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Staff emotional reactions to self-harm

The role of self-efficacy, attitudes, attributions and empathy

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GENERAL SUMMARY

Literature Review

Approximately 150,000 people annually present to hospital following self-harm (Hawton, Fagg, Simkin, Bale & Bond, 1997). However, self-harming behaviours remain poorly understood (Huband & Tantam, 2000). This literature review focuses on staff's emotional experience of working with people who self-harm. It has been documented that emotions evoked in staff include panic, hopelessness, anger and even hate, which makes a consistent, therapeutic response difficult to achieve (Allen, 1995). Despite this acknowledgment there has been little systematic study of how clinicians perceive and emotionally respond to clients who self-harm. This literature review investigates factors, which may help to explain emotional reactions to self-harm in order to guide staff training and support and optimise care provision for this client group.

Empirical Paper

The study investigated mental health professional's emotional reactions to self-harm and found that self-attributions of control (i.e. if staff thought they could control the behaviour) were associated with more negative emotional reactions. Self-efficacy was associated with staff feeling confident & relaxed. Staff who were more empathic were also less likely to experience negative emotional reactions.

Staff with more training and experience tended to report fewer negative emotional reactions. In predicting emotions, the study found some mixed results, which are likely to be due to problems with multicolinearity.

Conclusions are drawn about the clinical implications of these findings.

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A review of the literature on staff attitudes, emotional reactions and attributions regarding clients who self-harm

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Abstract

Approximately 150,000 people annually present to hospital following self-harm (Hawton, Fagg, Simkin, Bale & Bond, 1997). However, self-harming behaviours remain poorly understood (Huband & Tantam, 2000). This literature review focuses on staff's emotional experience of working with people who self-harm. It has been documented that emotions evoked in staff include panic, hopelessness, anger and even hate, which makes a consistent, therapeutic response difficult to achieve (Allen, 1995). Despite this acknowledgment there has been little systematic study of how clinicians perceive and emotionally respond to clients who self-harm. There is a clear need to explore those factors which may help to explain emotional reactions to self-harm in order to guide staff training and support and optimise care provision to this client group.

Literature Review Goals and Search Strategy

This literature review aims to address several key issues. Firstly and primarily, to investigate the clinical relevance of staff reactions to self-harm, i.e. to what extent may staff reactions influence the care provided to this client group? This involves finding evidence for possible negative attitudes and reactions in professionals who care for people whom self-harm. Secondly, the review outlines some theoretical frameworks in order to understand staff reactions. Lastly, it will be argued that there is a need to study staff emotional reactions to self-harm and to investigate how these in turn may relate to the attributions and attitudes staff hold.

A computer search of Ovid, Medline, Embase and Psychinfo using the key word self-harm, yielded few results. Several derivatives of self-harm, including *self-injury, self-mutilation, deliberate self-harm, parasuicide and attempted suicide*, were then used to search more literature. These terms were then combined with *emotional reactions, attitudes, stress* and *care provision.* These searches unearthed numerous papers of interest, hence additional selection criteria were applied, more specifically only papers written in English and published in a peer reviewed journal were included. Additionally, an internet search of two high calibre journal publishing websites (British Journal of Clinical Psychology and Clinical Psychology Review) was conducted, covering articles published in the period 1999-2007.

1. Introduction

1.1. Definition of self-harm

There has been considerable confusion surrounding the terms 'self harm' and 'deliberate self-harm'. These terms have both been used to refer to acts of varying frequency, severity and lethality but tell us nothing of the underlying function of the behaviour. Indeed, the term 'self-harm' has been used interchangeably with the terms 'parasuicide', 'attempted suicide', 'self-injury' and 'self-mutilation' (Tantam & Whittaker, 1992). With this ongoing debate in mind, it becomes clear that in order to define self-harm, different points should be considered and integrated. The definition presented here draws upon several authors' conceptualisations of self-harm. The definition of self-harm should take in to account directness, social acceptability, number of episodes, degree of damage and intent. It is direct and socially unacceptable, so differentiated from indirect self-harm such as drinking and driving, and from more socially acceptable bodily harm, such as ear piercing or

tattooing (Walsh & Rosen, 1988). It is repetitive and results in minor or moderate harm; it is differentiated from major or grave self-inflicted bodily harm, such as eye enucleation or self-castration, which are usually not repetitive, clearly more severe and generally associated with psychosis (Favazza & Rosenthal, 1990). Neither is it suicidal in intent; it is differentiated from suicidal acts and gestures in the patients' perception of the event, the proposed function of the behaviour and the associated features (Walsh & Rosen, 1988). Finally, self-harm is not related to general cognitive impairments; it is differentiated from the self-injurious repetitive behaviour seen in people with learning disabilities or autism (Favazza & Rosenthal, 1993). In summary, the following comprehensive, albeit lengthy, definition is presented: self-harm is a direct, socially unacceptable repetitive behaviour that causes minor to moderate physical injury; when self-harming the individual is intentionally harming himself or herself but is not attempting suicide or responding to a need for self-stimulation or a stereotypical behaviour characteristic of a learning disability or autism.

It is important to note that although in this review self-harm is defined as self-inflicted harm without suicidal intent, many authors have failed to make this distinction.

1.2. Prevalence and Epidemiology

Self-harm accounts for 150,000 presentations at Accident and Emergency (A&E) departments in the United Kingdom annually (Hawton et al., 1997) placing considerable demand on services. Although there were once between two or three times as many reported episodes in females, the sex-specific rates have steadily drawn closer together, so that self-harm is now only slightly more common in

women than men (Hawton et al., 1997). The mean age of the self-harm population is in the early 30's for both sexes; the peak age for presentation being 15-24 years for women and 25-34 years for men (Charlton, Kelly & Dunnell, 1993). Cutting is by far the most common type of self-harm, (up to 90% of reported cases), followed by inflicting blows, burning/scalding and picking/scratching (Arnold, 1995).

It is difficult to get an accurate picture of the epidemiology of self-harm; Oxford is the only UK centre with a continuous monitoring system. However, several studies have reported outcomes following self-harm, including suicide. Indeed, of known risk factors, intentional self-harm has been shown to have the strongest association with completed suicide. In reviewing the evidence, Hawton and Fagg (1988) reported that the suicide rate is highest in the first year after an episode of self-harm and within that year it is highest in the first few months. Given the general consensus that self-harm and suicidality are distinct classes of behaviour, the question then arises: 'why are people who self-harm more likely to commit suicide?' Of those who do attempt suicide, Favazza (1992) argued that suicide attempts are often a response to the person's inability to control his or her self-harm behaviour. Also, research has demonstrated that when individuals who self-harm attempt suicide, they do so through different means than their self-harm, most frequently in the form of an overdose (Stanley, Gameroff, Michalsen & Mann, 2001). Muehlenkamp (2005) postulated that "it is most effective to view suicide as a potential risk behaviour that is associated with a variety of disorders, one of which is a self-injury syndrome".

1.3. Diagnosis/classification of self-harm

The International Classification of Diseases, version 10, (ICD-10; World Health Organisation, 1992) lists self-harm under 'external causes of morbidity and mortality' and presents a variety of methods of 'purposely self-inflicted poisoning or injury', e.g. 'intentional self-poisoning by and exposure to non-opioid analgesics, antipyretics and antiheumatics' and 'intentional self-harm by sharp object'.

For many years, superficial/moderate self-harm was viewed as solely an associated symptom of borderline personality disorder (BPD, Muehlenkamp, 2005). The Diagnostic and Statistical Manual, version 4, (DSM-IV, American Psychiatric Association, 2000) describes the essential features of BPD as 'a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts, as indicated by five or more criteria, one of which being recurrent suicidal behaviour, gestures, or threats of self-mutilating behaviour'. Despite the undisputed occurrence of self-harm in individuals diagnosed with BPD, an increasing number of studies have noted the existence of self-harm among individuals without BPD. Indeed, it has also been associated with eating disorders (Favazza & Conterio, 1989) post-traumatic stress disorder (PTSD) (Herman, 1992; Pitman, 1990), depressive disorders (Ross & Heath, 2002), obsessive-compulsive disorder (Yaryura-Tobias, Neziroglu & Kaplan, 1995) and substance abuse disorders (Favazza & Conterio, 1989). Despite this plethora of associated disorders, people who self-harm are still often given the diagnosis of BPD, even when they lack many of the required diagnostic features (Crowe & Bunclark, 2000). McAllister (2003) suggested that there might be a cultural practice within psychiatry biased towards the diagnosis of

BPD that could be responsible for negatively shaping staff attitudes and therapeutic responses.

Several authors have argued a case for recognition of a 'deliberate self-harm syndrome' (Pattison & Kahan, 1983; Tantam & Whittaker, 1992). Muehlenkamp (2005) suggested that self-harm could be represented within the DSM-IV as an independent entity, because there is a prominent symptom pattern and relatively clear presentation of biological and associated features (e.g. age of onset, precipitants and course). Despite these efforts to delineate a self-harm/injury syndrome, the APA has so far failed to acknowledge the existence of an independent self-harm disorder. It should be noted that in contrast to attempts to classify self-harm as a pathological disorder, some authors (e.g. Arnold, 1995) have rejected notions of 'mental disorder' and have argued that self-harm should be perceived as a means of coping with unbearable experiences.

1.4. Risk factors for and functions of self-harm

Predisposing risk factors for self-harm behaviour include a history of physical or sexual abuse, physical illness or surgery at a young age, perfectionism, dissatisfaction with the body, and parental alcoholism or depression (Favazza & Rosenthal, 1993; Walsh & Rosen, 1988). Vivekananda (2000) suggested that understanding of self-harm needs to be located within the long-term effects of trauma, abuse, loss or neglect. Van der kolk (1991) found that 89% of people who self-harmed had disruptions in parental care, suggesting that attachment problems may be inherent in this population.

Many authors understand acts of self-harm to serve some purpose or function (see Suyemoto 1998, for a review of functional models). Suyemoto and Macdonald (1995) suggested that models explaining self-harm as an expression of overwhelming affect, an attempt to stop depersonalisation, or an attempt to create a boundary and sense of identity are the most accurate and useful therapeutically.

Other authors see the purposes of self-harm in terms of its possible effects on other people. Feldman (1988) suggested that self-injury might be carried out for secondary gain, i.e. to force others to provide love and attention. However, this has been disputed. Indeed, results of a survey by Arnold (1995) revealed that 'relief of feelings' (hatred, guilt or dirtiness), 'self-punishment' and 'control' were the primary functions of self-harm. Despite this, the commonly held myth that self-harm is 'attention seeking' remains (Vivekananda, 2000).

1.5. Care pathways in the UK

A&E departments may be critical in addressing the needs of this vulnerable group, as they are often the first point of call for people who self-harm. The National Institute for Clinical Excellence (NICE, 2004) guidelines clearly define key priorities for implementation with regard to the management people who self-harm in A&E, including: respect, understanding and choice, staff training, appropriate triage, assessment of needs, assessment of risk and consideration of referring on for psychological, psychosocial and pharmacological interventions. After an assessment in A&E, the NICE Guidelines (NICE, 2004) suggest that only those clients considered at risk of repetition of self -harm or suicide should be referred to specialist services. The aftercare now tends to be largely provided by community

mental health teams (CMHT's), although in many instances general hospital liaison psychiatric services continue to provide this care (Haw, Hawton, Whitehead, Houston & Townsend, 2003). This care may involve home treatment, telephone contact and a specified intervention, such as Dialectical Behaviour Therapy (DBT, NICE, 2004).

Despite treatment suggestions by NICE (2004), there has been a lack of consensus on what treatments are most effective in reducing self-harm. Different intervention strategies aimed at reducing the repetition of self-harm have been proposed (see Hawton et al, 1998, for a review), ranging from minimal interventions to problem solving therapy and psychodynamic oriented or cognitive-behavioural approaches, including DBT. However, there still remains some uncertainty about the effectiveness of preventative strategies and some results are contradictory, mainly due to insufficient sample sizes (Hepp, Wittmann, Scchnyder & Michel, 2004). Despite this, DBT is one approach that has reported to have some success in reducing self-harm rates in people with borderline personality disorder who self-harm regularly (Low, Jones, Duggan, Power & MacLeod, 2001) and reducing suicide attempts in this client population (Linehan, Comtois & Murray, 2006). Although the evidence for DBT is accumulating, the perception that people with personality disorders are 'untreatable' may prevail (NIMHE, 2003), despite the mental health act (Department of Health, 2006) introducing a generic and inclusive definition of mental disorder, which means that personality disorder is no longer a diagnosis of exclusion. If staff did perceive self-harming clients as 'untreatable', this may help to explain why self-harm behaviours can evoke negative emotional reactions. In other words, if staff feel helpless and hopeless in their own roles in

providing treatment, it is likely to impact upon how they feel about this client group. Indeed, Tantam and Whittaker (1992) have commented on the fear, anger and anxiety that a person deliberately harming themselves produces in carers and fellow patients, who may stigmatise the patient as 'bad', 'attention seeking' or 'manipulative'. This may result in staff distancing themselves from such clients, rationalising that the person cannot be helped (Vivekananda, 2000). One reason for the bias in over-diagnosing BPD and the negative attitudes of staff may lie in perceptions of controllability. As the Markham and Trowers (2003) study suggested, people with BPD may be seen as 'in control' of their actions. In other disorders, such as depression and anxiety, where the medical model implies the clients have a recognised and treatable mental disorder, clients are more likely to be perceived as having little or no control. In BPD, there is no conclusive evidence that pharmacotherapy is effective (Dahl, 2008). Therefore, as the medical model fails to explain or gain any control in treating this client group, there may be a tendency to ascribe control to the individual. In terms of self-harming behaviours, patients may be blamed for this action, which would have an impact upon staff, including the development of negative attitudes. As the 'typical' self-harming client is likely to encounter several different professionals as part of their care, it is of fundamental importance to address the attitudes of these professionals. This paper will now review the evidence for negative attitudes towards self-harming clients.

2. Attitudes to self-harm

2.1. Background

Ajzen (1988) cited in McLaughlin (1994) stated that a person's attitude towards another involves a disposition to react favourably or unfavourably to that person.

Internationally, attitudes towards mental disorders have been targeted. The World Psychiatric Association (2005) campaign against stigma has resulted in countries worldwide implementing campaigns to improve knowledge and attitudes towards mental health problems. In the UK, the Ten Shared Capabilities Framework (Department of Health, 2004) acknowledged the importance of attitudes of all health staff towards service users and carers.

This section will address A&E and mental health staff attitudes separately, in recognition of their differing roles in the assessment and treatment of self-harming clients. It should be noted that by association, attitudes to self-harm may reflect attitudes to BPD, which is important as research has repeatedly shown that mental health professional's attitudes towards clients with BPD can be negative (James & Cowman, 2007). Indeed, BPD has been described as a 'dustbin diagnosis' for patients considered 'different' or 'difficult' (Munro, 1999). Bowers (2002) revealed that forensic nursing staff viewed patients with BPD as "evil and monstrous". Moreover, there is evidence that negative attitudes are likely to translate into negative practice; Markham and Trower (2003) reported that nurses were more rejecting of clients with BPD than those with other diagnoses. Similarly, Fraser and Gallop (1993) reported that nurses were less empathic and confirming in their responses towards those with BPD compared with other diagnoses.

2.2. A&E staff

A&E department staff are often busy and confronted with competing issues and concerns in an emotionally charged environment. As patients are assessed and prioritised using a triage system, according to severity and threat to life, people who come to A&E following self-harm may not be perceived as 'good and deserving patients' (Sbaih, 1993). As a result staff may make the person wait, express frustration, anger, fear, and helplessness, fail to empathise and fail to maintain safety and respect within the A&E (Johnstone, 1997). This has been supported by consumer experiences. A recent survey of people who self-harm indicated that medical personnel were rated as providing the most unsatisfactory support (Warm, Murray & Fox, 2002).

Over the last 50 years, there has been a rise in the incidence of self-harm, with a marked increase since the 1960's (House, Owens & Patchett, 1998). The literature regarding A&E staff attitudes reflects this trend. Ramon, Bancroft and Skrimshire (1975) conducted one of the first published studies, exploring perceived motives for self-poisoning in a sample of medical and nursing staff. Nurses were generally more accepting and sympathetic, whereas doctors tended to ascribe 'manipulative motives. Ramon et al. (1975) cautiously interpreted these differences as reflecting the differences in responsibility that doctors and nurses hold for patients: the doctor carries greater responsibility and hence may feel more ambivalent about self-induced harm, whereas nurse's can maintain their role without worrying whether the person qualifies for help.

In contrast, Patel (1975) found that more junior staff, both nurses and doctors, reported the most unfavourable attitudes towards self-poisoning, compared with more senior staff. Patel (1975) proposed that more junior staff have more contact with this client group and therefore find the care of self-poisoning more aversive (such as gastric procedures), especially given patients often presented late at night or early in the morning. Junior staff expressed marked hostility towards patients who had taken an overdose, and in general patients were seen as unsatisfactory to treat and did not benefit from their stay in hospital.

Studies by O'Brien and Stoll (1977) and Platt and Salter (1987) replicated the finding that more senior psychiatrists held more neutral feelings towards patients and hence supported Patel's (1975) suggestion for this disparity. O'Brien and Stoll (1977) indicated that the more senior doctors did not spend as much time with overdose admissions, and hence feelings of irritation, as expressed by more junior staff, were not warranted. In addition, they found that nurses felt ill equipped to deal with the patients, which may further explain their less favourable attitudes.

More recently, there have been conflicting findings from studies that examine whether age and clinical experience may influence attitudes. McLaughlin (1994), in survey of A&E nurses in Northern Ireland, reported that older and more experienced nurses had more favourable attitudes towards self-harm than younger and less experienced colleagues. Similarly, Anderson (1997), in a comparative study of community mental health and A&E nurses, reported that positive attitudes towards suicidal behaviour among both nursing professions were associated with longer

clinical experience and increasing age. In contrast, McAllister, Creedy, Moyle and Farrugia (2002) found no such association.

One potential reason for these conflicting results may lie in the way that self-harm behaviours have been defined and attitudes measured. There has generally been a failure to recognise the severity or lethality of behaviours, and researchers have tended to develop their own, and often invalidated ways of measuring attitudes. Furthermore, reactions to clients who overdose may not be representative of staff reactions to other forms of self-harm. Presumably in growing recognition of the distinction between self-harming and suicidal behaviour, and a rise in the former, particularly in the last 10 years (Hawton, Fagg, Simkin, Bale & Bond, 1997), there has been more of a focus on self-harm behaviours in the absence of suicidal intent, and there is a growing literature, which has attempted to standardise the conceptualisation and measurement of attitudes.

McAllister et al (2002) aimed to develop and test a reliable scale to identify components of attitudes to self-harm, by conducting a review of the literature, then conducting focus groups to discuss staff responses to self-harm. The Attitudes to Deliberate Self-Harm Questionnaire (ADSHQ) was distributed to a large sample of A&E nurses. Using factor analysis, four factors were extracted: (F1) Perceived confidence in assessment and referral of DSH clients; (F2) Dealing effectively with DSH clients; (F3) Empathic approach; and (F4) Ability to cope with legal and hospital regulations that guide practice. The mean score for this sample indicated generally negative attitudes towards clients who self-harm, i.e. the nurses largely

agreed with statements such as 'dealing with self-harm clients is a waste of health care professionals time'.

Similarly, Friedman et al. (2006) used the methodology employed by McAllister et al. (2002) to investigate the attitudes of nurses and doctors towards patients who self-harm through laceration. However, they also focused on patient turnover, risk and the necessity for psychiatric assessment. Despite an acknowledgment that self-laceration was associated with distress, almost 80% felt it was also about 'seeking attention', which carried a negative connotation, being linked with 'manipulation'. Significant positive correlations were found between length of time worked in A&E and feelings of frustration/ anger and inadequacy. Interestingly, staff were also asked to estimate the number of cases of self-laceration they thought had presented to A&E in one year. Results showed a significant overestimation, i.e. the mean estimate was 2200, much greater than the actual figure of 300 cases. This seems to reflect the significant emotional impact of working with people who self-harm.

These two examples illustrate that, despite attempts to standardise and measure attitudes more accurately, there are very different ways of conceptualising and interpreting attitudes to self- harm. These of course will be guided by the author's own understanding of the literature and what factors they perceive most salient. To address the limitations of quantitative research in this respect, there have been attempts to use qualitative methodology to gather more in-depth and less directed information on practitioners attitudes towards patients who self-harm. For example, Anderson, Standen and Noon (2003) investigated nurses and doctors (A&E and mental health) perceptions of young people who engaged in suicidal behaviour.

Participants talked about the nature of their relationship with this client population, (or rather barriers impacting upon it), and the main recurrent theme was the experience of frustration in practice. In turn, frustration was strongly associated with the professional and clinical problem of insufficient time and available resources. Therefore, the frustrations may not have reflected self-harming behaviours per se, but more so limitations within the health care system to deal with these clients. Similarly, Hopkins (2002) found an association between nurses' perceptions of 'being busy' and the frustration of having not done enough for self-harming patients. However, at the same time Hopkins (2002) reported that nurses perceived people who had self-harmed as 'impeding the functioning of the unit by their actions'. This suggests that it is not only the behaviour or the patients themselves that may determine responses to self-harm, but also issues concerning service availability and provision. It also raises another interesting issue, namely the extent to which professionals perceive self-harming clients as 'inappropriate attendances' to A&E, alongside other patients who present with minor injuries, or non accidents/emergencies. Following this line of reasoning, one may assume that attitudes would be more favourable in mental health settings, where self-harm behaviours are more appropriately treated. In A&E, service contact is likely to be fleeting, managed by staff with little commitment to mental health care and with a significant focus on repairing physical injury. The client may expect a different response in a mental health setting, particularly inpatient units, from staff who have longer to work with the client and presumably have a commitment to caring for mental health problems specifically (Baker, Richards & Campbell, 2005). However, Anderson (1997) found no significant differences between a sample of A&E and community mental health nurses. Contrary to earlier studies, their results revealed

that nurses from both settings held generally positive attitudes towards suicidal clients, i.e. they were generally accepting of suicidal behaviour. However, the study did not control for variables such as training in self-harm. Anderson (1997) therefore stated that their results should be treated with caution.

2.3. Mental Health Staff

The incidence of self-harm is of particular concern within mental health services. According to Haw, Hawton, Houston and Townsend (2001), 92% of patients presenting to a general hospital after an episode of self-harm were diagnosed with a psychiatric disorder. However, little attention has been paid to psychiatric staff attitudes towards self-harm. Indeed, a literature search identified only a handful of peer-reviewed papers to date.

Gough and Hawkins (2000) investigated staff attitudes towards self-harm in a forensic psychiatric service. Results of a cluster analysis revealed the sample could be divided in to two groups. The first cluster was characterised by staff that held relatively punitive /negative attitudes, for example they agreed with statements such as 'people who self-harm are selfish' and 'dealing with them wastes staff time', as opposed to the more positive group. Similarly, there was a split in how staff preferred to manage self-harm with some favouring a preventative approach (stopping self-harm) or facilitative approach (allowing the person to self-harm, then talk it through). Rather than interpreting these finding as indicating positive or negative attitudes, they proposed that attitudes are complex and tend to involve a mixture of feelings including incompetence, powerlessness, empathy and moral judgement. Although the authors inferred that these findings might be unique to

forensic mental health staff, similar attitudinal themes, which have the ability to split team by opinion, have been highlighted amongst other mental health staff.

Huband and Tantam (2000) developed a survey derived from comments and beliefs frequently expressed by clinical staff working with self-harming clients. They asked staff to consider a case vignette of a typical self-harming client based on two frequently cited descriptions (Favazza & Conyterio, 1989; Simpson, 1976). A factor analysis of responses revealed five factors that mediated staff attitudes: the perception of the woman as being in control of her actions; the tendency to be undemanding versus difficult; her eligibility for tolerance and empathy; the difficulty staff had in understanding her actions and a weaker factor, termed 'therapeutic confidence'. Successive cluster analysis revealed two groups: the 'soft' attitude group was characterised by a perception of the client as not in control of her actions, more eligible for tolerance and empathy and less difficulty in understanding her actions, compared with the 'firm' group who held the opposite beliefs (Huband & Tantam, 2000).

These two studies reveal that negative attitudes prevail in mental health professionals, albeit maybe in subgroups, rather than whole teams. Given the potential for clients who self-harm to install such negative attitudes and reactions from staff, one would assume that the length of time worked with this population might impact upon staff's emotional reactions. Indeed it has been suggested that over time staff may start to develop more detrimental attitudes. Patterson, Whittington and Bogg (2007) purport that prolonged engagement with relapsing self-harming clients can lead to 'antipathy'. Antipathy is viewed as 'a relatively stable

negative individual attitude towards people who self-harm, which the health care professional takes from one relationship with a self-harming person to the next; the person is viewed as a member of a stereotyped group, rather than as an individual and the professional has negative emotional associations when encountering the stereotyped person together with hostile cognitions and rejecting behaviour' (Patterson, Whittington & Bogg, 2007). Patterson, Whittington and Bogg (2007) developed the Self Harm Antipathy Scale (SHAS) in order to test this hypothesis. They found that associations between scores on the SHAS and work experience did not fully support the concept of antipathy, as staff who had no, or limited experience with self-harming clients and staff with more than 10 years experience with this client group equally expressed antipathy. Although mental health nurses did score significantly lower in antipathy than general nurses, some nurses genuinely believed that they could not help people who self-harmed and that care was futile. As Patterson et al (2007) proposed, those with high antipathy scores may not necessarily be 'bad nurses', but instead feel powerless and incompetent in the face of a self-harming client. However, the client who self-harms is unlikely to have an awareness of how incompetent the nurse feels or how their beliefs have developed. Instead, they are likely to perceive just the negative attitude, which may have significant implications for service provision.

3. How do clients who self-harm perceive their care?

3.1. Background

Arnold (1995) conducted a survey of 76 women who self-harm. An important factor in determining whether a woman's experience of services was helpful was the perceived attitude and approach of the professionals involved. Overall, there was a

high degree of dissatisfaction expressed, with the exception of counselling/psychotherapy services. Participants reported being criticised, ignored, 'told of' and dismissed as 'attention seeking', 'a nuisance', or 'wasting time'. One young woman was told to 'grow up'. Other themes included staff being ignorant, failing to listen, providing inappropriate treatment and using excessive or abusive power or control.

It is difficult to ascertain how representative these findings are, due to a lack of studies exploring service users experience. However, some literature exists which suggests that staff acknowledge their role in poor care provision. Hemmings (1999) found significant ambivalence towards, frustration with and distress caused by self-harming patients, which resulted in explicit punitive behaviour, such as leaving the patient alone for prolonged periods, ignoring them or restricting attention. These examples are clear expressions of insufficient and inappropriate care provision associated with negative attitudes. However, it may be more likely that negative attitudes are expressed more subtly, which could have similarly detrimental effects on staff-client interactions and quality of care.

3.2. Staff interactions with the self-harming client

Rayner, Allen and Johnson (2005) discuss the emotional, cognitive and behavioural effects of self-harm on nursing staff and propose a cognitive-behavioural cycle to help understand care provision for this client group. When clients' present with self-harm the health care professional may question the extent to which the patient has self-harmed 'on purpose' or perceive it as 'wasting all of their work together'. As a result they may feel angry or annoyed, withdraw from the client, who may in turn interpret this as rejection or punishment, which may then lead to low mood and guilt

and an increased desire to self-harm. In addition, staff's response may also maintain the client's beliefs that they are 'bad' or 'worthless', further increasing the likelihood of repeated self-harm. This model implies that both staff and client may not be aware or paying attention to the processes involved in their interaction, and that vital messages are being missed. However, as their reactions are largely based on misinterpretations of the others emotions and behaviour, the cycle is maintained.

Other authors have also highlighted that staff and clients may not posses a shared understanding of self-harm. Reece (2005) conducted a study with a group of nurses and women who self-harmed. Certain qualitative concepts mentioned by both women and nurses were often understood differently by each group, most notably issues concerning power and control. Nurses assumed they had to control the behaviour, whilst the women indicated this was not necessarily helpful. In some of the interviews with the nurses, a tendency towards blaming the women who self-harmed was noted. It was proposed that nurses might feel attacked, or experience the self-harming behaviour as personal to them, which was not supported by the clients' views. These examples highlight the potential for difficult staff-patient interactions and the likelihood of frustrations on both sides. Interestingly, the nurses were not comfortable in verbally expressing these views in interview and preferred to do so in written anonymous submissions. Given this reluctance for staff to discuss these issues, it seems plausible that problematic staff-client interactions associated with misunderstanding/misinterpretation of behaviours, also occurs in other care settings.

In an attempt to investigate professional opinions of various strategies advocated for the clinical management of self-wounding female patients, Huband and Tantam (1999) distributed a large postal survey to mental health staff. Findings suggested a clear preference for maintaining regular discussions amongst staff and matching clients with staff who could remain emotionally neutral to the self-harm. Despite this overall agreement, respondents' views were also contradictory and more than 20% of respondents were 'unclear' in their opinions. These results highlight a potential for disagreement within staff groups working with clients who self-harm, with possible implications for treatment outcome (Huband & Tantam, 1999).

The process Huband and Tantam (1999) refer to may be viewed as staff splitting (polarisation of carers attitudes/responses to clients). Although current working practices in mental health care often reflect cognitive behavioural theories (National Institute for Clinical Excellence, 2004), psychoanalytical theory can also support understanding of self-harm. Indeed, even those endorsing cognitive behavioural models, suggest that one must integrate a psychoanalytic perspective (Rayner, Allen & Johnson, 2005) in understanding staff reactions to clients who self-harm.

Isabel Menzies-Lyth, a psychoanalyst, has written extensively about the use of defence in social structures. In her classic 1959 paper (as cited in Menzies-Lyth, 1988), she suggested the very nature of nursing elicits intense and unmanageable anxiety and that various defensive techniques are used to avoid experiencing this anxiety and feelings of guilt, doubt and uncertainty. These unconscious techniques include splitting the nurse-patient relationship, depersonalisation from the individual,

detachment and denial of feelings and attempts to eliminate decisions and responsibility.

Despite some controversy surrounding these ideas, they have been supported by some contemporary research. For example, Huband and Tantam (2000) found that the possession of a counselling/therapy qualification was strongly associated with perceptions of greater understanding of self-harm. They suggest that training allowed respondents to contain anxiety associated with self-harm and that one defence against such anxiety was to attribute responsibility and blame away from themselves and onto the patients. Similarly, Rayner, Allen and Johnson (2005) refer to the processes of splitting (a polarisation of feelings in the client which translates into seeing nurses as either 'good' or 'bad') and projective identification (projection of a part of the self on to another person) in staff caring for self-harming clients. They suggest that feelings of guilt, rage and hatred, helplessness and worthlessness and anxiety may be projected from clients on to carers, who then experience negative thoughts and resultant behaviours. The notion of projection is supported by the proposition that the core feature of clients who self-harm is emotional dysregulation, especially those with BPD (Linehan, 1993) and that self-harm represents a way of regulating these intense emotions.

Watts and Morgan (1994) also use psychoanalytical theory in describing 'malignant alienation', a process that appeared to be common before clients had committed suicide in a small series of psychiatric in-patients. This is characterised by a progressive deterioration in relationships with others, including loss of sympathy and support from members of staff and a tendency to construe the patients' behaviour as

provocative, unreasonable or over dependent. It seems that people who self-harm may be particularly susceptible to malignant alienation, as they are likely to possess several of the key identified patient characteristics, such as long standing difficulties communicating their needs effectively (Watts & Morgan, 1994).

This literature base suggests that staff may distance themselves or reject clients in order to protect themselves from experiencing negative emotions. Although research suggests that the precipitants for self-harm are multi-determined (Favazza, 1989), many tend to share a theme of real or perceived rejection or abandonment. In other words, a rejecting response from staff may serve to increase the likelihood of further self-harming behaviours (Rayner, Allen & Johnson, 2005).

Simpson's (2004) qualitative study investigated the experiences of people who self-cut. The incidents described centred on the experience of profound aloneness and a sense of being marginalised from their families, friends and other people around them. Over time, these conditions led to a collapse of self-esteem and what Simpson (2004) described as 'an invalidated or destabilised sense of self'. To this extent, self-harm can then be perceived as a way of managing associated distress. This line of reasoning would support the notion that staff responses, especially rejection, can serve to increase a sense of isolation and hence may lead to further self-harm.

Given the suggestion that staff may experience anxiety when dealing with self-harming clients and the adverse effect this may have on client care, it is important to review the empirical evidence for this and explore other work-related factors that could potentially increase stressful staff experiences.

4. Stress in health care professionals

4.1. Background

People in the caring professions are among the occupational groups consistently identified as being at high risk of experiencing work-related stress. For example, a recent survey of NHS staff found that work stress was cited as the most common cause of injury or illness in the workplace (The Health Care Commission, 2006). Prolonged exposure to stress may lead to burnout, which has been conceptualised as encompassing emotional exhaustion (feelings of being overextended and exhausted by the emotional demands of one's work), depersonalization (characterised by a detached and cynical approach to other people in the context of work) and personal accomplishment/efficacy (the self-evaluated feeling that one is no longer effective in one's work) (Maslach & Jackson 1981).

The concept of work stress is important for several reasons. Firstly, there are a plethora of reported symptoms of stress, which may be detrimental to staff well-being, including physical, emotional and psychological (see Kahill, 1988 for a review). This in turn has significant ramifications for the NHS. At the service level, stress and burnout have been associated with intention to leave organisations, actual staff turnover, and absenteeism (e.g. Hatton & Emerson 1993; Rose, 1995). The direct care interface can also be affected, with evidence that staff under stress are less likely to engage positively with their patients (Lawson & O'Brien, 1994). The role of work characteristics in stress and burnout has received considerable attention, including job demand/caseload, role ambiguity and conflict (see Melchoir, Bours, Schmitz & Wittich, 1997 for a review).

4.2. Stress in psychiatric settings

As psychiatric care involves dealing with the psychological distress and suffering of clients with complex mental health problems, it is intuitively a stressful environment to work in. Sullivan (1993) suggests the work is demanding, involving intimate and intense interactions with an often disturbed client group, including the confrontation of difficult and challenging behaviours on a regular basis. Several studies have reported high prevalence of stress and burnout in psychiatric nurses (Sullivan, 1993, Jenkins & Elliott, 2004), social workers (Evans, et al, 2006), in long stay (Melchoir et al, 1997), and community settings (Prosser et al, 1999). Despite these findings, overall, the empirical evidence related to the impact of working with certain groups of patients in psychiatric staff is scarce (Melchoir et al 1997). There are however a few published studies of relevance to this review.

4.2.1. Stress and self-harm

Clients who persistently self-harm are often admitted to psychiatric inpatient units for assessment and treatment. It is generally recommended that patients deemed at risk be put under special observation by mental health professionals (Stevenson & Cutliffe, 2006). Observational guidelines may vary from continual one to one observations (whereby a member of staff is present with the client 24 hours a day); to the client being checked every 5, 10 or 15 minutes. However, these observation recommendations are often planned with little regard to the associated demands for nursing staff, emotionally and logistically (Sainsbury Centre for Mental Health 1998).

Sullivan (1993) conducted semi-structured interviews and reported that dealing with potentially suicidal patients and observations were the most frequently cited stressors

by psychiatric staff. Two factors appeared to influence the intensity of such stressful experiences: first, the perceived level of predictability and secondly, the availability of manpower resources to deal with actual incidents. Nurses felt they lacked manpower resources to maintain observations at a safe level and did not feel supported by hospital management. Similarly, Burnard, Edwards, Fothergill, Hannigan, and Coyle (2000) reported that client self-harm and dealing with suicidal behaviours was frequently cited as main causes of stress by community mental health nurses. In support, Jenkins and Elliott (2004) reported that dealing with difficult or demanding patients was a problematic stressor for nursing assistants. Although these three studies provide some interesting qualitative themes, there is seemingly an absence of studies, which have formally measured the stress response in staff working with self-harming clients.

However, it is possible to extrapolate some relevant findings from related research. For example, persistent interpersonal problems are core to personality disorders (DSM-IV, APA, 2000) and clients with BPD may frequently fail to respond to therapeutic efforts and consequently place considerable demands on the emotional resources of psychiatric professionals (Linehan 1993). Therefore relationships with clients who have interpersonal problems may be a stressor aside from actual self-harming behaviours. Nathan, Brown, Redhead, Holt and Hill (2007) predicted that certain features of female forensic patients, notably the increased prevalence of disorder with a high interpersonal element and histories of self-harm, would be associated with increased levels of stress and interpersonal tension. They compared staff from male and female wards and found that working on the female ward was associated with greater emotional exhaustion. Nathan et al (2007) concluded that the delivery of therapeutically effective milieu under pressure from patients with

interpersonal dysfunction is likely to require sustained high moral among staff and may be linked to burnout (Nathan, Brown, Redhead, Holt & Hill, 2007). This finding was further supported by Burnard et al (2000) as results from their study revealed that difficulties arising from relationships with clients were the main source of nurses' stress over the last month.

These few studies do indicate that working with a client who self-harms is perceived as stressful by staff. The experience and effect of this stress will depend not only on the stressor itself, but also how the staff member copes with that stress.

4.3. Stress and coping

According to the 'stress and coping' paradigm developed by Lazarus and Folkman (1984), people will experience stress if they appraise an event as stressful and perceive the demands posed by that event as exceeding their ability to cope. Later, Smith and Lazarus (1993) considered the role of emotions in the appraisal response and proposed that loss appraisals could be associated with sadness, depression, despair and hopelessness, threat appraisals with anxiety, fear and anger, and challenge appraisals with worry, hope and confidence.

Application of Lazarus's model would suggest that occupational stress would occur when a member of staff appraises a discrepancy between an event at work and their perceived capability to resolve the situation. In support, Perseius, Kaver, Ekdahl, Asberg and Samuelsson (2007) measured stress and burnout in psychiatric professionals who were starting to use dialectical behaviour therapy (DBT) for self-harming behaviours in clients with BPD. Their results confirmed that staff found the experience of treating self-harm very stressful and that although learning DBT was

demanding, it decreased levels of stress and burnout. Decreasing stress was related to self-confidence, feeling more hopeful and satisfied in being able to help.

In contrast, Tiemey, Quinlan and Hastings (2007) assessed the impact of a 3-day training course (understanding challenging behaviour) on staff cognitive and emotional responses in intellectual disability staff. Participants completed a self-report survey including attributions for challenging behaviours, perceived self-efficacy and emotional reactions. Tiemey et al (2007) reported that, in line with existing literature, staff efficacy/confidence significantly increased after the course, and that self-efficacy/confidence levels were retained 3 months after the training took place. However, there were no changes in staff emotional reactions or attributions. Tiemey et al (2007) proposed that emotional reactions and attributions may have initially changed, but were not maintained at three months. Despite this finding, the relationships between training, attributions and emotional reactions have received some attention. Hence, attribution theory will be reviewed next, with a focus on how it may be applied to self-harm.

5. Attribution theory

5.1. Background

Attribution theory is concerned with how people explain behaviour. The basic tenant of attribution theory is that many behavioural sequences appear to be initiated following a causal ascription (attribution) for an event (Weiner, 1980). Weiner (1980) proposed a motivational sequence of help giving whereby thoughts, feelings and behaviours interact to determine whether or not help is offered. Referring to Piliavin et al (1969), Weiner (1980) postulated that the perception of an event gives

rise to a search for causation and a primary emotional appraisal based on responses such as fear or startle. Weiner (1980) suggested that the reasons for the observed behaviour are subject to a causal analysis, whereby attributions of the behaviour are placed within particular causal dimensions. Three dimensions were identified: locus of control, stability of the observed behaviour and controllability over the behaviour, with locus (internal or external to the person) and controllability (in control or not in control) thought to be the most important (Weiner, 1980). Causal attributions were thought to give rise to differential affects, i.e. pity and sympathy (towards the disabled person who fell) and disgust or anger (toward the drunk who fell). It was proposed that these affects result in either approach (helping) or avoidance (not helping) behaviours. In order to further test this emotion-action-motivation model of behaviour, Weiner (1980) conducted six experiments whereby the perception of control was manipulated (in control or not in control) and help giving was measured. Results confirmed that when participants saw the cause of the problem as internal to the person and controllable by the person, negative affect (anger and disgust) was experienced and avoidance behaviour ensued. The opposite was also true, with positive emotions (sympathy and empathy) related to external locus of control and low controllability attributions and in turn help giving behaviour.

5.2. Attribution and helping in professional health care staff

Despite theoretical and empirical support for Weiner's (1980) model, Sharrock, Day, Qazi and Brewin (1990) noted that the situations used to demonstrate helping were artificial and may not have any ecological validity in professional help giving. Sharrock et al (1990) also challenged the role of emotion in help giving responses, by proposing that optimism plays a more significant role. In their study, psychiatric

staff completed measures on optimism, helping behaviour, emotional responses and attributions, in relation to a 'target' client. 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 emotional reactions. In line with Weiner's theory, attributions of controllability were negatively associated with judgements of help giving, but also with ratings of staff optimism. Results also showed the stable attribution dimension was negatively related to levels of optimism, i.e. if client behaviour was considered stable over time, optimism was reduced. In explaining this result, Sharrock et al (1990) suggested that by attributing causality to factors internal and controllable to the patient, staff optimism was reduced as staff thought the patient had intended to behave in that way and that there was less scope for effective staff intervention. With regards to the finding that emotion did not contribute to variation in helping behaviours after optimism was taken into account, Sharrock et al (1990) proposed that as staff were faced with a high frequency of problem behaviours, they may have habituated to these, such that affective responses no longer effect levels of motivation to the extent presumed by Weiner (1980), who reported responses to infrequent events.

In a replication of Sharrock et al.'s (1990) study, Dagnan, Trower and Smith (1998) investigated staff responses to challenging behaviours in people with learning disabilities. They also found that optimism was predictive of help giving, but that optimism was mediated by negative emotion. More specifically, results indicated that if staff inferred the client was in control, or responsible for the behaviour, this resulted in negative emotion, lowering staff optimism and propensity to help. This finding is consistent with Weiner's (1980) model. However, this study did not

replicate the finding for positive emotion, as no such relationship was found between sympathy or pity and willingness to help.

In summary, there have been mixed results with regards to applying Weiner's model of helping behaviour in clinical settings, with some studies providing partial support (Stanley & Standen, 2000) and others suggesting it cannot fully explain staff responses (Bailey, Hare, Hatton & Limb 2006; Jones & Hastings, 2003). These studies have focused on attributions, emotions and helping in intellectual disability staff in relation to challenging behaviours. There has been significantly less interest in attributions, emotions and helping in relation to self-harming behaviour in people with mental health problems.

5.3. Attributions and self-harm

Mackay and Barrowclough (2005) explored help giving in A&E staff's care of clients presenting with deliberate self-harm. Using hypothetical scenarios, contextual factors describing a self-harm patient were manipulated, in order to influence attributions of control and stability. As predicted, the study found that where acts of deliberate self-harm were perceived as controllable, staff were more likely to express higher levels of irritation and less helping behaviour. In addition, beliefs that the self-harm was likely to be repeated (stability) were associated with less staff optimism for their own input and this was in turn associated with less willingness to help. Thus, the results were consistent with Weiner's proposal that causal attributions of controllability and stability mediate positive affect, which in turn, will be influential in determining the level of help offered. These results are difficult to generalise, as it appears to be the only study specifically addressing

attributions related to self-harm. However, to some extent one can draw upon evidence that is suggestive of attributional bias in help giving. Ramon, Bancroft and Skrimshire (1975) presented hospital staff with idealised case histories designed to elicit ratings for acceptability and understanding of self-harm, staff sympathy and readiness to help. Patients who appeared to take overdoses for 'depressive' reasons (to communicate despair, to escape or to die) evoked greater sympathy and willingness to help than those who took overdoses for 'manipulative' reasons (to influence others, to make others sorry). These results suggest that attributions of controllability and internality were influential in help giving behaviour, but were not formally measured.

More recently, attribution theory has been used to investigate the effects of a psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions of 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 examples of challenging behaviours (acting violently, setting off a fire alarm and failing to carry out a staff request). Nurses were then 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 clients with BPD were thought to be in more 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 clients with BPD and rated their personal experiences as more negative than clients with the other diagnostic labels.

Attribution theory has been largely associated with help-giving behaviours. However, it is likely that attributions and associated emotions may also affect other types of behaviours and responses to clients. The literature pertaining to expressed emotion if of particular relevance here.

5.4. Expressed emotion

Expressed emotion (EE) refers to a construct encompassing several key aspects of close interpersonal relationships. It reflects critical, hostile or emotionally over involved attitudes on the part of a carer towards a person with a disorder or impairment (Barrowclough & Hooley, 2003). Originally developed to assess the emotional climate of families with a relative with schizophrenia (for example Brewin, MacCarthy, Dida & Vaugh, 1991), EE is now a validated predictor of clinical outcome for this disorder as well as other psychiatric conditions (Butzlaff & Hooley, 1998) including BPD (Hooley & Hofman, 1999). The characteristic style of low EE relatives has been described as tolerant, non-intrusive and sensitive to the person's problem. In contrast, high EE relatives are inclined towards intolerance of the person's problem, being intrusive and using inappropriate and inflexible strategies in dealing with difficulties. Evidence is accumulating that high EE and low EE relatives may differ in their causal attributions of problem behaviours. In particular, several studies have shown that critical relatives are more likely than non-critical relatives to hold people responsible for their difficulties (See Barrowclough & Hooley, 2003 for a review).

5.5. Expressed emotion, attributions and self-harm

Barrowclough and Hooley (2003) conducted a review of the literature surrounding attributions and EE. They found that all of the published studies supported the hypothesis that criticism and hostility in relatives reflected their underlying beliefs that people could do more to control their symptoms and problems. Thus, relatives with high EE (criticism) consistently attribute more control than do relatives who are low in criticism. Another finding was that beliefs of hostile relatives are even more blaming of the person than are the beliefs of purely critical relatives. Hostility may manifest in either a generalisation of criticism to remarks about the person as a whole, or an explicit rejection of the person. Again this type of EE is positively correlated with internal attributions regarding the behaviour.

The effects of high EE on client outcome have been explored in relation to self-harm. Wedig and Nock (2007) found that parental criticism was positively associated with adolescent self-injurious thoughts and behaviours (SITB, suicide ideation, suicide plans, suicide attempts and non suicidal self-injury), i.e. increased criticism was associated with an increase in SITB. They referred to Barrowclough and Hooley's (2003) review and suggested that the link between attributions and expressed emotion may be especially relevant in the case of adolescents, whom parents may view as rebellious and acting intentionally. The findings also revealed that adolescent self-criticism does not mediate the relationship between parental criticism and SITB, but that both adolescent self-criticism and parental criticism were associated with engagement in self-harm behaviours. It should be noted that self-criticism was only associated with self harm behaviour when parental criticism was at a borderline or high level, and not for low parental criticism. This may be

indicative for a moderation of parental criticism, i.e. low levels of parental criticism protect the adolescent from the effect of self-criticism on self-harming behaviour.

Unfortunately there are no published studies, which investigate expressed emotion in staff working with self-harming clients. One may suggest that similar to the findings of Barrowclough and Hooley (2003), that staff would be no different to relatives, in that attributions of control would also be linked with high EE, and in turn that expressed emotion may affect the incidence of self-harm, as found by Wedig and Nock (2007). This is an area that requires further investigation.

6. Integrating findings and directing future research

Self-harming is a behaviour, which remains poorly understood and can evoke strong reactions from clinical staff (Huband & Tantam, 2000). The literature does suggest that attitudes are overall negative towards this client group (Patel, 1975; McAllister et al, 2002), which in turn can influence interactions with clients (Arnold, 1995) and care provision (Mackay & Barrowclough, 2005). Staff find it very stressful working with clients who self-harm (Jenkins & Elliott, 2004) which over time may lead to burnout ((Maslach & Jackson 1981). Cognitive-behavioural (Rayner, Allen & Johnson, 2005) and psychoanalytical (Menzies-Lyth, 1988) ideas have been applied to facilitate the understanding of staff-client relationships, and both approaches support the notion that staff emotional reactions may serve to increase self-harming behaviour. The expressed emotion literature further emphasises the need to explore staff emotional reactions to self-harm, as negative attitudes may translate into hostility and criticism, which has been associated with poor outcomes in people who self-harm (Wedig & Nock, 2007). Attribution theory (Weiner, 1980) provides another framework for understanding staff reactions to people whom self-harm,

especially with regards to care provision. However, within all of this literature there has been a consistent failure to measure emotional reactions to self-harm, despite an acknowledgment that the role of emotions in attributions is pivotal (Weiner, 1980). It is proposed that the links between emotional reactions to self-harm, attributions, attitudes and self-efficacy warrant further investigation, as they have some theoretical and empirical support in this area.

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Empirical Paper

Staff emotional reactions to self-harm

The role of self-efficacy, attitudes, attributions and empathy

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Abstract

Objectives

The aim of the study was to investigate emotional reactions to self-harm, and whether these are related to self-efficacy, attitudes, attributions and empathy.

Methods and design

The study utilised a within participants questionnaire methodology and participants comprised multidisciplinary mental health professionals, mainly drawn from acute service settings, such as inpatient units and Crisis Resolution Home Treatment Teams. The questionnaire contained a vignette, describing a self-harming client and measures of emotional reactions, self -efficacy, attributions, attitudes and empathy. Participants were asked to read the vignette and respond to each measure, with the self-harming client in mind.

Results

Staff reported both negative (depression/anger & fear/anxiety) and positive (confident/relaxed & cheerful/excited) emotional reactions. A series of Pearson Correlations, Multiple Regressions and MANOVA's were conducted to analyse the data. There was a negative association between universality and negative emotional reactions, i.e. if the behaviour was seen as less universal, or more unique to the client, staff experienced more depression/anger. In addition, self-attributions for control were also significant, i.e. staff that perceived themselves as more in control of the behaviour experienced more depression/anger and fear/anxiety. Self-efficacy was positively associated with staff feeling confident & relaxed. There were no associations between emotional reactions and empathy, although several items from

the attitudes measure subscale 'eligibility for tolerance and empathy' did significantly correlate. More specifically, staff who felt less uncomfortable if she cut again, felt more inclined to work with her if she cut again and agreed more that she had the same right to medical treatment, reported less depression/anger and fear/anxiety. Staff who felt less annoyed with her also reported fewer feelings of depression/anger.

Staff who possessed either a counselling or psychotherapy qualification reported less depression/anger, but not less fear/anxiety. Furthermore, possessing a counselling or psychotherapy qualification was a significant contributor in predicting depression/anger. Staff with more experience (10 years or more) in working/dealing with self-harm reported less fear/anxiety.

Conclusions

Despite some methodological problems, including a small sample, this study found several significant associations between emotional reactions (DV) and self-efficacy, attributions, attitudes and empathy (IV's). Furthermore, a combination of the IV's and demographic characteristics could help to predict emotional reactions to self-harm.

Introduction

Self-harm accounts for 150,000 presentations at Accident and Emergency (A&E) departments in the United Kingdom annually (Hawton et al 1997) placing considerable demand on services. For the purposes of this paper, the definition of self-harm incorporates several components. It is direct and socially unacceptable, (Walsh & Rosen, 1988), repetitive and results in minor or moderate harm (Favazza & Rosenthal, 1990), in the absence of suicidal intent (Walsh & Rosen, 1988) and is not related to general cognitive impairments (Favazza & Rosenthal, 1993). Self-harm represents a significant clinical management problem for services (Huband & Tantam, 2000; Loughery, Jackson, Molla & Wobbleton, 1997). However, it remains poorly understood, evoking strong reactions from clinicians (Huband & Tantam, 2000). The clinical management of clients who self-harm is further complicated by the capacity to evoke powerful emotions in staff and engender 'splitting' (polarisation of attitudes/responses to clients) in clinical services (Huband & Tantam, 2000; Simpson, 1980). Furthermore, emotional reactions to self-harm may affect the staff-client relationship, which in turn may potentially lead to further episodes of self-harm (Rayner, Allen & Johnson, 2005).

This paper aims to investigate emotional reactions to self-harm and then consider factors, which may help to explain these reactions.

Emotional reactions to self-harm

The majority of evidence suggesting that working with self-harming clients evokes strong emotional reactions, is largely anecdotal or emotional responses are addressed as a secondary or contributory factor in the research to date. Literature searches did

not reveal one study in which emotional reactions to self-harm have been addressed as the main, dependent variable of interest. However, a body of literature does suggest that emotions evoked by clients' self-harming behaviours pose a significant problem for staff.

Burnard, Fothergill and Coyle (2000) and Jenkins and Elliott (2004) highlighted that qualitatively, staff report that managing self-harm is stressful. Taking this a step further, Rayner, Allen and Johnson (2005) proposed that staff that feel angry or annoyed might withdraw from the client, leading to low mood and guilt and an increased desire to self-harm. Additionally, as clients who self-harm have difficulty regulating emotions (Suyemoto & Macdonald, 1995) and might also have a diagnosis of BPD, relationships with other people are likely to be difficult. Indeed, Nathan, Brown, Redhead, Holt and Hill (2007) concluded that the delivery of therapeutically effective milieu under pressure from patients with interpersonal dysfunction might be linked to burnout (Nathan et al., 2007).

Menzies-Lyth (1988) suggested that various defensive techniques are used to avoid experiencing anxiety and feelings of guilt, including splitting the nurse-patient relationship, depersonalisation from the individual, detachment and denial of feelings. In support, Wilstrand, Lindgren, Gilje and Olofsson (2007) have described the qualitative experience of working with clients who self-harm and found that 'being burdened with feelings', including fear, frustration and anger, was prominent. Furthermore, participants said they struggled with feelings and 'shut off' as a way of coping. The authors concluded that despite some awareness and reflection upon feelings, the nurses felt so overburdened with emotions that these interfered with their professional responsibility to care for the client.

These studies do give some valuable insight into the emotions staff may experience when dealing with self-harm, but do not provide any empirical evidence with regards to measuring these reactions. Within the learning disability literature the link between emotional reactions and challenging behaviour (including self-harm) has received considerable attention (Bromley & Emerson, 1995; Hastings & Remington, 1995). Mitchell and Hastings (1998) developed a tool to measure staff's emotional reactions. Factor analysis revealed two subscales: feelings of depression/anger and feelings of fear/anxiety. Due to the lack of a similar measure of potential positive affect, Jones and Hastings (2003) developed a rating scale to measure positive emotions. Feelings of confidence/relaxation and cheerfulness/excitement were extracted from a factor analysis. This scale represents the only reliable and valid measure of emotional reactions to date. Mitchell and Hastings (1998) recommended investigating the applicability of their scale in other contexts, e.g. staffing working with psychiatric populations.

Although empirically little is known about the emotions mental health staff experience, theoretically psychological models can help to understand these reactions, including attribution theory.

Attribution theory, emotional reactions and professional help giving

The basic tenant of attribution theory is that many behavioural sequences appear to be initiated following a causal ascription (attribution) for an event (Weiner, 1980). More specifically, attribution theory has been concerned with help giving behaviour. The cognitive attribution-emotion-action model of motivated behaviour (Weiner,

1980) describes a sequence in which attributions give rise to emotional reactions, which provide motivation for action. Weiner (1980) demonstrated that when a person is perceived as in control, the likelihood of offering help was significantly less than when the person was deemed not in control. He proposed that the emotions of disgust and anger mediate avoidance (not helping), whereas sympathy and pity lead to help giving.

In a clinical application, Sharrock, Day, Qazi and Brewin (1990) found that the tendency of staff to help across a range of situations was mediated by staff optimism and concluded that by attributing causality to factors internal and controllable to the client, staff optimism was reduced. In other words, when staff perceived the client's behaviour as intentional, they felt less opportunity for successful staff intervention (Sharrock et al, 1990). In a replication of Sharrock et al.'s (1990) study, Dagnan, Trower and Smith (1998) investigated staff responses to challenging behaviours in people with learning disabilities. In support of Weiner's (1980) model they found that optimism was predictive of help giving, but that optimism was mediated by negative emotion. Therefore, if staff inferred that the client was responsible for the behaviour, this resulted in negative emotion, lowering staff optimism and propensity to help.

More recently, attribution theory has been applied to clients diagnosed with BPD. Markham and Trower (2003) asked staff to imagine a client with a diagnosis of BPD, schizophrenia or depression and found that clients with a diagnosis of BPD attracted more negative responses from staff. Causes of clients' negative behaviours were rated as more stable and controllable. This suggests that attributions of control can influence staff reactions to clients with BPD, and therefore are important in understanding reactions to clients who self-harm.

Mackay and Barrowclough (2005) explored help giving in A&E staff's care of clients presenting with deliberate self-harm and as predicted, the study found that where acts of deliberate self-harm were perceived as controllable, staff expressed higher levels of irritation and less helping behaviour. Stable perceptions were associated with less staff optimism for their own input and this was in turn associated with less willingness to help. Thus, the results were consistent with Weiner's proposal that causal attributions of controllability and stability mediate positive affect and optimism, which in turn, will be influential in determining the level of help offered.

Most of the literature regarding attributions has centred on how we perceive other peoples roles in the cause and course of their behaviour. Geller and Jonhston (1995) were interested in the causal attributions mothers made for their child's behaviour (non-compliance) and how they perceived both their child's role and their own role in the cause of the child's behaviour, as internal and controllable. Geller and Johnston (1995) found that self and child causal attributions made significant contributions to affective and behavioural responses to the behaviour and proposed that the association between mothers' personal controllability attributions and the magnitude of their responses may reflect their beliefs about their ability to impact child misbehaviours. That is, attributions of personal controllability may be associated with the belief that their intervention might stop the child's behaviour and/or prevent it from recurring.

The research discussed so far has supported the association between attributions (controllable, stable and internal) and emotional reactions. Another factor, which may also help to explain emotional reactions to self-harm, is attitudes.

Staff attitudes to self-harm

The literature consistently reveals that staff attitudes to self-harm are negative. This has been shown in accident and emergency staff (Friedman et al, 2006; McAllister et al, 2002; Patel, 1975;) and mental health staff (Gough and Hawkins, 2000; Patterson, Whittington & Bogg, 2007). Huband and Tantam (2000) identified five factors that mediated mental health staff attitudes to a case of a self-harming woman described in a vignette, namely 1) 'in control of her actions'; 2) 'tendency to be undemanding versus difficult'; 3) 'eligibility for tolerance and empathy'; 4) 'difficulty understanding her actions'; and 5) 'therapeutic confidence'. Huband and Tantam (2000) also explored how the respondents might self-polarise on the basis of the attitudes towards the woman described and used a cluster analysis to split the group. The first cluster (soft group) was characterised by perceptions that she was less in control of her actions, that she was more eligible for tolerance and empathy, and that staff had less difficulty understanding her behaviour, as compared with the second cluster (firmer group). Huband and Tantam's (2000) study also showed that staff training could affect attitudes.

The effect of training and self-efficacy on attitudes and emotional responses

Crawford, Geraghty, Street and Simonoff (2003) found that knowledge of self-harm alone was not sufficient to influence attitudes. In support, Turnbull and Chalder (1997) provided a brief (4 hours over 4 weeks) self-harm training package for nurses

and despite an increase in knowledge, attitudes remained unchanged. Huband and Tantam (2000) also found that staff attitudes were not affected by training that related to the specific management of self-harm. They did however report that staff with qualifications in counselling or psychotherapy differed significantly in their attitudes, i.e. possessing a qualification was strongly associated with the perception that the woman had less control over her actions, and a greater understanding of her actions from staff perspective. This result had not previously been published in relation to working with self-harm (Huband & Tantam, 2000). Huband and Tantam (2000) offered two explanations of this finding. Firstly, that staff member's ability to contain their anxiety in response to client self-harm is enhanced by psychotherapy training. They suggested that one defence against anxiety is for the clinician to attribute responsibility and blame away from themselves and onto the client and that counselling or psychotherapy training 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. Their second line of thought suggested that staff who obtained a counselling or psychotherapy qualification constituted a subgroup, who even prior to training may have been less likely to attribute control to self-harming clients (Huband & Tantam, 2000). They therefore suggested that in-depth counselling or psychotherapy training can influence causal attributions, which in turn may be linked to attitudes and emotional reactions to self-harm, but that specific short term training in self-harm alone was not sufficient to have such an impact.

However, longer term training in self-harm may be effective. Patterson et al (2007) found that a 15 -week training course in self-harm resulted in significant attitudinal change, with participants having a 20% reduction in antipathy scores. There were

also changes in staff perceptions of self-harm, with a reduction in the view that it was done intentionally, or to manipulate staff. These results could be interpreted within a causal attribution framework, whereby the client was seen as less in control of their actions.

One possible explanation for attitude changes following training is that staff developed a sense of self-efficacy. Furthermore, it would seem plausible that self-efficacy is related to emotional reactions. This would be consistent with the 'stress and coping' paradigm model of coping (Lazarus & Folkman, 1984), which suggests that occupational stress occurs when a member of staff perceives a discrepancy between an event at work and their capability to resolve the situation. Tiemey, Quinlan and Hastings (2007) assessed the impact of a 3-day training package (understanding challenging behaviour), and although perceived self-efficacy increased significantly, there were no significant changes in emotional reactions to challenging behaviours or causal beliefs. There were however, non-significant trends for negative emotions to reduce after training. One possible explanation provided by the authors for these results, is that changes in emotional reactions and causal beliefs did initially occur, but were not maintained when they re-tested after three months. Support comes from Hastings and Brown (2002) who proposed that self-efficacy could help to predict negative emotional reactions and found that staff with greater feelings of self-efficacy in dealing with challenging behaviours reported fewer negative emotional reactions (both depression/anger and fear/anxiety). However, as they did not re-test participants, it cannot be concluded that effects were maintained.

Another factor that may help to explain the effects of training on staff reactions (attitudes, causal beliefs and emotional reactions) is empathy. Indeed, Huband and Tantam (2000) found that those with a 'soft attitude' were characterised as having more empathy. Ewers, Bradshaw and Ewers (2001) evaluated the effects of training on the knowledge, attitudes and levels of clinical burnout in a group of forensic mental health nurses and reported that staff showed significant improvements in knowledge and attitudes. They noted that providing nurses with a better understanding helped them to be more positive in their attitudes and experience less stress. It seems that they are also referring to the concept of staff empathy, of trying to place themselves in the client's shoes and understand their experience.

Summary

In summary, the current literature base has proposed several independent associations between emotional reactions, attitudes, attributions, self-efficacy, and more tentatively empathy.

Identifying variables related to staff emotional reactions is important for clinicians working with self-harming clients. This knowledge would help to facilitate staff support and provide guidance concerning the development of staff training.

Following the above the current research aims to address the following research questions:

Research Questions

1. To what extent are attributions associated with specific staff emotional reactions to self-harm? It is hypothesized that perceptions of controllability, stability and internality will be positively associated with negative emotional reactions

2. To what extent is self-efficacy associated with specific emotional reactions? It is hypothesized that self-efficacy will be negatively associated with negative emotional reactions

3. To what extent is empathy associated with specific emotional reactions to self-harm? It is hypothesized that empathy will be negatively associated with negative emotional reactions

4. To what extent is the attitudes profile associated with emotional reactions to self-harm? It is hypothesized that those with 'softer' attitudes (Huband & Tantam, 2000) will experience fewer negative emotional reactions.

5. Are emotional reactions associated with demographic characteristics of the sample, i.e. to what extent do profession, level of training and other demographic characteristics contribute to differences in emotional reactions to self-harm? It is hypothesized that those with a counselling or psychotherapy qualification will have lower negative emotional reaction scores than others.

6. To what extent are the above variables independently and in combination able to explain variance in emotional reactions to self-harm?

Method

Design

A cross sectional survey design was used to investigate emotional reactions, attributions, perceived self-efficacy, empathy and attitudes towards self-harm.

Ethical approval

Ethical approval was received from the University of Southampton, School of Psychology Ethics Committee (Appendix C). As each participating NHS site provides ongoing self-harm training, and this study may be part of the evaluation of previous training courses and provide guidance with regards to new teaching approaches, the National Research Ethics Service (NRES) advised that the study was best described as service evaluation, so did not require their ethical approval (Appendix D). However, approval was required from the Trust (Hampshire Partnership) Research and Development Department to proceed with the study (Appendix E), which was sought and received. In addition the research proposal was presented to and approved by a Clinical Governance Board of Hampshire Partnership NHS Trust.

Participants

Staff members from ten Hampshire Partnership NHS Trust teams were invited to take part. Health settings were selected to reflect typical care pathways for self-harming clients and to target those staff providing a significant proportion of care for this client population. These included Psychological Medicine (a team who receives referrals from A&E, often following an episode of self-harm or suicide attempt), three acute adult inpatient psychiatric units, two psychiatric intensive care units

(intensive, secure inpatient wards), two Crisis Resolution/Home Treatment Teams (providing home-based treatment for acute psychiatric patients) and two mental health rehabilitation units. All clinical staff groups were invited to partake, including nursing, medical, occupational therapy, clinical psychology, social work and all other allied clinical disciplines, irrespective of training or qualifications.

In total 193 staff members were approached to take part. Given the main analysis would consist of correlations and multiple regressions ($\alpha = .05$) it was calculated that assuming a medium effect size and with 4 independent variables a sample of N=84 was required (Cohen, 1992). However, after five months (following several reminders, via e-mail to each ward/team manager, and individually approaching some staff) a total of only 50 questionnaires were returned (response rate of 26%).

Procedure

The aims of the research were presented to each of the ten teams, first to management then the staff teams themselves. Two local Clinical Psychologists supported the overall recruitment process and facilitated initial meetings with staff at their respective units. A questionnaire pack was distributed to each staff member, with a prepaid envelope for return. Each questionnaire pack contained a participant information sheet reiterating the aims of the study (Appendix F), a consent form (Appendix G), and a brief demographics survey, including age, gender, profession, qualifications, training and experience of self-harm (Appendix H).

The questionnaire pack further included a vignette (Appendix I), five questionnaires (Appendix J) and a debriefing statement (Appendix K). Participants were instructed to read the case vignette describing a self-harming woman and to complete the measures with this case in mind. Participants were required to sign the consent form,

which was separated from the data upon return and codes assigned to each participant to ensure confidentiality and anonymity.

Materials

Vignette

The vignette was replicated 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-harming client. Participants were asked to read this vignette then in each questionnaire instructed to think back to the story and respond to each questionnaire item with 'Miss C' is mind.

Measures

Emotional Reactions

The Emotional Reactions to Challenging Behaviour Scale (Mitchell & Hastings, 1998) was developed to assess negative staff emotional responses to challenging behaviour in people with a learning disability, comprising Depression/Anger and Fear/anxiety subscales. Two positive subscales, Cheerful/Excited and Confident/Relaxed have since been added to the measure (Jones & Hastings, 2003). In total, 23 items measure emotional reactions on a 4-point Likert scale. Internal consistency is satisfactory, with Chronbach alpha's ranging from α=. 69 to .86. It has good face and construct validity. Permission was obtained to use and amend the measure for this population (R. Hastings, personal communication, 16.11.06)

Empathy

The Jefferson Scale of Physician Empathy (JSPE) Hojat et al, 2001; is an instrument developed specifically to measure empathy in health care providers in patient care

situations. Factor analysis has revealed four separate constructs, with 'Physicians view from the patients' perspective' the most dominant. The remaining three are: 'Understanding patients' experiences, feelings and clues', 'Ignoring emotions in patient care' and 'Thinking like the patient'. For the purposes of this study, only items from the first factor, 'Physicians view from the patients' perspective' were used, as "perspective taking" has been described as the core ingredient of empathy (Davis, 1994). This decision was also based on the fact that some items relating to empathy are present in the attitudes questionnaire (see below), hence possibly affecting the co-linearity between measures. It was necessary to slightly change the wording of each item to make it relevant to all clinical staff, not just doctors, for example, item 4. 'Empathy is a therapeutic skill without which my success as a physician would be limited' was changed to 'Empathy is a therapeutic skill without which my success would be limited". Good internal consistency of the total scale has been reported: Chronbach alpha $\alpha = .87$. (Hojat et al, 2001). It also has good content and concurrent validity.

Perceived Self-efficacy

The Difficult Behaviour Self-Efficacy Scale (Hastings & Brown, 2002) was designed as a measure of staff self-efficacy relating to challenging behaviour in people with learning disabilities. The five items measure staff perceived self-efficacy according to feelings of confidence, control, satisfaction, the perception that they have a positive impact upon the behaviour and how difficult they find working with the behaviour. Each of the items is measured on a 7-point likert scale. The scale was found to have excellent internal consistency (Chronbach's alpha $\alpha = .94$, Hastings & Brown, 2002). There is no validity data available.

Attributions

An attributional style measure (Cornah, 2001; Geller & Johnstone, 1995) was adapted for use in this study. The first five items reflect the attributional dimensions outlined by Weiner (1986); Internal/External, Controllable/Uncontrollable, Stable/Unstable, Universal/Personal and Global/Specific. These five items measure staff member's attributions concerning the person who displays the self-harming behaviour. Following Cornah (2001), two additional items were included to measure staff attributions concerning themselves, i.e. the extent to which staff member perceives the clients behaviour to be attributable to themselves as measured on the dimensions internal/external and controllable/uncontrollable. The seven items are presented on a five point likert scale and summed to provide a total score. No reliability data has yet been published in relation to this measure, but it has good content and concurrent validity.

Attitudes to Self-Harm

A questionnaire developed by Huband and Tantam (2000) was used to evaluate attitudes to a self-harming client. This measure is based on a survey conducted by the authors (Huband & Tantam, 1999), whereby 213 participants considered a single case vignette (Favazza & Conterio, 1989; Simpson, 1976) and then responded to 23 questions derived from the authors' experience of comments frequently expressed by clinical staff, having firm opinions about self-harming patients and their behaviour. Five key factors were identified, the first factor (F1) '*ability to be in control of her actions*', relates to the perception of client's capacity for consciously determining and moderating their behaviour, including self-harming behaviour; the second factor (F2) '*tendency to be undemanding versus difficult*', reflects how troublesome the

client is likely to be in her interactions with staff. Factor 3 (F3) '*eligibility for tolerance and empathy*', relates to the client's right to receive patience and warmth as well as a preference for a philosophy of care, which includes these qualities. The fourth factor (F4) '*difficulty in understanding clients* actions' reflects empathy with the client. The fifth factor (F5) lacks conceptual clarity (Huband & Tantam 2000), but is associated with the staff's perception of their *'therapeutic confidence'*.

The original questionnaire presented items as differential pairs involving two extreme opinions, opposite in nature and separated by a line 50mm in length. The respondents were asked to mark this line to show where their opinions lay and responses scored from -4 to +4, using an overlay to divide the line in to 9 equal segments. This was adapted, so that each item was measured on a 5-point likert scale, in line with the other measures in the study. Answers were then recoded to reflect original scoring and facilitate direct comparison with Huband and Tantam (2000). Huband and Tantam (2000) reported results from a cluster analysis whereby staff scores polarized into two very distinct groups, which they labelled 'soft' and 'firm' attitude groups. The 'soft' group was characterized by beliefs that the client has less control over her actions, was less demanding and was more eligible for empathy and tolerance. No psychometric data (reliability/validity) has yet been published in relation to this measure.

Data analysis

Preliminary analysis of the data (normally distributed, homogeneity of variance and interval level data) indicated that the use of parametric tests was appropriate. A series of Pearson Correlations were undertaken to explore associations between emotional reactions and other variables of interest. Hierarchical multiple regressions

were conducted to explain variance in emotional reactions and a series of Multivariate Analysis of Variance (MANOVA) were used to explore group differences.

Results

Over a period of five months, fifty mental health staff completed and returned questionnaires. Descriptive statistics for the study variables are presented in Table 1. Overall, 92% of all staff had worked with at least six women on the issues of self-harming, with 55% having worked with more than fifteen. Despite only 60% of staff having received specific training in self-harm, 76% considered themselves to be moderately or considerably experienced in this area.

Table 1. *Descriptive statistics – demographic variables*

Characteristic	N	%
Gender		
Male	13	26
Female	36	72
Missing	1	2
Age		
18-25 years	4	8
26-35	10	20
36-45	16	32
46+	20	40
Profession		
Psychiatry	1	2
Psychiatric nursing	31	62
Occupational therapy	4	8
Clinical psychology	6	12
Social work	4	8
Other	4	8
Team		
Acute assessment ward	9	18
Psychiatric intensive are unit (PICU)	12	24
Crisis Resolution Home Treatment Team	11	22
Rehabilitation	9	18
Psychology	6	12
Psychological medicine	3	6
Missing	1	2
Time worked in health care setting		
< 2 years	5	10
2-5 years	6	12
6-10 years	14	28
11- 20 years	14	28
>20 years	10	20
Missing	1	2
Time worked with clients who self-harm		
<2 years	6	12
2-5 years	10	20
6-10 years	18	36
11-20 years	10	20
>20 years	4	8
Missing	2	4
Number of clients worked with who self-harm		
None	3	6
1-5	9	18
6-10	7	14
11-15	3	6
>15	28	54
Missing	1	2

Table 1 continued. *Descriptive statistics – demographic variables*

Characteristic	N	%
Perceived experience in dealing with self-harm		
Relatively inexperienced	12	24
Moderately experienced	23	46
Considerably experienced	15	30
Specific training in self-harm		
Yes	30	60
No	19	38
Missing	1	2
Counselling qualifications		
Certificate level	3	6
Diploma level	5	10
BACP Accredited	0	0
Other accreditation	2	4
None	40	80
Psychotherapy qualifications		
Post-certificate level	0	0
BACP Accreditation	0	0
UKCP Accreditation	2	4
Other Accreditation	0	0
None	48	96
Counselling or psychotherapy qualification		
Yes	11	22
No	39	78

Table 2. *Descriptive statistics: study variables*

	Mean	SD
Emotional reactions		
Depression/anger	5.08	3.05
Fear/anxiety	2.72	2.48
Confident/relaxed	5.10	2.96
Cheerful/excited	.96	1.84
Empathy	53.70	10.48
Self-efficacy	22.42	4.27
Attitudes		
Ability to be in control of her actions	1.64	5.58
Undemanding versus difficult	2.48	3.19
Eligibility for tolerance and empathy	9.98	2.48
Difficulty understanding her actions	.36	2.09
Therapeutic confidence	4.80	3.05

	Mean	SD
Attribution client		
Internality	3.14	1.03
Controllability	3.14	1.03
Stability	3.78	.65
Universality	3.52	1.11
Globality	3.60	.91
Attribution self		
Internality	1.96	.83
Controllability	2.06	.97

Research Question 1

The first question regarded to what extent attributions are associated with specific emotional reactions. It was predicted that attributions to client would be associated with negative emotional reactions, specifically that if a member of staff perceived the client to have control over her behaviour (controllability), that the behaviour specifically had something to do with the client (internality) and that the cause of the behaviour would be present again (stability), the staff member would be more likely to experience negative emotions in reaction to the clients' self-harming behaviour. Two Pearson correlations were computed to investigate the relationship between emotional reactions and attributions to client and attributions to self respectively. See Table 3.

Contrary to prediction, the results for attribution to client revealed only one significant association, i.e. depression/anger was negatively associated with universality. Due to the inflated probability of conducting multiple tests, a Bonferroni correction was computed. 20 comparisons were computed in the matrix (4 emotional reactions x 5 client attributions); therefore the new significance level was set as $p<.0025$, meaning this result was not significant.

Interestingly, the results considering attributions to self revealed significant associations for controllability and both negative emotions, i.e. the more control over

the clients behaviour staff attributed to him/herself themselves, the more the self harming behaviour evoked depression/anger and fear/anxiety. A new significance level of p<. 0063 was set, as 8 comparisons were made (4 emotional reactions x 2 attributions to self). Therefore the association between self-controllability and depression/anger did not reach significance. However, self-controllability and fear/anxiety was nearly significant at the p<. 001 level, so one may conclude that this would be significant after the Bonferroni correction.

Table 3. *Correlations between emotional reactions and attributions, self-efficacy and empathy*

	Emotional reactions			
	Depression Anger	Fear anxiety	Confident relaxed	Cheerful excited
Attribution client				
Controllability	.04	-.16	.22	.11
Stability	-.00	-.08	-.24	.08
Internality	-.03	.04	-.24	-.16
Globality	-.04	-.23	.21	.07
Universality	-.36*	-.15	-.17	-.25
Attribution self				
Controllability	.36*	.44**	-.10	.22
Internality	.15	.07	.06	.25
Self-efficacy	.00	-.13	.53**	.13
Empathy	.11	.07	.12	.15

[8] p<.05; ** p<.01, *** p<.001

Research question 2

The second question considered to what extent self-efficacy is associated with specific emotional reactions. It was expected that there would be a negative association between self-efficacy and negative emotions, i.e. the more self-efficacious a staff member feels in regards to self-harm the fewer negative emotions self-harming behaviour would evoke. The relationship between self-efficacy and emotional reactions was investigated using Pearson correlation. See Table 3.

The results from the correlation analysis revealed no significant relationship between self-efficacy and negative emotional reactions to self-harm. However, a positive association between one positive reaction, i.e. feelings of confidence and relaxation and self-efficacy was found. In other words, if staff perceived themselves as effective in dealing with self-harm, they were more likely to feel confident and relaxed in response to the client's self-harming. This remained significant after Bonferroni correction; (4 comparisons were computed in the matrix, 4 emotional reactions x self-efficacy) thus the new significance level was set as $p<.0125$.

Research question 3

The third aim of the study was to investigate to what extent empathy is associated with specific emotional reactions to self-harm. It was expected that empathy would be negatively correlated with negative emotional reactions, i.e. the more empathic a staff member feels about the self-harming client, fewer negative emotions would be evoked. The relationship between empathy and emotional reactions was investigated using Pearson correlation (see Table 3). There were no significant associations between emotional reactions and empathy.

Research question 4

Research question 4 regarded the association between the attitudes profile and emotional reactions to self-harm. It was hypothesized that those with 'softer' attitudes (Huband & Tantam, 2000) would experience fewer negative emotional reactions. In accordance with Huband and Tantam (200) it was planned to divide the sample into 'soft' and 'firm' groups, whereby the soft group would be characterised by staff perceptions that the self-harming client is less in control of her actions, more eligible for tolerance and empathy and that staff would have less difficulty understanding her actions, compared to the firm group. As there are no published reliability data for the attitudes measure (Huband & Tantam, 2000), the internal consistency of the measure was checked. In the current study, the Cronbach alpha coefficients for all five subscales indicated that the subscales items are not sufficiently related, i.e. Chronbach alpha reliability coefficients were .54, .35, and .61 for the subscales 'ability to be in control of her actions', 'tendency to be undemanding vs. difficult' and 'eligibility for tolerance and empathy', respectively. For the subscales 'difficulty understanding her actions' and 'therapeutic confidence' negative alpha values were found, indicating reliability assumptions were violated. Additionally, there were significant differences between the mean scores from the present study and those reported by Huband and Tantam (2000), See Table 4.

Table 4. *Mean scores for attitude items from the present study and means reported by Huband and Tantam (2000)*

Item	Mean score reported by Huband and Tantam (2000)	Mean scores from present study
1	-3.36	2.72
2	1.66	-.92
3	1.03	-.36
4	-3.02	2.8
5	1.66	-1.44
6	1.20	-.36
7	1.97	.00
8	-1.20	1.16
9	-1.43	.40
10	0.51	-.76
11	0.99	-1.6
12	-1.99	2.4
13	-1.53	-2.08
14	2.32	-2.84
15	-2.39	1.48
16	-0.35	1.20
17	-2.03	1.0
18	1.27	-.48
19	-2.50	2.08
20	-0.97	1.32
21	-2.00	1.92
22	-0.50	.56
23	-0.81	.040

As the scoring pattern in the current sample deviates substantially from the original data set, it was not deemed appropriate to apply the same subscale structure or scoring profile, or split the sample into 'soft' and 'firm' group based on this structure. In addition, as the current sample was too small to conduct a (confirmatory) factor analysis, it was decided to analyse the data set on an item level instead.

In order to explore associations between emotional reactions to self-harm and attitudes, a Pearson correlation was conducted (see Table 5).

Depression/anger

There were six significant associations between depression/anger emotional reactions and items from the attitudes measure. There were four positive associations between depression/anger and specific attitudes, i.e. with 'feel uncomfortable if she cuts again', 'makes me feel annoyed', 'would not continue to work with her if cuts again' and 'a firm authoritative approach will reduce self-wounding'. More specifically, participants who felt more uncomfortable if the client cut again, felt more annoyed with her, felt less inclined to continue to work with her if she cut again and agreed more that a firm authoritative approach would reduce self-wounding felt more depressed and angry. In addition there were two negative associations between depression/anger and attitudes, i.e. 'same rights to medical treatment' and 'impossible to manage self-wounding without history' respectively. More specifically, those who agreed more that she had equal rights to medical treatment and more that it was impossible to manage her self-wounding without a history, were less likely to feel depressed and angry. However, after Bonferroni correction, (23 comparisons were computed in the matrix, 23 attitude items x 1 emotional reaction: depression/anger) and a new significance level of $p<.002$, only 'same rights to medical treatment' remained significantly (negatively) associated with depression/anger and continue to work with her if she cuts again significantly (positively) associated with depression/anger. The remaining correlations did not reach significance.

Table 5. *Correlations between emotional reactions and attitude items*

	Emotional reactions			
Attitude item	d/a	f/a	c/r	c/e
1	-.084	-.274	.158	.129
2	.33*	.57***	-.38**	.23
3	-.07	.04	-.22	.08
4	-.49***	-.28*	.219	-.09
5	.41**	.19	-.36**	-.15
6	-.15	.09	-.17	-.00
7	-.05	-.15	.25	.23
8	.11	.27	-.16	-.02
9	.06	-.20	.14	.00
10	.20	.06	-.06	-.03
11	-.04	.08	-.00	-.11
12	-.19	-.13	.16	.18
13	.28	.35*	-.11	.03
14	.51***	.34*	-.22	.07
15	.05	.08	-.00	-.07
16	-.15	.16	-.10	.17
17	-.00	-.08	-.05	.22
18	.41**	.35*	-.10	.26
19	-.11	-.02	-.01	.05
20	.10	.00	-.03	.09
21	-.23	-.11	.06	.15
22	-.30*	-.14	-.13	-.17
23	.08	-.04	-.06	.11

* p<. 05; ** p<. 01; *** p<.001

Note. d/a: depression/anger, f/a: fear/anxiety, c/r: confident relaxed, c/e: cheerful/excited

Fear/anxiety

There were five significant associations between fear/anxiety emotional reactions and the attitudes measure items. There were positive associations with 'feel

uncomfortable if she cuts again',' I don't have a theoretical understanding of why she cuts', 'would not continue to work with her if she cuts again' and 'a firm authoritative approach will reduce her self-wounding' and a negative association with 'same rights to medical treatment'. Therefore, staff who felt more uncomfortable if she cut again, had less theoretical understanding of why she cuts, felt more that they would not work with her again if she cut and agreed more that a firm authoritative approach would reduce her self-wounding and agreed less that she had the same right to medical treatment felt more fear and anxiety. However, after Bonferroni correction, (23 comparisons were computed in the matrix, 23 attitude items x 1 emotional reaction: fear/anxiety) and a new significance level of $p<.002$, only 'feel uncomfortable if she cuts again' remained significantly (positively) associated with fear/anxiety. The remaining correlations did not reach significance.

Confident/relaxed

There were two negative significant associations between confident/relaxed emotional reactions and items from the attitudes measure; 'feel uncomfortable if she cuts again' and 'makes me feel annoyed', i.e. if staff agreed more that they would feel uncomfortable if she cuts again and more that she made them feel annoyed, they felt less confident and relaxed. Neither reached significance after Bonferroni correction, (23 comparisons were computed in the matrix, 23 attitude items x 1 emotional reaction: confident/relaxed) and a new significance level of $p<.002$ applied.

Cheerful/excited

There were no significant associations between cheerful/excited emotional reactions and items from the attitudes measure.

It is noteworthy that only seven of the 23 items from the attitudes measure were in any way associated with emotional reactions to self-harm, and that five of these items were associated with at least two emotional reactions. Interestingly, five of the seven items were included in the subscale ' eligibility for tolerance and empathy' (Huband and Tantam, 2000), and one each from the subscales 'difficulty understanding her actions' and 'therapeutic confidence'.

Research question 5

The fifth research question considered the association between demographic variables and emotional reactions, i.e. to what extent do profession, level of training and other demographic characteristics contribute to differences in emotional reactions to self-harm? It was hypothesized that those with a counselling or psychotherapy qualification would have lower negative emotional reaction scores. To explore relationships between emotional reactions and demographic characteristics, those demographics coded as interval data were entered into a Pearson Correlation analysis (see Table 6).

Table 6. *Correlations between emotional reactions and demographic characteristics*

	Emotional reactions			
Demographic	d/a	f/a	c/r	c/e
Age	-.23	-.22	.15	-.07
Time worked in health care	-.46*	-.37**	-.07	-.19
Time worked with clients who self –harm	-.14	-.44**	.11	-.25
Number of people worked with who self-harm	-.06	-.57***	.47***	-.19

* p<. 05; ** p<. 01, *** p<. 001

As is shown in Table 6, 'Time worked in a health care setting' was negatively associated with both depression/anger and fear/anxiety scores, i.e. more experienced staff reported less depression/anger and less fear/anxiety in response to the clients' self harming behaviour. Similarly, the number of self-harming clients staff had worked with was negatively associated with fear/anxiety, i.e. staff who had worked with more self-harming clients showed less fear and anxiety in response to the self-harming behaviour. Interestingly, the number of clients a staff member had worked with was not only negatively associated with fear and anxiety but also positively associated with the positive emotional reaction confidence/relaxed. This means that staff members that had worked with more people who self-harmed not only responded in a less fearful/anxious way to the self- harming behaviour but also felt more confident/relaxed in how to deal with it. However, after Bonferroni correction, (20 comparisons were computed in the matrix, 5 demographic items x 4 emotional reactions) and a new significance level of p<. 0025, only 'number of people worked with who self-harm' remained significantly (negatively) associated with fear/anxiety and positively associated with confident/relaxed. The remaining correlations did not reach significance.

To explore relationships between emotional reactions and categorical demographic characteristics, (Multivariate) analyses of variance (MANOVA) were conducted (Table 7).

These were computed to explore group differences in negative emotional reactions (depression/anger and fear anxiety). As scores for positive emotional reactions were not correlated, a MANOVA was only conducted for negative reactions. Table 7 provides the MANOVA results per demographic variable.

Table 7. *MANOVA Summary for relationships between demographic characteristics (IV) and negative emotional reactions (DVs depression/anger and fear/anxiety)*

	λ	*df*	*F*	*p*
Profession	.93	10, 86	.34	ns
Possessing a professional qualification	.79	2, 46	6.14	<.01
Possessing a counselling or psychotherapy qualification.	.84	2, 47	4.44	<.05
Time worked in health care	.73	4, 90	3.82	<.01
Time worked with self-harming clients	.81	4, 88	2.48	.05
Number of people worked with who self-harm	.60	4, 92	6.80	<.001
Perceived experience in dealing with self-harm	.72	4, 92	4.20	<.01

All profession related variables were associated with negative emotional reactions to self-harm, except professional group. There was a statistically significant difference between qualified and unqualified staff on the dependent variable. An inspection of the mean scores indicated that qualified staff reported lower levels of

depression/anger (M=4.61) and fear/anxiety (M=2.11) than unqualified staff (M=6.82) and (M=4.82), for depression /anger and fear/anxiety, respectively. Similarly, there was a significant difference between staff with and without a counselling or psychotherapy qualification. Univariate results revealed that this difference was caused by significant differences between groups on the depression/anger subscale only (F (1,48)=4.95, p<. 05), i.e. staff possessing a counselling or psychotherapy qualification reported higher levels of depression /anger (M=6.82, SD=3.74) compared to those without such qualifications for depression/anger (M=4.59, SD=2.68). There were no significant differences for fear/anxiety. It must be noted that after Bonferroni correction was applied and the new significance level set at p<. 005 none of these results reached significance.

With regards to experience, there were significant differences between groups, i.e. in general, staff with more experience reported fewer negative emotional reactions than those with little experience. More specifically, there were statistically significant differences between time worked in health care. Univariate results revealed that there were significant differences for both the depression /anger and fear/anxiety subscales (F (2,46)=7.16, p<. 01 and (F 92,46)=4.85, p<. 05, respectively). Post hoc analyses (Scheffe) showed that staff with up to 5 years experience reported significantly more depression/anger compared to staff with 6 or more years experience, whilst there were no significant differences between the 6-10 and more than 10 years groups. For fear/anxiety, Scheffe's test revealed that staff with up to 5 years experience reported significantly more fear/anxiety (p<. 05) compared to staff with more than 10 years experience, whilst there were no significant differences between the 6-10 year and other groups. Similarly, there were statistically

significant differences between levels of experience in working with clients who self-harm, though this was only a marginal effect (p =. 05). Univariate results showed that this was caused by significant differences between groups on the fear/anxiety subscale only (F (2,45)=4.35, p<. 05). Post hoc analyses (Scheffe) revealed that staff with up to 5 years experience in dealing with people whose self-harm reported significantly more fear/anxiety (p<. 05) than staff with more than 10 years experience. Again, staff in the 6-10 year group did not differ from either group. There were also statistically significant differences between groups with different levels of experience as measured by the number of self-harming clients they have worked with. Univariate results showed that this differences was only apparent on the fear/anxiety subscale (F (2,47)=10.32, p<. 001). Post hoc analysis revealed that staff who had worked with up to 5 self-harming clients reported more fear/anxiety than those who had worked with more than 10 self-harming clients. The staff group that had worked with 6-10 clients did not differ significantly from either group. Lastly, there were statistically significant differences between the levels of perceived experience in dealing with self-harm. Again univariate results showed that this result was carried only by differences in scores on the fear/anxiety subscale (F (2,47)=5.34, p<. 01). A post-hoc analysis revealed that staff who perceived themselves as relatively inexperienced reported significantly more fear/anxiety than staff who perceived themselves as considerably experienced. Staff that perceived themselves as moderately experienced did not differ from either group.

It must be noted that post-hoc Bonferroni correction was applied (p<. 005) and only one result remained significant: number of self-harming clients worked with. Therefore, the results tentatively support the hypothesis that training and experience can reduce the level of negative emotional reactions to self-harm, particularly

fear/anxiety. This was most evident for those staff with more than 10 years experience, both in general health care and in working with clients who self-harm, and for those who had worked with more than 10 self-harming clients.

Research question 6

The final research question concerned the extent to which the independent variables independently and in combination are able to explain variance in emotional reactions to self-harm. To investigate these relationships, a series of multiple regressions were conducted, i.e. for each emotional reaction the most salient predictors were entered in the regression equation. To select the predictor variables, firstly the literature was considered, and as regression analysis is normally applied to datasets in which IVs are correlated with one another and the DV in varying degrees (Tabachnick and Fidell, 2001), only those variables that were significantly associated with the emotional reactions were considered (see results from the analyses conducted to answer research question 1-5).

Predicting emotional reactions

Based on the correlation matrices, those variables significantly associated with emotional reactions to self-harm, were entered into three hierarchical regression analyses to predict variance in emotional reactions (depression/anger, fear/anxiety and confident/relaxed). There were no significant correlations with the emotional reaction cheerful/excited, so this was omitted from analysis. Step 1: Qualifications (possession of a professional qualification and counselling or psychotherapy qualification), Step 2: Experience (time worked in health care, time worked with clients who self-harm, number of clients worked with who self-harm and perceived

experience in dealing with self-harm), Step 3: Attributions (universal and control - self), Step 4: Attitudes (items 2,4,5,13,14,18 & 22) and Step 5: Self-efficacy.

Predicting depression/anger

R^2 = .24 for Step 1(p<. 01); ΔR^2 =. 05 for Step 2 (ns); $\Delta R2$ = .03 for Step 3 (ns); ΔR^2 =. 23 for Step 4 (ns); ΔR^2 =. 01 for Step 5 (ns).

Based on this regression, step 1 was the only significant model. Step 4 was nearly significant (.06). Therefore, the regression was re-run to remove variables that did not significantly contribute to explaining variance in the DV. This was conducted to enhance understanding of salient predictors and increase power. See Table 8.

Table 8. *Summary of hierarchical regression analyses for qualifications in predicting depression/anger scores*

Variable	B	SE B	β
Step 1			
Qualifications			
Are you professionally qualified	2.342	.967	.321*
Counselling or psychotherapy qualification	-2.342	.967	-.321*

* p <. 05, ** p <. 01, *** p <. 001

This model can predict 20% of the variance in depression/anger scores.

One further regression was conducted to explore whether step 4 would add anything to this model: R^2 = .20 for Step 1(p<. 01); ΔR^2 =. 29 for Step 2 (p<. 05), thus predicting 49% of the variance. This result however must be interpreted with caution, as step 4 was not significant in the original model.

Predicting fear/anxiety

R^2 = .29 for Step 1(p<. 01); ΔR^2 = .18 for Step 2 (p<. 05); $\Delta R2$ = .05 for Step 3 (ns); ΔR^2 =. 16 for Step 4 (ns); ΔR^2 =. 01 for Step 5 (ns).

Based on this regression, steps 1 and 2 were significant. Therefore, the regression was re-run to remove variables that did not significantly contribute to explaining variance in the DV. See Table 9.

Table 9. *Summary of hierarchical regression analyses for qualifications and experience in predicting fear/anxiety scores*

Variable	B	SE B	β
Step 1			
Qualifications			
Are you professionally qualified	2.952	.726	.523***
Counselling or psychotherapy qualification	.673	.726	.119
Step 2			
Qualifications			
Are you professionally qualified	2.451	.774	.434**
Counselling or psychotherapy qualification	-.464	.756	-.082
Work experience[a]			
Time worked in HCS	.303	.315	.154
Time worked with people who SH	-.373	.369	-.175
Number people with SH treated	-.601	.287	-.340*
Experience in dealing with SH	-.328	.589	-.103

[a] SH=Self-harm, HCS=Health care Setting

* p <. 05, ** p <. 01, *** p <. 001

R^2 = .29 for Step 1(p<. 01); ΔR^2 = .18 for Step 2 (p<. 05). This model can therefore predict 47% of the variance in fear/anxiety emotional reactions. Possessing a professional qualification and number of people with self-harm treated were both significant predictors.

Predicting confident/relaxed

R^2 = .14 for Step 1(p<. 05); ΔR^2 = .27 for Step 2 (p<. 01); ΔR2 = .00 for Step 3 (ns); ΔR^2 =. 18 for Step 4 (ns); ΔR^2 =. 91 for Step 5 (p<. 01).

Based on this regression, steps 1, 2 and 5 were significant. Therefore, the regression was re-run to remove variables that did not significantly contribute to explaining variance in the DV. See Table 10. R^2 = .14 for Step 1(p<. 05); ΔR^2 = .27 for Step 2 (p<. 01); ΔR2 = .13 for Step 3 (p<. 01). Therefore the model can predict 54% of the variance in confident/relaxed emotional reactions. Possessing a counselling or psychotherapy qualification, perceived experience in dealing with self-harm, time worked with people who self-harm and self-efficacy were significant predictor

Table 10. *Summary of hierarchical regression analyses for qualifications, experience and self-efficacy in predicting confident/relaxed scores*

Variable		B	SE B	β
Step 1				
	Qualifications			
	Are you professionally qualified	-1.378	1.012	-.193
	Counselling or psychotherapy qualification	-2.247	1.012	-.314
Step 2				
	Qualifications			
	Are you professionally qualified	-1.911	1.037	-.267
	Counselling or psychotherapy qualification	-.471	1.013	-.066
	Work experience[a]			
	Time worked in HCS	-.815	.423	-.328
	Time worked with people who SH	-.674	.494	-.250
	Number people with SH treated	.651	.385	.291
	Experience in dealing with SH	1.903	.790	.474*
Step 3				
	Qualifications			
	Are you professionally qualified	-1.768	.931	-.247
	Counselling or psychotherapy qualification	.015	.920	.002
	Work experience			
	Time worked in HCS	-.358	.404	-1.44
	Time worked with people who SH	-1.196	.471	-.444*
	Number people with SH treated	.668	.345	.299
	Experience in dealing with SH	1.512	.718	.377*
	Self-efficacy	.294	.090	.431**

[a] SH=Self-harm, HCS=Health care Setting

* $p < .05$, ** $p < .01$, *** $p < .001$

Discussion

This study set out to investigate staff emotional reactions to self-harming behaviour, and more specifically if attitudes, attributions, self-efficacy and empathy are associated with these reactions.

Summary of results

Several correlations were conducted to investigate associations between emotional reactions and other variables of interest. Many were significant, however after applying Bonferroni corrections, due to multiple tests, several did not reach new levels of significance. Despite this, the directions of the effects do demonstrate several non-significant trends, and will be discussed accordingly. Therefore, any conclusions based on these analyses drawn must be done so with caution.

Hypothesis one was that patient attributions of internality, stability and controllability would be positively associated with negative emotions. However, analyses indicated no such relationship. However, there was a negative association between universality and negative emotional reactions, i.e. if the behaviour was seen as less universal, or more unique to the client, staff experienced more depression/anger. In addition, self-attributions for control were also significant, i.e. staff that perceived themselves as more in control of the behaviour experienced more depression/anger and fear/anxiety.

Hypothesis two was that self-efficacy would be negatively associated with negative emotions. Results did not support this, but did demonstrate that self-efficacy was

positively associated with a positive emotion, i.e. staff that felt more self-efficacious also felt more confident/relaxed in response to a client with self -harming behaviour.

The third hypothesis, that empathy would be negatively associated with negative emotions was not supported, as no significant relationships were found.

Hypothesis four was that staff with a 'soft' attitude would experience less negative emotions than those in the 'firm' group. It was not possible to split the group into these groups, as the items in subscales, which differentiate each group (Huband & Tantam, 2000), were not related (low internal consistency). Furthermore, the mean scores in the present study were significantly different to those reported in the original data set (Huband & Tantam, 2000). However, some individual items from the attitudes measure were significantly related to emotional reactions. These items were predominately from the original subscale 'eligibility for tolerance and empathy' (Huband and Tantam, 2000).

The fifth hypothesis was that staff with a counselling or psychotherapy qualification would report fewer negative emotions. This was supported for depression/anger, but not for fear/anxiety scores.

The final research question was related to whether emotional reactions could be predicted from the demographic and study variables. The results indicated that possessing qualifications, work experience, attributions, attitudes and self-efficacy could predict significant variance in emotional reaction scores.

These results are discussed in relation to previous findings, with proposed clinical implications and suggestions for future research in this area.

Although the study did not find all predicted relationships, the variables that were included in this study were independently or in combination able to explain significant variance in individual emotional reactions. This seems to provide a way forward in developing a better theoretical understanding of staff emotional reactions to self-harm, even though the results should be considered with caution given the small sample size and inflated probability due to multiple correlations.

Emotional reactions to self-harm

Firstly, it is difficult to assess whether the frequency and degree to which staff experienced emotional reactions to self-harm in the present study is comparable with other studies, which have used the same measure. Although several studies (Hastings, Tombs, Monzani & Boulton, 2003; Jones & Hastings, 2003; Mossman & Brown, 2002) have reported mean scores of 'The Emotional Reactions to Challenging Behaviour Scale' (Mitchell & Hastings, 1998), there are no published norms to indicate how representative these are of the wider care staff population. Thus, it cannot be ascertained whether the emotional reactions reported by staff, in this study are 'normal'. In addition, Mossman and Brown (2002), Jones and Hastings (2003) and Hastings, et al. (2003) all reported emotional reactions to challenging behaviours in people with learning disabilities (LD), in accordance with the development of the tool (Mitchell & Hastings, 1998). There do not seem to be any studies within the mental health literature which have used this measure, for comparison.

Furthermore, each study (Hastings, et al., 2003; Jones & Hastings, 2003; Mossman & Brown, 2002) reported mean scores in relation to different conditions, by manipulating the perceived function of the behaviour. Psychological models of challenging behaviour in LD are based on behavioural principles, whereby environmental events are seen as playing an important role in the maintenance of the behaviour (Emerson, 1995), such as attainment of desirable items, attention or escape from difficult tasks, which are mediated by staff attention (Hastings, et al., 2003). Psychological models of self-harm in people with mental health difficulties, including BPD, are different. Although staff reactions to self-harm may in the long run serve to affect the likelihood of the behaviour being repeated (Rayner, et al 2005) this is understood within a more complex cognitive behavioural model and does not support the notion that staff attention alone is sufficient to influence further episodes of self-harm. In combination, these factors prevent any accurate comparisons regarding the degree to which staff experienced emotional reactions in this study, as the functions, hence attributions, and in turn emotional reactions to self-harm in people with LD and people with mental health difficulties are so disparate.

However, overall, it is evident that staff experienced some negative emotional reactions to self-harm, as predicted, with more feelings of depression/anger reported than fear/anxiety. Again, this is difficult to place within the literature.

Emotional reactions and attributions

Contrary to prediction, the study found no significant associations between patient attributions of internality, stability and controllability, and negative emotions. In other words, where acts of self-harm were perceived by staff to be caused by

potentially controllable factors, and that the behaviour was stable and internal to the client, they were not more likely to express negative emotional reactions.
This is in contrast to Weiner's (1980) attribution theory, whereby perceptions that the client is in control of her actions and that the behaviour is stable, would lead to negative emotional reactions such as anger and disgust. Other studies have indeed supported the notion that causal attributions of controllability and stability will mediate affect in the observer (Dagnan, Trower & Smith, 1998; Mackay & Barrowclough, 2005).

One possible reason for this disparity may lie in the use of a vignette. Firstly, as the vignette contained little detail about the background and characteristics of the client, this provided staff with limited information on which to make causal judgments. Indeed, some staff did write comments such as "hard to say, as limited information" on the attributions measure. Also, as Mackay and Barrowclough (2005) suggest, when staff encounter patients in a clinical setting, it is likely that a range of contextual factors, such as the severity of the self-harm and the manner in which the patient behaves towards them, will affect staff responses. Therefore, the use of the vignette may not be capturing some salient factors that would naturally affect how staff perceive and make causal attributions regarding clients in their clinical practice. This may especially important for the staff in this study, as 76% provided care for patients hospitalised in acute inpatient settings or to clients in crisis. Both involve frequent and prolonged client contact, so contextual factors may be very important. Additionally, attribution theory might only apply to low-frequency behaviours (Willner & Smith, 2008). In combination, these factors suggest that the use of a

vignette to test Weiner's (1980) model is difficult to apply to care staff who work intensively with clients who self-harm in clinical settings.

A further methodological factor may also help to explain why patient attributions were not related to negative emotional reactions. Weiner (1980) proposed that the emotions of anger and disgust were pivotal, and although the present study did measure these they were in combination with other negative reactions. The depression/anger subscale (Mitchell & Hastings, 200) only contains one item for disgust and one for anger, alongside eight other emotional reactions. Therefore this tool may not provide an accurate or sensitive measurement of anger or disgust.

Despite the lack of support for Weiner's model (1980), other causal attributions were significantly associated with negative affect. More specifically, the more control over the clients behaviour staff attributed to him/herself, the more the self harming behaviour evoked negative emotions, both depression/anger and fear/anxiety. This makes logical sense, in that if staff perceive that they have some control over self-harming behaviour, hence they may prevent it from occurring, when clients do engage in self-harm they are more likely to experience negative emotional reactions. Geller and Johnston (1995) supported this notion. They found that mothers attributions for their own role in causing their child's behaviour, helped to account for differences in their affective responses. That is, attributions of personal controllability were associated with greater affect. Geller and Johnston (1995) proposed that self-attributions may be associated with feelings of self-efficacy and with the belief that that their intervention could stop the child's behaviour, or prevent it from recurring.

Surprisingly, there do not appear to be any studies related to how mental health staff attribute their own roles in clients behaviour. However it is an area that warrants further investigation.

Emotional Reactions and self-efficacy

The hypothesis that self-efficacy would be negatively associated with negative emotions was rejected in this study. This was surprising as it makes intuitive sense that emotional reactions, especially fear and anxiety would reduce as perceived self-efficacy increases.

The prediction that self-efficacy would be negatively associated with negative emotions is theoretically supported by the 'stress and coping' paradigm model of coping (Lazarus & Folkman, 1984) and empirically by Hastings and Brown (2002), who found that staff with greater feelings of self-efficacy in dealing with challenging behaviours reported fewer negative emotional reactions (both depression/anger and fear/anxiety). Tentative support also comes from Tiemey et al (2007) who found non-significant trends for negative emotions to reduce as self-efficacy increased. One reason for the disparity between the results from this study and the aforementioned, may be the way in which self-efficacy was conceptualised. Although self-efficacy as measured on the perceived self-efficacy scale (Hastings & Brown, 2002) was not related to negative emotional reactions in this study, experience in dealing with self-harm was. If staff perceived themselves as being relatively inexperienced in dealing with self-harm, they expressed more fear and anxiety than staff who perceived themselves as considerably experienced. Perceptions of experience could arguably be considered another way of measuring

self-efficacy. In support of this, a moderate correlation of .37 ($p<.01$) was found between self-efficacy and perceived experience. However, perceptions of experience could not explain any additional variance in predicting fear/anxiety scores, once years of experience had been accounted for. A probable reason for this lies in the way the regression was conducted. As 'experience' was entered in one block (time worked in health care, time worked with self-harming clients, number of self-harming clients worked with and perceived experience in dealing with self-harm) there may be problems associated with multicolinearity. In other words, as these separate measures of experience may actually quantify the same phenomenon then they are redundant. A principal danger of such data redundancy is that of over fitting in regression analysis models. The best regression models are those in which the predictor variables each correlate highly with the dependent (outcome) variable but correlate at most only minimally with each other. Given this, the correlations need to be further explored in order to assess for multicolinearity.

Aside from the methodological concerns regarding negative emotional reactions, the study did find that self-efficacy was positively related to a positive emotion. It is not surprising that staff who perceived themselves as more self-efficacious felt more confident and relaxed. Furthermore, self-efficacy explained significant variance in the prediction of confident/relaxed emotions. It seems that although self-efficacy increased confidence it was not sufficient to protect staff from experiencing negative emotions. It is interesting though that negative and positive emotions seem to be affected by different (though possibly related) factors. This (in combination with the low correlations found between negative and positive emotions) would suggest these are not emotions on a similar spectrum but that different mechanisms are at work that

relate to the way staff reacts negatively and/or positively to self-harming behaviour of their clients.

Emotional reactions, empathy and attitudes

Contrary to prediction, there were no significant associations between scores on the empathy measure and emotional reactions in the present study. However, several items taken from the 'eligibility for tolerance and empathy' subscale of the attitude measure were significant. More specifically, staff who felt less uncomfortable if she cut again, felt more inclined to work with her if she cut again and agreed more that she had the same right to medical treatment, reported less depression/anger and fear/anxiety. Staff who felt less annoyed with her also reported fewer feelings of depression/anger. Therefore it seems that having a more empathic attitude is in some way associated with experiencing fewer negative emotional reactions. A tentative explanation would suggest that empathy is linked with possessing a better theoretical understanding of the functions and causes of the behaviour.

If staff feel they know more about the underlying causes and functions of the behaviour, they may feel more empowered and have a greater sense that they can support the client, and hence experience fewer negative reactions. Indeed, those staff in the present study who agreed more that they did not have a theoretical understanding of why the client cut expressed more fear/anxiety. This is supported by Hastings and Brown (2002), who found that staff with higher levels of behavioural knowledge of challenging behaviours in clients with learning disabilities reported fewer negative reactions, both in scores of depression/anger and fear/anxiety. It may be that empathy and self-efficacy are related concepts. The

present study did not explore associations between these concepts, neither did Hastings and Brown (2002), but future research in this area seems warranted.

With regards to the measurement of empathy, it seems that the use of a generic tool may not be appropriate for staff working with self-harming clients. The Huband and Tantam (2000) attitudes measure is specifically designed for staff working with this client population and may help to explain why significant associations were found with emotional reactions.

The effects of training on emotional reactions

The hypothesis that staff with a counselling or psychotherapy qualification would experience fewer negative emotional reactions was partially supported by the study findings. More specifically those with a counselling or psychotherapy qualification reported less depression/anger, but not less fear/anxiety. Furthermore, possessing a counselling or psychotherapy qualification was a significant contributor in predicting depression/anger. However, this result should be interpreted with caution, as again there may be problems with multicolinearity. It may have been more appropriate to explore whether possessing a counselling or psychotherapy qualification was an independent predictor, by removing 'possession of a professional qualification' from the regression analyses.

It was predicted that possessing a counselling or psychotherapy qualification would be associated with less fear/anxiety, as suggested by Huband and Tantam (2000). The present study did not find this association, which may be explained by sample differences, i.e. Huband and Tantam (2002) based their study on a significant proportion of outpatient staff, and across more professional disciplines, compared with the current study.

However, the results did reveal that staff with more experience (10 years or more) in working/dealing with self-harm reported less fear/anxiety. Huband and Tantam (2000) suggested that staff's ability to contain anxiety is enhanced by therapy training. It seems plausible that the effects of experience in self-harm may work in a similar fashion, in enabling staff to process and cope with their emotional reactions. On the other hand, it may be that staff simply habituate to fearful responses.

Clinical Implications

Although it was not possible to answer all of the research questions fully, it is evident that staff are under emotional strain when faced with people who self harm. This is important, as work stress has been cited as the most common cause of injury or illness in the workplace (The Health Care Commission, 2006) and may lead to intention to leave organisations, actual staff turnover, and absenteeism (e.g. Hatton & Emerson 1993; Rose, 1995).

This study presents some preliminary findings regarding staff emotional reactions to self-harming clients. Although other studies have explored how emotions may mediate helping behaviour (Dagnan et al, 1998)) or staff optimism (Sharrock et al, 1990) this appears to be the first study that is specifically interested in the measurement of these reactions in their own right, i.e. with emotions as an outcome or dependent variable, within the mental health field.

The results have some clinical implications for staff working with this client group, particularly with regards to training and supervision. Firstly, if staff attribute control of the self-harm behaviour to themselves, and this in turn leads to experiencing

negative emotional reactions, as suggested by this study, staff may learn to distance themselves from the client in order to protect themselves. Conversely, there may be a tendency to become overly–involved, in attempts to stop further episodes of self-harm. Treatment approaches that are proving effective in reducing repetition of self-harm, such as DBT (Linehan, 1991) however seem to be based on helping the client to develop skills in order to better control their own behaviour. Therefore, by assuming self-responsibility, staff may be inadvertently maintaining the client's sense of having no control. This may be difficult to change as ultimately staff do hold some clinical responsibly for clients in their care. This is further compounded by the fact that staff may find it difficult to express these feelings (Reece, 2005). However maintaining regular discussions about self-harming clients may be one of the most effective management strategies for staff (Huband & Tantam, 1999).

Although short term training in self-harm may not be effective in changing emotional reactions to self-harm behaviour (Huband & Tantam, 2000) it has been noted that longer term training may help staff to manage their anxieties (Huband & Tantam, 2000). This study tentatively supports this. It would be unrealistic to propose that staff should undergo extensive psychotherapy training, however the use of supervision and reflective practice to address transference and countertransference issues that are inherent in working with this client group (Rayner, et al, 2005) may prove equally effective. This appears to be of particular importance for staff with less experience, as this study found that staff with less experience in health care (5 years or less) reported more negative emotional reactions.

Study limitations

Due to the relatively small sample, any generalisations of findings from this study must be considered cautiously. Furthermore, as the majority of participants were nursing staff (62%), and the other disciplines were not well represented, it further limits generalisation. The result that there were no differences in emotional reactions between professions may be in part due to this. Replication using a larger sample, with a better spread of disciplines is needed. This may be especially relevant, given that most of the literature is focused on nurses. However, this may be very difficult to achieve. The author repeatedly promoted participation in the study, both on a group and individual level, and reiterated that participation would be anonymous. It did seem that some staff were particularly reluctant to be involved. Furthermore, it would seem plausible that those staff who were reluctant to answer questions about their attitudes towards and emotional reactions to self-harm may constitute a group who are generally more negative in their reactions, and whom would benefit from further support and training.

As already discussed, there may have been problems regarding multicolinearity in the study. As 'experience in health care' and 'qualifications' included several seemingly overlapping measures, this may have affected the results of the regression analyses. Future research should address those variables, which are most salient in order to minimise this. One possible way forward would be to consider structural equation modelling whereby the related variables could load onto a latent variable, although a larger sample size would be needed, which may be hard to achieve.

In addition, the psychometric properties of the attributions and attitudes measures have not been established yet and this study found that they were not internally consistent.

The use of a vignette may also need careful consideration if this study were to be replicated. Although the one used in this study is based on a 'typical self-harming client' (Favazza & Conterio, 1989; Simpson, 1976) and has been successfully used by used by other authors, (Huband & Tantam, 2000) it may be an artificial representation of this behaviour.

Future Research

It is theoretically important to further explore relationships between self-efficacy, attributions, attitudes and empathy and to investigate whether independently or in combination they can help to predict emotional reactions. Little is known about the possible associations between these variables. In the current literature it has been suggested that empathy may contribute to differences in attitudes hence it would be conceivable that the association between empathy and emotional reactions is mediated by attitudes. Similarly, attributions may contribute to feelings of efficacy as attributed causes of behaviour may make staff more or less empowered to contribute to the treatment of the behaviour. Hence it would be possible that self-efficacy mediates the relationship between attributions and emotional reactions. Therefore future research could focus on these mediational models, with either multiple regression analyses or path analyses.

If this study were replicated, the author would suggest changing the vignette used in this study. It may not be ecologically valid for several reasons. Firstly, the vignette is based on early literature of self-harm, and may no longer be clinically meaningful, i.e. in comparison to typical inpatient clients, it reports far less severe self-harm and there is no indication of the enduring nature of the behaviour. One possible way of addressing whether the severity of self-harm is associated with emotional reactions, would be to manipulate the severity and chronicity in the vignette, and randomise staff to different experimental groups.

Conclusions

The results of this study suggest that staff emotional reactions to self-harm are related to a number of variables, including attributions, attitudes, self-efficacy and empathy. However, it is difficult to suggest how representative these findings are as there is such a paucity of empirical evidence in this area. It highlights the need to further explore these concepts in order to guide staff support and optimise care provision for this client group.

These results appear to support training in psychotherapeutic approaches in staff working in this area and the use of reflection and supervision to support staff in understanding their reactions to this evocative behaviour.

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APPENDICES

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APPENDIX A

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FORMAT: We accept most wordprocessing formats, but Word, WordPerfect or LaTeX are preferred. Always keep a backup copy of the electronic file for reference and safety. Save your files using the default extension of the program used.

Please provide the following data on the title page (in the order given).

Title. Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.

Author names and affiliations. Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work

was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name, and, if available, the e-mail address of each author.

Corresponding author. Clearly indicate who is willing to handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address.**

Present/permanent address. If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Abstract. A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.

STYLE AND REFERENCES: Manuscripts should be carefully prepared using the Publication Manual of the American Psychological Association, 5th ed., 1994, for style. The reference section must be double spaced, and all works cited must be listed. Please note that journal names are not to be abbreviated.

Reference Style for Journals: Cook, J. M., Orvaschel, H., Simco, E., Hersen, M., and Joiner, Jr., T. E. (2004). A test of the tripartite model of depression and anxiety in older adult psychiatric outpatients, *Psychology and Aging*, 19, 444-45.

For Books: Hersen, M. (Ed.). (2005). Comprehensive handbook of behavioral assessment (2 Volumes). New York: Academic Press (Elsevier Scientific).

TABLES AND FIGURES: Present these, in order, at the end of the article. High-resolution graphics files must always be provided separate from the main text file (see http://ees.elsevier.com/cpr for full instructions, including other supplementary files such as high-resolution images, movies, animation sequences, background datasets, sound clips and more).

PAGE PROOFS AND OFFPRINTS: When your manuscript is received by the Publisher it is considered to be in its final form. Proofs are not to be regarded as 'drafts'. One set of page proofs will be sent to the corresponding author, to be checked for typesetting/editing. No changes in, or additions to, the accepted (and subsequently edited) manuscript will be allowed at this stage. Proofreading is solely the authors' responsibility.

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APPENDIX B

Notes for Contributors

The *British Journal of Clinical Psychology* publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

Papers reporting original empirical investigations

Theoretical papers, provided that these are sufficiently related to the empirical data

Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications

Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Reviewing

The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be aware of the identity of the author. All information about authorship (including personal acknowledgements and institutional affiliations) should be confined to the title page (and the text should be free of such clues as identifiable self-citations, e.g. 'In our earlier work...').

4. Online submission process

1) All manuscripts must be submitted online at http://bjcp.edmgr.com.

First-time users: Click the REGISTER button from the menu and enter in your details as instructed. On successful registration, an email will be sent informing you of your user name and password. Please keep this email for future reference and proceed to LOGIN. (You do not need to re-register if your status changes e.g. author, reviewer or editor).

Registered users: Click the LOGIN button from the menu and enter your user name and password for immediate access. Click 'Author Login'.

2) Follow the step-by-step instructions to submit your manuscript.

3) The submission must include the following as separate files

Title page consisting of manuscript title, authors' full names and affiliations, name and address for corresponding author - Manuscript title page template

Abstract

Full manuscript omitting authors' names and affiliations. Figures and tables can be attached separately if necessary.

If you require further help in submitting your manuscript, please consult the Tutorial for Authors - Editorial Manager - Tutorial for Authors

Authors can log on at any time to check the status of the manuscript.

5. Manuscript requirements

Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate page. The resolution of digital images must be at least 300 dpi.

For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, results, Conclusions. Review articles should use these headings: Purpose, Methods, Results,

Conclusions: British Journal of Clinical Psychology - Structured Abstracts Information

For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.

SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

In normal circumstances, effect size should be incorporated.

Authors are requested to avoid the use of sexist language.

Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

For Guidelines on editorial style, please consult the *APA Publication Manual* published by the American Psychological Association, Washington DC, USA (http://www.apastyle.org).

6. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author and name and address are not included in the word limit.

7. Publication ethics

Code of Conduct - Code of Conduct, Ethical Principles and Guidelines (2004)

Principles of Publishing - Principles of Publishing

8. Supplementary data

Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

9. Post acceptance

PDF page proofs are sent to authors via email for correction of print but not for rewriting or the introduction of new material. Authors will be provided with a PDF file of their article prior to publication.

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11. Checklist of requirements

Abstract (100-200 words)

Title page (include title, authors' names, affiliations, full contact details)

Full article text (double-spaced with numbered pages and anonymised)

References (APA style). Authors are responsible for bibliographic accuracy and must check every reference in the manuscript and proofread again in the page proofs

Tables, figures, captions placed at the end of the article or attached as separate files

APPENDIX C

Your Ethics Form approval
Psychology.Ethics.Forms@ps1.psy.soton.ac.uk [Psychology.Ethics.Forms@ps1.psy.soton.ac.uk]

Sent: 03 September 2007 15:21
To: courtney h. (hc105)

This email is to confirm that your ethics form submission for "Staff emotional reactions to self-harm. The role of self-efficacy, attitudes, attributions and empathy." has been approved by the ethics committee

Project Title: Staff emotional reactions to self-harm. The role of self-efficacy, attitudes, attributions and empathy.
Study ID : 188
Approved Date : 2007-09-03 15:21:30

Click here to view Psychobook

You will now need to complete a form for indemnity insurance which can be found online at the link below:
Research Governance Form

This will need to be returned to the address provided on the form

APPENDIX D

RE: Doctoral thesis- Research or service evaluation - a query.
Queries [Queries@nationalres.org.uk]

Sent: 20 August 2007 15:45
To: Pit-ten Cate I.M.
Cc: courtney h. (hc105)

Thank you.
The following reply has been provided by Jo Downing, Information Officer

Thank you for your query. The Research Governance Framework for Health and Social Care sets out the responsibilities and standards that apply to work managed within the formal research context. Under the Governance Arrangements for NHS Research Ethics Committees (GAfREC), the main role of NHS RECs is to review research involving NHS patients. GAfREC is available on our website at www.nres.npsa.nhs.uk/applicants/help/guidance.htm.

Based on the information provided, we consider the study to be service evaluation and should not be managed as research. Staff reactions will undoubtedly influence care provided, and I think exploring this will allow units to develop services that accommoodate and support this. I would therefore deem this a service evaluation and development. Therefore it does not require ethical review by a NHS Research Ethics Committee.

The table in our leaflet 'Defining Research' sets out the criteria we use to distinguish between research, audit and service evaluation (link: http://www.nres.npsa.nhs.uk/applicants/review/apply/research.htm#audit).

Although ethical review by a NHS REC is not necessary in this case, all types of study involving human participants should be conducted in accordance with basic ethical principles such as informed consent and respect for the confidentiality of participants. When processing identifiable data there are also legal requirements under the Data Protection Act 2000.

[NHS sites - You should check with the clinical governance office for your organisation what other review arrangements or sources of advice apply to projects of this type. You should ensure that the project is not presented as research in the NHS organisation.]

[Universities - You may wish to check whether the project could be reviewed by the ethics committee within your own institution.]

The above advice does not constitute a form of ethical approval but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements.

However, if you feel that ethical review by a NHS REC is essential,

please write setting out your reasons and we will be pleased to consider further.

I hope this helps.

Regards

Queries Line
National Research Ethics Service (NRES)
National Patient Safety Agency
Website: www.nres.npsa.nhs.uk

Ref: 041/01

APPENDIX E

Hampshire Partnership NHS
NHS Trust

Research & Development
1st Floor Department of Psychiatry
Royal South Hants Hospital
Brintons Terrace
SOUTHAMPTON
S014 0YG

Tel: 023 8082 5054
Fax: 023 8023 4243

29 November 2007

Helen Courtney
Department of Clinical Psychology
34 Bassett Crescent East
SOUTHAMPTON
SO16 7PB

Dear Helen

Staff emotional reactions to self-harm. The role of self-efficacy, attitudes attributions and empathy

Thank you very much for submitting your proposal for the above project. Based on the information you have provided, I would consider the study to be a service evaluation and should not be managed as research. Therefore you do not require the written agreement from the Trust Research and Development Department to proceed with this project.

With best wishes

Yours sincerely

Professor David Kingdon
Director of Research and Development

APPENDIX F

ON HEADED PAPER

Participant Information Sheet

Staff emotional reactions to self-harm

You are being asked to take part in a research study. Before you decide it is important for you to understand why the research is being done 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 anything is not clear or if you would like more information. Thank you for reading this.

What is the purpose of the study?
This study is trying to find out about peoples feelings and views about self-harm. It is hoped that the research will help to support health care professionals who work with self-harming clients.

Why have I been chosen?
As you work with clients presenting with acute / complex difficulties, you are likely to meet people who self –harm, if you haven't already. Your views are therefore really important.

Do I have to take part?
It is up to you to decide whether or not to take part.

What will happen if I take part?
You will complete some questionnaires, which should take approximately 30 minutes to complete. Once you have filled in the questionnaires we would like you to send them to us in the prepaid envelope (provided). Completion and return of these 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.

Will my taking part in the study be kept confidential?
All information, which is collected during the course of the research, will be kept strictly confidential. The results of the study will have your name and any other identifying information removed.

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.

Who is organising and funding the research?
I am a Third Year Clinical Trainee at the University of Southampton, Doctoral Programme in Clinical Psychology. This research is being conducted as part of my training.

Who has reviewed the study?
The School of Psychology Research Ethics Committee, University of Southampton has reviewed the study. If you have any questions about your rights as a participant in this research or feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, School of Psychology, University of Southampton, Southampton, SO17 1BJ. Tel: 023 8059 3995

Contact for further information
If you have any questions, or you wish to request a summary please contact:
Helen Courtney, School of Psychology, University of Southampton, SO16 7PB
E-mail: hc105@soton.ac.uk

APPENDIX G

ON HEADED PAPER

Letter of Consent for Questionnaires

Staff emotional reactions to self-harm

I am Helen Courtney, a Trainee Clinical Psychologist from the University of Southampton. I am requesting your participation in a study regarding staff emotional reactions to clients who self-harm. This will involve completing five brief questionnaires, which should take approximately 30 minutes.
The information you provide will be securely stored for the duration of the study and 10 years thereafter (according to research data storage guidelines) and will not be released to or viewed by anyone other than researchers involved in this project. The information will be coded, so results of this study will not include your name or any other identifying characteristics.

Giving informed consent means that you agree to be included as a participant in this study, for your data to be used for the purposes of research, and that you understand that published results of this research project will maintain your confidentiality. Your participation is voluntary and you may withdraw your participation at any time. You may request a copy of this consent form for your own records.

A summary of this research project will be supplied upon request. To request a project summary please contact me Helen Courtney at hc105@soton.ac.uk.

Statement of Consent

I _____ have read the consent form
[Participants name]

I give consent to participate in the above study Yes ☐ No ☐

If you have any questions please contact Helen Courtney (hc105@soton.ac.uk) or Ineke Pit-ten Cate, Research Tutor, University of Southampton, 02380 595452, (ip@soton.ac.uk)

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: (023) 8059 399511

APPENDIX H

1. Tell me about yourself

Your gender ☐ F ☐ M

Your age ☐ 18-25 ☐ 26-35 ☐ 36-45 ☐ 46+

Your team

☐ Acute Assessment Ward

☐ Psychiatric Intensive Care Unit

☐ Rehabilitation Unit

☐ Crisis Resolution/ Home Treatment Team

☐ Assertive Outreach Team

☐ Community Mental Health Team

Other, please specify.....

Please indicate your profession within the team

☐ Psychiatry

☐ Psychiatric Nursing

☐ Occupational Therapy

☐ Art / Drama Therapy

☐ Clinical Psychology

☐ Social work

☐ Other (Please specify)

.....

Are you professionally qualified? ☐ Yes ☐ No

Are you qualified in any of the following? (Please tick all that apply to you)

Counselling:

☐ Certificate level

☐ Diploma level

☐ BAC accredited

☐ Other accreditation (Please specify)

.....

Psychotherapy:

☐ Post-certificate level ☐ UKCP accreditation

☐ BCP accreditation ☐ Other accreditation (Please specify)

.....

Please state any other relevant qualifications you may have

.....

.....

How long have you worked in a health care setting? _____

How long have you worked with people who self- harm? _____

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

☐ None ☐ Between 11 & 15

☐ Between 1&5 ☐ More than 15

☐ Between 6 &10

Have you received any specific training in the handling / care/ support of people who self harm?

☐ Yes ☐ No

Do you receive regular professional supervision? ☐ Yes ☐ No

If yes, please indicate whether this is ☐ Individual ☐ Group

Please indicate which of the following most applies to you

☐ I consider myself relatively inexperienced in dealing with people who self-harm

☐ I consider myself moderately experienced in dealing with people who self-harm

☐ I consider myself as having considerable experience in dealing with people who self-harm

APPENDIX I

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.

Take a few moments to consider your thoughts and beliefs in relation to this client.

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 years 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 that 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 attention. Since then, she has presented twice at 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 had 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 things that helps' and refused to say anymore.

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

APPENDIX J

2. Your feelings about self-harm

Below is a list of emotions that mental health staff have said they experience when they work with people who display self- harming behaviours. We want to know how *you* typically feel in this situation.

Think back to the story you have just read, then consider each of the emotional reactions, and select the response next to each item that best describes how you feel about this client.

	No, never	Yes, a little	Yes, moderately	Yes, very much
SHOCKED	0	1	2	3
CONFIDENT	0	1	2	3
GUILTY	0	1	2	3
HOPELESS	0	1	2	3
COMFORTABLE	0	1	2	3
AFRAID	0	1	2	3
ANGRY	0	1	2	3
INVIGORATED	0	1	2	3
INCOMPETENT	0	1	2	3
HAPPY	0	1	2	3
FRUSTRATED	0	1	2	3
HELPLESS	0	1	2	3
SELF-ASSURED	0	1	2	3
DISGUSTED	0	1	2	3
RELAXED	0	1	2	3
RESIGNED	0	1	2	3
FRIGHTENED	0	1	2	3
CHEERFUL	0	1	2	3
HUMILIATED	0	1	2	3
BETRAYED	0	1	2	3
SAD	0	1	2	3
EXCITED	0	1	2	3
NERVOUS	0	1	2	3

3. Your relationships with people who self-harm

Below is a list of statements about the relationships you have with your clients/patients. Think back to the story and indicate how much you agree with these statements, with this self- harming client in mind.

1	2	3	4	5	6	7
Strongly Disagree						Strongly Agree

An important component of the relationship with my patients is my understanding of the emotional status of the patients and their families.

1 2 3 4 5 6 7

.....

I try to understand what I going on in my patients' minds by paying attention to their nonverbal cues and body language

1 2 3 4 5 6 7

.....

I believe that empathy is an important therapeutic factor in patient treatment

1 2 3 4 5 6 7

.....

Empathy is a therapeutic skill without which my success would be limited

1 2 3 4 5 6 7

.....

My understanding of my patients' feelings gives them a sense of validation that is therapeutic in its own right

1 2 3 4 5 6 7

.....

My patients feel better when I understand their feelings

1 2 3 4 5 6 7

.....

1	2	3	4	5	6	7
Strongly Disagree						Strongly Agree

I consider understanding my patients' body language as important as verbal communication in staff-patient relationships

1 2 3 4 5 6 7

.....

I try to imagine myself in my patients' shoes when providing care to them

1 2 3 4 5 6 7

.....

I have a good sense of humour, which I think contributes to a better clinical outcome

1 2 3 4 5 6 7

.....

I try to think like my patients in order to render better care

1 2 3 4 5 6 7

.....

Patients' conditions can only be cured by medical treatment: therefore, affectional ties to my patients cannot have a significant place in this endeavour

1 2 3 4 5 6 7

.....

Attentiveness to my patients' personal experiences is irrelevant to treatment effectiveness

1 2 3 4 5 6 7

.....

4. Your responses to self-harm

Below are several questions that ask about your responses to self-harm.

Think back to the story, read each question, and place a circle around the number on the scale that reflects your own views about this client.

How confident would you be in dealing with the self-harming behaviours of this client?

1	2	3	4	5	6	7
Not at all confident						Very confident

How difficult would you personally find it to deal with the self-harming behaviours of this client?

1	2	3	4	5	6	7
Very difficult						Not at all difficult

To what extent do you feel that the way you would deal with the self-harming behaviours of this client would have a positive effect?

1	2	3	4	5	6	7
Has no positive effect at all						Has a very positive effect

How satisfied would you be with the way in which you dealt with the self-harming behaviours of this client?

1	2	3	4	5	6	7
Not satisfied at all						Very satisfied

To what extent would you feel in control of the self-harming behaviours of this client?

1	2	3	4	5	6	7
Not in control at all						Very much in control

5. Causes of self-harm

This questionnaire is to do with what you believe might cause self-harming behaviour in Miss C.

Please think back to the story, then read each item and place a circle around the number on the scale that reflects your views about this client. We would be grateful for any thoughts that you may like to add on the lines below each question.

1) What would be your immediate explanation for her self-harming behaviour?

.....

2) Was the self-harming behaviour caused by something specifically to do with Miss C or something else?

1	2	3	4	5
Something about Miss C				Something else

What sort of things are you thinking of in your answer?

.....

.....

3) Does Miss C have any control over behaving in this way?

1	2	3	4	5
Has no control				Has complete control

What makes you think that Miss C would or would not have control?

.....

.....

4) Will the cause of the behaviour be present again in the future or was it a one-off?

1	2	3	4	5
Will never be present again				Will always be present

What makes you think this?

.....

.....

5) Is the behaviour caused by something unique to her or by something common to most people of that age?

1	2	3	4	5
Something unique to Miss C				Something common to most people

What makes you think that?

.....

.....

6) Think about the possible cause of this self -harming behaviour. Would the cause influence Miss C in other situations? (for example if she was with friends)

1	2	3	4	5
Only influences this situation (with health care professionals)				Influences all situations in life

Can you give any examples of other instances when Miss C present in this way?

.....

.....

7) Do you think you would have any control over her behaviour?

1	2	3	4	5
Have no control over behaviour				Have complete control over behaviour

What makes you think you would or wouldn't have control?

.....

.....

8) If Miss C was admitted to the ward and self-harmed, do you think the self-harming behaviour would be caused by something specifically to do with you or something else?

1	2	3	4	5
Something about me				Something else

What makes you think this?

.....

.....

6. Your thoughts about self-harm

Below are a series of opinions that staff often hold about clients who self-harm. Please read these carefully as each one is presented with it's opposite, i.e. 1) she will or will not injure again.

Think back to the story and indicate your responses by circling the number that best fits your opinion.

The chances are that she will not Injure herself again — The chances are that she will injure herself again

1 2 3 4 5

.....

I would not feel particularly uncomfortable if she began cutting again — I would feel very uncomfortable if she began cutting again

1 2 3 4 5

.....

Her decision to cut is completely under her control — Her decision to cut is completely outside her control

1 2 3 4 5

.....

She has less right to expensive medical treatment of her wounds than other patients — She has the same right to expensive medical treatment of her wounds as any other patient

1 2 3 4 5

.....

This type of patient doesn't make me feel annoyed — This type of patient does make me feel annoyed

1 2 3 4 5

.....

She has complete control over the extent of her self-harming — She has no control over the extent of her self-harming

1 2 3 4 5

.....

It will be difficult to build a relationship

It will be easy to build a relationship

1 2 3 4 5

.....

If she cuts again, it will be with genuine suicidal intent

If she cuts again, it will not be with genuine suicidal intent

1 2 3 4 5

.....

I do not expect her to try to manipulate professional staff involved in her care

I do expect her to try to manipulate professional staff involved in her care

1 2 3 4 5

.....

Attempts at manipulating staff are likely to be unconscious and unintentional

Attempts at manipulating staff are likely to be conscious and intentional

1 2 3 4 5

.....

She is unlikely to comply with treatment and professional advice

She is likely to comply with treatment and professional advice

1 2 3 4 5

.....

She would stop cutting if there was no-one around to notice it

She would continue to cut even if there was no-one around to notice it

1 2 3 4 5

.....

I do have a theoretical understanding of why she cuts herself

I do not have a theoretical understanding of why she cuts herself

1 2 3 4 5

.....

I would continue to work with her if she began cutting again

I would not continue to work with her if she began cutting again

1 2 3 4 5

.....

Self-harming behaviour is easy to manage

Self-harming behaviour is difficult to manage

1 2 3 4 5

.....

She is not suffering from a treatable mental illness or mental disorder

She is suffering from a treatable mental illness or mental disorder

1 2 3 4 5

.....

She is unlikely to develop a dependency on her key-worker

She is likely to develop a dependency on her key-worker

1 2 3 4 5

.....

A firm authoritative approach is likely to increase her self-harming

A firm authoritative approach is likely to reduce her self-harming

1 2 3 4 5

.....

Developing an empathic relationship with her is not the first priority

Developing an empathic relationship with her is the first priority

1 2 3 4 5

.....

Setting firm boundaries with her is not the first priority

Setting firm boundaries with her is the first priority

1 2 3 4 5

.....

She is unlikely to benefit from psychotherapy or in-depth counselling

She is likely to benefit from psychotherapy or in-depth counselling

1 2 3 4 5

.....

It is quite possible to manage her self-harming without information from her past

It is quite impossible to manage her self-harming without information from her past

1 2 3 4 5

.....

Dependency on her key-worker is a negative and non-essential stage in the overall process

Dependency on her key-worker is a positive and essential stage in the overall process

1 2 3 4 5

.....

You have finished!

Please check that you have not missed a question

THANK YOU VERY MUCH FOR YOUR TIME

APPENDIX K

ON HEADED PAPER

Debriefing Statement

Staff emotional reactions to self-harm

Thank you very much for participating in this study. The aim of this research is to investigate emotional reactions to clients who self-harm. It is expected that staff will experience significant negative emotions, and that these emotions are affected by whether they believe the client is in control of their actions, the level of understanding of why they self–harm and the level of confidence they feel in managing such clients. Your data will help our understanding of this process. Once again results of this study will not include your name or any other identifying characteristics. The research did not use deception. You may have a copy of this summary if you wish and a summary of the research findings once the project is completed.

If you have any questions please contact Helen Courtney (hc105@soton.ac.uk) or Ineke Pit-ten Cate, Research Tutor, University of Southampton, 02380 595452, (ip@soton.ac.uk)

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: (023) 8059 3995