self-harm. Knowing this would no doubt enable us to demonstrate acceptance for them, listen to their views and provide support* (William, In: 11, 4).

Positive attitudes about self-harm can also be acquired through mentoring and supervision, not just via formal training programmes. This assertion is a function of the belief that people are more inclined to carry out a task if significant others like mentors and supervisors positively evaluate it and think they should perform the same. Acknowledging that the evaluation of self-harming behaviours could vary between significant others, it would not be surprising to find a range of positive and negative attitudes in clinical practice. Apparently, this is the case as illustrated in participants` narratives which contain both helpful and unhelpful evaluations of self-harming behaviours. Some of these evaluations were associated with the type of service setting, severity of harm and perceived cause, gender, age and duration of clinical experience of practitioners.

Commencing with experience, there appears to be a shared belief among some participants that longer clinical exposure to self-harm eventually contributes to the development of positive attitudes to user groups with this behaviour. It is the researcher`s opinion that longer clinical encounters with self-harm would ensure intense practice learning, which would enhance practitioners` confidence and skills of how to effectively care for this user group. Relating this to the Theory of Planned Behaviour, clinical exposure improves individuals` perceived behavioural control; perceived ease of caring for people who self-harm (Schifter and Ajzen, 1985). What was also related to clinical experience was the age of healthcare professionals. Some participants claimed that older practitioners have more supportive attitudes than younger ones. This assertion could be related o their life experiences which are believed to have psychologically equipped them to support people with significant emotional difficulties.

Even though doubts were expressed by some participants, others seemed to claim that female healthcare professionals are more positive in their attitudes to self-harm. This possible gender differential was based on the view that female practitioners are more able to empathise than their male counterparts. The ability to this can be related to the traditional gender role of females being more nurturing and willing to care for people. Some participants contradicted this and asserted that attitudes are not influenced by gender, but by people`s culture, personalities and care experiences. The experiences of practitioners are sometimes structured by clinical guidelines.

In the forensic mental settings, care provision and attitudes are guided by a range of healthcare policies, legal frameworks and professional stipulations. In relation to the Theories of Reasoned Action and Planned Behaviour (Ajzen and Madden, 1986), these structures are consistent with what is referred to as subjective norm; normative values which practitioners are required to follow. Any practice outside professional and legal guidelines provided in clinical practice could be deemed unprofessional. Thus, prolonged exposure to these structures could help shape attitudes. The final factor which deserves just a brief mention here, purely because it has been discussed in several places in this work, is impact of self-harm. Certainly, not discussing it would prevent repetition. Although this is the case, it is important at this stage to provide a diagrammatic representation of the factors that may influence professionals' attitudes and their inter-relationships. These are illustrated below in figure three in page 246. The directions of arrows are to be taken into account here as they indicate the relationship between factors. Because the role of age and gender was controversial, these factors are made conspicuous by presenting them in a circle.

10.6: Summary

This chapter has provided explanations of the relationships between people`s need to assume control of some aspects of their lives, their quest for a calm and stable emotional state, and self-harming behaviours. Self-harming acts are frequently reported in this work to generate a mixture of unpleasant feelings, such as anxiety and anger, in healthcare professionals. This chapter discussed the impact of these emotions and coping approaches adopted by practitioners. The coping strategies utilised are usually influenced by a multitude of factors. Examples of these include perceived severity of the harm and attitudes towards self-harm. A mixture of negative and positive attitudes was identified in the narratives of participants. It is noted in this study and in previous inquiries that attitudes can influence practitioners` responses to service users (Patterson *et al*. 2007). Hence, healthcare professionals` attitudes, and the factors that could lead to their acquisition, are discussed in this chapter.

One final important issue before moving to the overall conclusion chapter of the study, is practitioners` frequent use of the labels, "attention seeking" and "manipulation", to describe service users` motives underpinning self-harming behaviours. Such perceptions can distract practitioners from effectively engaging with users which, in turn, could result in not meeting the needs of the latter. It is believed that negative attitudes can be altered through training

and education. The role of these factors in attitude change is discussed in the following chapter.

Figure 3: Factors Influencing Attitudes Towards Self-Harm (FASH)
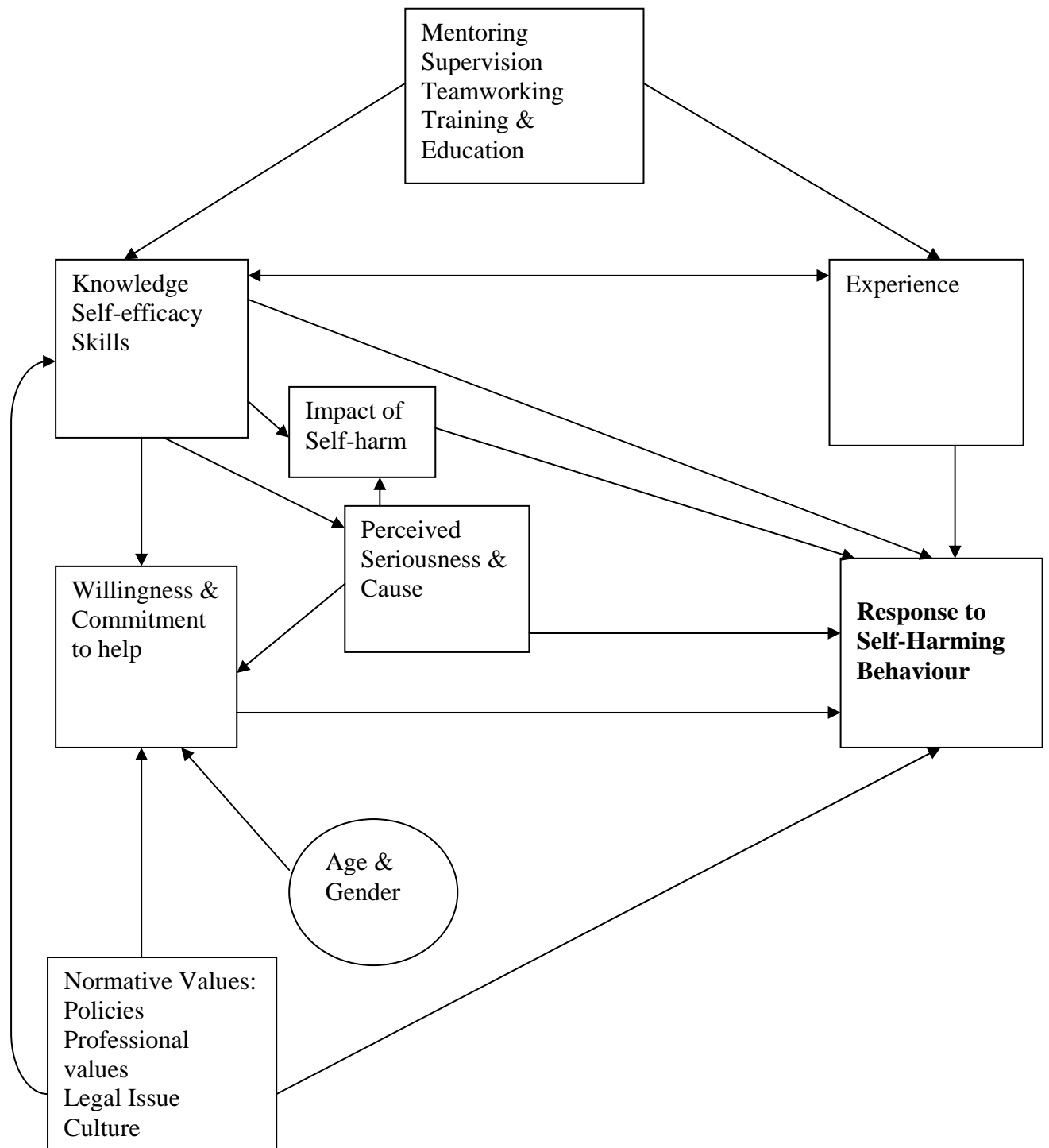
CHAPTER ELEVEN

CONCLUSION

11.1: Introduction

The preceding chapter offered a discussion of the study findings in relation to outcomes of previous studies. It became evident during the discussion that some of the findings or themes were interlinked. The interconnectedness of the themes is illustrated, for example, in figure 2 (self-harm explanatory model) and figure 3 (factors influencing attitudes towards self-harm). Such relationship between themes is certainly not surprising, since it indicates a fundamental aspect of human discourse; individuals sometimes agree with one another during interactions. The overarching impression gained from the findings was one of consistency with some of the conclusions in the extant literature. This is reassuring, as it adds to the believability of the outcomes and overall credibility of the study. More discussion of the rigour of the study is needed to confirm its trustworthiness or credibility. Thus, this chapter commences with discussions pertaining to the overall process of the research using a specific quality framework posited by Guba and Lincoln (1994). It then focuses on the contributions which the study has made to the existing body of knowledge within this subject area; self-harm. The chapter also looks beyond this to examine the implications of the study findings, followed by recommendations for improving future research and attitudes towards self-harm.

11.2: Rigour: Credibility of the Study

11.2:1 Reliability-Validity Debate

The discourse relating to establishing the quality or credibility of qualitative research has been lingering on for a number of decades, with discussions mainly focusing on the use of reliability and validity criteria in doing so (Morse *et al*. 2002; Polit and Beck, 2008). Many researchers tend to criticise such usage, claiming that these criteria are only applicable to quantitative research (Parahoo, 2006). However, such criticism does not imply that qualitative research cannot be depended upon to generate findings that are indicative of the truth or reality of phenomena. Reliability refers to the degree of consistency with which a data collection method produces the same findings when applied by a different researcher or by the same researcher on different occasions (Hammersley, 1992; Parahoo, 2006). Clearly, the concept of reliability relates to the replicability of findings. In other words, when

repeating studies, researchers adopting this concept are required to focus on achieving the same or similar findings (Silverman, 2006). While this is a possibility in quantitative research, applying the notion of reliability in qualitative inquiries, particularly where open interviews are used, is certainly ignoring the changing nature of our social worlds. Marshall and Rossman (1989:147) confirm this by writing that:

> *Positivist notion of reliability assumes an underlying universe where inquiry could, quite logically, be replicated. This assumption of an unchanging social world is in direct contrast to the qualitative assumption that the social world is always changing and the concept of replication is itself problematic.*

Even though this assertion is limited in the context that it totally ignores any possibility of the existence of some stable aspects of participants` social worlds, it indicates the uniqueness of open interview encounters. This study utilises open interviews using individual and group formats. Many researchers tend to believe that open interviews are not replicable, as each interview encounter is a unique interaction between participants and researchers, with the former having some input in its pace and direction (Porter, 2007). Arguably, in addition to the possible influences by participants on the data of open interviews, their differential perceptions of a phenomenon and the possibilities of these changing with time, make reliability, in the quantitative sense, difficult to establish in qualitative research. Since the application of reliability is problematic in qualitative research, one then needs to explore the effectiveness of validity as a criterion in determining the quality of the same. Hammersley (1990:57) defines validity as:

> *The extent to which an account accurately represents the social phenomena to which it refers.*

Simply, validity is the degree to which participants` constructions of a phenomenon are represented in the findings. So, if validity is to do with how far the findings of a study reflect the constructions of participants, then researchers should endeavour to provide accurate descriptions and explanations of phenomena studied (Porter, 2007). Doing this may not only enhance the outcomes of studies, but it may also increase confidence in healthcare professionals that the information they are provided with is sufficiently accurate, and can be used, where appropriate, to inform practice. Hence, this study includes rich and accurate descriptions and explanations of participants` accounts in order to improve its believability. The intention of this is to also allow readers to feel that they have actually been in the research setting. The question now arises: how will a reader, using these accurate

descriptions, be able to establish with certainty that the researcher has offered an accurate representation of participants` accounts?

Providing detailed answers to this question is beyond this study. However, it is certainly difficult for readers to accurately validate claims made by researchers, as these claims may contain, to a greater or lesser degree, factual accounts of events or attitudes. Compounded with this, is also the possibility of readers misinterpreting accounts presented by researchers. According to Kirk and Miller (1986), such misinterpretations are not uncommon. Arguably, from a quantitative perspective, establishing validity in qualitative research can be problematic. It is apparent at this point that validity and reliability are not appropriate criteria for judging the credibility of qualitative research, a view also highlighted by Morse *et al* (2002). Simply, the words of positivistic research, reliability and validity, are not congruent with qualitative approaches. What then could one use to establish the quality of this study? Exploring the possibility of errors in studies may provide vital clues for a suitable response to this question. Errors can be introduced in both the data collection and analysis phases of studies. So, minimising this possibility can enrich and strengthen the overall quality or rigour of a study.

Rigour is a measure of the overall quality of qualitative research, reflected in the data collection and analysis processes (Macnee and McCabe, 2004). With this in mind, it seems that the responsibility for ensuring rigour lies in the domain of researchers rather than in the readers. This is possibly a function of the view that readers are not actually involved in conducting studies. Although this is generally the case, the researcher of this study however believes that the responsibility for determining rigour is a shared one and lies in the domains of both researchers and readers. Porter (2007:81) reiterates:

> *The responsibility for rigour lies with both the reader and researcher. It is the researchers` responsibility to demonstrate that the research they are reporting has been conducted in a valid and rigorous manner, while the readers` responsibility is to interpret the report to ascertain whether or not they are persuaded that the researchers have indeed demonstrated rigour.*

Explicitly, embedded in the concept of rigour is also an interpretative process, involving the researcher's presentation of study reports and the readers` judgment of the veracity of the same. Taking into account the wide range of possible variations of readers` claims on study reports, it is important to have standardised criteria to prevent or at least minimise the chance

of readers making inaccurate interpretations. Clearly, standardised criteria assume the role of a mediator between researchers and readers, a common language spoken by both parties, with a clear remit of creating a common understanding of study reports.

Rolfe (2006) made an attempt to explore the possibility of using an overarching set of criteria for judging the quality of qualitative studies, but encountered great difficulties in doing so. These difficulties can be attributed to the multiple qualitative methodologies espousing different interpretations of quality. On the basis of this, it is more realistic and feasible for each methodology to be appraised on its own merits, a viewed echoed by Sparkes (2001). Hence, a range of sets of quality criteria are explored to identify one which could adequately meet the epistemological and ontological positions of the researcher. The researcher elects to adopt the framework of trustworthiness posited by Guba and Lincoln (1994) to discuss the rigour of the study, as it seems to fit in well with the qualitative world of multiple realities and ways of knowing. This framework includes five criteria: credibility, dependability, confirmability, transferability and authenticity. These criteria are discussed below within a chronological structure commencing with planning, through data collection (method), to analysis and interpretation. The adoption of such an approach is based on the notion that the rigour of the study is reflected in these areas.

11.2.2: Motivation and Planning

Planning is a prerequisite for a credible research project. The researcher and his educational supervisors engaged in numerous discussions relating to the best ways of achieving the study's aim and objectives. These discussions included completing ethical clearance application forms. The first application completed and submitted to the National Research Ethics Services for ethical clearance was rejected on the basis of the study's intended methodological approaches. This rejection led to intense consultations. Experts in the field of self-harm, including academic supervisors and peers (research students), were consulted both for their views about attitudes relating to this behaviour and for the appropriateness of methodologies and methods for exploring the same. Because little is known about self-harm in secure settings, a qualitative phenomenological methodology was utilised, purely because it has the potential of enhancing researchers` insight of the phenomenon. This suggestion is a starting point of meeting the credibility criterion of Guba and Lincoln's (1994) framework, as

it forms part of the process of building a sound foundation for commencing the research project.

Credibility refers to the confidence that researchers and readers can have in the truth of study outcomes. It is clear at this stage that the essence of this study is to gain a deeper understanding of self-harm and attitudes towards it. This can be achieved by researchers interacting with participants in order to understand their perceptions and understanding of their world. Kirk and Miller (1986:1) echo this:

> *Qualitative research is a particular tradition in social science that fundamentally depends on watching people in their own territory and interacting with them in their own language.*

In light of this, individual and focus group interviews, discussed below were suggested and used in the study as data collection strategies.

11.2.3: Methods

As already mentioned, this study utilises the trustworthiness framework of Guba and Lincoln (1994) to articulate the strategies employed in enhancing trust in its findings. Trustworthiness is a measure of the degree of confidence in the data collected in reflecting the meaning of a study phenomenon (Macnee and MaCabe, 2004). Sandelowski (1997) believes that steps taken to ensure this forms part of a credible qualitative research, which can be relied upon to generate knowledge claims that will beneficially inform clinical practice.

Establishing a trusting relationship with participants is an essential prerequisite for collecting trustworthy data, as people are more likely to share their experiences of a phenomenon if they feel respected, accepted, and fully informed about the same (Prever, 2010). In this vein, several meetings were convened at the study site to provide an overview of the study to prospective participants and for them to raise any concerns that they may have. Prospective participants agreeing to participate in the study were given additional information in a form of leaflets detailing the study's purpose, benefits, assurance of confidentiality, researcher`s contact details and rights to withdraw from the study. In this way, a trusting relationship between participants and researcher was established quite early in the research process. It is important to emphasise that this relationship needs to be maintained throughout the research process, particularly during interview encounters, in order to obtain meaningful and trustworthy data from participants. One of the many approaches the researcher employed to

achieve this was appropriate self-disclosure of personal experiences relating to self-harm. Empathising with participants in this manner would encourage free expression of feelings. This was apparently noted during interviews; participants freely expressed their views relating to the questions posed. This adds to the uniqueness and subjectivity of interview encounters. Although subjectivity of data is an important facet of qualitative inquiry, the researcher also believes in some degree of objectivity during data collection. Polit and Beck (2008) claim that adopting objective approaches could result in the production of data that are stable both over time and over conditions. The production of stable data is what Guba and Lincoln (1994) refer to as dependability, a concept which parallels the positivists` notion of reliability; a measure of the chance of obtaining similar findings if a study is repeated under similar conditions.

Dependability of a qualitative study can be established in a number of different ways. It was enhanced in this study by the use of an interview guide. Although the use of interview guide may appear contradictory to an open questioning style, which was adopted in this study, it however provided a consistent broad framework for data collection without restricting and structuring the data collected. One must highlight that an open questioning style, or quite rightly, the application of minimal structure at interviews, was viewed positively to have a huge potential for generating a good breath of response. However, the adoption of such a questioning approach requires delicate handling, purely because of the possibility of generating responses or discussions not related to the study phenomenon. To prevent this or at it least minimise its occurrence, the researcher was informally trained to facilitate focus and individual interviews, with an underpinning framework of an open questioning style. Consequently, a number of mock interviews, guided by clinicians experienced in interviews were conducted. Each mock interview was followed by detailed and constructive feedback. This was to enable the researcher to adopt a consistent or similar approach throughout the main interviews and to enhance his interviews skills. Adoption of a consistent approach is an important criterion for establishing the study's dependability.

Dependability was further assured in this study by audio-taping the entire interview process. In one sense, audio-taping ensures detailed account of participants` discussions, and hence, allowing researchers to focus on observing and listening to participants. In another sense, audio-taping allows for verbatim presentation of participants` words during analysis. However, one must emphasise that the use of audio-tapes at interviews is not always problem

free. They are limited in the sense that they are unable to capture the non-verbal aspects of interviews, such as body language and participant-researcher interactions. In other words, they are incapable of providing complete objective record of interview encounters. To address this constraint, Silverman (2006) tends to advocate for the use of video tapes, as these would capture both verbal and non-verbal language of participants and researchers. But because video recording was likely to be considered too intrusive by participants, this mode of data collection was not adopted in this study. Instead, a second researcher was involved in the focus group interviews with a distinct function of taking notes of non-verbal behaviours and interactions. In this way, the first researcher, main investigator, would have ample time to focus on the pace and direction of interviews.

A cursory glance at the literature reveals that note taking during and after interviews tends to play a significant role in increasing the confirmability and overall rigour of studies (Polit and Beck, 2007). Confirmability refers to the degree of agreement between two or more researchers about the accuracy, meaning and relevance of data (Macnee and McCabe, 2004). Implicit in this statement is that researchers can enrich and strengthen the rigour of their studies by adopting an objective approach in both the data collection and analysis stages of research and by taking all necessary steps not to introduce biases in the same. Hence, notes were carefully taken. These included clear and accurate descriptions of behaviours and interactions. The notes taken in both the focus group and individual interviews formed part of a triangulation of data, as they were compared with the data from the audio-tapes. While these multiple sources of data served as collaborating evidence to help understand or shed light on the study phenomenon and to strengthen the credibility of claims, Polit and Hungler (1999) advise researchers to be cautious when using notes. This is because they believe that notes can be vulnerable to a number of distortions and biases, such as halo, converse and assimilatory effects. The researcher was fully aware of the possible biases that can be introduced, and therefore, as already mentioned, made an effort to ensure that the notes taken are objective and not figments of his imagination. Nonetheless, the researcher of this study and others believe that total objectivity cannot be claimed as researchers do sometimes introduce their own perceptions and interpretations in the research process (Agar, 1986).

11.2.4: Interview Process, Results and Analysis

A re-examination of the literature on analytical approaches reveals that the use of Interpretative Phenomenological Analysis (IPA) (Smith, 1996) to analyse and interpret the data of this study will add credibility and as well as give confidence to its findings. This is because, as a tool of analysis, it offers a well structured process to produce true and detailed accounts of participants' discussions of the phenomenon under investigation. While the use of IPA is a slow and painstaking exercise, its structure offers a thorough and consistent approach to analysis and therefore generates convincing, stable and replicable findings. A systematic transcription and analysis allows others, including researchers and healthcare professionals, to assess how studies analysed and developed their findings (Sacks and Allsop, 2007). The findings of this inquiry included verbatim statements of participants, expressing their feelings and experiences of self-harm. Verbatim statements were presented and this approach was influenced by the view that rewording of participants` accounts may distort their meaning. Distortion in the meaning of statements inevitably creates difficulties for readers to establish credibility of studies (Flick, 2006). The verbatim statements and themes that are generated from transcribing and analysing the tapes were translated into a narrative account in the form of a report (thesis). In the report, the themes are explained, interpreted and illustrated, interspersed with verbatim extracts from transcripts. Arguably, the report is an expansion of the analysis process, demonstrating a range of different facets of participants` experiences of self-harm. A report presented with these qualities is considered to have achieved Guba and Lincoln's (1994) criterion of authenticity.

A sample of the interviews data, from which the report of this study was generated, was analysed by two researchers. This was a function of view that transcribing involving two or more researchers agreeing on outcomes has huge potentials for enhancing reliability, in this case, dependability of studies. The interviews were transcribed in their entirety, including verbal expressions such as "erm". Validity checks were also carried out by supervisors. In the context of transcribed data, one area of agreement between a range of researchers using a phenomenological methodology is that participants are in a better position to clarify their accuracy, completeness and interpretation (Macnee and McCabe, 2004; Creswell, 2007; Polit and Beck, 2008). So, transcripts could be returned to participants to judge how accurately they reflect the interviews. This was only done for two participants. This activity is referred to as member checking (Creswell, 2007). However, member checking can be carried out

safely, especially for sensitive subjects, with participants consenting to do so. Another problem area of member checking is the possibility of it resulting in misleading conclusions of credibility. In this vein, Polit and Beck (2008) note that participants might provide false interpretations or fail to disagree with researchers` interpretations even in instances where they sense inaccurate statements in the accounts presented. Such failure is, in the main, attributable to the politeness of participants and in the belief that researchers are more knowledgeable than them. This indicates a power differential between researchers and participants. Undoubtedly, efforts were made in this study to minimise any perception of such a differential, with the ultimate aim of giving participants the confidence to talk about their experiences and to enable them to recognise that they have greater the clinical knowledge of self-harm. In this respect, the contributions they made in establishing the correctness of transcribed data are useful in improving insight into the phenomenon of self-harm.

Another form of documentation that played a significant role in ensuring confirmability, dependability and overall rigour of these qualitative data, was an audit trail (Macnee and McCabe, 2004). It is a systematic documentation of the entire research process, including stages of data collection and analysis (Morse, 1999). Claims have been in the literature that the use of such process of documentation does assist in ensuring consistency in the conduct of research (Meyer, 2001). Acknowledging the issue of consistency, an audit trail can serve as a useful tool in supervision and peer review of study rigour. In the light of this, all stages of this inquiry were clearly and accurately documented to allow peer reviewers to come to a sound conclusion about the credibility of the study data. However, Morse *et al* (2002) warn the use of audit trails in determining credibility of studies, claiming that they can only provide proof of data collected, but not their underpinning quality. While this is a possibility, discussions of studies by peer reviewers and the subsequent provision of honest feedback on the same, particularly when adhered to, could improve its quality (Hammersley, 1992). Although they were not peer reviewers, supervisors provided regular feedbacks on the progress of the study. An example of such feedbacks includes suggestions to include in the study report accurate and rich descriptions of interview encounters, incorporating verbatim quotes. Such presentation of study findings could enable readers to make judgments about their contextual similarities to other groups or settings. Simply, readers would be able to explore the relevance of the findings of this study to other mental health settings. Making judgments or decisions in this way is what Hammersley (1992) terms generalisation and

Guba and Lincoln (1994) refer to as transferability. Explicitly, transferability refers to the extent to which study findings are confirmed by or have applicability in groups or settings other than those studied (Polit and Beck, 2007). This concept is significantly different from generalisability in the sense that its use is does not focus on generalising findings to a wider population. But rather, its focuses mainly on establishing or confirming the extent to which meaningful study findings or data are meaningful in other settings or groups. Arguably, transferability is the extent to which the findings of studies fit into contexts different from study situations.

In sum, the above discussion is an evaluation of the rigour of this study using Guba`s and Lincoln's (1994) framework of trustworthiness. It important to stress that this framework, although it is the most appropriate for this evaluation, it does not guarantee absolute determination of the study rigour, but it certainly provides structures for bolstering the confidence of others and the researcher that the study findings are an accurate representation of healthcare professionals` perceptions of self-harm behaviours. Now that the rigour of the study has been explored, it is necessary to expend some energy to examine the broader impact or contribution made to this research area.

10.3: Unique Contribution Made to the Research Area

It was said, rather more generally, by ones supervisors that the quality of a qualitative research study can be judged in terms of its contribution to knowledge. Hammersley (1992) agrees with this and adds that the credibility of these forms of inquiries cannot just be determined by their contribution to the body of knowledge, but it can also be assessed by their relevance to practice. It is clear from the discussion so far presented that self-harming behaviours are frequently seen in mental health settings, with the highest incident rates observed in secure services (Beasley, 1999 / 2000). It is noted in these areas of practice that service users with this behaviour usually do not seek professional help (Ikeda and Kresnow, 2001). Such avoidance of care is attributable to negative experiences with healthcare professionals, which could include ignoring behaviour and the use of derogatory comments like attention seeker and timewasters. These examples of negative commenting and the behaviours and emotions associated with them, are reported in the extant literature to lead to further self-harming acts (Wilson and Dean, 2001). Yet, very little empirical research has actually been conducted on self-harm in secure settings despite its alarming prevalence and

incidence. It is even more critical to note that very few published research studies in these services have addressed the impact of healthcare professionals` attitudes on service users` behaviours. It is for this reason that self-harm is still reported to be a poorly understood behavioural phenomenon in these areas of practice. This study therefore explored healthcare professionals` attitudes towards this behaviour with the aim of developing a better understanding of it, using a robust methodology and methods.

This study is embedded in methodological characteristics, which made it distinctively unique from previous studies on self-harm. It used Interpretative Phenomenological Analysis (IPA) both as a methodology and as a tool for examining the results. With respect to the methodological issues, this study used a multi-method approach to data collection which sets it aside from previous inquiries, within this subject area, that only utilised single data collection strategies. To be more precise, this study made use of both individual and focus group interviews to retrieve information from healthcare professionals about their perceptions of self-harm. To date, no published study has employed IPA to examine self-harm using individual and focus group interviews as information gathering approaches. Using these data sources strengthened the credibility of the claims or results of the study. Both the individual and focus groups generated similar claims, but discussions of some issues were richer in the latter than the former. This is a confirmation of the usefulness of the sequence of data collection, which commenced with individual interviews and followed by focus group discussions.

Traditionally, IPA researchers tend to adopt an idiographic mode of analysis which is purely a case-by-case examination of data. This suggests that researchers adopting this form of inquiry are more likely to discard the notion of data saturation. In contrast, the sample size, data collection and analysis of this study were significantly influenced by the principle of data saturation. Avoiding it would be to overlook the effect of professional socialisation on practice learning and care provision. Given that professional interaction can have an effect on attitude acquisition, the researcher took this principle seriously and incorporated it within the study`s guiding principles. Acknowledging this, this study utilised a modified version of IPA.

One important item of advice provided by IPA relates to the use of preconceptions in collecting and making interpretations of data. While this is at the heart of this study, the

researcher warns that they may distort understanding if used inappropriately. For instance, believing that service users who self-harm are a waste of time and beyond help could hinder attempts at exploring underlying behavioural motives. Thus, an attempt is made to prevent or at least reduce the chance of such a distraction from occurring. The study therefore employs the concept of "selective utilisation", proposed by the researcher. It refers to an active process of constant evaluation of prior experiences for their appropriateness and the timely use of the same in enhancing interpretation and understanding of the internal logic of self-harm. Underpinning this concept is the aim to enhance insight into the phenomenon explored.

Other notable areas that also made this inquiry unique are the findings that emerged from its analytical process. For example, the proposed matrix of factors influencing care approaches (FICA) provides an useful summary of issues in mental health settings that could affect practitioners` decision on the choice of approaches to care (figure 1, page 219). Taking into account the wide range of these influences, the matrix illustrates the complexity of the decision-making process. Despite this possibility of difficulties, this structure certainly serves as a useful framework for practitioners to use during the process of providing care, as it brings to fore the factors that may influence the same.

What can also be counted as unique to this inquiry is the suggested self-harm explanatory model (SEM) (figure 2, page 225). This is a framework for explaining the role of depletion of coping skills and service users` feelings of lack of control and the need to regain control in causing self-harm. Certainly, this framework should help practitioners to understand the context in which self-harm tends to occur. The development of such an understanding would enable healthcare professionals to be more hopeful and positive in their approaches to care. It can certainly be used as a teaching tool for developing professionals knowledge about self-harming behaviour..

The primary aim of this study is to explore healthcare professionals` attitudes towards self-harm. It is therefore critical to include in this discussion the study`s educative potential impact on attitude change. Hence, this inquiry offers an exclusive matrix that illustrates factors that may have an effect on professionals` attitudes to self-harm in mental health services (FASH) (figure 3, page 246). It can be used in practice to design in-service education interventions and workplace management changes for addressing the needs of

service users with self-harming behaviours. A number of conceptual frameworks have been postulated to explain factors which might influence people`s attitudes towards objects of thoughts. An example of a prominent structure that provided significant guidance to this study is the Theory of Planned Behaviour (Ajzen, 1985) (appendix 2). With respect to the findings, this study has identified two specific factors that could shape the attitudes of individuals. It is important to state that these factors (perceived cause and perceived seriousness of harm) are not part of the theory mentioned above. Additionally, they had not been previously reported in published work. They are therefore considered to be significant findings for understanding the subjects of attitudes and self-harm. In addition to the contributions which this study has made to the body of knowledge in this subject area, its findings undoubtedly have implications for service users, healthcare professionals and research, which deserve some degree of discussion. Doing so is an extension of the evaluation of the study`s trustworthiness.

11.4: Implications of Study of Study Findings

11.4.1: Implications for Training and Education

Many of the participants expressed during interviews their desire to receive specific training on self-harm. They indicated that they lacked sufficient knowledge and skills of how to effectively work with individuals who hurt themselves. Yet, they continue to engage with this user group. One would therefore expect their approaches to care to be inadequate and possibly inappropriate in some instances. Apparently, this is the case as illustrated by some of the study`s outcomes. Participants spoke about the frequent use of strategies such observation, searching and protective clothing to prevent and manage self-harming behaviours. Some participants reported that these approaches are in the main perceived by service users to be distressing rather than therapeutic. They were considered by many participants to be controlling and unhelpful as they usually fail to address the underlying feelings of service users. Hence, using them regularly is more likely to lead to more episodes of harm with some acts probably going to be severe as they might be carried out in a desperate and hasty manner.

Even though it has resource implications, regular provision of emotional support is critical in secure mental health services, as healthcare professionals are frequently exposed to stressful situations, such as self-harm, without adequate preparation. The present study therefore

raises the issue of whether every practitioner in these settings should be expected to care for individuals who harm themselves. The obvious response to this query is no, as it cannot be stated with certainty that all practitioners are prepared to assume the role of providing care to this user group. The findings of the current study support this in the sense that some participants openly declared that they do not have sufficient skills and knowledge to work with these service users. Although, they expressed willingness and commitment to provide care, this outcome indicates a lack of preparedness or readiness for this role. These practitioners are therefore vulnerable to being inundated by these behaviours and to develop attitudes that may place the users at increased risk to self-harm. Arguably, service users and healthcare professionals are potentially placed at risk from each other.

Negative attitudes were often associated with lack of or limited knowledge about self-harm. Thus, it could be argued that improving knowledge of self-harm could be a necessary and sufficient factor for enhancing attitudes of individuals. Bohner and Wanke (2002) agree with this by asserting that education is good predictor of attitude change. Taking this argument further, some participants claimed that training and education are not the only determinants of people`s attitude, a view also echoed in Ajzen`s (1985) Theory of Planned Behaviour. The findings of the present study also confirm this as a multitude of factors was attributed to shape practitioners` attitudes. Examples of these include perceived seriousness and cause of harm and cultural background. Acknowledging this, it could be argued that changing negative attitudes in clinical practice would be challenging given their enduring nature and multiplicity of influential factors.

11.4.2: Implications for Practice

The findings of the present study indicate that repeated self-harming behaviours in the face of substantial effort to prevent the same can cause healthcare professionals to feel frustrated, anxious and angry with possible thoughts of being a failure. These emotional experiences not only have the potential of disempowering healthcare professionals, they could also enable them to be punitive towards service users. Thus, repetition of self-harm has huge implications for support practitioners. For their sanity and for the welfare of the cared for, practitioners would feel urged to protect themselves against the impact of these unbearable emotions. Failure to find protective measures, in Baker`s (2000) view, would result in them "drowning" alongside with service users. The present study reported a range of strategies

that are noted to be effective for preventing and managing tormenting emotions that healthcare professionals may experience during care provision. Examples of these include teamworking, staff meetings and clinical supervision.

There is a pressing need to prevent the occurrence of this risk or at least to minimise its impact. One way of doing this would be to conduct a comprehensive risk assessment. The focus here would be to establish practitioners` readiness to work with service users with self-harming behaviours and what may constitute a safe workload for them. Not doing so, would be to ignore the psychological impact (distress) this may cause healthcare professionals and the negative attitudes that may be generated from the same. Examples of these attitudes reported in the present study include expressions such as "beyond help", "do it when I am not here" and "manipulator". Ascribing such labels not only distracts healthcare professionals from understanding the context in which the behaviours occur, it also enables them to respond to users as objects. Responding to users this way may inadvertently bring about the need for more self-harm.

A wide range of reasons for self-harm was reported by participants of the current inquiry. It is claimed that self-harm has the function of expressing anger, distress and protest. It is also believed to be a means individuals use to gain a sense of control over some aspects of their lives. Thus, preventing users from harming themselves, could result in their anger and wish for control to be expressed outwardly at healthcare professionals, objects and other members of practice settings. Acknowledging this, the provision of alternative means for emotional expression should be part and parcel of prevention strategies.

It is illustrated in the results of this study that self-harm and suicide or attempted suicides are separate acts, with different behavioural intentions. According to some participants, self-harm is sometimes undertaken by service users to avert suicidal feelings. For these service users, they may harm themselves whenever they are having tormenting thoughts of ending their lives. While this provides an explanation for the increased risk of suicide for individuals who repeatedly self-harm, it is critical to state that this behaviour only temporarily alleviates people`s distress (Hawton and Fagg, 1988). Taking this into account, the occurrence of self-harm should be considered a call for intense engagement to address the underlying motives for the behaviour.

11.4.3: Implications for Future Research

There was poor agreement between practitioners regarding the role of age and gender in influencing responses to service users` needs. While some participants discarded their influence, others do believe that they may have an effect in shaping attitudes. Such disparity in views can be clarified by conducting a study that would focus on these factors using a large sample of participants. Issues relating to future are discussed further in the recommendations section.

It is important at this point to state that some insights about self-harm and attitudes to it have been gained from examining the results of the current study and outcomes of previous inquiries. It is hoped that the knowledge gained will inform the researcher to provide succinct recommendations for policy, practice and research, which are believed will help improve care provision to users with this behaviour.

11.5: Recommendations and Conclusion

The previous section explored the implications of the study. This section focuses on making clear recommendations of issues which emerged from the findings and the research process. It is divided into four subsections; recommendations for practice, training and research, policy development and a summary which serves as a conclusion.

11.5.1: Recommendations for Practice

It is evident in the literature and the findings of this study that practitioners tend to consider self-harm as a negative, maladaptive and destructive behaviour. Pathologising the behaviour not only invalidates users' feelings and underlying motives, it also certainly distracts practitioners from developing a fuller understanding of its meanings and context in which it occurs. For users, self-harm serves useful functions such as communication of feelings and coping with distress. Acknowledging this disparity in views, it is critical for both parties to regularly engage in constructive discourse with a view of developing a common understanding of the behaviour. It is believed that this manner of engagement might result in the identification of more effective care for individuals. Thus, service users with this behaviour should always be encouraged to engage in constructive dialogue with healthcare professionals. Such a dialogue should emphasise on holistic care rather than just the physical needs of the users. It would enable practitioners to recognise the circumstances in which the

behaviour occurs. Contextualisation may help in overcoming prejudices regarding self-harm and the negative responses associated with the same.

A very close look at the findings reveals that negative attitudes are held by some healthcare professionals, and these attitudes tend to influence the manner in which practitioners respond to the needs of users. This study and previous inquiries suggest that responding to users in a negative manner perpetuates their need for more self-harming behaviours. It is therefore crucial for healthcare professionals to be aware of their feelings and the possible impact when working with users who self-harm. Additionally, practitioners need to be flexible and thoughtful in developing individualised care and not to adopt blanket approaches to managing the behaviour.

It is repeatedly stated by some participants that self-harm is an "attention seeking", "manipulative" and "time wasting" behaviour. Service users do find these descriptions insulting, as they clearly indicate a disregard of their behavioural motives. These are certainly erroneous beliefs that may impede effective care provision. Thus, healthcare professionals need to overcome these fallacies about self-harm and to recognise the private and useful functions it serves. Using these descriptors or negative attitudes could erode the self-esteem of individuals. It is therefore important for healthcare professionals to avoid being openly punitive and judgmental.

According to some participants service users harm themselves to regain control of some aspects of their lives. Arguably, feelings of loss of control or being out of control could precipitate self-harming behaviours. Hence, healthcare professionals should work in partnership with service users in planning, delivering and reviewing care. This implies taking into account their thoughts and feelings in these decision making processes, as ignoring the same could result in the generation of distress. Thus, approaches (such as observation and restraint) which remove control from service users should be used with caution.

Self-harm is also used by service users to cope with tormenting emotions. While this behaviour provides an immediate solution to deal with these feelings, its impact is usually temporary as it does not address the source of distress. Hence, the behaviour is more likely to be repeated in the face of stressful situations. Repeated use of this behaviour as a coping

strategy is believed to increase the risk of suicide. Hence, healthcare professionals should explore with service uses alternative means of coping with stress.

The behaviour of self-harm is reported by participants to evoke unbearable emotions in practitioners. If these emotions are not managed effectively, they could be expressed outwardly, in a negative manner, at service users for causing them. It is therefore important for people working with individuals who self-harm to be regularly and consistently provided with formal support such as clinical supervision and debriefing. An optimistic perspective is that supervision has enabled practitioner to be more empathetic with service users. If this is the case, then supervision should be fostered. During supervision meetings, practitioners would be provided with opportunities to express their feelings and to understand their own responses to service users. The motivations underpinning self-harming behaviours should be addressed as well. It is believed that exploring these issues would contribute to healthcare professionals` psychological well-being. It is also critical for practitioners` readiness or suitability for their continuing input with users with this behaviour to be risk assessed during supervision meetings.

11.5.2: Recommendations for Training and Future Research

Pre-registration education is a good starting point for the development of sensitive and effective care for individuals who self-harm (Liebling *et al*. 1975). It can therefore be assumed that providing significant information to learners of pre-registration courses would enable them to gain some understanding of the context of self-harm, it motives and the impact of the behaviour itself on individuals including practitioners. Doing so would have an effect on their perception of the behaviour. The effectiveness of such programmes could be enhanced by involving service users with experience of self-harm as co-facilitators. This would help shape professionals` attitudes towards service users. Noting that attitude can change with time, post-registration courses, as part of continuing professional development, should include issues relating to self-harm. This means that healthcare professionals caring for users with this behaviour should routinely undertake specific education and training in this subject area. It is important to stress that the precise content of the training should be determined by the roles and responsibilities of healthcare professionals. However, an examination of participants` narratives revealed fundamental topics that should be included in all training programmes. Examples of these include attitudes about self-harm, reasons for the behaviour, responding to people who self-harm, specific responsibilities, impact of self-harm,

264

support systems, and policies and guidelines. To impact significantly on attitude, it is believed that a large number of members of team would need educating. Team training is therefore recommended.

A significant source of learning in practice referred to by participants is reflective practice. They claimed that positive and lasting change can be achieved by encouraging practitioner to participate in self-reflection and reflective discussions regarding their attitudes, responses to service users and the impact of the behaviour on themselves and others. Patterson *et al* (2007) concur with this view by stating that these approaches have the potential to alter enduring attitudes.

As this subject area is still poorly explored, further research is needed to explore the attitudes of professionals toward self-harm, but using a multi-methodological approach. This means employing both quantitative and qualitative methodologies in a single study. Doing so would help enrich the knowledge base of self-harm. A comparative study exploring service users` and professionals` attitudes to self-harm, using the same methodology, would also help to enhance understanding. Additionally, further research is needed to explore specific areas of this study. For example, the impact of self-harm on professionals` attitudes and the role of care approaches on service users` self-harming behaviours.

The suggested conceptual models are yet to be tested. Even though their usefulness can be determine in clinical practice, there is a need for future researchers to judge their credibility.

11.5.3: Recommendations for Policy Development

It is evident from the discussions presented in the result and literature review sections of this thesis that safety is paramount in the care of people who self-harm. In the main, it is applied in practice using physical means such as restraint, observation, seclusion and searching. As noted in this study and previous ones, there are variations in the application of these safety measures in clinical practice. This inconsistency can be attributed to the view that the responsibility for developing policy for their implementation lies predominantly with individual NHS Trusts (Bowers and Gournay, 2000). There is little agreement between local authorities on what for example healthcare professionals should do during observation (Duffy, 1995). Given that these safety approaches are universally acknowledged as essential

to protect individuals in state of distress, it is important to prevent or minimise variation in their implementation. The researcher of this study therefore recommends the development of a clear national policy to ensure consistent and cautious use of safety approaches in practice.

The results of the present study highlighted variations in attitudes held by practitioners about self-harm. Some practitioners spoke about negative attitudes and beliefs during interviews, while some acknowledged that people who present with self-harming behaviours are distressed. They also believed that that the distress experienced by these individuals has underlying causes. It is also noted in this study and in the extant literature that the variation in attitudes could result in differential treatment or responses to service users. It is important to emphasis that negative responses could perpetuate service users` need for more acts of harm. Clear guidelines are needed to address this issue. The researcher of this study therefore recommends the development of guidelines to facilitate a non-judgmental and consistent approach to caring for people who self-harm.

11:5.4 Conclusion of the study

This study explored attitudes of healthcare professionals towards service users who self-harm in secure mental health services. It employed a multi-method interpretative phenomenological analysis approach to do this. To be specific it employed both individual and focus group interviews as data collection strategies within this methodological framework. It is important to emphasise that similar themes emerged from both of these sources of data. Expectedly, the discussions presented in the focus groups were relatively richer in the context of depth and breadth than those of the individual interviews.

The findings of the study, which are presented in the first four chapters in part two of this thesis, concur with some outcomes found in the extant literature. One notable outcome is the attitude of practitioners. A mixture of both positive and negative attitudes was presented by participants. It was noted that negative attitudes were more likely a function of practitioners` lack of or limited knowledge and skills of how to care for individuals who self-harm. It has been made clear that expression of negative beliefs would impede effective care provision as well triggers service users` motives to self-harm.

The findings also support an increasing body of literature that suggests that self-harm serves multiple functions for service users. Coping, tension release, the need to regain control, suicide aversion and communication of emotions were among the many reasons identified for service users` self-harming behaviours. While these are useful functions for service users, these behaviours do sometimes have an enormous impact on practitioners. They evoke a range of emotions that are experienced by healthcare professionals as an amalgamated whole, which is overwhelming and unbearable. These emotions therefore require safe expression in order to maintain psychological well-being. Consistent with the literature, this study has illustrated the use of teamworking, supervision, staff meetings and blaming as strategies healthcare professionals use to cope with the impact of self-harm.

Associated with blaming are the fallacies held by healthcare professionals. Some participants of the study, for example, consider self-harm as an attention seeking behaviour. While such beliefs disregard the private nature and useful functions of the behaviour, they have the potential for distancing practitioners from users. They could lead to users been treated punitively. Indications of these conclusions are noted in this study and in the extant literature. There is therefore a clear need for a non-judgmental approach to be adopted when working with this user group. This assertion has been echoed in a number of instances in this thesis. In addition to this, it important to conclude that users who self-harm can best be cared using a holistic approach to treatment, which the researcher believes would enable practitioners to look at the individual as a whole, not as separate "entities".

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