UNIVERSITY OF SOUTHAMPTON

SCHOOL OF PSYCHOLOGY

THE EFFECT OF AN ATTRIBUTION OF CONTROL TO A SELF-HARMING CLIENT ON MENTAL HEALTH STAFF ATTITUDES AND CHOICE OF CLINICAL MANAGEMENT STRATEGIES

by

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ABSTRACT

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THE EFFECT OF AN ATTRIBUTION OF CONTROL TO A SELF-HARMING CLIENT ON MENTAL HEALTH STAFF ATTITUDES AND CHOICE OF CLINICAL MANAGEMENT STRATEGIES

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Attribution theory (Sharrock et al., 1990) has highlighted the importance of attributions of control on staff optimism and help-giving. The perception of a self-harming client as in control of her actions has been identified as a crucial determinant of staff attitudes (Huband & Tantam, 1999) but has not been studied in relation to clinical management (Huband & Tantam, 1999).

This study aimed to investigate the effects of an attribution of control to a self-harming client on staff attitudes, optimism and choice of clinical management strategies. Attribution of control was manipulated in relation to two self-harming 'clients' presented in vignettes ('in control' and 'not in control' of behaviour). Staff were asked to complete questionnaires relating to their attitudes, optimism and preferred clinical management. The effect of counselling or psychotherapy training, associated with a more understanding approach (Huband & Tantam, 2000) was also studied.

Despite differing attributions towards the clients, staff were consistent in their attitudes and optimism. Similar clinical management strategies were endorsed for both clients. However, staff were less likely to refer a client for psychotherapy when control was attributed compared to when control was not attributed. Higher staff optimism was associated with increased likelihood of psychotherapy referral in this instance. Staff trained in counselling or psychotherapy did not differ significantly in their approach to staff without

such training. The results are discussed in relation to the high proportion of staff trained in counselling or psychotherapy in the participant group and the possible cultural effects this may exert on services working with self-harming clients.

CONTENTS

EMPIRICAL PAPER

LIST OF TABLES

UNIVERSITY OF SOUTHAMPTON

SCHOOL OF PSYCHOLOGY

A review of the literature on attribution theory, staff attitudes and clinical management strategies in working with self-harming clients

by

Antonella Luisa Brunetti

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1. INTRODUCTION

Recent governmental initiatives have highlighted the problem of self-harm, with prevalence estimates of self-harm related suicides in excess of 2, 000 per year[2] (Department of Health, 2002) and accompanied by considerable financial and economic costs. However, self-harming is a behaviour which remains poorly understood, evoking strong reactions from clinicians (Huband & Tantam, 2000). It is well documented that the clinical management of self-harm evokes powerful emotions from staff and engenders splitting (polarisation of carers' attitudes/ responses to clients) in the caring system (Book, Sadavoy & Silver, 1978; Boyce, Oakley-Browne & Hatcher, 2001; Gabbard, 1989; Huband & Tantam, 2000; Kernberg, 1987; Long, 1996; Loughrey, Jackson, Molla & Wobbleton, 1997; Novotny, 1972; Rea, Aitken & Borastero, 1997; Simpson, 1980), with the potential to adversely affect treatment outcome (Allen, 1995). Despite the significant demands placed on services that manage those who self-harm, there has been little systematic study of how clinicians perceive those who self-harm or of how their attitudes are modified by their attributions and professional training.

This is concerning given the risk of suicide posed by recurrent self-harm (Hawton & Fagg, 1992) and the considerable pressures placed on staff to manage these clients and their associated risks on a long-term basis. Such pressures are well known to increase staff anxiety, which, if not contained, can result in a reduced ability for staff to provide care for

[2] This figure is based on statistics for self-poisoning and self-wounding and excludes deaths by hanging, motor gas, jumping and undetermined suicides. Overall, the national total of suicide is 5, 000 deaths per year (Department of Health, 2002).

their clients (Allen, 1995). This is consolidated by evidence that self-harming clients are often critical of the care they receive and specifically of mental health staff's attitudes towards them and what they perceive as seemingly punitive or dismissing responses (Arnold, 1995).

In order to further examine the clinical significance of this problem, a number of issues must be addressed. Firstly, a formal definition of self-harm is required for the purpose of clarity and consistency. Secondly, the importance of focusing on self-harm will be addressed. Thirdly, the use of attribution theory as a framework to understand the problem of self-harm will be justified and its implications for how self-harming clients may helped in services will be discussed. The literature relating to the effects of staff attitudes in working with self-harming clients will be considered. The effects of staff training on staff attitudes to self-harm will be examined and strategies for clinical management of self-harm will be reviewed. The case is made for systematic study into possible links between attributions, staff attitudes and choice of clinical management strategies in staff working with self-harming clients.

2. DEFINITION OF SELF-HARM

Considerable confusion surrounds the term 'self-harm' or 'deliberate self-harm' in the literature. This generic term is utilised to refer to acts of harm towards the self of varying severity, frequency and lethality. It neither clarifies the intent behind the harming behaviour for the individual at a given time nor the likelihood of its repetition. Indeed, the term 'self-harm' has been used interchangeably with the terms 'parasuicide', 'attempted suicide', 'self-injury' and 'self-mutilation' (Tantam & Whittaker, 1992) and therefore requires clarification.

Tantam and Whittaker (1992) distinguish between self-mutilation and self-wounding. They state the primary aim of self-mutilation to be major anatomical change, for example, enucleation of the eye or castration, and may be associated with psychosis or religious practices. They further distinguish between self-wounding as that borne out of unequivocal depression which is commonly life threatening, and self-wounding which is a reactive or habitual behaviour, for example, cutting and slashing, commonly associated with the symptoms of borderline personality disorder (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 2000) which may serve as an end in itself.

For the purposes of this review, self-harm is defined in accordance with the definition proposed by McAllister, Creedy, Moyle and Farrugia (2002) as, "any intentional damage to one's own body without a conscious intent to die " p. 579. This definition excludes direct issues of suicidality, self-harm or self-mutilative practices as a response to psychosis or as a repetitive act characteristic of learning disability, developmental disorder or brain injury or other psychiatric disorders. This definition therefore includes the reactive and habitual self-wounding referred to by Tantam and Whittaker (1992), as well as other means including self-poisoning and self-injury by hitting, all of which constitute a significant clinical problem.

3. THE IMPORTANCE OF FOCUSING ON SELF-HARM

3.1 Prevalence of self-harm

The number of hospital admissions resulting from self-harm to Accident & Emergency Departments in England and Wales (including self-wounding and self-poisoning) has been estimated at 100, 000 per year (Hawton & Fagg, 1992). Whilst this does not distinguish

between those admissions which result from repeated or first instances of self-harm, or the proportion of those admitted who were experiencing suicidal intention, it does provide a crude illustration of the magnitude of the problem posed to services and the considerable economic costs.

3.2 Economic costs of self-harm

The number of beds available for mental health admissions in England and Wales is ever declining (63,000 beds in 1988/89 to 34,000 in 2000/01- Department of Health, 2003) and therefore in-patient resources are extremely limited. Self-harm is a clinical presentation which has a strong tendency for recurrence and increased severity, often requiring both in-patient and outpatient/ community care. The considerable co-ordination and provision of care for self-harming clients therefore presents a considerable economic burden to statutory services and Society as a whole (National Institute for Clinical Excellence ,NICE, 2003). The specific costing of self-poisoning based on 240 episodes over a five-month period at three teaching hospitals in the UK was between £17,117 (for selective serotonin re-uptake inhibitor overdose) and £78,612 (for tricyclic antidepressant overdose, Kapur, House, Dodgson, May & Creed, 2001). Overall, for the UK, this results in an estimated cost of £5.1 million per year (Kapur, et al. 2001) and this is before the costs of self-wounding (suturing, specialist assessments, in-patient stay) or aftercare for these individuals has been considered.

Whilst the estimated economic costs of self-harm are considerable, what is inestimable is the personal cost to those individuals and their family members when self-harm results in suicide.

3.3 Link between self harm and suicide

The link between self-harm and eventual suicide has been demonstrated by a number of prospective follow-up studies of individuals who presented to hospitals with an index act of self-harm. The follow-up period of these studies ranged from up to one year (short-term), between one and five years (medium-term), and greater than five years (long-term). Overall, the short-term studies show that in the first year of follow-up, between 1% and 3% of self-harming clients committed suicide (Kessel & McCulloch, 1966; Rosen, 1970; Sakinofsky, 1998; Spirito et al., 1992; Stenager, Stenager & Jensen, 1994; all cited in Sakinofsky, 2000). In the medium-term studies, the cumulative proportion of suicides increased to 9%. Suicide was significantly higher among elderly populations (5-9%) and was low for adolescent samples (0-4%) (Achte, 1985; Bille-Brahe & Jessen, 1994; Hengeveld et al., 1991; Lonnqvist & Pierce, 1996; all cited in Sakinofsky, 2000). In the long-term studies, however, there was wide variation in the number of suicides, ranging from 2% to 10% depending upon the age, gender composition and geographic location of the sample (for example, Dahlgren, 1977; Ekeberg, Ellingsen & Jacobsen, 1991; Kotila, 1992; Mehlum, 1994; Rygnestad, 1997; Zonda, 1991, all cited in Sakinofsky, 2000). These studies demonstrate the link between self-harm and suicide and the variation between this link for various demographic groups. However, only a small number of these studies stated the proportion of self-harmers seen during the index episodes who had previous histories of self-harm. For example, Kreitman and Casey (1988) reported that the proportion of 'first-evers' reported in the UK over 20 years ranged between 40-60%, suggesting that half of admissions were 'repeaters' which may have inflated prevalence estimates. Nevertheless

the extent of the problem posed by the link between self-harm and suicide has become an increasing concern for health care providers and government.

3.4 Policies on Suicide

Recently, the extent of the clinical problem posed by self-harm has been further highlighted by governmental initiatives to reduce the number of deaths resulting from suicide. In particular, objectives of the National Suicide Prevention Strategy for England (Department of Health, 2002) aim to reduce the number of deaths resulting from self-poisoning (currently 1330 deaths per year) and the number of suicides in the year following other forms of deliberate self-harm (currently 1180 deaths per year) each by 20%. Whilst the Strategy targets serve primarily to reduce the number of suicides, other actions include the development of clinical guidelines for the management of self-harm and training in risk-assessment to frontline clinical staff.

However, these targets are complicated by the fact that repeated self-harmers are a heterogeneous population whose suicidal intention is in a constant state of flux. Sakinofsky (2000) states that at one end of the spectrum are those self-harmers whose behaviour is of little or no suicidal intent, whilst at the other, are those who are frustrated by genuine attempts to end their lives, with those in the middle (estimated one-third of cases) who may make genuine suicide attempts at some point. This means that the prediction of suicide and assessment of risk arising from non-fatal self-harm is difficult and inaccurate (Cantor, 1994).

3.5 Ongoing need for clinical management

The magnitude of the problem of self-harm requires more intervention than an aim to reduce the number of suicides alone. Indeed, even if the number of suicides resulting from self-poisoning and other forms of self-harm as delineated in the Suicide Prevention Strategy were subtracted from the prevalence estimate of admissions cited by Hawton and Fagg (1992), the remaining number of admissions in England & Wales may still be in excess of 90,000 per year. Such magnitude represents an ongoing need for clinical management and service provision for those who engage in self-harming behaviour as a result of underlying mental health difficulties (e.g. Allen, 1995; Smith, 2002). Cowmeadow (1994), for example, suggests that an effective intervention for self-harm should aim to reduce the short-term and lifetime risk of suicide in these patients by preventing the repetition of self-harm. However, there is no formal guidance regarding how best to prevent repetition of self-harm. The very nature of the Government's setting of suicide targets, without specific guidelines for the management of recurrent self-harm, has been reported as increasing pressure on staff and affecting the practice of care, (Smith, 2002).

3.6 Pressures on staff and responses to self-harm

Such pressures on staff have been known to trigger a variety of negative emotions in those dealing with repeated self-harm. For example, Loughrey et al. (1997) illustrate the enduring feelings of anxiety, conflict and contradictions in personal values felt by staff when working with such clients, accompanied by frustration and guilt whenever injury occurs. Similarly, Simpson (1976) states that after an episode of client self-harm, staff members fluctuate between feelings of rage, guilt, sympathy, resentment and the bitterness of being unable to cope with the situation. At times, these negative emotions overwhelm staff who are seeking effective treatments to help their clients (Dunn & Parry, 1997).

Indeed, these powerful emotions may give rise to the polarised and potentially damaging service responses caricatured by Allen (1995). Allen (1995) argues that services respond along a continuum from the 'Counsel of Despair' to 'naïve therapeutic optimism'. She describes that proponents of the Counsel of Despair argue that self-harming clients are invariably personality disordered, incurable and that their self-harming will only be reinforced by staff indulging them in sympathetic listening and by attempts to help. At the other extreme, are the naïve therapeutic optimists, who believe that the self-harmer desperately needs therapy, of any sort, and that once the person's awful early experiences have been 'talked through', the problem will vanish. Allen (1995) states that elements of both of these positions invariably result in inappropriate service provision. The lack of consensus of a clinical response to self-harm strongly identifies the need for the development of clinical guidelines to inform understanding and service provision for these clients.

3.7 NICE Guidelines on self-harm

In response to the complexity of working with self-harming clients and the various pressures and different responses from staff, the National Institute of Clinical Excellence (NICE) has developed draft clinical guidelines for working with those who self-harm (NICE, November, 2003). Similarly, clinical management guidelines for self-harm are also detailed in related documents referring to working with personality disorder by the National Institute for Mental Health in England (NIMHE), (Bateman & Tyrer, 2002; NIMHE, 2003), and similarly iterate issues detailed by NICE. These long awaited guidelines attempt to address the short-term physical and psychological management and the secondary prevention of self-harm in primary and secondary care settings. The recommendations made by NICE have been informed by the literature available in this area, which will be subject to examination in this

review. Whilst these guidelines address direct issues of clinical practice and provide some reference to psychological explanations of client-staff processes, they do not provide an overall theoretical framework in which to consider the problem of self-harm. For the purposes of research in this area however, it is necessary to use a theoretical approach in which to address and question the factors which may be relevant to an understanding of this clinical problem.

3.8 The need for theoretical understanding

Focus on self-harm as a clinical issue is clearly timely and justified. Despite the abundance of literature reporting the difficult emotions and varied responses to working with self-harming clients, there is little reference to a psychological model or framework which integrates the varying aspects of belief, emotion and action involved in working with such clients. The need for a psychological theory is especially important in providing a framework through which the clinical experiences and empirical findings of working with self-harming clients can be understood. Such a framework should also be able to make clear predictions of outcome in response to a given scenario, proving beneficial to both clinical practice and research. Given the varying responses to working with self-harming clients discussed above, it would be important to know what specific variables were associated with providing help for a client. For example, a staff member who is more confident in their ability to help the client reduce their self-harming might provide more help than a staff member who felt that their efforts would be fruitless. Similarly, a staff member who is angry with a client for repeatedly self-harming might respond differently to a staff member who was more sympathetic. Such questions demonstrate the need for a theoretical framework or model which can link the cognitions (perceptions, thoughts and beliefs) and emotional responses

of staff to their actions (response to the client). A useful framework for theoretical consideration of these issues is attribution theory.

4. THE CONTRIBUTION OF ATTRIBUTION THEORY TO OUR UNDERSTANDING OF THE WAY SELF-HARMING CLIENTS ARE HELPED IN SERVICES

4.1 Introduction to attribution theory

Attribution theory is concerned with the explanations people give of behaviour. Inherent to attribution theory is the assumption that many behavioural sequences are initiated following causal ascriptions (attributions) for an event (Weiner, 1980). The importance of attributions in the development of depression has been highlighted by the 'learned helplessness' literature (e.g. Abramson, Seligman & Teasdale, 1978) as well as in the 'help-giving' literature (e.g. Weiner, 1980). Whilst both literatures similarly emphasise the role of attributions in a given outcome, of most relevance to understanding the way self-harming clients are helped is the literature related to help-giving.

The relationship between attributions and help-giving was illustrated in an early study conducted by Piliavin, Rodin & Piliavin (1969) in which an individual (a confederate) fell in a subway. In one condition, the confederate appeared to be drunk (carried a bottle and smelled of alcohol) whereas in a second condition he appeared to be disabled (carried a black cane). Piliavin et al. (1969) found that bystander help was related to the perceived cause of falling. In reference to this early study, Weiner (1980) postulated a motivational sequence of help-giving whereby thoughts, feelings and behaviours interact to determine whether or not help is offered in a given situation. This research has subsequently guided

development of a theoretical model of help-giving which has been developed further in relation to professional help-giving with psychiatric and learning disabled populations.

4.2 A Cognitive (attribution)- emotion-action model of motivated behaviour

The cognitive (attribution)-emotion-action model of motivated behaviour (Weiner, 1980), describes a temporal sequence of attribution-affect-action in which attributions guide emotional reactions which provide the motivation and direction for behaviour.

Referring to Piliavin et al. (1969), Weiner (1980) proposed that the perception of an event (falling) gives rise to a search for causation and a primary emotional appraisal based response such as fear or a startle. Weiner (1980) stated that the reasons for falling (made explicit by the experimental manipulations of drunkenness and illness) are then subject to causal analysis, with attributions placed within particular causal dimensions. Three types of causal dimensions were identified: locus, stability and controllability, with locus (i.e. internal or external to the person) and controllability (in control or not in control) thought to be most important (Weiner, 1980). Weiner (1980) reasoned that illness is perceived as not subject to personal control, whereas the individual is believed to be personally responsible for being drunk. These related constructs were thought to give rise to different affective responses, namely pity and sympathy (toward the disabled person) and disgust or anger (toward the drunk). These affects were hypothesized to result in either approach (helping) versus avoidance (not helping) behaviours, respectively.

In order to test this model, Weiner manipulated the circumstances surrounding a help-giving situation (in control or not in control of behaviour). When control was attributed as being internal to the person (in control), the likelihood of helping was significantly less than when control was perceived as external to the person (not in control). For example, university students were less likely to lend a class mate notes when the need was perceived as controllable (i.e. resulting from a lack of effort) than when the need was perceived as uncontrollable (i.e. resulting from ability or shortcomings in teaching). Weiner explains that this sequence is largely mediated by affect, such as anger and disgust (negative affect) when events are perceived as controllable and sympathy and empathy (positive affect) when events are perceived as uncontrollable. In the former, the result of controllable attributions and negative affect is avoidance behaviour (i.e. not lending notes) conversely, in the latter, uncontrollable attributions and positive affect, result in helping behaviour (i.e., lending class notes). Less emphasis is placed on the attributional dimension of stability (whether the cause is seen as stable or unstable over time), which was found to have no main effect or interaction with the other variables (Sharrock, Day, Qazi & Brewin, 1990; Weiner, 1980).

Later replications of Weiner's model confirmed the attribution-affect-action sequence using structural equation modelling (Reisenzein, 1986) and path analysis (Meyer & Mulherin, 1980; Schmidt & Weiner, 1988).

Whilst Weiner's model received considerable empirical and conceptual support, it was uncertain what range of helping contexts the model might encompass (Sharrock et al. 1990). Sharrock et al. (1990) questioned the ecological validity of the helping scenarios employed in Weiner's studies and highlighted the need for consideration of the variables

involved in the behaviour of helping professionals (Sharrock et al., 1990). Specifically, Sharrock et al. (1990) state that the expectancies or cost-benefit appraisals (Piliavin et al., 1969) involved in determining help-giving are also important but are not considered in Weiner's (1980) model. They argue that attributions may also affect the perceived costs and benefits of helping, and therefore the tendency to help (Carlson & Miller, 1987). They cite a later theory developed by Weiner (1986) relating to achievement motivation in which attributional stability is regarded as an important variable in determining expectations of success or failure. Sharrock et al. (1990) predicted therefore, that in the context of helping, if a problem behaviour is attributed to a stable cause, such as the client's personality, help is less likely to be elicited since expectations of that help being successful are low.

4.3 Testing Weiner's (1980) model in professional help-giving

Weiner's (1980) model was subsequently tested by Sharrock et al. (1990) in relation to judgements of help-giving amongst a group of psychiatric care staff towards a 'target' client who had been resident on their unit for over a year. Staff were asked to complete measures of staff optimism (i.e. the extent to which staff believed they could beneficially intervene with the client); to rate how much extra effort they would exert in helping this client (i.e. 'no extra effort at all' to 'as much extra effort as possible'); to rate their emotional responses towards the client (i.e. 'no anger at all' to 'extreme anger') and to complete a modified version of the Attributional Style Questionnaire (Peterson et al., 1982) in which staff wrote down the cause of each relevant behaviour demonstrated by the target client.

The results of this study challenged the role of affective responses in mediating help-giving behaviour as emphasised by Weiner (1980). Sharrock et al. (1990) found that the general tendency of staff to help across a range of situations was mediated by staff optimism rather

than by affective reactions. Attributions of controllability were negatively associated with ratings of staff optimism and judgements of help-giving. It was thought that by attributing causality to factors internal and controllable to the patient, staff optimism was reduced as staff thought that the target patient had intended to behave in that way and there was therefore, less scope for successful intervention (Sharrock et al. 1990). Further, a path analysis of the results also showed that stable attributions were negatively related to levels of optimism, independently of the attribution of controllability. In short, if client behaviour is attributed as being stable over time, staff optimism is likely to be reduced.

Sharrock et al. (1990) highlight the erroneous logic of such beliefs, stating that 'intentional' behaviours are nevertheless influenced by external factors, which are capable of modification and arguably therefore, potentially deserving of some degree of staff optimism. Similarly, simply because behaviours are considered to be stable over time does not mean that they cannot be altered in any way. Indeed, behaviours considered as 'stable' are more likely to yield stable baseline measurements in which to apply differing contingencies (Donnellan, Mirenda, Mesaros & Fassbender, 1984; Emerson & Emerson, 1987).

The finding that staff optimism mediated staff attributions and behaviour in Sharrock et al.'s (1990) study contrasts with the findings of Weiner (1980) where affect was found to play a mediating role. This difference was explained by Sharrock et al. (1990) as resulting, in part, from the differences between the professional help demonstrated in their study and the spontaneous help in Weiner's (1980) study. For example, Benson et al. (1980) distinguished between non-spontaneous helping, which involves planning and cognitive activity on the part of the helper and more spontaneous helping as represented in Weiner's (1980) research. Benson et al. (1980) argued that spontaneous help was influenced more

by situational cues (such as whether or not other potential helpers were present) whereas planned help was cognitively determined by individual differences in the attributions of staff.

Another factor which may explain the lack of affective mediation in professional help-giving was posited by Sharrock et al. (1990) as potentially arising from differences in the frequency of help between professional and non-professional situations. Weiner's research principally involved infrequent events such as helping a drunk in distress, whereas psychiatric care staff face a high frequency of problem behaviours (Sharrock et al., 1990). They suggest that there is a strong possibility that staff may habituate to problem behaviours and so affective responses no longer provide the level of motivation for behaviour as suggested by Weiner. However, Sharrock et al. (1990) do not discount the potential for psychiatric staff to be influenced by emotion in particular instances (since Weiner was concerned with emotional responses to specific situations) but state that the general tendency of psychiatric staff to help across a range of situations is more closely related to optimism than to affective reactions. The relationship between these variables has been further examined in relation to staff working in the field of learning disability.

4.4 Helping behaviour in staff working with people with learning disabilities

In a replication of Sharrock et al.'s (1990) study, Dagnan, Trower and Smith (1998) interviewed 40 care staff working with people with learning disabilities (20 of whom worked with individuals with challenging behaviours and 20 who did not). They presented staff with six examples of challenging behaviours. For each example, staff were required to give a probable cause, rate attributions of stability, internality, globality (the extent to which evaluations of behaviour were generalised to evaluations of the whole person), controllability for their cause, their optimism for change of the behaviour, their emotional

responses to the behaviour and their willingness to put extra effort in to helping change the behaviour.

A path analysis of the findings from Dagnan et al.'s (1998) study revealed that helping behaviour was best predicted by staff optimism, supporting findings of Sharrock et al. (1990). However, staff optimism was best predicted by negative emotion, which was best predicted by the attribution of controllability to the cause of the behaviour. The finding that negative emotion is predicted by attribution is also consistent with Weiner's (1980) model, suggesting that negative emotion may well play a part in determining helping behaviour

A summary of these findings provided by Dagnan et al. (1998) is that if the challenging behaviour is attributed as controllable, this results in negative emotion, less staff optimism and less willingness to help.

Dagnan et al. (1998) describe a model of helping behaviour that supports both the role of emotion and staff optimism in determining helping behaviour. However, this model may not be generalised outside the area of learning disability. For example, Dagnan et al. (1998) explain that there may be a number of factors that differentiate between their findings and those of Sharrock et al. (1998). They state that there is a significant difference in the way that carers of different client groups react to challenges. For example, those with more experience of challenging behaviours were more likely to evaluate the person exhibiting the challenging behaviours more favourably and were therefore more willing to help than those without such experience. Dagnan et al. (1998) also argue that the effects of training, experience and stress on cognitive, emotional and behavioural responses to challenging behaviour require further investigation. Indeed, Dagnan et al. (1998) sampled care staff

from care homes in their study, whereas Sharrock et al. (1990) used largely professional nurses in their sample. It may be that comparing the results of these two studies is unhelpful since the differences in results may be explained in terms of the differences between less qualified staff (care staff) and more professionally trained staff (nurses), giving rise to some of the factors differentiating professional from non-professional help-giving as outlined by Benson et al. (1980).

Further, one cannot assume that the responses of staff working in the field of learning disability are comparable to those working in the field of adult mental health. It may be that emotion plays a more crucial role in determining staff responses to challenging behaviours in this area since there is potentially less scope for the use of verbal language as an alternative expression of distress on behalf of the client or between staff and client. It is also uncertain to what extent the fact that the client has a learning disability effects staff attributional style even before a challenging behaviour occurs. Clearly, therefore, there are difficulties extrapolating from Dagnan et al.'s (1998) study to the field of adult mental health. This leaves Sharrock et al.'s (1990) findings as the most applicable theoretical position regarding attributions and helping behaviour.

4.5 Recent research on staff attributions to 'borderline personality disorder'

Recently, attribution theory has been explored in relation to the effects of a psychiatric label ('borderline personality disorder', BPD) on nursing staff's perceptions and causal attributions for challenging behaviours. Markham and Trower (2003) asked staff to imagine a client with a diagnosis of BPD, schizophrenia or depression and then presented them with six examples of challenging behaviours commonly exhibited by clients (based on those used by Dagnan et al., 1998). The nurses were asked to identify the likely cause of the

behaviour and rate attributions of internality, stability, globality and controllability and their optimism for change. Markham and Trower (2003) found that clients with a diagnosis of BPD attracted more negative responses from staff than those with a label of schizophrenia or depression. Causes of their negative behaviour were rated as more stable and BPD clients were thought to be more in control of the causes of their behaviour and the behaviour itself than those diagnosed with depression or schizophrenia. Nurses also reported less optimism towards the client with BPD and rated their personal experiences as more negative than their experiences of working with clients with a diagnosis of depression or schizophrenia. This was seen as consistent with Sharrock et al.'s (1990) findings[3] and the importance of such attributions in staff was discussed in relation to the implications for help-giving.

4.6 Current theoretical position

Sharrock et al.'s (1990) finding that helping behaviour depended upon staff attributions mediated by staff optimism is a useful framework for considering how staff might work with self-harming clients. For example, one might predict that staff attributions of control and/ or stability to the self-harmer would affect their optimism regarding their ability to beneficially intervene with the client and, as a result, determine how they might try to help. Clearly, attributions are important in care- giving and specifically to the label of BPD (Markham & Trower, 2003), which is often related to self-harming behaviour. However, the literature concerned with how self-harmers are cared for in services places a great emphasis upon the specific beliefs and attitudes of staff working with this client-group and how such beliefs may affect client care. Sharrock et al.'s (1990) model does not provide information about how attributions may be related to specific beliefs in staff and how such beliefs may impact

[3] However, these findings were not subject to a path-analysis.

upon care- giving. To address this, staff beliefs or attitudes in addition to attributions towards clients displaying self-harm would need to be investigated. This is the next area of literature for review.

5. STAFF ATTITUDES TO SELF-HARMING CLIENTS

5.1 Definition of 'attitude'

Ajzen (1988) cited in McLaughlin (1994) states that a person's attitude towards another involves a disposition to react favourably or unfavourably to that person. Andersen (1997) considers this a useful approach since it recognises that during an interaction between two people, their attitudes towards each other will depend upon their beliefs, which are based upon information, knowledge and thoughts about that person and their behaviour. In relation to staff working with clients who self-harm, this definition is useful since it includes reference to specific thoughts about a client, which inform attributional judgements and beliefs, as well as highlighting the dyadic nature of the therapeutic relationship. Staff attitudes are therefore a crucial consideration in how self-harming clients are helped and how clients subjectively experience this help.

5.2 Importance of staff attitudes to the subjective experience of care

The emotive nature of working with self-harm has been reported widely in the literature, (Allen, 1995; Bailey, 1994; Book et al., 1978; Gabbard, 1989; Huband & Tantam, 2000; Loughrey et al., 1997; Novotny, 1972; Pallikkathayil & Morgan, 1988; Simpson, 1980) as has the propensity for staff to become polarised in their views and practice about how to work with such clients (Allen, 1995). Unsurprisingly, these divisions and differences

between staff members are also noticed by service-users and a number of studies have highlighted the impact of staff attitudes upon clients' subjective experience of care.

Arnold (1995) surveyed 76 Bristol women, recruited from the general population, who self-harmed. In addition to asking the women about the precipitators, feelings towards and functions of their self-harm, Arnold (1995) was also interested in how these women experienced the services with which they had come into contact, what they had found helpful and how they saw their service needs. Overall, there was a high degree of dissatisfaction with many services, with the exception of counselling or psychotherapy services. The most important factor in determining whether a woman's experience of services was helpful was the attitude of the professionals involved.

Unhelpful responses were illustrated by women having experienced being ignored, told off, dismissed as 'attention seeking', 'a nuisance', 'childish', or 'wasting time'. Women also reported being made to wait longer than other patients for treatment, refused treatment altogether or treated cruelly such as being sutured without anaesthetic (Arnold, 1995). Women experienced such attitudes and responses to their self-harm as very distressing, sometimes deterring them from seeking help in future and at other times as reinforcing the self-hatred and desperation which precipitated their self-harm (Arnold, 1995). Helpful responses were illustrated by women who experienced sympathetic and supportive responses, staff taking time to listen to them and being given time to talk through their feelings and situations. Whilst this survey indicates the importance of staff attitudes and the perceived helpfulness of responses, it relies almost entirely upon retrospective and subjective accounts. Such results therefore need to be replicated using a more empirically rigorous approach.

Treloar and Pinfold (1993) aimed to investigate the perceived therapeutic effectiveness of the various mental health care professionals that self-harmers encountered during their stay in psychiatric hospital. They also wanted to compare the effectiveness of different groups of professionals involved in the hospital and to elucidate the relationship between various aspects of inpatient management and the amount of help received.

They devised and piloted a questionnaire consisting of rating scales, which asked clients to assess the amount of help they felt they received on the following aspects of care: sympathy, listening, opportunity to make suggestions and practical suggestions made by professionals involved in their care. The results indicated that clients' perception of the amount of help they received was highly significantly associated with staff attributes, particularly, sympathy (r = .60) and listening behaviour (r = .63). Also, significant differences were encountered between the professional groups involved in client care with nurses and social workers being regarded most favourably (Treloar & Pinfold, 1993).

Similar results have been reported by Samuelsson, Wiklander, Asberg and Saveman (2000). They interviewed 18 inpatients in psychiatric care in Sweden following a self-harm episode with considered moderate to high suicidal intent. Each inpatient was asked to narrate their experience of care concerning the following areas: admission to hospital, feelings and reactions, positive and negative experiences during the stay. The subsequent responses were subject to a content analysis to identify commonly reported themes. The results emphasised the importance of being well cared for, receiving understanding and confirmation on behalf of the service-users. Saveman (1994) cited in Samuelsson et al. (2000) describes these positive experiences as resulting from what he calls 'involvement',

that staff are not merely observers of the situation but rather they share responsibility for another human being and for what happens in the situation. Lack of confirmation was thought to contribute to feeling burdensome (in some cases) and demands for discharge or even another suicide attempt. Overall, however, most inpatient participants in the research reported positive experiences of care in this study, a finding consistent with Treloar and Pinfold (1993) but contrasting with that of Arnold (1995).

These differences between the largely positive experiences of care by Treloar and Pinfold (1993) and Samuelsson et al. (2000) and the negative experiences reported by Arnold (1995) may be explained in terms of the different contexts and methodologies assumed by both studies. For example, the service in which Treloar and Pinfold's (1993) research was carried out may be particularly aware of the issues in working with this client group. Similarly, Samuelsson et al. (2000) report that their inpatient unit was designated for the care of suicidal clients with specially trained staff. Further, it is possible that the results may be in part influenced by demand characteristics (i.e. that staff *should* be more caring and understanding of their clients) resulting from the specialised inpatient setting. However, Arnold (1995) used self-selected service-users from the general population who may not have been representative of the total population of self-harmers in their perceived experiences of care. The result of comparing the findings of these three studies, therefore, is that none necessarily gives a representative picture of how self-harmers experience their care. However, consistent across the studies, perceived helpfulness was largely dependent upon staff's interaction style and attitudes towards self-harmers.

These studies have largely contributed to NICE (2003) highlighting the importance of staff attitudes to self-harming clients in developing their guidelines. For example, the guidelines

recommend that staff ask service users to explain their feelings and understanding of the self-harm in their own words and ask staff to account for the underlying emotional distress as well as the severity of the injury in prioritising the client for treatment (NICE, 2003, p. 51).

Clearly, the attitudes of staff to self-harming clients are important. Early studies of staff attitudes towards working with this client group will now be reviewed.

5.3 Early studies of staff attitudes to self-harming clients

Ramon (1980) investigated different aspects of physicians', nurses' and psychiatrists' attitudes to self-poisoning clients. In this study, staff members were presented with four 'hypothetical' clients and asked to complete a questionnaire in relation to each one. The questionnaire consisted of items on the understandability of the act; the respondent's choice of an alternative behaviour; the motives for the act; the degree of acceptability of these motives; the degree of readiness to help; sympathy; and, the wish for further information. In addition, staff were also asked to complete these questionnaires for 'real' clients who self-poisoned. For these individuals, staff members were required to complete additional items regarding information relating to the mode of self-poisoning; the severity and number of previous attempts; the intervention offered to the client and the type of help that, ideally, would have been offered.

The findings revealed that there were no differences between staff attitudes and the amount of stereotyping regarding clients' motives for the 'hypothetical' or the 'real' clients. All staff indicated an ambivalent-stereotyped attitude towards all clients. This attitude included a high degree of readiness to help but low ratings of sympathy with negative attitudes towards the motive 'to frighten people' but highly positive attitudes towards the motive

'really wanted to die'. This paints a confusing picture for researchers trying to understand the links between attributions, attitudes and helping behaviours (and potentially for the staff and clients involved). If a high readiness to help was independent of the amount of sympathy or attitudes of staff towards the client and their motives then this fundamentally challenges the predictions of attribution theories (Sharrock et al. 1990; Weiner, 1980) which have linked attributions of the clients behaviour to the amount of help-giving.

Interestingly, most staff viewed the self-poisoning as purposive rather than being an expression of an inner state (Ramon, 1980). Consistent with Treloar and Pinfold (1993), Ramon (1980) also found that physicians had a more negative view of self-poisoning clients than nurses who were the more sympathetic group of staff. Ramon (1980) discusses these findings in relation to the differences in relative position between nurses and physicians. He suggests that the involvement and overall responsibility of the psychiatrist[4] may strip the physician of the power or position to do anything for the client other than resuscitation. This results in a highly ambiguous situation for the physician when encountering the client face-to-face and is consistent with reports that physicians consider self-poisoning clients less deserving of medical care than those with a physical illness (Ghodse, 1978; Patel, 1975). On the other hand, nurses are more suitably positioned to intervene sympathetically with these clients by providing empathic reassurance which Ramon (1980) describes as the 'calling of nursing'.

In conclusion, Ramon (1980) states that with such differences between staff attitudes and responses to these clients, the commitment of staff to life versus death is questionable. Hawton, Marsack and Fagg (1981) replicated Ramon's (1970) study utilising a similar

[4] Although Ramon (1980) also states that Psychiatrists are also often limited in their capacity to introduce changes into the lives of such clients.

methodology. Consistent results were found in that physicians were least sympathetic towards self-poisoning clients although nurses and psychiatrists were equally sympathetic and demonstrated a greater willingness to help. These studies provide some indication of the ambivalence of staff towards these clients, consolidating the reports of clients themselves (Arnold, 1995; Treloar & Pinfold, 1993). Since the studies of Ramon (1980) and Hawton et al., (1981), much of the research in this area has focussed specifically on nurses' attitudes towards self-harmers.

5.4 Nurses' attitudes to self-harming clients

Since the early studies in this area, Government directives such as Health of the Nation (Department of Health, 1992) were introduced and highlighted the increased risks of suicide for self-harming clients. Four years after this directive was introduced, Sidley and Renton (1996) carried out a questionnaire survey of general nurses at a Manchester general hospital to investigate nurses' perceptions and attitudes to self-harmers admitted for drug-overdose. The results showed that nurses generally displayed professional attitudes to the treatment of these individuals, for example, they appreciated that the risks of suicide were increased in this client group and agreed that they had equal right to expensive forms of treatment. However, these nurses also appeared to show negative personal reactions after caring for self-harmers. Most of them agreed that self-harm was a form of 'attention-seeking' and reported that the often negative impact of this work on nurses' own well-being meant that they often disliked working with this client group. This difference between professional attitudes and personal responses to working with self-harmers is consistent with the results of Ramon (1980). Overall, however, nurses displayed a wish for ongoing support in working with self-harmers and identified a training need with regards to working with the non-medical aspects of care (Sidley & Renton, 1996). However, this survey was

based upon responses from an unvalidated measure and the results must therefore be treated with caution. Further, it is uncertain how the attitudes of general nurses compare to those of nurses working in the community.

To investigate this very issue, Anderson (1997) compared the attitudes towards individuals with 'suicidal behaviour' [5] between A & E nurses and community mental health nurses (CMHNs) working in the same locality. Andersen (1997) developed and validated a questionnaire including attitudinal categories to measure the considered acceptability of the suicidal behaviour, the morality of the suicidal behaviour, the professional role, work and care of staff and the communicative aspects of such behaviour. Contrary to earlier studies, the results showed that nurses from both settings held generally positive attitudes towards suicidal behaviours. The length of nursing experience was related to an increasingly positive attitude. However, the study did not differentiate between first-time self-harmers or repeaters or control for variables such as staff training. Andersen (1997) argues that it is therefore inappropriate to draw generalised conclusions from this study. Indeed, the finding of positive attitudes to working with this client group has not been replicated in more recent studies of nurses' attitudes to self-harmers.

McAllister et al. (2002) were interested in developing a measure to identify relevant aspects of Emergency Department nurses' attitudes to clients who presented with self-harm. They used issues drawn from the literature and from focus group discussions as items for their Attitudes Towards Deliberate Self-Harm Questionnaire (ADSHQ). The questionnaire was completed by 352 Australian nurses and was subject to a principal components analysis. Four factors relating to nurses' attitudes were extracted and related to: perceived

[5] The use of the term 'suicidal behaviour' in this study is consistent with the use of the term 'self-harm' defined in this review.

confidence in assessment and referral of self-harming clients; dealing effectively with self-harming clients; empathic approach; and, the ability to cope effectively with legal and hospital regulations that guide practice. Overall, the results found that nurses' attitudes were generally negative. In particular, nurses indicated feeling unskilled in assessing self-harmers and helpless in dealing with their problems. McAllister et al. (2002) argue for the need for continuing professional development activities to address these negative attitudes and provide management strategies to inform clinical protocols. However, it is uncertain whether this is a justified conclusion based on their findings. Specifically, the psychometric properties of the ADSHQ reveal low reliability for the total scale and the four factors as accounting for only 36% of the total variance. Therefore, development of the ADSHQ is necessary to improve its psychometric properties before findings resulting from its use can be widespread. Even if this is achieved, the questionnaire has been developed for nurses alone and is, in its current form, limited to sampling nurses working in emergency settings.

Self-harming clients have contact with a wide variety of services and numerous professionals. What is of interest, therefore, is how the attitudes and responses of various professionals differ in relation to self-harming clients. In England, where aftercare of self-harming clients is usually provided by several professionals working in Community Mental Health Teams (CMHTs), it is relevant to examine staff attitudes and responses to self-harming clients as a group. This is particularly important given the reports of staff splitting in the literature (Book et al., 1978; Gabbard, 1989; Huband & Tantam, 2000; Loughrey et al., 1997; Novotny, 1972; Simpson, 1980) and the differences in the attitudes and responses of different professions reported by service-users (Arnold, 1995).

The only study which has sought to examine staff attitudes in mental health team staff is that of Huband and Tantam (2000).

5.5 Attitudes to self-harm in a group of mental health staff

Huband and Tantam (2000) devised a set of 23 questions derived from comments and beliefs frequently expressed by clinical staff who worked with self-harming clients. They asked staff to consider a case vignette of a typical self-harming[6] client based on two frequently cited descriptions (Favazza & Conterio, 1989; Simpson, 1976). From the responses of 213 staff, Huband and Tantam used a principal components analysis to identify five factors that mediated staff attitudes to the case of the woman in the vignette. These factors included: the perception of the woman as being in control of her actions; the tendency for her to be undemanding versus difficult; her eligibility for tolerance and empathy from staff; the difficulty on behalf of staff to understand her actions and a weaker factor broadly termed 'therapeutic confidence'. Component loadings for the five factors ranged from .40 to .78, accounting for 45.1% of the total variance.

Huband and Tantam found that staff members whose beliefs were characterised by the perception of the woman as not in control of her actions (termed the 'Softer Group'), also agreed that she was more eligible for tolerance and empathy and had less difficulty understanding her actions compared to the group who believed the woman to be in control of her actions (the 'Firmer Group'). These findings are consistent with the link between attributions and emotions as described by Weiner (1980). However, the study did not

[6] Huband & Tantam focussed on 'self-wounding' as a specific type of self-harm.

investigate the relationship between the 'Softer Group' and 'Firmer Group' attitudes in relation to their therapeutic optimism (Factor 5) in working with the woman. This was because Factor 5 loaded as a relatively weak factor (Huband, personal communication). According to Sharrock et al. (1990), staff optimism would be a crucial factor in determining how the client is helped. Therefore, by introducing a measure of staff optimism, Huband and Tantam's (2000) findings may be further explored using Sharrock' et al.'s (1990) model of help-giving.

Huband and Tantam's (2000) study also showed how staff attitudes to self-harming clients may be affected by staff training. This is important in light of studies which have identified differing attitudes amongst a variety of professionals towards self-harmers (e.g. Ramon, 1970; Hawton et al. 1981) and the differential impact of such attitudes on the subjective experience of care (Arnold, 1995).

5.6 Effects of training on staff attitudes

Interestingly, Huband and Tantam (2000) found that staff who had an additional qualification in counselling or psychotherapy differed significantly in their attitudes towards the self-harming woman described in the vignette. Specifically, the possession of a counselling or psychotherapy qualification was strongly associated with the perception that the woman in the vignette had less control over her actions and a greater understanding of her actions by staff. This is consistent with research on staff attitudes to challenging behaviours in the field of learning disabilities (Hastings, 1997) but is a result that has not been previously published in relation to working with self-harm (Huband & Tantam, 2000). However, staff attitudes were not affected by any other form of training, for example, training that related to the specific management of episodes of self-harm. This explains the

findings of Arnold (1995) who found that self-harming clients were dissatisfied with many services except counselling and psychotherapy services and that such satisfaction was solely determined by service-users' experience of staff attitudes towards them.

Huband and Tantam offer two interpretations of this finding. First, that the staff member's ability to contain their anxiety in response to client self-harm is enhanced by psychotherapy training. The self-harming client frequently raises anxiety in professional staff who are concerned about his or her safety, the possible repercussions if she cuts once too often and from complex counter-transference reactions (Feldman, 1988 cited in Huband & Tantam, 2000). Breeze and Repper, 1998; McAllister et al. 2002; Sidley and Renton, 1996; Smith, 2002 argue that self-harming behaviour challenges professionals' views of their autonomy, competence and role. They suggest that one defence against such anxiety is for the clinician to attribute responsibility and blame away from themselves and onto the client. Further, they postulate that the different attributions of control as found in their study may represent different degrees of defensive projection as there is evidence that perceived control is strongly associated with the attribution of responsibility (Fincham & Emery, 1998). Furthermore, Huband and Tantam (2000) argue that counselling or psychotherapy training often involves a strong educational component and is geared towards insight and personal growth. They suggest that this training and background may be effective in helping staff reduce their defensive responses and allow them to deal with unsettling presentations without needing to attribute disproportionate levels of responsibility onto the client. This contrasts with those staff who undertake training in a specific clinical problem (self-harm) who may acquire information and technique but are unlikely to gain insight into their own psychological or defensive responses (Huband & Tantam, 2000). Explanation for the differing staff attitudes between those staff with formal counselling/ psychotherapy training

and those without such training may also be understood in terms of differences in self-efficacy in relation to working with self-harming clients. Self-efficacy [the perceived ability to cope with specific situations, Bandura (1995)] may be increased through formal training in counselling/ psychotherapy as staff may feel more equipped to manage a client who has self-harmed than those without such training. Self-efficacy may also enable staff to manage any anxiety in response to a self-harming client and reduce the likelihood of the defensive projection posited by Huband and Tantam (2000). However, perceived self-efficacy as a theoretical construct has not been formally examined in relation to staff working with self-harming clients. Nevertheless, it remains an important factor for consideration in controlling for staff' perceived experience, competence and training in studying staff attitudes to self-harming clients.

Another interpretation of the effect of staff training on attitudes towards the self-harming woman is that those who sought to obtain a counselling/ psychotherapy qualification constitute a subgroup who, even prior to their training, may have been less likely to attribute control to self-harming clients (Huband & Tantam, 2000).

Indeed, whether either or both of these explanations is correct, staff training in counselling or psychotherapy appears to be an important consideration in determining attitudes to the self-harming client. However, it remains unclear how differing staff attitudes link to the clinical management of self-harming clients. To address this issue, the current literature surrounding clinical management of this client group will first be reviewed.

6. CLINICAL MANAGEMENT STRATEGIES FOR SELF-HARM

6.1 The need to address clinical management strategies

Despite the size of the problem of self-harm, there is a distinct lack of information regarding which clinical management strategies are effective in preventing repetition of self-harm and therefore reducing short-term and lifelong suicide risks (Cowmeadow, 1994).

The literature concerned with the management of self-harm reports a variety of differing management strategies, in differing service settings, using differing methodologies (Cantor, 1994; Hawton et al., 1998) and with largely different outcomes (Crowe & Bunclark, 2000; McElroy & Sheppard, 1999; Kumaraiah & Bhide, 2001; Sheard et al., 2000;). For example, Kapur et al. (1998) assessed the management of self-poisoning in four teaching hospitals in England using standardised methods of data retrieval and found striking variations in the management of episodes between study centres. They found a fourfold difference in discharge rates from A & E and an almost twofold difference in the proportion of clients who received a psychosocial assessment (in 220 out of 477 hospital attendances the service-user had no psychosocial assessment[7] during their hospital contact). Interestingly, these differences in clinical practice were not accounted for by differences in clients' characteristics. Kapur et al. (1998) argue that these findings illustrate a high-risk approach to intervention and a lack of consensus on the psychiatric management of self-poisoning. Research has shown that the initial management of self-harm is correlated with the rate of repetition. For example, Crawford and Wessely (1998) found that individuals who discharged themselves from A & E before an initial assessment was completed had three times the rate of repetition of self-harm than those who completed the assessment. Clearly, therefore, whilst the initial management of self-harm is a crucial determinant of prognosis, it is not carried out reliably in clinical practice. Indeed, Kapur et al. (1998) identified the need

[7] Despite Department of Health (1984) guidelines which outline the need for routine psychosocial assessment of a client following self-harm.

for large scale intervention studies to inform clinical practice and ensure that management of self-harm in the future is less arbitrary than it has been previously. This has prompted the systematic review of the efficacy of interventions for self-harm in the literature.

6.2 Evidenced-base interventions for self-harm

Hawton et al. (1998) synthesised findings from all randomised controlled trials that examined the effectiveness of treatments of patients who had self-harmed (*N* = 2452). They systematically reviewed both physical and psychological treatments for self-harm and compared the results with those of standard aftercare (i.e. the usual range of treatment options that were available in routine care at the time in each setting[8]) with the main outcome variable being the repetition of self-harm in participants. Overall, the results indicated reduced repetition for problem solving therapies[9] and for provision of an emergency contact card in addition to standard aftercare. Other studies such as dialectical behaviour therapy (DBT) indicated significantly reduced rates of repetition compared to standard aftercare although only one such study was included in the meta-analysis and sample size was small (*N* = 32) (Linehan, Armstrong, Suarez, Allmari & Heard, 1991).

In regard to physical treatments, significantly reduced rates of self-harm were observed for depot flupenthixol (antidepressant) compared to a placebo in multiple repeaters. Overall however, Hawton et al. (2003) concluded that, 'There remains considerable uncertainty about which forms of psychosocial and physical treatments of patients who harm themselves are most effective' (Hawton et al., 2003, pp 1-2). Indeed, these results and conclusions from Hawton et al.'s (1998) paper are consistent with subsequent meta-analysis (Hawton et al., 2003). Hawton et al. (2003) explained how an insufficient number

[8] Standard aftercare would therefore be largely variable between studies

[9] Problem solving therapies included components of problem solving but varied in their focus (e.g. task centered social work/ interpersonal problem solving skills training/ cognitive-behavioural problem solving)

of self-harming clients in the trials was the principal limiting factor in drawing conclusions from the data and argued the need for larger trials of treatments associated with reduced rates of repetition of self-harm. In the meantime, Hawton et al. (2003) highlight the need for caution in interpreting the results of small trials that have shown trends towards reduced repetition and emphasise the need for their replication.

Such uncertainty regarding the management of self-harming clients may amplify existing staff splits of how best to work with this client group (Main, 1957) and maintain the lack of a cohesive approach to the delivery of care (Allen, 1995). In an attempt to provide a more cohesive delivery of care, NICE has outlined clinical practice recommendations which focus on multi-disciplinary discussion and assessment for treating individuals who self-harm (see NICE Management of Self-Harm, 2003). For example, NICE (2003) tentatively recommends that individuals at risk of repetition of self-harm be considered for an intensive intervention accompanied by outreach (i.e. following up missed appointments) and that individuals diagnosed with borderline personality disorder be considered for DBT. However, these services are not consistently available in mainstream clinical practice and clinicians may be unable to act on these recommendations. This may mean that individuals who self-harm continue to receive inconsistent clinical management in areas of the NHS where intensive intervention services are absent compared to areas where such services have been developed.

Huband and Tantam (1999) sought to identify the preferred clinical management strategies of mental health staff working with self-harm, to identify if there is any consistency in approach.

6.3 Mental Health professionals' preferred clinical management strategies

Huband and Tantam (1999) developed a questionnaire assessing the preferred management of a case of a self-harming woman described in a vignette. Over two hundred participants identified the extent to which they would endorse each of 19 management strategies specific to self-harm drawn from the literature. This questionnaire was administered alongside a questionnaire detailing participant demographics and attitudes to the woman described in the vignette reported separately by Huband and Tantam (2000). Interestingly, the strategies of 'Maintaining regular discussion amongst involved staff' and 'Encourage the client to ventilate unexpressed feelings' were seen as the most helpful (endorsed by 94% and 87% of participants respectively) with medication and hospital admission regarded as the least helpful (endorsed by only 5% of participants, Huband & Tantam, 1999). However, ambivalence and uncertainty were expressed for many of the suggested strategies (for example, 'managing the client through the use of a no-harm contract', by 'referral to family therapy' and by 'offering a 24-hour contact number'). These differences of clinical opinion could not be explained in terms of gender, experience or training of the respondent and were consistent with the disparity of approaches evident in the literature, implying a potential for disagreement between staff (Huband & Tantam, 1999). It was concluded that, given the contrasting evidence for some of the suggested strategies, the strong preference for maintaining regular discussion between involved staff was encouraging since it may help to minimise management difficulties for this client group (Huband & Tantam, 1999). However, the relationship between staff attitudes to the self-harming client and their corresponding choice of clinical management strategies was not examined in this study.

7. INTEGRATING PREVIOUS FINDINGS AND DIRECTING FUTURE RESEARCH

As discussed, the care of self-harming clients is complicated by conflicting staff attitudes and approaches as well as a lack of consensus surrounding the clinical management of such clients.

The main factor shown to determine staff attitudes towards a self-harming woman is whether or not she is perceived as being in control of her actions (Huband & Tantam, 2000) and this is consistent with attributions of control as described by attribution theories (Dagnan et al., 1998; Sharrock et al. 1990; Weiner, 1980).

If attribution of control *is* the principal determinant of staff attitudes[10], attribution theory would predict that this would impact directly on the help-giving offered by staff to a self-harming client (Dagnan et al., 1998; Sharrock et al. 1990; Weiner, 1980;), Sharrock et al.'s (1990) model is important in studying whether attributions of control towards self-harming clients affect staff attitudes, optimism and how such clients are clinically managed. Given previous findings (e.g. Huband & Tantam 1999; Huband & Tantam, 2000; Markham & Trower, 2003 Sharrock et al., 1990), one would expect there to be some relationship between attribution of control, staff attitudes, optimism and the clinical management of self-harming clients. However, this has not been examined in the literature. Future research to address these issues is clearly of significant clinical concern with implications for training

[10] This finding has yet to be replicated

and supporting staff working with self-harming clients, service delivery and most vitally, the experience of care by the client.

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SCHOOL OF PSYCHOLOGY

The Effect of an Attribution of Control to a Self-harming Client on Mental Health Staff Attitudes and Choice of Clinical Management Strategies

by

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INTRODUCTION

The prevalence of self-harming related suicides is estimated at 1180 deaths per year (Department of Health, 2002) contributing to a total of 100,000[11] Accident & Emergency admissions per year (Hawton & Fagg, 1992).

For the purposes of this paper, self-harm is defined in accordance with the definition proposed by McAllister, Creedy, Moyle and Farrugia (2002) as, "any intentional damage to one's own body without a conscious intent to die" p.579. This definition therefore includes the reactive and habitual self-harming referred to by Tantam and Whittaker (1992), as well as other means including self-poisoning and self-injury by hitting, slashing and burning, all of which constitute a significant clinical problem. This is consistent with Huband and Tantam's (2000) and Tantam and Whittaker's (1992) use of the term 'self-wounding', that is self-harm as a reactive or habitual behaviour, commonly associated with the symptoms of borderline personality disorder (BPD), (American Psychiatric Association, 2000, Diagnostic and Statistical Manual of Mental Disorders) rather than self-harm as that borne out of depression; which is commonly life threatening.

Self-harming poses a significant clinical management problem for services (e.g. Book, Sadavoy & Silver, 1978; Gabbard, 1989; Huband & Tantam, 2000; Loughrey, Jackson, Molla & Wobbleton, 1997; Main, 1957; Novotny, 1972; Simpson, 1980). Nevertheless, self-harming is a behaviour which remains poorly understood, evoking strong reactions from

[11] This figure includes deaths resulting from self-poisoning.

clinicians (Huband & Tantam, 2000). The clinical management of self-harming is further complicated by the widely-reported capacity of self-harming clients to evoke powerful emotions in staff and engender "splitting" (polarisation of attitudes/ responses to clients) in the caring system (Huband & Tantam, 2000; Main, 1957; Novotny, 1972; Simpson, 1980). This can give rise to inconsistent staff attitudes and responses with the potential to adversely effect treatment outcome (Allen, 1995).

Whilst the importance of staff attitudes has been highlighted in the literature, there has been little systematic study of how staff attitudes differ between staff. For example, it is uncertain how the responses of staff to self-harming clients are modified by their attributions towards clients or their professional training. Such variables have been shown to be important determinants of staff attitudes (Huband & Tantam, 2000) and may, therefore, impact upon client care. Systematically, to investigate the effects of staff attributions and training on the clinical management of self-harming clients, a psychological theory from which the clinical experiences and empirical findings of working with self-harming clients can be understood is required. Attribution theory provides an understanding that enables the linking of cognitions (perceptions, thoughts and beliefs) and emotional responses of staff to their actions (response to the self-harming client).

Attribution theory and help-giving

Attribution theory is concerned with the explanations people give to behaviour. It assumes that many behavioural sequences are initiated following causal attributions for an event (Weiner, 1980). This is fundamental to understanding what variables are likely to affect how staff think about self-harming clients and ultimately how self-harming clients are helped in services.

The cognitive (attribution)-emotion-action model of motivated behaviour (Weiner, 1980) describes a temporal sequence of attribution-affect-action in which attributions guide emotional reactions, which provide the motivation and direction for behaviour. Weiner (1980) manipulated the circumstances surrounding a help-giving situation (in control or not in control of behaviour). When control was attributed as being internal to the person (in control), the likelihood of helping was significantly less than when control was perceived as external to the person (not in control). Weiner explains that this sequence is largely mediated by affect, such as disgust and anger when events are perceived as controllable and sympathy and empathy when events are perceived as uncontrollable. These affects were found to determine approach (helping) versus avoidance (not helping) behaviours respectively.

This model was further investigated by Sharrock, Day, Qazi and Brewin (1990) in relation to judgements of help-giving amongst a group of psychiatric in-patient staff towards a client. This study challenged the role of affective responses in mediating help-giving behaviour as emphasised by Weiner (1980). Instead the authors found that the general tendency of staff to help across a range of situations was mediated by staff optimism (the extent to which staff believed they could beneficially intervene with the client) rather than by affective reactions. Attributions of controllability were negatively associated with ratings of staff optimism and judgements of help-giving. It was thought that by attributing causality to factors internal and controllable to the client, staff optimism was reduced as staff thought the target client had intended to behave that way and there was therefore less 'opportunity' for successful intervention (Sharrock et al., 1990).

The difference between affect as a mediator between attribution and action in Weiner's (1980) study and the mediation of staff optimism in Sharrock et al.'s (1990) study was explained by Sharrock et al. (1990) as resulting, in part, from the differences between the professional help demonstrated in their study and the spontaneous help in Weiner's (1980) study. Benson et al. (1980) distinguished between non-spontaneous helping, which involves planning and cognitive activity on the part of the helper and more spontaneous helping represented in Weiner's (1980) research. Sharrock et al. (1990) argued that spontaneous help was influenced more by situational cues (such as whether other helpers were present) whilst planned help was cognitively determined by individual differences in the attributions of staff.

Another potential factor explaining the lack of affective mediation in professional help-giving was posited by Sharrock et al. (1990) as arising from differences in the frequency of help between professional and non-professional situations. Weiner's (1980) research principally involved infrequent events such as helping a drunk in distress, whereas psychiatric in-patient staff face a high frequency of problem behaviours. They suggest that there is a strong possibility that staff may habituate to problem behaviours and so affective responses no longer provide the level of motivation for behaviour as suggested by Weiner. However, Sharrock et al. (1990) do not discount the potential for psychiatric care staff to be influenced by emotion in particular instances (since Weiner was concerned with emotional responses to specific situations) but state that the general tendency of psychiatric staff to help across a range of situations is more closely related to optimism than to affective reactions.

In a recent study, Markham and Trower (2003) asked nursing staff to imagine a client with a diagnosis of Borderline personality disorder (BPD), schizophrenia, or depression and

presented them with six examples of challenging behaviours commonly exhibited by clients. The nurses were asked to identify the likely cause of the behaviour and rate their attributions of control and staff optimism in response to the clients. Markham and Trower (2003) found that clients with a diagnosis of BPD attracted more negative responses from staff than those with a label of schizophrenia or depression. BPD clients were thought to be more in control of the causes of their behaviour and the behaviour itself than those diagnosed with depression or schizophrenia. Nurses also reported less optimism towards the client with BPD and rated their personal experiences as more negative than their experiences of working with clients with a diagnosis of depression or schizophrenia. The effects of attribution of control and staff optimism are, therefore, important in staff working with clients diagnosed with BPD and may, therefore, be equally important in working with associated behaviours such as self-harming.

Staff attitudes to a self-harming client

Huband and Tantam (2000) studied attitudes to self-harming within a group of mental health staff. They identified five factors that mediated staff attitudes to a case of a self-harming woman described in a vignette. These factors included: the perception of the woman as in control of her actions; the tendency for her to be undemanding versus difficult; her eligibility for tolerance and empathy from staff; the difficulty on behalf of staff to understand her actions; and, a weaker factor broadly termed 'therapeutic confidence'.

The principal factor in distinguishing between different staff attitudes was found to be the extent to which staff believed the client had control over her actions. Staff members whose beliefs were characterised by the perception that the woman was less in control of her actions (termed the 'Softer Group') also agreed that she was more eligible for tolerance and

empathy and experienced less difficulty in understanding her actions compared to staff who believed the woman to be more in control of her actions (termed the 'Firmer Group'). This suggests that attribution of control may be an important variable in determining staff attitudes to a self-harming client.

Huband & Tantam's (2000) study also showed how staff attitudes to self-harming clients are affected by staff training.

Effects of training on mental health staff attitudes

Huband and Tantam (2000) found that staff with an additional qualification in counselling or psychotherapy differed significantly in their attitudes towards the self-harming woman. The possession of a counselling or psychotherapy qualification was strongly associated with the perception that the woman in the vignette had less control over her actions and a greater understanding of her actions by staff. This result had not previously been published in relation to working with self-harm (Huband & Tantam, 2000). Staff attitudes were not affected by training that related to the specific management of episodes of self-harm. This explains the findings of Arnold (1995) who found that self-harming clients were dissatisfied with many services except counselling and psychotherapy services and that such satisfaction was determined by service-users' experience of staff attitudes towards them (Treloar & Pinfold, 1993).

Huband and Tantam offer two interpretations of this finding. Firstly, that the staff member's ability to contain their anxiety in response to client self-harm is enhanced by psychotherapy training. The self-harming client frequently raises anxiety in professional staff who are concerned about the client's safety, the possible repercussions if she cuts once too often and

from complex counter-transference reactions (Feldman, 1988 cited in Huband & Tantam, 2000). Huband and Tantam (2000) argue that self-harming behaviour challenges professionals' views of their autonomy, competence and role (Breeze & Repper, 1998; McAllister et al. 2002; Sidley & Renton, 1996; Smith, 2002;). They suggest that one defence against such anxiety is for the clinician to attribute responsibility and blame away from themselves and onto the client. Huband and Tantam (2000) argue that counselling or psychotherapy training often involves a strong educational component and is geared towards insight and personal growth. They suggest that this training and background may be effective in helping staff reduce their defensive responses, allowing them to deal with unsettling presentations without attributing disproportionate levels of responsibility to the client.

A second interpretation of the effect of staff training on attitudes towards the self-harming woman is that those who sought to obtain a counselling or psychotherapy qualification constitute a subgroup who, even prior to their training, may have been less likely to attribute control to self-harming clients (Huband & Tantam, 2000).

Mental health staff' preferred clinical management strategies for a self-harming client

Huband and Tantam (1999) developed a questionnaire assessing the preferred management of a case of a self-harming woman described in a vignette. Over 200 participants identified the extent to which they would endorse each of 19 management strategies drawn from the literature[12]. The strategies of 'Maintaining regular discussion amongst involved staff' and 'Encourage the client to ventilate unexpressed feelings' were seen as the most helpful

[12] The management strategies in the questionnaire were drawn from the management strategies advocated in the literature specific to self-harming as well as generic clinical management strategies for self-harm (i.e. other forms of self-harm other than self-cutting).

(endorsed by 94% and 87% of participants respectively) with 'medication' and 'hospital admission' regarded as the least helpful (endorsed by only 5% of participants, (Huband & Tantam, 1999). Uncertainty was expressed for many of the suggested strategies (for example, 'managing the client through the use of a no-harm contract', 'by referral to family therapy' and 'by offering a 24-hour contact number'). These differences of clinical opinion were consistent with the disparity of approaches evident in the literature (Hawton et al., 1998), implying a potential for disagreement between staff (Huband & Tantam, 1999). The strong preference for maintaining regular discussion between involved staff was seen as encouraging since it may help to minimise management difficulties for this client group (Huband & Tantam, 1999) and is consistent with clinical guidelines (National Institute for Clinical Excellence [NICE] guidelines, Management of self-harm, 2003).

The effects of an attribution of control on staff attitudes and choice of clinical management strategies

Given previous findings (e.g. Huband & Tantam 1999; Huband & Tantam, 2000; Markham & Trower, 2003; Sharrock et al., 1990), one would expect there to be some relationship between attribution of control, staff attitudes, optimism and the clinical management of self-harming clients. However, this has not been examined in the literature. Such investigation is clearly of significant clinical concern with implications for training and supporting staff working with self-harming clients, service delivery and, most vitally, the experience of care by the client.

Huband and Tantam (2000) used an independent groups design in determining their differences between the 'Softer' and 'Firmer' groups. In light of their findings, if attribution of control *is* the principle factor determining staff attitudes to the client, it would be of interest for

this result to be replicated in a more rigorous experimental design, where the attribution of control to a self-harming client is manipulated between conditions, using a repeated measures design, where staff act as their own controls between conditions. It is predicted that the attribution of control to a self-harming client will result in a greater tendency to perceive the client as difficult; less eligible for tolerance and empathy; and a greater difficulty in understanding her actions than when control is not attributed to the client.

Huband and Tantam's (2000) study did not investigate the relationship between the 'Softer Group' and 'Firmer Group' attitudes in relation to their therapeutic confidence in working with the client. This was because this factor was shown to load relatively weakly[13], accounting for only 5% of the total variance (Huband, personal communication). According to Sharrock et al. (1990), staff optimism would be a crucial factor in determining how the client is helped. Therefore, by introducing a more widely used measure of staff optimism, Huband and Tantam's (2000) findings may be further explored using Sharrock' et al.'s (1990) model of help-giving. It is predicted that the attribution of control to a self-harming client will result in less staff optimism than when control is not attributed to the client.

The relationship between staff attitudes to the self-harming client, specifically the extent to which staff believed the woman was in control of her actions, and the corresponding choice of clinical management strategies was not examined by Huband and Tantam (1999; 2000). This is an important line of investigation, given Huband andTantam's (2000) finding that the extent to which staff perceived the woman as in control of her actions was a defining factor in their overall attitudes towards the client. This attitudinal factor (related to attribution of control) is consistent with Sharrock et al.'s (1990) model. The following study examines

[13] Attitudes factors were obtained following a principal components analysis (see Appendix 6).

whether attribution of control to a self-harming client affects choice of clinical management strategies. Possible associations between staff attitudes, staff optimism and the choice of clinical management strategies will be explored both when control is attributed to the client and when control is not attributed to the client.

Staff training in counselling or psychotherapy appears to be an important consideration in determining attitudes to the self-harming client (Huband & Tantam, 2000). This study attempts to replicate this finding. It is predicted that there will be an association between staff training in counselling or psychotherapy and staff attitudes and optimism towards the self-harming client.

It remains unclear whether staff training in counselling or psychotherapy links to the clinical management of self-harming clients. However, if staff training does affect staff attitudes and optimism, attribution theory (Sharrock et al., 1990) would predict that this would affect how the client is helped. Therefore, it is predicted that there will be an association between staff training in counselling or psychotherapy and choice of clinical management strategies.

METHOD

Design

A repeated measures design was used to investigate the effects of an attribution of 'control' (independent variable) to self-wounding clients (described in two vignettes) on staff attitudes and choice of clinical management strategies (dependent variables). This design was used to improve the external validity and generalisability of findings compared to the methods used by Huband and Tantam (1999; 2000) and allowed participants to act as their

own controls between conditions. The independent variable was manipulated between conditions ('control' and 'no control') to increase the internal validity of the study. In order to control for possible order effects of using two vignettes with two manipulations ('control' and 'no control'), a full factorial design was used to randomly allocate participants to one of four groups (see Table 1 below).

Participants

Ninety-one CMHT staff members (Adult Mental Health) were recruited from the West Hampshire & Isle of Wight NHS Trusts following a short presentation on the aims of the study. In their study of mental health staff attitudes to self-injury, Huband and Tantam (2000) calculated a medium effect size (.48) for staff with psychotherapy training compared to those without. With an alpha of .05 and a power of .80 (Cohen, 1992) a minimum sample size of 36 was required to find a difference (i.e. minimum of 9 participants per group). A total of 40 questionnaires were returned (response rate = 44%) with 10 participants in each group. This compares to a 55% response rate in Huband and Tantam's (1999; 2000) study. Ninety-five per cent of participants reported having some level of clinical responsibility for women who self-wounded (compared to 94% cited by Huband & Tantam, 1999; 2000). This demonstrates the common presentation of self-wounding in CMHTs and highlights the relevance of staff attitudes, clinical management and staff training in working with such clients (Huband & Tantam, 1999).

A breakdown of the professional discipline of participants is provided in Table 2 and a summary of participants' employment setting, age, gender, training and experience is summarised in Table 3. Overall, 72.5% of all staff had worked with at least 6 women on the issue of self-wounding, 75% considered themselves to be moderately or considerably

experienced in this area despite only 55% of staff having received specific training in the handling of clients who self-harm.

Table 1

Full factorial design- allocation of participants to four groups to counterbalance presentation order of vignettes with manipulation of 'control'.

Allocated Group (*N*)	Presentation 1 (Manipulation of 'control')	Presentation 2 (Manipulation of 'control')
1 (10)	Vignette 1 ('Control')	Vignette 2 ('No control')
2 (10)	Vignette 1 ('No control')	Vignette 2 ('Control)
3 (10)	Vignette 2 ('Control')	Vignette 1 ('No control')
4 (10)	Vignette 2 ('No control')	Vignette 1 ('Control)

Table 2

Distribution of professional disciplines

Professional discipline	Number of participants in sample (*N*)	Percentage of total sample
Psychiatry	2	5.0
Psychiatric nursing	16	40.0
Occupational therapy	1	2.5
Psychotherapy	1	2.5
Clinical psychology	5	12.5
Social work	10	25.0
Support work/ Community care	4	10.0
Undisclosed	1	2.5

Table 3

Characteristics of staff participants

	N	Percentage of total sample
Gender:		
Male	16	40.0
Female	24	60.0
Current employment:		
In-patient setting	7*	17.5
Out-patient/community setting	38*	95.0
Day hospital setting	1*	2.5
Therapeutic community[14]	1*	2.5
Training and experience:		
Specific qualification in counselling/ psychotherapy	21	52.5
Specific training in handling self-wounding clients	22	55.0
10 or more years experience in a health setting	20	50.0
Receiving regular supervision	36	90.0
Age (years):		
26-35	12	30.0
36-45	11	27.5
46+	17	42.5
Specific experience:		
Worked with no women on issue of self-wounding	2	5.0
Worked with 1-5 women on issue of self-wounding	9	22.5
Worked with 6-10 women on issue of self-wounding	2	5.0
Worked with 10+ women on issue of self-wounding	27	67.5
Self-assessment of experience in this area:		
Relatively inexperienced	6	15.0
Moderately experienced	24	60.0
Considerably experienced	10	25.0

Ethical approval

Ethics committee approval was obtained from both the Psychology Department at the University of Southampton and the Local Research Ethics Committee of the Trust (see Appendix 1) due to the involvement of National Health Service (NHS) staff. All participants were sent an information sheet (see Appendix 2) explaining the purpose of the study and it was made clear that there was no obligation to participate. Those who consented to participate did so by returning the questionnaires.

Measures

Equipment- Two vignettes were used. The first (Appendix 3) was replicated[τ] from Huband and Tantam (1999) who used two widely cited demographic studies of women who self-wound (Favazza & Conterio, 1989; Simpson, 1976) to compose a vignette of a typical self-wounding client. With reference to these studies, a second vignette was also composed (Appendix 4). Both vignettes were similar in that in both women, a history of self-harming (cutting and self-poisoning) was revealed, it was stated that there was no evidence of major depression or psychosis and there was no current history of suicidal intent. In neither vignette was a diagnosis provided. However, the vignettes differed as to the precise details of previous self-harming events, the nature of their circumstances, age and clinical presentation.

Staff attitudes measure- A questionnaire developed and published by Huband and Tantam (1999; 2000) to evaluate professional attitudes to a self-wounding client was used. Items were based on comments frequently expressed by clinical staff working with this client

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[14] (NB: * participants reporting working in more than one setting)

[τ] For copyright permission for this vignette see Appendix 12

group. The questionnaire highlights five factors of staff attitudes and component loadings range from .78 to .40. The first factor (F1) is termed *ability to be in control of her actions* and is related to the perception of her capacity for consciously determining and moderating her behaviour, including her self-wounding (14.3% of total variance). Factor 2 (F2) is termed *tendency to be undemanding versus difficult*, reflecting how troublesome she is likely to be in her interaction with staff (10.0% of total variance). Factor 3 (F3) is termed *eligibility for tolerance and empathy*, related to her right to receive patience and warmth as well as a preference for a philosophy of care, which includes these qualities (8.6 of total variance). Factor 4 (F4) is termed *difficulty understanding her actions* (6.3 of total variance). Factor 5 (F5) lacks conceptual clarity (Huband & Tantam, 2000), but is associated with the staff's perception of their own *'therapeutic confidence'* (5% of total variance).

The questionnaire items were presented as unambiguous semantic differential pairs involving two extreme opinions, rated on an ordinal scale (see Appendix 5). Participants were required to mark the line between the two extremes to show where their opinion lay, for example, 'The chances are that she will injure herself again' to 'The chances are that she will not injure herself again'. Responses were scored from –4 to +4 using an overlay to divide the line in to nine equal segments such that a line marked centrally carried a score of zero (Huband & Tantam, 2000). The score derived from the line was then multiplied by the component loading for each item (based on the reported loadings from the principal component analysis reported by Huband and Tantam, 2000, see Appendix 6). These values were then summed and divided by the total number of items in each factor to yield a weighted factor score for F1 to F5.

This measure has been shown to discriminate between 'Softer' and 'Firmer' attitudes in staff. Content validity has been demonstrated through the findings of a principal component analysis. No reliability data have yet been published in relation to this measure.

Optimism-pessimism scale- A measure of staff optimism derived from the Optimism-Pessimism Scale (Moores & Grant, 1976) was used. This scale has been modified to render items more appropriate to mental health populations rather than learning disabled populations (Sharrock et al., 1990). Validity data of the scale have not been published since its modification, however, the scale has been widely used in its modified form in previous studies to measure staff optimism, demonstrating validity of precedence (e.g. Allen, Gillespie & Hall, 1989; Dagnan et al., 1998; Garety & Morris, 1984; Sharrock et al., 1990). The current scale consists of 5 pessimistic statements reflecting the level of expectations of target clients' accomplishments and the extent to which staff consider that they could beneficially intervene (see Appendix 7). This ordinal scale has a reported internal-consistency reliability coefficient (Cronbach's alpha) of between .82 (Dagnan, personal communication, in use with staff working with learning disabled clients) and .76 (Sharrock et al., 1990).

Clinical management strategies measure- A measure of clinical management strategies for self-wounding developed by Huband and Tantam (1999) was used. They systematically selected a total of 19 management strategies advocated by the literature in the overall management of clients who self-wound in addition to working with specific incidents of self-harm (Huband & Tantam, 1999). They highlighted the fact that many of these strategies relate to the nature of therapeutic contact between the staff member and the client.

Participants were required to rate their agreement in relation to each clinical management strategy on an ordinal scale (+2 Strongly agree; +1 Agree; 0 Unclear; -1 Disagree; -2 Strongly disagree). As a check on the content validity of the measure, participants were asked to list additional management strategies and rate them in terms of their agreement (see Appendix 8). Huband and Tantam report test-retest reliability co-efficients of item scores ranging from .60 to .82, with .66 as the median correlation co-efficient.

Procedure

In order to determine the test re-test reliability of the staff attitudes measure and the Optimism-Pessimism Scale, a sample of 12[15] trainee clinicians (final year trainee clinical psychologists) were asked to complete these measures in response to one of the vignettes and to repeat this procedure following a three-month interval (see Results section, 'Preliminary analyses').

Following a brief presentation of the aims of the research (based on the Participant Information Sheet, Appendix 2), a questionnaire pack was distributed to each CMHT staff member. Each staff member was asked to complete the relevant demographic information, experience (past and present) with self-harming clients and any psychotherapy/ counselling qualifications they may have (see Appendix 9). Staff participants were not required to identify themselves on the questionnaires to ensure confidentiality and anonymity and to encourage disclosure of staff attitudes. Rather, each questionnaire was coded in order to monitor the return from each allocated group (as shown in Table 1).

[15] Size of sub-sample determined as 30% of the total sample size, i.e. $N = 12$ when total $N = 40$.

Staff were told that they were about to read an assessment summary of a woman. They were then told (depending upon their allocated group for vignette presentation) that 'This person's behaviour IS NOT under their control' or that 'This person's behaviour IS under their control and they have not followed the advice of their clinician as they should' and to 'Imagine that these thoughts truly characterise your beliefs in relation to this client'. This procedure was replicated from Weiner's (1980) studies which used the same wording to manipulate attribution of control between conditions.

Staff were then required to consider the first case vignette (each vignette approximately 340 words) describing the self-wounding woman and to complete the staff attitudes measure, the Optimism-Pessimism Scale and the clinical management strategies measure. This process was then repeated in relation to the second case vignette.

Analyses

The use of non-parametric descriptive and inferential statistics was determined by the ordinal nature of the scales used and the relatively small sample size.

To look for associations between staff demographic variables, attitudes, optimism and clinical management strategies, non-parametric correlations were used within the 'Control' and 'No control' conditions.

To examine differences between staff attitudes and clinical management strategies for the 'Control' and 'No control' conditions, the Wilcoxon Signed Ranks test was used. One-tailed tests were used when making directional predictions.

To examine differences between three groups of differently trained staff, the Kruskal-Wallis one-way ANOVA was used.

All statistical analyses were conducted using the SPSS computer software package (SPSS, 2001).

RESULTS

Over a period of 5 months, 40 mental health staff completed and returned questionnaires.

Preliminary analyses

To control for the effects of possible confounds arising from staff demographics on the dependent variables, a series of analyses was carried out. Correlational analyses were carried out to investigate any possible associations between gender, staff training in handling self-injury and years worked in a health setting on staff attitudes, optimism and choice of clinical management strategies. No significant associations were found ($p > .05$, one-tailed). To investigate any possible effects of age of staff, profession and staff experience working with self-harming clients on staff attitudes, optimism and choice of clinical management strategies, a series of Kruskal-Wallis one-way ANOVAs were carried out. No significant effects were found ($p > .05$, one-tailed).

Attempts were made to investigate the test-retest reliability of the staff attitudes measure and the optimism-pessimism measure on the sub-sample of trainee clinical psychologists, however, at the time of planning, it was not known that teaching sessions in working with self-harm were planned in the intervening 3-month period. For this reason and with further consideration, it was not thought to be appropriate to report any subsequent results as indicators of test-retest reliability (see Appendix 10).

In order to test whether the manipulation of attribution of control was effective between conditions, two items referring explicitly to the control of the self-harming client were analysed[16]. These items were removed from the attitudes measure to avoid circularity, as they constituted independent rather than dependent variables. Similarly, a further item referring to the likelihood that the client would comply with treatment[17] was also removed as this was referred to explicitly in the 'Control' condition vignette. (See Table 4).

Table 4

Staff responses to removed items from Staff attitudes questionnaire (1)- 'She has control over the extent of her self-wounding'; (2)- 'She has control over the decision to cut' & (3)- She is unlikely to comply with treatment'.

	Control			No Control		
Questionnaire Item	Median	Mode	Range	Median	Mode	Range
(1) Control over extent of cutting (N=40)	0.78	1.56	-2.34-3.12	-0.46	0.00	-3.12-3.12
(2) Control over decision to cut (N=40)	0.94	0.00	-2.25-3.00	-0.19	0.00	-4.00-3.00
(3) Unlikely to comply with treatment (N=40)	-0.47	0.00	-2.48-0.62	-0.62	-0.62	-1.86-0.62

[2] These items were from Factor 1 of the Staff attitudes questionnaire.
[3] This item was from Factor 2 of the Staff attitudes questionnaire.

Table 4 suggests that the manipulation of control between conditions was effective for items (1) and (2) as shown by increased scores in the 'Control' condition compared to the 'No control' condition. These differences were statistically significant (z = -3.51, *N*-Ties = 32, p = .000, one-tailed; z = -3.69, *N*-Ties = 31, p = .000, one-tailed- for items (1) and (2) respectively). This indicates that staff believed that the self-harming woman had more control over the extent of her cutting and her decision to cut in the 'Control' condition than in the 'No Control' condition. However, there was no significant difference in terms of whether staff believed the woman would comply with treatment between the 'Control' and 'No control' conditions (z = -0.73, *N*-Ties = 27, p = .431, one-tailed).

To test whether staff believed the self- wounding client was able to be in control of her actions once items relating explicitly to control were removed, the remaining items (Factor 1) were analysed.

Increased scores were found for the 'Control' condition (Median –0.30, Mode –0.58, Range –1.74 - 1.10) compared to the 'No control' condition (Median –0.64, Mode –1.16, Range –1.93 - 0.76) suggesting that staff believed the self-harming woman was more able to control her actions in the 'Control' condition than in the 'No control' condition (Wilcoxon Signed Ranks Test, z = -1.78, *N*-Ties = 34, p = .037, one-tailed).

These preliminary analyses show that the manipulation of the independent variable was effective in altering the attribution of control between conditions where items explicitly referred to control (as shown in Table 4) and further affected staff attitudes to items which were not explicit in their reference to the ability of the woman to control her behaviour. This

indicates that staff were able to achieve the 'mindset' of the differing attributions between conditions.

The effect of an attribution of control on the perception of the client as difficult

In order to test the hypothesis that the attribution of control to a self-harming client would result in a greater tendency to perceive the client as difficult (Factor 2- Staff attitudes questionnaire), non-parametric descriptive statistics were analysed for both 'Control' and 'No control' conditions.

There was no difference in staff attitudes towards the self-harming client between the 'Control' condition (Median –0.67, Mode –1.75†, Range –2.46 - 1.55) and 'No control' condition (Median –6.50, Mode –1.53†, Range –2.08 – 1.68), z = -0.33, N-Ties = 34, p = .360, one-tailed. Therefore, staff did not perceive the woman in the 'Control' condition to be more difficult than the woman described in the 'No control' condition.

The effect of an attribution of control on staff tolerance and empathy

To investigate the hypothesis that an attribution of control to a self-harming client would result in staff deeming her less eligible for tolerance and empathy (Factor 3- Staff attitudes measure) than when control is not attributed, non-parametric descriptive statistics were utilised.

No differences were found between the eligibility for tolerance and empathy for the 'Control' condition (Median 0.98, Mode –0.05, Range –0.72 – 2.19) and 'No control' condition (Median 0.98, Mode –0.05, Range –0.72 – 2.19), z = 0, N-Ties = 0, p = .050, one-tailed.

† = Multiple modes exist. The smallest value is shown.

Staff did not perceive the woman in the 'Control' condition to be less eligible for tolerance and empathy than the woman described in the 'No control' condition. Rather, they deemed them to be equally eligible.

The effect of an attribution of control on staff's ability to understand the actions of a self-harming client

In order to test the hypothesis that the attribution of control to a self-harming client would result in a greater difficulty in understanding her actions (Factor 4- Staff attitudes measure) than when control is not attributed, non-parametric descriptive statistics were utilised.

Staff responded with increased difficulty in understanding the actions of the woman in the 'Control' condition (Median –0.94, Mode –1.34†, Range –1.93 – 0.57) compared to the woman in the 'No control' condition (Median –0.86, Mode –1.79†, Range –1.79 – 0.56). However, these differences were not statistically significant (z = -0.67, N-Ties = 34, p = .252, one-tailed). Therefore, staff did not experience significantly greater difficulty in understanding the actions of the self-harming client in the 'Control' condition compared to the 'No control' condition.

The effect of an attribution of control on staff optimism

To test the hypothesis that an attribution of control to a self-harming client would result in less staff optimism than when control is not attributed to the client, non-parametric descriptive statistics were analysed.

There was no difference between staff optimism scores between the 'Control' condition (Median 28.5, Mode 28†, Range 5 – 35) and 'No control' condition (Median 28, Mode 28,

† Multiple modes exist. The smallest value is shown.

Range 14 – 35), $z = 0$, *N*-Ties = 27, $p = .500$, one-tailed. Therefore, an attribution of control did not result in less staff optimism in the 'Control' condition compared to the 'No control' condition, rather staff were similarly optimistic in both conditions.

The effect of an attribution of control on the choice of clinical management strategies

In order to test the hypothesis that an attribution of control would affect the choice of clinical management strategies, non-parametric statistics were conducted between 'Control' and 'No control' conditions. (See Table 5).

Table 5

Staff choice of clinical management strategies for 'Control' and 'No control' conditions (continued over page)

	Control			No control			Wilcoxon *z* statistic	Level of strategy endorsement
Clinical management strategy	Median	Mode	Range	Median	Mode	Range		(Median based)
Maintain regular discussion with involved staff members	2	2	0-2	1.5	2	0-2	-0.33	Strongly agree
Refer for exploratory psychotherapy	1	0†	-2-2	1	1	-2-2	-2.00*	Agree
Teach conflict management and assertiveness skills	1	1	-1-2	1	1	-2-2	-0.50	Agree
Teach emotional management (e.g. relaxation)	1	1	0-2	1	2	0-2	-0.30	Agree
Make available long-term relationship with key worker	1	1	-1-2	1	1	-1-2	-1.1	Agree
Refer to self-help group for people who self-injure	1	1	-1-1	1	1	0-2	-1.41	Agree
Avoid hospitalisation: if hospitalised, expedite discharge	1	1	-2-2	1	1	-2-2	-1.24	Agree
Encourage ventilation of unexpressed feelings about her past	1	1	-2-2	1	1	-1-2	-0.71	Agree
Encourage self-care of self-inflicted wounds	1	1	-1-2	1	1	-1-2	-0.30	Agree
Match with staff emotionally neutral to self-wounding τ	1	1	-1-2	1	1	-1-2	0.00	Agree

† = Multiple modes exist. The smallest value is shown. T = Actual wording was 'who can remain neutral to self-wounding'. * = Significant at the $p = .05$ level.

Table 5 continued:

Staff choice of clinical management strategies for 'Control' and 'No control' conditions

	Control			No control			Wilcoxon z statistic	Level of strategy endorsement
Clinical management strategy	Median	Mode	Range	Median	Mode	Range		(Median based)
Allow her a 24 hour 'emergency contact' telephone number	1	1	-2-2	1	1	-1-2	-0.67	Agree
Negotiate a no-harm contract with her	0	1	-2-2	0	1	-2-2	-0.18	Unclear
Look for underlying sexual trauma	0.5	1	-1-2	0	1	-2-2	-1.31	Unclear
Encourage medication/drug therapy	0	0	-2-1	0	0	-2-1	-0.21	Unclear
Refer for family therapy with parents	0	0	-2-1	0	0	-2-0	-0.36	Unclear
Restrict contact to named staff	0	0	-1-1	0	0	-1-1	-0.70	Unclear
Pay minimum attention to her wounds	0	1	-1-1	0.5	1	-2-2	-0.24	Unclear/Agree[b]
Ask responsible person to take care of sharp knives etc.	-1	-1	-2-1	-1	-1	-2-1	-0.24	Disagree
Admit to hospital under Section if necessary	-1	-1	-2-2	-1	-2†	-2-0	-0.82	Disagree

[b] = Unclear in 'Control' condition, 'Agree' in 'No control' condition. † = Multiple modes exist. The smallest value is shown.

Only one significant difference was found between staff choice of clinical management strategies between the 'Control' and 'No control' conditions. Descriptive statistics indicate that staff were unclear whether the woman in the 'Control' condition should be referred to psychotherapy whereas in the 'No control' condition, staff agreed that she should be referred. This difference was found to be statistically significant (z = -2.0, N-Ties = 13, p = .046, two-tailed). Staff were less likely to refer the woman for exploratory psychotherapy when control was attributed than when no control was attributed.

Staff did make additional suggestions regarding the clinical management of the self-harming client and these are described in Table 6. As these additional clinical management strategies have not been subject to a content analysis or test-retest reliability, only descriptive statistics were calculated to indicate the level of endorsement by staff.

Table 6

Staff suggestions for additional clinical management strategies for 'Control' and 'No control' conditions (continued over page)

		Control		No control
Clinical management strategy suggestion	*N*	Level of strategy endorsement (Median based)	*N*	Level of strategy endorsement (Median based)
Create a systemic /attachment framework to understand her problems	1	Strongly agree	1	Strongly agree
Develop a strong containing relationship	1	Strongly agree	1	Strongly agree
Keep a log of her self-harming incidents	1	Strongly agree	1	Agree
Support her carers	1	Strongly agree	1	Strongly agree
Understand why she cuts and the meaning of cutting	1	Strongly agree	1	Strongly agree
Solution focussed therapy	1	Strongly agree	1	Strongly agree
Validate self-wounding as self-management and offer potential for change	2	Strongly agree/Agree	1	Agree
Offer validation and encouragement not to self-harm	1	Strongly agree	0	N/A
Teach distress tolerance skills/DBT	5	Strongly agree	6	Strongly agree
Make an emergency plan of action	1	Strongly agree	1	Strongly agree
Carry out a chain-analysis of self-wounding incidents	1	Strongly agree	1	Strongly agree

N=sample size. N/A= not applicable.

Table 6 continued:

Staff suggestions for additional clinical management strategies for 'Control' and 'No control' conditions

		Control		No control
Clinical management strategy suggestion	*N*	Level of strategy endorsement (Median based)	*N*	Level of strategy endorsement (Median based)
Develop firm boundaries	1	Strongly agree	0	N/A
Communicate regularly with the client	0	N/A	2	Strongly agree
Develop a language for emotional expression	0	N/A	1	Strongly agree
Help find a safer means to release her feelings	5	Agree	1	Agree
Give all emergency telephone numbers	1	Agree	0	N/A
Assess for personality disorder	2	Agree	0	N/A
Refuse all treatment	1	Strongly disagree	1	Strongly disagree

N=sample size. N/A= not applicable.

As shown in Table 6, several of the additional management strategies were strongly endorsed by staff for both conditions, for example: 'Validate self-harm as self-management and offer the potential for change' and 'Understand the meaning of cutting'. However, some suggested strategies pertained only to the 'Control' condition, for example, 'Assess for personality disorder' and 'Develop firm boundaries'.

The relationship between staff attitudes and optimism on the choice of clinical management strategies in 'Control' and 'No control' conditions

To investigate the hypothesis that there would be a relationship between staff attitudes, optimism and the choice of clinical management strategies when control is attributed to a client compared to when control is not attributed to a client, a number of non-parametric correlational analyses were carried out.

Correlations were carried out between staff attitudes (Factors 1-4) and staff optimism in both 'Control' and 'No control' conditions and the choice of clinical management strategies. Kendall's Tau (non-parametric) was used as data were ordinal and the data set was small with a large number of tied ranks. It was thought that this would give a better estimate of the correlation of the population than Spearman's Rank correlation.

Due to the large number of correlations required, the likelihood of Type 1 errors is increased. To limit the number of type 1 errors, a Bonferroni correction[18] was applied to each analysis. In cases where the Bonferroni corrected *p*-value was thought to be too conservative, increasing the likelihood of a Type 2 error, the *p* - value was adjusted to *p* <

[18] For example, for 20 comparisons (19 clinical management strategies + staff optimism) 20x20=400, .05/400 = .0001.

.01 (two-tailed). Therefore significant results at the $p = < .01$ level are suggestive rather than conclusive indicators of significance (see Table 7).

Table 7

Correlations between staff attitudes (Factors 1-4), staff optimism and choice of clinical management strategies for 'Control' and 'No control' conditions

(continued over page)

	Control				(N = 40)	No control				(N = 40)
Clinical management strategy	Factor 1[19]	Factor 2	Factor 3	Factor 4	Optimism	Factor 1	Factor 2	Factor 3	Factor 4	Optimism
Refer for exploratory psychotherapy	-.30	-.08	.11	-.29	.34*	-.19	-.10	.01	-.08	.07
Teach conflict management/assertiveness	-.77	-.13	-.03	.03	.04	.22	.08	.04	.05	.07
Teach emotional management (e.g. relaxation)	-.20	.09	.18	.04	.16	.28	.11	.16	-.01	.07
Maintain regular discussion with involved staff	-.46**	.04	.21	-.30	.34	-.10	.07	.17	-.28	.27
Make available long-term relationship with key worker	-.33*	.26	.05	-.05	.11	-.13	.18	.23	-.25	.17
Negotiate no-harm contract	.19	-.13	-.37*	.21	-.30	.08	-.09	-.29	.08	-.30*
Admit to hospital (under Section if necessary)	-.06	.29	-.04	.11	-.08	.17	-.02	-.01	.06	-.31
Refer to self-help group for self-injury	.19	-.22	-.11	-.01	-.17	.23	-.14	-.09	.24	-.11
Ask person to take charge of sharp knives etc.	.02	.19	-.27	.33*	-.22	-.01	.10	-.16	.11	-.14

[19] Factor 1= Ability to be in control of her actions; Factor 2= Tendency to be undemanding versus difficult; Factor 3=Eligibility for tolerance and empathy; Factor 4= Difficulty in understanding her actions. N =sample size. *p < .01 level (two-tailed). **p < .001 level (two-tailed).

Table 7 continued:

Correlations between staff attitudes (Factors 1-4), staff optimism and choice of clinical management strategies for 'Control' and 'No control' conditions.

	Control (*N* = 40)					No control (*N* = 40)				
Clinical management strategy	Factor 1	Factor 2	Factor 3	Factor 4	Optimism	Factor 1	Factor 2	Factor 3	Factor 4	Optimism
Look for underlying sexual trauma	-.16	-.19	-.04	.04	.09	-.22	-.08	-.16	-.05	- .11
Encourage medication/ drug therapy	-.19	.05	.04	.12	.06	-.09	.03	-.01	.20	-.15
Refer for family therapy with parents	.01	-.16	-.23	.34*	-.00	-.05	.05	-.14	.13	.06
Avoid hospitalisation: if hospitalised, expedite discharge	-.16	-.10	.07	-.25	.01	.08	.10	.38*	-.08	.34*
Restrict contact to named staff	.21	-.11	-.20	.26	-.13	.04	-.22	-.19	.00	-.10
Encourage ventilation of unexpressed feelings of past	-.21	-.24	-.02	-.13	.12	.05	-.22	.14	-.01	.15
Pay minimum attention to wounds	.03	.10	.13	-.03	.02	.10	-.10	.04	-.09	-.06
Encourage self-care of wounds	.04	-.17	.15	-.26	.14	.11	-.19	.17	-.08	.16
Match with staff emotionally neutral to self-wounding T	.02	-.02	.25	-.20	.18	.14	-.10	.10	-.15	.01
Allow 24 hour emergency contact number	-.29	.07	.11	-.07	.06	-.09	.03	.01	-.14	.11

* = Significant at the $p < .01$ level (two-tailed). ** = Significant at the $p < .001$ level (two-tailed). T = actual wording was '...staff who can remain emotionally neutral to self-wounding'

Staff optimism- Table 7 shows that staff optimism was positively associated with referring the client for exploratory psychotherapy in the 'Control' condition only. This suggests that when control is attributed to a self-harming client, higher staff optimism increases the likelihood of her being referred to psychotherapy. Staff optimism was also negatively associated with negotiating a no-harm contract for the client in the 'No control' condition only. This suggests that the higher staff optimism when no control was attributed to the client, the less likely staff were to negotiate a no-harm contract with her. Staff optimism was positively associated with avoiding hospitalisation or expediting discharge in the 'No control' condition, suggesting that the more staff were optimistic, the more likely they were to avoid hospitalisation and expedite discharge.

Staff attitudes- Factor 1 (Ability to be in control of her actions) was negatively associated with maintaining regular discussion with involved staff in the 'Control' condition only. This indicates that the more staff thought the client was able to control her actions, the less likely they were to maintain regular discussion with involved staff. Factor 1 was also negatively correlated with making available a long-term relationship with the client's key worker in the 'Control' condition only. This suggests that the more staff thought the client was able to control her actions, the less likely they were to make available a long-term relationship with her key worker.

No significant associations were found between Factor 2 (Tendency to be undemanding versus difficult) and the choice of clinical management strategies for 'Control' and 'No control' conditions. This indicates that the perception of the client as undemanding or difficult has no impact upon the choice of clinical management strategy.

Factor 3 (Eligibility for tolerance and empathy) was negatively associated with negotiating a no-harm contract with the client in the 'Control' condition only. This suggests that when control was attributed to the client, the more staff deemed her to be eligible for tolerance and empathy, the less likely they were to negotiate a no-harm contract with her. Factor 3 was also positively associated with avoiding hospitalisation or expediting discharge in the 'No control' condition, suggesting that when no control is attributed to the client, the more eligible staff deem the client for tolerance and empathy, the more likely they are to avoid hospitalisation or expedite discharge.

Factor 4 (Difficulty in understanding her actions) was positively associated with asking a person to take charge of sharp knives etc. in the 'Control' condition only. This suggests that when control was attributed to the client, the more staff were able to understand her actions (i.e. experienced less difficulty), the more likely they were to ask a person to take charge of sharp knives etc. Factor 4 was also positively associated with referring the client and her parents to family therapy in the 'Control' condition, suggesting that when control is attributed to the client, the more staff were able to understand her actions, the more likely they were to refer her and her parents to family therapy.

Staff training, attitudes and optimism

To investigate the hypothesis that there would be an association between staff training and staff attitudes and optimism for 'Control' and 'No control' conditions a series of correlations were carried out. Again, Kendalls' Tau was used as data were ordinal (non-parametric) and the data set was small with a large number of tied ranks. (See Table 8).

Table 8

Correlations between staff training in counselling or psychotherapy and attitudes/ optimism for 'Control' and 'No control' conditions

Attitudes/ Optimism	'Control' (N = 40)	'No control' (N = 40)
Factor 1 score (Ability to be in control of her actions)	-.23	-.23
Factor 2 score (Tendency to be undemanding versus difficult)	.12	-.04
Factor 3 score (Eligibility for tolerance and empathy)	.10	.10
Factor 4 score (Difficulty in understanding her actions)	-.19	-.25
Optimism	.05	.15

No significant associations were found between staff attitudes or staff optimism and staff training in counselling or psychotherapy in the 'Control' and 'No control' conditions (p > .05, two-tailed).

Staff training and choice of clinical management strategies

To investigate the hypothesis that there would be an association between staff training and choice of clinical management strategies for 'Control' and 'No control' conditions, a series of correlations (Kendall's Tau) was carried out. (See Table 9).

To limit the number of type 1 errors, a Bonferroni correction[20] was applied to each analysis. In cases where the Bonferroni corrected p-value was thought to be too conservative, increasing the likelihood of a Type 2 error (acceptance of null hypothesis when it is false), the *p* - value was adjusted to $p < .01$ (two-tailed).

[20] For example, for 20 comparisons (19 clinical management strategies + staff training) 20x20=400, .05/400 = .0001.

Table 9

Correlations between staff training in counselling or psychotherapy and choice of clinical management strategies for 'Control' and 'No control' conditions

Clinical management strategy	'Control' condition (N = 40)	'No control' (N = 40)
Refer for exploratory psychotherapy	-.24	-.24
Teach conflict management/ assertiveness	-.13	-.25
Teach emotional management (e.g. relaxation)	-.02	-.19
Maintain regular discussion with involved staff	.33	.26
Make available long-term relationship with key worker	.31	.22
Negotiate no-harm contract	.02	-.15
Admit to hospital (under Section if necessary)	-.09	-.06
Refer to self-help group for self-injury	.12	.00
Ask person to take chare of sharp knives etc.	.15	.15
Look for underlying sexual trauma	-.20	-.10
Encourage medication/ drug therapy	-.17	-.09
Refer to family therapy with parents	-.21	-.11
Avoid hospitalisation, if hospitalised, expedite discharge	.11	.18
Restrict contact to named staff	-.17	.03
Encourage ventilation of unexpressed feelings of past	-.09	-.28
Pay minimum attention to her wounds	.13	.00
Encourage self-care of self inflicted wounds	-.10	-.12
Match with staff who can remain emotionally neutral to self-wounding	-.20	-.19
Allow a 24 hour 'emergency contact' telephone number	-.11	-.12

No significant associations were found between staff training and clinical management strategies in the 'Control' and 'No control' conditions.

Further exploration

It was thought that the absence of association between staff training in counselling or psychotherapy and staff attitudes, optimism and the choice of clinical management strategies may have been due to the fact that the data set was characterised not just by two groups of staff (those who have training in counselling/ psychotherapy and those who do not) but rather by three groups (support workers without professional training/ psychotherapy or counselling qualifications, $N = 2$; professional staff without psychotherapy or counselling qualifications, $N = 17$; professional staff with psychotherapy or counselling qualifications, $N = 21$). To investigate whether there were any differences between these three groups (with level of training as a between-groups factor) in terms of staff attitudes, optimism and choice of clinical management strategies, non-parametric descriptive statistics and Kruskal-Wallis one-way ANOVAs were carried out (see Tables 10 and 11).

Table 10

One-way ANOVA, median, mode and range scores for the level of staff training and staff attitudes/ optimism for 'Control' and 'No control' conditions (continued over page).

		Median, mode and range			
Condition	Attitudes/ Optimism	Support workers (*N* = 2)	Professional staff without psychotherapy or counselling training (*N* = 17)	Professional staff with psychotherapy or counselling training (*N* = 21)	*Chi-Square*[21] (*df* = 2)
'Control'	Factor 1 score (Ability to be in control of her actions)	.08, -.29, -.29 - .45	-.09, -1.14, -1.14 - .70	-.63, -1.74, -1.74 - 1.10	3.52
	Factor 2 score (Tendency to be undemanding versus difficult)	-.93, -.93, -.93 - -.93	-.88, -2.21, -2.21 - 1.03	-.52, -.51, -2.46 - 1.55	1.14
	Factor 3 score (Eligibility for tolerance and empathy)	1.05, .08, .08 - 2.01	.74, -.72, -.72 - 2.10	1.15, -.05, -.05 - 2.19	0.74
	Factor 4 score (Difficulty in understanding her actions)	-.92, -1.23, -1.23 - -.61	-.61, -1.10, -1.34 - .57	-1.06, -1.93, -1.93 - .54	2.56
	Staff optimism	29.5, 29, 29 - 30	28, 28, 15 - 35	29, 35, 5 - 35	0.79

[21] The calculated values for the Kruskal-Wallis is assessed for significance using the *Chi-square* distribution. *N* = Sample size. *df* = degrees of freedom.

Table 10 continued:

One-way ANOVA, median and range scores for the level of staff training and staff attitudes/ optimism for 'Control' and 'No control' conditions

		Median, mode and range			
Condition	Attitudes/ Optimism	Support workers ($N = 2$)	Professional staff without psychotherapy or counselling training ($N = 17$)	Professional staff with psychotherapy or counselling training ($N = 21$)	*Chi-Square* ($df = 2$)
'No control'	Factor 1 score (Ability to be in control of her actions)	.67, .58, .58 - .76	-.45, -1.32, -1.32- .19	-1.05, -1.16, -1.93 - 1.60	6.79*
	Factor 2 score (Tendency to be undemanding versus difficult)	-1.18, -1.82, -1.82 - -.55	-.63, -1.69, -1.69 - 1.03	-.79, -.208, -2.08 - 1.68	1.12
	Factor 3 score (Eligibility for tolerance and empathy)	1.05, .08, .08 - 2.01	.74, -.72, -.72 - 2.10	1.15, -.05, -.05 - 2.19	0.74
	Factor 4 score (Difficulty in understanding her actions)	-.27, -1.11, -1.11 - .56	-.61, -.61, -1.79 -.18	-1, -1.37, -1.79 -.18	3.62
	Staff optimism	28.5, 28, 28 - 29	28, 28, 18 - 35	30, 32, 14 - 35	1.33

* = Significant at the $p < .05$ level (two-tailed)

Table 11

One-way ANOVA, median, mode and range scores for the level of staff training and choice of clinical management strategies for 'Control' and 'No control'

conditions (continued over page)

		Median, mode and range[22]			
Condition	Clinical management strategy	Support workers (N = 2)	Professionals without psychotherapy or counselling training (N = 17)	Professionals with psychotherapy or counselling training (N = 21)	Chi-Square (df = 2)
'Control'	Refer for exploratory psychotherapy	1, 1, 1 - 1	1, 0, 0 - 2	0, -1, -2 - 2	2.69
	Teach conflict management /assertiveness	1, 1, 1 - 1	1, 1, 0 - 2	1, 1, -1 - 2	0.78
	Teach emotional management (e.g. relaxation)	1, 1, 1 - 1	1, 1, 0 - 2	1, 1, 0 - 2	1.07
	Maintain regular discussion with involved staff	1.5, 1, 1- 2	1, 1, 0 - 2	2, 2, 1 - 2	4.86
	Make available long-term relationship with key worker	0.5, 0, 0 - 1	1, 1, -1 - 2	1, 1, 0 - 2	4.50
	Negotiate no-harm contract	0, -1, -1 - 1	0, 1, -2 - 2	0, 1, -2 - 2	0.02
	Admit to hospital (under Section if necessary)	-1, -2, -2 - 0	-1, -2, -1 - 2	-1, -2, -2 - 0	0.40
	Refer to self-help group for self-injury	0.5, 0, 0 - 1	1, 1, -1 - 1	1, 1, 0 - 2	0.81

[22] -2 indicates 'disagree strongly'; -1 indicates 'disagree'; 0 indicates 'unclear'; 1 indicates 'agree'; 2 indicates 'strongly agree'. N = Sample size. df = degrees of freedom.

Table 11 continued:

One-way ANOVA, median, mode and range scores for the level of staff training and choice of clinical management strategies for 'Control' and 'No control' conditions.

		Median, mode and range			
Condition	Clinical management strategy	Support workers (*N* = 2)	Professionals without psychotherapy or counselling training (*N* = 17)	Professionals with psychotherapy or counselling training (*N* = 21)	*Chi-Square* (*df* = 2)
'Control'	Ask person to take charge of sharp knives etc.	-1, -2, 0 - 2	-1, -1, -2 - 1	-1, -1, -2 - 1	1.02
	Look for underlying sexual trauma	0, 0, 0 - 0	1, 1, 0 - 2	0, 0, -1 - 2	3.68
	Encourage medication/ drug therapy	-1, -1, -1 - -1	0, 0, -2 - 1	0, -1, -2 - 1	5.16
	Refer for family therapy with parents	0, 0, 0 - 0	0, 0, -1 - 1	0, 0, -2 - 1	1.98
	Avoid hospitalisation: if hospitalised, expedite discharge	0.5, -1, -1 - 2	1, 1, -2 - 2	1, 1, -2 - 2	0.53
	Restrict contact to named staff	-0.5, -1, -1 - 0	0, 0, -1 - 1	0, 0, -1 - 1	3.35
	Encourage ventilation of unexpressed feelings of past	1, 1, 1 - 1	1, 1, -2 - 2	1, 1, -1 - 2	0.52
	Pay minimum attention to wounds	1, 1, 1 - 1	0, -1, -1 - 1	1, 1, -1 - 1	3.42
	Encourage self-care of wounds	1.5, 1, 1 - 2	1, 1, -1 - 2	1, 1, 0 - 2	1.08

Table 11 continued:

One-way ANOVA, median, mode and range scores for the level of staff training and choice of clinical management strategies for 'Control' and 'No control' conditions (continued over page)

		Median, mode and range			
Condition	Clinical management strategy	Support workers (*N* = 2)	Professionals without psychotherapy or counselling training (*N* = 17)	Professionals with psychotherapy or counselling training (*N* = 21)	*Chi-Square* (*df* = 2)
'Control'	Match with staff emotionally neutral to self-wounding	1.5, 1, 1 - 2	1, 1, 0 - 2	1, 0, -1 - 2	3.04
'No control'	Allow 24 hour emergency contact number	0.5, -1, -1 - 2	1, 1, 0 - 2	1, 1, -2 - 2	0.63
	Refer for exploratory psychotherapy	1, 1, 1 - 1	1, 1, 1 - 2	1, 1, -2 - 2	2.58
	Teach conflict management /assertiveness	2, 2, 2 - 2	1, 1, 0 - 2	1, 1, -2 - 2	5.92
	Teach emotional management (e.g. relaxation)	1.5, 1, 1 - 2	2, 2, 0 - 2	1, 1, 0 - 2	1.45
	Maintain regular discussion with involved staff	1, 1, 1 - 1	1, 1, 0 - 2	2, 2, 1 - 2	3.73
	Make available long-term relationship with key worker	0.5, 0, 0 - 1	1, 0, -1 - 2	1, 1, -1 - 2	2.38
	Negotiate no-harm contract	0.5, 0, 0 - 1	0, 1, -2 - 2	0, -1, -2 - 2	1.21
	Admit to hospital (under Section if necessary)	-1, -1, -1 - -1	-1, -2, -2 - 2	-1, -1, -2 - 1	0.17

Table 11 continued:

One-way ANOVA, median, mode and range scores for the level of staff training and choice of clinical management strategies for 'Control' and 'No control' conditions (continued over page)

		Median, mode and range			
Condition	Clinical management strategy	Support workers ($N = 2$)	Professionals without psychotherapy or counselling training ($N = 17$)	Professionals with psychotherapy or counselling training ($N = 21$)	*Chi-Square* ($df = 2$)
'No control'	Refer to self-help group for self-injury	1, 0, 0 - 2	1, 1, 0 - 2	1, 1, 0 - 2	0.01
	Ask person to take charge of sharp knives etc.	-1, -2, -2 - 0	-1, -1, -2 - 1	-1, -1, -2 - 1	1.01
	Look for underlying sexual trauma	0, 0, 0 - 0	1, 1, -2 - 2	0, 0, -2 - 2	1.36
	Encourage medication/ drug therapy	-0.5, -1, -1 - 0	0, 0, -2 - 1	0, 0, -2 - 1	1.24
	Refer for family therapy with parents	-0.5, -1, 0- -1	0, 0, -1 - 0	0, 0, -2 - 0	1.68
	Avoid hospitalisation: if hospitalised, expedite discharge	1.5, 1, 1 - 2	1, 1, -2 - 1	1, 1, -1 - 2	4.08
	Restrict contact to named staff	-0.5, -1, -1 - 0	0, 0, -1 - 1	0, 0, -1 - 1	1.19
	Encourage ventilation of unexpressed feelings of past	1.5, 1, 1 - 2	1, 1 -1 - 2	1, 1, -1 - 2	4.43
	Pay minimum attention to wounds	1, 0, 0 - 2	0, 1, -2 - 2	1, 1, -2 - 1	1.10

Table 11 continued:

One-way ANOVA, median, mode and range scores for the level of staff training and choice of clinical management strategies for 'Control' and 'No control' conditions (continued over page)

		Median, mode and range			
Condition	Clinical management strategy	Support workers ($N = 2$)	Professionals without psychotherapy or counselling training ($N = 17$)	Professionals with psychotherapy or counselling training ($N = 21$)	Chi-Square ($df = 2$)
'No control'	Encourage self-care of wounds	2, 2, 2 - 2	1, 1, 0 - 2	1, 1, -1 - 2	3.74
	Match with staff emotionally neutral to self-wounding	2, 2, 2 - 2	1, 1, -1 - 2	1, 0, -1 - 2	5.09
	Allow a 24 hour emergency contact number	1, 0, 0 - 2	1, 1, -1 - 2	1, 1, -1 - 2	0.66

There were no significant differences between the level of staff training and staff attitudes or optimism for 'Control' and 'No control' conditions with the exception of Factor 1 'No control', indicating a significant difference between the level of staff training and staff attitudes and the extent to which staff believed the woman was in control of her actions. Overall, staff attitudes and optimism were not affected significantly by the level of staff training in psychotherapy or counselling.

As shown in Table 11, descriptive statistics indicate little difference between the level of staff training and the choice of clinical management strategies. Kruskal-Wallis one-way ANOVAs showed no significant differences between the level of staff training and the choice of clinical management strategies in the 'Control' and 'No control' conditions.

DISCUSSION

This study set out to investigate the effects of an attribution of control to a self-harming client on staff attitudes, optimism and choice of clinical management strategies.

Summary of results

Preliminary analyses found no relationship between gender, staff handling in self-injury, years worked in a health setting, effect of age, profession or experience in working with self-harming clients and staff attitudes, optimism and choice of clinical management strategies. Therefore, one can be confident that any observed differences were due to the experimental manipulation rather than possible confounding variables.

A visual assessment of the quality of the data did not reveal any noticeable outliers in respect of staff attitudes, optimism or clinical management strategies. Unfortunately, the data from this study cannot be compared with those from other studies (e.g., Huband & Tantam, 1999; 2000) as previous studies utilised parametric analyses.

The results of this study indicate that the experimental manipulation was effective in inducing differing attributions between conditions, with staff identifying the woman described in the 'Control' condition as having significantly more control over her decision to cut and over the extent of her cutting than the woman described in the 'No control' condition. This difference was also evident in the items that did not explicitly refer to control included in the Factor 1 attitudes measure: staff perceived the woman as more able to control her actions in the 'Control' condition than in the 'No control' condition.

Despite the significant differences in attribution of control between conditions, no differences were found in staff attitudes or optimism between the 'Control' and 'No control' conditions.

With the exception of referring for exploratory psychotherapy, attribution of control did not affect staff choice of clinical management strategies, with staff endorsing similar management strategies for both 'Control' and 'No control' conditions.

The exploratory part of the study investigated possible links between attribution of control, staff attitudes, optimism and choice of clinical management strategies. Some associations were found between staff attitudes, optimism and choice of certain clinical management strategies, although these associations are suggestive rather than indicative (possibly arising from Type 1 errors) and may require future exploration.

No association was found between staff training in counselling or psychotherapy and staff attitudes, optimism and choice of clinical management strategies in the 'Control' and 'No control' conditions. Further exploration revealed three staff groups (support workers without professional training; professionals without psychotherapy or counselling training and professionals with psychotherapy or counselling training) who differed only in the extent to which they perceived the woman to be in control of her actions in the 'No control' condition. No significant differences were found between these three groups on staff attitudes, optimism or choice of clinical management strategies, suggesting little difference in the approach of staff with or without counselling or psychotherapy training to the self-harming client.

Overall, the attribution of control did not significantly affect staff attitudes or optimism towards the self-harming clients, rather staff held similar attitudes and optimism for both clients. However, attribution of control did affect whether the client was referred to psychotherapy in the 'Control' condition and was also influenced by staff optimism.

These results are discussed in relation to previous findings (e.g. Huband & Tantam, 1999; 2000), theory (e.g. Sharrock et al., 1990) and clinical implications with suggestions to guide future research in this area.

The effect of an attribution of control on staff attitudes

Despite the effectiveness of the experimental manipulation, attribution of control did not affect staff attitudes to the self-harming client.

Rather, staff attitudes were consistent across both conditions. Staff did not perceive the client as significantly more difficult (Factor 2) in the 'Control' condition than in the 'No control' condition. Further, staff did not perceive the client in the 'Control' condition as less eligible for tolerance and empathy (Factor 3) than in the 'No control' condition. Instead, staff deemed both clients as equally eligible for tolerance and empathy and this was reflected by the fact that all data were tied between conditions. Further, staff did not experience a greater difficulty in understanding the actions of the self-harming client (Factor 4) when control was attributed ('Control' condition) than when control was not attributed ('No control' condition). Therefore, with regards to the effect of an attribution of control on staff attitudes to a self-harming client, the experimental hypothesis was rejected.

The finding that an attribution of control did not affect staff attitudes, specifically that staff attitudes were consistent across conditions appears to conflict with the findings from the Huband and Tantam (2000) study. These authors identified that the perception of the woman as able to control her actions defined staff attitudes to the self-harming client. In their study, staff were found to polarize into 'Softer' and 'Firmer' groups according to the extent to which they believed the woman to be in control of her actions (Factor 1). The 'Softer' group (where staff believed the woman had less control over her actions) was found to have more empathy for the woman and experienced less difficulty in understanding her actions than those staff in the 'Firmer' group (who believed the woman had more control over her actions). The current study was designed to induce such an attributional split between conditions whilst controlling for participant variables by adopting a repeated measures design. Indeed, whilst this split was effectively induced through the experimental manipulation, this did not give rise to differing staff attitudes towards the client.

This apparent contrast to Huband and Tantam's (2000) findings may be explained in terms of the different staff characteristics they elucidated in their discrimination between 'Softer' and 'Firmer' groups and the characteristics of the participants in this study. Huband and Tantam (2000) found that the 'Softer' group included mainly staff who worked in an outpatient setting (57%) whereas the 'Firmer' group included mainly staff who worked in an in-patient setting (57%). Huband and Tantam (2000) explained that the different compositions of these groups may have arisen from the fact that outpatient staff were more likely to have a formal qualification in counselling or psychotherapy than in-patient staff.

Another of the principal findings in their study was that the possession of a counselling or psychotherapy qualification was associated with the perception that the woman had less control over her actions (and a greater understanding of her actions). It is likely, therefore, that the use of a sample drawn solely from outpatient settings in the current study, with a high proportion of staff formally qualified in counselling or psychotherapy (52.5%) may have overridden the effect of the attributional manipulation on staff attitudes. If this is the case, this has significant implications for supporting staff training in counselling or psychotherapy in staff working with self-harming clients.

The effect of an attribution of control on staff optimism

In spite of the effectiveness of the experimental manipulation, staff optimism was unaffected by attribution of control. Staff optimism (the extent to which staff believed they could beneficially intervene with the client) was consistent between conditions. The experimental hypothesis was therefore rejected.

This result contrasts sharply with Sharrock et al.'s (1990) findings. Sharrock et al. (1990) found that staff optimism was directly and negatively related to the attribution of control and mediated between such attributions and help-giving. Thus, where control was attributed to a client for his or her behaviour, staff optimism was found to be less than when control was not attributed to the client. Further, staff optimism was found to impact directly on the amount of help given to the client (Sharrock et al., 1990). In the current study, staff made different attributions of control to the client in both conditions but remained consistent in their level of optimism. However, further study is required to determine whether this lack of difference is indicative of a lack of a direct link between

attribution of control and staff optimism theoretically or whether this difference is explained by other factors such as the characteristics of participants or the work setting of staff.

The contrasting results in *this* study to those of Sharrock et al. (1990) may be explained in terms of the difference in the respective participant groups. For example, Sharrock et al. (1990) included psychiatric in-patient staff whereas the sample used in this study drew on outpatient or community staff.

As discussed above, Huband and Tantam (2000) distinguished between these different staff groups, reporting that in-patient staff perceived the woman as having a greater ability to be in control of her actions than outpatient staff, which affected staff's tolerance and empathy and staff's understanding of the client's actions. They also explained that this difference may have been due to the fact that in-patient staff were less likely to possess formal training in counselling or psychotherapy compared to outpatient staff since such training was associated with a perception that the woman was unable to control her actions, increased tolerance and empathy and the ability to understand the client's actions. Therefore, there may be genuine limitations in generalising from attribution theory based on in-patient studies to outpatient staff or between staff without formal psychotherapy or counselling training to those with such training.

Indeed, recent support of Sharrock et al.'s (1990) model by Markham and Trower (2003) was also based on in-patient staff. Markham and Trower (2003) found that staff attributed greater control to a client diagnosed with BPD than clients diagnosed with depression or schizophrenia. Staff also reported significantly less sympathy and staff optimism towards

the BPD client than they did for the clients with other diagnoses. However, it is uncertain whether Markham and Trower's support of Sharrock et al's (1990) findings was due to staff setting (i.e. in-patient ward) or staff training in counselling or psychotherapy since the latter was not controlled for in the study. It is possible that staff setting and staff training in counselling or psychotherapy are both important variables in studying staff optimism and may interact to affect the wider culture of services. It is, therefore, important that attention is paid to both these variables in future research in this area.

The current study revealed that staff optimism was unaffected by attribution of control band further that staff optimism was high in both conditions. This reflects a positive and hopeful view of the staff working with self-harming clients in this sample and contrasts with much of the literature in this area (e.g. Book et al., 1978; Main, 1957; Novotny, 1972; Simpson, 1980), which has reported the often critical, punitive and dismissive approaches of staff to self-harming clients.

Again, this difference may be due to the high proportion of counselling or psychotherapy in *this sample* and/or the fact that much of the previous literature has focussed on in-patient samples or individual professional groups. However, *this* is the only known study to date which has looked at the attitudes of a variety of professionals working with self-harming clients in outpatient or community settings in the UK and some caution is required in generalising these results to other groups or settings. The sample in this study was drawn mainly from a City locality, a locality closely associated with a high level of professional dissemination of psycho-educational approaches for working with specific clinical and diagnostic groups to local services. It may be, therefore, that this sample is not representative of other outpatient or community teams, working in less urban settings

and/or without psychological input from an allied professional body. In addition, it may be that due to the self-selected nature of the participant group that staff who held a positive interest in working with self-harming clients and related research participated in the study whereas those who held more negative views did not.

Allen (1995) distinguished between the 'Naïve therapeutic optimism' amongst some staff and the 'Counsel of Despair' view of others. It is possible that the optimistic view of staff in this study reflects a tendency towards the former rather than the latter viewpoint. However, median staff optimism could be considered to be within realistic limits (Median value = 28 & 28.5 for 'Control' and 'No control' conditions respectively, out of a possible total score of 35). Further, the majority of staff were experienced in working with self-harming clients (67.5% had worked with more than 10 self-harming women and 50% had worked in a health setting for more than 10 years). Therefore, it is likely that any unrealistically optimistic view of working with such clients would have been challenged through experience.

With these points in mind, the fact that a variety of mental health professionals were optimistic about working with self-harming clients contrasts reports of positive and sympathetic approaches restricted to one or two professional groups. Arnold (1995) described how service-users expressed a high degree of dissatisfaction with all services except counselling or psychotherapy services. Similarly, Treloar and Pinfold (1993) found nurses and social workers to be the most sympathetic to self-harming clients. The fact that staff optimism did not differ significantly between professional groups in this study *may* suggest that positive approaches to working with self-harming clients are not limited to individual professional groups or uni-disciplinary services. However, caution is required

in making such suggestions, as there may be a difference between staff holding a positive or optimistic view of working with such clients and clients' perceptions or experience of care as positive. Nevertheless, the benefit of shared psychological approaches, whether from within the community team or from outside, is likely to be beneficial in fostering such an approach.

Attribution of control on clinical management strategies

Attribution of control had little effect on the choice of clinical management strategies with the exception of referring the client for exploratory psychotherapy. This suggests that an attribution of control may affect client referrals to psychotherapy but may not impact upon other forms of clinical management.

Staff were less likely to refer the client for exploratory psychotherapy when control was attributed to the client than when no control was attributed. This is particularly interesting due to the fact that attribution of control had no overall effect on staff attitudes and optimism, suggesting that the difference in clinical management in terms of referring to psychotherapy is unlikely to result from a more dismissive attitude towards the client in the 'Control' condition compared to the client in the 'No control' condition.

Instead, a possible explanation for this result is that because staff perceive the woman as having control over her actions, they feel she already has the ability to stop self-harming (but has not acted on it) and, therefore, little is to be gained from exploratory psychotherapy whereas the woman perceived as having no control over her actions may not have this ability (possibly self-reflection) and would therefore benefit more from psychotherapy. Also, staff may feel more comfortable managing clients who they

perceive are in some way able to control their self-harming behaviour without necessitating psychotherapy whereas they may feel clients without such control are too challenging to manage alone. It may be that staff do discriminate between those clients who are likely to benefit from one approach over another client with the same presenting problem due to limited psychotherapy resources.

Nevertheless, it may be useful for psychologists to explore staff reasoning for why some self-harming clients are referred to psychotherapy services whilst others are not. This has important implications for ensuring that self-harming clients are able to access psychotherapy services equally, whether they are able to control their self-harming most of the time, sometimes or not at all (i.e. a needs-led rather than resource-led model of service provision). Discussion of potential referrals of self-harming clients (with concurrent psychological difficulties) to psychotherapy is delineated by NICE (NICE, November, 2003, guideline 4.5.3, p.66), therefore such discussion is likely to form part of good clinical practice as well as contribute to future audit or research.

In terms of the overall choice of clinical management strategies, chosen strategies were consistent with staff choices reported by Huband and Tantam (1999). This suggests a consistency in approach to the clinical management of self-harming clients in staff in different NHS localities[23]. Staff most strongly endorsed the strategy of maintaining regular discussion with involved staff, consistent with NICE guidelines emphasising the importance of multi-disciplinary discussion in the management of self-harming clients.

[23] Huband & Tantam (1999; 2000) collected their data in a different English county NHS locality to the current study.

Other agreed strategies for clinical management consistent with Huband and Tantam's (1999) findings were: teaching conflict management and assertiveness; teaching emotional management (e.g. relaxation); making available a long-term relationship with the client's key worker; referring to a self-help group for self-injury; avoiding hospitalisation or expediting discharge and allowing a 24-hour 'emergency contact' telephone number. Staff were unclear as to whether the client should be referred for family therapy with her parents (a finding also consistent with Huband & Tantam, 1999) but were also unclear of strategies such as: negotiating a no-harm contract and looking for underlying sexual trauma; restricting contact to named staff and paying minimum attention to her wounds (all of which were endorsed in Huband & Tantam's study) and encouraging medication or drug therapy, which most staff disagreed with in the Huband and Tantam (1999) study. Staff disagreed with the strategies of admitting the woman to hospital (under Section if necessary) and asking a responsible person to take care of sharp knives etc. This is consistent with staff in Huband and Tantam (1999).

Additional clinical management strategies suggested by staff indicated strategies preferred by some clinicians including DBT skills (such as teaching distress tolerance) and providing validation for self-harming as self-management. The apparent preference for these strategies is consistent with the existing evidence supporting DBT in working with self-harming clients (Linehan et al., 1991).

Of interest, was that only in the 'Control' condition was the assessment for personality disorder suggested along with a re-emphasis of firm boundaries. Such clinical management may be indicative of attribution of control affecting the clinical management

of individual clinicians adopting a 'firm' or 'diagnostic' approach. However, these differences were not reflected in the overall sample.

Association between staff attitudes, optimism and clinical management strategies

In exploring possible relationships between staff attitudes, optimism and clinical management strategies, it was found that there was a negative association between staff's perception of the woman as in control of her actions (Factor 1) and the strategies of maintaining regular discussion with involved staff and making available a long-term relationship with the client's key worker. However this association was only evident in the 'Control' condition. Therefore, the more staff perceived the woman as being in control of her actions, the less likely they were to maintain regular discussion with involved staff or make available a long-term relationship with the client's key worker.

This result makes links between attributions of control and clinical management although it does not link directly to staff attitudes, which were unrelated to the experimental manipulation (i.e. Factor 1 scores even though not explicit regarding control, nevertheless load onto the independent variable). The lack of association between staff attitudes or optimism implies that differences in clinical management were not the result of unsympathetic or pessimistic attitudes, but rather differences in case management. For example, staff who perceived the woman to be more in control of her actions may have believed that fewer resources were required in continuing to support her, or she was less 'at risk' and so staff were therefore less likely to maintain discussion with other staff or provide her with a long-term relationship with a key worker than a woman they perceived as having less control over her actions who may be more 'at-risk'.

Other associations between staff attitudes and clinical management strategies included a negative association between staff tolerance and empathy (Factor 3) and negotiating a 'no-harm' contract in the 'Control' condition, implying that the less eligible staff deemed the client for tolerance and empathy, the more likely they were to negotiate a 'no-harm' contract with her. One tentative explanation may be that staff who are less tolerant or empathic towards a client may be less able to appreciate or validate the function of self-harming for a client by requesting they simply stop this behaviour. Staff tolerance and empathy was also positively associated with avoiding hospitalisation in the 'No control' condition, implying that the more tolerant and empathic staff were towards a woman they perceived as having no control over her self-harming, the more likely they were to avoid hospitalisation or expedite discharge. Again, a tentative explanation of this result may be that staff with a more tolerant or empathic attitude were more aware of the possibly unhelpful consequences of being admitted to hospital or were more aware of the function of self-harming for the client. However, caution is required in interpreting and generalising these results as both of these correlations were only significant at the $p < .01$ level, and may, therefore, be indicative of Type 1 errors.

Further positive associations were found between staff difficulty in understanding the actions of the self-harming client and clinical management strategies of asking a responsible person to take charge of sharp knives etc. and referring the client to family therapy in the 'Control' condition. Increased staff difficulty in understanding the actions of a self-harming client may explain a lack of general understanding about why clients self-wound and/or or what interventions are most effective since there is little empirical consensus as to which strategies are the most effective interventions for self-harm.

However, these associations were only significant at the $p = < .01$ level and so must be interpreted with caution.

Staff optimism was positively associated with referring the client for exploratory psychotherapy in the 'Control' condition only. Therefore, when control was attributed to the client, the more staff were optimistic, the more likely they were to refer the client for psychotherapy. This may explain the previous result, namely that staff were less likely to refer the client to psychotherapy in the 'Control' condition than in the 'No control' condition. It is possible that staff optimism plays a crucial role in mediating between attribution of control and referring the client to psychotherapy. This would be consistent with Sharrock et al.'s (1990) model. However, this interpretation is tentative and would need to be demonstrated by a path analysis (prevented by insufficient sample size). Further, this result was only significant at the $p < .01$ level and again, may be indicative of a Type 1 error.

Association between staff training and staff attitudes and optimism

No association was found between staff training in counselling or psychotherapy and staff attitudes or staff optimism in either the 'Control' or the 'No control' condition. This *appears* to contradict Huband and Tantam's (2000) findings that staff who possess a counselling or psychotherapy qualification differ significantly in their attitudes to the self-harming client than those who do not possess such a qualification. The difference in these findings may relate to a difference arising from the characteristics of the participant group in this study (i.e. largely outpatient or community staff with a high proportion of counselling or psychotherapy training) compared to Huband and Tantam's (2000) study (who found that community staff were more likely to have counselling or psychotherapy

training, and therefore be more understanding of the self-harming client than in-patient staff).

Further, it was uncertain whether there were differences between the three groups of staff in the participant group (support workers without professional training; professionals without psychotherapy or counselling training and professionals with psychotherapy or counselling training), or whether the culture of the staff teams involved in the study was psychologically oriented. Further exploration was therefore required.

Association between staff training and clinical management strategies

No associations were found between staff training in counselling or psychotherapy and choice of clinical management strategies in either the 'Control' or the 'No control' condition. It was uncertain whether this lack of association was due to the existence of three groups of staff with differing professional training (as above), or that there was little difference in the clinical management of self-harming clients irrespective of level of counselling or psychotherapy training. Further exploration was therefore required.

Further exploration: The effect of staff training on staff attitudes and optimism

Further exploration of possible differences between support workers without professional training, professionals without psychotherapy or counselling training and professionals with psychotherapy or counselling training on staff attitudes and optimism to a self-harming client revealed a difference only in the three groups' perception of the woman's ability to be in control of her actions (Factor 1) in the 'No control' condition. There was no effect on other attitudes factors or on staff optimism. This suggests that, whilst staff may differ somewhat in their attributions of control towards a client, this does not affect their

wider attitudes towards the client. However, despite the lack of difference between staff trained in counselling or psychotherapy and staff attitudes, this does not challenge the importance of such training for staff working with self-harming clients. Rather, the result may be an artefact of the high proportion of counselling or psychotherapy trained staff in the study and the possible effects this may exert on the culture of services (it may also be that the culture of services has supported a psychological approach and further staff training in counselling or psychotherapy). As described above, the service locality receives psycho-educational provision from the allied professional body, which is likely to increase the psychological awareness of staff who do not possess a formal qualification in counselling or psychotherapy. Nevertheless, this result suggests that a high proportion of staff with counselling or psychotherapy qualifications and/or allied psycho-educational service input may support staff working in this area by enabling them to be consistent in their attitudes towards clients and the belief that they can provide beneficial interventions (staff optimism).

Further exploration: The effect of staff training on clinical management strategies

Further exploration of possible differences between support workers without professional training, professionals without psychotherapy or counselling training and professionals with psychotherapy or counselling training on staff choice of clinical management strategies revealed no significant differences between groups in either the 'Control' or the 'No control' conditions. This suggests that, in this sample, formal staff training in counselling or psychotherapy did not directly affect how self-harming clients are managed clinically. However, as above, this may be understood in accordance with a psychologically - oriented service culture as mentioned above.

Study limitations

Due to the relatively small and locality specific nature of the sample, any generalisation of findings from this study must be considered cautiously. This study sought to understand staff attitudes in response to female self-harming clients whose main mode of self-harm was cutting, as consistent with the literature (Favazza & Conterio, 1989; Simpson, 1976). However, it is important to consider whether staff would respond consistently to a male self-harming client or a client who harmed using a mode other than cutting in their attitudes and clinical management and explore possible differences further. Also, the psychometric properties of the attitudes measure and the optimism-pessimism scale must be considered.

Steps were taken to perform test-retest reliability analyses on these measures, however, these data were not thought to be appropriate indicators of reliability (see Appendix 10) due to confounding factors such as the evolving attitudes of trainee clinical psychologists following specific clinical presentations in the intervening test-retest period. Further, performing reliability analysis on one professional sub-group is unlikely to be a representative indication of the reliability of a measure to be used with differing mental health professionals. The issue of reliability for these measures must, therefore, be addressed, using a larger sample of qualified mental health professionals and potentially a shorter intervening test-retest period (i.e. less than three months). Further, it would be useful to perform a test of internal consistency on the attitudes factors. However, this was not possible due to the lack of pre-manipulation attitudes data. This would need to be addressed in future research (see below).

The optimism-pessimism scale has been used in a number of previous studies (e.g. Dagnan et al., 1998; Markham & Trower, 2003; Sharrock et al., 1990) but has drifted in its original use, which was to assess the optimism of staff working in psychiatric institutions (Moores & Grant, 1976). Overtime, the questionnaire has been shortened for pragmatic reasons and been developed for use in community settings although it has retained a similar level of internal consistency as the 11 item measure used by Sharrock et al., (1990), (Dagnan, personal communication). It would be useful to measure the internal consistency of this scale in its use with staff working with self-harm. However, this was not possible in this study due to the fact that no pre-manipulation data were available. Therefore, in future research, the optimism-pessimism scale should be administered without manipulations to a sub-group of staff so that a test of internal consistency can be carried out.

Further, the likelihood that staff conferred with each other regarding their responses to the vignettes cannot be ruled out. Clear instructions not to confer are required in future replications of this study.

Suggestions for future research

Following the necessary demonstration of reliability and internal consistency for the attitudes and optimism-pessimism scales, this study may be replicated in other localities in the UK to research whether there are consistent or different staff approaches to working with self-harming clients. Indeed, this may be a helpful means of investigating the role of psycho-education or psychotherapy training in other services.

In addition, it may prove useful to develop the attitudes measure further, potentially including an item referring to the perceived service culture from individual staff members'

perspectives. This may enable researchers to gauge whether individual staff views are in accordance with the team or service culture and so identify any possible biases in the self-selection of participants.

Importantly, the replication of this study drawing on in-patient staff is required. This would enable comparison between staff attributions, attitudes and clinical management for staff working in in-patient and outpatient settings and may clarify any differences in psychological-orientation or training.

CONCLUSIONS

The results of this study suggest that an attribution of control does not affect staff attitudes or staff optimism in outpatient or community staff towards a self-harming client in a psychologically – oriented service culture. The effect of having a high proportion of staff with counselling or psychology qualifications and/ or input from an allied psychological body may increase consistency in staff attitudes and optimism towards self-harming clients. An attribution of control may exert some effects on how clients are clinically managed, and may be explained in terms of staff optimism (in the case of referring to psychotherapy) and/ or differences in case management, independent of staff attitudes. Overall, this study revealed a highly consistent approach to the self-harming client, with staff demonstrating attitudes characterised by high tolerance and empathy, optimism and understanding, contrasting with much of the literature in this area. These results appear to support psychological input and/ or formal training in psychotherapeutic approaches in staff working in this area. However, replication of this study is required in in-patient

samples and settings where psychological training or input is not as prevalent before this can be determined conclusively.

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APPENDIXES

APPENDIX 1

Ref: CPW/hph

SOUTHAMPTON & SOUTH WEST HAMPSHIRE LOCAL RESEARCH ETHICS COMMITTEES
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03 October 2003

Ms A Brunetti
6 St Johns Road
Thatcham
West Berkshire
RG19 3SY

Dear Ms Brunetti,

RE: Submission No. 204/03/t – The effect of perceiving a self-harmer as in control of their actions on mental health staff attitudes and choice of clinical management strategies.

The Vice Chair, Mr Mervyn Griffiths of the Southampton & South West Hampshire Ethics Committee has considered your response to the issues raised by the committee at the earlier review of your application on 12th August 2003 as set out in our letter dated 19 August 2003. The documents considered were as follows:

- Letter dated 15th September 2003
- Participants Information Sheet, Version 2 dated September 2003

The Vice Chair, acting under delegated authority, is satisfied that your response has fulfilled the requirements of the committee. You are therefore given **APPROVAL** for your research on ethical grounds providing you comply with the conditions of approval set out below:

Conditions:

- You do not recruit any research subjects unless you have received notification of no objection from the relevant locality agent.
- You do not undertake this research in a NHS organisation until the relevant NHS Management approval has been received and indemnity confirmed.
- You do not deviate from, or make changes to, the protocol without prior written approval of the REC, except where this is necessary to eliminate immediate hazards to research participants. In such cases the REC should be informed within 7 days of the implementation of the change.
- You complete and return the standard progress report form to the REC, 1 year from the date on this letter and thereafter on an annual basis. This form should also be used to notify the REC when your research is completed and in this case should be sent to this REC within 3 months of completion.

  Failure to submit an annual report on the progress of the study may affect the approval.
- If you decide to terminate this research prematurely, you send a report to this REC within 15 days, indicating the reason for the early termination.

- You advise the REC of any unusual or unexpected results that raise questions about the safety of the research.

- The project must be started within **3 years** of the date of this letter.

- If Staff/students of the School of Medicine/Southampton University Hospitals Trust are to be used as Healthy Volunteers in this study, it is the researchers responsibility to ensure compliance with the Institutions policy entitled: "Staff and Students as Human Volunteers in Research".

This committee is fully compliant with the International Committee on Harmonisation/Good Clinical Practice (ICH) Guidelines for the Conduct of Trial involving the participation of human subjects as they relate to the responsibilities, composition, function, operations and records of an Independent Ethics Committee/Independent Review Board. To this end, it undertakes to adhere as far as is consistent with its constitution, to the relevant clauses of the ICH Harmonised Tripartite Guideline for Good Clinical Practice, adopted by the Commission of European Union on 17 January 1997.

The composition of the committee is enclosed for your files and confirms which members were present at the meeting.

Yours sincerely,

Mrs Clair Wright
LREC Manager

c.c

Enc:

- Conditions of Approval
- Start Date Form
- Insurance Form
- Amendment Request Form
- Progress Report Form

APPENDIX 2

204/03/t
Version 2 (Sept.2003)

PARTICIPANT INFORMATION SHEET
MENTAL HEALTH STAFF ATTITUDES AND RESPONSES TO SELF-HARMING CLIENTS

You are being asked to take part in a research study. Before you decide it is important for you to understand why the study is being carried out and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information (contact details below).

Thank you for reading this.

What is the purpose of the study?

This study is trying to find out about peoples' attitudes and responses about self- harming clients/patients. It is hoped that this study will help improve understanding of the pressures that self- harming clients may place on the health care workers who work with them.

Why have I been chosen?

In order to gain an idea of how community mental health staff view self-harming behaviour and manage self-harming clients, a number of staff from community mental health teams located in the Southampton area have been selected. In this way, we hope to gather information from a representative sample of those health care workers who spend most face-to-face contact with this client group.

Do I have to take part?

It is up to you to decide whether or not to take part. However, you may be reassured to know that this study has been agreed by management.

What will happen if I take part?

First, you will complete a short questionnaire detailing your job description and previous training and experience with this client group. Second, you will read a summary describing a self-harming client. You will then fill-in the attached questionnaires relating to your attitudes to this client and your responses to working with her. You will then repeat this procedure but this time responding to a different self-harming client. This should take around 20 minutes to complete. Once you have filled in the forms and questionnaires we would like you to return them in the envelope provided.

Completion and return of the questionnaires will be taken as evidence of you having given informed consent to be included as a participant in this study and for the data to be used for the purposes of research.

Please then send them to me at the address below.

Will my taking part in the study be kept confidential?

All information, which is collected during the course of the study, will be kept **strictly confidential**. Questionnaires will be numerically coded, so there is no need for you to write your name or identifying information on the forms. Responses will therefore be **anonymous**.

What will happen to the results of the study?

A report of the study will be written. A summary of the results will be made available on request. A presentation of the results of the study will be made at a team meeting once the investigation is complete.

Who is organising and funding the research?

I am a second year clinical trainee at the University of Southampton, Doctoral Programme in Clinical Psychology. This study is being conducted as part of my training. Costs are covered by the University.

Who has reviewed the study?

The Local Research Ethics Committee has reviewed the study.

Contact for further information

Please contact me:

- if you have any questions
- if you wish to request further copies of the questionnaires
- or you wish to request a summary of the study results

Antonella Brunetti,
Trainee Clinical Psychologist,
Clinical Psychology Doctoral Programme,
Building 44 (Shackleton),
Highfield,
Southampton,
SO17 1BJ.

Tel: 023 8059 5321
Email: alb301@soton.ac.uk

IF YOU ARE WILLING TO TAKE PART PLEASE COMPLETE RETURN YOUR COMPLETED QUESTIONNAIRES (ADDRESS ABOVE):

THANK YOU FOR PARTICIPATING.

APPENDIX 3

Below is a summary, written by one of your colleagues, who has carried out a brief assessment of Miss C, a single, 24 year old woman.

You know this person's behaviour **IS NOT** under their control.

Take a few moments to imagine these thoughts truly characterise your beliefs in relation to this client,

i.e. You believe that this person is UNABLE to control her self-harming.

You are asked to read the following summary and answer the questions that follow.

Dear Colleague,

Miss C is a 24 year old, single woman who was recently referred by her GP for specialised care and support.

Her GP informs us that Miss C first deliberately harmed herself with a penknife when 14 yrs old. He describes her childhood as 'unhappy'. In early adolescence, she went through a brief period of starving herself because she perceived her body as being too fat.

At 21, she took an overdose of hay-fever tablets, saying she 'wanted to be out of it', but eventually got a neighbour to call an ambulance for her. The Casualty Department discharged her the same day.

Two years ago (aged 22) she cut her left wrist, but it appears the wound was superficial and did not require medical intervention. Since then, she has presented twice to A&E, both times with quite deep cuts to her left forearm. Both lacerations required suturing.

She has never been hospitalised and currently lives with her parents. She works as a care assistant at a local nursing home.

At assessment, I observed a thin, troubled woman. Her mood was difficult to assess. She seemed to fluctuate between being quite confident and talkative one minute, to being distant and silent the next.

I asked her to describe herself. Miss C said she is 'often misunderstood'. Also that she usually feels 'empty inside', but that 'I can never really say how I feel'. She also said she has difficulty with close relationships and occasionally suffers from 'angry outbursts' which she often regrets later.

When asked about her self-harming, she admits this is normally by cutting herself with a razor. She refuses to say how often she self-harms. However, she volunteered the information that she has not cut herself in the last two months. When asked if she feels the need to continue to self-harm, she replied 'It's the only thing that helps' and refused to say more.

During this brief assessment, I found no evidence of major depression or psychosis. Direct questioning revealed no evidence of current suicidal intent.

APPENDIX 4

Below is a summary, written by one of your colleagues, who has carried out a brief assessment of Miss D, a single, 24 year old woman.

You know this person's behaviour **IS** under their control and they have not followed the advice of their clinician as they should.

Take a few moments to imagine these thoughts truly characterise your beliefs in relation to this client,

i.e. You believe this person IS ABLE to control her self-harming.

You are asked to read the following summary and answer the questions that follow.

Dear Colleague,

Miss D is a 22 year old, single woman who was recently referred by her GP for specialised help.

Her GP informs us that Miss D first deliberately self-harmed with a piece of broken glass at 13 years of age, around the time she began to menstruate. He describes her childhood as 'miserable'. During adolescence, she went through a period of bingeing and vomiting because she did not like the shape of her body and perceived herself as 'fat'.

At 18, she took an overdose of prescription cough medicine, saying she 'wanted to switch everything off', but in the end asked someone for help. She was monitored in A&E and later discharged.

A year later, she cut her right wrist (albeit not seriously) and the wound was bandaged by her GP. She has since presented three times to A&E, twice with deep cuts to her forearms and once with a deep cut to her inside thigh. On all three occasions, medical intervention was required.

She has no history of hospitalisation and lives with her grandparents. At present, she works as a nursery assistant at a playgroup although she is looking for a new job.

At assessment, she appeared pale and distressed and smelled of liquor. Her mood seemed to shift between being quiet and withdrawn one minute to being quite self-assured and verbose the next.

When asked to describe herself, Miss D said 'I hate myself' and ' Most of the time I feel numb'. Also, she said that she and experiences periods of intense anger, which she believes has contributed to her difficulty in sustaining relationships and most recently to the break up with a boyfriend of three months.

When asked how she usually harms, she said it is usually by cutting herself with a kitchen knife. She would not disclose the frequency of her self-harm, although she did state that she had not cut herself for about 10 weeks. I asked her if she feels the need to continue to self-harm to which she replied, 'It's the only thing that stops me feeling numb' and declined to say anything more.

During this brief assessment, I found no evidence of major depression or psychosis. Direct questioning revealed no evidence of current suicidal intent.

APPENDIX 5

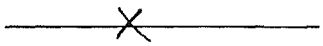
Based on what you have just read, please answer the following questions.

You will see that each question contains two statements representing opposite points of view.

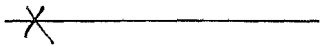
Simply place a cross on the line between these two extremes to show where your opinion lies.

For example:

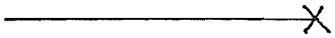
- If you find you partly agree with both statements, place your cross in the middle of the line.



- If, say, you lean more towards the left-hand statement, you might mark the line



- If, for example, you strongly agree that the right-hand statement is correct and the other statement is wrong, you might mark the line



The chances are that she will injure herself again.	_____	The chances are that she will not injure herself again.
If I was working with her, I would feel very uncomfortable if she began cutting again.	_____	If I was working with her, I would not feel particularly uncomfortable if she began cutting again.
Her decision to cut is completely outside her control.	_____	Her decision to cut is completely under her control.
A firm, authoritative approach is likely to reduce her self-wounding.	_____	A firm, authoritative approach is likely to increase her self-wounding.
She has the same right to expensive medical treatment of her wounds as has any other patient.	_____	She has less right to expensive medical treatment of her wounds compared to others injured, say, in an accident.

This type of patient makes me feel annoyed.	_____	This type of patient doesn't make me feel annoyed.
She has no control over the extent of her self-wounding.	_____	She has complete control over the extent of her self-wounding.
The first priority is to develop an empathic relationship with her.	_____	Developing an empathic relationship with her is not the first priority.
The first priority is to set firm boundaries with her.	_____	Setting firm boundaries with her is not the first priority.
It will be easy to build a relationship with her.	_____	It will be difficult to build a relationship with her.
She is likely to benefit from psychotherapy or in-depth counselling.	_____	She is unlikely to benefit from psychotherapy or in-depth counselling.
If she cuts again, it will not be with genuine suicidal intent.	_____	If she cuts again, it will be with genuine suicidal intent.
I expect her to try to manipulate professional staff involved in her care.	_____	I do not expect her to try to manipulate professional staff involved in her care.
Attempts at manipulating professional staff are likely to be conscious and intentional.	_____	Attempts at manipulating professional staff are likely to be unconscious and unintentional.
She is likely to comply with treatment and professional advice .	_____	She is unlikely to comply with treatment and professional advice.
She would continue to cut herself even if there was no-one around to notice it.	_____	She would stop cutting herself if there was no-one around to notice it.

I have a theoretical understanding of why she cuts herself.	_____	I don't have a theoretical understanding of why she cuts herself.
I would not continue to work with her if she continued to self-wound.	_____	I would continue to work with her if she continued to self-wound.
Self-wounding behaviour is difficult to manage.	_____	Self-wounding behaviour is easy to manage.
It is impossible to manage her self-wounding without further information about her past.	_____	It is quite possible to manage her self-wounding without further information about her past.
She is suffering from a treatable mental illness or mental disorder.	_____	She is not suffering from a treatable mental illness or mental disorder.
She is likely to develop a dependency upon her key worker.	_____	She is unlikely to develop a dependency upon her keyworker.
Dependency on her key worker is a positive and essential stage in the overall therapeutic process.	_____	Dependency on her key-worker is a negative and non-essential stage in the overall therapeutic process.

P. T. O.

APPENDIX 6

Table 1. Principal component analysis

	F1	F2	F3	F4	F5	Factor interpretation
Has control over extent of her cutting	**.78**	−.12	.00	.03	.01	F1:
Has control over her decision to cut	**.75**	.06	.05	.02	.12	Ability to be in control
Dependency on keyworker negarive	**.58**	.31	−.10	.36	−.07	of her actions
Manipulation of staff unconscious	**−.47**	.21	.29	−.13	−.09	
Unlikely to benefit from psychotherapy	**.40**	.14	−.24	.16	−.18	
Not expected to manipulate staff	−.11	**.77**	.09	−.10	.20	F2:
Dependency on keyworker unlikely	.10	**.76**	.04	.24	.04	Tendency to be
Unlikely to comply with trearment	−.07	**.62**	.21	.35	.06	undemanding vs.
Next cut with suicidal intent	−.13	**.41**	−.13	.25	.03	difficult
Would continue to work with her	.00	−.04	**.73**	−.11	−.11	F3:
Firm boundaries not first priority	.02	−.03	**.55**	.26	.19	Eligibility for
Emparhic relationship not first priority	.11	−.02	**.53**	.16	.23	tolerance and
Doesn't make me annoyed	−.22	.15	**.51**	−.07	.29	empathy
Less right to medical treatment	.10	−.14	**.49**	.23	.24	
Me not uncomfortable if she cuts again	.31	−.19	**.48**	.03	.28	
No theoretical understanding	.13	.13	−.03	**.73**	−.14	F4:
Stop cutting if no-one around to notice	.19	−.16	−.29	**.61**	.24	Difficulty in understanding
Difficult to build relationship with her	−.31	−.27	.19	**.42**	−.20	her actions
Behaviour easy to manage	.06	.25	−.08	−.05	**.68**	F5:
Manage withour info from her past	.12	.03	.14	−.10	**.56**	Therapeutic confidence
Unlikely to injure herself again	.00	.13	−.15	.21	**.45**	
Variance accounted for	14.3%	10.0%	8.6%	6.3%	5.9%	

Note. Variables with loadings >0.40 are in bold type.

APPENDIX 7

Please indicate your opinion on the following statements based on what you have been told about Miss C (Please circle a number to show where your opinion lies).

(1) All one can do for this person is look after their basic physical and emotional needs.

Strongly agree 1 2 3 4 5 6 7 **Strongly Disagree**

(2) There is little point in arranging psychotherapy for a person who behaves like this.

Strongly agree 1 2 3 4 5 6 7 **Strongly Disagree**

(3) This problem is usually so ingrained that the patient will not be responsive to treatment.

Strongly agree 1 2 3 4 5 6 7 **Strongly Disagree**

(4) A patient exhibiting this problem is usually getting worse.

Strongly agree 1 2 3 4 5 6 7 **Strongly Disagree**

(5) A patient will always have this problem once they have developed it.

Strongly agree 1 2 3 4 5 6 7 **Strongly Disagree**

APPENDIX 8

Please indicate your opinion of the following management strategies for dealing with Miss C's self-harming.

Space is provided for you to add any other management strategies you consider missing from the list below. Please indicate your opinion of these accordingly.

	Strongly agree	agree	unclear	disagree	strongly disagree
Refer for exploratory psychotherapy	☐	☐	☐	☐	☐
Teach conflict management and assertiveness skills	☐	☐	☐	☐	☐
Teach emotional management (e.g. relaxation)	☐	☐	☐	☐	☐
Maintain regular discussion with involved staff member	☐	☐	☐	☐	☐
Make available long-term relationship with key worker	☐	☐	☐	☐	☐
Negotiate a no-harm contract with her	☐	☐	☐	☐	☐
Admit to hospital (under Section if necessary)	☐	☐	☐	☐	☐
Refer to self-help group for people who self-injure	☐	☐	☐	☐	☐
Ask responsible person to take charge of sharp knives etc.	☐	☐	☐	☐	☐
Look for underlying sexual trauma	☐	☐	☐	☐	☐
Encourage medication/drug therapy	☐	☐	☐	☐	☐
Refer for family therapy with parents	☐	☐	☐	☐	☐
Avoid hospitalisation; if hospitalised, expedite discharge	☐	☐	☐	☐	☐
Restrict contact to named staff	☐	☐	☐	☐	☐
Encourage ventilation of unexpressed feelings about her past	☐	☐	☐	☐	☐
Pay minimum attention to her wounds	☐	☐	☐	☐	☐
Encourage self-care of self-inflicted wounds	☐	☐	☐	☐	☐
Match with staff who can remain emotionally neutral to self-wounding	☐	☐	☐	☐	☐
Allow her a 24 hr "emergency contact" telephone number	☐	☐	☐	☐	☐
Additional management strategies					
1. _____	☐	☐	☐	☐	☐
2. _____	☐	☐	☐	☐	☐
3. _____	☐	☐	☐	☐	☐

APPENDIX 9

Please state which of the following is included in your current Job Description:
(Please tick all that apply to you)

☐ generic responsibility for the care and/or treatment of patients with Mental Health problems

☐ specific responsibility for the care and/or treatment of patients who self-harm.

☐ specific responsibility for the care and/or treatment of patients with personality difficulties/disorders.

Please state:

your gender ☐ **M** ☐ **F**

your age ☐ **18 - 25** ☐ **36 - 45**
☐ **26 - 35** ☐ **46 +**

In which of the following areas are you qualified?
(Please tick all that apply to you)

☐ Psychiatry
☐ Psychiatric Nursing
☐ Occupational Therapy
☐ Art/Drama Therapy
☐ Clinical Psychology
☐ Social Work
☐ other . . . . . (please specify)

Counselling:
- ☐ Certificate level
- ☐ Diploma level
- ☐ BAC Accredited
- ☐ other accreditation . . . . . (please specify)

Psychotherapy:
- ☐ post-Certificate level
- ☐ UKCP Accreditation
- ☐ BCP Accreditation
- ☐ other accreditation . . . . . (please specify)

For how many years have you worked in a health setting? ___ yrs

---

Clinical setting(s) in which you currently work: (Please tick all that apply to you)

- ☐ In-patient care
- ☐ Out-patient/community care
- ☐ Day Hospital care
- ☐ Therapeutic community
- ☐ Individual therapy:

  if so, is this ☐ Supportive only? ☐ Systemic?

  and is it ☐ time-limited? ☐ open-ended? ☐ long-term, but with minimum treatment length?

- ☐ Group Therapy:

  if so, is this ☐ Supportive only? ☐ Systemic?

  and is it ☐ time-limited? ☐ open-ended? ☐ long-term, but with minimum treatment length?

- ☐ Family Therapy:

  if so, is this ☐ Supportive only? ☐ Systemic?

  and is it ☐ time-limited? ☐ open-ended? ☐ long-term, but with minimum treatment length?

How many women have you worked with on the issue of self-wounding? (Self-wounding is defined as cutting, slashing, hitting or burning)

- ☐ None
- ☐ Between 1 and 5.
- ☐ Between 6 and 10.
- ☐ More than 10.

Have you received any specific training in the handling of patients who self-harm?

☐ yes ☐ no

Do you receive regular professional supervision? ☐ yes ☐ no

If yes, please state whether this is: ☐ individual ☐ group

How frequent is this supervision: .....

Please indicate which of the following most applies:

- ☐ I consider myself relatively inexperienced in dealing with patients who self-wound.
- ☐ I consider myself moderately experienced in dealing with patients who self-wound.
- ☐ I consider myself as having considerable experience in dealing with patients who self-wound.

You are now asked to consider the short case description on the following page . . . . . .

APPENDIX 10

To investigate the test-retest reliability of the staff attitudes measure and the optimism-pessimism measures were administered to a sample of trainee clinical psychologists (N = 12) following presentation of the Huband & Tantam (2000) vignette.

The second administration of the measures followed an intervening period of three months. However, during the intervening period, some self-harm teaching was scheduled into the timetable which focussed on addressing self-harming clients with validating non-judgemental attitudes. This no doubt had an effect on the subsequent administration of the attitudes and optimism-pessimism measures as the teaching would have, in effect, served an intervention. Therefore, it was considered a major confound in any subsequent test-retest analyses.

In retrospect, using a sample of trainee clinical psychologists was not ideal since their ongoing training and learning experiences would have invariably affected their attitudes about working with a particular client group. In addressing this issue in future, it would be more useful to use a sample of qualified psychologists who have over 2 years of post-qualification experience and are not engaged in formal training. This would enable the analysis of test-retest reliability for these measures although caution would be required in generalising the resulting psychometric properties to professionals in other disciplines. One alternative to this problem would be to include a stratified sample of mental health professionals (i.e. drawn from 'typical' CMHT composition) on which to administer test-retest reliability or other psychometric analyses such as tests of internal consistency. Such a sample would not be able to be involved in the experimental participant group however, as further administration of the measures would involve practice effects. This may limit the number of staff recruited for the participant group.

Further, it was thought that the intervening test-retest period (three months) was too long. In future, it would be more useful to allow a long enough period of time for test-items to be forgotten but not so long that staff are subject to extra training or policy initiatives which may replicate the problems experienced in this study.

APPENDIX 11

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26 May 2005

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Many thanks

Best wishes,

C Shinfield

Claire Shinfield
Journals Department

APPENDIX 12

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