The impact on mental health professionals of working with individuals who self-harm

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**An exploration of Health Care Support Workers'
experience of working with young people who self-harm**

Abstract

A thesis was completed as part of the requirements of the Doctorate in Clinical Psychology. Having previously worked with young people who self-harmed, the author was interested in the impact of work on professionals. When reading around the subject, it was possible to identify that whilst a wealth of research has been undertaken into healthcare professional attitudes towards self-harm, few studies have explored the impact of such work on staff. The impact of work with self-harm on professionals is an important area of enquiry as it is acknowledged that mental health workers are vulnerable to compassion fatigue (Figley, 2002) and vicarious traumatisation (McCann & Pearlman, 1990) through their empathy with those who are suffering. This impacts on staff well-being and morale, as well as service users' experience and outcomes. A review of the literature was conducted in order to ascertain what was already known and where gaps existed. Nine studies were identified and evaluated. Working with self-harm had both an emotional and cognitive impact on professionals, with work eliciting strong emotions and some staff describing responses such as sleep disturbance and relational conflict that were consistent with compassion fatigue (Bride, 2004). Most research had been carried out with qualified staff working with adults who self-harmed. Therefore, a gap was identified around unqualified staff experience of working in inpatient settings with adolescents who self-harm. Since the aim was to explore staff experience, a decision was made to use Interpretative Phenomenological Analysis to explore the experience of healthcare support workers (HCSWs) in an inpatient unit. Six HCSWs were interviewed using a semi-structured format. Four superordinate themes were found: trying to make sense of self-harm, emotional impact, relationships, and HCSW role. Participants' responses were reflective of components of compassion fatigue and vicarious traumatisation, highlighting the profound impact of such work and the need for structured training and support. Findings were supported by research with qualified staff. However, existing knowledge was extended by providing detail of the meaning of experience for HCSWs. The thesis concludes with the author's reflections on her own experience of working on an inpatient unit with adolescents who self-harm.

What is the impact on mental health professionals of working with people who self-harm?

Abstract

Self-harm is estimated to be increasing and is a significant public health concern (James, Stewart & Bowers, 2012). National Institute of Clinical Excellence (NICE) guidelines (2004) advised that staff working with self-harm should be aware of their own fears and prejudices in working in this area. Research has generally found negative attitudes in health professionals towards self-harm. Such findings are important as staff attitudes may influence practice and therefore the experience and outcomes of service users who self-harm (Saunders, Hawton, Fortune, & Farrell, 2012). Working with self-harm has been recognised to be stressful (Royal College of Psychiatrists, 2010), however, there is little research into the impact on mental health professionals of working with self-harm.

A systematic literature review was undertaken in order to ascertain what is known about the impact on mental health staff of working with people who self-harm. The nine articles included in this review were identified through searching health related electronic databases. An evaluation of the studies was guided by the Critical Appraisal Skills Programme (2013) and Downs and Black (1998) checklist.

Two main themes emerged when exploring the impact on mental health professionals of working with self-harm; the emotional impact, and the cognitive impact of working with self-harm. Participants experienced a range of very strong emotions and responded cognitively in a number of ways to manage the impact of such work; descriptions were consistent with compassion fatigue (Figley, 2002), which has been identified as occurring in mental health professionals (Rossi et al., 2012).

Working with people who self-harm is complex and has both positive and negative effects on mental health professionals. Most research has concentrated on work with adult service users and been undertaken with qualified healthcare staff. This focus means there are gaps in the research exploring work with adolescents and the experience of unqualified staff. A gap such as this is important in inpatient settings, where unqualified staff spend the most time with adolescents who self-

harm. It is therefore important to explore the experience of unqualified staff working in an inpatient unit with adolescents who self-harm.

Introduction

Definition

Self-harm is not a new phenomenon but research has indicated it is an increasing concern (Saunders, Hawton, Fortune & Farrell, 2012).   Self-harm does not necessarily involve suicidal intent, although suicide risk amongst service users who self-harm is significantly higher than in the general population (Owens, Horrocks, & House, 2002). There is little research with participants who self-harm but in the small number of studies which have been undertaken, there is a consensus that self-harm is a survival strategy which makes it possible to manage intense and overwhelming emotions (Babiker & Arnold, 1997; Brown & Kimball, 2013; Connors, 1996; Pembroke 1998a,1998b).

A number of definitions are used in the literature about self-harm, for example, NICE guidelines defined self-harm as "any act of self-poisoning or self-injury carried out by an individual irrespective of motivation" (p.4, NICE, 2011). The review defined self-harm as intentional harm of one's own body as a way to decrease emotional pain, as well as to cope with overwhelming emotions (Turner, 2002). This definition was selected because it is most reflective of the meaning of self-harm for individuals who use this behaviour (Brown & Kimball, 2013). The phrase 'deliberate self-harm' used in some literature was intentionally avoided as this is pejorative and implicitly conveys the idea that an individual can stop self-harming by applying sufficient will-power (Lindgren, Oster, Astrom, Hallgren Granheim, 2011).

Prevalence

It is difficult to establish rates of self-harm in young people as it is not always reported. Young, Sweeting and West (2006) found an estimated lifetime prevalence rate of 7.1% in adolescents in the UK. Muehlenkamp, Claes, Havertape and Plener (2012) observed that numbers of adolescents reporting self-harm remained relatively stable from 2007 – 2011. However, numbers of 10 – 14 year olds attending Accident and Emergency Departments for reasons related to self-harm, increased by 70% from 2012 to 2014 (HSCIC, 2014).

Historical context

Self-harm is a topic which has historically evoked strong feelings and reactions. This is vividly illustrated in the years before the Suicide Act (1961), when suicide and self-harm were illegal and therefore dealt with by the law. In this context, an unsuccessful suicide attempt (which could have been an act of serious self-harm) was perceived as fake, with the individual being regarded as insincere, or dishonest. It was only after the 1961 Act, which decriminalised self-harm and suicide, that self-harm became an issue for the medical professions (Cresswell & Karimova, 2010).

Current context

However, despite decriminalisation, the echo of pre-Act attitudes can still be heard in the vocabulary of mental health professionals today, with descriptions such as 'attention-seeking' and 'manipulative' (Wilstrand, Lindgren, Gilje & Olofsson, 2007) being reminiscent of dishonest and insincere. It is interesting that NICE guidelines stressed the need for a non-judgemental approach to work with service users who self-harm (NICE, 2011). A recent systematic review of the literature found that negative attitudes towards self-harming service users were common in healthcare staff, although more positive attitudes were found in psychiatric professionals (Saunders, Hawton, Fortune & Farrell, 2012). Saunders et al., (2012) observed only minor differences in staff attitudes between newer and older studies in spite of significant advances in national guidance, publicity and awareness of self-harm. It is important to consider staff attitudes to self-harm, as these have been found to influence their practice, which in turn affects experiences of service users and their outcomes (Pompili, Girardi, Ruberto, Kotzalidis & Tatarelli, 2005). Patterson, Whittington and Bogg (2007) postulate that if negative attitudes could be changed, this would lead to an improvement in the quality of care for this group of service users.

Service user experience

NICE (2004) guidance acknowledged that the experience of health services for service users who self-harm is often unacceptable and recommended that all healthcare staff should undergo training to enable them to 'understand and to care for' those who have self-harmed. Negative experience of health services by service users who self-harm has been found in the research, where service users

recommended that staff should be more sympathetic towards them, have more knowledge about self-harm and greater and better communication between staff and service users (Taylor, Hawton, Fortune & Kapur, 2007). Service users who self-harm can discern negative attitudes in staff (Shaw, 2002; Warm, Murray & Fox, 2002). Rayner, Allen and Johnson (2005) proposed that nurses' reactions to self-harm can have a significant impact on those who self-harm, with negative nursing responses having the potential to elicit self-harm (Pembroke, 1996).

Review Aims and Rationale

Research has generally concentrated on attitudes to self-harm by general healthcare staff. Whilst this is important and could lead to service improvement with individuals presenting to general healthcare settings, it largely does not address the needs of service users who come into contact with psychiatric services. These service users are likely to have been affected by the recent inclusion of new conditions introduced by the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-V), namely suicidal behaviour disorder and nonsuicidal self-injury (NSSI). The recent addition of these diagnostic conditions means that it is now even more likely that individuals who self-harm could be constructed as 'mentally disordered' (Crowe, 2014), which increases the stigma around a behaviour which is already highly stigmatised (Long, Manktelow & Tracey, 2013).

This review aimed to concentrate on mental health professionals. This is an important group of staff as they are likely to have significant and prolonged contact with individuals who self-harm. This type of work has a profound emotional effect on professionals which is often referred to as compassion fatigue (CF) or vicarious traumatisation (VT) (Figley, 2002; McCann & Pearlman, 1990). Terms are used interchangeably within the literature to describe the cognitive and emotional impact of empathising with those who are suffering, including, nightmares, sleep disturbances, relational conflict, anxiety, depression, etc. (Bride, 2004; Ray, Wong, White & Heaslip, 2013). Such difficulties have both a human and financial cost to organisations including a negative impact on service users experience (Austin, Goble, Leier, & Byrne, 2009; Phelps, Lloyd, Creamer, & Forbes, 2009; Stamm, Varra, Pearlman, & Giller, 2002; White, 2006). Therefore, it is important to ascertain the impact on the mental health professionals of working with people who self-harm.

Method

A review of the literature was undertaken in order to identify the impact on mental health professionals of working with self-harm and to evaluate the studies found. The appropriate articles for review were identified through a systematic search strategy which is described below.

Search Strategy

On the 15th October 2015, the EBSCO host was used to search the following electronic databases: The Allied and Complementary Medicine Database (AMED), Medline, PsycINFO, SPORTDiscus, AgeLine, Cumulative Index to Nursing and Allied Health Literature Plus (CINAHL), PsycARTICLES. On the 24th October 2015, the ISI Web of Science was used to search the following databases: Biosis Citation Index, Current Contents Connect, Data Citation Index, Derwent Innovations Index, Medline SciELO Citation Index, Web of Science Citation Index, (also including: Conference Proceedings, Book Citation Index, and Index Chemicus) and Zoological Record. Finally the Cochrane library was searched on 1st November 2015 using the same search terms and limiters.

Search terms were:

Mental health nurs* or psychiatric nurs* or psychiatrist* or psychologist* or psychotherapist* or therapist* or counsellor* or mental health practitioner* or mental health clinician* or mental health therapist* or case manager* or social worker* or staff or professional*

AND

Impact or effect* or influence or reaction or response or experience

AND

Self-harm* or self-mutilat* or self-poison* or self-injur*

Limiters were then applied. These were English language and a date limiter from 2004. The date was chosen as it was deemed to be important to look for studies completed after the publication of the NICE (2004) guideline: "Self-harm: The short term physical and psychological management and secondary prevention of self-harm in primary and secondary care". This was the first national guideline

published for working with self-harm, it identified that service users experience of services was unacceptable and that staff needed to be helped to understand self-harm. After a brief screen of results a further limiter of NOT attitudes or perceptions was added because this topic was not the focus of the review and has already been explored in a comprehensive review (Saunders et al., 2012). Further inclusion criteria were that participants were mental health professionals or comprised the majority of participants. Studies were based on direct observation or other forms of research with evidence of a sampling strategy. The flow diagram below outlines the process by which the final 9 articles were selected as eligible and included in the review.

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┌─────────────────────────────────────────┐
│         Search terms, no limiters        │
│  EBSCO, Web of Science, Cochrane library │
└─────────────────────────────────────────┘
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┌─────────────────────────────────────────┐
│              5220 results:               │
│            EBSCO (n = 3541)              │
│        Web of Science (n = 1447)         │
│        Cochrane Library (n = 232)        │
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┌─────────────────────────────────────────┐
│        Papers excluded by limiters:      │
│       English language (n = 1222)        │
│     Date limiter (from 2004) (n = 831)   │
│   NOT attitudes or perceptions (n = 385) │
│            Total left = 2782             │
└─────────────────────────────────────────┘
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┌─────────────────────────────────────────┐
│       Papers excluded by titles          │
│                screen:                    │
│              (n = 2710)                   │
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┌─────────────────────────────────────────┐
│           Abstracts screened             │
│               (n = 72)                   │
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Papers removed by application of exclusion criteria:

Majority of professionals not working in mental health services (n = 9)

Participants not solely people who self-harm (n = 6)

No evidence of sampling strategy (n = 11)

Not National guidelines (n = 1)

Not position paper (n = 9)

Focus not on working with self-harm (n = 23)

Article not obtainable (n = 1)

Total left = 12

⇩

Full articles screened

(n = 12)

⇩

Papers removed by application of exclusion criteria:

Majority of professionals not working in mental health services (n = 1)

Focus not on working with self-harm (n = 2)

Total left = 9

⇩

Articles selected

(n = 9)

Results

  A data extraction table summarising the title, authors, date, aims, methods, and results and relevance of each study can be found below.

No.	Title, authors & date	Aims	Participants	Study type/method	Key findings	Relevance
1	The attitudes of nursing staff in secure environments to young people who self-harm Dickinson, Wright & Harrison (2009)	- To explore attitudes of nursing staff in secure environments to young people who self-harm	- 60 registered nurses and nursing aides (NAs) working in young people's forensic units and a young offender's institute - 19 NAs, 37 RNs, 3 student nurses, 1 dental nurse	- Cross sectional - Mixed methods: Questionnaire - Quantitative data analysis: Mann-Whitney U test, independent samples t test, linear regression - Qualitative data analysis: Grounded theory	- Education decreased mean antipathy scores - Antipathy scores increased with the length of time spent caring for self-harming clients - Grounded theory analysis identified 8 key themes including: - Sympathy and empathy - Antipathy - - Difficulty in communicating therapeutically and forming therapeutic relationships - Labelling used	- Participants described working with this client group as difficult - This included difficulties building relationships and communicating therapeutically - Negative labels given to individuals who self-harm
2	"The ailment" revisited: Are manipulative patients really the most difficult? Hayward, Tilley, Derbyshire, Kuipers & Grey (2005)	- Identify groups of behaviour that mental health staff may find challenging	- Study One: 65 staff working in mental health trust and affiliated mental health research institution - Study Two: 58 staff from above sites	- Cross sectional - Mixed methods; questionnaires & case vignettes - Data analysis: factor analysis, ANOVA & t-tests	- Study One: Staff found self-harming behaviour difficult - Study Two: Staff found aggressive or self-harming clients the most difficult and distressing to work with	- Mental health staff find self-harming behaviour difficult and distressing to work with - Discussion with colleagues, clear treatment structure and realistic expectations are helpful
3	Meanings of caring for people who self-harm as disclosed in narratives of dialectical behaviour therapy professionals Lindgren & Hallgren Graneheim (2015)	- Explore meanings of caring for adult people who self-harm as described by professionals trained in dialectical behaviour therapy (DBT)	- 9 participants, 8 females, 1 male - Aged 35-51 - Work experience in psychiatric care: 8-30 years - Psychiatric nurses, psychologists, occupational therapists	- Qualitative: Interviews - Data analysis: Phenomenological hermeneutic method	- 2 main themes: - Embarking on an unpredictable journey - Travelling alone but also together	- Professionals sought to understand those who self-harmed - Professionals sought to guard boundaries - Work was an emotional strain

						- Supervision and support of team helpful
4	Responding to repetitive, non-suicidal self-harm in an English male prison: Staff experiences, reactions, and concerns Marzano, Adler & Ciclitira (2015)	- To increase knowledge and awareness of the effect(s) of repetitive, non-suicidal, male self-harm on prison officers and health care staff, on both personal and professional levels	- 30 staff - 15 officers, 5 female, 10 male - 15 healthcare staff, 6 female, 9 male - Aged 27-50	- Qualitative: interviews - Data analysis: Thematic analysis	- 3 main themes: - Prolific self-harmers draining limited resources - Subverted power relations and role expectations - Switching off	- Working with prisoners who self-harm is challenging, draining, stressful and frustrating - Staff felt useless - Self-harmers seen as attention seeking - Staff switched off to cope
5	Understanding Psychiatric Nursing Care with Nonsuicidal Patients in Acute Psychiatric Admission Units: The Views of Psychiatric Nurses O'Donovan & Gijbels (2006)	- Gain an understanding of the Psychiatric Nursing practice in relation to people who self-harm	- 8 psychiatric nurses in acute psychiatric admission unit (6 women, 2 men) - Aged 25-55 6 months - 15 years' experience in unit	- Qualitative: semi-structured interviews - Data analysis: thematic and content analysis	- 6 themes including: - Psychiatric nurses understanding of self-harm: "it's many things" - Psychiatric nurses approach to care - The acute psychiatric admission setting: "a stressful place"	- Psychiatric nurses work to understand the meaning of self-harm - Working with self-harm was experienced as frustrating and challenging
6	Stress and burnout in psychiatric professionals when starting to use dialectical behavioural therapy in the work with young self-harming women showing borderline personality symptoms	- Investigate how starting to use dialectical behavioural therapy (DBT) in work with young self-harming women showing symptoms of borderline personality disorder (BPD) affected psychiatric professionals	- 22 therapists (19 women, 3 men) (2 physicians, 3 psychologists, 8 nurses, 8 mental care assistants, 1 occupational therapist) - 6-32 years in psychiatric care, adult & child	- Cross sectional - Mixed methods; inventory, questionnaire, group interviews - Data analysis: t-tests, chi square qualitative content analysis	- No significant results found in t-tests or chi square - 7 categories found in content analysis, including: - Working with self-destructive patients is stressful - DBT decreases stress in direct work with patients	- Treatment of self-harming patients is experienced as stressful by psychiatric professionals - Supervision and team support was helpful

	Perseius, Kaver, Ekdahl, Asberg & Samuelsson (2007)				- Mindfulness training helpful in managing stress - The team and supervision brings support	
7	Community psychiatric nurses' experience of working with people who engage in deliberate self-harm Thompson, Powis & Carridice (2008)	- Explore community psychiatric nurses (CPNs) experiences of working with people who self-harm	- 8 CPNs (4 women, 4 men) - Average age: 40 - Average years' experience: 18 - Working in CMHTs	- Qualitative: Semi-structured interview - Data analysis: Interpretative Phenomenological Analysis	- 7 superordinate themes including: - Trying to understand: - Monitoring risk: - Struggle with boundaries - Emotional impact: - Learning to cope	- Nurses struggled to understand self-harm - Sometimes self-harm perceived to be due to negative causes - Self-harming patients are difficult to work with and evoke a range of emotions, including anxiety, anger, shock and disgust.
8	Mental Health Nurses' Experiences of Caring for Patients Suffering from Self-Harm Tofthagen, Talseth & Fagerstrom (2014)	- Explore mental health nurses experiences of caring for inpatients who self-harm during an acute phase	- 15 participants - 2 male and 13 female - 12 MHNs and 3 RNs - Worked in acute psychiatric care for mean of 5.1 years	- Qualitative: Interviews - Data analysis: content analysis	- 2 main categories found: - Challenging and collaborative nurse-patient relationship - Promoting well-being through nursing interventions:	- Nurses strove to understand the patient as a person - Nurses bore hope for recovery - Nurses were emotionally affected by work - Repeat self-harming could be experienced as a defeat
9	Being burdened and balancing boundaries: a qualitative study of nurses' experiences of	- To describe nurses' experiences caring for patients who self-harm	- 6 psychiatric nurses (3 women, 3 men) - Aged 27-53 - Worked in psychiatric care 1-18 years	- Qualitative: narrative interviews - Data analysis: qualitative content analysis	- 2 overarching themes: - Being burdened with feelings and - Balancing professional boundaries	- Working with self-harm can evoke 'heavy' overwhelming emotions

caring for patients who self-harm Wilstrand, Lindgren, Gilje & Olofsson (2007)					- Feelings included fear, anger, frustration and abandonment. - Work is difficult due to powerful feelings elicited - Caring for self-harming patients can be satisfying

Figure 1: Table presenting summary of papers identified for inclusion in this review

Critical Appraisal

An appraisal of the evidence was informed by the Critical Appraisal Skills Programme (CASP, 2013), Downs and Black (1998) checklist, and guidelines about quality in qualitative research (Elliott, Fischer & Rennie, 1999; Yardley, 2000). The CASP (2013) and Downs and Black (1998) checklist have been identified as being good quality assessment tools in an investigation of appraisal tools (Deeks et al., 2003) and are recommended by NICE in the development of their guidelines (NICE, 2015).

Three papers using quantitative methods were included in this review. A summary of these studies is presented below, with a critique of key points incorporated into the summary. Articles were critiqued using an adapted version of the Downs and Black (1998) checklist (see Appendix A). An example of a full critique of Dickinson, Wright and Harrison's (2009) study, using the adapted Downs and Black checklist (1998) is provided in Appendix B. A summary of the appraisal of the other two papers is presented in Appendix C. Articles were scored out of a total of 22 points: all papers were rated as good as they scored between 12 – 17 points. Full details of the scoring system is provided in Appendix A.

Following the summary and critique of studies using quantitative methods, a summary and critique of papers which used qualitative methods will provided, after which a synthesis of results is presented.

Summary and Critique of quantitative study and quantitative methods in mixed method studies

Dickinson, Wright and Harrison's (2009) observational study had a clear aim which was to explore the attitudes of nursing staff in secure settings to adolescents who self-harm. The Self-Harm Antipathy Scale (SHAS; Patterson, Whittington & Bogg, 2007) was distributed to nurses and nursing assistants working in young people's forensic units and a young offender's institute. The sample was representative of the population. Sixty nursing professionals completed questionnaires, participants' characteristics are described. The study used statistical tests which appeared to be appropriate and reported probability values and confidence intervals. No significant difference in levels of antipathy was found between qualified and unqualified staff. The staff who had received education in

self-harm had significantly lower antipathy scores than those who had not been trained. Men had significantly higher scores than women. Scores were higher when participants had been caring for adolescents who self-harmed over longer periods of time. No confounding factors were identified. There was no power calculation, which meant it was not possible to determine whether sample size was sufficient to detect differences in participants groups (Pallant, 2010). No effect size was reported, which undermines the precision of results.

Hayward, Tilley, Derbyshire, Kuipers and Grey (2005) used an observational study to investigate which patient behaviours were most difficult and distressing for mental health staff. Two studies were undertaken. In the first study, sixty five participants were drawn from a Mental Health Trust and affiliated Research Institution. Participants' characteristics were described. The sample was representative of the population, but no information was included about the study settings, which means that important information about context, including Trust values is missing. The authors designed a questionnaire about a range of patient behaviours, with a Likert scale. Participants rated their level of difficulty and distress with each behaviour. Behaviours which had the highest rating included verbal and physical aggression, self-harming behaviour, suicide attempts, and angry outbursts. A Principle Component Analysis was used and a six factor solution was the best fit for the data; this appeared to be an appropriate statistical test and probability values were reported.

In a follow up study, behaviours from the first questionnaire were used to design a number of vignettes describing six different patients (e.g. 'aggressive', self-harming, depressed). Vignettes were distributed to staff in the same settings, with a Likert scale to rate how difficult and distressing staff found vignettes. Fifty eight clinicians returned questionnaires. Participants' characteristics were described. Results showed that aggressive and self-harming clients were rated the most difficult and distressing to work with. Statistical analysis showed the difference between levels of distress working with these clients compared to other clients was significant.

Perseius, Kaver, Ekdahl, Asberg and Samuelsson's (2007) observational study aimed to explore stress and burnout in mental health professionals using a dialectical behavioural therapy (DBT) programme to work with young women with

self-harming behaviour who were showing symptoms of borderline personality disorder. Mixed methods were used. Twenty two therapists working in a DBT project agreed to participate. The Maslach Burnout Inventory – General Survey (MBI-GS; Maslach, Jackson & Leiter, 1996) was distributed. The MBI-GS has good reliability and validity (Shutte, Toppinen, Kalimo & Scaufeli, 2000) and has been identified by research as the preferred instrument to measure burnout (Makikangas, Hatinen, Kinnunen & Pekonnen, 2001). However, unlike the MBI-HSS (Maslach Burnout Inventory-Human Services Settings; Maslach & Jackson, 1981), it was not specifically designed for human services settings and therefore may not be sensitive to the particular stresses involved in mental health work. The MBI-GS was administered at the commencement of training in DBT and after six, twelve and eighteen month intervals. Scores were analysed using t-tests and chi square. No significant differences were found in scores. However, the exhaustion and cynicism subscales of the MBI-GS increased from baseline to six month, after which they decreased. In the personal efficacy subscale, burnout was increasing from baseline to twelve months, after which it decreased. Some participants scored above the clinical cut off for exhaustion and cynicism. It was not possible to determine whether sample size was sufficient to detect differences in participant groups as no power calculation was provided. Confounding factors were discussed, although there was no acknowledgement that the second author's role as manager of the programme could have led to bias in participants' responses.

Summary and Critique of qualitative studies and qualitative methods in mixed method studies

Six studies used a qualitative methodology, and gathered data through interviews (Lindgren & Hallgren Graneheim, 2015; Marzano, Adler, & Ciclitera, 2015; O'Donovan & Gijbels, 2006; Thompson, Powis, & Carradice, 2008; Tofthagen, Talseth & Fagerstrom, 2014; Wilstrand, Lindgren, Gilje & Olofsson, 2007). Two studies used mixed methods (Dickinson, Wright & Harrison, 2009; Perseius, Kaver, Ekdahl, Asberg & Samuelsson 2007), with questionnaires used to gather data. Analysis of text was undertaken using content analysis (Perseius et al., 2007) and grounded theory (Dickinson, et al., 2009).

Articles were critiqued using the CASP (2013) (see Appendix D). Guidelines for qualitative research are also used (Elliott, Fischer & Rennie, 1999; Yardley, 2000). Appendix E provides an example of a full critique of Lindgren and Hallgren Graneheim's (2015) study. A summary of the critique and rating of all remaining papers in presented in Appendix F. Five papers were rated 'very good' (Lindgren & Hallgren Granheim, 2015; Perseius et al., 2009; Thompson et al., 2008 & Tofthagren et al., 2014), one was rated 'good' (Marzano et al., 2015) and two were rated 'below average' (Dickinson et al., 2009; O'Donovan & Gijbels, 2006). Key points from the critique are presented below in the summary of studies.

Aims

All papers included a clear aim. Most sought to explore the experience of mental health professionals working with self-harm in community or inpatient settings (Lindgren & Hallgren Graneheim, 2015; O'Donovan and Gijbels, 2006; Thompson et al., 2008; Tofthagen et al., 2014; Wilstrand et al., 2007). Finally, one aimed to explore the experience of prison staff working with self-harm (Marzano et al., 2015).

Data collection

Every qualitative study was clear about its methods of data collection; interviews. Interviews are widely recognised as an appropriate method of collecting data for qualitative analysis (Willig, 2001). Six studies provided detail about topics explored in interview (Lindgren & Hallgren Graneheim, 2015; Marzano et al., 2015; Perseius et al., 2007; Thompson et al., 2008; Tofthagen et al., 2014; Wilstrand et al., 2007). However, two studies (Dickinson et al., 2009; O'Donovan & Gijbels, 2006) did not provide detail about methods of data collection, which detracted from the clarity of these pieces of research.

Data Analysis

Detailed accounts of data analysis improves the quality of research because it demonstrates rigour (Yardley, 2000). Seven studies provided an account of their data analysis (Lindgren & Hallgren Graneheim, 2015; Marzano et al., 2015; O'Donovan & Gijbels, 2006; Perseius et al., 2007; Thompson et al., 2008; Tofthagen et al., 2014; Wilstrand et al., 2007). Accounts varied in detail, with two studies' rigour

weakened as only minimal detail was provided (Dickinson et al., 2009; O'Donovan and Gijbels, 2006).

All studies used quotes to support their findings. Quotes are important because they provide evidence that the raw data supports the analysis.

Studies used a variety of strategies to demonstrate credibility. Elliott et al., (1999) recommend this as good practice.   A small number of articles did not discuss how this was achieved (Dickinson et al., 2009; Marzano, et al., 2015). However, the majority used a variety of methods to demonstrate credibility; these included inter-rater discussion (Lindgren & Hallgren Graneheim, 2015; Wilstrand, et al., 2007), member checks (O'Donovan & Gijbels, 2006), member validation (Thompson et al., 2008), and researchers analysing data independently before discussion (Perseius, et al., 2007; Thompson, et al., 2008; Tofthagen, et al., 2014).

Clarity of results

Making results explicit is a characteristic of good qualitative research (Yardley, 2000). All studies were clear in their presentation of results, with themes presented as headings. Some presented short quotes in italics in the main body of text, with longer quotes differentiated (Lindgren & Hallgren Graneheim, 2015; Marzano, et al., 2015; Perseius, et al., 2007; Wilstrand, et al., 2007). Others differentiated all quotes from other text (Dickinson, et al., 2009; O'Donovan & Gijbels 2006; Thompson, et al., 2008; Tofthagen, et al., 2014). However, O'Donovan and Gijbels' (2006) study only elaborated on three out of the total six themes found. No explanation was provided about why this choice was made.

Reflexivity

Reflexivity increases the quality of qualitative studies (Willig, 2013). Studies varied in their exploration of reflexivity. The mixed method studies alongside three of the qualitative articles, made no reference to issues of reflexivity (Dickinson, et al., 2009; Marzano, et al., 2015; O'Donovan & Gijbels, 2006; Perseius, et al., 2007; Thompson, et al., 2008). The omission was particularly relevant for Thompson, et al., (2008) as the authors used Interpretative Phenomenological Analysis, a methodology which specifically acknowledges the impact of the researcher in making sense of participant's sense making, which is termed the double hermeneutic (Smith,

2011). Lack of reference to reflexivity made it impossible to determine how the authors had influenced the research.

The remaining articles partially explored issues of reflexivity. One cited researchers' professional background with reference to rigour of data analysis (Tofthagen, et al., 2014). Whereas, Wilstrand, et al., (2007) provided authors' professional background and acknowledged how this influenced their interpretation of data. Similarly, Lindgren and Hallgren Graneheim (2015) noted their existing knowledge, interpretations of data, and insights from literature combined to result in their final interpretation and reflected on the process of interpretation.

Synthesis of findings

A thematic analysis was undertaken of the results of all articles, using guidelines from Braun and Clarke (2006). This method was chosen to synthesize results because it is not bound to any theoretical framework (Braun & Clarke, 2006) and can therefore be used across the differing methodologies used by the papers appraised in this review. Familiarity with articles enabled the development of a list of initial codes. Colour coding was used to group together similar codes across the articles. Once these had been grouped together, it was possible to search for themes across the codes. Two main themes were found across all articles, with subthemes in each. These were: the emotional impact and the cognitive impact of working with self-harm. For clarity, each theme will be presented separately, including subthemes. Although they are presented separately, they are conceptualised as overlapping. This is primarily because the most common words used by studies to describe working with self-harm (e.g. difficult, challenging) involve emotional and cognitive components.

Emotional impact of working with self-harm

This theme was prevalent in all articles and was used to describe the strong emotional reaction elicited by working with self-harm. Emotions included anger, frustration, anxiety, revulsion and fear (Lindgren & Hallgren Graneheim, 2015; Marzano, et al., 2015; O'Donovan & Gijbels, 2006; Perseius et al., 2007; Wilstrand et al., 2007; Thompson, et al., 2008). The study which found revulsion (O'Donovan & Gijbels, 2006) was of below average quality, with major weaknesses particularly in the rigour of their data analysis. This means that it should only be accepted with

caution. Fear and anxiety were related to perceived risk of suicide and the possibility of being held accountable for this as a professional (Marzano,et al., 2015; Perseius, et al., 2007; Thompson, et al., 2008; Wilstrand, et al., 2007). Professionals often described experiencing loneliness and isolation when working with this group (Lindgren & Hallgren Graneheim, 2015; Marzano, et al., 2015; Thompson et al., 2008; Wilstrand, et al., 2007). The studies in which these results were found were of good quality, which means that findings can be regarded with confidence because of the rigour involved in the research process.

At times the emotional impact of this type of work was experienced by staff as being overwhelming, and led to feelings of powerlessness, helplessness and inadequacy (Lindgren & Hallgren Graneheim, 2015; Marzano, et al., 2015; Tofthagen, et al., 2014). Staff felt powerless in the face of repeated self-harming because they felt their attempts to prevent the behaviour were ineffective.

Individuals who self-harmed were viewed as a difficult and distressing group to work with, partly due to challenges communicating and building a therapeutic relationship; the work was perceived as stressful and demanding (Dickinson, et al., 2009; Hayward, et al., 2005). Some caution should be used when accepting this finding as Dickinson et al.'s (2009) study lacked rigour in their data analysis.

In contrast, some studies found people said that work with this group was a privilege (Lindgren & Hallgren Graneheim, 2015), and could be rewarding (Thompson, et al., 2008). Participants reported feelings of hopefulness in relation to working with this client group (Tofthagen, et al., 2014; Wilstrand, et al., 2007).

Impact on patient care

Only a few of the articles explicitly referred to the possibility that the emotional impact of the work could directly impact on patient care. These were all of good quality and thus should be taken seriously. Participants in one study (Wilstrand, et al., 2007) described feeling overwhelmed by frustration and noticed that at times staff appeared to become emotionally dysregulated, shouting at patients, gripping patient's limbs too tightly and humiliating patients. Another group of participants talked of patient's emotions being projected or transferred into them. They believed the negative feelings elicited within the nurse could provoke a patient to further self-harm (Tofthagen, et al., 2014).

Cognitive impact of working with self-harm

This theme was observed across all the studies and is used to describe a range of cognitive responses that arose as a result of the impact of working with those who self-harm.

Sense-making

The primary cognitive response that emerged was that of sense-making around self-harming behaviour (Hayward, et al., 2005; Lindgren & Hallgren Graneheim, 2015; O'Donovan & Gijbels, 2006; Thompson, et al., 2008; Tofthagen, et al., 2014). Findings from O'Donovan and Gijbel's (2006) study should be regarded cautiously due to major weaknesses, but confirmation in good quality studies makes it possible to have more confidence in this finding. Attempts to sense-make included participants believing self-harm might be a way of coping or releasing emotion; this resulted in participants feeling empathy towards those who self-harm (O'Donovan & Gijbels, 2006; Thompson, et al., 2008). Some participants developed a positive view of those who self-harmed through recognising a shared sense of humanity with their patients. This was achieved through imagining oneself in the situation of those who self-harm (Lindgren & Hallgren Graneheim, 2015) and a genuine wish to see and understand the suffering human being using self-harming behaviour (Tofthagen, et al., 2014).

Conversely, some studies reflected the development of negative ways of understanding self-harm in descriptions such as attention-seeking and manipulative (Dickinson, et al., 2009; Marzano, et al., 2015; Thompson, et al., 2008; Wilstrand, et al., 2007). The majority of papers in which this subtheme was found were of good quality. However, Dickinson et al. (2009) lacked rigour in their data collection. This may mean that their analysis involved an over-simplified reading of the data that was not reflective of the complexity of participant's sense-making. Marzano, et al.'s (2015) findings over-represented prison officers and so were not reflective of mental health professional's understanding.

Thinking about boundaries

Working with this client group required consideration around the issue of professional boundaries; most participants believed it was important to maintain

clear, firm boundaries in relation to their work with individuals who self-harmed (Hayward, et al., 2005; Thompson, et al., 2008; Tofthagen, et al., 2014; Wilstrand, et al., 2007). This was partly related to fear and anxiety about the perceived risk of suicide previously discussed in emotional impact. This finding is robust, given the good quality of papers in which it was found.

Coping strategies

Professionals described a variety of coping strategies and resources to manage the emotional impact of such work. Discussion with colleagues, team work and supervision were resources used by participants in a number of studies, which were rated as good quality (Hayward, et al., 2005; Lindgren & Hallgren Graneheim, 2015; Perseius, et al., 2007; Thompson, et al., 2008; Wilstrand, et al., 2007). In contrast, some articles described participants using strategies, such as emotionally shutting off (Marzano, et al., 2015; Wilstrand, et al., 2007) which is reminiscent of the detached approach to work that is characteristic of individuals scoring highly on the depersonalisation scale of Maslach's burnout inventory (Maslach, et al., 1996). Sometimes strategies were not effective and the emotional impact of work spilled over into home, causing sleep disturbances (Thompson, et al., 2008), nightmares, flashbacks and conflict with family members (Marzano, et al., 2015). One of the articles in which this was found primarily focussed on prison staff in their reporting of findings (Marzano, et al., 2015). This means that on its own, it could not be accepted to be representative of mental health professionals. However, the presence of these reactions in papers where participants were mental health professionals makes it possible to have more confidence in this subtheme.

Discussion

A review of the research was conducted to explore the impact on mental health professionals of working with self-harm, an area in which there has been very little research compared to the wealth of research investigating professional attitudes to self-harm (Saunders, et al., 2012). Self-harm is a topic of current interest, given recent NICE guidelines on longer term management (2011) and the creation of a new diagnostic category of NSSI in DSM-V (American Psychiatric Association, 2013). It tends to be studied alongside parasuicide within the literature (James, Stewart & Duncan, 2012). There is some argument that the lack of differentiation is

unhelpful, because although self-harm is associated with increased risk of suicide (Chen, et al., 2011), to suggest the former has a causal relationship with the latter is an oversimplification - just as it would be to propose that crossing the road leads to heightened risk of being run over (Allen, 2007). There is a general consensus in the literature that NSSI can be formulated as a form of coping utilised to manage overwhelming and unbearable feelings (Crowe, 2014). Butler and Malone (2013) suggested that self-harm should be clearly differentiated within the literature, in order that a clear understanding of the topic can be developed. This review has attempted to do this by concentrating solely on papers which investigated the impact on health professionals of working with self-harm.

Nine articles were identified which met the inclusion criteria. They were summarised and appraised. A rating was given based on their strengths and weaknesses. Articles generally concentrated on exploring work with adults who self-harmed.

A thematic analysis showed that working with self-harm was found to have both an emotional and cognitive impact on mental health professionals; a robust finding due its presence in articles rated as good to very good quality. The two main themes were presented separately, but conceptualised as overlapping. The emotional impact involved professionals experiencing strong feelings that at times were overwhelming; this is consistent with compassion fatigue (CF) (Figley, 2002) which research has found to occur in mental health professionals (Rossi et al., 2012). Some participants felt that this sometimes impacted on patient care, with some nurses believing that their negative feelings could elicit self-harm in patients.

The cognitive impact of self-harm involved a number of cognitive responses that participants utilised to manage work with those who self-harm. This included sense-making which sometimes resulted in participants' feeling empathy for those who self-harmed, but could also lead to the development of negative labels around those who self-harmed, including attention seeking and manipulative. However, some of these findings were drawn from a study whose qualitative methods were rated as below average quality and therefore should be regarded with greater caution.

The second theme also included being thoughtful about boundaries with this group of service users. This was partly in order to manage the risk of suicide perceived with these individuals. It also involved the development of coping strategies. Some of these were healthy and included support from clinician's team and supervisor. However, some strategies were indicative of CF and reminiscent of dimensions of burnout (BO) (Maslach, et al., 1996), such as 'switching off' from emotions elicited by work with self-harm. Research has identified a positive correlation between CF and BO in mental health professionals (Rossi et al., 2012). Some coping strategies were less effective and consequently some impact leaked into professional's personal lives, evidencing the presence of compassion fatigue (Ray et al., 2013). This highlights the need for good quality supervision and the development of interventions to promote self-care for clinicians working in this area. Research has found that meaning making and self-care can reduce CF in mental health professionals (Shapiro, Warren Brown & Biegel, 2007; Phelps et al., 2009).

This review has explored the impact on mental health professionals of working with self-harm. From the evidence reviewed, it has been possible to establish that work with self-harming adults has a significant emotional and cognitive impact on mental health staff. Findings suggest the impact also affects service users and can result in increased self-harming. However, no research was identified that concentrated on unqualified staff's experience working with young people who self-harm. This is an important area as there is some evidence that self-harm is most common in 15 – 24 year olds (Hawton, et al., 2012) and that young people find it difficult to discuss their self-harming behaviour and do not feel that they are listened to when they do (Bostik & Everall, 2006; Mental Health Foundation, 2006). On inpatient units, unqualified staff spend the most time with young people who self-harm (Wheatley & Austin-Payne, 2009). James, Stewart and Bowers (2012) noted that providing appropriate inpatient care for young people who self-harm is complex and there is a need for more investigation in this field. Given that this is an area in which very little study has been undertaken, it is proposed that a qualitative approach could be helpful in establishing areas that further quantitative enquiry could build upon (Henwood & Pidgeon, 1992).

References

Allen, S. (2007). Self-harm and the words that bind: a critique of common perspectives. *Journal of Psychiatric and Mental Health Nursing*, 14 , 172–178.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

Austin, W., Goble, E., Leier, B., & Byrne, P. (2009). Compassion fatigue: The experience of nurses. Ethics and Social Welfare, 3, 195-214.

Babiker, G., & Arnold, L. (1997). *The language of injury: Comprehending self-mutilation.* Leicester: BPS Books.

Bostik, K.,E., & Everall, R., D. (2006). In my mind I was alone: suicidal adolescents' perceptions of attachment relationships. *International Journal for the Advancement of Counselling,* 28, 269–87.

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.

Bride, B. E. (2004). The impact of providing psychosocial services to traumatized populations. Stress, Trauma, and Crisis, 7(1), 29-46.

Brown, T. B., & Kimball, T. (2013). Cutting to live: A phenomenology of self-harm. *Journal of Marital and Family Therapy, 39*, 195-208.

Brown, S., Williams, K., & Collins, A. (2007). Past and recent deliberate self-harm: Emotion and coping strategy differences. *Journal of Clinical Psychology*, 63, 791–803.

Butler, A. & Malone, K. (2013). Attempted suicide v. non-suicidal self injury: behaviour, syndrome or diagnosis. *The British Journal of Psychiatry*, 202, 324–325.

Chen, V. C. H., Tan, H. K. L., Chen, C. Y., Chen, T. H., Liao, L., R., Lee, C. T., Dewey, M., Stewart, R., Prince, M, & Cheng, A. T. (2011). Mortality and suicide after self-harm: Community cohort study in Taiwan. *The British Journal of Psychiatry*, 198, 31–36.

Connors, R. (1996). Self-injury in trauma survivors: Functions and meanings. *American Journal of Orthopsychiatry*, 42, 243–245.

Cresswell, M., & Karimova, Z. (2010). Self-harm and medicine's moral code: A historical perspective, 1950–2000. *Ethical Human Psychology and Psychiatry: An International Journal of Critical Inquiry, 12*, 158-175.

Critical Appraisal Skills Programme (CASP) (2013). *CASP Checklists*, Oxford: CASP.

Crowe, M. (2014). From expression to symptom to disorder: The psychiatric evolution of self-harm in the DSM. *Journal of Psychiatric and Mental Health Nursing, 21*, 857-858.

Deeks, J. J., Dinnes, J., D'Amico, R., Sowden, A. J., Sakarovitch, C., Song, F., Petticrew, M., Altman, D. G., (2003). Evaluating non-randomised intervention studies. *Health Technology Assessment*, 7, 1 – 192.

Dickinson, T., & Hurley, M. (2012). Exploring the antipathy of nursing staff who work within secure healthcare facilities across the United Kingdom to young people who self-harm. *Journal of Advanced Nursing, 68*, 147-158.

Dickinson, T., Wright, K. M., & Harrison, J. (2009). The attitudes of nursing staff in secure environments to young people who self-harm, *Journal of Advanced Nursing*, 147-158.

Downs, S. H., & Black, N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *Journal of Epidemiology and Community Health, 52:377–384.*

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *The British Journal Of Clinical Psychology*, 38, 215-229.

Figley, C. R. (2002). Compassion fatigue: Psychotherapist's chronic lack of self care. Journal of Clinical Psychology, 58(11), 1433–1441.

Fortune, S., A. & Hawton, K. (2005). Deliberate self-harm in children and adolescents: a research update. *Current Opinion in Psychiatry*, 18, 401– 406.

Hawton, K., Bergen, H., Waters, K., Ness, J., Cooper, J., Steeg, S., Kapur, N. (2012). Epidemiology and nature of self-harm in children and adolescents: findings from the multicentre study of self-harm in England. *European Child & Adolescent Psychiatry*, 21, 369–77.

Hayward, P., Tilley, F., Derbyshire, C., Kuipers, E. & Grey S. (2005) The ailment" revisited: Are "manipulative" patients really the most difficult?, *Journal of Mental Health,* 14, 291-303.

HSCIC (2014). Self-Harm Area Teenage gender 2011 – 2014. Retrieved from http://www.hscic.gov.uk/media/14858/Self_harmAreaTeenagegender2011-2014/xls/Selfharm_AreaTeam_age_gender_2011-2014.xlsx

James, K., Stewart, D., & Bowers, L. (2012). Self-harm and attempted suicide within inpatient psychiatric services: A review of the Literature. *International Journal of Mental Health Nursing,* 21, 301–309.

Klonsky, E., D. (2007) .The functions of deliberate self-injury: a review of the evidence. *Clinical Psychology Review,* 27, 226–239.

Klonsky, E., Oltmanns, T., & Turkheimer, E. (2003). Deliberate self-harm in a nonclinical population: Prevalence and psychological correlates. *American Journal of Psychiatry*, 160, 1501–1508.

Lindgren, B. - M., & Hällgren Graneheim, U. (2015). Meanings of caring for people who self-harm as disclosed in narratives of dialectical behaviour therapy professionals. *Journal of Psychiatric & Mental Health Nursing, 22*(6), 371-378.

Lindgren, B., Öster, I., Åström, S., & Graneheim, U. H. (2011). 'They don't understand . . . you cut yourself in order to live.' interpretative repertoires jointly constructing interactions between adult women who self-harm and professional caregivers. *International Journal of Qualitative Studies on Health and Well-being, 6*, 1-13.

Lindgren B.-M., Wilstrand C., Gilje F., & Olofsson, B. (2004) Struggling for hopefulness: a qualitative study of Swedish women who self-harm. *Journal of Psychiatric and Mental Health Nursing,* 11, 284–291.

Long, M., Manktelow, R., & Tracey, A. (2013). We are all in this together: working towards a holistic understanding of self-harm. *Journal Of Psychiatric & Mental Health Nursing, 20,* 105-113.

Makikangas, A., Hatinen, M., Kinnunen, U., Pekkonen, M., (2001). Longitudinal factorial invariance of the Maslach Burnout Inventory – General Survey among employees with job-related psychological health problems. *Stress & Health,* 27, 347 – 352.

Marzano, L., Adler, J. R., & Ciclitira, K. (2015). Responding to repetitive, non-suicidal self-harm in an English male prison: Staff experiences, reactions, and concerns, *Legal and Criminological Psychology,* 20, 241-254

Maslach, C., Jackson, S., E., (1981). The measurement of experienced burnout. *Journal of Organizational Behaviour,* 2, 99 – 113.

Maslach, C., Jackson, S., E. & Leiter, M., P. (1996). *Maslach Burnout Inventory*, 3rd edn. Consulting Psychologists Press: Palo Alto, CA.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress,* 3, 131–149.

Mental Health Foundation. (2006). *Truth hurts—report of the National Inquiry into Self-harm among Young People.* Mental Health Foundation: London.

Muehlenkamp, J. J., Claes, L., Havertape, L. & Plenar, P. L. (2012). International prevalence of adolescent nonsuicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health*, 6, 1 – 9.

National Institute for Clinical Excellence (2004). *Self-harm in over 8s: short-term management and prevention of recurrence.* NICE: London

National Institute for Clinical Excellence (2011). *Self-harm in over 8s: long-term management.* NICE: London.

National Institute for Clinical Excellence (2015). *Developing NICE guidelines: the manual appendix H.* NICE: London.

O'Donovan, A. & Gijbels, H. (2006). Understanding Psychiatric Nursing Care with Nonsuicidal Patients in Acute Psychiatric Admission Units: The Views of Psychiatric Nurses, *Archives of Psychiatric Nursing,* 20, 186-192.

Owens, D., Horrocks, J., House, A., (2002). Fatal and non-fatal repetition of self-harm: systematic review. *The British Journal of Psychiatry*, 181, 193–199.

Pallant, J. (2010). *SPSS Survival Manual: A step-by-step guide to data analysis using SPSS* (4th Ed.). Maidenhead: Open University Press.

Patterson, P., Whittington, R. & Bogg, J. (2007). Measuring nurse attitudes towards deliberate self-harm: the Self Harm Antipathy Scale (SHAS). *Journal of Psychiatric and Mental Health Nursing*, 144, 438–445.

Pembroke L.R. (1996) *Self-harm: Perspectives from Personal Experience.* Survivors Speak Out, London.

Pembroke, L. (1998a). Only scratching the surface. *Nursing Times*, 94, 38–39.

Pembroke, L. (1998b). Self-harm: A personal story. *Mental Health Practice*, 2, 20–24.

Perseius, K., Kåver, A., Ekdahl, S., Asberg, M., & Samuelsson, M. (2007). Stress and burnout in psychiatric professionals when starting to use dialectical behavioural therapy in the work with young self-harming women showing borderline personality symptoms. *Journal of Psychiatric and Mental Health Nursing, 14*, 635-643.

Phelps, A., Lloyd, D., Creamer, M. & Forbes, D. (2009). Caring for Carers in the Aftermath of Trauma. *Journal of Aggression, Maltreatment & Trauma*, 18, 313-330.

Pompili, M., Girardi, P., Ruberto, A., Kotzalidis, G. D., & Tatarelli, R. (2005). Emergency staff reactions to suicidal and self-harming patients. *European Journal Of Emergency Medicine: Official Journal Of The European Society For Emergency Medicine*, *12*, 169-178.

Ray, S. L., Wong, C., White, D. & Heaslip, K. (2013). Compassion Satisfaction, Compassion Fatigue, Work Life Conditions and Burnout Among Frontline Mental Health Professionals. *Traumatology*, 19, 255 – 267.

Rayner, G. C., Allen, S. L., & Johnson, M. (2005). Countertransference and self-injury: A cognitive behavioural cycle. *Journal of Advanced Nursing, 50*, 12-19.

Rossi, A., Cetrano, G., Pertile, R., Rabbi, L., Donisi, V., Grigoletti, L., Curtolo, C., Tansella, M., Thornicroft, G. & Amaddeo, F. (2012). Burnout, compassion fatigue, and compassion satisfaction among staff in community mental health services. *Psychiatry Research*, 200, 933 – 938.

Royal College of Psychiatrists (2010). *Self-harm, suicide and risk: helping people who self-harm: Final report of a working group.* RCP: London

Saunders, K. E. A., Hawton, K., Fortune, S., & Farrell, S. (2012). Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review. *Journal of Affective Disorders, 139*, 205-216.

Shapiro, S. L., Warren Brown, K., Biegel, G. M. (2007). Teaching Self-Care to Caregivers: Effects of Mindfulness-Based Stress Reduction on the Mental Health of Therapists in Training. *Training and Education in Professional Psychology*, 1, 105–115.

Shaw, S. (2002). Shifting conversations on girls' and women's self-injury: an analysis of the clinical literature in historical context. *Feminism & Psychology*, *12*, 191-219.

Shutte N., Toppinen S., Kalimo R., & Schaufeli, W. (2000). The factorial validity of the Maslach Burnout Inventory-General Survey (MBI-GS) across occupational groups and nations. *Journal of Occupational and Organizational Psychology,* 73, 53–66.

Smith, J. (2011) Evaluating the contribution of interpretative phenomenological analysis. *Heath Psychology Review*, 5, 9 – 27.

Stamm, B. H., Varra, E., Pearlman, L., & Giller, E. (2002). *The helper's power to heal and to be hurt-or helped-by trying.* Washington, DC: National Register of Health Service Providers in Psychology.

Taylor, T., Hawton, K., Fortune S., & Kapur, N. (2009). Attitudes towards clinical services among people who self-harm: A systematic review. *British Journal of Psychiatry*, 194, 104 – 110.

Thompson, A. R., Powis, J., & Carradice, A. (2008). Community psychiatric nurses' experience of working with people who engage in deliberate self-harm. *International Journal of Mental Health Nursing, 17*, 153-161.

Tofthagen, R., Talseth, A.-G., & Fagerstrom, L. (2014). Mental Health Nurses' Experiences of Caring for Patients Suffering from Self-Harm, *Nursing Research and Practice,* Volume 2014, 1-10.

Turner, V. (2002). *Secret scars: Uncovering and understanding the addiction of self-injury.* Hazelden: Center City, MN.

Warm, A., Murray, C., & Fox, J. (2002). Who helps? Supporting people who self-harm. *Journal Of Mental Health*, *11*, 121-130.

Wheatley, M. & Austin-Payne, H. (2009). Nursing Staff Knowledge and Attitudes Towards Deliberate Self-Harm in Adults and Adolescents in an Inpatient Setting. *Behavioural and Cognitive Psychotherapy,* 37, 292 – 309.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in Theory and Method.* Buckingham: Open University Press.

Willig, C. (2013). *Introducing qualitative research in psychology.* Buckingham: Open University Press.

Wilstrand, C., Lindgren, B., Gilje, F., & Olofsson, B. (2007). Being burdened and balancing boundaries: A qualitative study of nurses' experiences caring for patients who self-harm. *Journal of Psychiatric & Mental Health Nursing, 14*(1), 72-78.

White, D. (2006). The hidden costs of caring what managers need to know. *Health Care Manager*, 25, 341-347.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, *15*, 215-228.

Young, R., Sweeting, H., West, P. (2006). Prevalence of deliberate self harm and attempted suicide within contemporary Goth youth subculture: longitudinal cohort study. *British Medical Journal*, 332, 1058-1061.

Appendix A: Downs and Black (1998) checklist and scoring system

ALL CRITERIA	DESCRIPTION OF CRITERIA (with additional explanation as required, determined by consensus of raters)	POSSIBLE ANSWERS
1	Is the hypothesis/aim/objective of the study clearly described? Must be explicit	Yes/No
2	Are the main outcomes to be measured clearly described in the Introduction or Methods section? If the main outcomes are first mentioned in the Results section, the question should be answered no. **ALL** primary outcomes should be described for YES	Yes/No
3	Are the characteristics of the patients included in the study clearly described? In cohort studies and trials, inclusion and/or exclusion criteria should be given. In case-control studies, a case-definition and the source for controls should be given. Single case studies must state source of patient	Yes/No
4	Are the interventions of interest clearly described? Treatments and placebo (where relevant) that are to be compared should be clearly described.	Yes/No
5	Are the distributions of principal confounders in each group of subjects to be compared clearly described? A list of principal confounders is provided. YES = age, severity	Yes/No
6	Are the main findings of the study clearly described? Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions.	Yes/No
7	Does the study provide estimates of the random variability in the data for the main outcomes? In non normally distributed data the inter-quartile range of results should be reported. In normally distributed data the standard error, standard deviation or confidence intervals should be reported	Yes/No
8	Have all important adverse events that may be a consequence of the intervention been reported? This should be answered yes if the study demonstrates that there was a comprehensive attempt to measure adverse events (COMPLICATIONS BUT NOT AN INCREASE IN PAIN).	Yes/No
9	Have the characteristics of patients lost to follow-up been described? If not explicit = NO. RETROSPECTIVE – if not described = UTD; if not explicit re: numbers agreeing to participate = NO. Needs to be >85%	Yes/No
10	Have actual probability values been reported (e.g. 0.035 rather than <0.05) for the main outcomes except where the probability value is less than 0.001?	Yes/No
11	Were the subjects asked to participate in the study representative of the entire population from which they were recruited? The study must identify the source population for patients and describe how the patients were selected.	Yes/No/UTD
12	Were those subjects who were prepared to participate representative of the entire population from which they were recruited? The proportion of those asked who agreed should be stated.	Yes/No/UTD
13	Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of patients receive? For the question to be answered yes the study should demonstrate that the intervention was representative of that in use in the source population. Must state type of hospital and country for YES.	Yes/No/UTD
14	Was an attempt made to blind study subjects to the intervention they have received? For studies where the patients would have no way of knowing which intervention they received, this should be answered yes. Retrospective, single group = NO; UTD if > 1 group and blinding not explicitly stated	Yes/No/UTD
15	Was an attempt made to blind those measuring the main outcomes of the intervention? Must be explicit	Yes/No/UTD
16	If any of the results of the study were based on "data dredging", was this made clear? Any analyses that had not been planned at the outset of the study should be clearly indicated. Retrospective = NO. Prospective = YES	Yes/No/UTD
17	In trials and cohort studies, do the analyses adjust for different lengths of follow-up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls? Where follow-up was the same for all study patients the answer should yes. Studies where differences in follow-up are ignored should be answered no. Acceptable range 1 yr follow up = 1 month each way; 2 years follow up = 2 months; 3 years follow up = 3months.........10years follow up = 10 months	Yes/No/UTD
18	Were the statistical tests used to assess the main outcomes appropriate? The statistical techniques used must be appropriate to the data. If no tests done, but would have been appropriate to do = NO	Yes/No/UTD
19	Was compliance with the intervention/s reliable? Where there was non compliance with the allocated treatment or where there was contamination of one group, the question should be answered no. Surgical studies will be YES unless procedure not completed.	Yes/No/UTD
20	Were the main outcome measures used accurate (valid and reliable)? Where outcome measures are clearly	Yes/No/UTD

	described, which refer to other work or that demonstrates the outcome measures are accurate = YES. ALL primary outcomes valid and reliable for YES	
21	Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population? Patients for all comparison groups should be selected from the same hospital. The question should be answered UTD for cohort and case control studies where there is no information concerning the source of patients	Yes/No/UTD
22	Were study subjects in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited over the same time? For a study which does not specify the time period over which patients were recruited, the question should be answered as UTD. Surgical studies must be <10 years for YES, if >10 years then NO	Yes/No/UTD
23	Were study subjects randomised to intervention groups? Studies which state that subjects were randomised should be answered yes except where method of randomisation would not ensure random allocation.	Yes/No/UTD
24	Was the randomised intervention assignment concealed from both patients and health care staff until recruitment was complete and irrevocable? All non-randomised studies should be answered no. If assignment was concealed from patients but not from staff, it should be answered no.	Yes/No/UTD
25	Was there adequate adjustment for confounding in the analyses from which the main findings were drawn? In nonrandomised studies if the effect of the main confounders was not investigated or no adjustment was made in the final analyses the question should be answered as no. If no significant difference between groups shown then YES	Yes/No/UTD
26	Were losses of patients to follow-up taken into account? If the numbers of patients lost to follow-up are not reported = unable to determine.	Yes/No/UTD
27	Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance <5% Sample sizes have been calculated to detect a difference of x% and y%.	1-5

This study only used questions: 1, 2, 3, 6, 7, 10, 12, 18, 20, 25, 27 as other questions were not deemed to be relevant to the observational studies included in this review.

Scoring system:

Articles scored 2 points when a criterion is fully met, 1 point when a criterion is partially met, 0 points if a criterion is not met or it is impossible to determine.

Articles are scored out of a total of 22 points. Articles scoring under half are scored as below average. Articles scoring 12 – 16 are rated good; those scoring 17 – 22 are rated very good.

Appendix B: Example of full quality appraisal

The table below details the appraisal of Dickinson, Wright and Harrison's (2009) study using an adapted version of the Downs and Black (1998) checklist

Quality criteria	Comments	Score and Rating (Yes = 2, partly = 1, unable to determine = 0, no = 0)
1. Aim clearly described	Yes, in title	2
2. Main outcomes to be measured clearly described in methods	Yes, measuring antipathy using SHAS	2
3. Characteristics of participants clearly described	Partly, 60 nurses and nursing aides, speciality given, but no age or length of experience	1
6. Main findings clear	Yes, no significant difference in levels of antipathy in qualified and unqualified staff, participants who has received education in self-harm had lower levels of antipathy than those who had not, male participants had higher antipathy than female, antipathy score increase with length of time working with those who self-harm	2
7. Estimates of random variability in the data for main outcomes	No	0
10. Actual probability values reported	Yes (e.g. p = 0.75 for no difference in antipathy between qualified and unqualified staff)	2
12. Participants representative of entire population	Yes: population nursing staff working in secure settings. Sample was respondants to questionnaire sent out to qualified and unqualified staff working in these settings.

However, unclear how sites were selected for the sending of questionnaires | 2 |
| 18. statistical tests appropriate to assess main outcomes | Yes, independent sample t test to compare mean of different groups. Simple linear regression used to analyse scores in relation to gender education, amount of time in job | 2 |

20. Main outcome measures used valid and reliable	Yes: acceptable face validity, good internal consistency and some evidence of good test–retest reliability (Patterson, Whittington & Bogg, 2007)	2
25. Adequate adjustment for confounding in analyses from which main findings drawn	Not stated	0
27. Sufficient power to detect clinically important effect	Not stated	0
Total score = 15 (out of total 22) Rating: Good		

Appendix C: Summary of appraisal of papers using quantitative methods

Quality criteria	Authors of paper	
	Hayward, Tilley, Derbyshire, Kuipers & Grey (2005)	Perseius, Kaver, Ekdahl, Asbeerg & Samuelsson (2007)
	Yes = 2, partly = 1, unable to determine = 0, no = 0	
1. Clear aim	2	2
2. Outcomes clear	2	2
3. Characteristics of participants clear	2	2
6. Main findings clear	2	2
7. Estimates of random varaibility	0	0
10. Probability values	2	2
12. Sample representative of population	2	2
18. Statistical test appropriate	2	2
20. Measures reliable and valid	1	2
25. Adjustment for confounders	0	0
27. Sufficient power	0	0
Total score	15	16
Rating	Good	Good

Appendix D: CASP for qualitative studies

1. Was there a clear statement of the aims of the research?

HINT: Consider: What was the goal of the research? Why it was thought important? Its relevance

2. Is a qualitative methodology appropriate?

HINT: Consider: If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants? Is qualitative research the right methodology for addressing the research goal?

3. Was the research design appropriate to address the aims of the research?

HINT: Consider: If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?

4. Was the recruitment strategy appropriate to the aims of the research?

HINT:Consider: If the researcher has explained how the participants were selected? If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study? If there are any discussions around recruitment (e.g. why some people chose not to take part)

5. Was the data collected in a way that addressed the research issue?

HINT: Consider: If the setting for data collection was justified? If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)? If the researcher has justified the methods chosen? If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)? If methods were modified during the study. If so, has the researcher explained how and why? If the form of data is clear (e.g. tape recordings, video material, notes etc)? If the researcher has discussed saturation of data?

6. Has the relationship between researcher and participants been adequately considered?

HINT: Consider: If the researcher critically examined their own role, potential bias and influence during (a) Formulation of the research questions (b) Data collection, including sample recruitment and choice of location? How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

7. Have ethical issues been taken into consideration?

HINT: Consider: If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained? If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study

on the participants during and after the study)? If approval has been sought from the ethics committee

8. Was the data analysis sufficiently rigorous?

HINT: Consider: If there is an in-depth description of the analysis process? If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data? Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process? If sufficient data are presented to support the findings? To what extent contradictory data are taken into account? Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

9. Is there a clear statement of findings?

HINT: Consider: If the findings are explicit? If there is adequate discussion of the evidence both for and against the researchers arguments? If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)? If the findings are discussed in relation to the original research question

10. How valuable is the research?

HINT: Consider: If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature? If they identify new areas where research is necessary? If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Rating system:

Articles are scored 2 points when criterion is fully met, 1 point when criterion is partially met, 0 points if criterion is not met or it is impossible to determine.

Articles are scored out of a total of 20 points. Articles scoring under half are scored as below average. Articles scoring 11 – 15 are rated good; those scoring 16 – 20 are rated very good.

Appendix E: Example of full quality assessment

The table below details the appraisal of Lindgren and Hallgren Graneheim's (2015) study using the CASP (2013)

Quality criteria	Comments	Score
1. Clear statement of aim	Yes, aims to add a phenomenological hermeneutic perspective on the meanings of caring for adults who self-harm as described by professionals trained in DBT	2
2. Is qualitative methodology appropriate?	Yes, as about exploring meaning of experience	2
3. Was research design appropriate to address aims?	Yes, used interviews and phenomenological analysis	2
4. Was the recruitment strategy appropriate to the aims?	Yes, participants recruited from professionals trained in DBT working with adults who were using self-harming behaviour	2
5. Was the data collected in a way that addressed the research issue?	Yes, through semi-structured interviews, tape recorded and transcribed. Example questions are provided	2
6. Has the relationship between researcher and participants been adequately considered?	Yes, researchers reflect on impact of their pre-understandings, although this is not explored in detail	1
7. Have ethical issues been taken into consideration?	Yes, an explanation of process of consent provided and there is an acknowledgement of the potential of distress for participants due to subject matter discussed in interviews	2
8. Was the data analysis sufficiently rigorous?	Yes, a thorough explanation is provided of the stages of analysis, supporting quotes are given alongside themes	2
9. Is there a clear statement of findings?	Yes, themes are presented in italics with supporting quotes	2
How valuable is the research?	Some clinical implications are discussed	1
Score: 18 Rating: very good		

Appendix F: Summary of critique for remaining papers

	Authors of study							
	Dickinson, Wright & Harrison (2009)	Marzano, Adler & Ciclitira (2015)	O'Donovan & Gijbels (2006)	Perseius, Kaver, Ekdahl, Asberg & Samuelsson (2007)	Thompson, Powis & Carridice (2008)	Tofthagen, Talseth & Fagerstrom (2014)	Wilstrand, Lindgren, Gilje & Olofsson (2007)	
Quality criteria no.	Score							
1	2	2	2	2	2	2	2	
2	2	2	2	2	2	2	2	
3	2	2	2	2	2	2	2	
4	2	2	2	2	2	2	2	
5	0	2	1	2	2	2	2	
6	0	0	0	0	0	1	1	
7	1	0	0	2	0	2	1	
8	0	1	0	2	2	2	2	
9	0	1	1	2	2	2	2	
10	1	1	0	1	2	1	2	
Score	10	13	10	17	16	18	18	
Rating	Below average	Good	Below average	Very good	Very good	Very good	Very good	

Appendix G: Author Guidelines for Journal

Journal of Psychiatric and Mental Health Nursing

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Edited By: Lawrie Elliott

Impact Factor: 0.844

ISI Journal Citation Reports © Ranking: 2014: 65/109 (Nursing (Social Science)); 68/111 (Nursing (Science)); 107/133 (Psychiatry (Social Science)); 117/140 (Psychiatry)

Online ISSN: 1365-2850

Author Guidelines

Content of Author Guidelines: 1. <u>Aims and Scope</u>, 2. <u>Authorship, appeals and permissions</u> 3. <u>Submission of Manuscripts</u>, 4. <u>Manuscript Types</u>, 5. <u>Manuscript Format and Structure</u>, 6. <u>After Acceptance</u>.

1. AIMS AND SCOPE

The *Journal of Psychiatric and Mental Health Nursing* is an international journal which publishes research and scholarly papers that advance the development of policy, practice, research and education in all aspects of mental health nursing. We publish rigorously conducted research, literature reviews, essays and debates, and consumer practitioner narratives; all of which add new knowledge and advance practice globally.

All papers must have clear implications for mental health nursing either solely or part of multidisciplinary practice. Papers are welcomed which draw on single or multiple research and academic disciplines. We give space to practitioner and consumer perspectives and ensure research published in the journal can be understood by a wide audience. We encourage critical debate and exchange of ideas and therefore welcome letters to the editor and essays and debates in mental health.

Please read the instructions below carefully for details on the submission of manuscripts, the journal's requirements and standards as well as information concerning the procedure after a manuscript has been accepted for publication in the *Journal of Psychiatric and Mental Health Nursing*.

Authors are encouraged to visit: Wiley Author Services for further information on the preparation and submission of articles and figures.

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It is a requirement that all authors have been accredited as appropriate upon submission of the manuscript. Contributors who do not qualify as authors should be mentioned under Acknowledgments.

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· 	If you are creating a new account.
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Manuscripts should be uploaded as Word documents or Rich Text Format (.rft) files (not write-protected) and not as PDFs, plus separate figure files. GIF, JPEG, PICT or Bitmap files are acceptable for submission, but only high-resolution TIF or EPS files are suitable for printing. The files will be automatically converted to HTML and PDF on upload and will be used for the review process.

A covering letter/e-mail must also be included with each submission stating, on behalf of all the authors, that the work has not been published and is not being considered for publication elsewhere. It should also confirm the contact details and e-mail address of the correspondence author, in case there is a problem with the electronic file. All papers will then be peer-reviewed. Authors should ensure they keep an up-to-date copy of their paper for reference.

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Before peer review, all manuscripts are screened by the editors for their suitability for publication in the journal on the basis that they meet the criteria laid out in the Aims and Scope. Papers that pass the initial screening are assigned to an Editor and double-blind peer reviewed. The names of the reviewers will thus not be disclosed to the author submitting a paper and the name(s) of the author(s) will not be disclosed to the reviewers.

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and consequently will be able to identify authors names and organisational affiliations. Registered studies will therefore be subject to single blind review (i.e. the reviewer may be aware of the name and affiliation of the author but reviewers will remain anonymous). The registration number should be supplied in the main body of the paper for example the methods section and can be obtained retrospectively. The title page should also be included in paper.

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The journal welcomes methodologically, ethically and theoretically rigorous original research (primary or secondary) which adds new knowledge to the field and advances the development of policy and practice in psychiatric and mental health nursing. We will consider research papers of up to 5,000 words and review papers of up to 7,000 words. The decision on the final word count rests solely with the Editor and Associate Editors.

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As part of its mission to facilitate the translation of research into psychiatric and mental health nursing practice and give space to practitioner and consumer perspectives, *JPMHN* aims to engage with and be relevant to all those who are involved in the development of mental health knowledge, policy and practice. The journal therefore welcomes consumer

and practitioner narratives which have the potential to improve mental health nursing practice and/or advance knowledge.

The narrative can be authored by a single person concerning their own experience, or jointly, for example, one person relating their own experience and another person providing context and analysis. In either case, the paper should contextualise the experience with reference to relevant literature (in the arts and/or the sciences) and answer the following questions: how does this experience fit within the context of the literature and how does it inform other consumers, practitioners or researchers?

Joint authors of consumer narratives should ensure that there is a genuine and equal collaboration, and that the contextualisation and analysis avoids any interpretation of someone else's experience that has not been validated with that person.

This section will be subject to full double blind peer review. Papers must contribute to theoretical, conceptual, or methodological knowledge, and/or practice development. There is no need to provide an abstract, however an accessible summary is required (See MANUSCRIPT FORMAT AND STRUCTURE section 5.2). No more than 10 references are allowed. We will consider papers of up to 5000 words. The decision on the final word count rests solely with the Editor and Associate Editors.

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• To provide a rigorously developed theoretical perspective on a topic relevant to the Journal aims.

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Abstract: The abstract should be less than 200 words in length and should be followed by six keywords in alphabetical order for indexing purposes. You should as far as possible use the following structure for research papers: Introduction; Aim/Question; Method; Results; Discussion; Implications for Practice. For consumer and practitioner narratives this should be: Introduction; Aim; Methods (if applicable); Thesis; Implications for Practice

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- What is known on the subject
- What this paper adds to existing knowledge
- What are the implications for practice

Authors are asked to:
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• Explain the importance of the paper's findings for a non-specialist audience.

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• Non-randomised controlled trials: TREND checklist
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Where there are no established guidelines for the study design, please use the same headings as the abstract.

Abbreviations should be written in full at the beginning of a sentence. Footnotes should be avoided. Spellings should conform to those used in the Concise Oxford Dictionary. SI units should be used throughout and authors should refer to Units, Symbols and Abbreviations published by the Royal Society of Medicine.

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5.3 References

Please ensure that references in the text exactly match those in the manuscript's reference list. If editing sections of text please ensure that any references that are affected are amended accordingly in the reference list.

In the text, cite the authors' names followed by the date of publication e.g., Bowers & Thompson (2013). Where there are three or more authors, the first authors name followed by *et al.* will suffice, e.g. Kennard *et al.* (2012). Where more than one reference is cited they should be listed in chronological order. Authors should use the examples given below for referencing style. References to personal communications or unpublished results should be

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An exploration of Health Care Support Workers' experience of working with young people who self-harm

Abstract

Self-harm is common amongst young people; it is suggested that 13% of adolescents may self-harm between the ages of 11 – 16 (selfharmUK, 2016). It has been found to be a risk factor for suicide (Owens, Horrocks & House, 2002; Townsend, 2015). In the most serious cases, young people are admitted to inpatient units. The ultimate aim of such admissions is to reduce the risk to young people. In these settings, Health Care Support Workers (HCSWs) spend the most time with young people. However, there has been no previous research focussing on exploring the experience of HCSWs working in inpatient facilities with young people who self-harm. This is an important area as previous research has identified that mental health professionals are vulnerable to developing compassion fatigue (CF) (Figley, 2002), which not only impacts on staff well-being, but also has a financial cost to the organisation and negatively affects service users' experience (Austin, Goble, Leier, & Byrne, 2009; Phelps, Lloyd, Creamer, & Forbes, 2009; White, 2006). Therefore, it is important to explore HCSWs' experience of such work. The research questions were: What is the impact on HCSWs of working with young people who self-harm? How do they manage the impact of this work? Does this work have an impact on their sense of self efficacy?

Given that the aim of the research was to explore HCSW's experience of this type of work, Interpretative Phenomenological Analysis (IPA) was chosen as the most appropriate methodology. Six HCSWs from an inpatient unit in the Midlands gave consent to participate and were interviewed using a semi structured format. Transcripts of interviews were analysed using IPA. Four superordinate themes were found; trying to make sense of self-harm, emotional impact, relationships and HCSWs' role. These themes indicate that this type of work has a profound impact on HCSWs, including experience of CF, which highlights the need for specific training and structured support.

Introduction

A number of terms are used to describe self-harm, including self-injury, deliberate self-harm and self-mutilation. This study will use self-harm as it has been

identified as preferable by service users (Anderson, Woodward & Armstrong, 2005). Deliberate self-harm is commonly used within the literature but has been argued to be pejorative for service users as it implies self-harm is an act of will and can thus be stopped using sufficient will-power (Pembroke, 1994, 2000).

Attitudinal research

Much research into self-harm has focussed on professional attitudes. Staff have been drawn from a number of different settings, for example Accident and Emergency (A&E) Departments (Friedman, et al., 2006), general hospital settings (Mackay & Barrowclough, 2005), psychiatric provision (Huband & Tantam, 2000), Child and Adolescent Mental Health Services (Hay, Majumder, Fosker,, Karim, & O'Reilly, 2013), and schools (Timson, Priest & Clark-Carter, 2012). A recent systematic review found that mental health staff have more positive attitudes than other healthcare staff and that doctors have more negative attitudes than nurses towards self-harm (Saunders, et al., 2012). Earlier research found more positive attitudes towards adolescents who self-harm (Crawford, Geraghty, Street & Simonoff, 2003). Conversely, more recent research found more negative feelings about self-harm in staff working on an adolescent unit, than their counterparts in an adult ward (Wheatley & Austin Payne, 2009). Research into attitudes is an important area of enquiry because they have an impact on professionals' behaviour which could affect service users' experience of services and, ultimately, their outcomes (Wheatley & Austin Payne, 2009).

However, attitudinal research is limited, as self-report of attitudes is affected by social desirability bias, where an individual can be influenced to report socially desirable behaviour when they perceive their responses could be evaluated (Davis, Thake & Vilhena, 2010).

Professionals' experience of work with self-harm

Little research has been conducted into professionals' experience of working with service users who self-harm, despite it being recognised as a distressing and challenging area of work (Royal College of Psychiatrists, 2010). Most studies have focussed on work with adult service users (Dickinson, Wright & Harrison, 2009). The small number of studies into work with adolescents who self-harm have found that staff who felt effective with this group of service users, also felt more positive about

this group (Crawford, et al., 2003). Conversely, feeling negative about adolescents who self-harm was associated with feeling less effective in one's work (Timson, et al., 2012). There is some indication that negative feelings in mental health nurses can elicit self-harm in service users (Tofthagen, Talseth & Fagerstrom, 2014).

Although more positive attitudes have been found in mental health staff, findings from these studies also suggest that this area of work elicits strong emotions in mental health staff, for example, anger, frustration, anxiety and fear (Lindgren & Hallgren Graneheim, 2015; Marzano, Adler & Ciclitira, 2015; O'Donovan & Gijbels, 2006; Perseius, Kaver, Ekdahl, Asberg & Samuelsson, 2007; Thompson, Powis & Carradice, 2008; Tofthagen et al., 2014; Wilstrand, Lindgren, Gilje & Olofsson, 2007). Some clinicians described feelings of helplessness, powerlessness and inadequacy in relation to working with individuals who self-harm (Lindgren & Hallgren Graneheim, 2015; Marzano, et al., 2015; Tofthagen et al., 2014). Staff have also described emotionally shutting off from this client group (Marzano et al., 2015; Thompson et al., 2008; Wilstrand et al., 2007).

The cost of caring

Working in the healthcare profession has been recognised as carrying its' own particular stresses. Having compassion for those who are suffering involves taking the perspective of those who are in pain; an act which implicitly includes sharing their suffering (Figley, 2002). Figley (2002) suggests that prolonged engagement in compassionate work can lead to the development of compassion fatigue (CF), which reduces capacity to show empathy for those who are in pain. Research has found CF in staff working in mental health services as well as a positive correlation between CF and burnout (BO) (Rossi et al., 2012). An overlapping concept with CF is vicarious traumatisation (VT), which describes the negative psychological consequences of working with survivors of trauma including cognitive and emotional changes in staff who are exposed to clients' traumatic material (McCann & Pearlman, 1990). Similar to CF, empathic engagement with clients is key to the development of VT (Pearlman & Saakvitne, 1995; Salston & Figley, 2003). Both CF and VT impact on staff morale and well-being, as well as their capacity to perform in their professional roles (Austin et al., 2009; Stamm, Varra, Pearlman, & Giller, 2002; White 2006). This is highly relevant to working on an inpatient unit with adolescents who self-harm, where professionals are exposed to young people's accounts of

traumatic experiences, as well as witnessing and caring for serious injuries resulting from acts of self-harm.

Service user experience

Young people who self-harm have reported that being listened to, not feeling judged and being able to trust professionals is key to talking about self-harm (McAndrew & Warne, 2014). This is important because repeated self-harm ultimately leads to associated feelings of shame (Fortune, Sinclair & Hawton, 2008), which can result in further self-harm due to increased negative feelings about self and a need to punish oneself (Scoliers, et al., 2009). This could result in people feeling alone, stigmatized and shamed, which may ultimately lead to suicidal ideation (McAndrew & Warne, 2014). Young people who self-harm have identified their fear of being labelled as attention seeking is a barrier to them seeking professional help (Fortune et al., 2008), which highlights the need for professionals to offer non-judgemental, empathic relationships to young people who self-harm. Staff were viewed as unwilling to listen and unsympathetic and negative and unhelpful attitudes were encountered by service users who self-harm (Mental Health Foundation, 2006; Storey, Hurry, Jowitt, Owens & House, 2005). These results are inconsistent with the attitudinal research, which found positive attitudes towards service users who self-harm, suggesting that there are weaknesses in this type of enquiry, including that of social desirability bias.

Rationale for study

No published research has been identified which focuses specifically on the experience of unqualified staff working in an inpatient unit with young people who self-harm. Research which has included this group of staff has found more negativity and worry about this client group than in their qualified counterparts (Wheatley & Austin-Payne, 2009), which highlights the need to concentrate on the experience of unqualified staff. The research questions, therefore, are: What is the impact on HCSWs of working with young people who self-harm? How do they manage the impact of this work? Does this work have an impact on their sense of self efficacy?

This study aims to investigate the experience of unqualified staff working with adolescents who self-harm in an inpatient unit, the qualitative methodology of

Interpretative Phenomenological Analysis (IPA) was selected. This method has been designed to explore details of participants' lived experience and the meaning of this for participants (Smith, 2004). IPA is a useful first step in a new area of enquiry, as a thorough understanding of relevant issues can be used to guide the creation of measures including questionnaires, for quantitative research (Henwood & Pidgeon, 1992).

Methodology

Qualitative research is interpretivist, meaning each unique human being actively strives to make sense of their world. The specific approach used in this research is rooted in phenomenology, the study of experience and hermeneutics, which is concerned with interpretation. In phenomenological inquiry, it has been suggested that preconceptions can be bracketed in order that the essence of phenomena can be determined through detailed reflection (Husserl, 1927). The concept of bracketing contrasts with the recognition that assumptions, preconceptions and experiences will be intrinsically involved with any interpretative endeavour, which is suggested by proponents of hermeneutics (Smith, Flowers & Larkin, 2009). Both positions have influenced IPA, with the latter leading to the development of a central tenet of IPA, that of the double hermeneutic; the process in which the researcher makes sense of participants' sense-making (Smith, 2004).

IPA is also influenced by idiography, as observed in the commitment to small, purposive sampling, including single case studies; idiography involves a commitment to the particular. IPA is concerned with the detail of participants' lived experiences and how they make sense of these (Millward, 2006). This is accessed in verbal descriptions of how they have made sense of their experience, and is interpreted by the researcher to create another layer of meaning through a double hermeneutic (Smith, 2004). IPA is therefore well suited to explore how HCSWs make sense of their experience of working with young people who self-harm.

Method

Design

An exploratory design was used consisting of individual semi structured interviews which were analysed using Interpretative Phenomenological Analysis

(IPA). Semi-structured interviews were chosen as they enable the interviewer to adapt questions in order to probe areas of significant interest that arise in interviewees' responses (Smith & Osborn, 2008). It is therefore well suited to IPA which is concerned with the detail of participants' lived experience (Smith, Flowers & Larkin, 2009).

Setting

The research was undertaken in a fifteen bedded general inpatient unit for young people between the ages of 12 – 18. The senior leadership team comprises of two consultant psychiatrists, a modern matron, a senior clinical psychologist, a clinical psychologist (CP), a systemic family practitioner (SFP), an occupational therapist (OT), an approved mental health social worker (AMP), a ward manager and a deputy ward manager (both mental health nurses) and a deputy head teacher. A staff group of 6 teachers provide education to under 16s. The inpatient unit is staffed by 14 full time equivalent (FTE) mental health nurses (RMNs) and 12 FTE healthcare support workers (HCSWs). The senior CP and AMP were the only MDT members for a number of years until an expansion at the end of 2015, when a CP, an OT and a SFP joined the team. Three nursing staff left in the quarter in which the research was carried out. Reasons were retirement and secondment.

Young people are referred by local CAMHS or from out of area CAMHS through NHS England based on their presentation being indicative of acute mental illness. Consultant psychiatrists assess suitability for admission. Generally, young people are admitted on a voluntary basis, but on some occasions are sectioned under the Mental Health Act (1983) due to risk of suicide. Once a young person is admitted they are allocated a named nurse, shadow nurse and HCSW. Goals of admission are set and a care plan is developed to achieve goals. An assessment takes places in the first 4-6 weeks of admission to determine work necessary to achieve goals, including which members of the MDT are involved and what frequency of sessions are provided. The CPs provide weekly or biweekly sessions and the OT offers weekly sessions. Family sessions are offered 2-3 weekly. Adolescents have a weekly medical review with psychiatry. Their care plan is reviewed six weekly. Length of admission varies from 1 day to 18 months, with the average length being sixty days. Risk assessments are undertaken to determine if

young people can leave the unit for time out including home leave. Most young people have regular periods of time out and home leave.

A handover meeting takes place three times a day, led by an RMN. MDT staff attend a minimum of daily. At this meeting a description is given of a young person's behaviour and any developments in their physical or mental health since the last handover meeting.

Therapeutic orientation is integrative, with some staff (CP and RMNs) having been trained in Dialectical Behaviour Therapy (DBT).

The nursing team are diverse in their experiences, training, psychological knowledge and skills. The general standard of nursing communication is descriptive and depends on observations of young people's behaviour. Understanding the meaning of a young person's behaviour can inevitably rely on subjective interpretation and opinion. Sometimes there are differences of views in making sense of adolescents' behaviours. Plans to improve forums for MDT formulation sharing and case reflection have been put in place in order to develop and broaden psychological understanding and promote a culture of reflection.

Participants

The idiographic roots of IPA mean that small sample sizes are typically used and purposive sampling is employed (Smith et al., 2009). Six HCSWs took part in the study. Participants were assigned a pseudonym after interviews to protect anonymity. Pseudonyms were: Brenda, Ian, Mandy, Ria, Richard, Tarquin.

The age range of participants was between 30 – 65. Three men and three women took part. All were employed by the Trust as HCSWs. Qualifications varied from NVQ II to degrees in relevant subjects. Length of experience was between 1 and 23 years. A decision was made not to link participants' pseudonyms to demographic details in order to protect anonymity.

Materials

A Participant Information Sheet (see Appendix A) provided details of the research area, brief background and methodological information. An explanation of IPA was provided, as well as the need for pseudonyms to protect anonymity. The

consent form (see Appendix B) specified that participation was voluntary and could be withdrawn at any point.

The interview schedule (see Appendix C) was designed using guidance from Smith and Osborn (2008). The schedule guided the semi-structured interview. Three main questions were asked:

How do you find working young people who self-harm?

Why do you think young people self-harm?

How does it make you feel?

Interviews varied due to the commitment to explore each participants' unique experience (Smith, et al., 2009),

Procedure

Information packs containing participant information sheets and consent forms were handed out at a staff meeting at the local inpatient unit. After the meeting, HCSWs approached the researcher to express interest in taking part, who answered their initial enquiries; six HCSWs then agreed to take part. Consent forms were collected from participants prior to the interview and an opportunity was provided to ask any further questions. Semi structured interviews were undertaken in a private room on Trust premises and took between 30-50 minutes. The Interview Schedule was used to guide questions (see Appendix C). Interviews were recorded using an audio digital recorder. The researcher transcribed the recordings. The transcripts were analysed using IPA.

Ethical considerations

Ethical approval was sought and gained from the University Ethics Panel and the Trust Research and Development Department. The research was undertaken in accordance with the British Psychological Society's (BPS) (2010) Code of Human Research Ethics including the principle of protection from harm for participants.

It was important to safeguard participants' anonymity given the small scale of the research and the plan to publish the research. Therefore, a decision was made not to link demographic information with pseudonyms and any potentially identifiable information was removed from quotations.

Rigour

Sections of anonymised transcripts were shared with four independent colleagues, who contributed to the development of descriptive, linguistic and interpretative codes. Sections of transcripts were analysed independently by a member of the research team. These codes were compared with the researcher's. Supervision with the independent analyst was used frequently.

A central idea in IPA is that of the double hermeneutic, where the researcher makes sense of participants' sense making (Smith et al., 2009). It is therefore important to reflect on the researcher's experience of the area under exploration. The researcher has previously worked in Child and Adolescent Mental Health Services as a social worker with children and young people who self-harm. The researcher found this type of work elicited some difficult emotions, including stress and distress. Supervision and peer support were key to managing the emotional impact of the work.

Analysis

Analysis was undertaken using guidelines from Smith, Flowers and Larkin (2009). Since all transcriptions were conducted by the researcher, this facilitated familiarity with the data. A single transcript was read and re-read, whilst descriptive and linguistic codes were added in the right hand margin. Colour coding was used to identify similar codes. Codes were modified during the process of re-reading and interpretative codes were added in the left hand margin (See Appendix G for an example of analysis). These were modified at each re-reading until a list of main themes was completed. The process was repeated for all remaining transcripts.

Lists of main themes from all transcripts were printed and cut into sections so that similar themes could be grouped together. Groups of similar themes were studied in order to develop titles for themes. Initially thirteen themes emerged from the data. Gradually by moving back and forth between the themes and the data, some themes were subsumed within others, for example, emotional regulation and defences became part of the emotional impact superordinate theme. Eventually, three superordinate themes were identified and a short statement for each was written, with supporting quotes identified from each participant. At this stage, an

additional theme emerged, as opportunities and challenges of healthcare support work was separated from relationships.

Finally, the table of themes with accompanying quotes was assembled. Transcripts were re-read at this point to check coherency. All annotated copies of transcripts and groups of similar themes were retained to provide an audit trail.

Results

Four main themes were identified as being relevant to participants' experience of working on an inpatient unit with teenagers who self-harm. Themes and subthemes are presented in Figure 6. Quotes are used to support themes in order to provide the reader with the opportunity to independently audit results. Figure 7 presents a key to presentation of quotes.

Figure 6: Table showing main and subthemes

Theme no.	Main themes	Subthemes
1	Trying to make sense of self-harm	a) Self-harm is incomprehensible b) Sense-making
2	Emotional impact	a) Emotional responses b) Empathy c) Defensive strategies
3	Relationships	a) Relationship as agent of change b) Working with resistance
4	HCSW role	a) Opportunities b) Challenges

Figure 7: Table showing key for quotations

Notation	Key
italics	Direct quote from participant
Bold type	Indicates participant's emphasis
Dotted line	Indicates a pause
Brackets and dotted line	Some words have been removed

1. Trying to make sense of self-harm

This theme reflects participants' attempts to make sense of self-harm. Participants struggled with sense-making because of difficulty understanding how a young person could inflict physical harm on themselves. Despite this, HCSWs had thought about why young people self-harmed, to try and understand the meaning of the behaviour. Their sense-making drew on the principle of operant conditioning, where ignoring a behaviour leads to it being extinguished (Skinner, 1938). Developing an understanding of self-harm was particularly challenging in the face of repetitive self-harm.

1a: Self-harm as incomprehensible

This subtheme is used to describe participants struggle to understand an act which seemed beyond their understanding. Tarquin described this:

> *but for me in rational mind, having that thought of doing that is like, whichever way it is, whether it's cutting or overdosing or drinking or whatever you know……I've never been in that situation where I've felt the need to, …desperate need to do that or to be so…….it's, it's difficult to understand*

Tarquin's struggle to understand is clear from his choice of words and number of pauses in this short extract. The pauses indicate difficulty finding appropriate words, which is particularly evident in the third pause where he was unable to find a word to describe the emotional state of a young person who is desperate enough to harm themselves. His use of the word 'rational' implies that the act of self-harm is irrational and hence beyond his 'rational' understanding. At the same time, he

acknowledged that young people can feel a strong need to self-harm, as though it is essential to them in some way.

Brenda reflected on her experience of a specific young person's self-harm:

> *There was one girl who, you know, it was so sad, she was so scarred, so clever and so confident, in some ways, and so, ah, so accomplished and just well, it's just really sad to, to see. So intelligent and all that waste… Perplexing. I find it very perplexing.*

In this quote, scarred is juxtaposed with positive attributes, such as cleverness. The contrast is further highlighted through the close positioning of intelligent with waste. There is a feeling that although the young person's potential achievements could be significant, her self-harm cancels these out, leading to her talents being 'wasted'. Use of perplexed communicates complete confusion, thus capturing the depth of Brenda's struggle to make sense of self-harm. Brenda also talked of her sadness, there is a sense of grief, as if she is mourning the loss of the person the adolescent could be, were it not for her self-harming behaviour.

This subtheme has reflected participants' struggle to understand self-harm. However, despite the challenges, HCSWs worked to make sense of it, as captured in the following subtheme.

1b: Sense-making

All participants strived to make sense of self-harm. There was a feeling that understanding it was necessary in order to work with it as otherwise it could be emotionally overwhelming (connecting it to next main theme). One participant explained their reason for sense-making:

> *I mean, I think the more you understand about something, the more you can not only deal with it more effectively, but perhaps prevent something from happening, perhaps…….*(Richard)

For Richard, dealing successfully with self-harm is only possible if it can be understood. His quote illustrates the importance of understanding the underlying reason for self-harming behaviour in order to work effectively with it. He tentatively

suggests that it may be possible to prevent self-harm if it can be made sense of; although his hesitation about this is evident in the repetition of 'perhaps'.

Participants shared a belief that self-harm occurred for a reason. Most believed that self-harm brought young people a *release* (Mandy, Ria, Richard, Tarquin) from feelings or was a:

way to deal with emotional pain (Brenda).

There was also a suggestion that it could be self-*punishment* (Ria, Tarquin). A variety of explanations were offered about why adolescents self-harmed:

self-hatred (Tarquin),

voices in their heads (Ian and Ria)*,*

something bad in the past (Ian)*,*

abuse (Ria)*,*

something they've thought or done (Ria)*,*

a bad text message, feeling excluded, parents not visiting (Mandy)*.*

Half the participants showed an understanding of the behaviour as a form of communication:

their way of asking for help (Mandy),

because they find it hard to vocalise things (Richard).

HCSWs varied with regard to whether self-harm was viewed as within or outside of young people's control. Generally there was a sense of uncertainty about this, perhaps because of a struggle to conceptualise an act of self-inflicted pain as a voluntary decision. It may be that a view of self-harm as a compulsion was easier and some took this view; in Ria's words:

I suppose the self-harmer can't help but harm. (…).. I do think some people could, could stop themselves if they engaged, if they spoke about it.

The word 'self-harmer' narrows the characteristics of a young person to their self-harming behaviour. In stripping the young person of all other characteristics, it conjures up a sense of hopelessness and reduces possibilities of change. This is

contradicted by her use of 'suppose' and repetition of 'could' which indicate hesitation and uncertainty about whether change is possible. She has an idea is that talking may lead to cessation of the self-harm. Her quote captures the uncertainty that most participants felt about the degree of control young people have over their self-harming behaviour.

Participants' sense-making informed their interventions, in a way which shared some similarities with the formulations that guide intervention in clinical psychology (BPS, 2011). Most drew on the principle of operant conditioning (Skinner, 1938), particularly when responding to superficial self-harm*:*

> *if it's a scratch or whatever, you don't want to over-react to it, because then that's like reinforcing this bad stuff* (Brenda).

Brenda's use of 'whatever' as an alternative to scratching trivialises the act of superficial self-harm whilst 'bad stuff' implies a degree of moral judgment. Choice of 'reinforcement' invokes the principle of operant conditioning (Skinner, 1938) as the reason for her lack of response. There is a clear sense that she believes paying attention to such behaviour would reinforce it.

There was a feeling that work was hardest with young people where no sense could be made of their self-harming behaviour. Ian's quote captures the connection between lack of understanding and increased difficulty working with self-harm:

> *I'd say the people who you don't know why they're doing it are the hardest, there's no feedback, there's no understanding of why they're in hospital....*

For Ian, the biggest challenge in his work is functioning without a reason for self-harming behaviour. His repetition of 'why' underlines the degree to which he searches for meaning in the behaviour.

Participants struggled to understand self-harm and at times felt it to be beyond their comprehension. Despite their difficulties, they all made attempts to understand the meaning of the behaviour and sometimes this shaped their responses. Sense-making appeared to be connected to coping with the emotional impact of the work as discussed in the next theme.

2. Emotional impact

This theme explores participants' experience of the powerful emotional impact of this type of work.   Some of this resulted from participants empathising with the young people they cared for. At times the emotional impact of the work became overwhelming and necessitated participants employing defensive strategies because of the intensity of their emotions.

2a: Emotional responses

HCSWs described their work using words that reflected its' emotional impact, including that it could be:

> *hard,* (Richard),

> *difficult* (Brenda, Ian)*,*

> *distressing* (Mandy),

> *challenging* (Ria, Tarquin)*,*

> *disturbing* (Ian)*.*

A variety of emotions were referred to during interviews; anxiety was a common example, as Richard commented:

> *It can be anxiety provoking, it can bring out the adrenaline rush and I think a large part of that is you're anticipating something.*

In this quote, Richard described his anxiety rising in situations where he perceived there to be increasing possibility of an incident of self-harm. His use of 'anticipating', and 'adrenaline rush' emphasized the intensity of the emotional experience for him which included a strong physiological component. He made it clear that the possibility of self-harm elicited high levels of anxiety in him.

Not all participants were as explicit in their identification of emotions evoked by the work. When describing an incident that occurred over a decade ago, Tarquin said:

> *we had a girl who did it and she did it really badly, **really** badly whereas all up her shoulders and arms and it was **really** deep and all the,.. all the sort of the*

> *fat was sticking out (…..) and I was like…. wow you know she really did a*
> *nasty job on herself and er …….yeah..*

Tarquin's description of the incident, including his reference to the physical results of the self-harm, paints a vivid picture. He did not make reference to how he felt, but his pauses are reflective of difficulty finding words to describe the event. This, combined with his use of 'wow', suggest that he experienced strong emotion. The vividness of the description is reminiscent of flashbacks described by survivors of trauma despite the historic nature of the incident.

In addition to the emotions elicited by the work, participants were emotionally affected by their empathy with young people as reflected in the next subtheme.

2b: Empathy

Participants experienced empathy for the young people they were caring for; this subtheme is connected to next main theme of relationships, as empathy was experienced in the context of their relationships with young people. At times HCSWs' experience of empathy was painful for them. Ria described this:

> *Sometimes it is horrifying that these youngsters feel so low that they… that*
> *they can tie things round their necks.*

Ria's choice of the word 'horrifying' to describe how she feels conveys intense feelings of shock and fear. Her pause partway through the quote indicates she struggled to find words to describe young people's attempts to end their lives. She is horrified by the power of young people's low mood. It is as if the intensity of their low mood is matched by her horror, conveying that although she is experiencing another emotion, it is similarly unbearable.

HCSWs experience of intense emotions through empathy was illustrated by Richard:

> *as a fellow human, you can feel, you can pick up the emotions, you can pick*
> *up the anguish*

Richard vividly described the process of the experience of empathy. It is clear that his sense of shared humanity with the young people is key to his empathising with them. Repetition of 'pick up' conveys a sense that he is like a magnet, with emotion

drawn to him like iron. This indicates a lack of control on his part that is underlined by his use of anguish. His selection of anguish has echoes with Ria's experience of being horrified, in terms of conveying an intense and intolerable emotional experience.

The intensity of HCSWs emotional experience of their work with young people who self-harm led to them using defensive strategies as described in the next subtheme.

2c: Defensive strategies

Participants' accounts reflected defensive strategies, usually involving cutting off from or minimising painful or uncomfortable emotions, rapidly focussing on more positive aspects of the work. Mandy's quote is an example of this:

> it's nice going though nice things with them and then when you go through the bad things, it usually comes out nice anyway so….

The extract above implies that Mandy shared young people's pleasant experiences through empathy. She identified that there are always difficult times, in her choice of 'when' not 'if', but quickly shifts focus back to 'nicer' times. The rapid shift in focus is in spite of her implicit acknowledgement that there are not always happy endings to more difficult experiences. However, it is as if more detailed reflection on these unpleasant times is something she wished to avoid.

Tarquin gave an example which is illustrative of him minimising his emotional experience, when reflecting on how he had managed the incident of severe self-harm described in the subtheme 'emotional responses' (2a):

> it was a bit shocking at first, but I went into automatic mode and did it …..so you know I didn't feel anything……. at that time and even, even after it was like…..oooof…

His use of 'bit shocking' implied a minor emotional reaction. He described himself as having acted automatically; it is as if he closed himself off from his emotions. He believed that he did not experience an emotional reaction at the time or afterwards. However, the declaration of an absence of emotion is undermined by the noise he made, which was reminiscent of something hitting him hard, knocking breath from

his body. There is a sense of metaphor here; the impact of the incident was so strong, it knocks emotion from his body. His reference to 'did it' was about him having to restrain the young person so a doctor could undertake stitching the wound. Entering automatic mode was helpful for him in the moment so that he could do the task expected of him. However, even some time later, when reflecting on the event he only briefly allows himself to connect with his feelings ('bit shocking'), before quickly cutting off into a state of numbness.

This theme has reflected the emotional impact of the work with young people who self-harm. Participants experienced intense emotions, sometimes as a result of empathy with adolescents. They managed their emotional responses through the use of defensive strategies including cutting off from their feelings.

3. Relationships

All participants considered that part of their role was to prevent acts of serious self-harm and support young people in the development of healthier coping strategies. They used their relationship with young people as the primary agent of change. There were times when they felt their relationship with adolescents was undermined. This occurred when young people engaged in acts of repetitive self-harm. HCSWs perceived repeated self-harm to be a form of resistance to their relationship with participants.

3a: Relationship as agent of change

Building relationships with young people involved HCSWs getting to know young people and becoming familiar with their characteristics and patterns of behaviour. This enabled HCSWs to develop an awareness of young people's needs and how these were signalled. Mandy described this when asked how she knew a young person intended to self-harm:

> If you know somebody...after a couple of days with them you get to know them really well (…..)….So erm you can tell. Like you can see their face changes, they're doing anxiety things…

In the excerpt above, Mandy explained that the amount of contact she had with young people enabled her to develop an understanding of their non-verbal communication. The phrase 'you can tell' implies an intuitive component, combined

with reading behavioural cues. She felt that spending time with young people enabled her to attune to them, developing an understanding of their emotional needs. Not long after this extract, Mandy repeated the following four times:

that's why we're here

She made this repetition when discussing her wish for young people to seek her out when they are struggling with thoughts of self-harm. The repetition suggested that she had a strong sense of her function to be available to young people, both in physical presence and emotional availability to support them with their difficulties. Her hope is that talking will relieve them of their need to self-harm. She viewed herself as soothing them, which echoes the secure attachment relationship in which a primary caregiver's attunement to an infant makes it possible to respond to cues and meet needs (Bowlby, 1988).

The view of relationship as the primary means through which young people's emotional needs could be met and behavioural change occur was common across interviews. Ria explained what she thought made the difference when young people did not self-harm:

I think that sometimes it is somebody's presence being there.

The description 'being there' is reminiscent of a secure attachment in which the primary caregiver's physical proximity and emotional availability soothes a crying baby and is the secure base from which they can explore (Bowlby 1988). The extract echoes Mandy's and demonstrates how HCSWs believed that their relationship with young people was the primary agent of change. However, sometimes there were challenges to the relationship, as captured in the next subtheme.

3b: Working with resistance

HCSWs viewed the time they spent with young people as an essential part of their work. They believed the relationships they built with young people would enable them to cease self-harming. When young people continued to self-harm, this was difficult for participants to understand and was perceived as resistance within the relationship. Ian referred to this:

Yeah, they're just wanting to die and you try and support them but you can't seem to……

Ian describes adolescents' preoccupation with suicide and his attempts to change this through offering a supportive relationship with them. He believed they want to die, this implied an act of will, a choice. Since the alternative choice would be to accept his support, not choosing this feels like a kind of rejection. Use of 'can't' conveys a feeling of helplessness and a struggle to understand the young person's choice. There is a sense that he feels stuck in not knowing how to help the young person to move forward, beyond their wish to die. Such a feeling was evident in most participants' accounts. Tarquin commented:

it's ..it's.. it seems frustrating for people when it keeps happening and you're thinking, oh you know you're banging your head against a brick wall so…

Tarquin's quote vividly captured intense feelings of frustration about continued self-harm, particularly conveyed through the last part of the extract. There is a strong feeling of getting nowhere despite repeated attempts to promote change. His use of the third person may be a defence due to the intensity of feelings of frustration.

Participants often referred to frustration around repetitive self-harm. Lack of change in young people's behaviour was sometimes experienced as a rejection of their relationship with them. It was hard for HCSWs to know how to move forward and continue to work with young people with repetitive self-harm. Lack of training and supervision meant that they did not have the resources to understand and work with this pattern of behaviour. These issues are discussed in the next theme

4. HCSW Role

HCSWs are part of a team that works with adolescents on the unit. They spend the most amount of time with young people and therefore have an opportunity to build supportive relationships with them. Each adolescent has an identified HCSW allocated to them as part of their core team.

4a: Opportunities

Participants were in a unique position in terms of their opportunity to observe and develop understandings of young people. Tarquin explained this:

> *I think it's more contact and there's less paperwork ummm…there's more*
> *……erm…..sort of social interaction with the kids and you're seeing them in*
> *different settings.*

The above extract helpfully encapsulates the value of the HCSW role. Repetition of 'more' emphasized the amount of time participants spend with young people. This includes time spent away from the unit with opportunities to observe the adolescents in a variety of settings.

HCSWs also valued being part of a team and the support this provided. Richard described this:

> *I've got limits as to how much empathy or support I can give and that's when*
> *you depend on your colleagues to step in or take over.*

In this extract, Richard illustrated how important his colleagues were in supporting him in his work. It is as if working with adolescents who self-harm pushes him to the limits of his capacity to empathise and offer support. Reduction in capacity to empathise is a feature of CF (Figley, 2002a, 2002b). Richard shows self-awareness in his capacity to recognise his limitations and it is clear that he considers the support of colleagues as integral to being able to do his job.

4b: Challenges

Even with the support of the team, HCSWs sometimes struggled to manage their work, particularly the emotional demands it made on them. In addition, they sometimes felt marginalised in the team. When responding to a question about whether Ian felt his voice was heard, he gave an example of a situation in which he tried to voice his opinion about what might be helpful for a young person. The example clearly demonstrated how Ian felt his voice was lost within the team.

> *No, definitely not, I don't feel even when …no I don't think it is…even you*
> *though mentioning it that family work might work for this one …maybe it's put*
> *into someone's head …but they were already thinking about it anyway*

There is a combination of certainty and uncertainty in the above extract. Ian began confidently, but then became more hesitant. He seemed to be thinking as he spoke, as evidenced by the pauses and repetition of phrases. His reference to his

experience in the example seems to help him clarify that he feels his voice in lost within the team. It is clear that he was left feeling dismissed. The member of staff he spoke to made him feel that he was not contributing any new insights to the package of care provided to the young person.

Participants struggled with a lack of support in helping them manage the challenges of their role. Two participants explicitly referred to the need for training:

Training would be wonderful, if there was anything out there at all, whatever there was that would help me understand it and be able to do my job more effectively (Richard)

Richard believed that training would be exceptionally helpful. His use of 'anything' and 'whatever' reflect a level of desperation. There is a sense he is searching for anything that might tell him how to feel more effective in his job. The struggle to maintain a sense of self-efficacy was present in most participants' accounts. This is related to subtheme 3b, as working with repetitive self-harm impacted on HCSWs' sense of self-efficacy. When talking about this, Ria said:

I'll be thinking, am I doing something wrong, why aren't they engaging with me, what can I do to help them more? And I do look, I reflect on that myself

Ria's series of three consecutive questions indicated she was really struggling with making sense of young people's lack of progress as evidenced by their continued self-harm. She questioned herself, wondering whether there was a weakness or absence within her. She went on to refer to her use of self-reflection to try and make sense of her struggle and find a way forward.

This theme has reflected the opportunities and challenges of the HCSW role. Participants are in a unique position in the team, because of the amount of time they spend with young people, both on the unit and in the community. They valued the support of colleagues in performing their role. However, there were significant challenges within their role. They were not provided with opportunities to contribute to care planning around adolescents, they lacked training and support to help them make sense of challenging behaviour. These challenges led to an impact on their sense of being effective in their jobs.

Discussion

This study used a phenomenological approach to explore HCSWs' experience of working on an inpatient unit with young people who self-harm in order to ascertain the impact of the work. It is the first published study to focus on unqualified staff. The analysis has shown a number of different ways in which working with self-harm impacts on HCSWs and how the impact is managed.

Trying to make sense of self-harm

Participants struggled to understand self-harm, it was difficult for them to make sense of why young people would make a choice which involved inflicting pain on themselves. At times they were unsure about whether self-harming behaviour resulted from a choice or compulsion. Weiner's (1980, 1986) attributional model of helping behaviour suggests that people are more likely to provide help to another if the cause of need is attributed to being outside of the other's control. It may be that HCSWs found it easier to support young people when they judged their self-harming behaviour resulted from a compulsion and was thus outside of their control.

Despite the challenge in understanding, HCSWs strived to make sense of young people's self-harming behaviour. This theme is supported by wider research into the experience of qualified staff working with adults who self-harmed, where participants tried to understand self-harming behaviour (Hayward, et al., 2005; Lindgren & Hallgren Graneheim, 2015; O'Donovan & Gijbels, 2006; Thompson, et al., 2008; Tofthagen, et al., 2014). However, previous research which examined attitudes of unqualified staff towards adolescents who self-harm, found negative attitudes and some pejorative labelling, such as 'personality disorder' and 'attention seeking' (Dickinson, et al., 2009; Wheatley & Austin-Payne, 2009). Fear of receiving the latter label has been identified by adolescents as a barrier to seeking help for self-harm (Fortune et al., 2008). It is therefore encouraging that such a result was not found by this study.

The act of striving to understand, occurred for a number of reasons. Participants needed to make sense of a behaviour that was incomprehensible. Initially work with self-harm was unchartered territory and participants' sense making gave them a map, which enabled them to understand the area, as well as providing direction about how to respond. The participants' understanding of the triggers for

and the function of self-harm as reflects those described by individuals who use self-harm (Brown & Kimball, 2013; McAndrew & Warne, 2014), which shows that HCSWs had grasped both causes for and the meaning of the behaviour, as defined by service users. Participants' sense-making directly affected their approach to their work, for example ignoring superficial self-harm so as not to reinforce the behaviour; a clear demonstration of how professional's beliefs can impact on service users' experience. However, research has found that individuals use superficial self-harm to help them regulate their emotions and report that it is helpful to experience emotional support which includes acknowledgement of the severity of their distress (Ryan, Heath, Fischer & Young, 2008; Trepal & Wester, 2006 & 2007). These findings suggest that HCSWs' decision to ignore superficial self-harm might not be experienced as helpful by the young people using this behaviour, which means the provision of training should be considered.

The finding that HCSWs try to make sense of self-harm provides some answer to the research question about how HCSWs manage the impact of working with young people who self-harm. Future research could focus on how sense making impacts on service user experience, perhaps using dyads of HCSWs and young people.

Emotional impact

Working with young people who self-harm had a powerful emotional impact on participants due to emotions elicited by anticipating an act of self-harm and witnessing injuries caused by self-harm; this is consistent with research with qualified staff working with adults who self-harm (Lindgren & Hallgren Graneheim, 2015; Marzano, et al., 2015; O'Donovan & Gijbels, 2006; Perseius et al., 2007; Thompson, et al., 2008, Tofthagen et al., 2014; Wilstrand et al., 2007). Findings indicate that some of the emotional impact was a result of empathy with adolescents. The experience of empathic engagement with someone who is suffering, is suggested to be fundamental to the development of CF or VT (Ray, Wong, White & Heaslip, 2013). CF is characterised by a state of tension and preoccupation alongside reduced capacity to bear empathy for others (Figley, 1995, 2002a, 2002b; Wright 2004). Although participants' accounts reflected empathy for young people, their experience of strong, uncomfortable feelings was difficult for them to tolerate and so

frequently resulted in the use of defensive strategies that enabled HCSWs to minimise or cut off from their feelings. Numbing and avoidance are also features of CF (Figley, 1995, 2002b; Wright 2004). Such a findings adds more detail to the understanding of how HCSWs manage the impact of work with self-harm.

This theme highlights that work with self-harm has an emotional impact on HCSWs. Their management of the impact of this type of work includes the use of defensive strategies to minimise their emotional responses, indicating the presence of CF. Self-care practice has been found to reduce symptoms of CF and protect against its' development (Alkema, Linton & Davies 2008; Phelps et al., 2009). Future research could explore levels of CF and whether training in self-care reduces this.

Relationships

Despite the cognitive and emotional impact of the work, participants demonstrated skill in their capacity to build relationships with young people with self-harming behaviour, who often have complex difficulties (Butler & Malone, 2013). HCSWs established supportive relationships, through offering young people physical proximity and emotional availability. Participants worked to 'attune' to young people in order to meet their emotional needs. They believed their relationships were key to adolescents being able to develop healthier coping strategies, thus resulting in cessation of their self-harming behaviour.   Meeting emotional needs through a relationship reflects the process of emotional co-regulation which is a hallmark of secure attachment (Bowlby, 1988). Research has found secure attachment is key to the development of self-regulation, in emotion and behaviour (Lewis & Carpendale, 2009). It is to participants' credit that they were able to establish relationships of this quality despite minimal training and support; highlighting the vital role that HCSWs play in the care of young people who self-harm.

Repetitive self-harm was experienced by participants as young peoples' resistance to their developing relationship with HCSWs. This may be because repetitive self-harm was perceived to be a stable behaviour; Weiner's (1986) model predicts there will be a lower propensity to help another where the other's behaviour is perceived to be relatively stable due to low expectations that help will be effective. Extracts from participants' accounts indicate low expectations that their interaction

with young people will be successful in changing their repetitive self-harm; their frustration about this is very evident.

HCSWs experience of the impact of work with self-harm included their experience of relationships with the young people. Their capacity to build such relationships despite their struggle to understand the behaviour and the powerful emotional impact of the work is indicative of their strengths and resources. Future research could explore young peoples' experience of relationships with staff in inpatient settings.

HCSW role

Participants are part of a multi-disciplinary team (MDT) which works with young people; they spend the most time with the adolescents on the unit. Findings showed they experienced opportunities and challenges within their role. There was evidence that HCSWs were aware of the opportunity this provided in terms of developing an understanding of young people's behaviour. They appreciated being part of a team, because they had the support of their colleagues, this has been found in previous research with qualified staff working with adults who self-harm (Hayward, et al., 2005; Lindgren & Hallgren Graneheim, 2015; Perseius, et al., 2007; Thompson, et al., 2008; Wilstrand, et al., 2007). Conversely, lack of support has been found to be a significant risk factor for the development of CF (Killian, 2008).

However, there were also significant challenges within the HCSW role. A key challenge is their vulnerability to the development of CF through prolonged empathic engagement with young people who are suffering. CF can lead to increased anxiety and reduced morale and well-being (Clark & Gioro, 1998; Stamm et al., 2002; White, 2006). It is also related to service users being less satisfied with their experience of services (Austin et al., 2009; Phelps et al., 2009; White, 2006). Consequently, there can be financial costs to the organisation as experiencing CF can include increased physical illness, greater use of sickness absence and higher turnover (Austin et al., 2009; White, 2006). The HCSWs who took part in this study can therefore be considered to be survivors of vicarious trauma.

Clinical implications

There is a need for specialist training and support for HCSWs working on inpatient units with adolescents who self-harm. Greater staff knowledge is associated with increased self-efficacy in staff and decreased negative feelings towards those who self-harm (Timson, et al., 2012). The training should include an explanation of the aetiology and function of self-harm, including the role it can play in emotional regulation. Service users' views of self-harm and their preferences about professionals' responses to them should also be included. Some examples of formulations should be provided to support HCSWs in making sense of self-harm. An explanation of CF should be included in order to acknowledge and normalise the emotional impact of the work. Key principles of DBT could also be disseminated as there is evidence to show that this approach is effective in reducing self-harm (Fischer & Peterson, 2015).

Findings demonstrate a need for HCSWs to be provided with opportunities to reflect on their practice; a group with other members of the MDT could provide this. Reflection can contribute to the development of self-awareness, which is key to early identification of signs of CF. Such awareness makes it possible for self-care strategies to be implemented that are protective against the development of CF (Phelps et al., 2009). Clinical psychologists are trained in formulation and reflection and are therefore well placed to facilitate such groups within an MDT.

There is a need to consider the implications of findings for recruitment, selection and retention of HCSWs working with adolescents who self-harm. Lack of experience, personal history of trauma, poor self-awareness, long working hours, infrequent supervision and high caseloads are all associated with higher risk of developing CF (Chrestman, 1999; Cunningham, 2003; Killian, 2008). These factors should be recognised during recruitment and incorporated into policies, for example, regular supervision of HCSWs could promote self-awareness and self-care thereby protecting against CF (Killian, 2008).

Methodological considerations

The sample size of this study is small, this enabled a detailed exploration of participants' lived experiences. Results are consistent with the wider literature on

the experience of clinicians working with service users who self-harm, which contributes to the credibility of results.

It is likely that participants' accounts were influenced by the social desirability bias (Davis, Thake & Vilhena, 2010). The author's position as researcher and trainee clinical psychologist on placement placed her in a position of power, thereby increasing the likelihood that participants would feel their responses would be evaluated. This means it is probable that adjustments were made to their thoughts and feelings about their experiences.

A major limitation of the study was that all six participants worked on the same inpatient unit and therefore findings should be considered as reflective of the unit's culture and values. An example of this is in the lack of description of significant emotional experiences of particular young people in participants' accounts which is reflective of the strongly pragmatic culture in the unit. This means that findings cannot be assumed to be generalisable to HCSWs working in other settings.

Conclusion

This study has demonstrated that working on an inpatient unit with adolescents who self-harm has a powerful impact on HCSWs both cognitively and emotionally, and affects sense of self-efficacy. Building and maintaining relationships with young people is a key component of HCSWs work. There are challenges within the HCSW role, particularly in their vulnerability to the development of CF, which establishes a need for tailored training and opportunities for reflection for this group of staff, as well as consideration of personal and environmental vulnerability factors in recruitment, selection and retention of HCSWs working in this area.

References

Alkema, K., Linton, J. M., & Davies, R. (2008). A study of the relationship between self-care, compassion satisfaction, compassion fatigue, and burnout among hospice professionals. *Journal of Social Work in End-Of-Life & Palliative Care*, 4, 101-119.

Anderson, M., Woodward, L., & Armstrong, M. (2004). Self-harm in young people: A perspective for mental health nursing care. *International Nursing Review, 51*, 222-228.

Austin, W., Goble, E., Leier, B., & Byrne, P. (2009). Compassion fatigue: The experience of nurses. *Ethics and Social Welfare*, 3, 195-214.

Bowlby, J. (1988). *A Secure Base.* London: Routledge.

British Psychological Society (BPS) (2010). *Code of Human Research Ethics*. Leicester: BPS.

British Psychological Society (BPS) (2011). *Good Practice Guidelines on the use of psychological formulation*. Leicester: BPS.

Brown, T. B., & Kimball, T. (2013). Cutting to live: A phenomenology of self-harm. *Journal of Marital and Family Therapy, 39*, 195-208.

Butler, G. (1998). Clinical formulation. In A.S. Bellack & M. Hersen (Eds.), *Comprehensive clinical psychology*. Oxford: Pergamon.

Butler, A. M., & Malone, K. (2013). Attempted suicide v. non-suicidal self-injury: Behaviour, syndrome or diagnosis? *The British Journal of Psychiatry, 202*(5), 324-325.

Carroll, M. (2009). Supervision: Critical Reflection for Transformational Learning, Part 1. *The Clinical Supervisor,* 28, 210 – 220.

Chrestman, K. R. (1999). Secondary exposure to trauma and self-reported distress amongst therapists. In B. H. Stamm (Ed.) *Secondary Traumatic Stress: Self-care Issues for clinicians, researchers and educators.* (pp. 29 – 36) Lutherville MD: Sidran Press

Clark, M., & Gioro, S. (1998). Nurses, indirect trauma, and prevention. *Journal of Nursing Scholarship*, 30, 85.

Crawford, T., Geraghty, W., Street, K., & Simonoff, E. (2003). Staff knowledge and attitudes towards deliberate self-harm in adolescents. *Journal of Adolescence, 26*, 623-633.

Cunningham, M. (2003). Impact of trauma work on social work clinicians: empirical findings. Social Work, 48, 451 – 459.

Davis, C. G., Thake, J., & Vilhena, N. (2010). Social desirability biases in self-reported alcohol consumption and harms. *Addictive Behaviors, 35*(4), 302-311.

Dickinson, T., Wright, K. M., & Harrison, J. (2009). The attitudes of nursing staff in secure environments to young people who self-harm. *Journal of Psychiatric & Mental Health Nursing, 16*(10), 947-951.

Figley, C. R. (1995). *Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatised.* New York: Brunner/Mazel.

Figley, C. R. (2002a). Compassion fatigue: Psychotherapist's chronic lack of self care. *Journal of Clinical Psychology*, 58(11), 1433–1441.

Figley, C. R. (2002b) (ed.). *Treating Compassion Fatigue.* New York: Brunner
    Routledge

Fischer, S., & Peterson, C. (2015). Dialectical behavior therapy for adolescent binge
    eating, purging, suicidal behavior, and non-suicidal self-injury: A pilot study.
    Psychotherapy, *52*(1), 78-92.

Fortune, S., Sinclair, J., & Hawton, K. (2008). Help-seeking before and after
    episodes of self-harm: A descriptive study in school pupils in England. *BMC
    Public Health, 8*, 369-369.

Friedman, T., Newton, C., Coggan, C., Hooley, S., Patel, R., Pickard, M., & Mitchell,
    A. J. (2006). Predictors of A&E staff attitudes to self-harm patients who use self-
    laceration: Influence of previous training and experience. *Journal of
    Psychosomatic Research, 60*, 273-277.

Gibb, S. J., Beautrais, A. L., & Surgenor, L. J. (2010). Health-care staff attitudes
    towards self-harm patients. *Australian & New Zealand Journal of Psychiatry,
    44*(8), 713-720.

Hay, A., Majumder, P., Fosker, H., Karim, K., & O'Reilly, M. (2015). The views and
    opinions of CAMHS professionals on their role and the role of others in attending
    to children who self-harm...child and adolescent mental health services. *Clinical
    Child Psychology & Psychiatry, 20*(2), 289-303.

Hayward, P., Tilley, F., Derbyshire, C., Kuipers, E., & Grey, S. (2005). 'The ailment'
    revisited: Are 'manipulative' patients really the most difficult? *Journal of Mental
    Health, 14*, 291-303.

Henwood, K. L., & Pidgeon, N. F. (1992). Qualitative research and psychological theorizing. *British Journal of Psychology, 83*, 97-111.

Huband, N. & Tantam, D. (2000). Attitudes to self-injury within a group of mental health staff. *British Journal of Medical Psychology,* 73, 495 – 504.

Husserl, E. (1927). Phenomenology. For *Encyclopedia Brittanica* (R. Palmer, Trans. and revised). Available at: http://www.hfu.edu.tw/~huangkm/phenom/husserl-brittanica.htm.

Jeffery, D., & Warm, A. (2002). A study of service providers' understanding of self-harm. *Journal of Mental Health, 11*(3), 295-304.

Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology*, 14, 32-44.

Lakeman, R. (2012). What is good mental health nursing? A survey of Irish nurses. *Archives of Psychiatric Nursing, 26*(3), 225-231.

Lewis, C., & Carpendale, J. I. M. (2009). In Lewis C., Carpendale J. I. M. (Eds.), *Social interaction and the development of executive function.* San Francisco, CA, US: Jossey-Bass.

Lindgren, B., & Hällgren Graneheim, U. (2015). Meanings of caring for people who self-harm as disclosed in narratives of dialectical behaviour therapy professionals. *Journal of Psychiatric & Mental Health Nursing, 22*(6), 371-378.

Mackay, N., & Barrowclough, C. (2005). Accident and emergency staff's perceptions of deliberate self-harm: Attributions, emotions and willingness to help. *British Journal of Clinical Psychology, 44*, 255-267.

Mangnall, J., & Yurkovich, E. (2008). A literature review of deliberate self-harm. *Perspectives in Psychiatric Care, 44*, 175-184.

Marzano, L., & Adler, J. R. (2007). Supporting staff working with prisoners who self-harm: A survey of support services for staff dealing with self-harm in prisons in england and wales. *International Journal of Prisoner Health, 3*, 268-282.

McAndrew, S., & Warne, T. (2014). Hearing the voices of young people who self-harm: Implications for service providers. *International Journal of Mental Health Nursing, 23*(6), 570-579.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3, 131–149.

Mental Health Foundation (2006). *Truth Hurts: Report of the National Inquiry into Self-harm among Young People.* London: Mental Health Foundation.

Millward, L. J., (2006). The transition to motherhood in an organizational context: An interpretative phenomenological analysis. *Journal of Occupational and Organizational Psychology,* 79, 315-333.

O'Donovan, A., & Gijbels, H. (2006). Understanding psychiatric nursing care with nonsuicidal self-harming patients in acute psychiatric admission units: The views of psychiatric nurses. *Archives of Psychiatric Nursing, 20*, 186-192.

Owens, D., Horrocks, J., & House, A. (2002). Fatal and non-fatal repetition of self-harm. *British Journal of Psychiatry,* 181, 193 – 199.

Pearlman, L. A. & Saakvitne, K. W. (1995). Treating therapists with vicarious traumatisation and secondary traumatic stress disorders. In C. R. Figley (Ed.)

Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatised. (pp 150 – 177) New York: Brunner/Mazel.

Perseius, K., Kåver, A., Ekdahl, S., Asberg, M., & Samuelsson, M. (2007). Stress and burnout in psychiatric professionals when starting to use dialectical behavioural therapy in the work with young self-harming women showing borderline personality symptoms. *Journal of Psychiatric and Mental Health Nursing, 14*(7), 635-643.

Pembroke, L.R. (ed.) (1994) *Self-Harm: Perspectives from Personal Experience.* London: Survivors Speak Out

Pembroke, L.R. (2000). Damage Limitation. *Nursing Times*, 96, 34–35.

Phelps, A., Lloyd, D., Creamer, M., & Forbes, D. (2009). Caring for carers in the aftermath of trauma. Journal of Aggression, Maltreatment & Trauma, 18, 313-330.

Ray, S. L., Wong, C., White, D. & Heaslip, K. (2013). Compassion Satisfaction, Compassion Fatigue, Work Life Conditions and Burnout Among Frontline Mental Health Professionals. *Traumatology*, 19, 255 – 267.

Rossi, A., Cetrano, G., Pertile, R., Rabbi, L., Donisi, V., Grigoletti, L., Curtolo, C., Tansella, M., Thornicroft, G. & Amaddeo, F. (2012). Burnout, compassion fatigue, and compassion satisfaction among staff in community mental health services. *Psychiatry Research*, 200, 933 – 938.

Royal College of Psychiatrists (2010). *Self-harm, suicide and risk: helping people who self-harm.* London: Royal College of Psychiatrists.

Ryan, K., Heath, M. A., Fischer, L., & Young, E. L. (2008). Superficial self-harm: Perceptions of young women who hurt themselves. *Journal of Mental Health Counseling, 30*(3), 237-254.

Ryle, A. & Kerr, I. B. (2002). *Introducing Cognitive Analytic Therapy: Principles and Practice*, Oxford: Wiley-Blackwell.

Salston, M. & Figley, C. R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress,* 16, 167 – 174.

Saunders, K. E. A., Hawton, K., Fortune, S., & Farrell, S. (2012). Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review. *Journal of Affective Disorders, 139*, 205-216.

Scoliers, G., Portzky, G., Madge, N., Hewitt, A., Hawton, K., de Wilde, E. J., Ystgaard, M., Arensman, E., De Leo, D., Fekete, S. & van Heeringen, K. (2009). Reasons for adolescent deliberate self-harm: A cry of pain and/or a cry for help? Findings from the child and adolescent self-harm in europe (CASE) study. *Social Psychiatry and Psychiatric Epidemiology, 44*(8), 601-607.

selfharmUK (2016). The Facts: Who Self Harms. Retrieved from: http://www.selfharm.co.uk/get/facts/who_self_harms

Skinner, B. F. (1938). *The Behavior of organisms: An experimental analysis*. New York: Appleton-Century.

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*(1), 39-54.

Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis.* London: Sage.

Smith, J. A. & Osbourn, M. (2008). Interpretative Phenomenological Analysis. In J. A. Smith (ed.), *Qualitative Psychology: A Practical Guide to Methods* (2nd ed). London: Sage.

Stamm, B. H., Varra, E., Pearlman, L., & Giller, E. (2002). *The helper's power to heal and to be hurt-or helped-by trying*. Washington, DC: National Register of Health Service Providers in Psychology

Storey, P., Hurry, J., Jowitt, S., Owens, D., & House, A. (2005). Supporting young people who repeatedly self-harm. *Journal of the Royal Society for the Promotion of Health, 125*(2), 71-75.

Thompson, A. R., Powis, J., & Carradice, A. (2008). Community psychiatric nurses' experience of working with people who engage in deliberate self-harm. *International Journal of Mental Health Nursing, 17*(3), 153-161.

Timson, D., Priest, H., & Clark-Carter, D. (2012). Adolescents who self-harm: Professional staff knowledge, attitudes and training needs. *Journal of Adolescence, 35*(5), 1307-1314.

Townsend, E. (2015). Self-ham in young people. *Evidence Based Mental Health*, 17, 97 – 99.

Tofthagen, R., Talseth, A., & Fagerström, L. (2014). Mental health nurses' experiences of caring for patients suffering from self-harm. *Nursing Research and Practice, 2014*, 905741-905741. doi:10.1155/2014/905741

Trepal, H. C., & Wester, K. L. (2006). School counselors and self-injurious behaviors: Assessing perceptions, prevalence, and training issues. *Journal of School Counseling*, 4, 15-23.

Trepal, H. C., & Wester, K. L. (2007). Self-injurious behaviors, diagnoses, and

treatment methods: What mental health professionals are reporting. *Journal of

Mental Health Counseling, 29*(4), 363-375.

Weiner, B. (1980). A cognitive (attribution)-emotion-action model of helping behavior:

an analysis of judgements of help giving. Journal of Personality and Social

Psychology, 39, 186 – 200.

Weiner, B. (1986). Attributional Theory of Motivation and Emotion. New York:

Springer-Verlag.

Wheatley, M., & Austin-Payne, H. (2009). Nursing staff knowledge and attitudes

towards deliberate self-harm in adults and adolescents in an inpatient setting.

Behavioural and Cognitive Psychotherapy, 37(3), 293-309.

White, D. (2006). The hidden costs of caring what managers need to know. Health

Care Manager, 25, 341-347.

Wilstrand, C., Lindgren, B., Gilje, F., & Olofsson, B. (2007). Being burdened and

balancing boundaries: A qualitative study of nurses' experiences caring for

patients who self-harm. *Journal of Psychiatric & Mental Health Nursing, 14*(1),

72-78.

Wright, B. (2004). Compassion fatigue: how to avoid it. *Palliative Medicine*, 18, 4 – 5.

Appendix A: Participant Information Sheet

Study title: An exploration of Healthcare Support Assistant's experience of working with young people who self-harm

Invitation and Brief Summary:

This is a study exploring staff member's experience of working with teenagers who self-harm and how this is managed. If you are interested in taking part, please read on.

Explanation: purpose of and background to the research:

You are invited to take part into research that is being undertaken as part of a Doctorate in Clinical Psychology. There is very little research into HCAs experience of working with young people who self-harm in inpatient units. Referrals to CAMHS of young people who self-harm have increased by 20% over the last 2 years. It is important to develop a better understanding of clinician's experience of this in order to ascertain whether any support may be helpful.

Please feel free to contact the researcher or supervisors, Claire Halsey, Heather Mason and Helen Dent to ask further questions. Contact details are at the end of this form.

Do I have to take part?

No, you do not have to take part. It is completely up to you whether you want to take part in this study.

What would taking part involve?

You would need to complete and sign the informed consent form in this pack and then contact the researcher at the email address at the end of this form to arrange a convenient time for an interview. The interview will take about 45 minutes and will be recorded. It will take place in a quiet, private room on Trust premises or at Staffordshire University if you would prefer this. The researcher will collect your signed informed consent form and check whether you have any questions about the research prior to starting the interview.

Following this, the researcher will transcribe the interview, removing any names. A pseudonym will be assigned to you, or you can choose your own. The researcher will send you a copy of the transcript in order for you to check that you are happy with the content, as it is possible that quotes will be used. If you are happy, the researcher will analyse your transcript using Interpretative Phenomenological Analysis. This method of analysis is about exploring the meaning of your experience. It results in the production of themes. Quotes are used to illustrate themes. Your pseudonym will be used alongside any quotes.

What are the possible benefits of taking part?

Increased understanding of staff member's experience of working with young people who self-harm could lead to the development of different, more effective support for practitioners involved in this work. It is hoped that the research will be published; this could help raise awareness about the experience of this work for clinical staff.

What are the possible disadvantages and risks of taking part?

It may be upsetting for you to talk about your experience of working with teenagers who self-harm, as this type of work can present challenges. If this is the case for you, you can seek support from your clinical supervisor and / or colleagues, and/ or from Trust counselling services or the Trust Occupational Health Department. If you do not feel able to do this, you may want to talk to the Samaritans (08457 90 90 90) or to your G.P., or to the Mental Health Helpline (0300 5000 927).

It is possible that a safeguarding issue or concern about practice may emerge during the interview. If this does happen, the Researcher will need to follow Trust procedures and report the concern to the appropriate members of staff. The Researcher will inform you of her intention to do this.

In order to describe participants accurately, the Researcher will need to include staff member's gender. This means it is not possible to guarantee anonymity from your colleagues, so you may be identifiable to them in the final write up. If you would prefer to avoid any possibility of being recognised then you may wish to decide not to take part.

Further information:

The informed consent forms and transcripts will be kept in separate locked boxes for 10 years in keeping with University guidelines, but will be destroyed after this time.

If you complete the informed consent form and take part in an interview, you can still withdraw from the study without giving a reason up until the point at which the data is analysed, 3 weeks from the date of your interview. You can withdraw by sending the Researcher an email stating you want your data to be removed from the study. You do not have to give a reason for this.

It is good practice for some analysis of transcripts to be performed by someone experienced in IPA but not actively involved in the research, in order to ensure the quality of the analysis. In order to do this, this person needs access to transcripts. Your name will have been removed. Dr Stephanie Hutton (clinical psychologist) will take this role within the analysis.

The research is supervised by Professor Helen Dent, Dr Claire Halsey and Dr Heather Mason.

External examiners may also have access to your anonymised transcripts for the purposes of audit and governance.

The Researcher is employed by the Trust.

The research will be submitted to Staffordshire University as part of the requirements of a doctorate. If you would like a summary of the completed project, you can tick the relevant box on the informed consent form. It is hoped that the research will be published in an academic journal and findings may be presented to interested professionals.

If you have further questions about the research please feel free to contact the Researcher or Research Supervisors. The Researcher can be emailed at myra.baker@........ Research Supervisor Dr Claire Halsey can be contacted at

Claire.Halsey@........, Dr Heather Mason at Heather.Mason@.......... and Professor Helen Dent can be contacted at H.R.Dent@staffs.ac.uk

Many thanks for your time

Myra Baker

Trainee clinical psychologist

v.1, 28.8.15

Appendix B: Consent Form

Participant pseudonym:

CONSENT FORM

Title of Project: An exploration of Healthcare Support Assistants' experience of working with young people who self-harm

Name of Researcher: Myra Baker

Please initial box

1. I confirm that I have read the participant information sheet for the above study. I have

   had the opportunity to consider the information, ask questions and have had these

   answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time (up until the analysis takes place) without giving any reason, without my rights being affected.

3. I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers.

4. I understand that my anonymised information will be used in a paper that will be submitted for publication and that full anonymity cannot be guaranteed

5. I understand that my information will be held for 5 years and then destroyed

6. I agree to take part in the above study.

Impact of self-harm on mental health professionals

Participant information:

Gender: M/F   Age: …………   Professional qualification: ……………………………………

Educational qualification(s): ………………………………….

Please tick this box if you would like to receive a summary of the final project: ☐

_____   _____   _____

Name of Participant   Date   Signature

_____   _____   _____

Name of Person taking consent   Date   Signature

Appendix C: Interview schedule

1. How long have you worked here?

2. Have you worked with this population before?

3. How do you find working young people who self-harm?

4. Why do you think young people self-harm?

5. When you reflect on your work, how do you make sense of your experience of working with young people who self-harm?

6. Could you share with me some of the ways that this kind of work impacts on you?

Prompts:

Do you have a characteristic response/particular feeling when you are with a teenager who self-harms?

What kind of emotions do you feel when you are with young people who self-harm?

Do you feel empathy towards these young people? Do you ever find that you don't feel this way towards them?

What kind of thoughts do you have? Both about the teenager and about yourself?

What do you find most difficult about spending time with young people who self-harm?

What impact do you think the time you spend with a young person could have/ on their self-harm?

How does it make you think and feel about yourself as a member of staff?

Do you think/feel that you can have a positive impact on the young people you work with?

Do you believe that you are effective in your job working with these young people? If not, why not?

How important is it to you that they stop self-harming?

How do you think the self-harm should be treated?

7. Can you tell me about how you manage the impact on yourself of working with these young people who self-harm?

Prompts:

What are the positive and negative impacts of this kind of work?

How do you feel after spending time with the young people on the ward?

What do you find yourself thinking?

What might you do after work to manage the impact of this kind of work?

Do you find yourself doing anything differently when you get home after working with someone who has self-harmed?

Do you find yourself thinking or feeling about yourself in a particular way after spending the day working with young people who self-harm?

How do you feel when a young person is discharged from the unit?

What do you think about when the young person is discharged but has continued to self-harm?

Do you worry about them?

Do you think that the time you have spent with them has led to any change in their self-harming behaviours?

What do you find helps you when working with this group of young people?

What do you find unhelpful when working with this group of young people?

Has this changed over time? If so how and why?

Version 1, 28.8.15

Appendix D: University Ethical Approval

Faculty of Health Sciences

ETHICAL APPROVAL FEEDBACK

Researcher name:	Myra Baker
Title of Study:	An exploration of Healthcare Support Assistant's experience of working with young people who self harm
Status of approval:	Approved

Dear Myra

Thank you for addressing the committee's comments. Your research proposal has now been approved by the Faculty's Ethics Panel and you may commence the implementation phase of your study. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site.

Signed: Professor Karen Rodham   **Date:** 20 November 2014
Chair of the Faculty of Health Sciences Ethics Panel

Appendix E: NHS R&D Permission

26 January 2016

Myra Baker
Trainee Clinical Psychologist

c/o Staffordshire University
Science Centre
Stoke on Trent ST4 2DE

Dear Myra

The Research and Development [R&D] Office has reviewed the research study described below against NIHR assurance criteria for research undertaken within the NHS, and are pleased to confirm it has successfully met all criteria, therefore NHS Permission for a Research Site at North Staffordshire Combined Healthcare NHS Trust has been granted, and details entered onto the R&D database.

This letter has been issued on the basis that the research study is conducted in accordance with the version of the protocol and supporting documents submitted with the application and on the understanding that you comply with the *Terms & Conditions* described below. You are advised to read these conditions carefully as failure to comply could invalidate the research permission.

Original Date of Issue: 26/01/2016

R&D Reference:	CHC0125/RS		
Principal Investigator:	Myra Baker		
Directorate:	CYP		
Date of NHS Permission:	26/01/2016		
Date Research Ends at Site:	30/04/2016		
Research Reference Numbers:	*IRAS Code:* 193586	*REC Ref.:*	N/A
	UKCRN ID: N/A	*Protocol Version/Date:*	1 (25/10/2015)
Research Title:	Exploring HCAs experience of working with self harm in young people		
Date Research Ends:	30/04/2016		

Chief Investigator/Employer:	Myra Baker /
Research Sponsor:	Staffordshire University
Research Funder:	N/A

Documents Reviewed:	**Version Number**	**Date**
Protocol	1	25/10/2015
Participant Information Sheet	1	28/08/2015
Consent Form	1	28/08/2015
Interview Schedule	1	28/08/2015

If you require any advice in relation to the conduct of the research, experience difficulties with recruitment or need further assistance, please contact the R&D Office.

May I take this opportunity to wish you well with your research and we look forward to hearing the progress and outcomes for the study.

Yours sincerely

26| |16

Dr Richard Hodgson
Associate Director for R&D

Copies to:
Helen Dent, Academic Supervisor
Dr C Halsey, Clinical Supervisor
N Leighton, Sponsor Contact
Dr J Barton, Clinical Director

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Appendix F: Author Guidelines for Journal

Qualitative Research in Psychology

ISSN 1478-0887 (Print), 1478-0895 (Online)

Publication Frequency

4 issues per annum

Instructions for authors

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read them and follow the instructions as closely as possible.

Should you have any queries, please visit our Author Services website or contact us at authorqueries@tandf.co.uk.

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Qualitative Research in Psychology is dedicated to exploring and expanding the territory of qualitative psychological research, strengthening its identity within the international research community and defining its place within the undergraduate and graduate curriculum. The journal will be broad in scope, presenting the full range of qualitative approaches to psychological research. The journal aims to firmly establish qualitative inquiry as an integral part of the discipline of psychology; to stimulate discussion of the relative merits of different qualitative methods in psychology; to provide a showcase for exemplary and innovative qualitative research projects in psychology; to establish appropriately high standards for the conduct and reporting of qualitative research; to establish a bridge between psychology and the other social and human sciences where qualitative inquiry has a proven track record; and to place qualitative psychological inquiry appropriately within the scientific, paradigmatic, and philosophical issues that it raises.

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1) Theoretical papers that address conceptual issues underlying qualitative research, that integrate findings from qualitative research on a substantive topic in psychology, that explore the novel contribution of qualitative research to a topic of psychological interest, or that contribute to debates concerning qualitative research across the disciplines but with special significance for psychology
2) Empirical papers that report psychological research using qualitative methods and techniques, those that illustrate qualitative methodology in an exemplary manner, or that use a qualitative approach in unusual or innovative ways
3) Debates
4) Book reviews

Submissions for special issues will normally be announced via an advertisement in the journal, although suggestions for topics are always welcome. Book reviews will normally be suggested by the Reviews Editor, although unsolicited reviews will be considered. The journal will also review other relevant media as well as qualitative research software.

All papers are refereed by, and must be to the satisfaction of, at least two authorities in the topic. All material submitted for publication is assumed to be exclusively for *Qualitative Research in Psychology*, and not to have been submitted for publication elsewhere. Priority and time of publication are decided by the editors, who
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Manuscripts should be double-spaced throughout, especially the references. Pages should be numbered
in order. The following items must be provided in the order given:

1) Title Page *.*

Authors and affiliations: Authors should include their full name and the establishment where the work was carried out (if the author has left this establishment, his/her present address should be given as a footnote). For papers with several contributors, the order of authorship should be made clear and the corresponding author (to whom proofs will be sent) named with their telephone/fax/e-mail contact information listed.

Abstract: Please provide an abstract of approximately 150 words. This should be readable without reference to the article and should indicate the scope of the contribution, including the main conclusions and essential original content.

Keywords: Please provide at least 5–10 key words.

About the author: Please provide a brief biography to appear at the end of your paper.

2) Text.

Subheadings should appear on separate lines. The use of more than three levels of heading should be avoided. Format as follows:
1 Heading
1.1 Subheading
1.1.1 Subsubheading
Footnotes should be avoided. If necessary, they should be supplied as end notes before the references.

3) References.

The Harvard style of references should be used. The reference is referred to in the text by the author and date (Smith, 1997) and then listed in alphabetical order at the end of the article applying the following style:

For a book: Hollway, W & Jefferson, T 2000, *Doing qualitative research differently: free association, narrative and the interview method,* Sage, London.
For an edited book: Brown, LM 2001, 'Adolescent girls, class, and the cultures of feminity', in MJ Packer & MB Tappan (eds.), *Cultural and critical perspectives on human development,* SUNY Press, Albany, NY, pp. 219–240.

For a journal article: Madill, A, Jordan, A and Shirley, C 2000, 'Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies', *British Journal of Psychology,* vol. 91, pp. 1–20.

4) Acknowledgements.

Authors should acknowledge any financial or practical assistance.

5) Tables.

These should be provided in a separate file from the text and should be numbered in sequence. Each table should have a title stating concisely the nature of information given. Units should be in brackets at the head of columns. The same information should not be included in both tables and figures.

6) Figure captions.

These should be provided together on a page following the tables.

7) Figures.

Figures should ideally be sized to reproduce at the same size. All figures should be numbered consecutively in the order in which they are referred to in the text. Qualifications (A), (B), etc., can only be used when the separate illustrations can be grouped together with one caption. Please provide figures at the end of your paper on a separate page for each figure. Once accepted, you will be required to provide a best quality electronic file for each figure, preferably in either TIFF or EPS format.

Illustrations. Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean

originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

- 300 dpi or higher

- Sized to fit on journal page

- EPS, TIFF, or PSD format only

- Submitted as separate files, not embedded in text files

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Appendix G: Example of IPA

Extract taken from interview with Tarquin, lines 52 – 67:

Sometimes…yeah because you know you …um its happened in the past whether people are seen by the nurses regularly or.. by a therapist …and then they'll they'll go away from that and then they'll self harm so you get afterwards ==ooh== you've know, you've just had that that work so ==why why do you express it in that way== you know I so…my expertise has always been in eating disorders that's what my sort of focus is so I get ==a bit sort of== with people with self harm ==I don't like sort of oooh== you know (laughs) ==it's not that I don't understand== it it's just frustrating cos you're thinking well ==you've got the opportunity to to to tap into us and use us but but then you go away and self-harm==…now …..to all these kids that do that, ==a lot of them say its not about that its about release for them its about sort of== ==ummm== ……..==a way to let things go rather than== ==you know== and what we try and do or the way I said to them is that we want to try and get you to try and express that in a different so its so the self harm isn't the first thing that you fall back on so there's other ways to do it …so yeah ==I guess, I guess== ==for me, it's like==, ==(groans)== ==you know==……but ==people have do different things for themselves==..==I guess people with eating disorders they do it in a different way it's about food for them and punishing themselves with that so you know I have an understanding of more of **that** than I do have of the self-harm==, the cutters and the overdosers, that kind of thing so you know its …..its …..==frustrating== ==but then its rewarding again because you know you know that that this will go on for a period and then hopefully it'll subside and they'll look at they will pick things up here even though they don't seem like they are they definitely they do actually pick things up here that we're trying to do with them==

Descriptive coding: questioning why young people self-harm, frustration about why they cant stop self-harming, feels more comfortable with young people with eating disorders, trying to understand why young people self-harm – is about release or punishment

Key for linguistic and interpretative coding:

==Blue highlight== = struggle to find words; hesitations, noises

==Yellow highlight== = making sense of self-harm

==Green highlight== = emotional impact

==Purple highlight== = defensive strategy, moves quickly away from frustration into focussing on hope for change

Author's Reflections

Introduction

Reflective practice is important within clinical psychology, as it contributes to continued professional development, promotes learning from experience and ensures safe and effective practice within the law (BPS, 2009; HCPC, 2011). The British Psychological Society (BPS) recommended that trainees be equipped to be reflective scientist practitioners in clinical and research skills following training (BPS, 2014). There are a number of theoretical models which can be used to structure reflection, including Kolb's (1984) learning cycle, Schon's (1983) concepts of reflection- in and reflection-on-action and Boud, Keogh and Walker's (1985) model. All models share an acknowledgement that reflection is key to learning from experience and developing a deeper understanding (Dallos & Stedmon, 2009). Reflection also contributes to self-awareness which is a key element of self-care. Self-care has been found to be important in protecting against the development of compassion fatigue (CF) (Phelps, Lloyd, Creamer & Forbes, 2009). Working in mental healthcare with individuals who are suffering has been recognised to be a risk factor for the development of compassion fatigue (CF) (Figley, 1995, 2002).

The author will adapt Boud, Walker and Keogh's (1985) model to reflect on the impact of working in an inpatient unit with young people who self-harm. The first two stages of the model will be used concurrently in the main body of this report; these are: returning to experience, and considering thoughts and feelings. Following this, the final part of the report will conclude by presenting what has been learned.

Returning to experience with detailed consideration of thoughts and feeling

This stage entails providing a non-judgemental and detailed account of the experience, including detail about thoughts and feelings elicited. The author has worked with a number of young people who self-harm and has kept a reflective journal throughout placement. The main theme of entries will be presented in sections with accompanying quotes. For the sake of coherence in describing experience, the first person will be used.

Emotional impact

Work with young people on the unit has had a profound emotional impact on me. Hearing stories of their preoccupation with suicide and self-harm was painful and difficult. Understanding the need to regulate my own emotional response whilst at the same time showing them empathy through my verbal and non-verbal communication was challenging, as at times I felt almost overwhelmed by their pain. The extract below demonstrates this:

Had a really difficult session with C today. He'd just been discharged from A&E after swallowing bleach. It was so hard to sit with him, he wouldn't talk to me at all. I felt like I could feel his pain in my stomach, like a heavy weight, it was almost unbearable, even now it's really hard to write about, I keep stopping and starting.

Even reading this back, I experience an echo of the intense emotional response I felt in this session. It is interesting that my experience mirrors his, with my stopping and starting echoing his difficulty finding words for his experience and my bodily experience of his pain being located in my stomach. A key challenge in the work with this young person was engagement as he found it really hard to put his thoughts and feelings into words, so we would often have sessions where his verbal contribution was minimal. His lack of engagement in sessions, combined with my strong emotional responses lead to my feeling ineffective in my work with him. It is interesting to note that in spite of this, I did not experience any reduction in my capacity to empathise with him, which would have indicated the presence of CF. This was partly because of the support I received in supervision (which will be discussed later) but may also have been because of contrasting feelings elicited by other young people, for example:

Last session with B today. We reflected on progress he's made. I remember after one of my first sessions with him making myself a hot chocolate, something I hardly ever do at work but felt a strong need to nurture myself. I think I felt a sense of his sadness and loneliness. Today he trusted me enough to tell me about how he's grown to trust me over time. He knows he has a journey ahead of him, but said that he's learnt it's OK to feel sad and 'not OK'. I feel really honoured to have shared some of his journey and grateful for his trust in me.

This extract demonstrates my own journey from empathising with him in his loneliness and sadness, to a sense of emotional reward at the ending of our work together. I think this was because it was clear that he had shifted in his understanding and acceptance of his emotions and I felt that our relationship had contributed to this. Consequently, I had a sense of my own efficacy as a psychologist and I think this was at least partly why my emotional experience was more positive with this young person. It is interesting to note that my experience in this case is consistent with compassion satisfaction (CS); the positive aspects of caring, including feelings of reward, satisfaction and gratification (Phelps et al., 2009; Simon, Pryce, Roff, & Klemmack, 2006). CS has been identified as a protective factor against the development of CF (Collins & Long, 2003; Gentry, Baggerly, & Baranowsky, 2004). I experienced these feelings of satisfaction and gratitude with all the young people I worked with at one time or another, so this could partially account for my not having experienced CF.

Conclusion: What has been learned

It is interesting to note that the emotional impact of the work has been a consistent theme both throughout my own work with young people and in research with qualified staff and Healthcare Support Workers, underlining that working with individuals who self-harm has an emotional cost whether it leads to the development of CF or CS. The reasons why some professionals experience CS instead of CF have yet to be established, but some important factors have been identified including personality traits, having a faith, self-awareness and supervision (Agaibi & Wilson, 2005; Collins & Long, 2003; Kim & Seidlitz, 2002; Phelps et al., 2009; Siegel, Anderman, & Schrimshaw, 2001). Although painful at times, I feel it has been helpful to experience strong and uncomfortable emotions. I understand that this experience is an integral part of working with self-harm and hence I think this is good preparation for qualified work.

The importance of reflection in processing and digesting emotions elicited by the work has also been a key learning point. Reflective writing and supervision have been the processes by which this has taken place. Supervision has been the key to enabling me to learn from my experiences of this type of work, instead of being overwhelmed by it. Being honest about how I have felt in sessions with young

people was central to this, but would not have been enough without my supervisor's empathy and skilled questioning to promote my capacity to reflect. This is an important lesson in the value of supervision and the qualities that are important to me in a supervisor, particularly in working with complex presentations including self-harm.

Therefore, to conclude, the process of working with self-harm has provided opportunities for me to learn some valuable lessons which will help to equip me for clinical practice. Although sporadically challenging and uncomfortable, I want to acknowledge the helpfulness of the process and express my gratitude to those who have contributed to my learning, particularly the young people I have worked with and my supervisor.

References

Agaibi, C. E., & Wilson, J. P. (2005). Trauma, PTSD, and resilience: A review of the literature. *Trauma Violence & Abuse*, 6, 195–216.

Boud, D., Keogh, R. and Walker, D. (1985). Promoting reflection in learning: A model. In D. Boud, R. Keogh, & D. Walker, (ed.s). *Reflection: Turning experience into learning*. London: Kogan Page.

British Psychological Society (BPS) (2009). *Code of Ethics and Conduct*. Leicester: BPS.

British Psychological Society (BPS) (2010). *Code of Human Research Ethics*. Leicester: BPS.

British Psychological Society (BPS) (2014). *Standards for Doctoral programmes in Clinical Psychology*. Leicester: BPS.

Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: consequences for mental health care workers – a literature review. *Journal of Psychiatric and Mental Health Nursing*, 10, 417 – 424.

Figley, C. R. (1995). *Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatised*. New York: Brunner/Mazel.

Figley, C. R. (2002). Compassion fatigue: Psychotherapist's chronic lack of self care. *Journal of Clinical Psychology*, 58(11), 1433–1441.

Gentry, J. E., Baggerly, J., & Baranowsky, A. (2004). Training-as-treatment: Effectiveness of the certified compassion fatigue specialist training. *International Journal of Emergency Mental Health*, 6, 147–155.

Health and Care Professions Council. (2011). Your guide to our standards for continuing professional development. Retrieved from http://www.hpcuk.org/assets/documents/10003858your_guide_to _our_standards_for_cpd.pdf.

Kim, Y., & Seidlitz, L. (2002). Spirituality moderates the effect of stress on emotional and physical adjustment. *Personality and Individual Differences*, 32, 1377–1390.

Kolb, D. (1984). *Experiential Learning*. New Jersey; Prentice Hall.

Phelps, A., Lloyd, D., Creamer, M., & Forbes, D. (2009). Caring for carers in the aftermath of trauma. Journal of Aggression, Maltreatment & Trauma, 18, 313-330.

Schon, D. (1983) *The Reflective Practitioner*. London: Temple Smith.

Siegel, K., Anderman, S. J., & Schrimshaw, E. W. (2001). Religion and coping with health-related stress. *Psychology & Health*, 16, 631–653.

Simon, C. E., Pryce, J. G., Roff, L. L., & Klemmack, D. (2006). Secondary traumatic stress and oncology social work: Protecting compassion from fatigue and compromising the worker's worldview. *Journal of Psychosocial Oncology*, 23, 1-14.

Stedmon, J. & Dallos, R. (2009). Flying over the swampy lowlands: Reflective and Reflexive Practice. In J. Stedmon (ed.). *Reflective Practice In Psychotherapy And Counselling.* (pp. 1- 22). Maidenhead: Open University Press.