Emergency department staff attitudes towards people who self-harm and the influences of norms on behaviour.

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May 2012

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Target Journal:	Advanced Emergency Nursing Journal
Research Setting:	Emergency Department
Literature review word count:	3986
Research paper word count:	7878
Expanded appendices word count:	3196

Submitted in partial fulfilment of the requirements for the Doctorate in Clinical Psychology degree, University of Exeter

Statement of academic probity and professional practice:

"I certify that all material in this assignment which is not my own work has been identified and properly attributed. I have conducted the work in line with the BPS DCP Professional Practice Guidelines."

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Acknowledgements

I would like to thank my research supervisor, Joanne Smith, for all her support, inspiration and time.

Thanks also go out to Jennifer Scarff for her help with the co-ordination of interviews, and Tess Drabble for her support and agreement to allow this project to be conducted with ease – without your support, this project would have been ten times more difficult.

Finally, I would like to thank all of the participants who provided a wealth of information. Thank you for your involvement; for taking the time out to be interviewed and allowing me to record your thoughts and experiences.

Thank you all.

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Chapter One

Emergency Department staff attitudes towards people who self-harm and

the influences of norms on behaviour: A literature review

Abstract

Self-harm is defined as self-poisoning or self-injury, irrespective of the apparent purpose of the act. It has been widely reported by people who self-harm that, on presentation to services, staff attitudes towards them have been generally negative. This has prompted recent interest in staff attitudes towards patients who self-harm. Research indicates that frustration, irritation and helplessness are common feelings when working with people who self-harm, but that positive attitudes may be increasing. Results are mixed regarding particular groups of people more or less likely to feel negatively towards people who self-harm. The present article reviews the current literature on staff attitudes towards self-harm, incorporating social psychological theory to propose a link between staff attitudes and behaviours towards such people. Specifically, theory on group norms and identity and pluralistic ignorance is reviewed.

Background

The National Institute for Clinical Excellence (NICE; 2004) defines self-harm as "self-poisoning or self-injury, irrespective of the apparent purpose of the act" (p. 16). It is difficult to estimate the prevalence of self-harm; however, prevalence rates are reported to be between 4.6 and 6.6% of the UK population (Meltzer, Lader, Singleton, Jenkins, & Brugha, 2002). NICE (2004) reviewed literature on the perspectives of people presenting to services having self-harmed. It was found that, although positive perceptions were recorded, many people who self-harm perceived staff attitudes towards them to be negative and, at times, their behaviour punitive (see also Taylor, Hawton, Fortune, & Kapur, 2009). Given these results and the high prevalence of self-harm, qualitative research was elicited to understand further the psychological and social origins of attitudes (NICE, 2004). Literature pertaining to this will be reviewed and social psychological concepts, especially in relation to group norms, pluralistic ignorance (PI) and social identity will be highlighted in order to gain insight into the social origins of attitudes towards people who self-harm. In this review, the following concepts will be described and discussed: social norms (as shown through people's behaviour); PI (a self-other bias whereby people mistake others' behaviour as being indicative of their private beliefs, when their own behaviour is not); and social identity (the extent one feels part of a group). It is proposed that these factors may provide a unique theoretical perspective on the development of staff attitudes towards people who self-harm.

Review of Literature on Staff Attitudes toward Self-harm

Search Strategy and Inclusion Criteria

A search of MEDLINE and PsychINFO was conducted, using the Boolean thesaurus to explode 'self-harm', 'staff' and 'attitudes'. ICI Web of Knowledge, AMED, BNI, MEDLINE, PsychINFO, CINAHL and SELF BUSINESS ELITE were searched, using 'self'

AND 'harm' combined with 'staff' AND 'attitudes'. Articles were then hand searched for relevant references. The dates searched were from 1980 to present and only articles written in English were selected. Both qualitative and quantitative research is included in the review. Inclusion criteria specified papers exploring self-harm (and derivatives such as 'self-poisoning') and ED staff attitudes, even if these were as part of a wider study also exploring the attitudes of other professionals, such as psychiatric staff. Studies that only discussed suicidal behaviour were excluded, as were those regarding people with a learning disability who self-harm. The rationale for the latter exclusion was that learning disability itself can be stigmatising and subject to negative attitudes. Furthermore, the confounding factor of self-stimulation due to under stimulation can be misperceived as self-harm. This is consistent with McAllister, Creedy, Moyle and Farrugia (2002) who excluded suicidality and self-harm due to psychotic episodes or as a repetitive behaviour seen in some individuals with a developmental disorder or brain injury. In total, 12 quantitative articles, six qualitative articles, and one literature review were included in the review (see Figure 1.1).
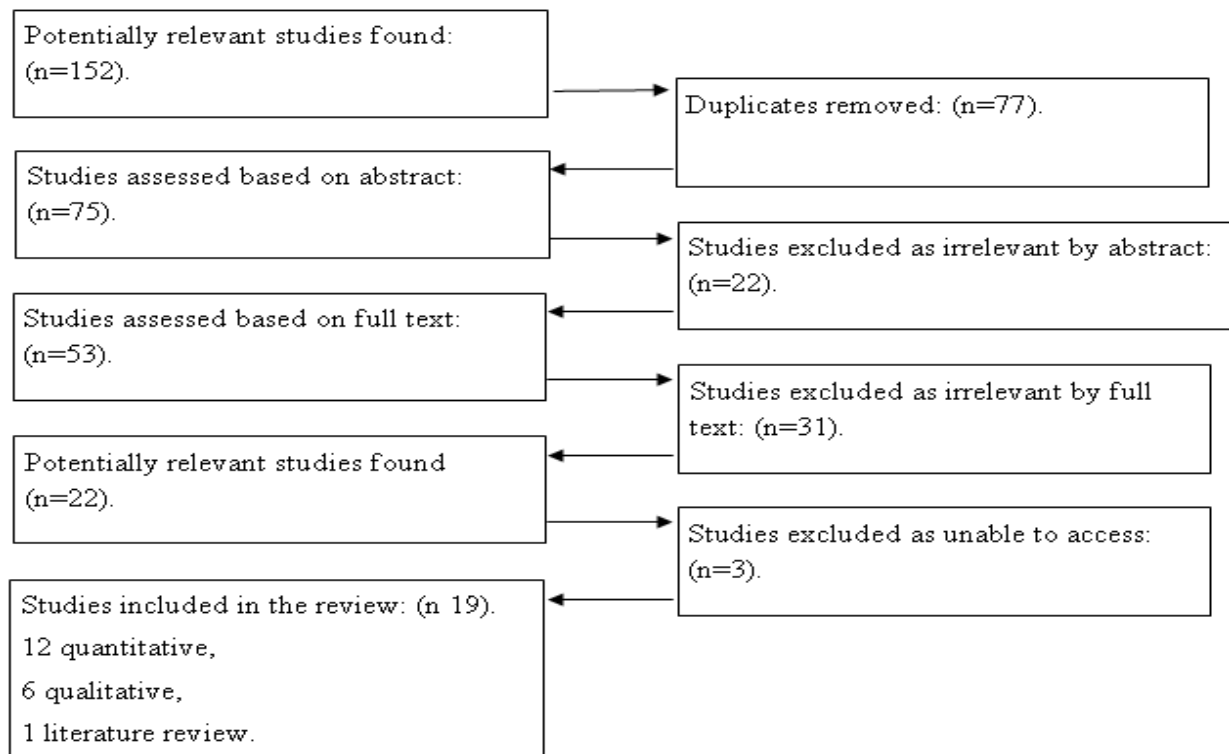
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│ Potentially relevant studies found: │        ┌──────────────────────────┐
│ (n=152).                    │───────────────▶│ Duplicates removed: (n=77). │
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*Figure 1.1: S*tudies included in the review

Quantitative Research

Patterson, Whittington and Bogg (2007) developed the Self-Harm Antipathy Scale (SHAS), a questionnaire designed specifically to measure nurse attitudes to deliberate self-harm. They found nurses trained in general nursing reported significantly more antipathy compared to those trained in mental health. In addition, further post-qualification training specifically in self-harm decreased antipathy (see also Winship, 2009). Huband and Tantam (2000), however, found attendance at self-harm training had no impact on attitudes, although therapeutic training increased perception of patient control over self-harm. Winship, also using the SHAS, found increased antipathy in men and a positive correlation between antipathy and length of service, but no difference between antipathy in registered and non-registered nurses.

McAllister et al. (2002) developed the Attitudes Towards Deliberate Self-Harm Questionnaire (ADSHQ). They reported negative attitudes towards self-harm, with a large hospital reporting less empathy compared to a smaller one, although feeling able to help increased positive attitudes. McCarthy and Gijbels (2010), using an adapted version of the ADSHQ, found nursing staff generally held positive attitudes, although, older (between 51 – 60 years) and hospital trained nurses had less positive attitudes. Crossover of these aspects was not explored. Positive attitudes were reported by Anderson and Standen (2007), and McCann, Clark, McConnachie, and Harvey (2006, 2007), using the Suicide Opinion Questionnaire (SOQ). Anderson and Standen found self-harm was mainly viewed as a 'cry for help', rather than a 'moral evil', in staff working with young people, although this appeared to be a recent shift. Age, gender, length of experience and clinical speciality made no difference to attitudes reported. McCann et al. (2006, 2007), however, found older or more experienced nurses to be more sympathetic. Huband and Tantam (2000) found no effect for gender, but found significant differences for age and work setting: younger participants had less understanding of self-harm and doctors and inpatient staff believed the self-harming patient to be more difficult. Crawford et al. (2003) similarly found a low incidence of negative attitudes, especially in those who reported feeling more effective. In contrast, Mackay and Barrowclough (2005) found that males reported more frustration and less sympathy. Junior doctors reported less optimism and more irritation and indicated less helping behaviour compared to nursing staff, although overlap between gender and profession was not reported. Believing that self-harming behaviour is within the person's control (also found to have the most dominant effect by Huband & Tantam, 2000) increased levels of irritation and frustration, which, in turn, decreased helping behaviour. However McCann et al. (2007) reported that perceived negative attitudes of others (indicated using the statement "why didn't they do it [killing themselves] right this time") either did not impact or

increased care slightly. Although McCann et al. (2006, 2007) found attitudes to be sympathetic, many staff reported hearing negative attitudes.

McKinlay et al. (2001) used the theory of reasoned action (TRA; Fishbein & Ajzen, 1975) to examine nurses' helping behavioural intentions in relation to self-poisoning patients. The TRA suggests that intention is the main predictor of behaviour and that intention itself is influenced by one's attitudes and subjective norms (beliefs regarding whether relevant others approve or disapprove of a behaviour). The study found that only attitudes were a unique predictor of behaviour; however, nurses with a more positive attitude to self-harm were more identified more with doctors and psychiatric staff, who also reported more positive attitudes.

Ramon (1980) compared the attitudes of doctors and nurses in a psychiatric and general medical setting. It was found that, readiness to help was generally high, but was lower in doctors and nurses in a general, compared to psychiatric setting, despite decreased sympathy in the latter. Furthermore, Ramon found that, compared to perceived manipulation, a perceived genuine wish to die increased sympathy, which was linked with the highest readiness to help. This implies that both group norms and personal attitudes are important to consider when exploring staff behaviour.

Methodological Considerations

The design of these studies enabled large samples and had high response rates (circa 70 – 80%). They also looked at attitudes towards self-harm in young people (Anderson & Standen, 2007; Crawford et al., 2003) and adults, while covering many countries (England, Australia, Malta, and Israel).

Of the scales developed, the SOQ has been criticised in its use by McCarthy and Gijbels (2010), who argue it is inappropriate, given its reference to suicide, rather than self-harm,

possibly evoking different attitudes. The SHAS reported a higher overall Cronbach's Alpha than the ADSHQ, suggesting it has greater internal consistency and is a more accurate measure. Even when adapted by McCarthy and Gijbels (2010) for use in their study, Cronbach's Alpha on the ADSHQ did not greatly improve. Both the SHAS and the ADSHQ gained face validity through literature searches, focus groups, and through completion of a pilot study. Other questionnaires, such as that by Crawford et al. (2003) were developed to answer a specific research question directly, but did not present data on the internal consistency or face validity, although this may have been completed.

Hopkins (2002) argued that in questionnaire studies participants are self-selected and therefore potentially biased, and may be influenced by political correctness, also acknowledged by Crawford et al. (2003). These criticisms reflect all the quantitative studies described; however, the impact of these criticisms on reporting of negative behaviours can only be assumed, especially as confidentiality was assured in all studies. Furthermore, the categorisation of attitudes as being either positive or negative is open to criticism. Some of attitudes, such as frustration, are labelled as negative when they may not be because of or directed towards a patient.

In sum, there are gaps in the quantitative research related to more in-depth exploration of attitudes, such as, what constitutes a 'negative' attitude, and contextual information regarding when and why particular attitudes may occur, which qualitative research attempts to address. Furthermore, there is a lack of research into whether and when staff attitudes are related to actual behaviour..

Qualitative Research

Hadfield, Brown, Pembroke, and Hayward (2009) used Interpretative Phenomenological Analysis (IPA) to answer questions about staff experiences of working with people who self-

harm and their understanding of this. The findings were that staff expressed feelings of frustration and futility on many levels: When the person self-harming is perceived as being manipulative, with the medical model 'treating the body', and with keeping feelings inside and 'silencing the self' (two themes also found by Wilstrand, Lindgren, Gilje, & Olofsson, 2007; named 'cutting self-off emotionally' and the fear and frustration of 'being burdened'). Frustration was linked with giving patients less time, especially when anger and irritation arose from perceptions of manipulation. Also using IPA, Thompson, Powis, and Carradice (2008) found many similar themes, such as; 'trying to understand', 'boundaries of responsibility', and 'learning to cope'. Interviewees spoke of frustration and irritation and perceptions of being manipulated. However, Thompson et al. argued that within the frustration and irritation, there was also a wish to understand, a richness, they argue would not have become apparent within a quantitative study. Winship (2009), using Grounded Theory, found themes congruent with the above studies. He found that sympathy and empathy were described, but that antipathy and labelling also occurred. Insufficient training and concern about harm minimisation were recorded. Saturation, however, was not reported.

Hopkins (2002) used an ethnographical approach to analysis and used observation and interviews. Difficulties in understanding why people self-harmed and the perception of not having the skills required to help were discussed. This was related to frustration and helplessness, along with feeling responsibility for people who self-harm. There was evidence that, over time, people became cynical, with sympathy turning to frustration.

S. E. Smith (2002) found explicit reporting of negative attitudes in relation to expressed negativity of others (with half the participants reporting negative treatment and treatment being dependent on the attitudes of those that are working at the time).

Methodological Considerations

Qualitative methodologies were chosen and described appropriately. The aims of these studies were to gain insight into the lived experience (therefore using a phenomenological approach), the culture of a group (using ethnography) and to generate new theory, using Grounded Theory and Content Analysis techniques. Many of the authors described their own theoretical perspective and personal experiences that led them to research attitudes towards self-harm.

The majority of studies used semi-structured interviews and many authors described the inductive process of adapting the interviews to better capture themes earlier participants had raised. Hopkins (2002) used observation as well as interviews to increase validity, but there was little other evidence of triangulation. Only one study reported using more than one researcher to analyse data and contact participants to ensure accuracy (Thompson, Powis, & Carradice, 2008).

Although themes described were always supported with appropriate quotations, there was, at times, a lack of depth in the descriptions surrounding the generation of codes and themes and it was not always explicit whether the themes were generated by one person or if they were cross referenced with other authors. Many studies did, however, describe the process of revisiting interviews during theme generation. Strikingly, although different in name, the themes generated in the qualitative research were very similar. All discussed frustration and irritation, a tendency to believe some patients who self-harmed were manipulative, and the perceived lack of training, education and knowledge to manage or 'cope' with working with people who self-harm. This gives credibility to the themes generated and lends to the 'trustworthiness' of the data.

Few studies explored the behavioural outcomes of attitudes and only S. E. Smith (2002) was explicit in recording participants' beliefs about others' attitudes and how behaviour can change dependent on the attitudes of who is working. This gap in the research is pertinent to the importance of the social context for attitudes and behaviours and can potentially be explained through social psychological theory.

Literature Review: Attitudes and Knowledge of Clinical Staff Regarding People Who Self-harm

In a broad literature review by Saunders, Hawton, Fortune and Farrell (2012), attitudes of staff in medical settings were found to be predominantly negative, especially if the patient presented repeatedly or under the influence of alcohol. These attitudes were found to be relatively stable over time, despite changes in awareness and guidance on working with people who self-harm. However, there were reports of more positive attitudes (sympathy) in some studies. Sympathy was often linked to having lethal intent or a diagnosis of a mental illness. There is a need for clarification and exploration of potential reasons for these differences. Knowledge and understanding of self-harm was explored in many studies; however, this was related more to identification of risk and management procedures, rather than understanding of what self-harm is and why people engage in it. Training was often seen to improve attitudes; however, the impact of this on behaviour was only cited in one paper, finding that changing attitudes did not change behaviour (Gask, Dixon, Morriss, Appleby, & Green, 2006). This shows that while individual attitudes may change through training, it will not necessarily improve patient care. Furthermore, perceptions regarding the EDs role appeared to influence attitudes, with more negative attitudes being reported in medical settings, compared to psychiatric ones. This might be related to the ED being perceived as not the place to treat people who have self-harmed, or that the constraints within a medical setting impact on the ability to build relationships with patients. What is noticeably

absent in the literature review are any links between attitudes and behaviour. This highlights the lack of exploration of the links between attitudes and behaviour within research on staff attitudes towards self-harm.

Methodological Considerations

The author of the current review notes that the search strategy was restricted to articles published in the English language, resulting in a potential over-representation of Western cultures. It is suggested that cultural attitudes towards self-harm may play an important role, but these are not discussed. Although this critique is raised and an explicit search strategy provided, the number of studies in languages other than English found was not reported. This results in uncertainty as to whether it is only an issue of the language used, or whether there is also a lack of research into self-harm within non-Western cultures. This review is helpful in gaining a broad overview of the literature; however, it is noted by the author that its broadness results in general themes being elicited, but restricts the ability to provide more detailed critique or comparison. Again, the lack of research into attitude-behaviour links is highlighted.

Limitations and Summary of this Review

The limitations of the present review are similar to those reported by Saunders et al. (2011). The inclusion of both quantitative and qualitative research may have impacted on the ability to draw more in-depth conclusions. While the more stringent search criteria enabled more in-depth critique of the research, it resulted in a loss of breadth that the review by Saunders et al. (2011) provided.

The current review has highlighted recurring themes in the qualitative studies, but findings from quantitative studies varied. In addition, the majority of the quantitative research

focused on developing and testing self-harm attitude scales or used suicide attitude scales. Gaps in the research that have been highlighted through this review are the lack of contextual understanding regarding when particular attitudes may occur, what constitutes a negative attitude, and links between attitudes and behaviour. Social psychological theory may provide insight into the attitude-behaviour relationship and an explanation for the apparent stability of attitudes and resulting behaviours despite changes in understanding, training, support and provision of services. For example, attitudes, while a possession of the individual, are also reflections of the social context. As NICE (2004) argue, the social context should be considered when attempting to understand attitudes in relation to behaviour. Therefore, the following factors that may increase understanding of this relationship will be discussed: social norms, PI, and social identity.

Norms, Pluralistic Ignorance, and Social Identity

It is argued that attitude is not always the best predictor of behaviour (J. R. Smith & Louis, 2009). Social norms are a set of often unspoken and implicit rules defined by people's behaviour. Social norms can determine behaviour as they provide information on what behaviours are seen to be acceptable and those that are not. Individuals may therefore use these norms to act in ways that will receive social reward/avoid punishment or that are perceived to be most effective within the group (Prentice & Miller, 1993; J. R. Smith & Louis, 2009). As these norms are implicit, they are prone to misperception. These misperceptions can lead to PI, whereby people mistakenly believe that while what other people do reflects their private beliefs, this is not true for themselves (a self-other bias). This causes an internal conflict between the perceived norms (that the behaviour is common and accepted) and private beliefs (that the attitude or behaviour is unacceptable). Prentice and Miller (1993) designed four studies on college student drinking to study the phenomenon. They found that PI was evidenced by a reported difference between students' own attitudes

and their beliefs about the attitudes of other students. Pluralistic ignorance has also been found in other areas (see Bowen & Bourgeois, 2001; Sallot et al., 1998; and Wenzel, 2005).

Differences found in some of these studies highlight the importance of social identity when looking at normative behaviour. Social identity describes members and prescribes appropriate behaviour (norms). Terry and Hogg (1996) found that people were more likely to change their behaviour to conform with the perceived group norm if they identified strongly with that group, and that personal attitudes were a more important predictor of behaviour for those who did not have a strong group identification. They also argued that for there to be any impact, the group had to be behaviourally relevant to the behaviour, hence finding a greater effect when looking at sun protection behaviour in a group of Australian women (a behaviour highly relevant to the group) compared to looking at exercise behaviours among a group of college peers (where exercising behaviour may not be the most salient point of reference for the group).

There is evidence that exposure of PI may change people's understanding of others' attitudes and result in behaviour change (Wenzel, 2005), but that this is more likely to happen if individuals have a strong group identity (Terry & Hogg, 1996). Prentice and Miller (1993) cite caution when using counselling and information techniques to change group behaviour, because although these may impact on the individual's attitudes, it may not change their perception of others' attitudes, therefore not impacting on their behaviour.

Summary and Linking of Themes

Evidence suggests that social psychological theory regarding norms, identity, and PI can shed light on staff attitudes towards self-harm. Research on self-harm has alluded to a conflict within staff, where they accept that treatment is not always as it should be and recognise that they will at times behave in ways congruent with this, despite the internal distress this causes.

It is suggested that misperception of group norms can influence behaviour of an individual within a team, and therefore, patient care. The equivocal findings from the quantitative studies support the argument that norms influence the attitude-behaviour relationship. A person's reference group is likely to impact on their attitudes and behaviour, as suggested by the social identity approach, possibly explaining the discrepancies found in attitudes and behaviour between different 'groups' (e.g., age, training, background, and clinical setting). This is especially important as the NHS, rightly, places great emphasis on teamwork. Pluralistic ignorance could explain why some studies have found positive attitudes in staff towards people who self-harm, when there are contradictory reports both in research on staff attitudes and patients' perceptions of staff attitudes. This could be a clinical example of a self-other bias; that is, I give people who self-harm less time to fit in, but others do it because that is what they believe. This is likely to contribute to the conflict that staff report in the qualitative studies, clarifying the more congruent themes in qualitative research, compared to the contradictory findings of the quantitative research.

The current NHS ethos prioritises training and research regarding self-harm highlights the importance of further training, suggesting it is wanted (Saunders et al., 2012). Social psychological theory suggests that any training, especially directed at changing staff attitudes should be completed with caution (Cialdini, 2003). Individual work may change personal attitudes, but will not change beliefs regarding peer attitudes and providing information may result in inferences being made that negative attitudes towards self-harm are prevalent, therefore increasing them. Therefore, the most helpful training would expose PI, while providing normative information that highlight positive attitudes and ethos.

Recommendations for Future Research

This review on staff attitudes towards self-harm has highlighted gaps in the research and, at times, equivocal results. There is allusion to a self-other bias; however, few studies research attitude-behaviour links. Further research into staff attitudes to self-harm would benefit from gathering qualitative information on the realities of experience and contextual factors impacting on ED staff, while exploring group norms, PI, and social identity, providing a unique link between attitudes and behaviour.

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Chapter Two

Emergency department staff attitudes towards people who self-harm and the influences of norms on behaviour: A thematic framework analysis.

Abstract

Patients who self-harm reported negative staff attitudes towards them on presentation to an Emergency Department (ED). The present research aims to explore staff attitudes and behaviours (own and perception of others') and the impact of this on behaviour, barriers and facilitators of effective treatment, and team identification and norms.

Ten staff members from one ED were interviewed, representing all major professional groups working non-therapeutically in the ED. A thematic framework analysis was applied and cross-referenced with another researcher and participants for validation.

Analysis identified the following themes: Beliefs about self-harm, attitudes and behaviours, influences on behaviour, and identity, culture and role; related through an overarching theme of balancing difference and diversity.

Evidence of PI was found, although interviewees were able to accurately recognise a mixture of beliefs and attitudes in both themselves and others. Influences on behaviour and identity were important in gaining a contextual perspective, and the concept of a 'fluid team', relating to patient needs, was highlighted. Results suggest that exposure of the phenomenon of PI may be useful, in conjunction with training to minimise feelings of failure/frustration. This could increase understanding and improve patient care; however, further research is required prior to this. Team stability must, however, be considered.

Limitations included restricted participation across one ED and a powerful advocate for mental health patients. Although this is positive for the department, it may set it apart from others.

Key Words: Self-harm; Staff attitudes; Pluralistic Ignorance; Group norms; Thematic framework analysis.

Background

In 2002, the Office for National Statistics reported that between 4.6 and 6.6 per cent of adults

in the UK had previously self-harmed (Meltzer, Lader, Singleton, Jenkins, & Brugha, 2002),

although this may not be the full extent of self-harm (Hawton, Rodham, Evans, & Weatherall,

2002; Meltzer et al., 2002). It is also reported that rates of self-harm are increasing

(Saunders, Hawton, Fortune, & Farrell, 2012). It is important that this increase is considered,

as people who self-harm are likely to present to an Emergency Department (ED) due to their

injuries at some point, where the majority of staff are not trained in mental health. The

National Institute for Clinical Excellence (NICE; 2004) compiled a literature review

regarding the views of patients who self-harm. Although there was a mixture of perceived

attitudes, the major finding of this review was that patients perceived staff attitudes as

generally negative, which can lead to punitive behaviour. These findings were replicated in a

review by T. L. Taylor, Hawton, Fortune, and Kapur (2009), leading to a recent increase in

research into staff attitudes towards people who self-harm. This research aims to explore

staff attitudes and behaviours (own and perception of others') and the impact of this on

behaviour, barriers and facilitators of effective treatment, and team identification and norms.

Staff Attitudes Towards Self-harm

In a broad literature review by Saunders et al., (2011), attitudes of staff in medical settings

were found to be predominantly negative, especially if the patient presented repeatedly or

under the influence of alcohol. These attitudes were found to be relatively stable over time,

despite changes in awareness and guidance on working with people who self-harm. Some

studies reported positive attitudes, such as sympathy, although these were most often linked

to lethal intent or a diagnosis of a mental illness. This shows the need for further clarification

relating to staff attitudes and potential reasons for these differences. Knowledge and

understanding of self-harm was explored in many studies; however, this was related more to identification of risk and procedures for managing patients who self-harm, rather than increasing understanding of self-harm. Training was also often explored and seen to impact positively on attitudes. However, whether this improvement in attitudes was translated into behaviour was only considered in one paper (Gask, Dixon, Morriss, Appleby, & Green, 2006), finding that changed attitudes did not change behaviour. This shows that while training may influence individual attitudes, it will not necessarily improve patient care. Furthermore, perceptions of the EDs role appeared to influence attitudes, with more negative attitudes found in medical settings, compared to psychiatric ones. This might be related to perceptions that EDs are not the place to treat people who have self-harmed, or constraints within a medical setting. Furthermore, the reporting of an attitude as negative is contentious. While attitudes, such as frustration and helplessness may not be comfortable for the professional, this may be more related to contextual factors, such as time constraints, rather than the patients themselves. This suggests that further research is needed. What is noticeably absent in the literature review is the exploration of links between attitudes and behaviour.

As noted above, the review highlights the lack of research on attitude-behaviour links, despite this being an important consideration relating to patient experience. A fuller description of individual studies can be found in Chapter 1; however, five studies that reported influences of attitudes on behaviour will be discussed here. Ramon (1980) found that, while readiness to help was generally high, doctors and nurses in a general, rather than psychiatric setting, showed less readiness, but those in psychiatric settings showed less sympathy. This was despite increased sympathy being the highest indicator of readiness to help. This apparent contradiction between attitudes and behaviour may be a result of professional norms and social identity influencing behaviour. This needs further exploration in order to better

understand behaviour. Furthermore, Ramon (1980) found that a patient perceived as having a genuine wish to die was shown more sympathy than when the motive was seen as manipulative, highlighting the importance of contextual factors, group norms, and personal attitudes. Mackay and Barrowclough (2005) found that increased irritation among staff decreased helping behaviour and McCann et al. (2007) found that hypothetical comments such as "why didn't they do it [killing themselves] right this time" were reported to either not affect behaviour or increase care given slightly. Although they did not provide an explanation as to why this might be the case, they noted the prevalence of such negative comments and the need for further investigation into the relationships between attitudes and patient care.

McKinlay, Couston, and Cowan (2001) used the Theory of Reasoned Action (TRA; Fishbein & Ajzen, 1975) to study behaviour. Findings suggested nurses' behavioural intentions are linked to both attitudes and subjective norms, although attitudes are a stronger predictor of intention. This study also highlighted the importance of identification with a reference group, as nurses with a more positive view of self-harm identified more with senior medical and psychiatric staff (who held a similar view), and were more motivated to comply with ways of behaving supported by them. Of all studies, S. E. Smith (2002) is the most explicit in reporting the influence of group norms and identification on behaviour. Although this was not reported as a main finding, she reports that "the treatment/care [of patients who self-harmed] received was 'dependent on who is in the service and what their attitude is towards them'" (p.598). There is, however, no further explanation of this, highlighting the importance of further research to identify reference groups and their influences within the ED and explore the impact of them on attitudes and behaviour.

In sum, results of past research are equivocal and demonstrate the complexities of staff attitudes towards self-harm. Also, few studies explored the behavioural outcomes of

attitudes, either positive or negative. Social psychological theory may be able to provide insight into the attitude-behaviour relationship and an explanation for the apparent stability of attitudes and resulting behaviours despite changes in understanding, training, support and provision of services. For example, attitudes, while being individual, are also reflections of the social context. The social context is highly important in determining whether or not an attitude will be translated into behaviour, and therefore should be considered when attempting to understand attitudes in relation to behaviour. Factors that could increase understanding of the relationship between attitudes and behaviour are social and group norms, pluralistic ignorance and group identity, which will be explained and discussed next.

Social Norms

J. R. Smith and Louis (2009) argue that attitude is not always the best predictor of behaviour, suggesting that norms are also influential. This is consistent with the above findings that although individual staff attitudes towards self-harm changed through training, their behaviour did not. First then, to define norms: Social norms refer to our perceptions of how our peers behave, and are defined by group members' public behaviour (McAlaney, Bewick, & Bauerle, 2010; Prentice & Miller, 1993); they are the unwritten and unspoken rules that guide our behaviour (J. R. Smith & Louis, 2009). Subjective norms are norms based on perceptions of others' attitudes and the desirability of a particular behaviour (Terry & Hogg, 1996). When behaviour is consistent with private beliefs, the social and subjective norms will be concurrent. However, when behaviour does not concord with private beliefs, the subjective norm is open to misperception (Prentice & Miller, 1993) and can motivate behaviour in different ways (Cialdini, 2003: see Appendix 1).

Norm Misperceptions and Pluralistic Ignorance

Perkins, Craig, and Perkins (2011) recognised a wealth of research that suggests negative

attitudes and behaviours are often misinterpreted as being the norm and are therefore seen as

more salient. They suggest that this misinterpretation may be due to an attribution error or

due to an inordinate amount of attention being given to negative behaviours, which can lead

to an increase in the behaviour due to its perceived salience. This is an example of where

public behaviour, such as treating people who self-harm perfunctorily, can be misperceived

as being a common behaviour and therefore the behaviour is replicated. Norm misperception

can lead to a phenomenon called pluralistic ignorance (PI). This is where people mistakenly

believe that others' behaviour is indicative of their private beliefs, but do not see this to be the

case for themselves (a self-other bias). This causes a conflict between the perceived norms

(that the attitude/behaviour is common and accepted in others) and their own personal values

(of not holding the attitude and the behaviour perceived as unacceptable). In their seminal

study of PI, Prentice and Miller (1993) designed four studies on college student drinking to

look at the phenomenon. Evidence of PI was found, where students rated their own beliefs to

be significantly more negative towards drinking than a 'typical' student and their friends.

Furthermore, the behavioural consequences of PI were that, over time, exposure to a

misperceived norm either changes attitudes to conform to the perceived norm, or alienates

individuals from the group. One explanation for this came from research by Lewis and

Neighbors (2006), who suggest that conformity or alienation will be dependent on the value

placed on the group, highlighting the importance of reference groups (discussed later).

Ultimately, however, the consequences of PI are that negative behaviours can be reinforced

and, as shown with drinking behaviour, increased. Within the realms of attitudes towards

self-harm, this could mean that, although individuals hold positive private beliefs about

people who self-harm, they may perceive this view to be in the minority. This misperception

could result in the individual engaging in more negative behaviours in order to fit in with the (mis)perceived norm.

Although PI has been found in other areas (e.g., tax compliance; Wenzel, 2005), there is not much research that focuses on PI and workplace behaviour. Sallot, Cameron, and Weaverlariscy (1998) explored attitudes of PR professionals in relation to their peers and consensus of agreement on professional standards. Evidence of PI was found, where individuals believed that they were more professional and held higher status than their peers; however, there was little agreement on factors involved with professional standards. This research highlights two important issues. First, that professional norms (standards) are not accurately described; and second that these norms are misperceived in relation to others' beliefs.

Understanding the social norms within a group context and the extent to which they are misperceived is, therefore, important. Norms do not exist in isolation and are a result of social interactions, therefore social identity and reference groups must also be explored to determine whether attitudes and norm perceptions are translated into behaviour.

The Importance of Identity

Terry and Hogg (1996) critically reviewed the normative component of theories on the attitude, norms, and behaviour relationship. They argued that norms were misconceptualised and seen to be independent of attitudes, suggesting that a wider, social definition of norms must be considered. Furthermore, they suggest that the effects of social influence should be seen as related to, rather than independent of, attitudinal influence; meaning that "an attitude will be expressed behaviourally only when a supportive normative environment exists" (p. 778). The result is, when social identity is salient, group members' behaviour is guided more by group norms than individual properties of the self.

It is important to look at social identity within organisations. Indeed, Obschonka, Goethner, Silbereisen, and Cantner (2012) found in their study of scientists' engagement in entrepreneurship that group identification moderated the routes to entrepreneurial behaviour. Although intention and behaviour were the same in both high and low group-identifiers, high-identifiers' behaviour was influenced more by social norms. In the study by Sallot et al. (1998) it could be argued that PI did not affect behaviour as the lack of consensus in professional norms and therefore low group identification meant other PR professionals were not a valid reference group. Research supports this, by recognising that exposing PI may result in behaviour change (Wenzel, 2005), but that this is more likely to happen if individuals have a strong group identity (Terry & Hogg, 1996). These findings highlight the importance of identifying what the social norms within a group are in order to determine the effects of identification on behaviour. For example, if ED staff identify highly with the team, they are more likely to engage in behaviour that is consistent with the perceived social norms. If the norm (mis)perception is that people who self-harm should be treated as quickly as possible, high-identifiers are likely to engage in this behaviour, regardless of their private beliefs, whereas if identification was low, individual factors may be more influential and this behaviour not engaged in.

Fluid Teams

Current research on identity makes the assumption that teams are fixed and stable; however, Fried, Leatt, Deber, and Wilson (1988) described a dynamic team, where the needs of the patient determined team members. Interest in the changing nature of teams has increased recently (Bushe & Chu, 2011; Tannenbaum, Mathieu, Salas, & Cohen, 2012a), highlighting the fact that teams no longer meet previous definitions (e.g., that membership is stable and unitary). One change identified is that of dynamic composition; that is, modern teams demonstrate fluidity of membership, with some teams forming inner and outer circles.

Linking Theory and Practice

Research on self-harm has alluded to a conflict within staff, where they accept that treatment is not always as it should be while recognising that they will, at times, behave in ways congruent with this, despite internal distress. Furthermore, it appears that social norms may influence behaviour (through conforming to the behaviour of a reference group). A person's reference group may impact on their attitudes and behaviour, as suggested by the social identity approach (Terry & Hogg, 1996), possibly explaining the equivocal results reported (e.g., Saunders et al., 2011). This is especially important as the NHS emphasises teamwork. Pluralistic ignorance could explain the negative patient experiences reported and the discrepancy between the high percentage of staff describing their attitudes as being positive, in contrast with high reports of negative attitudes in others (McCann, Clark, McConnachie, & Harvey, 2006; McCann et al., 2007). This could be a clinical example of a self-other bias. Staff may believe they give people who self-harm less time in order to fit in, but that others behave in this way because it fits their beliefs, leading to the conflict reported.

Gaps in the Research

To sum, there are gaps in the existing literature. Further research into staff attitudes to self-harm would benefit from gathering information on social identity, group norms, and perceptions of peers' attitudes and behaviours. This will provide a unique understanding of the link between attitudes and behaviour, by understanding the norms that shape individual attitudes and behaviour. The existence of PI and social norm misperception can exacerbate undesired behaviour, although this will be more influential for those who identify highly with the group. Given these considerations, and the relative infancy of this area, the current research will use qualitative interviews to explore these issues.

Aims and Hypotheses

The current study aims to explore:

1. ED staff attitudes towards people who self-harm and the impacts of this on behaviour.

2. ED staff perceptions of other team members' attitudes towards people who self-harm and how they believe this impacts on behaviour.

3. The perceived barriers to and facilitators of effective working with people who self-harm.

4. Who ED staff identify with as their team and the perceived team norms.

Method

Participants

The sample comprised of ten NHS staff in an Emergency Department (ED). All healthcare staff with one-off patient contact to treat initial presenting problems were included in the study, therefore excluding any staff whose main remit is to work therapeutically with patients. The ED was chosen due to its location for the main researcher. Furthermore, as the interviews were initially intended to facilitate the development of a questionnaire as part of a larger project, and due to the limited timeframe of the project, it was agreed that a small sample would be sufficient. Two doctors, one manager, four senior nurses, two staff nurses and one health care assistant (HCA) were interviewed. Of these, three were men and seven women. Full demographic information will not be given to ensure participant confidentiality; however, basic information is provided in Table 2.1.

Table 2.1

Participant Demographics

Participant	Sex	Professional Role
1	Female	Managerial staff
2	Female	Senior Nurse
3	Female	Senior Nurse
4	Female	Staff Nurse
5	Male	Doctor
6	Female	Senior Nurse
7	Female	Staff Nurse
8	Male	Doctor
9	Male	Senior Nurse
10	Female	Health Care Assistant

Recruitment

Initial contact was made through the manager of the department and a field collaborator was identified. Recruitment was through self-selection and word of mouth (see Appendix 2.1). Those willing to participate provided written informed consent prior to interview commencement (Appendix 2.2*).*

Design and Procedure

An interview schedule was developed to meet the research aims (Appendix 2.3), to which changes were made as a result of pilot interviews with trainee psychologists (see Appendix 2.4). Srivastava and Thomson (2009) suggest that interview schedule questions, derived from the research aims, have particular objectives, such as to understand why

something occurred (i.e., a diagnostic objective). Understanding the objectives can be helpful when exploring recommendations based on the results and emphasise the purpose of the questions. Table 2.2 shows the interview questions and the objectives.

Table 2.2

Research Objectives and Interview Questions

Objective		Research question(s) (Aim)
(a) Contextual	i.	What is understood about self-harm? (Aim 1).
	ii.	What are the attitudes towards people who self-harm (self and others)? (Aim 1 and 2).
	iii.	What happens when someone with self-harm presents (self and others)? (Aim 1 and 2).
	iv.	What is the experience of working with someone who self-harms? (Aim 1).
	v.	What support is available? (Aim 3).
(b) Diagnostic	i.	Why do people hold these attitudes towards those that self-harm? (Aim 1, 2, and 3).
	ii.	Why do people behave in these ways when presented with someone who self-harms? (Aim 1, 2, and 3).
(c) Evaluative	i.	What factors facilitate the effective treatment of people who self-harm? (Aim 3).
	ii.	What are the barriers to effective treatment of people who self-harm? (Aim 3).
	iii.	What is the impact of experiences of working with people who self-harm? (Aim 1, 2, and 3).
(d) Strategic	i.	What are team norms? (Aim 4).
	ii.	How do people identify with the team? (Aim 4).
	iii.	Is there a difference between own attitudes and perception of others' attitudes? (Aim 1 and 2).
	iv.	What might improve treatment offered? (Aim 3).

The use of a semi-structured interview allowed the researcher to adapt questions to each individual participant. Interviews were conducted with individuals in a private room, lasting from 20 minutes to one hour (Appendix 2.5*).* Interviews were digitally recorded and transcribed verbatim. Sections of transcripts were cross-referenced with interview recordings by another researcher to ensure accuracy. Although saturation may not have been reached, the timeframe and initial remit of the project allowed for a smaller number of interviewees.

Ethics

Ethical approval was sought through the University of Exeter Ethics Committee, the National Research and Ethics Committee, and the Research and Development Department for the NHS Trust through which participants were recruited (Appendix 2.6*).*

Analysis

A thematic framework analysis was chosen, as it allows for the research objectives to be developed *a priori* and expects that the framework, at least in the early stages, to concord with these objectives, while facilitating inductive reasoning based on data gathered during the interview process. A thematic framework analysis was applied to all the interviews following guidance provided by Ritchie and Spencer (2002). NVivo was used to facilitate this analysis, which involved a five stage process of *familiarisation, identifying a thematic framework, indexing, charting* and *mapping and interpretation..* Table 2.3 shows a summary of these processes.

Table 2.3

Process of Thematic Framework Analysis (Pope, Ziebland, & Mays, 2000)

Stage	Description
Familiarisation	Immersion in the raw data by listening to tapes, reading transcripts etc. in order to list key ideas and current themes.
Identifying thematic framework	Identifying all the key concepts, ideas, and themes that the data can be examined, coded, and referenced by. This uses both *a priori* objectives as well as issues emergent from the data.
Indexing	Applying the framework systematically to all data using framework codes.
Charting	Rearranging the data according to the appropriate part of the thematic framework to which they relate and forming charts. This involves charting each theme, using distilled summaries of the main points from each participant. This process requires abstraction and synthesis.
Mapping and interpretation	The charts are used to define concepts, map the range and nature of phenomena, create typologies and find associations with the themes, with a view to providing explanations for the findings. This is influenced by the research objectives and the emergent themes.

The researcher sought to discuss identification of themes with individual participants. Furthermore, another researcher coded and extracted themes, which were then compared to initial codes and themes found by the primary analyst (Appendix 2.7*)*. The inter-rater reliability was high, suggesting that themes identified accurately described the data presented. The key features of a framework analysis (Ritchie & Spencer, 2002) were adhered to (Table 2.4).

Table 2.4

Key Features of a Framework Analysis (Ritchie & Spencer, 2002)

Key Feature	Description
Grounded or generative	Heavily based in, and driven by, the original accounts and observations of the people it is about.
Dynamic	Is open to change, addition and amendment throughout the analytic process.
Systematic Comprehensive	Allows methodical treatment of all similar units of analysis. Allows a full, and not partial or selective, review of the material collected.
Enables easy retrieval	Allows access to, and retrieval of, the original textual material.
Allows between- and within- case analysis	Enables comparisons between, and associations within, cases to be made.
Accessible to others	The analytic process, and the interpretations derived from it, can be viewed and judged by people other than the primary analyst.

Researcher Position

Braun and Clarke (2006) suggest that thematic analysis is a useful tool for those early on in their qualitative research career as it is an accessible and flexible method to be used within different theoretical frameworks. It is impossible to partake in research from a neutral position, therefore the researcher interests in self-harm and norms theory are acknowledged as driving this research.

The researcher position is within a contextualist approach; one that acknowledges the realities of participants, while recognising contextual factors (Appendix 2.8*).* A thematic framework analysis was deemed to be an appropriate method of analysis, due to the dual recognition of *a priori* research aims and the maintenance of the inductive process of qualitative research. This positioning was held in mind throughout the research and, given the impossibility of avoiding such influences, the researcher chooses to acknowledge these at this point and invite the reader to examine the following analyses within the context of this positionsing.

Results

Through the process of *familiarisation, identifying a thematic framework, indexing, charting* and *mapping and interpretation* (Appendix 3) the interview data was explored in relation to the aim of the research, which was to explore staff attitudes and behaviours (own and perception of others') and the impact of this on behaviour, barriers and facilitators of effective treatment, and team identification and norms.

Through the mapping and interpretation process, initial indexing themes were assimilated and patterns identified in the interview data to meet the requirements of the research aims. An overarching theme, with four sub-themes, was identified (Figure 2.1).
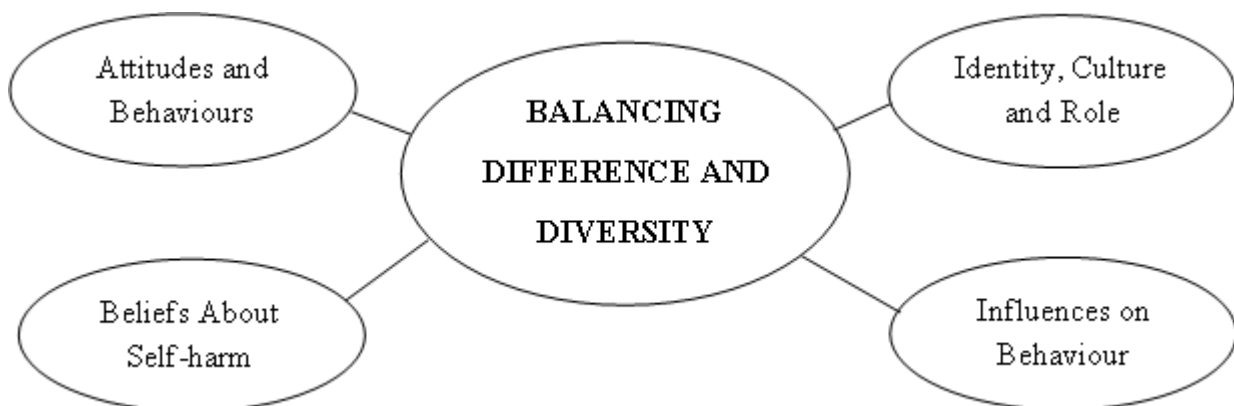

Figure 2.1: Overarching theme and sub-themes.

While the research aims were borne in mind, this process also highlighted unexpected areas of interest. All of the themes will be discussed, using a balance of interview extracts and analytic interpretations.

Balancing Difference and Diversity

An overarching theme of balancing difference and diversity was identified, whereby staff felt that they were often balancing on a knife edge in order to meet the different expectations of them and keep all these in mind. Feelings of frustration at balancing the needs of the patient with the needs of "the system" were raised by two interviewees, whose role included the strategic planning of services. There was a recognition that attempts were made to create a balance between being empathetic and supportive without reinforcing the behaviour by being "too nice". This was made more difficult because "what's gonna work for one won't necessarily work for another" (Female, Senior Nurse). Furthermore, an emotional balance was described, whereby staff had to balance keeping a professional distance while building rapport with patients who could "tip over the edge" at any point in an emotive environment. Some interviewees spoke about distancing when this balancing act became too much, "taking a step back" and keeping emotional distance in order to continue with their job:

It's getting that fine balance that they feel that they're getting the right kind of treatment, balanced with, obviously my other workload as well. (Female, Staff Nurse).

Beliefs About Self-harm

Interviewees identified many different ideas about self-harm both in relation to what constitutes self-harm and what causes someone to self-harm. While some interviewees took the stance that self-harm constituted deliberate acts of harm to the self, such as cutting and

overdosing, others suggested that things such as excessive alcohol consumption and smoking could also be described as such. One interviewee even commented on the difficulty in defining self-harm due to definitions changing over time. The majority of interviewees reported the reasons for self-harm as being a personal trait or way of coping, but within this, self-harm was equally seen as being "attention-seeking" along with being "a cry for help". Interestingly, only four interviewees gave manipulation as a reason for self-harm, whereas nearly all reported self-harm to be a reactive behaviour to an event:

Err, yes, so a number of clinical presentations and allied to that, a number of psychological reasons why people perform the behaviours that they do which leads to the self-harm. (Male, Doctor).

Interviewees also recognised the impact of social context, self-harming behaviours seen as "contagious" and perceived as a "status-symbol". Moreover, while one interviewee commented on the current "social health" of the nation, linking self-harm to low socioeconomic status, another suggested that self-harm may be a product of life being "too comfortable", and it is this that has caused an increase in the behaviour. While all interviewees reported the belief that self-harm patients should be treated the same as any other patient (in terms of triage, assessment, respect and dignity), the majority also recognised that this was balanced with recognising the psychological distress as being "something deeper" than the physical wounds. It was, however, noted by many interviewees that treating the psychological was something they did not feel they had the skills and knowledge to do effectively.

Understanding beliefs about self-harm is important as they impact on other areas as well. Most notably they are likely to influence attitudes and behaviours; however, the balance

between the physical and psychological may impact on perceptions regarding the role of the ED.

Attitudes and Behaviours

The first and second aims related to the attitudes and behaviours of the individual, and their perception of others' attitudes and behaviours and how this might influence behaviour. The complexities of attitudes and behaviours were highlighted during the interviews, with all interviewees reporting mixed emotions. Furthermore, links to behaviour were at times vague. One association identified was between patient story and lethality, which impacted on attitudes (Figure 2.2). Many interviewees spoke about the patient story, which was often perceived to be "horrific". They described how this influenced their thoughts about the patient. Interviewees described how, the more horrific the story, the more sympathy they had for the patient. They then allowed themselves "more time" with that patient. This was also the case when an act had potential to be lethal, as it was inferred that there must be something "horribly wrong" to drive someone to do such a thing, increasing sympathy and caring behaviour. Conversely, when patients were perceived to have no story or harm was minimal, many interviewees described feeling frustrated and, at times, annoyed with this. This was seen as taking time away from "genuine patients", which a few interviewees recognised as influencing their behaviour because they would then be more perfunctory with that patient, as illustrated below:

There was this young woman… Came in, had taken a big overdose … So with her, I did feel fairly sorry for her and probably if I had had any involvement with her I would have spent quite a lot of time with her, which is quite different for some other folk I've seen, giggling, saying "hi doc, I'm back now" and… yes, my empathy runs a little bit thin. (Male, Doctor).
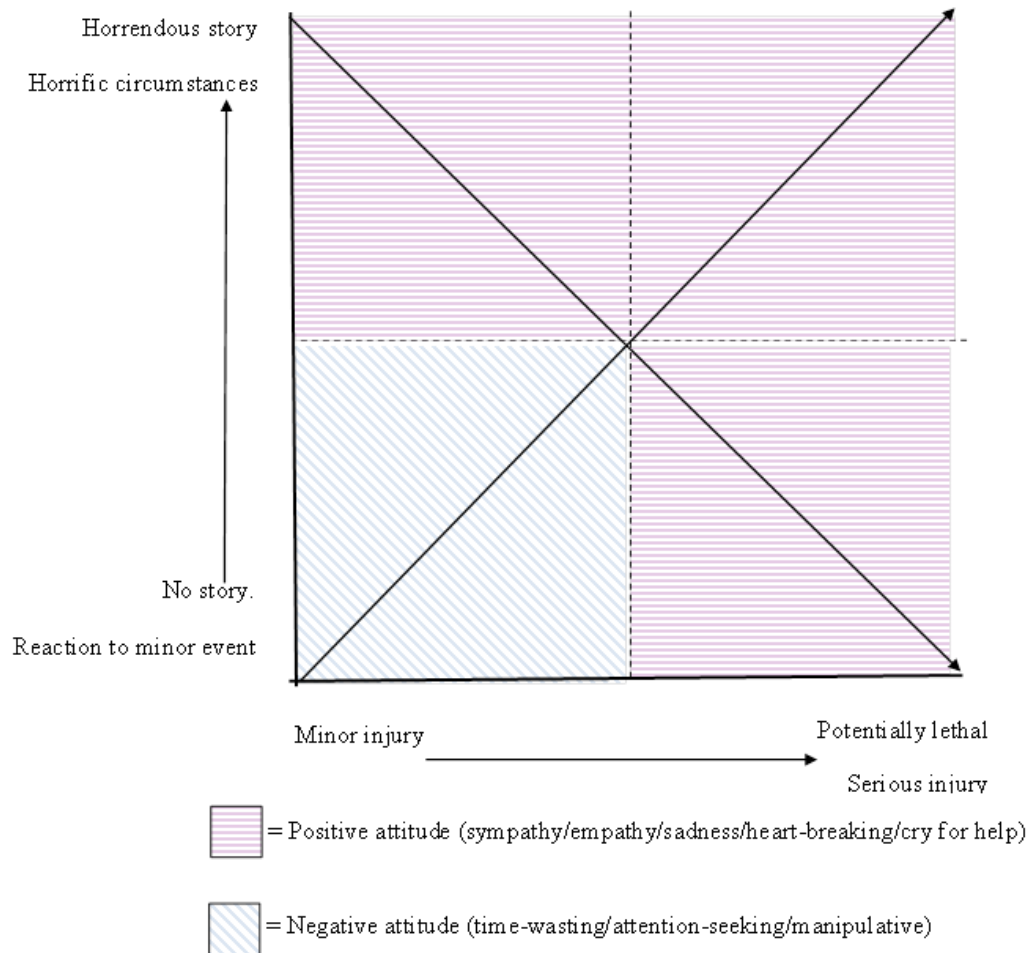
Figure 2.2. Model to show the implications of patient story, lethality and staff attitudes.

It appears that the reality is that attitudes are variable and changeable, and that this is correctly perceived in both self and others. Despite this, interviewees reported more negative attitudes in others, suggesting that others were more likely to think people who self-harm take up too much time and see it as being acceptable to spend less time with them, compared to themselves. When discussing their own behaviour, most interviewees described following an assessment procedure, but also emphasised building rapport as well. Two interviewees specifically stated that their own attitudes did not impact on their behaviour negatively. However, one identified that they could get caught up in making flippant comments. When describing others' behaviour, many participants described others as being more perfunctory, short tempered and having less communication with patients than themselves, although this

was seen to be in the minority and always on the "continuum of what is acceptable". Furthermore, one interviewee identified some as being better able to cope due to their training. There was also evidence that some interviewees did mistake behaviour as being indicative of attitudes, describing approach and opinion as being "the same thing", and one highlighted how others will "curb [their] behaviour to fit with the norm". Although behaviours were seen to be professional, it appeared that negative attitudes were overestimated, as some interviewees saw "a lot of people" as "very judgemental". Furthermore, nearly half of the interviewees compared their team favourably to other departments, indicating PI on a team, rather than individual level:

[I] know that some of the departments… their tolerance for self-harm is very, very low… and they see it as somebody who's taking up a lot of their time. (Female, Senior Nurse).

Internal conflict also appeared to be an issue, where some interviewees did not "like them [own attitudes] to be different" but believed that their viewpoint was "slightly different from that of most". In addition, interviewees raised the discomfort at hearing attitudes or seeing behaviours that they did not agree with. When this occurred, some described changing their behaviour, for example being "very busy" in order to avoid being part of the behaviour, rather than challenging it. In the interviewee this was most pertinent for, a feeling of alienation and distance from the group was also described.

Influences on Behaviour

The third aim was to explore the perceived barriers and facilitators of effective working with people who self-harm. Barriers will be discussed first, then facilitators.

Interviewees generally agreed about the barriers to effective service, viewing organisational constraints, role limitations and staff attributes as being the most limiting factors. Time

limitations were the most significant factor for interviewees, who felt that even if there were increased resources or training, there would still "not be the time" to implement learning. One interviewee did, however, note how he had become "more relaxed" with experience, allowing him to take more time, despite departmental pressures. Further to this, limitations were seen as within the divide of the physical and psychological, such that the ED did not have the appropriate facilities, such as private rooms and increased patient supervision, and was seen as the place to treat the physical wounds, but not the psychological ones. This then increased feelings of frustration, futility and failure, where interviewees reported feeling unable to do their job and the pressure they feel to see that "they've made a difference":

I feel like I'm not doing my job properly, because my job is to help people and I can't help them. (Female, Health Care Assistant).

Patient attributes were also noted by most interviewees, who saw some patients who self-harm as being disinterested in change and, at times, disruptive to the department. One interviewee did recognise the impact that past poor treatment may have on patient expectations, resulting in them not engaging with staff. Furthermore, one interviewee felt that patients may feel a sense of futility at self-harming, which is mirrored in interviewees own feelings, who felt out on a limb when working with self-harm, as they did not have the "deeper understanding" required in order to help. This was exacerbated by limited opportunities for training and the removal of mental health teaching as part of general nurse training. Three interviewees did acknowledge the current recession and cutbacks as impacting on care, especially in relation to access to training and increased resources.

Interviewees recognised how these barriers impacted on their behaviours, through decreased confidence in intervening, not having the time to build rapport, not always being able to offer the privacy needed, and feeling as though they are "treading water" and getting nowhere. It

is helpful to look at these across the individual, professional, organisational, and social contexts (Figure 2.3), as this provides further understanding and may avoid attempts to intervene, for example, on an individual level, when the critical context is organisational and individual control is low.
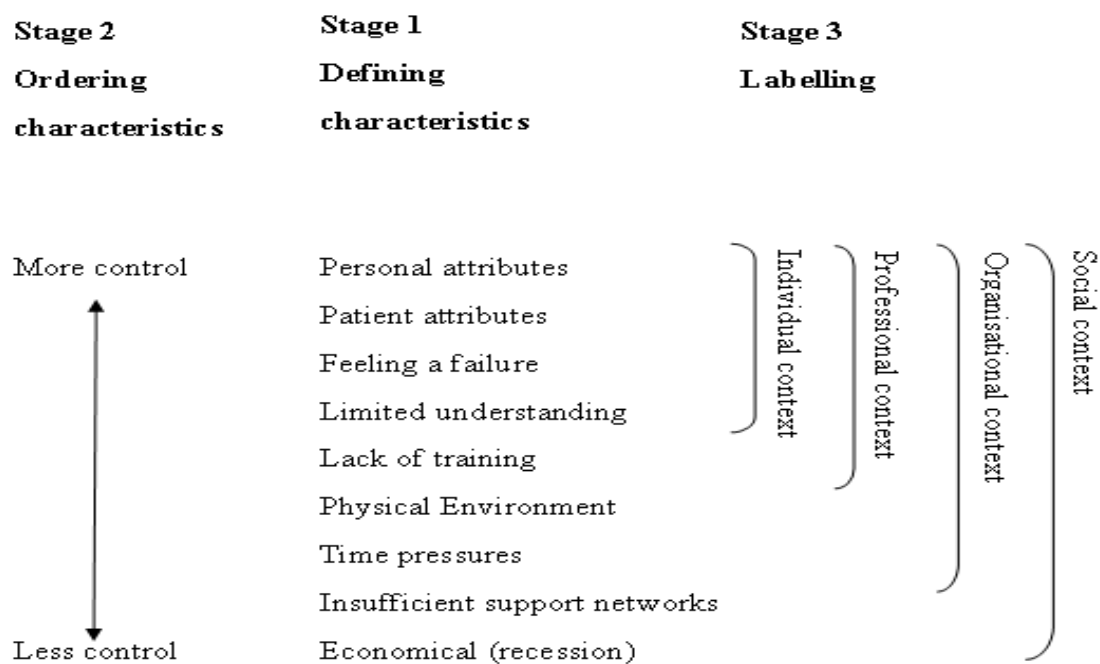

Figure 2.3. Barriers to effective behaviour.

Interviewees were also consistent in their ideas about the facilitators of effective behaviour, with all recognising the role of support, and most the role of communication, reflection, training and a powerful voice. Informal support structures within the ED were identified as being used most often and most helpful as there was a sense of shared experiences. This was seen to enable people to "do their jobs" and allowed for necessary "offloading", even if it was "over a cup of tea"; however, three interviewees also noted how staff support can benefit patients through improved care and increased empathy. This was noted in others less explicitly through recognising support as enabling the ED to work effectively, and to "relieve the burden" of having a limited role with self-harm. This was closely linked with communication, which interviewees reported as being important, both for professionals to

communicate together, providing feedback, but also for individuals to communicate with patients. Three interviewees identified good communication as essential for building rapport, something they all agreed was highly important in enabling patients to "feel comfortable" and "open up" in a distressing situation.

Training was something that most interviewees rated as important in increasing understanding and confidence, although the levels of training differed, with the two doctors reporting the most training in mental health, along with the one nurse interviewed who had trained initially as a mental health nurse. This interviewee reported that training, although beneficial, does not trump experience. This contrasted with the majority view, which viewed experience as a good way of learning, but not enough to increase confidence in approach and understanding. For this, training was seen as essential. Those in the department who had received mental health training were noted by many interviewees as having a powerful voice in advocating mental health. It was stated that you "could tell" who had this training as they could "cope" much better with self-harm, would implement pathways for patients and "keep the topic interesting" for others. A further powerful voice reported by some was that of celebrities and the media. Comic Relief was noted to be "thought provoking" in that it got people talking about mental health issues at work after watching it, raising public awareness. One interviewee did note however that a powerful voice could be either positive or negative, depending on the views.

Again, the facilitators of effective treatment can be put into context in order to further understand how the individual through to society may influence behaviour and where the control lies (Figure 2.4).
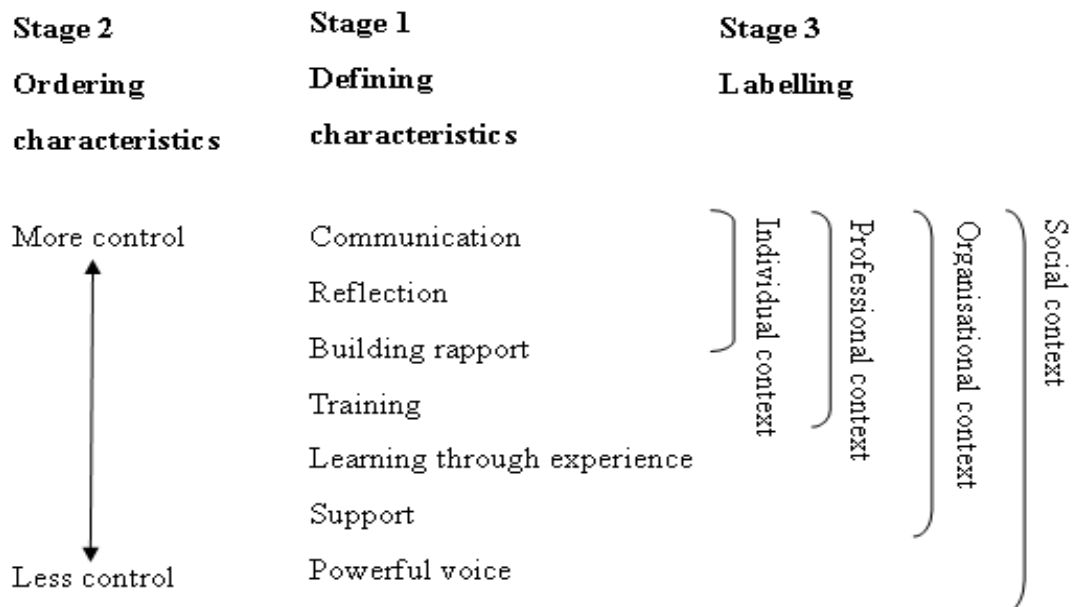
```
Stage 2              Stage 1              Stage 3
Ordering             Defining             Labelling
characteristics      characteristics
```

More control ↑ │ Communication   ⎫ Individual context
               │ Reflection   ⎬
               │ Building rapport   ⎭
               │ Training   ⎱ Professional context
               │ Learning through experience
               │ Support   ⎱ Organisational context
Less control ↓ │ Powerful voice   ⎱ Social context

Figure 2.4. Facilitators of effective behaviour.

Identity, Culture and Role

The final aim was to explore team identification and to identify some of the perceived norms for this team. Interviewees reported the ED as being the core element to the team they worked in. However, it became apparent that many interviewees saw the team changing in relation to the needs of the particular patient they were working with at the time. The idea of having a 'fluid team' was an unexpected concept, but one that came across strongly:

It [the team]… depends on what that person's got, so I think it like, branches out, depending on what that patient needs was elicited. (Female, Health Care Assistant).

How much interviewees identified with the team was difficult to determine, most probably due to this fluidity, but one interviewee likened the organisation to a "machine" where each professional was a "cog" required in order to keep the machine working, and most recognised the sharing of experiences as being a defining factor. Despite the difficulties in identifying with a particular team, similar ideas regarding group norms were identified among all, although interviewees initially struggled to name them. It was found that values such as

being caring, respectful and kind were reported by most interviewees (Figure 2.5).

Furthermore, a shared ethos of putting patients first and providing the best clinical care

possible was reported. Interviewees recognised the need for support; however, one norm that

was highlighted was that of only seeking informal support to "offload" and "have a chat",

rather than using formal support structures. An often unspoken norm noted by many

interviewees is that formal support is only for the "big things". Furthermore, there was a

pressure noted by some to be a "jack of all trades" and "keep going" regardless, always

keeping emotions "in check". There was also seen that working in the ED was "not for

everyone", suggesting a particular kind of person for the job, one who fit the perceived norms
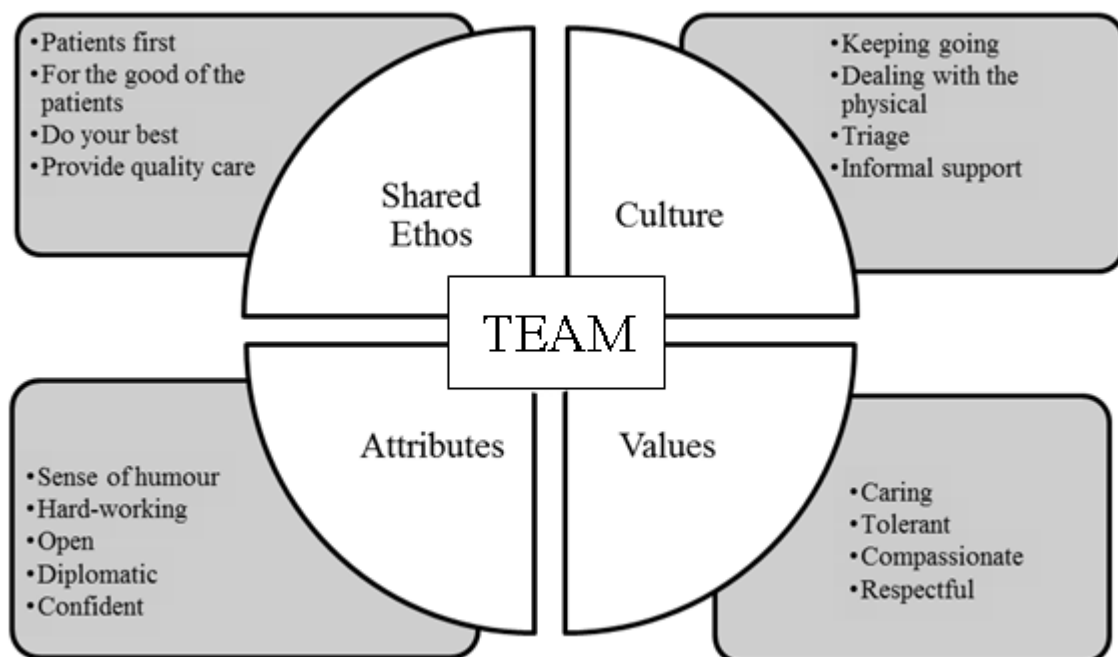
of hard-working, humorous and confident, among others.

Figure 2.5: The ethos, values, culture and attributes of the team identified by interviewees.

Discussion

Aims of the Research

This research aimed to explore staff attitudes and behaviours (own and perception of others') and the impact of this on behaviour, barriers and facilitators of effective treatment, and team identification and norms.

Summary of the Main Themes

Balancing difference and diversity. Insight was gained into the realities of working in the ED through this overarching theme and other, distinctly separate, but interrelated sub-themes. Interviewees expressed the need for balance and recognised diversity across all individuals and the organisation.

Beliefs about self-harm. A multiplicity of beliefs about self-harm were identified, both in ways of, and reasons for, self-harming. The main point, however, was that self-harm was something both physical and psychological in nature. Balancing treating the physical and managing the psychological symptoms was a focus for all interviewees, who felt able to treat the wounds but unsure how best to manage psychological distress.

Attitudes and behaviours. The current research demonstrated the complexities and diversity of attitudes when working with people who self-harm. Attitudes seemed to be moderated by two factors: the patient's story and perceived lethality of the self-harming incident. Attitudes could not always be defined as being either positive or negative; indeed, most interviewees defined their own and others' attitudes as being on a fluctuating continuum, depending on situation and context. While attitudes reportedly fluctuate, behaviour was always described as professional. Furthermore, some misperceptions were noted. For example, there appeared to be an overestimation of negative attitudes, especially

in others, and the belief that public behaviour affirmed private beliefs, although this was challenged by one interviewee.

Influences on behaviour. The range and characteristics of barriers to effective behaviour and facilitators of effective behaviour were explored. These were found to range in terms of control (either within an individual's control or not) and characterised by individual, professional, organisational, and social contexts. The models drawn out were able to map the whole range and nature of characteristics as identified by interviewees.

Identity, culture and role. Interestingly, when asked to define their team, interviewees described the ED as being central to their team, but not the extent of the team. The concept of a fluid team was identified, whereby patient needs are the main determinant of the team at any one time. While the team itself was determined to be flexible, the norms identified were all congruent among interviewees, identifying shared ethos, values, culture, and attributes. Beliefs regarding the role of the ED in treating the physical, but not the psychological further impacted on how staff felt when presented with people who have self-harmed.

Theoretical Implications

The finding of the current research will now be discussed in relation to previous research conducted on staff attitudes towards self-harm and on the social psychological theories relating to social norms and social identity theory. Areas of divergence will be prioritised over areas of similarity (Appendix 4.1)

Staff attitudes towards people who self-harm. The findings of the current research are generally concordant with the broader findings of other studies, in that attitudes are mixed (Saunders et al., 2012). In addition, however, this study acknowledges the frustrations of staff, but put these firmly within the context of personal, professional, organisational, and

broader social contexts, rather than defining them as negative attitudes towards people who self-harm, a criticism of the majority of previous research.

  Although Ramon (1980) found lethality to impact on attitudes, the current study expands on this, suggesting that lethality and story both have an impact. Furthermore, the suggestion is made that both of these factors must be absent for attitudes to become more negative towards individual patients. This is not something that appears to have been explored previously. The other area of divergence relates to changes over time. Hopkins (2002) reported increasing cynicism over time, sympathy turning to frustration, and people who self-harm being seen as 'other' by society. In contrast, the current study describes a more positive change in attitudes, concordant with a societal shift in perceptions through increased experience, better service structures, and importantly, through the role of the media in reducing the stigma of self-harm. Although there is acknowledgement of increased feelings of futility over time in two interviewees, this is less apparent. The findings of the current study may provide an explanation for the positive shift in attitudes described by Anderson and Standen (2007).

The current research found some similar findings to previous studies, but added to these by explicitly stating the difference between attitudes towards people and attitudes towards the surrounding organisational and social context. The complexities of attitude-behaviour links are acknowledged and this research attempts to use social psychological theory to explain the results further.

Norm misperception. While team norms were shared among interviewees, often there was an initial difficulty in naming them. This suggests, in this case, team norms are implicit. A concern is that the implicit nature of group norms often results in norm misperceptions (e.g., J. R. Smith & Louis, 2009). The current study also found evidence of PI causing conflict in

individuals through misperception of others' negative attitudes. Furthermore, while individuals might experience conflict through disagreeing with a behaviour, they might "be very busy" keeping away from the group, rather than confronting it. This supports the arguments that misperceived norm are rarely challenged (Perkins et al., 2011) and alienation occurs (Prentice & Miller, 1993). Interviewees also reported that negative attitudes were more likely to result in unhelpful behaviours, such as being perfunctory, in others than in themselves. This is consistent with findings by Sallot et al. (1998), who noted that public relations professionals rated themselves as more professional then their peers.

The current study also found evidence of PI relating to the ED team, compared to other ED teams and some bias based on professional groupings. It was important for interviewees to portray a positive group image, for example, between their ED, compared to other EDs. This suggests that there may be in-group/out-group formation, as described by Terry and Hogg (1996). This highlights the important to consider social categorisation and social identity when exploring attitudes and behaviours within the ED.

Social identity. The current study adds to the argument that the TRA does not take full account of social influence when exploring behaviour (Terry & Hogg, 1996). The exploration of team norms and identity in the current study highlighted the importance of fitting in with the team and behaving congruently with the perceived norms. This contrasts from the findings by McKinlay et al. (2001) who, using the TRA, found attitudes to be a better predictor of behaviour. Furthermore, interviewees reported the influences of a 'powerful voice' and the perceived attitudes of others on shift (congruent with findings by S. E. Smith, 2002, who described treatment being dependent on the attitudes of those that are working at the time).

Strong identification with an ethos of patient care and values of respect and tolerance was reported by interviewees, therefore it is unsurprising that internal conflict was also reported when attitudes and/or behaviour was perceived as dissonant with this.

Fluid team. When exploring team identity, an unexpected conceptualisation of 'team' was reported by interviewees. The fluid team described in the present study does not fit with that described in some research (Bushe & Chu, 2011; Fried et al., 1988) – in the current study, there was not a universal caseload, or one managerial structure. The idea of a core and peripheral team fits best (Tannenbaum, Mathieu, Salas, and Cohen, 2012a), while recognising members of other teams being part of the peripheral team (DeCostanza, DiRosa, Rogers, Slaughter, & Estrada, 2012; Wageman, Gardner, & Mortensen, 2012). For example, members of the ED might be joined by members of the surgical team. Tannenbaum, Mathieu, Salas, and Cohen (2012b) argue that this is a multiteam system (MTS), rather than a fluid team; however, interviewees clearly include staff from other teams as part of their own team, rather than viewing them as part of a separate, but overlapping system.

Clinical Implications and Recommendations

The findings of the current research have raised some clinical implications that will be discussed in relation to beliefs about self-harm, attitudes, norm misperceptions and social identity. Again, due to size limitations, discussion of unique implications will be prioritised over those already recorded in other research (Appendix 4.2*).* Suggested recommendations, however, will include both unique recommendations and those concurrent with other findings.

While the informal support networks were perceived to be helpful, it was apparent that there was a stigma attached to seeking more formal support. Furthermore, the informal support available does not appear to combat feelings of helplessness, due to uncontrollable barriers,

and feelings of failure when working with people who repeatedly attend. This can result in behaviour becoming more perfunctory. A more formal structure of support might be useful, for example through a facilitated reflective practice group. This would take into account the benefits reported of talking to those that have shared experiences and acknowledges the usefulness of being reflective and letting off steam through having a more formal, but hopefully less stigmatising, structure. However, time constraints must be considered when implementing such a group.

Given the norm misperceptions reported, training should be considered carefully. The implications are that the existence of PI will exacerbate and increase the salience of negative attitudes and behaviours toward people who self-harm if not exposed, or lead to feelings of alienation, which may impact on staff cohesiveness and performance. It is important that further research be conducted prior to any behaviour intervention so as not to inadvertently increase the saliency of negative attitudes, further exacerbating behaviour. It would be more helpful to highlight how many people wanted to better understand self-harm, alongside the staff ethos of care and tolerance.

Team fluidity and multiple membership may increase difficulty in determining norms and increase role ambiguity. While roles within the ED were generally well defined, role boundaries become more blurred when working with people who self-harm, resulting in reduced confidence. This may also result in a changeable reference group depending on the patient. Furthermore, the fluidity of the team highlights the importance of communication and feedback between staff, which was reported as something that could be improved on.

Table 2.5 shows areas for suggested recommendations, although these are not exhaustive, and must be considered within the organisational context.

Table 2.5

Suggested Recommendations

Area	Recommendation
Training	1. For staff to access training on reasons for self-harm and ways of engaging people who self-harm.
	2. To explore potential for training to include information on norms, such as the ethos of care and tolerance.
Team culture	1. To expose the culture of carrying on and the impact of this on staff, potentially in relation to seeking support.
	2. To reduce the stigma of formal support and raise awareness support structures.
Norms and identity	1. To increase knowledge of the link between team norms, identity and practise in those who plan care delivery.
	2. To determine a reference group within EDs (see further research).
Service structure	1. To implement structures that facilitate good communication and feedback between teams. This should help reduce role ambiguity across teams and increase awareness of support networks.
	2. To raise awareness of systems, such as the self-harm proforma.
	3. To look at the implementation of a reflective practice group for staff.

Limitations of the Current Research

Limitations to the current research have been identified and will be discussed briefly (see

Appendix 4.3 for more detail*).* It may be that further exploration of other professionals'

views (e.g., reception/domestic staff) could have highlighted new concepts.   Furthermore,

while the professional mix of participants enabled a broad view of the perceived realities

within an ED, the differences in roles and professional expectations made comparisons more difficult (e.g., the level of training received varied greatly)

A further limitation is that interviewees were all from one ED, (which had a powerful advocate for mental health patients) meaning that their reality may not be generalisable to other departments.

Directions for Future Research

Qualitative interviews with different professionals, combined with field observations, and including patient reports could be conducted across multiple EDs. This would provide insight from multiple perspectives. Alternatively, interviews could concentrate on one professional group, enabling more detailed comparisons across interviewees. It may be helpful to further explore group identity in a broader context, rather than in conjunction with self-harm, as this may have influenced the answers given.

Further to this, quantitative research is recommended to develop a scale that accurately measures self and other attitudes and behaviour and team identification, to determine the extent of attitudes and evidence of PI on a wider scale. This would gather further information in a shorter timeframe, allowing for wider comparisons across departments. Furthermore, dependent on the findings, this could direct the implementation of a normative-based training programme to counter PI by highlighting norm misperceptions, although this must be treated with caution (Appendix 4.4*).*

Conclusion

This study has provided an understanding of the realities experienced by ED staff when working with people who self-harm, which has been explored in relation to the impact of organisational, cultural, and societal influences. This has highlighted the complexities of

both attitudes towards self-harm and working within a team, and the perception of the need to balance difference and diversity in all aspects of work. The application of social norms and social identity theory have provided a framework in which to explore these concepts and provided useful ideas into the discrepancies highlighted in existing research, such as differences in staff and patient perceptions of attitudes, and the high reports of positive self-attitudes, but also high reporting of negative behaviours witnessed. While this study has filled some of the gaps in research, it has also highlighted further research needs and emphasised the importance of support and training for staff working in EDs, where the physical and the psychological at times collide.

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Appendix

Appendix 1: Instructions to Authors for submission to Advanced Emergency Nursing Journal

Advanced Emergency Nursing Journal
Online Submission and Review System

Scope:
The *Advanced Emergency Nursing Journal (AENJ)* is a quarterly, peer-reviewed journal designed specifically to meet the needs of clinical nurse specialists, nurse practitioners, experienced clinicians, and clinical and academic educators in emergency nursing. The focus is on in-depth, evidence-based, state of the science content. Practical information to help advanced practice nurses integrate the information into clinical care and implement system changes is also emphasized. Ongoing columns include Cases of Note, Applied Pharmacology, Evidence to Practice, and Radiology Rounds.

Manuscripts should focus on in-depth, state of the science content relevant to advanced practice nurses and experienced clinicians in emergency care. Wherever possible, articles should include discussion of how to integrate the information into clinical practice. Articles should be evidence-based to the extent possible and reflect the most current references on the topic, including clinical research studies.

Query letters including an outline of the proposed manuscript are encouraged and should be e-mailed directly to both editors. Authors are encouraged to submit articles that provide practical, authoritative, clinical information that encompass the practice and management responsibilities of advanced practice roles in the emergency care. Acceptance or rejection of an article is based on the judgment of peer reviewers.

All manuscripts must be submitted on-line through the journal's Web site at http://aenj.edmgr.com.

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Conflicts of Interest and Source of Funding: A has received honoraria from Company Z. B is currently receiving a grant (#12345) from Organization Y, and is on the speaker's bureau for Organization X — the CME organizers for Company A. For the remaining authors none were declared.

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Authors: Please click the log-in button from the menu at the top of the page and log in to the system as an Author. Submit your manuscript according to the author instructions. You will be able to track the progress of your manuscript through the system. If you experience any problems, please contact K. Sue Hoyt, Editor, e-mail: karensuehoyt@gmail.com or Jean Proehl, Editor, e-mail: jean.proehl@gmail.com. Requests for help and other questions will be addressed in the order received.

- Manuscripts should be created on IBM-compatible (PC) equipment using Windows 95 or higher operating system. Our preferred software is Microsoft Word.
- Electronic files should be submitted for all text. Authors have the option of submitting high-resolution, camera-ready artwork electronically using the guidelines outlined under "Illustrations."
- Manuscripts should be double spaced (including quotations, lists, and references, footnotes, figure captions, and all parts of tables).
- Manuscripts should be ordered as follows: title page, outline of manuscript, abstracts, text, references, appendixes, tables, and any illustrations.

Preparation of Manuscript:
Manuscripts that do not adhere to the following instructions will be returned to the corresponding author for technical revision before undergoing peer review.

Each manuscript **must** include the following:

- Separate title page including (1) title of the article, (2) author names (with highest academic degrees) and affiliations (including titles, departments, and name and location of institutions of primary employment), and (3) any acknowledgments, credits, or disclaimers.
- Abstract of no more than 300 words and 3-5 key words that describe the contents of the article like those that appear in the Cumulative Index to Nursing and Allied Health Literature (CINAHL) or the National Library of Medicine's Medical Subject Headings (MeSH).
- An outline of the manuscript inclusive of all headings and sub-headings.
- Clear indication of the placement of all tables and figures in text.
- Author Biography (a brief autobiographical sketch from each author including pertinent education and work experience).
- Signed and completed Copyright Transfer Agreement*.
- Written permission* for any borrowed text, tables, or figures.

  * All forms are available at: http://aenj.edmgr.com

The title page must also include disclosure of funding received for this work from any of the following organizations: National Institutes of Health (NIH); Wellcome Trust; Howard Hughes Medical Institute (HHMI); and other(s).

Manuscript Text

- **Do NOT include any identifying author information in the text or headers of the manuscript.**
- Use generic medication names followed by the trade name in parentheses if appropriate
- Cite values such as weight and temperature in both metric and non-metric terms
- Avoid error prone abbreviations; see the following web site for a complete list: http://www.ismp.org/Tools/errorproneabbreviations.pdf

KeyWords - *Include in Manuscript Text File* List three to five key words or phrases for indexing.

Unstructured Abstract and Key Words - *Include in Manuscript Text File* Limit the abstract to 300 words. It must be factual and comprehensive. Limit the use of abbreviations and acronyms, and avoid general statements (e.g. the significance of the results is discussed, etc.)

Abbreviations
Write out the full term for each abbreviation at its first use unless it is a standard unit of measure. Avoid error prone abbreviations as identified by the Institute for Safe Medicine Practices, a complete list is available at:
http://www.ismp.org/Tools/errorproneabbreviations.pdf

REFERENCES
The authors are responsible for the accuracy of the references. The style of references is the Sixth Edition of the *Publication Manual of the American Psychological Association (APA)*, pages 193—224. References used in the text are cited by the author's name and date of publication in parentheses (Smith, 2000), with page numbers cited for direct quotations. All references cited in the text must be included on the reference list. The reference section lists citations alphabetically by the first author's last name. The reference list should include *only* references cited in the text. Examples of correct forms of references:

Standard journal article: Author, A. A., Author, B. B., & Author, C. C. (year). Title of article. *Journal title*, volume, inclusive pages.

Davis, R., Wells, C. J., & Crislip, K. E. (2006). Systems of trauma care: A study of two counties. *Archives of Surgery*, 23, 170–184.

Paschall, N. (2000). Healthcare quality improvement in clinical practice. *American Journal of Public Health*, 64,12–22.

Whiting, J. D., Tate, R., Cowling, C.A., & Brown, L.H. (1998). EMT knowledge of ambulance traffic laws. *Prehospital Emergency Care*, 2, 136-140.

Complete book: Author, A. A. (year). *Book title.* Place of publication: publisher.

Revak, J. S., Pinkus, R.M., & Vecchioni, T. L. (2000). *Advanced practice nursing: Changing roles and clinical applications.* Philadelphia: Lippincott Williams & Wilkins.

Chapter in an edited book: Author A. A & Author B. B. (year). Title of chapter author. In: A. Editor, B. Editor, & C. Editor (Eds.), *Title of book* (pp. page range). Place of publication: publisher.

Henken, J. (1999). History of trauma. In: M. L. Dupuis, C. E. Falcon, & C. K. Lovett (Eds.), *Trauma* (pp. 10—24). Washington, DC. National Academy Press.

Online document: Author, A. A. (2004). Title of work. Retrieved from source. Simons, D. (2000). *Challenging a hidden obstacle to alcohol treatment: Ensuring solutions to alcohol problems.* Retrieved from http://www.ensuringsolutions.org. *General child seat use information.* Retrieved from www.nhtsa.gov

For multiple authors: Give surnames and initials for only up to and including seven authors. When authors number eight or more, retain up to seven authors, use ellipses, and then give the last author.

ILLUSTRATIONS

- High-resolution, camera-ready images may be submitted electronically as either a Tagged Image File Format (TIFF) or an encapsulated PostScript (EPS) file in Adobe Illustrator®, Adobe Photoshop®, or QuarkXPress®. Please save files in both the application in which they were created (i.e., Adobe Illustrator® or Corel Draw) and as either EPS or TIFF files. Use computer-generated lettering. Do not use screens, color, shading, or fine line. We *cannot* accept art that has been photocopied, is embedded in a Word document (has a .doc extension), was downloaded from the internet, is supplied in JPEG or GIFF formats, or was created in Pagemaker or Powerpoint. A laser proof may be requested by editor if artwork isn't suitable.
- In lieu of original drawings and other material, a sharp, glossy, black-and-white photographic print between 5" × 7" and 8" × 10 is acceptable.
- Each figure should have a label on the back indicating the number of the figure, the names of the authors, and the top of the figure. Do not write on the back of figures, mount them on cardboard, or scratch or mark them using paper clips. Do not bend figures.
- Cite each figure in the text in consecutive order. If a figure has been previously published, in part or in total, acknowledge the original source and submit written permission from the copyright holder to reproduce or adapt the material. Include a source line. Type "Source: Author" on figures that you created. This will help Lippincott Williams & Wilkins identify the status of each figure.
- Supply a caption for each figure, typed double spaced on a separate sheet from the artwork. Captions should include the figure title, explanatory statements, notes, or keys; and source and permission lines.
- Provide a separate electronic file for each piece of artwork.
- Do **not** embed art in your text file.

TABLES
- Tables should be on a separate page at the end of the manuscript.

- Number tables consecutively and supply a brief title for each.
- Include explanatory footnotes for all nonstandard abbreviations.
- Cite each table in the text in consecutive order.

- If you use data from another published or unpublished source, obtain permission and acknowledge fully. Type "Source: Author" on tables that you created.

MANUSCRIPT REVIEW PROCESS

It is understood that articles are submitted solely to *AENJ* and have not been published previously. There are two stages of manuscript review prior to acceptance of the article.

First, all manuscripts are reviewed by at least two members of the Editorial Board. Members of the Board evaluate manuscripts based on the following criteria:

- concise, logical ordering of ideas;
- sound argument and defense of original ideas;
- accuracy of content;
- adequacy of documentation;
- consistency with the purpose of the journal.

Manuscripts are sent to the reviewers anonymously, with a form for recording their evaluation according to the criteria. The comments of both reviewers are sent to the Journal Editor. The anonymous reviewer's comments and the Editor's summary, indicating the Editor's evaluation of the article, are returned to the author.

Second, the Editor makes a decision regarding acceptance of the article for publication based on the comments and recommendations of the Editorial Board reviewers. At least two reviewers must recommend the article for publication for the article to be accepted by the Editor.

AFTER ACCEPTANCE

Page Proofs and Corrections: Corresponding authors will receive electronic page proofs to check the copyedited and typeset article before publication. Portable document format (PDF) files of the typeset pages and support documents (e.g., reprint order form) will be sent to the corresponding author by e-mail. Complete instructions will be provided with the e-mail for downloading and printing the files and for faxing the corrected page proofs to the publisher. Those authors without an e-mail address will receive traditional page proofs. It is the author's responsibility to ensure that there are no errors in the proofs. Changes that have been made to conform to journal style will stand if they do not alter the authors' meaning. Only the most critical changes to the accuracy of the content will be made. Changes that are stylistic or are a reworking of previously accepted material will be disallowed. The publisher reserves the right to deny any changes that do not affect the accuracy of the content. Authors may be charged for alterations to the proofs beyond those required to correct errors or to answer queries. Proofs must be checked carefully and corrections faxed within 24 to 48 hours of receipt, as requested in the cover letter accompanying the page proofs.

Chapter Three

Expanded Appendices.

Appendix 1: Expanded Introduction

More on Norms

As well as social norms previously discussed, there are descriptive and injunctive norms. Descriptive norms are perceptions about what behaviours are common or prevalent and motivate behaviour though what it likely to be effective in a given situation. Injunctive norms are perceptions regarding behaviours typically approved or disapproved of and motivate actions for social reward or to avoid punishment and potentially being ostracised. Cialdini (2003) suggested that norms can motivate behaviour in different ways. People may behave in a way that gains social reward or avoids punishment, or to do what is effective within a particular social group. Social psychological theory suggests that training directed at changing group attitudes should be completed with caution (Cialdini, 2003; Perkins et al., 2011). This is because providing information on only the descriptive norm, even if this is only through inference may result in the overestimation of negative attitudes, and therefore, concordant behaviour being increased. For example, by raising awareness of the need to change negative attitudes towards people who self-harm, it can be inferred that those attitudes are prevalent, which in turn, be perceived as a socially acceptable and potentially desired behaviour.

Appendix 2: Expanded Method

a. Recruitment

Posters were placed in the ED, asking for staff asking for staff to declare their interest in participating in the study. Information sheets and consent forms were sent to those who responded and the following flow chart used to determine further contact (Figure 3.1). Figure 3.1 was displayed with the recruitment poster, in order to keep the recruitment process transparent, and alert all potential participants to the fact that they would be reminded on one occasion about their interest.

Research Project

Self-harm, group dynamics, attitudes and behavior.

My name is Laura Artis.
I am a Trainee Clinical Psychologist.

As part of my degree, I would like to interview 8—10 people on their experiences of working with people who have self-harmed and working in NHS teams.

This should take approximately 45—90 minutes and is authorised to be conducted during working hours.

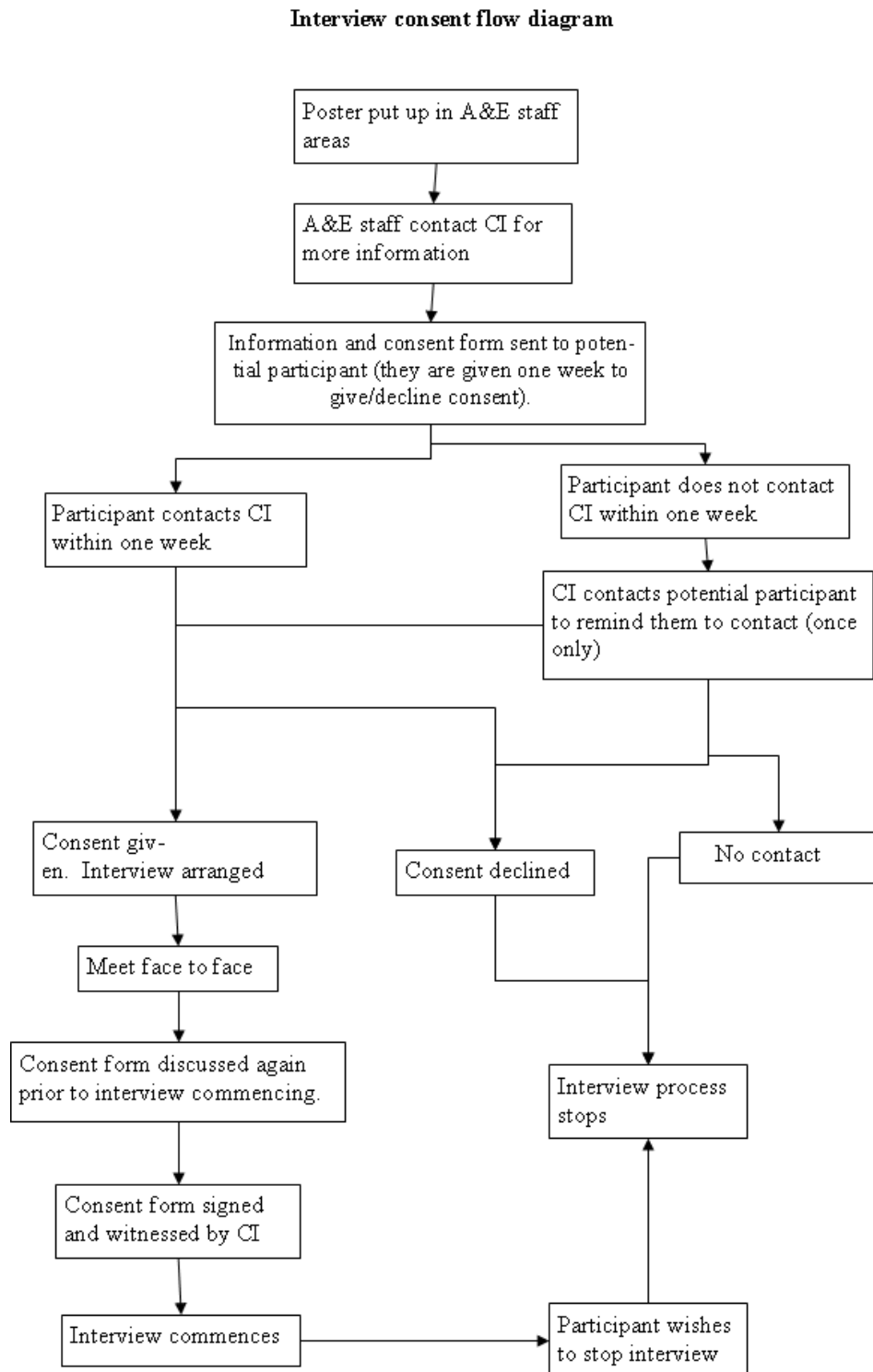**If you are interested please contact me on: la261@exeter.ac.uk for further information**

Interview consent flow diagram

Figure 3.1:

Interview flow diagram.

Further participants were recruited via word of mouth during contact with the department.

b. Participant information and Informed consent
Participant Information Sheet

INFORMATION SHEET FOR INTERVIEW PARTICIPANTS
SELF-HARM, GROUP DYNAMICS, ATTITUDES AND BEHAVIOUR

Dear NHS employee,

My name is Laura Artis and I am a Trainee Clinical Psychologist.

I would like to invite you to take part in my research study. Before you decide, I would like you to understand why the research is being done and what it would involve for you. **If you would like, I will go through the information sheet with you and answer any questions you have.** Talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study.

Please ask me if there is anything that is not clear.

PART 1

What is the purpose of this study?
Self-harm can be an emotive subject that many NHS staff find difficult to manage, both on a personal and a procedural level. Our research is concerned with both individual and team attitudes and behaviours towards people who present to Accident and Emergency departments having self-harmed. Barriers to effective ways of working will be discussed along with the emotional impact of working with people who self-harm within a busy department. As the NHS encourages and relies upon effective teamwork, it is important to look at the impact working in teams and other team members have on individuals.

Do I have to take part?
You do not have to take part in this research project. It is up to you to decide to join the study. I will describe the study and go through this information sheet with you before collecting any data. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This will have no detrimental effect on your employment.

What will happen to me if I take part?
During this session, you will participate in an interview. You will be the only person in the room with me (Laura Artis). You will be asked to respond to a series of questions about your experiences and your perception of others' experiences of working with people who self-harm. There are no right or wrong answers to our questions and it is fine if you do not feel comfortable discussing a particular topic. The interview is anticipated to take between 45 – 90 minutes and it has been agreed that this can be done in work time.

For the analysis, themes from the interviews will be generated. As part of ensuring an accurate analysis, I would like to send you the themes generated from your interview, either by secure NHS e-mail or post (you can state your preference and leave the appropriate information) so that you can check their accuracy.

You will get the opportunity to ask me any questions before the interview begins and there will be time at the end of the interview to discuss any issues that arise.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The details are included in part 2.

Will my taking part in the study be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

PART 2

What will happen if I don't want to carry on with the study?
You have the right to withdraw your participation at any time. If you wish to withdraw from the study this will not have any detrimental effect your employment. Any information that has already been written up in the study will remain, but you can request for your transcript to be destroyed. Your transcript will only be identifiable until the end of the study, when all links between you and your transcripts will be destroyed. This information is kept until the end of the study so that themes can be checked by you for accuracy.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers, who will do their best to answer your questions. This can be done via e-mail on la261@exeter.ac.uk. If you would prefer to speak in person, a call back can be arranged. If you remain unhappy and wish to complain formally, you can do this by contacting the College Dean for the College of Life and Environmental Sciences, Professor Mark Goodwin.

Will my taking part in the study be kept confidential?
A transcript of the interview will be written, however no identifiable information will be on them – all responses will be **anonymous and confidential**. We will record the interview but your responses will not be linked to you by name or by any other identifying information. Only the researchers involved in this study will have access to the original recordings of the interview. The original recordings of the interview will be stored in a locked office at the University of Exeter and will be deleted once the write-up of the project is complete. There will be a list of participants linking them to their transcripts, so that themes generated during analysis can be sent to them. This will be done via secure e-mail or post. This list will be kept in a password protected document, separate from the transcripts and will be destroyed at the end of the study.

Anonymised transcripts will be kept for **five years**, as required for research that may be published. These will be kept securely at the University of Exeter. The university or review boards will be able to look at the interview transcripts if they request it, however they will not be given access to any information that would identify you.

Disclosure of unprofessional conduct:
If unprofessional conduct is identified during the interviews, then this would have to be reported, in the first instance to management staff, and would be dealt with in an appropriate manner.

What will happen to the results of the study?
The results of the study will be written as part of the requirements for the award of a doctorate in clinical psychology. This may also be presented to a scientific journal for publication. You will not be identified in any report or publication, however annonymised quotes from the interview may be used.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the South West (Exeter) Research Ethics Committee.

Further to this, the research has been given favourable opinion through the University of Exeter ethics committee.

Further information and contact details:
Please feel free to contact either myself (Laura Artis) or the research supervisor (Dr Joanne Smith) if you have any further questions.

Laura Artis   Dr. Joanne Smith

College of Life and Environmental Sciences   College of Life and Environmental Sciences
University of Exeter   University of Exeter
Washington Singer Laboratories   Washington Singer Laboratories
Perry Road   Perry Road
Exeter   Exeter
EX4 4QG   EX4 4QG

E-mail: la261@exeter.ac.uk   E-mail: J.R.Smith@exeter.ac.uk

If at any time in the future you need to discuss any issues raised in the interview, you can contact myself. Alternatively The Samaritans offer confidential emotional support 24 hours a day.

You can contact The Samaritans on: Tel: 08457 90 90 90
**   E-mail: jo@samaritans.org**

Interview Consent Form

Study Number: 11/SW/0089
Patient Identification Number for this trial:

CONSENT FORM

Title of Project: Self-harm, Group Dynamics, Attitudes and Behaviour

Name of Researcher: Laura Artis

Please
Initial box

1   I confirm that I have read and understand the information sheet dated
     10/06/2011 (version 3) for the above study. I have had the opportunity to
     consider the information, ask questions and have had these answered
     satisfactorily.

2   I understand that my participation is voluntary and that I am free to withdraw at
     any time without giving any reason, without my legal right being affected.

3   I understand that relevant sections of data collected during the study, may be
     looked at by individuals from the University of Exeter, from regulatory
     authorities or from the NHS Trust, where it is relevant to my taking part in this
     research. I give permission for these individuals to have access to the data
     collected during the study.

4   I agree to take part in the above study.

Contact e-mail/address (to ensure accuracy of themes):

Participant name: Name of person taking consent:

………………………………………………….   ………………………………………………….

Date: Date:

Signature: Signature:

c. Interview Schedule

Introductions.
Orientation to the project.
Consent form discussed and signed.
Discussion of techniques orienting to the present (ask if okay to check in and use).

What do you know/understand about self-harm?
Why do you think people self-harm?
Have you had any training on self-harm?

Tell me a bit about your experience of working with self-harm

What do you think when you see someone who has self-harmed?
Prompts: Does seeing someone who has self-harmed make you feel anything/does it bring up any emotions for you? If so, why do you think this is?
Do you get any supervision/an opportunity to debrief to help with this?
Does this fit with what you think other people think/feel?

What do you think other people in your team think/feel (positive and/or negative) about people who self-harm?
Prompts: What have you heard others say about self-harm?

What do you think (positive and/or negative) about people who self-harm?
Prompts: Do you think your attitude is largely positive/negative?
Has your attitude changed? If so, why do you think this is?
How does this fit with your perception of what other people think about people who self-harm?

How do the people you work with behave towards people who self-harm?
Prompts: How have you seen people behave when working with people who self-harm?
Do you agree/disagree with this? Why do you agree/disagree?

What do you do when presented with someone who has self-harmed?
Prompts: How does this fit with the way you behave when presented with someone who has self-harmed?

How do you think someone should behave when presented with someone who self-harms?
Prompts: How does it make you feel seeing people acting/not acting in this way? Why?
Do you agree/disagree with the way people behave towards people who self-harm?

What factors influence the way in which people who self-harm are treated?

Who do you see as being part of your team?
Prompts: Are these the people that you: Work with/The NHS/In the same professional group as you?

Is this the team you work with usually?

How much do you feel part of the team you identified?
Prompts: Do you feel like you fit in with the team?
What does fitting in mean to you?
What makes you feel like this?
Do you share goals/interests/values with the team?

d. Pilot Interviews

Pilot interviews were conducted with clinical psychology trainees. Although trainee's were not the intended participants, it was agreed that they would be well placed to engage in pilot interviews, as they would be able to reflect on their own experiences as staff working with people who self-harm, while also holding in mind research needs, such as the ordering of the interview schedule. Furthermore, trainees are used to exploring and describing their own emotional responses, something which was important to consider when discussing a potentially emotive subject, such as self-harm. In response to feedback, the interview schedule order was changed and further prompts added to increase clarity. Most importantly, one pilot participant reported the intrusion of memories relating to witnessing an incident of self-harm. Although it was recognised that full informed consent would be given, it was decided that the interviewer would have a script to orient participants to the present if they reported intrusive memories should they be unable to continue the interview.

e. Interview Technique

Semi-structured interviews were conducted with all participants. In line with the techniques noted by Taylor (2005), prompts, summaries, reflections and affirming comments were made to facilitate participant engagement, ensure accuracy of understanding and encourage further detail.

f. Ethical Considerations and Documents

The ethical procedure highlighted issues in the recruitment procedure, maintaining anonymity and the risk of malpractice being reported. These were resolved with a transparent recruitment process and assurances that confidential information would not be made available and all identifiable information to be changed or removed. It was clearly stated that malpractice would be reported to the ED manager. Participants gave full informed consent with these issues highlighted. During a pilot of the interviews, consideration was given

regarding the emotional impact of interviews and procedures were implemented to manage

this if necessary. Furthermore, while interviewing, the necessity to keep ED patient

confidentiality became apparent. While no interviewee named any patient, details of their

self-harm may make them identifiable, therefore caution was needed when using quotations.

National Research Ethics Service (NHS Ethics) Approval

NHS

National Research Ethics Service
NRES Committee South West - Exeter

South West REC Centre
Level 3
Block B
Lewins Mead
Whitefriars
Bristol
BS1 2NT

Telephone: 0117 342 1332
Facsimile: 0117 342 0445
e-mail: ubh-tr.SouthWest2'nhs.net

10 August 2011

Miss Laura Artis
Trainee Clinical Psychologist
Taunton and Somerset NHS Trust
University of Exeter
Washington Singer Laboritories
Perry Road
Exeter
EX4 4QG

Dear Miss Artis

Study title:	**NHS staff attitudes towards people who self-harm: The influence of norms on behaviour.**
REC reference:	**11/SW/0089**

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

The further information was considered by a sub-committee of the REC at a meeting held on 4 August 2011. A list of the sub-committee members is attached.

Confirmation of ethical opinion

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

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

This Research Ethics Committee is an advisory committee to South West Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

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

Document	Version	Date
Advertisement	1	10 June 2011
Covering Letter		08 April 2011
Covering Letter		20 June 2011
Evidence of insurance or indemnity		02 August 2011
Interview Schedules/Topic Guides		08 April 2011
Investigator CV		08 April 2011
Investigator CV	Jennifer ...aff	
Letter from Sponsor		28 March 2011
Other: CV - Joanne R Smith		
Other: Flowchart	1	10 June 2011
Other: Letter form A&E Manager		09 June 2011
Other: Letter form Dr Miller		13 June 2011
Other: Letter for second questionnaires	1	09 June 2011
Participant Consent Form: Interviews	2	08 April 2011
Participant Consent Form: Questionnaires	3	08 April 2011
Participant Consent Form	1	10 June 2011
Participant Information Sheet: Questionnaires	4	10 June 2011
Participant Information Sheet: Interview	3	10 June 2011
Protocol	2	08 April 2011
Questionnaire		08 April 2011
REC application	3.1	08 April 2011
Response to Request for Further Information		

Statement of compliance

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

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

11/SW/0089	**Please quote this number on all correspondence**

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

Yours sincerely

Kirsten Peck

pp **Dr Lee Burton**
Vice Chair
NRES Committee South West - Exeter

Enclosures:	*List of names and professions of members who were present at the meeting and those who submitted written comments*
	"After ethical review – guidance for researchers"
Copy to:	*Dr Michael Wykes*
	Dr Christopher Miller, Dorset County Hospitals NHS Foundation Trust

NHS Trust Research and Development Ethical Approval

Dorset County Hospital **NHS**
NHS Foundation Trust

Miss Laura Artis
1 Netherway Cottages
Lower Street
Okeford Fitzpaine
Blandford Forum
Dorset
DT11 0RW

Date of Trust Permission: 31/08/2011

Dear Miss Artis,

PERMISSION TO INITIATE A RESEARCH PROJECT AT DORSET COUNTY HOSPITAL

PROJECT TITLE: NHS STAFF ATTITUDES TOWARDS PEOPLE WHO SELF-HARM: THE INFLUENCE OF NORMS ON BEHAVIOUR.
REC REFERENCE: 11/SW/0089

I am happy to inform you that Trust (NHS) permission has been granted to initiate the above project at Dorset County Hospital on the basis described in your application form, protocol and supporting documents. The documents reviewed were:

Protocol number/date: Version 2 / 08/04/2011
REC letter date: 10 August 2011

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, Good Clinical Practice, Trust policies and procedures and all relevant legislation. As Chief Investigator, with no Principal Investigator in this Trust, you retain overall responsibility for compliance with all of these requirements.

As Chief Investigator, you may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The Research Department should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The Research Department should be notified within the same time frame of notifying the Sponsor and any regulatory bodies.

All research carried out at this Trust is subject to the terms and conditions identified on the web-site of the Dorset Research Consortium at http://www.dorsetresearch.org/docs/drc/TC_for_research_within_DRC.pdf. You must read this document before you start your study and comply with all the conditions listed. Trust permission for your research is subject to continued compliance with these terms and conditions.

This Trust will, at various times, monitor the progress of your study and will reserve the right to terminate permission if it is discovered that you are not adhering to either your original application or any of the requirements outlined above.

Q:\TRIALS\Self Harm\Self Harm DCH Permission letter.rtf

Should you have any queries or feel I can be of any help, please do not hesitate to contact me.

Yours sincerely

Dr Christopher Miller
Research & Development
Dorset County Hospital Foundation Trust
Williams Avenue
Dorchester
Dorset, DT1 2RW
Tel 01305 255734/255298
Email – Christopher.Miller@dchft.nhs.uk

CC: (Local Contact) Ms Jennifer Scarff

Q:\TRIALS\Self Harm\Self Harm DCH Permission letter.rtf

MAJOR RESEARCH PROJECT

University of Exeter Ethical Approval

UNIVERSITY OF EXETER

SCHOOL of PSYCHOLOGY
ETHICS COMMITTEE

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To:	**Laura Artis**
From:	**Louise Pendry**
CC:	**Joanne Smith**
Re:	**Application 2009/156 Ethics Committee**
Date:	**September 4, 2012**

The School of Psychology Ethics Committee has now met and discussed your proposal, **2009/156 – *Phase 1: Investigation into the beliefs regarding self harm and group norms in NHS staff*.** The project has been approved in principle for the duration of your study.

The agreement of the Committee is subject to your compliance with the British Psychological Society Code of Conduct and the University of Exeter procedures for data protection (http://www.ex.ac.uk/admin/academic/datapro/). In any correspondence with the Ethics Committee about this application, please quote the reference number above.

I wish you every success with your research.

L. Pendry

Louise Pendry
Chair of School Ethics Committee

g. Validation of Analysis

The analysis was validated where possible at all stages. First, interviews were transcribed verbatim by the researcher and then validated as being accurate by the research supervisor, who listened to excerpts of recordings. After validation of transcripts, data was triangulated, with the researcher and research supervisor agreeing on initial ideas at the familiarisation stage and the resulting thematic framework. Once the thematic framework had been applied to all the transcripts and then charted (indexing and charting phases), the resulting charts were again checked by the research supervisor, and agreed to fit with the themes identified at that stage. Furthermore, interviewees were sent copies of the themes identified and the charts containing a summary of their interview quotations indexed to that theme. They were invited to respond to the researcher with any comments they had on the interpretation of the data, especially if they disagreed or did not understand the interpretation of their comments. Two participants responded to say that they were happy with the themes and the way their comments were interpreted and summarised in the charts. No other interviewees responded and it was therefore inferred that they did not want any changes to be made. At all points the researcher attempted, and was encouraged to reflect on the research aims and the data to balance meeting the research aims with inductively extrapolating and identifying themes from the data.

h. Researcher Position

As Braun and Clarke (2006) argue, thematic analysis enables researchers to be transparent about the exploration of a particular phenomenon without being wedded to a pre-existing theoretical framework. As it is impossible for the researcher to partake in analysis from a neutral position, the researcher position is expanded upon here. The main researcher has a long-standing interest in self-harm, combined with knowledge gained through working with people who self-harm, influencing the choice of subject for this research. This has led to an

interest in the realities of staff working in an ED with people who self-harm. Furthermore, the supervisor chosen by the researcher has heavily influenced the progression of the research aims and questions, by highlighting social contexts and phenomenon that may influence participants. Assumptions made through working with people who self-harm, and the systems they are in; and a theoretical understanding of group norms and identity have shaped the way the research has progressed.

This research, therefore, is theory-driven, focusing on how PI can be used to understand the negative attitudes and behaviours reported by those who self-harm, but also inductive in the exploration of participant realities. To fully understand the researchers' position, it is important to acknowledge two methods – essentialism and constructionism. Essentialist methods report experiences, meanings and the reality of participants, whereas constructionist methods examine the ways in which events, realities, meanings and experiences are the effects of a range of discourses operating within society. For this research, the position taken sits between these two methods, often described as a contextualist approach. It seeks to understand the meanings that individuals place on their experiences of working with people who self-harm, through acknowledgement of wider social constructs surrounding attitudes towards self-harm and the social context (e.g. the phenomenon of PI), while acknowledging the participants' realities, such as the realities of working within an organisation and the constraints associated with this.

It is because of the recognition that further qualitative research is needed in the area of attitudes towards self-harm, and the researcher positioning that a thematic framework analysis (Ritchie & Spencer, 2002) has been chosen as the method of analysis. A thematic analysis allows for a contextualist approach and the framework method is helpful when aims and a theoretical perspective have been identified *a priori*. It is widely used in social policy research as it provides systematic and methodical treatment of all data gathered, ensuring a

comprehensive and accessible analysis within the parameters set by objectives and time-frames (Ritchie & Spencer, 2002). A further benefit of this thematic framework is its practical nature and applicability to an NHS setting, through informing policy development and facilitating audit.

The risk in holding theoretical positions prior to commencement of interviews is that preconceptions and judgements can be over-influential. It was important to hold this in mind when interviewing and analysing data in order to allow the participants' voice to be heard and any preconceived judgements to be challenged through this process.

Appendix 3: Expanded Results

The analysis generated rich data, with a wealth of information at each of the various stages of analysis. This section will focus on a small sample of data to highlight the process of analysis further; ensuring the transparency of the analysis, and allowing others to determine the extent to which they agree with the researcher as to the interpretation of the data. Each stage of analysis will be discussed in turn, with data extracts to highlight the process. Although each stage was conducted systematically with each transcript, full information cannot be included, as it is too large to fit in this report.

Familiarisation

The interviews were transcribed by the researcher, therefore beginning the process of familiarisation. Once the transcripts were completed, they were re-read and initial ideas written down it the margins. The transcripts were also given to a second researcher, who completed the same process. These were then compared. Figure 3.2 shows an example of the transcripts with initial annotations by both researchers.
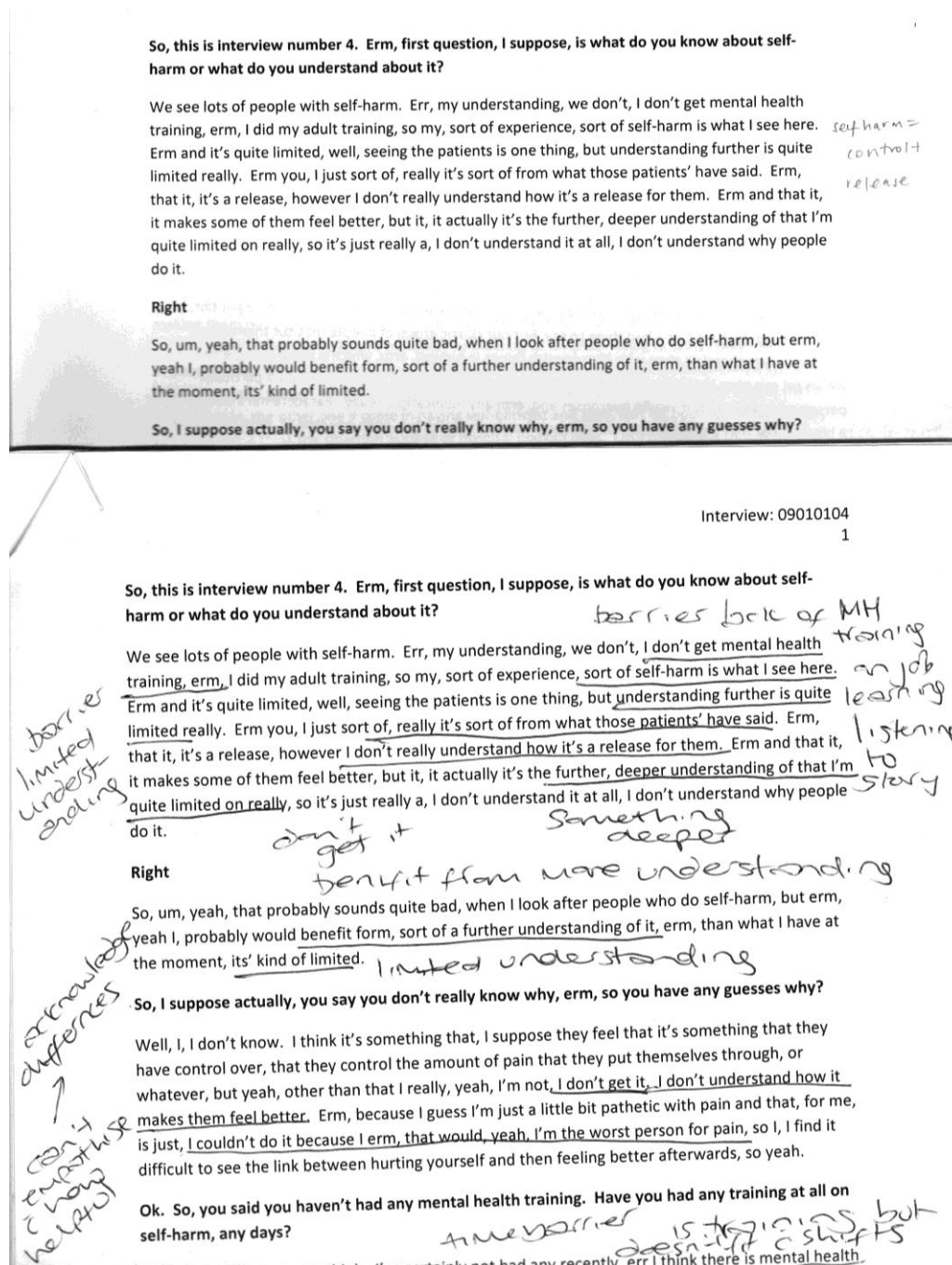
Figure 3.2: Initial familiarisation extract.

After initial familiarisation, ideas and themes from each interview were pulled together, again by both researchers independently and compared. Figure 3.3 and Table 3.1 show the themes identified in interview four, by both researchers.

INTERVIEW 4

+ Self-harm as control + release
    – attention seeking – unreasonable demands.

+ Repeat offenders vs first-timers
    – first-timers receive more sympathy; repeat offenders = frustration

+ Need for more specialist training i.e., mental health nurses better able to deal with patients

+ Self-harm takes resources (e.g., time) from the 'real' job of A+E

+ Acknowledging lack of confidence in own ability.

+ Acknowledging negative attitudes + behaviour of staff to patients

+ Suicide vs. self-harm.

+ Team as support network.

+ Frustration b/c feel that you're not able to help + resolve issue

+ Negative attitudes communicated within the team (norms)
    – not communicated – at least explicitly – to patients

+ Behaviour to patients not rude or unprofessional but perhaps blunt + business-like.

+ Expressing negative attitudes as a coping mechanism for staff.

+ A+E 'space' defines who is in the team.

Figure 3.3: Initial themes.

Table 3.1

Initial Themes

Interview	Familiarisation to initial themes		
4	Lack of training	Unable to access training	Needing to manage emotions
	MH vs. general training	Advocates	
	Experiential learning	Media	Fear of making things worse
	Understanding	Outside influences	
	Story	Story	Attention-seeking
	Something deeper	Repeat attenders	Something deeper/sinister
	Individual differences	Risk	
	Time pressures	Fear of harm	Facilitators
	Procedures in place	Feeling responsible	Own attitudes
	Comparison to other patients	Feeling blamed	Using the system
		Barriers	Seriousness
	Feeling unequipped	Transference of responsibility	Attitude-behaviour link
	Trust		Being professional
	PI (within team)	Genuineness	SH takes up time
	Keeping means of SH	Everyone deserves the same treatment	Unsure how to access support
	Feedback		
	Frustration	All human beings	Powerful voice
	Cry for help	Time-wasting	Advocate
	Wanting to make a difference	Few individuals	Close team
		Nursing culture – stigma re formal support	Outside support
	Failure		Similar situations
	Patient compliance	Keeping going	Wider consequences
	Motivation	Cycle	Being professional
	Disappointment	Futile/hopeless	Needing support
	Fear of being ostracised	Struggle to accept	Family rules
	Justification of comments	Emotional	PI (within team)
		Uncertainty	Communication
	Silenced by group	Distancing	Risk of gossiping
	Experiences/personality don't predict behaviour	Attention-seeking	Self-reflection
		Desensitisation	Abandoned after hours
	Work/home distinction	Shared experiences	Professional PI
	Low identifier	Treating physical wounds	Not just SH
		Procedures in place	Personal experiences
		Team within wide context	Personal characteristics
			Socialising

Identifying a Thematic Framework

A thematic framework was developed, based on the comparison of initial annotations(

Table 3.2).

Table 3.2

Indexing Framework

Theme	Sub-theme	
(a) Reasons for self-harm	i.	Personal traits and coping.
	ii.	Social context
	iii.	Something deeper
	iv.	Reaction
	v.	Manipulation
(b) Attitudes and Behaviours	i.	Own attitudes
	ii.	Others' attitudes
	iii.	Own behaviours
	iv.	Others' behaviours
	v.	Pluralistic ignorance
(c) Difference and Diversity	i.	Balancing
	ii.	Changes over time
	iii.	Physical vs. psychological
	iv.	Story, seriousness and lethality
	v.	Ideal treatment
	vi.	Coping
(d) Barriers to Effective Treatment	i.	Personal attributes
	ii.	Patient attributes
	iii.	Organisational constraints
	iv.	Role limitations
	v.	Futility and failure
	vi.	Lack of training
	vii.	Limited understanding
(e) Facilitators of Effective Treatment	i.	Communication
	ii.	Support
	iii.	Powerful voice
	iv.	Training
	v.	Building rapport
	vi.	Learning through experience
	vii.	Reflection, understanding and awareness
(f) Identity, Culture and Role	i.	Personal
	ii.	Professional
	iii.	Team
	iv.	Organisational
	v.	Responsibility
	vi.	Identification

Indexing

Each transcript was then read and indexed using NVIVO. This involved exploring

each sentence and extrapolating meaning, both through what was being said and what was

inferred. Table 3.3 shows an example of interview quotations indexed into the theme

psychological vs. physical. Although there were items indexed from each interviewee, not all

have been included.

Table 3.3

Physical vs. Psychological Indexing Quotations

Interview Number	Quotation
1	**Reference 2** - 0.37% Coverage: I think it's twofold for me, that they've got the physical as well as the more mental and the non-physical.
	Reference 9 - 0.47% Coverage: Someone comes in pain and they walk out without pain, that's making a difference, but with self-harm, it might not always be like that.
5	**Reference 1** - 0.84% Coverage: There are some kids in school seems to make it into a status symbol that they've harmed themselves. Erm, I don't think that's all the story. There, there is some psychological distress that's underlying it, I think. I think it's quite variable.
6	**Reference 3** - 0.55% Coverage: I know you've got support in place, I'm gonna bounce you back to that because that's their speciality not mine – I can treat your medical condition, not your psychological condition"
7	**Reference 2** - 0.73% Coverage: My initial role in here is to make sure that they are safe, that if they've got any wounds that they are seen to and then they get the appropriate, sort of, crisis input.
8	**Reference 3** - 0.72% Coverage: Err, yes, so a number of clinical presentations and allied to that, a number of psychological reasons why people perform the behaviours that they do which leads to the self-harm which then brings them to hospital.
	Reference 6 - 0.90% Coverage: Erm, so it's quite a sad, sad case in many ways, quite frustrating to think well "you know we don't seem to be able to get this person better and here is again presenting with a life threatening problem because we haven't been able to treat his psychological problems".
10	**Reference 1** - 0.61% Coverage: People tend to self-harm when they either feel really depressed and they can't express emotionally what they want
	Reference 6 - 1.00% Coverage: I tend to just do the obs and then the nurses come in and they clean them up or if they've taken an overdose, then they tend to find out what they've done and what they need to give them

Charting

The process of charting ensured that all indexing quotations were included for all interviewees and all themes, enabling cross-referencing between and within interviewees and themes. Each interviewee was sent a copy of every chart pertaining to their interview to check through. Although the charts cannot all be included in this report, as they are too large to fit, an example of the chart for physical vs. psychological has been provided to demonstrate the process (Table 3.4).

Table 3.4

Charting for Physical vs. Psychological

Interview	Physical vs. psychological
1	There is the physical aspect to self-harm, but also psychological. You can treat physical conditions and see an outcome, but you do not get the same picture with psychological difficulties. It is not just a matter of patching people up - there needs to be something for the psychological difficulties as well. Some might only see it as their role to treat the physical condition. There is a difference between patients who haven accidental physical trauma and those who have deliberate wounds and psychological issues. You can see the difference you have made to the physical pain, but not the psychological pain.
5	Self-harm can be seen as a status symbol, but there is some underlying psychological distress. The crisis team will review the psychological distress, so in the ED the focus is on the physical aspects. There is an automatic reflex that says that people who self-harm should not be in the ED because they have more psychological issues than physical, however if the physical can be treated they are in the right place.
6	Self-harm is a result of a psychological disorder. In the ED you must initially treat the physical wound, but then you can explore the psychological aspects in relation to risk and provision of further support. I can treat the medical condition, but not the psychological condition.
7	Although the self-harm impacts on physical health, it is more a psychological condition than physical. The initial role is to treat the physical wound and refer to the crisis team if the psychological condition needs addressing further.
8	Self-harm encompasses a number of clinical presentations. A more psychological condition underlies the physical manifestations of self-harm, such as cutting. Sometimes the psychological aspects to the patient cannot effectively be treated and then you can agree to treat only the physical wounds. You should respect a patients' right to choose. You deal with the clinical side first, which is more straight forward than the psychological aspects. There are times when patients' lives are threatened due to the inability to manage the psychological distress.
10	Just wanting to know why they do things - psychological aspects to it. Just go in and do obs - manage physical.

Mapping and Interpretation

Charting provided a comprehensive overview of the whole data. This allowed for the initial sub-themes to be compared and moved to where they best fit. While certain themes were identified inductively, some were a result of the research aims and the related questions that focused interviewees on a particular topic, such as attitudes and behaviours. This was where the overarching theme of balancing difference and diversity was identified after the indexing category 'difference and diversity' was seen to be better integrated into other themes. The discussion of the steps followed highlights how the process used in a thematic framework analysis embeds results in the data, while condensing and conceptualising. Figure 3.4 illustrates each of the four main themes and their further sub-themes, all under the overarching theme balancing difference and diversity.
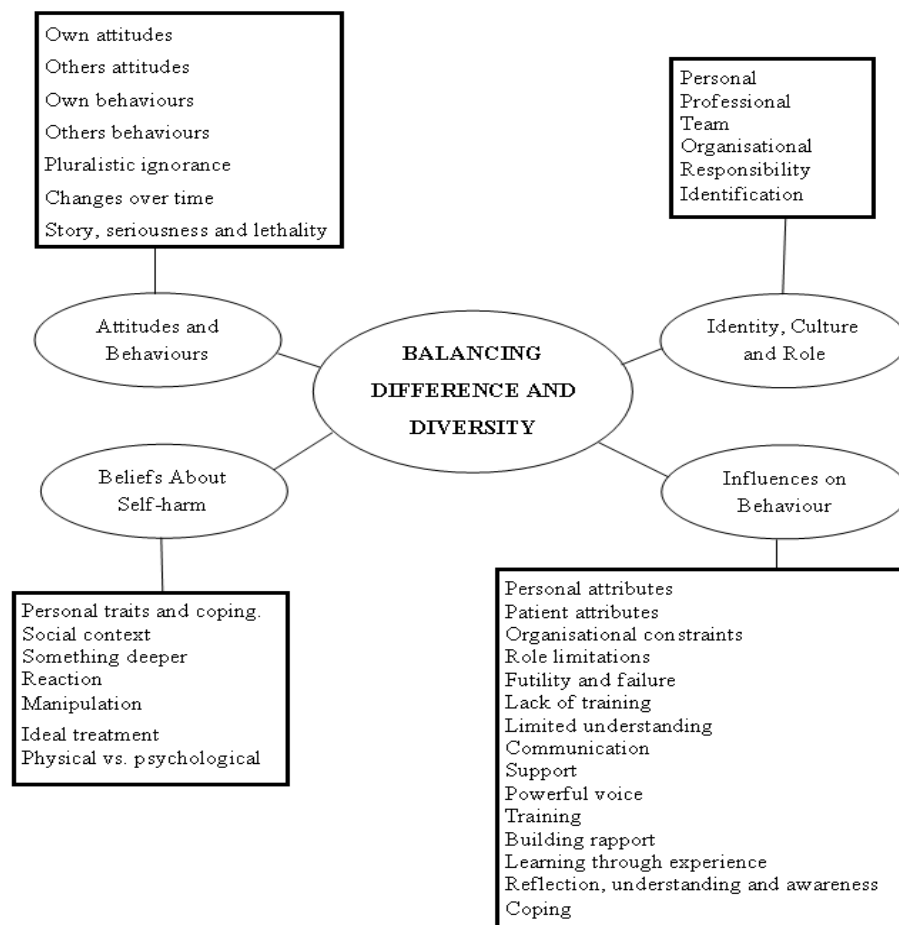

Figure 3.4: Final themes after mapping and interpretation.

Appendix 4: Expanded Discussion

    a. Theoretical Implications

Although some unique and unexpected findings were identified in the data, there were also many areas of congruence between the results of the current study and previous research. These will be discussed here.

Although attitudes between mental and general health trained nurses were not compared in this study, many interviewees reported a more positive attitude in those in the department who had mental health training (as found by Patterson et al., 2007; and Ramon, 1980). Using the ADSHQ, McAllister et al. (2002) identifies four dimensions that increased positive attitudes; confidence in assessment and referral, the ability to deal with patients (supported by Crawford et al., 2003), an empathic approach, and the ability to cope with regulations. This fits with the feelings of frustration, futility and failure expressed by interviewees at their perceived lack of understanding, knowledge, and organisational constraints; and also the reassurance provided by assessment tools, such as a self-harm proforma. Furthermore, interviewees often reported that having an empathic approach increased feelings of frustration and failure when faced with people presenting with self-harm as they wanted to do something different, but felt restricted and unable to. In the current study, frustration was recognised to, at times, result in perfunctory behaviour, which is consistent with findings that frustration reduced helping behaviour and resulted in less time being given (Mackay & Barrowclough, 2005; Wilstrand, Lindgren, Gilje, & Olofsson, 2007). As also found in the current study, perceived manipulation, service constraints and an inability to express feelings increased feelings of frustration, helplessness, and responsibility for people who self-harm and linked to a lack of understanding (consistent with the findings of Hadfield, Brown, Pembroke, & Hayward, 2009; Hopkins, 2002). The need for and importance of training was also noted in the current study, consistent with findings reported by Saunders, Hawton,

Fortune, and Farrell (2011) and Winship (2009). Training was seen as a facilitator to effective behaviour, and a way of building confidence in ability and knowledge, thereby reducing feelings of frustration and failure.

It appeared to be especially important for the team to feel as if they are pulling together at times of need, where communication and support were identified as facilitating effective care. This is consistent with findings by Rooney (2009) who identified that a supportive team culture is important in allowing them to complete difficult tasks. The attitude that working with self-harm is difficult, as found in the current study, highlights the impact the team may have on behaviour towards people who self-harm, both in relation to their social identity but also team cohesiveness. This is an interesting point, as interviewees reported feeling a strong sense of team cohesiveness, while struggling to clarify who was in their team. This could be a result of the perceived fluid nature of the team.

b. Clinical Implications

Again, areas of commonality between the findings of the current study and past research will be discussed here. The current research has highlighted the need for practical knowledge in assessment, therapeutic responses, referral pathways and regulations relating to SH patients (also reported in McAllister et al., 2002). These have been shown to impact on staff confidence when dealing with people who self-harm, leading to uncertainty and, at times, contradictory behaviour. The introduction of a self-harm risk proforma has shown to be effective in reducing some anxiety, however there continues to be a lack of understanding reported. By reducing the uncertainty and role ambiguity when working with people who self-harm, staff may be more able to engage patients, without their fears becoming a barrier. This is important as the ED is the interface where boundaries between the physical and psychological become blurred, made explicit when people present having self-harmed.

Training has been identified as a need for most staff, however this must also be considered in the ED context. Increasing knowledge and understanding about why people self-harm would appear to be useful to staff, as there is a genuine concern about how to engage without making things worse. However, it would not be helpful to train ED staff therapeutically, when the organisational constraints of working within a busy ED do not allow them to utilise this skill, as this would be likely to increase feelings of failure. Therefore, it would be helpful to include basic strategies, such as how to best engage patients and effective communication (including active listening), to reduce the fear of making things worse or reinforcing self-harming behaviour by being "too nice".

c. Limitations

The limitations of the current study and their consequences will be discussed in more detail here. While there was a professional mix of interviewees, only one Health Care Assistant (HCA) was interviewed and males were under-represented. Also, no reception or domestic staff responded to the recruitment poster. While it was agreed that saturation occurred, it may be that further exploration of other professionals' views could highlighted further concepts. While the professional mix of participants enabled a broad view of the perceived realities of working within an ED, the differences in roles and professional expectations made comparisons more difficult, for example the level of training received is far greater for a medical doctor than for an HCA and may impact on feelings of confidence. Expectations are important to consider when looking at role boundaries, as it seemed to be that having less autonomy increased the feeling of being unable to transcend role expectations and boundaries.

A further limitation is that interviewees were all from one ED, meaning that their reality may not be generalizable to other departments. This is highlighted through comments about a powerful voice within the department (a nurse with both mental and general health training),

advocating for mental health patients. While this is a positive for the department, as it appears to have increased communication amongst staff, it may set this ED apart from others

d. Directions for Future Research

Norms-based approaches have been shown to be effective in changing behaviours in other areas, such as recycling, bullying, and drinking behaviour (Cialdini, 2003; Perkins, Craig, & Perkins, 2011; Prentice & Miller, 1993). Further research into norm misperceptions in EDs wold be beneficial to direct future training. The clinical implications of this follow-up research are great and could shape staff training in the NHS to increase understanding of self-harm, but also to expose norm misperceptions. This dual focus would hopefully change behaviour through two different modalities. One, by changing individual attitudes and building confidence in staff when helping self-harming patients; and two, by exposing PI and correcting misperceptions of the social norms. This should only be attempted after further research, as there are potential negative ramifications if the normative message is misinterpreted (Cialdini, 2003; Perkins et al., 2011), which could influence the way in which the training would be implemented. It is for this reason that it would be helpful for future research to explore this further in relation to staff attitudes towards people who self-harm, to determine the most effective training strategies to use.

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Dissemination Statement

The following steps will be taken to ensure that the research findings are disseminated accordingly.

1. Participants have all been sent copies of the coding tables generated from their own interview data. It is hoped that this will facilitate reflection through reading and ensuring accuracy.

2. A version of this report will be sent to any participants that are interested in receiving a copy.

3. The manager of the ED will be provided with a copy of the final report.

4. A copy of the full manuscript will be available online at the University of Exeter's open access resources (ERIC).

5. This paper will be submitted to the Advanced Emergency Nursing Journal. The aims of this journal are to provide information and ideas for best practice and improving care, for senior ED staff. Initial correspondence with the editors of the journal, prior to submission suggests that the subject would be of interest to the journal and its readers.

These methods of dissemination allow for the research findings to be discussed with those involved in the research as interviewees, those involved in the service, and a wide range of professionals in the ED field, and those interested in self-harm. Through the dissemination of the research findings, is my intention that those implementing procedures in EDs will be able to use this information to reflect on the impact of attitudes and social identity on team behaviour and to highlight the importance of communication with staff. Furthermore, I hope that ED staff are recognised as being caring professionals, who struggle working within an environment that is set up to treat the physical, rather than the psychological.