THE UNIVERSITY OF HULL

NURSES' MANAGEMENT OF DELIBERATE SELF-HARM IN AN ACUTE RESIDENTIAL SETTING

being a Thesis submitted for the Degree of Doctorate in Clinical Psychology in the University of Hull

by

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ABSTRACT

The study aimed to address the question of what represents the most therapeutic response when a client self-harms on an acute inpatient mental health unit. The null hypothesis was that nurse response type would have no bearing on how long it was before a client went on to self-harm again. Pilot studies and qualitative analysis led to the development of questionnaires which sought to measure nurse-client interactions across four dimensions: 1) The content of what the nurse said to the client; 2) The length of time the nurse spent with the client; 3) The emotional tone of the response; and 4) The strength of emotion expressed by the nurse.

The participants were 19 inpatients and 29 nurses who described incidents of self-harm. Nurses and clients completed questionnaires describing the nurse's response type the first time that a client self-harmed during a new admission.

Most of the statistical analyses supported the null hypothesis that nurse response type has no bearing on how long it is before a client engages in self-harm again. There was no evidence that the content, duration or emotional tone of a nurse's response had any bearing on how long it was before the client self-harmed again. The only statistically significant finding was that nurses perceiving themselves to be more strongly emotional was correlated with a longer delay before self-harm was repeated. A finding not directly related to the hypotheses was that nurses and clients perceived behaviour differently. There was poor agreement in terms of their perceptions of the number of minutes that an interaction lasted, how strongly emotional the nurse was, and the severity of the clients' self-harm.

The implications of these findings are discussed, together with suggestions for future research.

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CHAPTER ONE

INTRODUCTION

HISTORY

Human beings have harmed themselves since before some of our oldest historical documents were written. Favazza (1998) notes that in Book Six of the *History,* Herodotus, writing in the fifth century B.C., described the behaviour of a Spartan leader thus: "As soon as the knife was in his hands, Cleomenes began to mutilate himself, beginning on his shins. He sliced his flesh into strips, working upwards to his thighs, hips and sides until he reached his belly, which he chopped into mincemeat". Favazza goes on to cite the fifth chapter of Mark's Gospel in which Mark describes a man who "cut himself with stones".

The first medical article on self-mutilation was published in 1846, in which Bergmann described a woman who enucleated herself. Favazza (1998) tracks the earliest phases in professional interest in self-mutilation.[1] He observes that literature on the subject in the nineteenth century was mainly concerned with eye enucleation and self-castration. During the first three decades of the twentieth century, there was a great deal of interest in psychoanalytic circles in self-castration. This behaviour was understood to be related to suicide in that it marks the end of potential for propagation.

It was in the 1960s that psychiatrists began to take an interest in self-cutting, and Pao (1969) wrote the paper in which he referred to 'delicate self-cutting', which he proposed was distinct from attempted suicide. Simpson (1976) supported this view and called self-mutilation "an act of anti-suicide for the cutting is used as a direct, reliable and rapidly effective way of coming back from the dead unreal preceding state".

[1] There follows later in this introduction a discussion regarding classification and definitions. In particular, attention is paid to the relationship between 'self-mutilation' and the broader concept of 'deliberate self-harm'. Favazza focuses his historical review on self-mutilation. No parallel historical interest in other forms of self-harm was found.

Whilst others were writing about self-mutilation, Morgan (1979) in England described 'non-fatal deliberate self- harm' behaviours. As well as self-mutilation, he included overdosing and suicide gestures under this term. Four years later in the United States, Pattison and Kahan (1983) developed a prototype model for a deliberate self-harm syndrome. This paper marked the beginning of modern psychiatric interest in self-mutilation. Their conceptualisation included low lethality self-mutilative acts (especially cutting and burning), with no conscious suicide intent, but in contrast to Morgan's excluded true suicide attempts and drug overdoses.

CLASSIFICATION

CLASSIFYING ON THE BASIS OF DIFFERENT DIMENSIONS

Intent

In their 1975 paper, Beck and his colleagues proposed that suicidal intent and lethality are useful dimensions in classifying suicidal behaviour. They found only a low correlation between intent and lethality, this relationship being moderated by individuals' preconceptions about the lethality of an act. It remains the case that in clinical research, this finding is often forgotten, so that intent is often inferred, wrongly, from the lethality of the behaviour. Linehan (1997) notes that efforts to actually measure suicide intent are the exception rather than the rule. She warns that failure to make distinctions on the dimension of intent leads to the false classification of behaviour, and calls for reliable assessment of behavioural and outcome intent.

As indicated above, early conceptualisations of self-harm did not distinguish between self-harm and an intent to commit suicide. Menninger (1935) linked self-mutilative behaviour with suicide, seeing them both as an expression of destructive drives. More recently too, Linehan (1993) has been loathe to separate suicide from self-mutilation, seeing them rather as similar reflections of self-destructiveness.

In contrast, the majority of writers on the subject now are keen to distinguish attempted suicide from other forms of self-harm. Simpson (1976,1980) proposed the view that self-mutilation represented the opposite of attempted suicide in that it was an attempt to regain a sense of being alive. Kreitman (1977) supported this view, suggesting that it was possible to separate attempted suicide from self-mutilation conceptually, but he cautioned that the empirical definition was fraught with difficulty. Walsh and Rosen (1988) have written the most comprehensive review of the difference between self-mutilation and suicide/parasuicide.

The issue of intent is also relevant in the distinction that Babiker and Arnold (1997) make between self-mutilation and factitious disorders such as Munchausen's syndrome, simulated illness and polysurgery. They argue that these conditions may involve self-mutilation, but as a means to an end rather than as an end in itself.

Finally, Babiker and Arnold (1997) consider the issue of intent in distinguishing self-mutilation from marginal self-injurious behaviours such as reckless driving, fighting, over-work, smoking or dangerous sports. They reason that in such activities damage to the body is not the primary purpose of the behaviour.

Method of Self-harm: Whether Harm is Direct or Indirect.

Some writers are more concerned with the commonalities between self-mutilation and other forms of self-harm, whilst other writers are more concerned with the differences between these phenomena.

Of those more concerned with the similarities, Morgan and his colleagues (1975) first proposed the concept of a self-harm syndrome. Self-poisoning has been included as well as self-mutilation. Allen (1995) too has preferred to retain the term 'deliberate self-harm', since in her experience many people who poison themselves without suicidal intent also wound themselves.

In contrast to these perspectives, there are more publications which include strong arguments for studying self-mutilation as a discrete entity. Walsh and Rosen (1988) have voiced concerns that a broad concept of 'deliberate self-harm' blurs distinctions. They argue that in the case of self-poisoning, the harm caused is uncertain, ambiguous, unpredictable and basically invisible. In addition, self-laceration often results in sustained or permanent visible disfigurement to the body, which is not the case for self-poisoning.

In addition to distinguishing other discrete self-harm acts (such as hanging or self-poisoning) from self-mutilation, Babiker and Arnold (1997) seek to distinguish self-mutilation from other indirectly self-destructive behaviours such as eating disorders, alcohol abuse, or sexual risk-taking. They quote Ross and McKay (1979) who maintain that in direct self-injury, the consequence is immediate and unequivocal. Farberow (1980) expands this discussion as he defines direct self-harm as "immediate, concrete and physical harm", but indirect self-harm as "repetitive behaviours over time resulting in cumulative harm".

Social Acceptability

Babiker and Arnold (1997) distinguish self-mutilation from body 'enhancement', which may include cosmetic surgery, tattooing, or piercing, and which is socially prescribed. Walsh and Rosen (1988) have acknowledged that there is sometimes a blurred line between socially-sanctioned physical self-alteration and deviant self-mutilation.

Intellectual Functioning

This dimension of classification was used by Suyemoto (1998) in her classification system of self-mutilation. She maintained that self-mutilation is different from the self-injurious, stereotypical behaviour seen in severely learning disabled children, which may be different in intent, underlying dynamics, and associated developmental and psychological experiences.

Psychological State at the Time of the Act

This final dimension was employed by Walsh and Rosen (1988) in their classification of self-mutilative behaviour. They separated, for example, mildly to moderately severe wrist cutting in a psychological state of psychic crisis, from acts such as autocastration, which usually occur in a state of psychotic decompensation.

CLASSIFICATION SYSTEMS

A review of the literature yielded only three attempts to classify self-harm behaviours that did not only include self-mutilation. Hawton et al (1982) separated adolescents who had overdosed into three groups: acute, chronic, and chronic with behavioural disturbance. Lester (1990) proposed a classification of attempted suicide based on whether the resulting self-harm was foreseen or desired. He distinguished five groups: failed suicides, deliberate self-harm, sub-intentioned self-harm, counterproductive self-harm, and pseudoself-harm. Kurz et al (1987) used a cluster analysis to separate three categories within a group of people who had poisoned themselves.

Eight further classification systems of self-harm were found, but all of these restricted their focus to self-mutilation only. Menninger's (1935) was the first to be published and comprised six categories. This system was criticised by Ross and McKay (1979), who said that it incorporated a high level of speculation. They therefore proposed an alternative system in which nine categories were couched exclusively in behavioural terms. Finding this system to be overly restrictive, Walsh and Rosen (1988) devised a system which went beyond the behavioural-descriptive, but did not include speculations about psychodynamics. Their multidimensional system was based on the dimensions of severity, psychological state, and social acceptability. Other classification systems include those published by Favazza (1992), Pattison and Kahan (1983), and Hawton and Catalan (1987).

DEFINITIONS

In 1975, Morgan and his colleagues defined self-harm thus: "Non-fatal episodes of self-harm may be referred to collectively as problems of self-poisoning and self-injury...We have used the term...as...a way of describing a form of behaviour which besides including failed suicides embraces many episodes in which actual self-destruction was clearly not intended." Kreitman (1977) coined the term 'parasuicide' to refer to the same group of behaviours, which he referred to as "non-fatal self-injurious behaviour with clear intent to cause bodily harm or death".

Since these definitions were written, other workers have sought to define narrower concepts. In 1983, Pattison and Kahan defined self-harm, but excluded cases with apparently high lethal intent and/or overdoses, exclusions which Morgan and Kreitman and their respective colleagues had not applied. In 1989, Favazza defined self-mutilation as "a complex group of behaviours in which a person participates in the deliberate destruction of body tissue without conscious suicidal intent". Four years later, in 1993, Favazza and Rosenthal defined a narrower term, 'repetitive self-harm syndrome', which they regarded as a subset of self-mutilation. They used the term to refer to "self-mutilating behaviour in otherwise normal-appearing individuals with post-traumatic or attachment disorders". Finally, Walsh and Rosen (1988) have defined self-mutilative behaviour as "deliberate, non-threatening, self-effected bodily harm or disfigurement of a socially unacceptable nature".

SUMMARY REGARDING CLASSIFICATION

In summary, different attempts at the classification and definition of self-harm have placed emphasis on different dimensions of distinction. One reason that definitive classification remains elusive is that, as Linehan (1997) points out, there is co-occurrence of behaviours in repeaters over time. Indeed, in a review in 1983, Pattison and Kahan found that 63% of individuals who had mutilated themselves more than once had used multiple methods.

INCIDENCE AND PREVALENCE RATES

The incidence and prevalence of the broader terms of deliberate self-harm and parasuicide will be addressed first. Attention is then paid to the narrower categories of self-mutilation/self-injury and self-poisoning.

Deliberate Self-harm/Parasuicide

As indicated above, Kreitman's (1977) term 'parasuicide' encompasses all non-fatal self-injurious behaviour with clear intent to cause bodily harm or death. Appleby reported in 1993 that there had been around 100 000 admissions for parasuicide in

Britain annually in recent years. In the United States, Linehan (1997) estimated a parasuicide rate of about 300 people per 100 000 population per year for all types of parasuicide. She bases this (probably invalid) claim on the work of Favazza (1987) and Walsh and Rosen (1988) who have reviewed prevalence estimates. At best these estimates are imprecise. There is the problem of underreporting of incidents, as well as difficulties of overinclusivity and underinclusivity in the studies under review, with varied definitions being applied. In New Zealand, Fanslow (1994) reported that parasuicide was the fifth leading cause of injury hospitalisation for women, and the eighth leading cause for men.

Dennis and his colleagues (1997) studied consecutive admissions for self-inflicted injury (they included overdosing under this term) to the Leicester Royal Infirmary. They found a mean age of 32 years. Kreitman (1990) found that being young and being female were risk factors for first episodes of parasuicide. Hawton and Catalan (1987) found the highest parasuicide rate amongst girls and women aged 15-19, with a mean annual rate of one per 100 in this group. They found the highest rate for males in the 25 to 29 year age group, with one in 200 referred to hospital for parasuicide in any one year.

Platt et al (1989) also found parasuicide to be more common amongst women. They estimated that the rate for medically treated parasuicides is 139 per 100 000 for males, but 189 per 100 000 for females. MacLeod et al (1992) reported that the proportion of women to men presenting with parasuicide ranged from 1.5 to 2.5:1. Hawton and Catalan (1987) did not find equal rates of parasuicide between the genders until age 50.

A difficulty with these claims (of greater prevalence amongst particular ages and genders), is that they are based on the population presenting to hospital. The studies do not take into account the possibility that episodes of parasuicide amongst older women (or indeed men) in the general population, may go undetected.

In contrast to the studies cited above, the Leicester study cited above found an even gender distribution. House et al (1992) also reported a consistent trend towards parity of incidence of deliberate self-harm in the two genders.

Parasuicide has often been linked with lower socioeconomic status. Hawton and Catalan (1987) studied rates in Oxford between 1980 and 1982. They found parasuicide to be eight times higher in social class V than in classes I and II. They found an even greater difference in Edinburgh. Kreitman (1977) found a strong link between parasuicide rates and unemployment. Drawing conclusions about relationships between parasuicide and lower socioeconomic status/unemployment may be problematic. An alternative explanation is that those who harm themselves in these groups are more likely to present to hospitals.

Marital status has also been found to have a bearing on parasuicide rates. Kreitman (1977) found that those who were divorced were most at risk, followed by those who were single, and with those who were married being least at risk. In women aged under 35, the rate was higher for those who were single. After the age of 35, the incidence among single women reduced by three quarters, taking it below the level for married women of comparable age. Single men of all ages had higher rates than married men. Again, concluding that being divorced or being single predisposes individuals to parasuicide may be erroneous. Those in these groups may just be more likely to report parasuicide. Alternatively, having parasuicide as a coping strategy, or having such a personality structure, might interfere with the formation of stable relationships.

The Dennis et al study (1997) found overdosing to be by far the most common method, occurring in 91.5% of cases. House et al (1992) found that the use of tranquillisers, hypnotics and other psychotropics had become less prevalent, as the use of analgesics has become more so. Hawton and Catalan (1987) mentioned that self-injury was much less commonly seen in general hospitals. Kreitman (1977) and Morgan et al (1975) in Bristol both reported that self-injury constituted around 5% of those who presented at general hospitals having self-harmed. Others calculated a larger proportion: Weissman (1975) and Hawton and Catalan (1987) found that among 'attempted suicide', 'parasuicide' or 'deliberate self-harm' referrals to accident and emergency, 10-15% would be cases of self-injury.

Self-mutilation/Self-injury

It is difficult, if not impossible to determine accurately the incidence of self-mutilation. This is partly as a result of underreporting. Suyemoto (1998) cautions that many estimates are based only on the most severe cases which require legal or medical intervention. Favazza and Rosenthal (1993) quote a prevalence rate for self-injury of between 400 and 1400 per 100 000 per year, whilst Tantam and Whittaker (1992) report that at least one in 600 injures himself or herself enough to require hospital treatment. (This figure excludes those who present with an 'accidental' injury). In a rare study of a non-clinical group, Briere and his colleagues (1990) sent questionnaires to a university population. 11% reported that they had cut themselves at some point in their lives. In a similar study, Favazza (1992) found that of 500 unselected American college students, 14% had had at least one episode of self-mutilation. Although specifically student groups, these two studies are more representative of the general population than hospital groups. Walsh and Rosen (1988) commented on a worrying trend: In a review of epidemiological studies from Canada, England, Denmark and the US, they found self-mutilation to have increased markedly since the 1960s.

Some authors, including Favazza (1992), have claimed that self-mutilation is more prevalent amongst women, although he did mention that the greatest concentration of affected men was to be found in prisons. Weissman (1975) and Hawton and Catalan (1987), however, report roughly equal numbers of men and women who allude to cutting themselves, but explain that many more women enter treatment.

Overdosing

Kapur et al (1998) looked at self-poisoning in four British hospitals. They found that the average rate was 310 per 100 000 population per year, suggesting that self-poisoning accounted for 170 000 hospital attendances in the UK annually.

Hawton et al (1982) looked at 50 consecutive adolescents who were admitted to a general hospital because of having overdosed. 90% were girls, and only 10% boys.

Repetition

Appleby (1993) reported that a third of those admitted for parasuicide had self-harmed before. From a review of the literature, Cowmeadow (1994) reported that repetition of self-harm occurs in between 12% and 25% of cases within one year after the initial episode. Kreitman (1990) found that individuals characterised by multiple episodes occur more frequently in the middle age band than in the younger group. Among those aged 55+ years, this pattern was reversed, so that more parasuicides at this age are first-ever cases than repeaters. He found that being male and aged between 35 and 54 was associated with multiepisode status.

Of course a proportion of those who repeat go on to commit suicide. Cullberg (1988) followed up 163 suicide attempters for 8-10 years. During this time scale, there were six verified suicides and four possible/probable suicides (that is, 3.7%-6.1%). In 1994, Gunnell and Frankel found that 1% of those who self-harm will commit suicide in the following year (a figure which Hawton and his colleagues had proposed in 1988), whilst 10% will do so eventually. Ovenstone et al (1974) and Foster et al (1997) have found that about 1/2 of all people who kill themselves have a history of deliberate self-harm (DSH).

ATTEMPTS TO UNDERSTAND SELF-HARM

Crawford and Wessely (1998) caution that among those being excluded from studies of self-harm are those who are at greatest risk of repeating, that is those who discharge themselves from general hospitals even before completing an initial assessment. It is worth bearing in mind then that many of the papers reviewed here, which attempt to understand self-harm, do not take account of this group of people.

A) PREDISPOSING FACTORS

i) DSH/Parasuicide

Problem solving

A body of research has emerged that demonstrates cognitive deficits in those who self-harm. Such individuals are observed to have specific difficulties with problem solving, characterised by rigid and inflexible thinking (Neuringer 1964; McLeavey et al 1987). It is thought that this may lead to difficulties in developing new or alternative solutions to

problems, so the person may resort to deliberate self-harm because he or she can see no other way out of difficulties. Whilst this is an interesting hypothesis, it would be premature to assume this relationship. It would be necessary first to disentangle possible alternative causal relationships, such as the negative impact on problem-solving ability of self-poisoning. In a study of 228 individuals three months after they had harmed themselves, a comparison was made between those who had resolved their problems and those who had not (Sakinofsky, Roberts, Brown et al 1990). More powerlessness was found in those who had not resolved their difficulties. A second study (Sakinofsky and Brown 1990) compared those who repeated within three months with those who did not. Those who repeated experienced greater feelings of externally directed hostility and powerlessness. The prospective element in this study ensured less bias, and the large sample size consisting of consecutive individuals presenting to general hospitals, increases the validity of these findings. Sakinofsky, Roberts, Brown et al (1990) cite a paper by D'Zurilla and Goldfried (1971) in which they suggest that powerlessness may act as a self-fulfilling prophecy inhibiting problem-tackling. This perspective has some empirical support: Rotheram-Borus et al (1990) compared a group of adolescents who had harmed themselves, with a group of adolescents who had not done so. Those who had self-harmed reported significantly fewer alternatives for solving interpersonal problems, were significantly more focussed on their problems, and were more likely to report a wishful thinking style of coping in stressful situations than were members of the comparison group. Interpersonal problem-solving ability and attributional style best distinguished those in the self-harm group. Linehan (1993) also views self-harm as resulting partly from inadequate problem-solving and finds those who self-harm to have individual expectancies of the differential efficacy of suicidal behaviour. A number of studies have found parasuicidal people to have poor performance in terms of the *number* of solutions generated. Others have found deficits in terms of the *quality* of solutions offered, (Linehan et al 1987; Orbach et al 1990). Building on the paper by D'Zurilla and Goldfried above, further attempts have been made to understand why parasuicidal individuals have difficulty with problem-solving. Such individuals have been shown to be more overgeneral in their autobiographical memories than matched general medical ward patients (Williams and Broadbent 1986; Evans et al 1992) and than non-patient

controls (Williams and Dritschel 1988). In his review, Sidley (1998) concludes that such an overgeneral memory database is not conducive to creative problem-solving, as it provides fewer prompts for the generation of potential strategies to overcome life difficulties. The proposal is that an overgeneral autobiographical memory leads to reduced problem-solving because the database used to define the problem and generate alternative coping strategies is inadequate. There is empirical support for this proposal in that a significant correlation has been found between specificity of autobiographical memory and effectiveness of problem-solving. This model is also supported by the success of specific problem-solving interventions (Salkovskis et al 1990).

Affect regulation

MacLeod, Williams and Linehan (1992) report that parasuicidal patients appear more angry, hostile and irritable compared to non-suicidal psychiatric patients. They suggest that parasuicidal patients may be unable to regulate affective responses. This hypothesis is based not only on observation, but on data from a variety of measurement instruments, and in comparison with non-suicidal psychiatric patients, as well as general population control groups, lending the claim some validity. A low tolerance for distress has been found among those who self-harm (Linehan 1993). In this context, parasuicidal behaviour can be extraordinarily effective at emotion regulation, since it can reduce the intensity of aversive emotions in the short term. This remains a hypothesis, however, which requires further testing, since the statistical significance of the relationship between anger, hostility and irritability, and parasuicidal behaviour says little about the size of the association. Further work would need to establish the power of the effect of these variables. Indeed it may be flawed to make causal inferences at all about these variables, since they are not stable characteristics.

Sense of coherence

Petrie and Brook (1992) have studied psychological factors that promote adjustment as well as pathology in an attempt to assess/predict suicidal ideation and behaviour. They studied people who had been admitted to hospital having overdosed or caused injury to themselves. They used Antonovsky's (1979, 1987) construct of sense of coherence

(SOC). SOC is defined as a personal orientation that predicts effective coping and good health, and is comprised of three dimensions: meaning (e.g., How often do you have the feeling there is little meaning in the things you do in your daily life?), manageability (e.g., How often do you have feelings that you're not sure you can keep under control?), and comprehensibility (e.g., How often do you have the feeling you are in an unfamiliar situation and don't know what to do?). Petrie and Brook (1992) found that on admission, suicidal ideation was best predicted by a low score on meaning. At six month follow-up manageability and comprehensibility were the best predictors of suicidal ideation and the best discriminators of suicidal behaviour. Evidence for the validity of the SOC scale, and the discriminant analysis design of this study, using psychological and background variables as predictors, provide strong support for Petrie and Brook's findings.

Hopelessness

Those who self-harm have been found to have negative expectations of the future (Linehan 1993), and scores on the Beck Hopelessness Scale (Beck et al 1974) have been found to be a powerful predictor of parasuicide (Petrie et al 1988).

Social factors

Various social factors have been associated with repetition of self-harm. A correlation has been found between repetition and both social class V and unemployment (Bancroft et al 1979). A group of 42 people who had been admitted three times in one week for the effects of DSH were found to be mostly young, unemployed, lacking a partner, and of low social class (Stocks et al 1991). Meanwhile, Kreitman (1990), has studied trends in parasuicide. He found fluctuations over time which seemed to correlate with fluctuations in unemployment rates.

Biochemical factors

Biochemical factors have been implicated in a predisposition to self-harm. A negative correlation has been found between serotonin turnover in the brain and impulsive self-destructive acts (Roy et al 1988). Whilst low serotonin turnover may play an aetiological role in DSH, this study does not demonstrate such an effect.

ii) Self-mutilative behaviour

The studies in the previous section referred to factors that may predispose to a broad group of behaviours contained in the DSH/Parasuicide category. The studies cited in this next section have examined cutting behaviour in particular.

Psychosocial Factors

It has been proposed that pathological childhood experiences (such as isolation, abandonment, neglect, and physical, sexual, and/or physical abuse by parents), predispose individuals to self-mutilative behaviour (SMB) (van der Kolk et al 1991). This proposal is supported by studies that have found histories of sexual abuse, physical abuse and witnessing violence to be significantly correlated with subsequent self-destructive behaviours (Sansone et al 1995; Romans et al 1995; Shapiro 1987). Indeed two studies (Van der Kolk et al 1991; Romans et al 1995) have found more intrusive and frequent childhood sexual abuse to be more strongly associated with subsequent self-harm. A weakness of this conclusion is the possibility of retrospective distortion. Nevertheless, Herman (1992) suggests that the normal regulation of emotional states is disrupted by traumatic experiences that repeatedly evoke terror, rage and grief. Abused children discover at some point that intolerable feelings can be most effectively terminated by a major jolt to the body, the most dramatic method being the infliction of injury. A similar proposition (Van der Kolk et al 1991) is that ongoing dissociation is associated with cutting, and that dissociative experiences are correlated highly with childhood trauma and neglect. The hypothesis is that the immaturity of the central nervous systems of children may make them vulnerable to flawed biological self-regulation as a consequence of trauma and neglect.

Feminist writers such as Courtois (1988) highlight the perspective that women and girls are more likely to be recipients of aggression and abuse by others and to direct aggression and hostile feelings towards themselves. This observation requires more systematic testing. The observation is the basis for their explanation for self-damaging behaviours, which they see as involving some measure of self-directed hatred and rage.

Biochemical Factors

Serotonergic hypofunctioning has been implicated in self-cutting (Simeon et al 1992; Pies et al 1995; Herpertz et al 1997). This could explain why Selective Serotonin Re-uptake Inhibitors have been found to have a beneficial effect on SMB (Markowitz et al 1994), although it could be that this represents an indirect effect, with SSRIs influencing a third variable with a more powerful aetiological role. When SMB occurs within the context of severe learning disability, including in Lesch-Nyhan syndrome, Tourette's and Cornelia de Lange's syndrome, it is predominantly understood to be a biologically driven behaviour (Favazza 1989; Winchel et al 1991).

iii) Overdosing

Jack et al (1991) found overdose patients to have significantly higher stable and global attributions for negative events than controls, but found no difference in attribution for positive events. This study would have been strengthened had it used a control group more similar to the target group in all respects except the presence of overdosing behaviour. It may be that such attributions described are not specific to those who overdose.

MacLeod and his co-authors (1992, 1994) have also looked at cognitive processes mediating overdosing behaviour. They found that those admitted after an overdose could generate fewer things in the future they were looking forward to than a non-hospital group. Whilst there was some evidence that these people actually did have less to look forward to, there was also evidence of a cognitive component. Parasuicidal individuals have shown less disadvantage in being able to think of positive future personal events when provided with cues (Williams et al 1992). This suggests an actual deficit in positive anticipation, although like the study above, there is no evidence that this deficit is specific to those who overdose. MacLeod and his colleagues (1992) propose that having borne the brunt of aversive experience, a person then disengages from thinking about the future, and so is less likely to initiate arrangements that could lead to positive events. The overgeneral autobiographical memory discussed above may account for a lack of

positive anticipation, since if a person finds it difficult to access specific memories of happier times, it will be equally difficult to predict discrete positive events (Williams et al 1992). This hypothesis merits further investigation.

MacLeod and his colleagues (1994) went on to look at the probability judgements of future negative events in people who had overdosed. They found that people who had overdosed judged negative events to be more likely than did a control group. They also found it more difficult to think why those events might not happen. They conclude that those who overdose may not actively anticipate future negative outcomes, but that when presented with the possibilities, they judge them to be likely because of an inability to think of positive aspects of themselves or their circumstances which would prevent those events happening. MacLeod and his colleagues did not control for depression, a psychological state in which similar cognitive processes have been found. One could challenge the inference that judging negative events to be more likely is specific to overdosing behaviour.

B) PRECIPITATING FACTORS

i) DSH/Parasuicide

Some regard psychosocial difficulties as the usual precipitating factor for parasuicide (Bancroft et al 1979). This, however, is inconsistent with the findings of another study (Sakinofsky, Roberts, Brown et al 1990), which followed up a group of parasuicides for three months. No relationship was found between whether or nor individuals had resolved their precipitating problems, and whether or not they harmed themselves again within the three months. This led the authors to question why it was that 'resolvers' repeated self-harm at the same rate as 'non-resolvers'. They concluded that repeaters experienced greater feelings of externally directed hostility, powerlessness and normlessness. (See section on predisposing factors).

ii) Self-mutilative behaviour

The most common precipitants of SMB have been described as situations that produce feelings of rejection, helplessness, anger or guilt (Favazza 1998). It has also been reported

that self-mutilators often describe a profound dissociative state preceding SMB (van der Kolk et al 1991; Herman 1992). Herpertz too (1995), describes a state characterised by feelings of emptiness and numbness as having a precipitating effect, whilst DSM-IV (American Psychiatric Association 1994) describes experiences of depersonalisation. These hypotheses concerning possible precipitating factors have not been empirically tested.

iii) Overdosing

Hawton et al (1982) studied 50 consecutive adolescents who had overdosed. He found the most common precipitants to be problems with parents, boy or girlfriends, or with school/work including unemployment. He reported that a substantial proportion had concurrent physical ill-health. In the majority of cases, the problems were transient. It would be beneficial to assess the comparative frequency of such precipitants in groups of adolescents who do not overdose.

C) MAINTAINING FACTORS/FUNCTIONS

i) DSH/Parasuicide

Sidley (1998) warns that those who self-harm form a a heterogeneous group of individuals for whom DSH can serve different functions. There is therefore a need for individual conceptualisation in every case.

Allen (1995) distinguishes three functions of DSH: Firstly, she observes the function that it can have in managing moods and feelings. A mechanism has been proposed whereby self-harm provides distraction from emotional stimuli, or has a direct biological effect on the emotion system (MacLeod et al 1992). Sidley's clinical impression is that this feature is more prominent in self-cutting than in deliberate overdoses. Secondly, Allen sees DSH as being, in some instances, a response to beliefs and habitual thoughts. Such beliefs and thoughts include punishment for badness, pre-empting inevitable hurt from others, or channelling aggression so as not to harm others. Shapiro (1987) believes that cognitions

about self-blame and self-punishment mediate between early abuse and DSH. Thirdly, Allen sees DSH as being a way to manage interactions with others. This third function she notes to be often assumed by helpers, but mentioned less by clients.

ii)Self-mutilative behaviour

Dallam (1997) and Suyemoto (1998) have reviewed papers identifying various functions of self-mutilation:

1) Affect regulation models

A satisfying release from tension and anxiety is described which for some may only be achieved when they see blood appear (van Moffaert 1990). A desire to avoid or reduce the intensity of painful affects was the most frequently cited intent for self-mutilative acts according to Walsh and Rosen (1988). Favazza (1998) sees SMB as providing temporary relief from feelings of depersonalisation, guilt, rejection and boredom as well as sexual preoccupations and chaotic thoughts. Self-mutilation can be seen as an addictive behaviour once it becomes established as a tension-reducing habit (Faye 1995).

2) Interpersonal Model

This model states that perceived abandonment creates intense emotions that threaten to engulf the self of the patient since his/her lack of boundaries leads to experiencing the loss of other as a loss of self. This loss is combated by SMB, which serves to define the boundaries of the self, as the skin is the most basic boundary between self and other, and the blood or scar an indication of self-reality (Raine 1982; Simpson and Porter 1981).

3) Environmental Model

This model assumes that SMB begins through modelling or vicarious reinforcement. The individual thinks the SMB is right, and links pain and care. Favazza (1989) has proposed that SMB can represent an attempt at the repetition of childhood when individuals received nurturance after physical abuse. The environmental model goes on to state that SMB is maintained because it is reinforced by operant conditioning and it serves the system by

maintaining homeostasis and expressing threatening systemic conflicts. Feminist thinking, (for example, Burstow 1992) proposes that in a patriarchal society, women are encouraged to engage in some form of self-injury such as hair removal. Burstow's perspective is that SMB includes a 'spoiling quality' and may reflect a defiance of oppressive rules about beauty and the female body. Favazza (1987) points out that the rejection and condemnation with which individuals can be met in response to their behaviour, or to physical disfigurement can provide a maintaining factor in itself. Babiker and Arnold (1997) have reviewed anthropological writings which note that it is a universal feature of human societies that certain social functions are served by the infliction of pain, modification, mutilation or marking upon the body. Traditional functions include healing, the restoration of order, a means of expressing grief, or release from guilt. It has been reported that in certain African tribes (Abiji, Bantu, Kikuyu and Xoruba), self-injury is fundamental to their cultural and religious beliefs (Greenwood et al 1997). In some societies, Babiker and Arnold (1997) observe that sacrifice and scapegoating are seen as serving important social functions in focussing community tension into individual victims, thus preserving overall social harmony. They point out that those oppressed groups which are scapegoated are the very groups in which self-injury is more common. They conclude, "It is as if they have taken on the role of 'sacrificial victim' which the community has ascribed them".

4) Drive models

The antisuicide model (Menninger 1938) purports that SMB is suicide replacement and a compromise between the life and death drives. The sexual model (Simpson 1975) proposes that SMB stems from conflicts over sexuality, menarche and menstruation.

5) Biological model

Finally, a biological reinforcement theory (Vollmer 1994), is that self-mutilation may sometimes be maintained by automatic reinforcement in the form of sensory stimulation or the release of endogenous opiates that reduce dysphoria. A cycle might then develop whereby habitual self-mutilators hurt themselves to feel better.

It is Suyemoto's (1998) opinion that SMB serves more than one function simultaneously. She presumes that an alternative behaviour could also provide a solution, but concludes that perhaps the behaviour is chosen because it meets a variety of needs.

iii) Overdosing

It has been proposed that sleep following an overdose can be an effective means of emotion regulation, which might maintain the behaviour (MacLeod et al 1992).
All of these proposed functions are hypothetical, and none has been empirically proven.

UNDERSTANDING DELIBERATE SELF-HARM WITHIN THE CONTEXT OF THE HEALTH SERVICE

Hawton and his colleagues (1997) provide a reminder that those who present at general hospitals who have deliberately self-harmed, and who require psychiatric hospital inpatient care, represent a minority of those who present with deliberate self-harm. For this minority, their self-injury is seen within the medical model as a symptom to be brought under control.

Babiker and Arnold (1997) discuss the way in which self-injury is pathologised as a manifestation of various psychiatric disorders. According to the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 1994) non-psychotic, intellectually normal individuals who self-mutilate may be diagnosed as suffering from a disorder of impulse control (Favazza 1992; Pattison and Kahan 1983), posttraumatic stress disorder, borderline personality disorder (Walsh and Rosen 1988; Favazza and Rosenthal 1993), multi-impulsive personality disorder (Lacey and Evans 1986), or one of the dissociative disorders. Favazza and his colleagues (1989) in particular have focussed on the notion of an impulse control disorder. They observe that those with eating disorders are at high risk of self-mutilation, and postulate that such a combination may be a manifestation of an impulse control disorder they call the 'DSH syndrome'.

Watts and Morgan (1994) have presented a formulation of the dynamics that can arise between those who engage in self-destructive behaviours and health services. Their theory is that clients unable to contain their own hate for a needed person project it. They characterise this attitude as "I hate him and he hates me". They suggest that direct and

indirect means are used to provoke carers' hate in order to substantiate the projection. The client then feels better supposedly as responsibility for the hate is shared, and anxiety reduces, but Watts and Morgan warn of the dangers of countertransference hate. They cite Parsons (1951) who discussed the idea that adoption of a sick role is only permissible when the disability is 'genuine' and the patient cooperates with efforts to return to health. Parsons suggests that if not, an infringement of the code relating to illness behaviour has taken place, a code held particularly strongly by healthcare professionals.

Babiker and Arnold (1997) have also looked at dynamics that can arise between healthworkers and those who self-injure. Their model, however sees healthworkers as playing a more active role in the process. There is often a ban against self-injury, with healthworkers taking care in a parental fashion. Healthworkers can be fearful of being held accountable for clients' SMB and can feel vulnerable to blame or legal action. They can feel responsible for individuals' behaviour, yet inadequate to effect change. Maltsberger and Buie (1974) have referred to this dynamic as representing 'narcissistic snares' where carers have unrealistic expectations and aspirations for caregiving and ultimately, feeling helpless and guilty, disengage. Hawton and Catalan (1987) suggest that the results of intervention for chronic self-harmers are often disappointing and that this contributes to the negative attitudes towards them. Staff can perceive their own role as being to protect or heal, and referring agencies or families may expect healthworkers to prevent SMB. As a result, healthworkers can see a client self-injuring as representing failure on their part. This however, is at odds with clients' needs for autonomy, privacy and responsibility for themselves. Patients have an inherently passive role to follow the prescribed treatment of an expert who has diagnosed. There is a handing over of responsibility and power, with an over-emphasis on the use of medication, compulsory admission, close observation and behaviour modification. A difficulty arises in that controlling approaches which might be most likely to reduce SMB in the short-term can have a detrimental effect in the longer-term. Babiker and Arnold (1997) present a controversial perspective: Although statutory health services exist to make people better, they and the power structures they serve may be threatened if large numbers of hitherto quiescent individuals stop hurting themselves and start directing their anger and

resistance outward at the people and institutions which oppress them. Babiker and Arnold (1997) suggest that statutory health services are usually staffed by representatives of privileged groups, and that the 'solution' of these groups to the dilemma outlined above is to individualise and pathologise people's distress. The question that is asked is not 'What is wrong with our society?', but 'What is wrong with these individuals?'.

Aldridge (1988) also sees SMB in patients as being functional for staff as a response to increasing confusion and conflict between nurses and medics. When SMB by patients increases, there is temporary clarification of staff roles. SMB thus has the effect of reducing conflict amongst staff, and so is maintained.

Some attempts have been made to investigate, in a systematic way, the attitudes of healthworkers to people who harm themselves. The findings are inconsistent. Platt and Salter (1989) reviewed three studies (Patel 1975; Ghodse 1978; Goldney and Bottrill 1980), that found negative attitudes to parasuicide amongst medical and nursing staff in a district general hospital and amongst ambulance personnel. These findings are often cited as evidence of generalised hostility towards those who self-harm amongst healthworkers. From their review of further studies, however, Platt and Salter found that most reported predominantly neutral or favourable/sympathetic attitudes. Platt and Salter themselves found considerable variation between staff groups, but an overall tendency to view parasuicide patients in a positive and sympathetic manner. Sidley and Renton (1996) made a similar finding. They carried out a questionnaire survey of nurses working on general hospital wards and found that most described generally professional attitudes to the treatment of patients who had harmed themselves. (Worryingly, a third stated that such work made them uncomfortable, whilst a fifth said it made them feel depressed). Platt and Salter consider what the explanation might be for inconsistent findings regarding positive and negative attitudes. Possible explanations include different definitions of attitudes, different techniques of measurement, or variability in the representiveness of samples. A further explanation for inconsistent findings is that staff reports may not be reliable. It may well be that when nurses are asked to report attitudes to an external person, they are inclined to bias their report in a favourable manner.

Provision of statutory health services for DSH has been reported to be inconsistent and inadequate. Crawford and Wessely (1998) found that 103 out of 308 individuals presenting at an A&E department in South London received follow-up from mental health services. Another paper looking at the management of 934 consecutive episodes of self-harm in an A&E department in Leicester identified a need for improved planning and delivery of services (Dennis et al 1997). This paper found staff to have made only sketchy assessments.

INTERVENTIONS FOR DELIBERATE SELF-HARM

It has been proposed that approaches to DSH can range from one non-interventionist extreme, (where the primary intention is not to reinforce the behaviour) to another extreme of 'naive therapeutic optimism', where the assumption is that talking through an appalling history will help (Allen 1995). A literature review has found interventions to be discussed on two levels:

A) THE MANAGEMENT/SUPPORT LEVEL

General Hospitals/Accident and Emergency Departments

Aoun (1999) describes an intensive six week follow-up programme for all who presented at A&E having made a suicide attempt or having been identified as being at risk. This 'High Intervention Approach' involved risk estimation, crisis management, the development of a therapeutic alliance with the client, coordination of long term follow-up, and liaison between community and treatment agencies. The study found that the intervention programme significantly reduced hospitalisation rates for re-attempts in the study period, as compared with the standard intervention. This study did not demonstrate the particular benefits of this intervention per se, but did demonstrate that more contact between healthworkers and those who self-harm may have a beneficial effect.

A second study of the management of DSH at A&E has been carried out by Crawford and Wessely (1998). They noted an earlier observational study that some people who

receive a psychiatric assessment as part of their initial management may have lower rates of repetition of self-harm (Hawton et al 1992). They studied 308 individuals who had self-harmed and presented either to A&E or to GPs. They found that those who discharged themselves before completion of the initial assessment had three times the rate of repetition of self-harm as those who completed the initial assessment. On this basis, Crawford and Wessely (1998) advocate that psychosocial management by staff at A&E departments should be optimised. This study does not demonstrate the positive impact of a psychiatric assessment, since it does not control for the probable increased vulnerability anyway of those who discharge themselves prior to assessment.

In a third study, this time in Bristol, individuals who were admitted to general hospitals having harmed themselves were given a green card offering emergency telephone support. Individuals were encouraged to seek help at an early stage should problems arise. Follow-up at one year found that those with a history of DSH repeated more often when provided with a green card, whilst first timers appeared to benefit. The intervention displayed a significant reduction in overall self-harm repetitions, with those in the intervention group being offered fewer psychiatric outpatient appointments and fewer non-psychiatric inpatient admissions than controls (Morgan et al 1993; Evans M.O. et al 1999, 2000). This study is persuasive in its findings, since it included random allocation and a large sample size.

Waterhouse and Platt (1990), have compared those admitted to a general hospital with those discharged. The study did not indicate a beneficial effect of general hospital admission after deliberate self-harm. The finding does not account for the likely existing differences between those admitted and those discharged.

Pierce (1986) has studied the perceived attitudes of general hospital staff to individuals who deliberately self-harm, and found no relationship linking the patient's view of staff attitudes with the likelihood of repetition. This finding was based on a reasonable sample (100 patients), as well as on a follow-up period of a whole year. Outcome, however, was only based on further episodes of DSH leading to hospital treatment. The study did not take into account DSH not requiring such treatment.

Mental Health Services as an Outpatient

Bateson, Oliver and Goldberg (1989) compared two different responses to those presenting at A&E having deliberately self-harmed. Some received only a psychiatric assessment, whilst others received joint psychiatric and social work assessment and management. Those in the latter group were offered more follow up, which was received sooner. There were more home visits and fewer outpatient appointments. In contrast to the findings of Aoun (1999), this more intensive intervention found no significant differences in terms of repetition, but clients were significantly more satisfied with the service. Their social circumstances had significantly improved with better family relationships and better financial circumstances at follow-up. They also reported better general health. Ettlinger (1975) made a similar finding that a psychosocial programme had no effect on repetition, but produced some evidence of improvement in social function.

In contrast to the findings outlined above, Greer and Bagley (1971) found a reduced rate of repetition over one to two years in parasuicides who received psychiatric follow-up. Appleby (1993) however, has identified methodological problems with this finding given the retrospective nature of the study and the increased vulnerability of those who reject or who are not offered treatment.

Hawton et al (1998) have systematically reviewed six studies of intensive care plus outreach compared with standard care (Chowdhury et al 1973; Welu 1977; Hawton et al 1981; Allard et al 1992; Van Heeringen et al 1995; Van der Sande et al 1997). Intensive care generally involved regular appointments, home visits and telephone contact. They found no consistent direction of effect among the six studies that they reviewed.

Hawton et al (1998) also reviewed a study comparing an experimental group who received continuity of care (therapy with the same therapist who assessed the patient in hospital after the attempt) with a control group who received change of care (Torhorst et al 1987). Those in the experimental group had a much higher rate of repetition of self-harm, but the authors explained that despite randomisation, this group was vulnerable to more risk factors.

Mental Health Services as an Inpatient

Allen (1995) proposes that should therapy be deemed inappropriate for an individual, there are alternatives:

i) Healthy and appropriately assertive expression of negative feelings should be encouraged and rewarded.

ii) Alternative ways of dealing with unpleasant mood changes should be explored, offering opportunities for success and control. Babiker and Arnold (1997) recommend the value of promoting peer support amongst clients and developing ways of coping that do not require immediate staff involvement, whilst Favazza (1998) has proposed the value of exercise and vocational rehabilitation. Hawton and Catalan (1987) discuss the importance of finding alternative means of reducing tension, especially with those who engage in SMB. Different means include relaxation, distraction, counter-thoughts in which different ways of viewing the situation are entertained, and vigorous exercise. Further strategies include switching to pre-rehearsed thoughts of circumstances where the individual felt relaxed, or venting feelings through punching a rubber object. Thomas (1984) has proposed the value of squeezing a small rubber ball repeatedly until this produces discomfort in the wrist and forearm, whilst Graff and Mallin (1967) have suggested that the provision of physical comfort by a therapist can be beneficial.

iii) It is recommended that staff make time to be with the person when self-harm is not an immediate issue. Indeed, Hawton and Catalan (1987) recommend that the therapist may only see the client at length when he or she does not repeat. Self-harm should be talked about in a practical, problem-solving way. The response to DSH should be low key, matter-of-fact and unpunitive. Hawton's view (1990) is that there should be a clear, written contract detailing what will happen if an individual has further episodes of self-injury. Babiker and Arnold's view is that the policy on self-injury of an institution should be made explicit to the client, and that clients should be provided with a first aid kit and instruction on how to deal with their injuries themselves. In summary, Babiker and Arnold promote a model in which those who self-harm are seen as capable adults who can take control of their own recovery.

Bunclark too (1996) has sought to find a position between non-intervention and over-control. She recommends an approach that conveys respect and understanding, but which encourages clients to exercise choice and control over their DSH. She concurs with Allen's recommendations and adds the importance of identifying triggers to DSH, whilst exploring its function. She suggests that planning should take place about how crises will be dealt with, and that there should be collaborative agreement about at what point staff will intervene.

Bonnivier (1996) describes a completely open inpatient setting in Massachussets where individuals assume responsibility for their own care, and there are no external controls. She reports that because staff and patients do not immediately engage in a power struggle over self-destructive impulses, the focus shifts to supporting the patient's own incentive to preserve treatment , the development of internal controls and the exploration of secondary gains.

Nurses on an acute admissions psychiatric ward were recommended to take a stance where they anticipated attempts to give up responsibility and recognised the addictive nature of DSH (Cremin et al 1995). The paper reports an observation that applying this approach seemed to reduce DSH in the first week of care, but that in subsequent weeks, the behaviour increased again.

When DSH occurs within the context of personality disorder, recommendations regarding psychiatric care include the following (Gallop 1992; Tantam and Whittaker 1992): Limited admission (if at all), avoidance of use of the Mental Health Act, the encouragement of self-responsibility, the setting of clear limits, supportive relationships acknowledging the addictive nature of DSH, the anticipation of difficulties in withdrawing from DSH, and assistance in the development of alternative behaviours. Hawton and Catalan (1987), propose that, when repeated crisis admissions occur, it is often necessary to take considered risks.

Aldridge's model of SMB (1988) presented earlier suggests that SMB should be addressed as a response to distress within the whole system.

At its broadest, the system to be considered is society itself. Babiker and Arnold's (1997) perspective is that the role of social forces needs to be recognised. They see self-injury as a political rather than a personal issue and state that the approach of professionals implicitly reflects a political stance. They argue the importance of empowering those oppressed by social relations and highlight the importance of professionals being conscious of the ways in which SMB may be functional for the institution, or for society.

None of these recommendations (regarding how best to manage individuals who self-harm as inpatients) is based on empirical work. Suggestions are only proposed on the basis of clinical impressions and have not been empirically assessed.

B) THE FORMAL THERAPY LEVEL

Dallam (1997) states that regardless of the intervention modality, establishing a trusting relationship appears to be the most critical and difficult component of working with those who self-mutilate.

Linehan (1997) discusses the way in which some strategies assume that DSH is a symptom of an underlying mental disorder which is targeted, whilst other strategies target DSH directly.

Counselling

Sachs (1983) has warned that unfocused counselling has the potential to be harmful, since it can break down, challenge or undermine habitual coping strategies or defenses (Lambert and Bergin 1994). Hawton et al (1987) have evaluated outpatient counselling as compared with general practitioner care following overdoses. They found no effect on repetitions. Appleby (1993) notes that such treatment involves support, but does not include teaching about alternative ways of communicating distress. No outcome studies demonstrate the clinical effectiveness of counselling on DSH.

Psychodynamic Psychotherapy/Psychoanalysis

These approaches may be used to address supposed repressed psychosexual development conflicts and to attempt to reconcile the life and death drives (Suyemoto 1998). The boundaries model discussed above regards merger issues as being so salient

that the relationship is the primary agent of change. The provision of a reparative experience is therefore seen as crucial (Pao, 1969; Raine, 1982; Woods, 1988). Such proposals are not based on an empirical evidence base.

Cognitive-Behavioural Therapies including Problem Solving Training

Linehan et al (1991,1993) have developed Dialectical Behaviour Therapy (DBT) which combines the need for change in behaviour with acceptance of negative feelings and takes a skills-based approach. They have found a significantly lower rate of repetition of self-harm during follow-up in individuals who received DBT. Parasuicides were also found to be less medically severe, there were fewer inpatient psychiatric days, and those in the experimental condition were more likely to stay in individual therapy. The findings are robust in that they are based on random allocation. They do not however isolate the particular elements of DBT which might produce the effect. The treatment group was compared only with treatment as usual, and so the hypothesis remains that simply having increased contact with healthworkers produced a beneficial effect.

A randomised controlled trial of manual-assisted cognitive-behaviour therapy containing elements of DBT was carried out in West London (Evans et al 1999). The participants were people with personality disturbance who deliberately harmed themselves. Those in the intervention group were found to have a significantly lower rate of suicidal acts at six month follow-up. A similar criticism can be applied to this study as to the study above, in that the intervention was compared only with treatment as usual, which possibly involved less contact with service providers.

Allen (1995) has proposed the possible effectiveness of exposure (to wishes to self-injure) and response prevention, which she demonstrates using a case example.

Four studies have reported reduced repetition of DSH in patients in the experimental groups: i) Gibbons et al (1978) compared an experimental group who received crisis orientated, time limited, task centred social work (a problem solving intervention), with a control group who received treatment as usual; ii) Hawton et al (1987) compared

outpatient problem orientated therapy with GP care; iii) Salkovskis et al 1990 compared domiciliary cognitive behavioural problem solving with treatment as usual; and iv) McLeavey et al (1994) compared interpersonal problem solving skills training with brief problem solving therapy. One study that did not find such an effect was that of Patsiokas and Clum (1985) who compared cognitive therapy and skills training in problem solving with nondirective, reflective psychotherapy. They found no beneficial effect in terms of lower repetition rates of being in an experimental group.

MacLeod et al (1992) have discussed the findings that DBT and cognitive behavioural problem solving (Salkovskis et al 1990) have both been shown to be effective. Their interpretation is that both these treatments involve repeated practices at accessing specific episodes. They hypothesise that the emphasis on fine-grained specific analysis of behaviour is probably important. They suggest that such analysis provides more choice points between impulse and action, and that by going beyond a general summary of what happened, more problem solving alternatives become available. They believe that detailed recollection assists reconstruing and reattribution, and that practice at encoding and retrieving episodes in a more detailed way allows the person to see connections between thoughts, feelings and behaviour. This hypothesis is supported by research demonstrating overgeneral autobiographical memories in people who self-harm. A second hypothesis is that targeting hopelessness is important by helping people to detach from unrealistic goals, and make plans to attain goals which may be effective. Research demonstrating a lack of positive anticipation in people who harm themselves indicates the importance of challenging beliefs about the absence of future positive events (Sidley 1998).

Behavioural Therapy/Management

Most of the papers referring to the behavioural management of self-injurious behaviour are based on single case studies of interventions with people with severe learning disabilities. Interventions producing significant reductions in self-injurious behaviour include the following: i) Extinction and noncontingent reinforcement supplemented by a

cue indicating that a preferred object would be removed, or a task presented (Boyajian Mace et al 1998); ii) Restraint fading (Fisher et al 1997); iii) The application of wrist-weights (Hanley et al 1998); iv) Neutralising routines (Horner et al 1997); v) An initial noncontingent reinforcement schedule and noncontingent reinforcement without extinction (Lalli et al 1997); vi) Placing the therapist a specific distance from the individual (Lalli et al 1998); vii) Continuous schedules of time out, contingent restraint and thinning from continuous to intermittent schedules of punishment (Lerman et al 1997); viii) Noncontingent reinforcement and sensory extinction (Roscoe et al 1998); and ix) Functional communication training (Vollmer et al 1998).

Favazza (1992) has discussed the hospital management of repetitive self-mutilation in individuals who are not learning disabled. He suggests that repetitive SMB should be understood within an addiction model, and that the purpose of hospitalisation should be to eliminate the behaviour for 30 days. Behavioural strategies to facilitate this include the use of one-to-one observations and the taping of bulky gloves on to the hands during the acute phase. These suggestions are not based on empirical evidence.

Liberman and Eckman (1981) have compared an experimental group who received inpatient behaviour therapy with a control group who received insight orientated therapy. No added benefit was found in subsequent suicide and parasuicide rates in the experimental group.

There is some evidence that token economies to address secondary gains and to change environmental contingencies may be helpful (Offer et al 1960; van Moffaert 1989; Podovoll 1969; Schartz et al 1989).

Group Therapy

Group therapy may be helpful in sharing coping strategies and in attempting to maintain a milieu where SMB is not valued, but positive change is (Gardner et al, 1985; Grunebaum et al, 1967). This suggestion is yet to be systematically assessed.

Family Therapy

This may serve the function of exploring the reactions of the environment to see how SMB is serving the system (Grunebaum et al 1967). As yet, no studies test this hypothesis.

Pharmacotherapy/Physical Treatment

Dallam (1997) reviews drug treatments of SMB. Markowitz et al (1994) found that after 12 weeks of treatment with fluoxetine, self-mutilating outpatients demonstrated a 97% reduction in the total number of self-mutilating episodes. No apparent benefit, however, has been observed from the administration of another antidepressant, mianserin (Hirsch et al 1982; Montgomery et al 1983). This latter finding is consistent with a paper published by Linehan et al (1991) which found that a cognitive behavioural therapy resulted in a significant reduction in parasuicide repeat rates compared to treatment as usual, despite being no more effective at reducing depression and hopelessness in the control condition. A similar finding has been made by Sakinofsky and Roberts (1990). Montgomery et al (1979) compared the administration of flupenthixol with a placebo. There was a significant reduction in the repetition of DSH in patients receiving flupenthixol. Opioid blockers have also been found to be effective in attenuating self-injurious behaviour particularly with people with severe learning disabilities (Kars et al 1990; Sandman et al 1990).

Burd and Alon (1998) experimented with the use of Transcutaneous Electrical Nerve Stimulation (TENS) in a man with Down Syndrome who self-injured. They found no clinically significant results, but observed a clear difference in the rates of self-injurious behaviour during active and inactive TENS.

REVIEWS

Mark Evans et al (1999) conclude that attempts at the prevention of DSH are unsuccessful on the whole, with intervention trials lacking the power to detect clinically important effects.

Hawton et al (1998) have systematically reviewed the efficacy of psychosocial and pharmacological treatments in preventing repetition of DSH. They have found evidence of only four interventions being beneficial: problem solving therapy, intensive intervention plus outreach, the provision of an emergency 'green card', and flupenthixol. They conclude that evidence is lacking to indicate the most effective forms of treatment for patients who deliberately self-harm.

Linehan et al (1997) systematically reviewed 20 studies of interventions aimed at reducing suicidal behaviour. She reviewed only controlled studies, and only those that were randomised, (or at least which achieved a close approximation). There had been comparatively little research in this field. She found that there were only three reasonably designed studies which showed psychosocial interventions to be effective in reducing the risk of subsequent parasuicidal behaviour (Van Heeringen et al 1995; Salkovskis et al 1990; Linehan 1991). Linehan notes that all of these were focused behavioural interventions with a problem solving focus. She also noted that nine of the studies excluded those at high risk for suicide and that the effectiveness of an experimental treatment could be almost perfectly predicted by whether or not those at high risk were included. This prediction was in the opposite direction to that which might be expected: If those at high risk were included, the study was more likely to show a beneficial effect. Linehan concludes that individuals who engage in self-harm, but do not have serious mental disorders or high suicide risk, may benefit from very minimal interventions. That is, the control condition may often be sufficient. Hospitalisation therefore, based solely on acute parasuicide, is not warranted. On the other hand, intensive or special outpatient treatments are more likely to be effective when the individual is seriously disordered or at high risk for further suicidal behaviour. The key word here is 'outpatient': Inpatient psychiatric hospitalisation has never been shown to be effective for suicide attempts or other parasuicidal acts.

INTERVENTION SUMMARY:

Clearly, there is a need for individual case conceptualisation so that these research findings can be applied sensibly. Formal therapy needs to be carefully timed. Allen (1995) has suggested that criteria for psychological therapy include the individual taking responsibility

for making and keeping appointments, the individual being distressed by DSH, the individual having some experience of controlling his/her behaviour, and the individual having some ability to reflect on and discuss thoughts and feelings. She recommends that Prochaska and DiClemente's model (1983) be employed in assessing readiness to change. Sidley (1998) reiterates that interventions need to be matched to the temporal proximity of the suicidal behaviour: i) Initially survival is the main priority, and discussion needs to take place regarding strategies to increase the chances of survival. ii) Later, crisis resolution becomes the priority, with an emphasis on problem solving. Heed needs to be taken of the function of the deliberate self-harm, since if it has a mood regulatory function, means of modifying affect will be more important. iii) The restructuring of beliefs can become a priority if DSH is unlikely for hours or days. The belief that self-harm is a preferable solution, and beliefs that maintain hopelessness/aversive affect may need to be restructured. iv) Finally, schematic change may be indicated when DSH is unlikely within months.

SPECIFIC ASPECTS OF THE LITERATURE REVIEW PERTINENT TO THIS STUDY

There were no empirical studies examining the effect of initial nurse-patient interaction following self-harm on acute inpatient mental health units. These interactions usually take place during the survival phase described by Sidley (1998), when formal therapy is not indicated. The empirical study that has come closest to examining this issue is Pierce's study (1986) which found no relationship between the patient's perception of the attitudes of general hospital staff towards self-harm, and repetition. A number of authors (Allen 1995; Babiker and Arnold 1997; Bunclark 1996) make broad recommendations about achieving an approach between non-intervention and overcontrol. These recommendations have not been empirically tested.

AIMS AND HYPOTHESES

When people harm themselves, they are often met with intense emotional reactions. The project stemmed from a clinical awareness that clients on inpatient units were often met with

inconsistent management ranging from emotional reinforcement through to hostility. Different nurses within the same unit could apply models which were at variance with one another, on an ad hoc basis. This issue gives rise to conflict, stress and confusion within staff groups. DSH can take up enormous amounts of staff time in terms of high observation levels. Staff can then feel overburdened and may become angry and punitive to clients who frequently self-harm. Babiker and Arnold (1997) have pointed out that witnessing repeated incidents and attempting to anticipate and control risk can lead to immense strain. When staff flounder due to this, to inadequate information, and to role confusion, attitudes and feelings are often not processed and therefore rational decision-making is blocked. Resolution of this question would benefit clients as well as the nurses charged with their care.

The study was a response to Linehan's concern (1997) that the treatment of suicidal behaviour seems to be an exceptionally low priority within the clinical research community. Linehan has stated that such an absence of treatment development, especially given the seriousness of the problem, is remarkable. She warns that we have very little evidence about what is effective in reducing suicidal behaviours, and virtually no evidence that the standard treatments work.

The purpose of the study was to address the lack of systematic empirical research that investigates what represents the most therapeutic response when a client self-harms on an acute inpatient mental health unit. The intention was to establish whether staff response type had an impact on how long it was before a client self-harmed again. The research hypothesis was that i) the content of what a nurse says to a client, ii) the duration of the interaction, iii) the emotional tone of the nurse's communication, and iv) the strength of emotion communicated by the nurse, (which represent a nurse's response to an incident of self-harm), will have an effect on how long it is before self-harm is repeated. The expectation was that interactions not characterised by overcontrol (where there is a ban against self-injury and healthworkers take care in a parental fashion, as described by Babiker and Arnold 1997) or by non-intervention (where the primary intention is not to

reinforce the behaviour, as described by Allen 1995) would be associated with more of a delay before self-harm was repeated. The null hypothesis was that nurse response type would have no bearing on how long it was before a client went on to self-harm again. Morgan and his colleagues' definition of self-harm (1975) was adopted: "Non-fatal epsisodes of self-harm may be referred to collectively as problems of self-poisoning and self-injury... We have used the term... as... a way of describing a form of behaviour which besides including failed suicides embraces many episodes in which actual self-destruction was clearly not intended." The intention was that, given enough data, narrower definitions could be applied to examine sub-groups.

CHAPTER TWO

METHOD

PILOT STUDIES

DATA SOURCES

The design of the questionnaire was based on data collected from three sources: (1) from audiotaped interviews with nurses, (2) from psychologists' comments on these interviews, and (3) from a nurse survey. These data were then subjected to a qualitative data analysis.

Study One-Audiotaped interviews and psychologists' comments on these interviews

The purpose of the study was to provide nurses with open-ended questions so as to impose as few constraints on the respondents' answers as possible. This would generate information for analysis. It was envisaged that such analysis could provide a comprehensive framework of categories (in terms of content and emotional tone) that could be used to describe individual nurse-patient interactions. It was hoped that information generated would be as exhaustive as possible in covering all potential responses. The overall purpose was to identify specific characteristics of communications systematically in order to convert the raw material into scientific data. Psychology colleagues were involved in commenting on the interview data. The intention was to see if there was consensus amongst the psychologists in their allocation of the interview responses to categories generated by the investigator, which might suggest that the categories were meaningful and valid.

Method

Nursing staff of an acute psychiatric residential unit were recruited. There were 16 nurses in total of whom 10 were interviewed. Those nurses excluded were those who were either on annual leave, or were working night shifts at the time of data collection.

Two of the interviews were not used in the subsequent qualitative analysis: one because the individual in question had not nursed a client immediately following an incident of self-harm for several years and one because she described an incident involving a client who was psychotic.

Of the eight nurses whose interview responses were included for analysis, five were men, and three were women. One of the nurses was an `F' grade, three were `E' grades, three were `D' grades, and one was an unqualified nursing assistant.

The interviews were semi-structured. Each nurse was asked 15 questions pertaining to the last incident of self-harm that he or she had had to manage (see Appendix I). The questions were generated on the basis of clinical experience and a review of the literature. The intention was to get as much data as possible to describe the nurse's behaviour, both verbal and non-verbal.

The other psychologists working in the Adult Mental Health specialty with the author were then asked for comments on the interviews. Three colleagues (a B grade Clinical Psychologist, an A grade Clinical Psychologist and a Trainee Clinical Psychologist all of whom were women), were provided with transcripts of the eight interviews, and listened to the tape recordings. They were asked to:

a) Provide a phrase or short sentence to describe the majority of the content of what the nurse said in each case.

(b) Provide a single word for each interview, which described the most salient characteristic of the nurse's management style.

and (c) Allocate each of the interviews to one of three categories, to show how they would describe the nurse's management style. The categories were "Rescuing", "Matter-of-Fact", and "Hostile", and were generated by the author on the basis of clinical impression.

Results - content

Responses to the question, 'What did you say to the client?' were analysed by the investigator, paying attention to the semantics and meaning of what was said, rather than to the actual syntax used. This generated 15 categories of communication, (see Appendix II). This list could be regarded as being exhaustive in that everything that those eight nurses described having said to their clients, was represented within it.

This list formed the basis of the `content' section of the questionnaire. Two more items were added: `Other' (in case a nurse said something to a client not included in the list) , and `None of the above' (in case the nurse said nothing at all in response to learning about the self-harm, and disengaged totally).

It was possible to subsume the psychologists' comments regarding what formed the majority of the content in each of the eight nurse-client interactions (see Appendix IV) within the author's 17 content categories already devised (see Appendix II).

Results - emotional tone

Attempting to generate a list of words or phrases to describe the nurse's emotional tone was more complicated. Transcriptions of the eight interviews were read carefully. Particular attention was paid to nurses' responses to the following questions: "How did you feel towards the client?", "What would someone neutral have seen?" and "How did the client perceive you?". Any words describing emotional tone were selected and formed a list of 28 words (see Appendix III) which was subjected to further analysis. (See section on categorisation of descriptions of emotional tone).

The psychologists' responses yielded 23 words pertaining to emotional tone. Seven of these words had already been used by the interviewed nurses themselves. The 16 new words were added to the list of words describing emotional tone, (see Appendix V), which had been selected from the interview transcripts by the author (see Appendix III).

When the psychologists allocated each of the interviews to one of the three categories ("Rescuing", "Matter-of-Fact", and "Hostile"), there was only 37.5% consensus. That is, in only 3 of the 8 interviews, were the 3 psychologists unanimous in category allocation. This suggested that the categories were not helpful in distinguishing between the different tones of response of nurses to clients who have self-harmed.

Discussion

Strengths in the methodology of this study included the open-ended nature of questions included in the interview; the fact that data were generated from interviews with nurses of both genders, of varying ages, with varying experience; and the way in which the pool of content and emotional tone items generated from the nurse interviews was supplemented by data from another source (that is, psychologists' comments).

Weaknesses included the fact that six nurses were not interviewed, which could potentially have yielded qualitatively different responses. For example, staff who regularly worked night shifts might have developed very different working practices and attitudes towards self-harm. A second possible weakness is that the study did not take account of the possibility of 'impression management' on the part of nurses. This might have been overcome to a degree if nurses were asked directly to describe an incident of self-harm which they had not managed in the way they would like to have done. Alternatively, (or in addition), interviewing clients regarding the responses they had received from staff might have been a fruitful method of enquiry. A third weakness is that categorisation was carried out only by the investigator. Establishing some inter-rater reliability would have strengthened the design. Psychologists were asked to allocate interviews to one of three categories, but these categories had been generated by the author alone. The design would have been strengthened had the psychologists been involved in generating possible categories, with the psychologists going on to attempt allocation according to different categorisation systems. Merits or otherwise of different systems might then have been established.

Despite these methodological weaknesses, this first study produced a number of items of content and emotional tone that had not previously occurred to the investigator.

Study Two-Nurses' Survey

The aim was to collect information from a bigger population sample regarding possible responses to DSH. The study was designed to establish whether a bigger population sample would suggest additional responses to DSH (in terms of content and emotional tone), which had not previously been generated through nurse interviews, or from psychologists' comments on them.

Method

All of the nursing staff (both qualified staff and nursing assistants) who worked within acute mental health inpatient facilities in Hull received a letter asking them the following question: "Nurses can have many different styles of reacting to clients when they repeatedly self-harm. How would you define or describe what the different styles of response are?"

114 nurses working across seven inpatient facilities were sent the questionnaire. This represented all of the mental health nurses employed on permanent contracts in these units. Nine were G grades, five were F grades, 32 were E grades, 27 were D grades, two were C grades, eight were B grades, and 31 were A grades. 21 nurses replied. This comprised six (67%) of the G grades, one (20%) of the F grades, eight (25%) of the E grades, one (4%) of the D grades, and five (16%) of the nursing assistants. See Appendix XXI for a Chi-square analysis of the nurses' response rate.

Results - content

Again, it was possible to subsume nurses' comments regarding content (see appendix VI) within the author's 17 content categories (see Appendix II).

Results - emotional tone

The nurses' responses yielded 72 words regarding emotional tone. 13 of these words had already been used by the interviewed nurses and the psychologists, but the 59 new words (describing emotional tone) were added to the list. (See Appendix VII).

Discussion

Only 18% of the nurses replied to this survey. Although the respondents did represent a good spread of qualifications and experience, there was a significantly greater return rate from the higher grade nurses (χ^2=18.97, df=2, p<.001). The possibility remained that the nurses who did not reply to the survey (82%) might have had different responses to DSH to suggest. The design would have been strengthened had the author followed up some of those who did not respond. Again, interviewing clients themselves would also have improved the study.

Study Three-Categorisation of Descriptions of Emotional Tone

Data from the three sources yielded a pool of 103 words describing the potential emotional tone of a response. The pool of words was presented individually to an opportunity sample of five nurses: a G grade, an F grade, an E grade, a D grade, and an A grade, (three of whom had previously provided interview responses). The nurses were given the following instruction:

"Here are 103 words that have been generated to describe ways in which nurses can respond to people who repeatedly deliberately self-harm, immediately following an incident of self-harm. Please categorise them. Have as few categories as possible, whilst ensuring that the categories remain meaningful."

The way in which the nurses categorised the words was then analysed. In instances where all five nurses put two words in the same category, these two words were selected.

Where there was disagreement between nurses regarding the association of one particular word with another, those two words were removed. 62 words were deselected at this stage because there was disagreement between the nurses regarding with which other words they should be linked.

Thus attention was focused on 41 words (see Appendix VIII).

Each of the five nurses grouped these 41 words in his/her own particular way. If all of the subdivisions were taken into account, this would leave 11 categories (labelled A-K in Appendix VIII), which would clearly be unwieldy for research purposes. The aim then, was to integrate some of these small categories to form a fewer number of categories, which were bigger in size.

The words "fearful" and "inadequate" were maintained in a distinct category of their own, since there was consensus in that all five nurses kept these words separate from the others.

This however, left 39 words in 10 categories that needed to be condensed into fewer, bigger groups. Two of the nurses placed categories A, B, C, D and H in one large category. Four of the nurses grouped categories F and G together. Three of the nurses grouped E with J, and two also included I in this bigger group. On this basis, and on the basis that, from the author's viewpoint, they seemed to represent distinct attitudes, these remaining 10 categories were collapsed down into three bigger categories, (see Appendix IX).

Study Four-The main study

Having established possible categories of content and emotional tone, the main study was concerned with prospective measuring of actual interactions that took place, in order to find whether there was a relationship between nurse response type and the length of time that elapsed between a client self-harming for the first time during an admission, and the client self-harming again.

DESIGN

The principal study took the form of a quasi-experimental, prospective group comparison with the intention of investigating resulting data using survival analysis. A Mann-Whitney U Test was also utilised. The length of time that elapsed between a client self-harming for the first time during a new admission, and the client self-harming again ('delay') formed the dependent variable. There were four independent variables, which were measures of nurses' responses to the self-harm across four dimensions: 1) The content of what the nurse said to the client; 2) The length of time the nurse spent with the client; 3) The emotional tone of the response; and 4) The strength of emotion expressed by the nurse. The prospective element within the design decreased the possibility of memory bias and distortion.

PARTICIPANTS

The participants who completed questionnaires (at least partially) were 21 inpatients and 31 nurses who responded to incidents of self-harm on one of 15 acute inpatient psychiatric units. Seven of these units were in Hull, and eight were in Bristol. In total, 34 index incidents of inpatients self-harming were reported.

Inclusion criteria were as follows:

1) The incident of self-harm had to be the first incident during that admission.

2) Either the person him/herself who had self-harmed, or the nurse who had dealt with the incident (or both) had consented to complete a questionnaire.

3) The index incident of self-harm must have occurred within the time frame that data were being collected at that particular unit.

The only exclusion criterion was that the inpatient should not have been acutely psychotic at the time of harming him/herself.

The age range of the inpatients who were included in the study was from 18 years to 55 years, with a median age of 32 years (lower quartile=23, upper quartile=39). Twenty-four

were women and ten were men. The types of self-harm represented by the index incidents are shown in table 1 below. In half of the incidents, cutting was the means of self-harm.

Harm type	no. of incidents	percentage
cutting	17	50%
strangulation/suffocation/hanging	6	17.65%
overdose	5	14.71%
burning	3	8.82%
headbanging	2	5.88%
pinching[1]	1	2.94%

Table 1: Means of self-harm of the clients who participated.

The clients who participated presented with a range of psychological problems. Information regarding what psychiatric diagnoses people had received was obtained either by the author reading the client's psychiatric notes, or by her asking for this information from a trained nurse on the unit. Table 2 shows the various diagnoses that clients had been given. Most people had received more than one diagnosis. Appendix XIX shows the specific combination of diagnoses that individual clients had received.

	PD	Substance Use	Psychosis	Eating Disorder	BLD	Trauma	Affective Disorder	Epilepsy
Total	24	8	13	4	2	4	12	1
%	67.7	23.5	38.2	11.8	5.9	11.8	35.3	2.9

PD = Personality Disorder BLD = Borderline Learning Disability

Table 2: Diagnoses that clients had been given.

Participants were categorised into four groups ('fearful', 'indifferent', 'hostile', and 'sympathetic'), based on the emotional tone of the response that they received from nurses when they harmed themselves. (See the sections on Pilot Study Three and Questionnaire Design for an explanation of this process).

[1] This was very severe self-pinching causing bruising.

PROCEDURE

Permission for the study was initially sought from and granted by the Hull and East Riding Research Ethics Committee (see Appendix X), the North Bristol NHS Trust (Frenchay) Research Ethics Committee (see Appendix XI), the Southmead Local Research Ethics Committee (Bristol), the Weston Ethics Research Committee, and the United Bristol Hospitals Trust Research Ethics Committee (see Appendix XII). It was also necessary to gain approval from the NHS Trusts' managers, senior nurses and consultant psychiatrists (see Appendix XIII).

Having gained approval, data collection was initiated in Hull. The managers of the seven Acute Mental Health Residential Units were contacted to arrange meetings with groups of nurses. These meetings took place between the 2nd March 1998 and 7th April 1998, when the purpose of the study was presented. Thereafter, nurses were asked to complete a questionnaire the first time that a client self-harmed during a new admission (see Appendix XIV). Data were drawn from consecutive incidents where an inpatient self-harmed for the first time during a particular admission. (Whether or not a person had a history of self-harm was irrelevant. The first time a person self-harmed during a new admission represented an index incident). It was asked that the nurse who had had most contact with the client immediately after the incident complete the questionnaire, regardless of whether that person was a qualified nurse, or a healthcare assistant. Inclusion and exclusion criteria were explained and it was asked that nurses send the questionnaire through the internal mail system to the author. The nurses were assured of the confidentiality of their responses, which would only be breached were a nurse's behaviour not to comply with the code of professional conduct of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

In addition to completing a questionnaire him/herself, the nurse who had had most contact with the client immediately after the incident of self-harm was asked to approach the client with the Client Questionnaire (see Appendix XV). It was made clear that the nurse should use his/her clinical judgement in deciding at which point this would be

most appropriate, and acknowledged that a client might be approached with a questionnaire a few minutes after an incident of self- harm, a few hours later, or even a few days later. The author also pointed out that nurses should not approach clients with questionnaires should nurses regard doing so as clinically inappropriate in that instance. Where nurses believed that presenting clients with a questionnaire was appropriate, the nurse who had dealt with the incident of self-harm gave the client a questionnaire, together with a Client Information Sheet/Consent Form (see Appendix XVI), and an envelope addressed to the author marked 'Private and Confidential'. If the client wanted to consent to participating in the research, s/he was asked to send the completed questionnaire and consent form to the author through the internal mail system. A pack of questionnaires, Client Information Sheets/Consent Forms and addressed envelopes was left on each of the units. In two instances clients contacted the author for assistance in completing the questionnaire. Where face-to-face contact happened in this way, communication was restricted to repetition of information contained on the questionnaire.

Thus data collection on these units in Hull commenced in March/April 1998 when the author met with the nursing staff on each unit. Each week, (unless she was on annual leave), the author contacted the units by telephone to check on incidents of self-harm. When an index incident was reported, questionnaire completion was prompted. The author also checked on developments with regard to clients who had fallen into the study, and the first self-harm repeat date in each case was recorded. When clients had been discharged without having self-harmed again, enquiries were made regarding community follow up. If clients had a community keyworker, this person was contacted for information regarding further self-harm. Sometimes community keyworkers were contactable and were able to give reliable information regarding whether or not the client had harmed him/herself again and if so, on what date. On other occasions, either clients were discharged without community follow-up, or community keyworkers were not contactable, or did not know the relevant information. Data collection and monitoring of clients in this way continued in Hull until 18th September 1998, by which time the author had relocated to Bristol and it became unfeasible to maintain contact.

The North Bristol NHS Trust (Frenchay) Research Ethics Committee required the preparation of an Information Sheet for the nurses, (see Appendix XVII) and some modification of the Client Information Sheet/Consent Form (see Appendix XVIII). Data collection commenced in Bristol on 1st June 1999, when the author met with the nursing staff at one unit. By the Autumn of that year, it became clear that insufficient data would be forthcoming, and so further data collection was initiated on two more Hospital sites. Four acute psychiatric units were engaged in the study. Three psychiatric wards at another hospital also became involved. Data collection on these units began in March and April 2000. The procedure was exactly as it had been in Hull. No clients in Bristol took up the offer of being assisted in questionnaire completion. Data collection and monitoring of incidents of self-harm continued on the eight Bristol units until 31st October 2000. This date was decided as the cut-off in order to allow enough time for statistical analysis and writing up before the study had to be completed in September 2001.

According to untoward incident reporting within the two NHS Trusts, a total of 80 people harmed themselves on these units (sometimes more than once) during the time frame that the author was studying them. (Time frames varied from one unit to another, depending on when it was possible to meet with a staff group to get the study up and running in a particular unit. Data collection ceased in Hull and began in Bristol when the author relocated). Data were received regarding only 34 of these 80 inpatients. Efforts were made to establish whether the remaining 46 would have been eligible for the study. Four of these 46 could definitely be excluded since they had already self-harmed during that admission and before data collection had commenced at that particular unit. This left 42 inpatients, 13 of whom had certainly not had a previous incident of self-harm during that admission. In 29 instances, it was not possible to establish whether or not there had been previous self-harm incidents during the admission in question. Of the remaining 42, 12 had diagnoses referring to psychotic symptoms. It was therefore possible that some of these had been excluded as a result of being acutely psychotic at the time of self-harm. Of the 42 who might have been eligible, 10 had diagnoses where no reference was made to psychosis, increasing the likelihood that they would have been eligible for the study. In 20 of these 42 cases, it was not possible to access information about diagnoses.

The final sample of 34 then was drawn from a pool of 76 possible index incidents, and therefore represents a minimum of 45% of the potential data set. This is a conservative estimate, however, because in 39 of the instances where questionnaires were not received, there was insufficient information to establish whether the inpatient would have been eligible for the study or not. The most liberal estimate, (assuming that none of these people would have been eligible), is that the final sample of 34 represented 92% of the potential data set.

MEASURES

A questionnaire was designed to gather information about interactions that took place between clients and nurses immediately following an incident of deliberate self-harm. The questionnaire sought to measure interactions across four dimensions:

i) the content of what a nurse said to a client; ii) the duration of the interaction; iii) the emotional tone of the nurse's communication; and iv) the degree to which the nurse was emotional during the interaction.

QUESTIONNAIRE DESIGN

Two questionnaires were developed: one on which the nurses were asked to describe their behaviour towards a client in dealing with an incident of deliberate self-harm, and a parallel version on which clients were asked to describe the nurse's behaviour towards them. (See Appendices XIV and XV).

Firstly, participants were asked for their initials, for the date of birth of the client who had self-harmed, for the time and date of the self-harm, and for the form that the self-harm had taken. Both clients and nurses were asked to explain their perspective on why the client had harmed him/herself and what the client had been trying to achieve. Both clients and nurses were asked to indicate how serious they thought the self-harm had been in terms of the risk that the client would die. They were asked to make a mark along a 10cm long scale, where 0 represented 'not at all serious' and 10 represented 'extremely serious'. There were 31 nurses who

answered this question. The responses ranged from 0.1 to 10 with a median severity score of 1.4 (lower quartile=0.5, upper quartile=3.7). There were 21 clients who answered the question regarding perceived seriousness of the self-harm. Their responses ranged from 0 to 10 with a median severity score of 1.8 (lower quartile=0.2, upper quartile=4.1). Thus the average seriousness of self-harm perceived by both clients and nurses was mild.

Secondly, clients and nurses were presented with the 17 categories of communication (in terms of content) which had been generated during the questionnaire design phase (see above). They were asked to tick all of those boxes that had applied to the interaction, that is, to indicate the full range of subject matter that had formed the basis of the conversation between the nurse and the client. In addition, they were asked to indicate what they had spent most of the time talking about.

Thirdly, all participants were asked for an estimate of the number of minutes that the nurse had spent with the client immediately following the incident of self-harm.

Fourthly, participants were asked to select one category (to describe the nurse's emotional tone) from the four categories describing emotional tone that had been defined during the questionnaire design phase (see above). In addition, they were given the opportunity to describe the nurse's attitude in their own words.

Fifthly, participants were asked to comment on the degree to which the nurse had expressed emotion of any kind along a 10cm long scale, with 0 representing 'not at all emotional', and 10 representing 'extremely emotional'.

Finally participants were given the opportunity to make any further comments they wished to.

STATISTICAL ANALYSIS

A survival model was constructed, using the method described by Collett (1994). This was then applied to the data to determine whether nurse response was associated with

the length of time that elapsed before self-harm was repeated. Having done this analysis, a Mann-Whitney U Test, chi-square, and the Fisher Exact Probability Test were applied. Spearman Rank Order Correlations were also calculated. Stata Statistical Software and SAS Institute Inc. were the computer programmes used in the analysis.

CHAPTER THREE

RESULTS

1) DESCRIPTIVE STATISTICS

Variable	N	Median	Lower quartile	Upper quartile	Min	Max
Delay	28	3	2	9	1	105
Nurses' perceptions of severity	31	1.4	0.5	3.7	0.1	10
Clients' perceptions of severity	21	1.8	0.2	4.1	0	10
Nurses' perceptions of minutes	31	25	10	45	0	480
Clients' perceptions of minutes	16	20	12.5	32.5	1	75
Nurses' perceptions of strength of emotion	30	3.9	1.4	5.2	0	8.3
Clients' perceptions of strength of emotion	15	3.9	1.3	6.8	0	7.9

Table 3: Medians, interquartile ranges, and ranges for seven of the variables.

Table 3 shows the medians, inter-quartile ranges, and ranges for the dependent variable (delay), and for six of the independent variables.

Delay/Repeat

One of the 34 clients (whose index incidents were reported by nurses and/or by clients themselves) was lost to any follow-up. Of the remaining 33, five did not harm themselves again during the follow-up period. These five individuals were lost to follow-up after 50, 75, 80, 108 and 148 days respectively. Of the 33 who were followed up, three (9.1%) harmed themselves again on the same day, three (9.1%) harmed themselves again on the following day, four (12.1%) repeated self-harm two days later, and six (18.2%) repeated self-harm three days later. Within four days, half of the clients had harmed themselves again, and within 44 days, three-quarters had done so.

Severity of self-harm

31 nurses reported on the self-harm of their clients. The median severity score was 1.4, which represented only mild severity. There was, however, a broad range, from 0.1 to 10.

21 clients reported on the severity of their self-harm. This included 18 self-harm incidents that the nurses had described, together with three where the nurse had not completed a questionnaire. The median severity score was 1.8, which represented mild severity as the nurses had reported. Again, there was a broad range, from 0 to 10.

Efforts were made to establish the relationship between how severe nurses perceived self-harm to be and how clients described it. There were 18 nurse-client pairs where both reported on the severity of the client's self-harm. The distribution of the differences in nurses' and clients' perception of the severity of self-harm ranged from -9.8 to 8 with a median difference of 0 (lower quartile=-1.4, upper quartile= 2.9, n=18). This was clearly a massive range. As the distribution of differences was highly skewed, it was necessary to apply a natural log transform to the data prior to constructing a limits of agreement plot (see figure 1). The limits of agreement were calculated such that approximately 95% of differences between the two readings would lie between the limits.

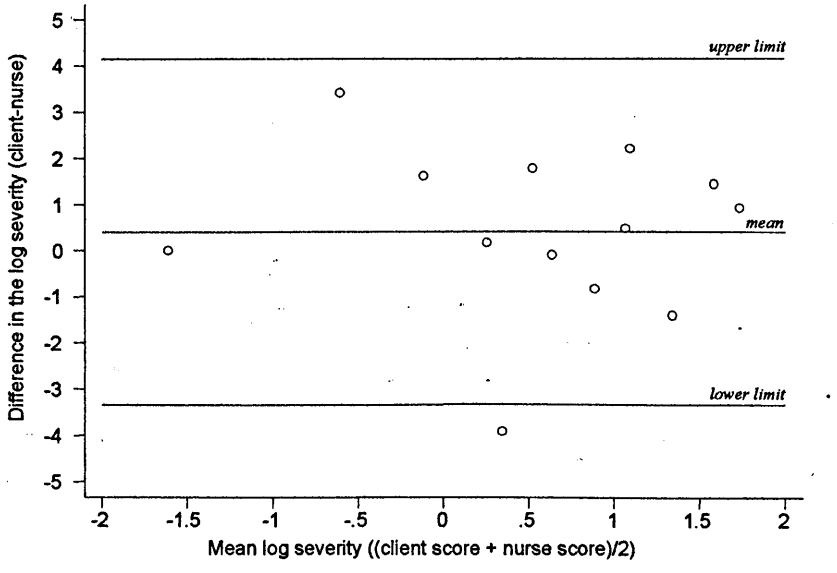

Figure 1: Log differences against log mean for severity of self-harm (post-transformation).

Table 4 shows the mean and limits of agreement estimates for data post-transformation.

	Estimate
Mean	1.51
Lower limit of agreement	0.04
Upper limit of agreement	63.43

Table 4: Mean and limits of agreement for nurses' and clients' reports on the severity of clients' self-harm.

If the clients' and the nurses' perceptions of severity of self-harm were equivalent and any differences in readings between the two methods could be attributed to chance variation, any difference in readings would be just as likely to be positive as negative. That is, the client/nurse ratio for a given client would be just as likely to be >1 as <1. For this data set, however, the client's perception of the severity of his/her self-harm was, on average, 1.51 times higher than the perception of the nurse's. As the 95% confidence interval for the mean (0.62 to 3.64) did include the value 1 (representing equivalence) there was no evidence to suggest a significant bias. The data suggested that nurses and clients did not agree on the severity of self-harm. In some cases, clients reported their self-harm to be more severe than the nurses did. In other cases, this relationship was reversed. The limits of agreement on the ratio scale (0.04-63.43) indicated that there was very poor agreement between the two methods. A client's perception of self-harm severity could well be as much as 63.43 times the nurse's perception. It also became evident that the more severe the self-harm, (as perceived by either the client or the nurse), the more likely the client and the nurse were to disagree.

Length of time the nurse spent with the client

31 nurses estimated the length of time that they had spent with the client after self-harm. The median number of minutes was 25, with a range of 0 to 480 minutes.

16 clients estimated the length of time that nurses had spent with them after self-harm. This represented 13 interactions that the nurses also described as well as three additional interactions where nurses had not completed a questionnaire. The median number of minutes was 20 with a range of 1 to 75 minutes.

As with perceptions of self-harm severity, an attempt was made to establish the relationship between nurses' and clients' perceptions of the length of interactions. There were 14 nurse-client pairs where both had estimated the duration of the interaction. Table 5 shows the mean and limits of agreement estimates for these data.

	Estimate
Mean	-3.21
Lower limit of agreement	-43.87
Upper limit of agreement	37.45

Table 5: Mean and limits of agreement of nurses' and clients' reports of interaction duration.

As the 95% confidence interval for the mean difference (-14.08 to 7.66) included the value 0 (representing equivalence), there was no evidence to suggest a significant bias. That is, a nurse and client were equally likely to disagree in either direction. The differences between each client's and nurse's estimate (client-nurse) ranged from -35 to 30 minutes. The limits of agreement suggested that a client's perception of duration of interaction was likely to differ from a nurse's perception by between -43.87 and 37.45 minutes. Agreement between nurses and clients was therefore not good regarding the number of minutes that a nurse spent with a client.

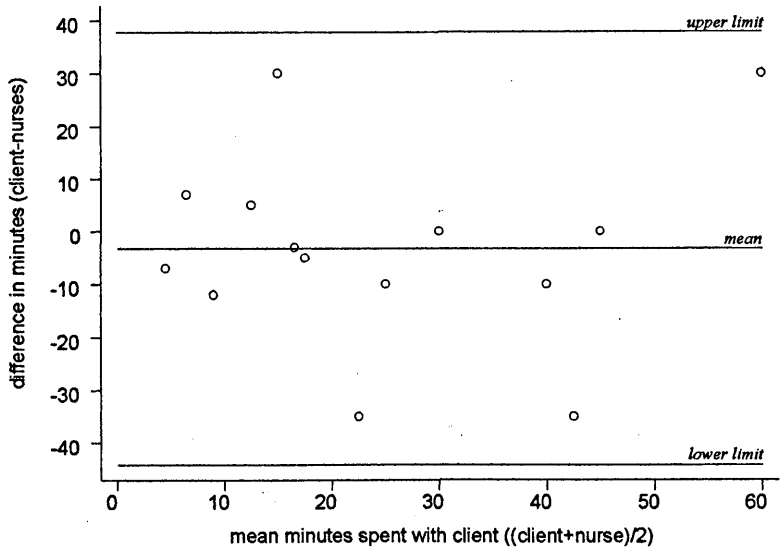

Figure 2: Differences against the mean for nurses' and clients' reports of interaction duration.

Strength of emotion

30 nurses recorded how strongly they had expressed emotion in interactions with clients who had just harmed themselves. Responses were recorded on a 10cm long scale, with 0 representing 'not at all emotional' and 10 representing 'extremely emotional'. Emotion strength ranged from 0 to 8.3 with a median of 3.9, (lower quartile =1.4, upper quartile=5.2). This represented a broad range of strength of emotion expressed as perceived by nurses from 'not at all emotional' to 'very emotional'. The average emotion strength was mild to moderate.

15 clients recorded the strength of the nurses' emotion in interactions with them following DSH. These descriptions included 14 interactions that nurses had already described, with one additional interaction where the client responded, but the nurse did not complete a questionnaire. Perceived nurse emotion strength for these 15 interactions ranged from 0 to 7.9 with a median of 3.9 (lower quartile=1.3, upper quartile=6.8). Again, a broad range of nurse emotion strength was perceived by the clients.

Where both a client and a nurse had reported on the nurse's emotion strength, (in 14 instances), degree of agreement was analysed. Table 6 shows the mean and limits of agreement for these data.

	Estimate
Mean	0.51
Lower limit of agreement	-4.18
Upper limit of agreement	5.20

Table 6: Mean and limits of agreement for nurses' and clients' perceptions of strength of nurses' emotion.

As the 95% confidence interval for the mean (-0.74 to 1.76) included the value 0 (representing equivalence), there was no evidence to suggest a significant bias. The difference between clients' and nurses' reports ranged from -3.6 to 4.5. The limits of agreement suggested that a client's report of a nurse's emotion strength was likely to differ from the nurse's report by between -4.18cm and 5.20cm on the scale. The degree of agreement then between nurses and clients was poor.

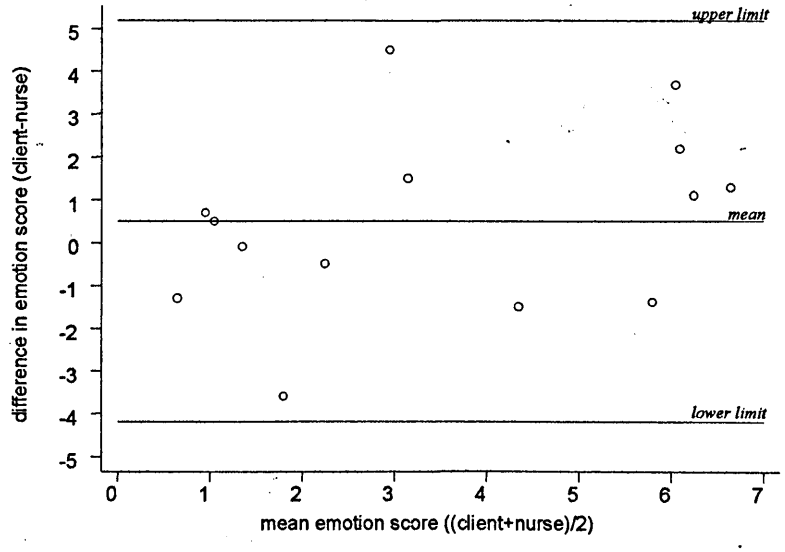

Figure 3: Differences against the mean for emotion data.

Content

The following tables summarise data for the content variables, indicating where nurses and clients regarded a particular content as having formed some of the interaction.

Apologising

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	No	8	2	2	12
	Yes	4	1	1	6
	Not answered	14	2	0	16
Total		26	5	3	34

Questioning about how or when you harmed yourself

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	No	0	3	2	5
	Yes	3	9	1	13
	Not answered	6	10	0	16
Total		9	22	3	34

Pointing out bad things about self-harm

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	No	7	3	3	13
	Yes	2	3	0	5
	Not answered	12	4	0	16
Total		21	10	3	34

Expressing disappointment

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	No	12	2	3	17
	Yes	1	0	0	1
	Not answered	15	1	0	16
Total		28	3	3	34

Joking

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	No	14	0	3	17
	Yes	1	0	0	1
	Not answered	15	1	0	16
Total		30	1	3	34

Open questioning , exploring feelings

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	No	3	3	1	7
	Yes	1	8	2	11
	Not answered	6	10	0	16
Total		10	21	3	34

Telling you about what would happen next

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	No	4	3	1	8
	Yes	3	5	2	10
	Not answered	7	9	0	16
Total		14	17	3	34

Questioning about why you harmed yourself

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	No	4	1	3	8
	Yes	5	5	0	10
	Not answered	8	8	0	16
Total		17	14	3	34

Practical things about physical care

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	No	10	1	2	13
	Yes	1	3	1	5
	Not answered	9	7	0	16
Total		20	11	3	34

Expressing frustration

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	No	15	0	2	17
	Yes	0	0	1	1
	Not answered	16	0	0	16
Total		31	0	3	34

Explaining why his/her actions are right

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	No	7	1	3	11
	Yes	2	5	0	7
	Not answered	11	5	0	16
Total		20	11	3	34

Showing that he/she accepts the self-harm

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	No	11	2	3	16
	Yes	1	1	0	2
	Not answered	16	0	0	16
Total		28	3	3	34

Offering help

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	No	7	2	1	10
	Yes	4	2	2	8
	Not answered	9	7	0	16
Total		20	11	3	34

Trying to stop you harming yourself in the future

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	No	2	3	1	6
	Yes	3	7	2	12
	Not answered	3	13	0	16
Total		8	23	3	34

Things other than self-harm

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	No	8	2	2	12
	Yes	1	4	1	6
	Not answered	9	7	0	16
Total		18	13	3	34

Other

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	No	12	2	3	17
	Yes	1	0	0	1
	Not answered	12	4	0	16
Total		25	6	3	34

None of the above

		Nurse's opinion			Total
		No	Yes	Not answered	
Client's opinion	**No**	15	0	3	18
	Yes	0	0	0	0
	Not answered	16	0	0	16
Total		31	0	3	34

Tables 7-23: Frequencies of nurses' and clients' reports of content.

31 of the nurses completed items to describe the content of what they said to clients during interactions. The most common content item reported by nurses was 'Trying to stop the client harming in the future'. This included trying to agree with the client on a plan including alternative coping strategies. This was reported to form some of the content in 23 of the interactions. The second most common content item was 'Questioning about how or when the client had self-harmed'. 22 of the 31 nurses said this had formed some of the interaction. The third most common content item reported was 'Open questioning exploring feelings'. 21 of the 31 endorsed this item. Between a half and three quarters of the nurses endorsed these three items, as well as a fourth item: 'Telling the client what would happen next'. Six items were endorsed on between a quarter and a half of questionnaires: 'Questioning about why the client self-harmed'; 'Things other than self-harm'; 'Practical things about physical care'; 'Explaining why your actions are right'; 'Offering help'; and 'Pointing out bad things about DSH'. The remaining content items were endorsed in less than a quarter of cases. None of the nurses reported expressing frustration directly.

Only 13 nurses indicated which item they thought formed the main content of what they said to clients. 'Open questioning exploring feelings' was the most frequently reported main content.

Main content as reported by nurses	Frequency
Questioning about how or when you harmed yourself	4
Pointing out bad things about self-harm	1
Open questioning exploring feelings	5
Explaining why his/her actions are right	2
Other	1
Total	**13**

Table 24: Frequencies of content items described by nurses as forming the main content.

18 of the clients completed items to describe the content of what nurses had said to them during interactions. In 15 of these cases, a nurse also described the interaction. The three remaining interactions, however, were only described by the client who had self-harmed, the nurse in these cases not having completed a questionnaire.

The most common content item reported by clients was 'Questioning about how or when you had harmed yourself'. This was reported to form some of the content in 13 of the 18 interactions. The second most common content item was 'Trying to stop you harming yourself in the future'. 12 of the 18 clients said this had formed some of the interaction. The third most common content item reported was 'Open questioning exploring feelings'. 11 of the 18 endorsed this item. These three items were endorsed in between a half and three quarters of cases, as were two more items: 'Telling you about what would happen next' and 'Questioning about why you harmed yourself'. Six items were reported in between a quarter and a half of instances: 'Offering help'; 'Explaining why his or her actions are right'; 'Apologising'; 'Things other than self-harm'; 'Pointing out bad things about self-harm'; and 'Practical things about physical care'. The remaining content items were endorsed in less than a quarter of cases.

Only two clients indicated which item they thought formed the main content. One client reported this to be 'Questioning about how or when you had harmed yourself'. The other reported the main content to be 'Things other than self-harm'.

Emotional tone of nurses' responses

A total of 30 nurses described their attitudes to the clients who had self-harmed. 26 (86.7%) reported an attitude falling in the 'sympathetic' category, two nurses (6.6%) described an attitude in the 'indifferent' category, one nurse (3.3%) said she had an attitude which was 'fearful/inadequate', whilst the final nurse stated that his attitude fell in the 'hostile' category.

A total of 16 clients described the attitudes of nurses towards them. This represented 14 interactions which nurses also described, plus two further interactions where nurses did not produce a response. 15 of the 16 (93.8%) described a nurse attitude towards them falling in the 'sympathetic' category. Only one client (6.2%) gave a different answer: She reported that the nurse's attitude had fallen in the 'hostile' category.

There were fourteen instances where both the nurse and the client described the nurse's attitude. In the majority of these pairs (12), both the nurse and the client agreed that the nurse's response had fallen in the 'sympathetic' category. In two pairs, the nurse and client disagreed. In one case, the nurse said his attitude had fallen in the 'indifferent' category, yet the client perceived him to be sympathetic. In the other case, the nurse reported an attitude falling in the 'sympathetic' category, but the client perceived her to have an attitude falling in the 'hostile' category.

2) TESTING OF HYPOTHESES

A survival model was constructed using the method described by Collett (1994). The survival time was defined as the length of time from the date of initial self-harm to the date of repeated self-harm ('delay'). The survival times for patients who had not self-harmed at their last follow-up date were calculated as the length of time from the initial self-harm date to the date of the last follow-up and were treated as censored observations. One client was removed from the analysis as there was no follow-up.

Only three prognostic factors could be considered due to the size of the sample. Client

perceptions of nurse response types were considered to be most relevant, but clients had returned insufficient data to make this feasible. Nurses' perceptions of their response types were therefore selected instead. Nurses' perceptions of the length of time they had spent with clients were selected to form one prognostic factor, and nurses' perceptions of the strength of their emotion to form a second. A decision then had to be made as to whether to look at content or emotional tone as the third prognostic factor. Given the distribution of responses regarding emotional tone, (with 86.7% of the nurses responding within the 'sympathetic' category), it was unlikely that this variable would have any discrimination value. A decision was therefore made to look at a content variable. 'Open questioning exploring feelings' was selected since a) it had been reported sufficiently frequently to potentially have some discrimination value; and b) it represented a response type that could potentially avoid control of the client, whilst not characterising an alternative extreme of non-intervention.

29 out of the 33 remaining interactions had data for all three prognostic factors. The first stage was to fit separate models for each of the prognostic factors under consideration. Any variables significant at the 10% level would be considered for inclusion in the final model. Neither a) nurses' perceptions of number of minutes spent with the client, nor b) nurses' perceptions of emotion strength, nor c) whether the nurse had engaged in open questioning exploring feelings, was found to be univariately significant ($p=0.34$, $p=0.21$, and $p=0.94$ respectively).This meant that there was no evidence that any of these three variables significantly affected the delay before self-harm was repeated.

Of this sub-group of 29 (for whom data on all three prognostic factors were available), 25% had harmed themselves again within two days. This estimate is obviously based on the population monitored in this study. In the true population (of all people who self-harm during admissions to acute inpatient mental health units), there was 95% confidence that 25% of individuals would harm themselves again between one and three days later. 50% of the population under study had harmed themselves again within three days. In the true population, there was 95% confidence that self-harm would be repeated by between 3 and 6 days later in 50% of cases.

Figure 4 shows a survival curve for time before repeating self-harm for the 29 clients for whom all three prognostic factors were available.

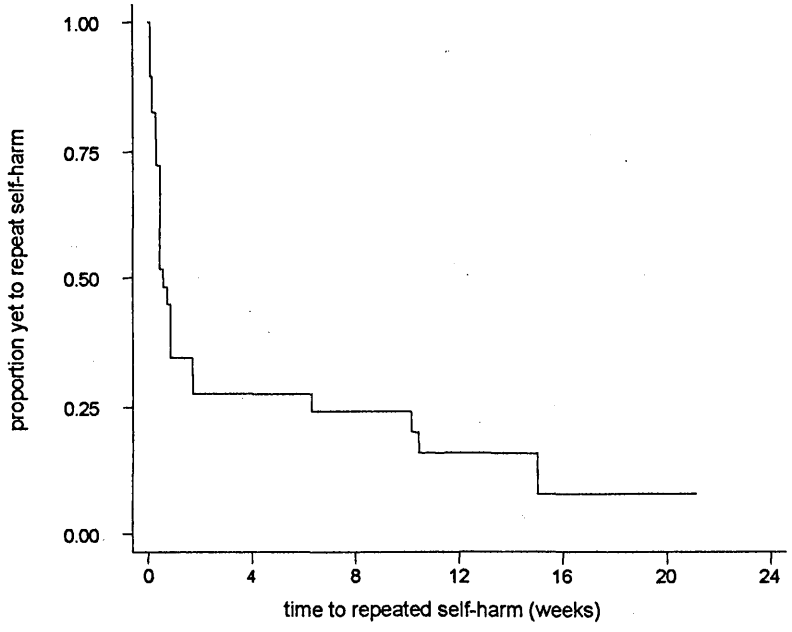

Figure 4: Kaplan-Meier survival estimate of time to repeat self-harm.

3) EXPLORATORY STATISTICS

Having carried out the formal survival model analysis, exploratory analyses were applied, not with the intention of testing hypotheses, but in order to generate further hypotheses.

The individual relationships between 'delay' and 21 variables representing dimensions of nurse response types were explored. The relationships are summarised in table 25.

Variable	N	Analysis		Significance
Nurses content 14	26	Chi-square	$\chi^2 = 1.89$	N.S.
Nurses content 2	26	Chi-square	$\chi^2 = 0$	N.S.
Nurses content 6	26	Chi-square	$\chi^2 = 0.17$	N.S.
Nurses content 7	26	Fisher	$p = 0.0846$	N.S.
Nurses content 8	26	Chi-square	$\chi^2 = 0.11$	N.S.
Nurses content 15	26	Chi square	$\chi^2 = 0.67$	N.S.
Nurses content 9	26	Chi-square	$\chi^2 = 0.11$	N.S.
Nurses content 11	26	Chi-square	$\chi^2 = 0.77$	N.S.
Nurses content 13	26	Chi-square	$\chi^2 = 0.11$	N.S.
Nurses content 3	26	Chi-square	$\chi^2 = 0$	N.S.
Clients' content 2	15	Fisher	$p = 0.446$	N.S.
Clients' content 14	15	Fisher	$p = 0.659$	N.S.
Clients' content 6	15	Fisher	$p = 0.2867$	N.S.
Clients' content 7	15	Fisher	$p = 0.168$	N.S.
Clients' content 8	15	Fisher	$p = 0.4048$	N.S.
Clients' content 13	15	Fisher	$p = 0.427$	N.S.
Nurses' perception of minutes	26	Spearman	RHO = 0.122	N.S.
Clients' perception of minutes	14	Spearman	RHO = 0.307	N.S.
Nurses' emotional tone	25	Fisher	$p = 0.618$	N.S.
Nurses' emotion strength	25	Spearman	RHO = 0.347	$p = 0.05$
Clients' perception of emotion strength	13	Spearman	RHO = 0.181	N.S.

Table 25: Relationships between the dependent variable, 'delay' and 21 outcome variables.

Content

Ten of the content variables as perceived by nurses, and six of the content variables as perceived by clients were studied in relation to 'delay'. These 16 were selected because they were those reported sufficiently frequently that they might have some discrimination value. Where possible, chi-square analyses were applied to the data. This involved some pooling of cells, in order that they might contain frequencies of sufficient size to proceed. In some cases, despite pooling of 'delay' values, cells contained insufficient frequencies, and so the Fisher Exact Probability Test was applied. No significant relationships were found between whether or not these content variables had

been present and how long it was before clients went on to harm themselves again. In two cases, however, a trend was identified. This was in relation to 'Telling the client/you what would happen next'. Both nurses' and clients' reports regarding whether or not this content was present in the interaction showed a trend in relation to the 'delay' variable. In both of these cases, if the figures were doubled (assuming maintenance of the same distribution), a significant relationship would have been found between the presence of this content in the interaction and a longer delay before self-harm was repeated.

Length of time the nurse spent with the client

Spearman Rank Order Correlations were calculated to look at the relationship between the number of minutes that a nurse spent with a client (as estimated by nurses and clients) and 'delay'. These calculations found no significant correlations.

Emotional tone of nurses' responses

A 2x2 contingency table was developed, and 'delay' categorised into <5 or >6. Despite this pooling, small frequencies would not permit a chi-square test, and so the Fisher Exact Probability Test was applied. This did not find there to be a significant relationship. No similar analysis could be carried out on the clients' reports of nurses' emotional tone, because all but one reported a sympathetic response.

A further analysis involved matching the five clients where either the nurse or the client had reported a response other than a sympathetic response with five clients who had received a sympathetic response. Clients were matched principally on the basis of diagnosis. If there was more than one client who had received a sympathetic response and who had the same diagnosis, then the closest in age was selected. Appendix XX describes the five clients where either the nurse or the client reported a response other than a sympathetic response. The Appendix also outlines the individuals with whom these clients were matched.

The original intention had been to carry out an analysis of variance looking at the effects of all four categories, ('fearful', 'indifferent', 'hostile', and 'sympathetic'). This was not

possible, however, because in all but five cases, responses fell exclusively in the 'sympathetic' category. A Mann-Whitney U Test was applied to the data instead, to look at the relationship between differences in length of delay before repeated DSH and whether or not clients had received a sympathetic response from nurses (U=7, n1=5, n2=5, p=.16). This test found no significant relationship between whether or not nurses were sympathetic, and how long it was before clients went on to harm themselves again.

Strength of emotion

Spearman Rank Order Correlations were calculated to look at the relationship between the strength of the nurses' emotion (as perceived by nurses and clients), and 'delay'. No relationship was found between clients' perceptions of emotion strength and 'delay', but the correlation between nurses' perceptions of their emotion strength and 'delay' was found to be significant at the .05 level. Thus nurses perceiving themselves to be more strongly emotional was correlated with a longer delay before self-harm was repeated.

CHAPTER FOUR

DISCUSSION

AIMS AND HYPOTHESES

Most of the data supported the null hypothesis that nurse response type has no bearing on how long it is before a client engages in self-harm again. This is consistent with Pierce's study (1986) which found no relationship between the patient's perception of the attitudes of hospital staff towards self-harm, and repetition.

MAIN FINDINGS

There was no evidence that the length of time a nurse reported spending with a client who had just self-harmed, or that the attitude towards a client reported by a nurse, had any bearing on how long it was before the client harmed him/herself again. No particular content items were found to have a significant relationship with delay, although a trend was observed for a longer delay to be associated with a nurse talking to a client about what would happen next. The only statistically significant finding was a positive correlation between nurses' perceptions of how strongly emotional they were in their interactions with clients, and the length of time before clients harmed themselves again. That is, nurses perceiving themselves to be more strongly emotional was correlated with a longer delay before self-harm was repeated.

A finding not directly related to the hypotheses was that nurses and clients perceived behaviour differently. There was poor agreement between nurses and clients in terms of their perceptions of the number of minutes that an interaction lasted, in terms of how strongly emotional the nurse was, and in terms of the severity of the client's self-harm. None of these relationships showed a significant bias in any direction. It was observed that the more severe a client's self-harm (as perceived by either the nurse or the client), the more likely it was that the nurse and client would disagree about the severity of the self-harm.

Moving from experimental to descriptive results, the study found that the proportion of female to male clients completing questionnaires was 2.4:1. It is unclear how representative this figure is of the proportion of women to men in the group of individuals who harm themselves during acute mental health admissions. The finding is consistent with studies in general hospital settings that have found deliberate self-harm to be more common amongst women (Kreitman 1990; Platt et al 1992; MacLeod et al 1992; Hawton and Catalan 1987). It is not consistent with the finding of House and his colleagues (1992) of an even gender distribution. One possibility is that more women than men self-harm during acute mental health admissions (of course it may be the case that more women than men are admitted anyway). An alternative explanation is that systematic bias was operating in the completion of questionnaires, with women being more ready to complete questionnaires than men, or nurses being more ready to ask women than men to take part in the research.

As regards means of self-harm, cutting was by far the most common in this study. This is consistent with other reports of cutting being more frequent in specific populations: Cutting has been reported in 40% of patients with bulimia (Mitchell et al 1986), in 35% of those with anorexia (Jacobs et al 1986), in 52% of adult female inpatients with borderline personality disorder (Brodsky et al 1995), and in 48% of patients with dissociative identity disorder (Coons et al 1990). The picture in mental health services is a very different picture from presentations to general hospitals, where overdosing is by far the most common means, with only 5% of those who present with deliberate self-harm having self-injured (Dennis et al 1997). Whilst it is consistent with clinical impression that self-injury is the most common means during acute mental health admissions, the possibility remains that systematic bias may have been operating. For example, when a client had overdosed, arranging for transfer to the Accident and Emergency Department may have taken priority over questionnaire completion.

One of the 34 clients in the experimental group (2.9%) went on to commit suicide during the study period. Gunnell and Frankel (1994) found that 1% of all those who self-harm will commit suicide in the following year, and 10% will do so eventually. It is to be expected that those admitted to acute mental health units will form a higher risk group. The vast majority of the experimental group harmed themselves again within the study period, and half of them did so within

just 4 days. This is not surprising, given that, as acute psychiatric inpatients, individuals were in a crisis phase, as described by Sidley (1998). This said, the DSH was generally not very severe in terms of the risk that the client would die. Presumably, having to anticipate self-harm, when severe self-harm is intermittent, must increase the stress for nurses.

There was not a great deal of evidence of the kind of countertransference hate described by Watts and Morgan (1994). There are two possible explanations: One possibility is that such counter-transference hate occurs infrequently or not at all. The second possibility is that it was just not reported. Neither was there much evidence of nurses having unrealistic expectations about care-giving which are dashed, leaving them feeling helpless and guilty (Maltsberger and Buie 1974). The finding of generally positive attitudes amongst nurses towards individuals who self-harm is consistent with the work of Platt and Salter (1989) who found generally neutral or favourable attitudes to those who self-harm amongst staff in a poisoning treatment centre and staff in a conventional medical environment. The finding in this study of generally positive attitudes was not consistent with Patel (1975), Ghodse (1978) and Goldney (1980), who found negative attitudes. These latter studies, however, are older and were not based on mental health staff populations.

As regards the content of nurse-client interactions, it is interesting to note that the most common content item reported by nurses, and the second most common content item reported by clients, was 'Trying to stop the client/you self-harming in the future'. This assumes motivation on the part of the client to stop harming him/herself, and could be counter to the proposals of Allen (1995), Bunclark (1996), and Babiker and Arnold (1997), who recommend leaving more responsibility with the client.

CRITIQUE OF THE STUDY

1) The use of self-report

The accuracy of self-reports could be questioned. Despite assurances of confidentiality, nurses may have been wary to report interactions with clients in such a way that they may fear criticism. Equally, clients may have feared repercussions were they to

describe some aspects of nurses' behaviour. There may have been an investigator effect in that some of the participants knew the investigator prior to data collection, whilst some did not. It could be argued that a research clinical interview would have been preferable to self-report questionnaires. Alternatively, (and ideally), independent observation of nurse-client interactions may have produced more reliable information about how nurses responded to clients. Unfortunately, interviewing and observation would have required more of a time commitment than was possible.

2) The questionnaire

The questionnaire employed did not have robust psychometric characteristics. It is difficult to know how this problem could have been overcome, since there existed no standardised instruments which measured the variables under consideration. The design was strengthened in that the questionnaire was developed on the basis of qualitative studies, and all participants received the same questionnaire. Nevertheless, the questionnaire had no demonstrable discriminatory power, reliability or validity.

3) Sampling

The most conservative estimate is that the final sample represented a minimum of 45% of the potential data set. Although a more liberal estimate is that the final sample might have represented 92% of the potential data set, it is a matter of concern that sampling could have introduced a significant amount of bias. One hypothesis is that nurses were much more likely to complete questionnaires, (and to ask clients to do so), when they judged that their response to a client had been sympathetic. Nurses were assured of confidentiality, (unless they breached the code of professional conduct of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting), but may have been wary of trusting this assurance, especially when they had not met the author prior to being asked to implement questionnaire completion. The design would have been strengthened had more data been gathered regarding incidents where questionnaires were not completed, in order to assess whether there was any systematic bias in

the cases where questionnaires were completed. Ultimately, this was impractical due to time limitations, and to data collection being an understandably low priority for over-worked NHS staff. The possibility then remains of interactions which were not reported being significantly different, in terms of nurse response types, from those interactions which were described. This must be borne in mind when interpreting the data.

4) Attrition and follow-up

Following-up clients was markedly easier when they remained as inpatients for some time. In some instances, however, individuals were discharged before they had harmed themselves again. In these cases, community keyworkers were contacted when possible. The degree to which a community keyworker was contactable could have introduced some bias. It is likely that there were some instances of repeated self-harm about which community keyworkers were unaware.

5) Power

As a result of having many variables and comparatively few data sets, it may be that the study lacked the power to detect clinically important effects.

6) Time lapse before questionnaire completion

Information was not collected about how long it was after the nurse-client interaction had taken place that questionnaires were completed. Nurses were asked to use their discretion regarding when to approach clients with questionnaires, and it was acknowledged that in some cases, it may not be appropriate until hours after the incident had taken place. This potential time lapse weakens the design, since it allows for memory effects and distortions. Salter and Platt (1990) have written about this phenomenon. They found that the interval between the commencement of the suicidal act and of the research interview was a significant predictor of reported degree of suicidal intent. One

explanation that they propose is that elapsed time is an indirect or proxy measure of medical seriousness, whilst a second explanation they offer is that prolonged hospital stay may impact on a person's understanding of his/her behaviour. They therefore recommend that researchers take into account the moderating effect of elapsed time when designing studies which examine psychological processes in parasuicide. In this study, elapsed time may have affected reports of response type (of either nurses or clients), because of confusion with subsequent interactions. A concern is that the index interaction (that is, the first nurse-patient interaction that took place after the index self-harm incident) may not have formed the basis of questionnaire completion in all cases. It remains a possibility that in some instances, another nurse-patient interaction had taken place more immediately following the self-harm, which went unreported. The design would have been strengthened had the questionnaires contained questions such as: 'Were you the first nurse to speak to the client/ Was this the first nurse to speak to you after the incident?' 'Roughly how long after the incident did the conversation take place?' Although it was not the investigator's impression that such procedural inconsistencies occurred, they cannot be ruled out. Elapsed time may also have affected reports of the intent behind and seriousness of self-harm.

7) The heterogeneity of the sample

As outlined in the 'Method' section, the clients who participated presented with a range of psychological problems. Nurses and clients reported a range of functions for clients' self-harm, including 'punishment', 'death', 'to inflict physical pain to help stop the mental pain', and 'I didn't like the idea of moving to rehab'. One hypothesis is that nurse response type does have a bearing on delay, but that clients with different presentations will benefit from different approaches. The intention had been that, given enough data, it might have been possible to examine sub-groups. There were insufficient data, however, to enable such a fine-grained analysis. Information about whether or not clients had a history of repeated self-harm would have facilitated a comparison between those who did and those who did not.

8) The quasi-experimental nature of the study

Ideally, the study would have included random assignment to different conditions. As Linehan (1997) has discussed, without such random assignment, any findings are essentially correlational. It would be difficult, however to justify ethically such random allocation, with clients receiving a predetermined response type (such as non-intervention or overcontrol) for which there is no evidence of a beneficial effect.

9) Effect of nurses presenting questionnaires to clients

The procedure required the nurse who had dealt with a particular incident of self-harm to ask the client to complete a questionnaire describing the nurse's behaviour. It is likely that nurses would be reluctant to do so in instances where they had reservations about how they had managed an incident. There may also have been reluctance on the part of clients to describe nurses' behaviour in such a way that the nurse could be criticised. Although clients were given an envelope (marked 'private and confidential'), in which they could place their questionnaires before sealing the envelope, clients might understandably have been sensitive to the possibility of nurses becoming privy to their descriptions of the nurses' behaviour. This may have had an effect on the accuracy of reports. A research clinical interview would have been preferable, but was not possible due to data collection taking place over sites which were geographically dispersed. Knowing that they would be handing a questionnaire to the client after the intervention may have modified or attenuated the nurse's behaviour towards the client.

Despite methodological criticisms to which this study can be subjected, it does represent a preliminary investigation into the range of behaviours that can constitute a nurse's response to an individual who has just harmed him/herself. No published studies have investigated this area.

IMPLICATIONS OF FINDINGS

Concluding from this study that nurse response type has no effect on delay could represent a type two error, given that the study may have lacked power to detect clinically important effects. In particular, it is not possible to comment on the expectation that interactions not characterised by non-intervention or overcontrol would be associated with a longer delay before self-harm was repeated. This was because there were few instances where nurses were reported to be anything other than sympathetic. It is a matter for concern that the survival analysis used only nurses' perceptions of response type. This is particularly relevant given that nurses were found to perceive responses very differently from the way in which clients perceived them. It could be reasoned that a client's perception of a nurse's response to him/her might be much more likely to have an effect on outcome. This said, other analyses did use clients' reports.

The possibility remains, however, that nurse response type has no bearing on delay. Clearly nurse response type is only one of many variables that could affect delay. It is possible that other variables such as an individual's mental health generally, or relationships with significant others, might have much more of an effect on delay. Indeed there is some support for this latter hypothesis in that Pierce (1986) found that the perceived negative attitudes of family members were positively correlated with repetition of DSH.

The one significant finding as regards the initial hypotheses, was that nurses perceiving themselves to be more strongly emotional was positively correlated with a longer delay before self-harm was repeated. It is clearly important not to make inferences about causation when considering this relationship. One hypothesis is that a nurse being more strongly emotional *causes* a client to have a longer delay before harming him/herself again. Equally, a second hypothesis is that nurses are more likely to express strong emotion to clients who are less likely to repeat self-harm in the near future anyway. For example, a client who repeatedly self-harms and who is diagnosed as having a personality disorder, may be much less likely to get a strongly emotional response from a nurse than a client who has never harmed him/herself before, where the diagnosis is one of affective disorder. Indeed a closer look at the data did find that fewer people with a diag-

nosis of personality disorder received a strongly emotional response than those without such a diagnosis.

Finding such poor agreement between nurses and clients regarding the severity of self-harm, the duration of the interaction and the strength of the nurse's emotion, had not been anticipated. It would be interesting to see if there were a significant bias in any direction with particular sub-groups of clients. Such analysis was not possible in this case because of insufficient data. There is a possible clinical implication of the finding of poor agreement between nurses and clients regarding nurses' response types: Such differences of opinion could be clarified by discussion between nurses and clients after the event. It is hypothesised that joint reflection regarding the helpfulness (or otherwise) of the nurse's response and planning regarding how to respond to future incidents may have a beneficial effect. A modified version of the questionnaire developed in this study incorporating the range of possible response types could form a helpful basis to such a discussion.

The finding of little in the way of countertransference hate, helplessness and guilt discussed above has been understood to represent either little occurrence of these responses amongst mental health nurses, or little reporting of them. An optimistic perspective is that improved training and supervision of nurses (and hence a better understanding) regarding DSH, has led to nurses formulating in a more psychological way, facilitating empathy and enabling nurses to take care in less of a parental fashion. If this is the case, then such a development should be fostered.

Finally, the finding that the experimental group was so heterogeneous, with very different diagnoses and functions for their self-harm, leads to a crucial implication: It is not sufficient for nursing staff to employ blanket care plans in their approaches to managing DSH. Assumptions should not be made about the function that self-harm serves in each individual case. This is complicated by the fact that DSH can serve different functions for one individual at different times. Nurses need to be flexible and thoughtful in developing individualised case conceptualisations and care plans.

DIRECTIONS FOR FUTURE RESEARCH

It is hypothesised that nurse response type could have much more relevance for individuals for whom self-harm serves the function of managing interactions with others. Where the function is to manage moods, as a response to beliefs or thoughts, or indeed to end life, it is expected that nurse response type is of less importance to the individual. It is therefore recommended that future research in this area is more specific, ensuring as far as possible that self-harm serves a similar function for all members of the experimental group. The author supports the approach of classifying on the basis of function/intent rather than on the basis of behaviour, and in this respect supports Morgan et al (1975) and Allen (1995) who favour retaining the term 'deliberate self-harm' (rather than distinguishing between different means of self-harm).

The relationship of delay with the strength of emotion expressed by the nurse, and the possible relationship with whether or not the nurse explains what will happen next, may merit further attention.

This study did not include interviews with clients as part of the questionnaire design, and comparatively few clients completed questionnaires. It is recommended that focussing attention on clients' experiences may provide a fruitful and valid line of enquiry.

No published studies have looked at the incidence of deliberate self-harm amongst acute mental health inpatients. This may be worthy of examination, although is likely to vary from one unit to another, and across time. A clinical impression is that fewer individuals who self-harm are admitted to inpatient units than was the case a few years ago.

The literature review found some published empirical studies regarding formal therapeutic work, but no empirical studies of how to manage mental health inpatients. The recommendations which were discovered, were based only on clinical experience. Whilst it is true that there is a need for more research and development of formal therapeutic approaches, there is an even greater need for attention to the management of inpatients in the crisis phase, an area which has been almost completely neglected by the

research community. Nurses are left to rely on their clinical experience, and on unsubstantiated recommendations. When faced with disturbing, potentially even traumatising experiences of clients' self-harm, nurses need to have some degree of confidence in the approaches they take.

It is fitting to finish with a quote from one of the nurse interviews used in the questionnaire design where an experienced, thoughtful nurse describes the conclusions to which he has come:

"My attitude personally is never to fight with anyone with a razor blade. People cut themselves for a reason... So I think you have got to be calm, you've got to be level-headed, you've got to just sit there. I have sat with some unbelievable cutting and I think you have just got to be strong and just bite your lip and be there to support them and show them that you are not going to fight them. I think that in that situation she needed that. She needed someone there to show her that they were interested in her, they cared about her, they wanted to help her and that if she wanted to cut herself then she would stop when she wanted to stop."

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Questions asked of nurses pertaining
to the last incident of self-harm
that they had had to manage

1. How did you become aware of the self-harm?
2. What form did it take?
3. How lethal do you think it was?
4. What do you think the client's motivation for self-harming was?
5. Tell me a bit about what your immediate response was.
6. What did you do?
7. How long did you spend with the client?
8. What did you say to the client? What did you talk about?
9. Did you touch the client, for example, to give medical attention, to restrain, or to give physical comfort?
10. How did you feel towards the client?
11. What did you think about him or her?
12. If someone neutral had been watching you interacting with the client, what would he or she have seen?
13. How did the client perceive you?
14. How well or badly do you think you managed that situation?
15. Is there anything else relevant about that interaction that you think it might be worth reporting?

Kinds of communication described
by the nurses in the audiotaped interview

1. Apologising.
2. Questioning about how or when the client had self-harmed.
3. Pointing out bad things about self-harm.
4. Expressing disappointment.
5. Joking.
6. Open questioning (other than about why the client has self-harmed), exploring feelings.
7. Telling the client about what would happen next.
8. Questioning about why the client self-harmed.
9. Practical things about physical care.
10. Expressing frustration.
11. Explaining why the nurse's actions are right.
12. Showing that the nurse knows about and accepts the self-harm.
13. Offering help.
14. Trying to stop the client self-harming in the future.
15. Things other than self-harm.

Appendix III

Words describing emotional tone from the audiotaped interviews

annoyance
frustration
clinical
sorry
understanding
sympathetic
empathetic
anger
supportive
caring
irritated
uncaring
ambivalent
disappointed
cold
unfeeling
interested
dislike
betraying
rotten
unemotional
hard
harsh
uninterested
giving up
authoritative
foolish
sadness

Psychologists' comments regarding what formed the majority of the content in each of the eight nurse-client interactions

1 a Talked about her past.
b General small talk about the client's daily activities.
c I would just like to talk to you and give you attention.

2 a The weather's nice, isn't it?
b Questions about what she had done.
c You're a bad person. I don't like you.

3 a Why did you do it? I'm trying to help. You've let me down.
b The impact of what the client had done on her relationship with the worker.
c I am here for you, so how could you have done it?

4 a Which bandages do you want? Does it hurt?
b Practical details of what she had done.
c Cracking jokes.

5 a Look what you could have done to yourself. Listen to me.
b Trying to justify her decision to let the overdose be known about.
c Arguing about whether she should have done it and whether it should have been reported.

6 a I'm getting fed up with you now. Why don't you talk to me like we told you to.
b Trying to establish whether the client wanted to talk, although not really wanting to talk himself.
c I'm fed up with you.

7 a You can come and ask for attention any time and that's OK. I care.
b Verbal reassurance that the client can talk to staff.
c I am here for you. I am frustrated that you still did it.

8 a Asking what she'd taken.
Practical information gathering.
Giving reassurance about what would happen.
b Communicating support, reassurance, that things would be OK. Information about what was happening.
c This is your way of coping. I'll teach you new ways.

Appendix V

Words describing emotional tone from the psychologists' comments on the audiotaped interviews

Words already used by the nurses in the interviews

anger
supportive
caring
irritated
uncaring
ambivalent
disappointed

New words generated

intolerant
critical
dutiful
good enough care
pragmatic
off-hand
abandoning
sceptical
thoughtful
gentle
firm
emotional blackmail
needy
controlling
negative
concerned

Pilot questionnaire responses by nurses
indicating different varieties of response
to repeated deliberate self-harm in terms of content

Diversion.

Alternative coping strategies/mechanisms.

Contracting (against further self-harm).

Care planning.

Problem solving.

Come to the clinic and we'll get things dealt with.

Perfunctory response.

Minimal interaction.

Look at the trouble you're causing.

Negotiation.

Encouraging exploration of feelings.

Boundary setting.

Exploring possible reasons.

Assess trigger.

Find out what type of support client feels they need to help this situation not to occur.

Asking about feelings.

Giving reassurance.

Questioning.

Challenging.

Words describing emotional tone from the nurses' pilot questionnaire data

Words already used by the nurses in the interviews and the psychologists

controlling
negative
concerned
anger
caring
sympathetic
annoyance
frustration
clinical
sorry
understanding
empathetic

New words generated

rescuing
suffocation
overreaction
protective
over involvement
over protectiveness
mothering
nurturing
sensitively
friendly
compassionate
responsive
considerate
respectful
reassuring
confrontative
challenging
questioning
directive
let down
disbelief
shock
inadequacy
uselessness
impatience
exasperation
hostility
punitive
abusive
repulsion
contempt
belittling
condescending
patronizing
calm
matter-of-fact
non-judgemental
cool
unconcerned
distant
professional
upset
hurt
fear
anxiety
helplessness
confusion
guilt
not bothering
dismissive
minimal interaction
disinterested
unsympathetic
indifferent
ignoring
cynical
perfunctory
resigned
avoidance

Appendix VIII

41 from a pool of 103 words describing emotional tone, which were selected for ongoing analysis

A	impatient	F	distant
	critical		indifferent
	hard		uninterested
B	hostile	G	dismissive
	belittling		disinterested
	patronizing		
	harsh	H	unsympathetic
			abandoning
C	intolerant		
	cynical	I	protective
			mothering
D	contemptuous		
	negative	J	nurturing
	unfeeling		understanding
	uncaring		empathetic
			supportive
E	non-judgemental		caring
	sensitive		reassuring
	friendly		interested
	compassionate		
	sympathetic	K	fearful
	responsive		inadequate
	considerate		
	respectful		
	thoughtful		
	gentle		

A
impatient
critical
hard

B
hostile
belittling
patronizing
harsh

C
intolerant
cynical

D
contemptuous
negative
unfeeling
uncaring

H
unsympathetic
abandoning

K
fearful
inadequate

F
distant
indifferent
uninterested

G
dismissive
disinterested

E
non-judgemental
sensitive
friendly
compassionate
sympathetic
responsive
considerate
respectful
thoughtful
gentle

I
protective
mothering

J
nurturing
understanding
empathetic
supportive
caring
reassuring
interested

HULL AND EAST RIDING RESEARCH ETHICS COMMITTEE

APPLICATION FOR APPROVAL OF A RESEARCH PROPOSAL

TITLE OF PROJECT: Nurses' management of repeated deliberate self-harm in an acute residential setting.

PRINCIPAL INVESTIGATOR: Caroline Steere
DESIGNATION: Clinical Psychologist
ADDRESS: New Bridges, Birkdale Way, Newbridge Road,HULL, HU9 2BH

TEL: 01482 - 321703

OTHER INVESTIGATORS: None

CONSULTANT IN CHARGE:
RESEARCH SUPERVISOR: Dr Michael Wang

Is the principal investigator involved in the conduct of any other research projects concurrently with the proposed research. **YES/NO.**

If YES please list all projects on a separate sheet.

MAIN PURPOSE OF STUDY: (indicate clinical/scientific value).

For many clients who repeatedly harm themselves, the behaviour does not appear to be aimed at suicide. The purpose of the study is to address the lack of systematic empirical research that investigates what represents the most therapeutic response when a client repeatedly self harms and whether the staff response type affects the probability of further attempts. The project stems from a clinical awareness that clients are often met with inconsistent management ranging from emotional reinforcement through to hostility. Different nurses within the same unit can apply models, which are at variance with one another, on an ad hoc basis. This issue gives rise to conflict, stress and confusion within staff groups. Resolution of this question would benefit clients as well as the nurse charged with their care.

BRIEF DESCRIPTION OF STUDY (DESCRIBE DESIGN OF STUDY, WHAT WILL BE DONE, MEASUREMENTS TO BE MADE - DATA ANALYSIS).

The study consists of a prospective group analysis design based on data collected from nursing staff and clients regarding the nurse's immediate response to an incident of self harm. The enclosed questionnaires, (see appendices I and II), seek to measure the response across four dimensions: 1) The content of what the nurse said to the client. 2) The length of time the nurse spent with the client. 3) The emotional tone of the response and 4) The strength of emotion expressed by the nurse. The principal investigator will monitor clients following this index incident of self harm in order to record the length of time that elapses before the client harms him/herself again. This time duration forms the dependent variable.

All clients will be followed up for one month following the index incident through liaison with residential staff or community keyworkers.

A one-way analysis of variance and a correlation analysis will then be applied to the data to determine whether nurse response is associated with duration before self harm is repeated.

WHERE WILL RESEARCH TAKE PLACE?

At the six Community Acute Residential Units in Hull (Westlands, Margaret St, Aysgarth, Nidderdale, New Bridges, and Rosedale) and at the Thornella Unit.

NATIONAL AGENCY/PHARMACEUTICAL COMPANY (SPECIFY) n/a

GP TO BE INFORMED? YES/NO

OTHER DEPARTMENTS INVOLVED (EG LABORATORY) n/a

HAS THEIR INVOLVEMENT BEEN COSTED AND APPROVED n/a

PAYMENT OR BENEFITS FROM COMMERCIAL SPONSOR TO STAFF OR DEPARTMENT (DETAIL HOW MUCH AND TO WHOM IT IS TO BE PAID) n/a

---

SUBJECTS: Inpatients who self harm during an admission.

AGE: 16-65 years **SEX** : male and female

EXEMPTIONS: Clients who are acutely psychotic at the time of self harm.

SUBSTANCES TO BE GIVEN TO PATIENTS:

DRUG (DOSE, FREQUENCY, ROUTE, LIKELIHOOD OF SIDE EFFECTS, DRUG INTERACTIONS) - n/a

DOES IT HAVE A PRODUCT LICENCE, CLINICAL TRIAL CERTIFICATE OR CLINICAL TRIALS EXEMPTION CERTIFICATE? n/a

ANY OTHER PROCEDURES? NO

IS ANY ROUTINE TREATMENT BEING WITHHELD? NO

FROM THE PATIENT'S POINT OF VIEW, WHAT ARE THE MAIN POTENTIAL:

A) **HAZARDS** - None

B) **INCONVENIENCES** - Time taken to complete the questionnaires.

C) **BENEFITS** - Potentially subsequent management that is more therapeutic and evidence based.

ARRANGEMENTS FOR COMPENSATION IN THE EVENT OF INJURY? n/a

CONSENT:

WHO WILL EXPLAIN THE INVESTIGATION TO THE PATIENT/RESEARCH PARTICIPANT, WHAT INFORMATION WILL BE GIVEN AND WHERE WILL CONSENT BE RECORDED? IF YOU DO NOT BELIEVE INFORMED CONSENT IS NECESSARY, STATE REASONS. PLEASE ENCLOSED COPIES OF CONSENT FORM/INFORMATION SHEET.

The investigation will be explained to all the participants on the consent forms (see appendix III). In addition, participants can telephone the principal investigator with any queries. Clients' consent forms will be presented to the prospective participant, together with the questionnaire, by the nurse who managed the index incident.

SIGNATURE:..... DATE 2.12.97

HULL AND EAST RIDING
RESEARCH ETHICS COMMITTEE

c/o East Riding Health,
Grange Park Lane,
Willerby,
HULL, HU10 6TD

Our Ref: MRFR/JC/97/191
Your Ref:

Phone: 01482 672070
Fax: 01482 672062

18 December 1997

Caroline Steere
Clinical Psychologist
New Bridges, Birkdale Way
Newbridge Road
HULL HU9 2BH

Dear Ms Steere

97/191 NURSES' MANAGEMENT OF REPEATED DELIBERATE SELF-HARM IN AN ACUTE RESIDENTIAL SETTING

Thank you for your research application. A couple of points have come up in the Committee's consideration of this project. Firstly we recognise that this is potentially a sensitive area between the nursing staff questionnaire and the patient questionnaire relating to the way in which a particular incident was handled. We wondered whether the nursing staff would feel comfortable for the cross-referencing of their attitude and action to be set against those of the patient. There will clearly have to be a one to one link by yourself in order to make comparisons but the nursing staff might be concerned about any inference that might be drawn and any confidentiality which might be broken. Have you given this thought and have you any reason to believe that the nursing staff would be reasonably happy about this approach?

I am also seeking confirmation with regard to the patient questionnaire. From reading it I am assuming that this will be administered by yourself reading out the questions. Some of them use some fairly complicated language and concepts and therefore would need to be interpreted for some patients. Is our understanding of this correct or is this a questionnaire which might be self administered by the patient?

I would be glad to have confirmation from you on both of these points. I would be hopeful

18 December 1997

Caroline Steere
Newbridge Road
HULL

Ref No 97/191

of granting Chairman's approval once you have replied rather than your having to wait for the next full Committee.

Yours sincerely,

Dr Martin R F Reynolds
Chairman
Hull and East Riding Research Ethics Committee

cc Hull & Holderness Community Trust

12/01/98
(dictated 7 January)

CS/CC

Dr Martin Reynolds
Chairman
Hull and East Riding Research Ethics Committee
c/o East Riding Health
Grange Park Lane
WILLERBY
HU10 6TD

Dear Dr Reynolds

Re: 97/191 Nurses Management of Repeated Deliberate Self Harm in an Acute Residential Setting

Thank you for your letter of the 18 December 1997. You raised two points, each of which I shall address in turn.

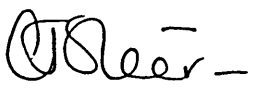
Firstly, I shall address the question of inferences that might be drawn from comparing nurses` reports and clients` reports, regarding how an incident was handled, and associated confidentiality issues. I am aware that a situation could arise where a nurse and client reported the nurses actions very differently. I shall make it clear to my nursing colleagues that each of the reports (the nurse`s and the client`s) will be attended to carefully and that each person`s perception will be valued. I will guard against either the nurse`s or the client's viewpoints being dismissed and will he aware that two apparently conflicting reports of an incident might be equally valid. I also appreciate the need to assure nurses of confidentiality in order to promote accurate self reporting. I do intend to present the finding from my research within the Trust, but will make no specific reference to any individual nurse or unit, and will make this clear to staff participating in the study. This confidentiality would only be breached in extreme cases where a nurse`s behaviour did not comply with the code of professional conduct of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

continued .....

As regards your second point, I had anticipated that clients would be able to complete this questionnaire unaided. On reflection, however, I agree that it contains fairly complicated language and concepts, which could need interpreting for some clients. I have therefore attempted to simplify the questionnaire (an amended version of which I enclose), and will add the option of me administering the questionnaire if the client has difficulty. (See the amended client information sheet).

I hope that this addresses your reservations adequately and look forward to hearing from you.

Yours sincerely



CAROLINE STEERE
Clinical Psychologist
East Hull Community Mental Health Team

Enc

HULL AND EAST RIDING RESEARCH ETHICS COMMITTEE

c/o East Riding Health,
Grange Park Lane,
Willerby,
HULL, HU10 6DT

Our Ref: MRFR/JC/97/191
Your Ref:

Phone: 01482 672070
Fax: 01482 672062

19 February 1998

Caroline Steere
Clinical Psychologist
New Bridges, Birkdale Way
Newbridge Road
HULL HU9 2BH

Dear Ms Steere

97/191 NURSES' MANAGEMENT OF REPEATED DELIBERATE SELF-HARM IN AN ACUTE RESIDENTIAL SETTING

Thank you for your letter confirming the various points regarding sensitivity and confidentiality of the information. The Committee is pleased to accept these reassurances and therefore confirms that it will now grant full ethics approval for you to proceed.

Although the Research Ethics Committee has now granted approval, if you have not already done so you should ensure that you also have the approval of the management in the Trusts(s) in which the research is to take place.

The Research Ethics Committee in granting ethics approval requires that you submit an end of research summary and (where available) report. The enclosed pro forma should be used when the research has been completed.

Yours sincerely

Dr Martin R F Reynolds
Chairman
Hull and East Riding Research Ethics Committee

cc Hull & Holderness Community Trust

Appendix XI

SOUTH AND WEST LOCAL RESEARCH ETHICS COMMITTEE APPLICATION FORM

For Ethics Committee use only	Number:	Date received: .....
	Outcome:	Applicant informed: .....

INSTRUCTIONS: Please complete in typescript. Please select Yes/No options as appropriate. A version of this form is also available on disc in Word for Windows from the Ethics Committee Secretary or the Regional Research and Development Directorate.

It is essential that this form is completed fully and the relevant enclosures are received if the study is to receive proper scrutiny by the Ethics Committee. Please refer to the accompanying Guidance Notes when completing the form. Please complete the checklist before sending the form.

CHECKLIST

Please indicate if the following have been enclosed by selecting *Yes/No/Not applicable* options below. For details of the numbers of copies of the form and relevant enclosures required, please contact the relevant LREC secretary. (See Appendix 5 in the Guidance Notes for details.)

	Yes	No	Not applicable
..... copies of application form (double-sided if possible)	☑	☐	☐
..... copy/ies of protocol	☑	☐	☐
..... patient consent form(s)	☑	☐	☐
..... patient information sheet(s)	☑	☐	☐
..... GP/consultant information sheet(s)	☐	☐	☐
..... copy/ies of lead applicant's CV on 2 sides A4 *(Do not submit if already submitted in last 12 months.)*	☑	☐	☐
Questionnaire* ☑ Finalised ☐ Not yet finalised	☑	☐	☐
Copy of manufacturers data sheet for all drugs (one copy only)	☐	☐	☑
Copy of investigators brochure (one copy only)	☐	☐	☑
Copy of manufacturers indemnity (2 copies only)	☐	☐	☑
Copy of CTX/CTL/DDX (one copy only)	☐	☐	☑
Annexe A**	☐	☐	☑
Annexe B***	☐	☐	☑
Annexe C†	☐	☐	☑

* *Please indicate if not yet finalised.*

** *If the study involves the use of a new medicinal product or medical device, or the use of an existing product outside the terms of its product licence.*

*** *If the study includes the use of ionising or non-ionising radiation, radioactive substances or X Rays.*

† *For research in general practice.*

Please indicate below to which LREC this application is to be submitted:

Avon Health Authority, Frenchay Healthcare NHS Trust, Research Ethics Committee

March 1998

SECTION 1 — Details of applicant(s)

1. Short title of project *(in not more than 6 words)*

Full title
Nurses' management of repeated deliberate self-harm in an acute residential setting.

Summary of practical benefits/improvements in patient care which are envisaged
To promote consistent, evidence-based management by nurses of clients who repeatedly self-harm.

2. Applicant *(All correspondence will be sent to this address unless indicated otherwise.)*

Surname: Steere Forename: Caroline Title: Ms

Present appointment of applicant: Clinical Psychologist

Qualifications: MSc in Clinical Psychology (Professional Qualification)

Address: Psychology Department
Cedar House, Blackberry Hill Hospital, Manor Road, Fishponds, Bristol BS16 2EW

Tel: (0117) 9754844 Fax: Out of hours tel: (0117) 9741968

3. Other workers and departments/institutions involved

Dr Michael Wang
Clinical Psychology Course Director
University of Hull

4. Signature of relevant bodies

I undertake to carry out the work in accordance with the principles of the Declaration of Helsinki (copy available from the LREC secretary) and its amendments.

Signature of applicant ..... Date 12.3.99

Signature of Head of Department/~~Supervisor/Principal in General Practice~~ with overall responsibility for the project ..... Date 19/2/99

NAME AND TITLE IN CAPITALS A.E. HAYWARD, HEAD OF CLINICAL PSYCHOLOGY SERVICES (MENTAL HEALTH)

I am fully aware of the details of this project and happy for it to continue as outlined here.

Signature(s) of relevant Clinical Director(s) where study is being conducted/Medical Director(s) signing on behalf of Trust(s) involved (where appropriate)

..... Date 22.2.99

NAME AND TITLE IN CAPITALS Dr. M. METCALFE, CLINICAL DIRECTOR

SECTION 2 Details of project

This section must be completed. A copy of the protocol should be enclosed with the application form, but it is not sufficient to complete questions by referring to the protocol.

5. Aims and objectives of project (i.e., what is the intention of the project?)

To investigate (using systematic empirical research methods) what represents the most therapeutic response from inpatient staff when a client repeatedly self-harms.

Study endpoints: Following collection of data pertaining to 25-30 index incidents of self-harm at Oakwood House.

6. Scientific background of study

There is a lack of research that investigates what represents the most therapeutic response when a client repeatedly self-harms, and whether the staff response type affects the probability of further attempts. The project stems from a clinical awareness that clients are often met with inconsistent management ranging from emotional reinforcement through to hostility. Different nurses within the same unit can apply models which are at variance with one another, on an ad hoc basis. This issue gives rise to conflict, stress and confusion within staff groups. Resolution of this question would benefit clients as well as the nurses charged with their care.

7. Brief outline of project (i.e., what do you intend to do?)

The study consists of a prospective group analysis design based on data collected from nursing staff and clients regarding the nurse's immediate response to an incident of self-harm. The enclosed questionnaires, (see appendices 1 and 11), seek to measure the response across four dimensions:

1) The content of what the nurse said to the client. 2) The length of time the nurse spent with the client. 3) The emotional tone of the response and 4) The strength of emotion expressed by the nurse. The principal investigator will monitor clients following this index incident of self-harm in order to record the length of time that elapses before the client harms him/herself again. This time duration forms the dependent variable.

All clients will be followed up for one month following the index incident through liaison with residential staff or community key workers.

A one-way analysis of variants and a correlation analysis will then be applied to the data to determine whether nurse response is associated with duration before self-harm is repeated.

8. **Study design** *(e.g. cohort, case control)*

Prospective group analysis design.

9. i) **How was the size of the study determined?**

SEE ATTACHED SHEET

ii) **Was there formal statistical input into the overall study design?**

☒ Yes ☐ No

If *Yes*, please give name of adviser: Dr Michael Wang, University of Hull

iii) **What method of analysis will be used?**

One-way analysis of variance and a correlation analysis.

10. **Does the study fall into any of the following categories?**

Pilot	☐ Yes	☒ No
Multi-centre study	☒ Yes	☐ No
Student project *(part of course requirement)*	☒ Yes	☐ No

If student project, what course is being undertaken, in which institution?

Independent part-time research to convert MSc in Clinical Psychology into Clin Psy D (Clinical Psychology Doctorate) registered at the University of Hull.

If this is a multi-centre study, please complete the details below, otherwise go to Question 11.

i) **Which centres are involved?**

Acute mental health residential units in Hull.
Oakwood House, Bristol.

ii) **Which ethics committees have been approached, and what is the outcome to date?**

Hull and East Riding Research Ethics Committee. Ethical approval was granted on 19th February 1998. (Letter enclosed)

iii) **Who will have overall responsibility for the study?**

Caroline Steere

iv) **Who has control of the data generated?**

Caroline Steere

11. Where will the study take place and in what setting?

Data have already been collected from the units in Hull. Further data will be collected from Oakwood House.

12. Is any payment being made, or actively being sought by the investigator or department/unit in respect of this study (include research grants)? ☐ Yes ☒ No

If Yes, complete the section below; if No, go to Question 13.

i) Is the payment:

a) A block grant ☐ Yes ☐ No

If *Yes*, give details, including amount and source of funding £

Name of funding body: .....

b) Based on the number of subjects recruited ☐ Yes ☐ No

If payment is based on number of subjects recruited (per capita/payment), state total sum payable for each subject completing the study. £

State number of subjects agreed.

Will patients have their travel costs paid? ☐ Yes ☐ No

If multi-centre study, state total number of subjects to be recruited.

ii) Is the payment made in order to:

			If *Yes* state sum
a) Pay a salary(ies)	☐ Yes	☐ No	£
b) Fund equipment	☐ Yes	☐ No	£
c) To support further departmental research	☐ Yes	☐ No	£
d) Other (state)	☐ Yes	☐ No	£

iii) Who will have control of the funds? eg Charitable Trust etc.

iv) Does the investigator(s) have any direct personal involvement (eg financial, share-holding etc.) in the sponsoring organisation? ☐ Yes ☐ No
(If *Yes*, give details.)

v) Will all the costs incurred by the institution be covered by the grant? ☐ Yes ☐ No

vi) If the project is to be carried out in a Trust has the R&D lead in the Trust been notified of the project? ☐ Yes ☐ No ☐ NA
If *no/NA* give reasons:

13. Schedule

Proposed starting date: When ethical approval given Proposed duration: 6-12 months

14. How will the patients or subjects in the study be selected, approached and recruited; what inclusion and exclusion criteria will be used? STATE IF THEY ARE THE SUBJECT OF THERAPEUTIC OR NON-THERAPEUTIC RESEARCH

Inpatients who self-harm during an admission to Oakwood House will be selected. Clients who are acutely psychotic at the time of self-harm will be excluded. Nursing staff will approach clients with the Client's Information Sheet/Consent Form and the Client's Qestionnaire, and give them the option of consenting to take part in the study. In addition, potential participants can telephone the principal investigator with any queries.

15. How many subjects will be recruited and of what age group?

25-30 participants aged between 18 and 65.

16. How will the control group (if used) be selected, approached and recruited; what inclusion and exclusion criteria will be used? Type *NA* if no controls.

NA

17. How many controls will be recruited and of what age group?

NA

18. Are the subjects or controls included in this study involved in any other research investigation at the present time?

☐ Yes ☐ No ☒ Not known

If *Yes*, please give details.

19. Will healthy volunteers be used?

☐ Yes ☒ No

If Yes, complete details below. If No, go to Question 20.

i) What is their relationship to the investigator?

ii) Will they receive any payment, and if so, what is the source of that funding? ☐ Yes ☐ No

If *Yes*, give details of payment per subject.

Applicants should undertake to explain to volunteers that the researcher will contact their GP to ask about any drug therapy and that they must inform the researcher if they consult another doctor during the study, and that this doctor will be informed of this study.

SECTION 4 Consent

20. Is *written* consent to be obtained?

☒ Yes ☐ No

If *Yes*, please attach a copy of the consent form to be used.
(Guidance on consent is given in Appendices 2, 3, 4 in the Guidance Notes.)

If no written consent is to be obtained is it because one of the following methods of research is employed?

Postal questionnaire	☐ Yes	☐ No
Interview	☐ Yes	☐ No
Other	☐ Yes	☐ No

If *Other*, please justify.

21. Does the study include subjects for whom English is not a first language?

☒ Yes ☐ No ☐ NA

If *Yes* give details of arrangement made; if *No* please justify.

Should this situation arise, an interpreter would be arranged through the Patient Representative.

22. Are the subjects or controls in one of the following vulnerable groups?

Children under 16	☐ Yes	☒ No
People with learning difficulties	☐ Yes	☒ No
Other vulnerable groups e.g. mental illness, dementia	☒ Yes	☐ No

If Yes, please complete the details below, otherwise go to Question 23.

i) What special arrangements have been made to deal with the issues of consent and assent, e.g. is parental or guardian agreement to be obtained, and if so in what form?

Clients who are acutely psychotic will be excluded.

ii) In what way, if any, can the proposed study be expected to benefit the individual patient/subject on whom it is performed?

New information for nursing staff could foster better evidence-based practice and might impact directly on the client should he or she be readmitted following desemination of the research findings.

23. Will the patient/subject be given a written information sheet or letter?
(For suggested format see Appendix 1 in Guidance Notes.)

☒ Yes ☐ No

If *Yes*, please attach copy to this application form.
If *No*, please justify.

24. **Does the study involve the use of a new medicinal product or medical device, or the use of an existing product outside the terms of its product licence?**

☐ Yes ☒ No

If Yes, please complete Annexe A in the Guidance Notes, otherwise go to Question 25.

25. **Will any ionising or non-ionising radiation, or radioactive substances or X-Rays be administered to a patient or volunteer?**

☐ Yes ☒ No

Please ensure information in Q14 includes exclusion criteria with regard to ionising radiation if appropriate.

If Yes, please complete Annexe B in the Guidance Notes, otherwise go to Question 26.

26. **What investigations and/or interventions will subjects and/or controls have over and above routine care?**

(Please complete the table below by selecting YES/NO options as appropriate. If YES, please give details.)

Investigation		
Self completion questionnaires	☒ Yes	☐ No
Interviews/interview administered questionnaires	☐ Yes	☒ No
Video/audio tape recording	☐ Yes	☒ No
Physical examination	☐ Yes	☒ No
Internal physical examination	☐ Yes	☒ No
Venepuncture*	☐ Yes	☒ No
Arterial puncture*	☐ Yes	☒ No
Biopsy material*	☐ Yes	☒ No
Other tissue/body sample*	☐ Yes	☒ No
Imaging investigations (not radiation)	☐ Yes	☒ No
Other investigations not part of normal care	☐ Yes	☒ No
Additional outpatients attendances	☐ Yes	☒ No
Longer inpatient stays	☐ Yes	☒ No
Local anaesthetic	☐ Yes	☒ No
General anaesthesia	☐ Yes	☒ No
Other	☐ Yes	☒ No

Details:

Copies of questionnaires are enclosed.

* *Please see guidance notes.*

If additional investigations or tests are involved with revenue consequences for the NHS the relevant head(s) of department(s) *must* be contacted.

Signature of Head of Department..... Date.....

NAME IN CAPITALS..... Position.....

27. **Are there any ethical problems or considerations that the investigators consider to be important or difficult with the proposed study?**

☐ Yes ☒ No

If *Yes*, please give details:

27a. **Is it possible that the trial medication will not be available at the end of the trial?**

☐ Yes ☐ No ☒ N/A

27b. **If *yes*, is this made clear in the patient information sheet?**

☐ Yes ☐ No

If *No*, give reasons

28. **Are there any potential hazards to subjects or patients?**

☐ Yes ☒ No

If *Yes*, please give details, and give the likelihood and details of precautions taken to meet them, and arrangements to deal with adverse events and overdoses, including reporting to the relevant authorities.

29. **Is this study likely to cause discomfort or distress to subjects/patients?**

☐ Yes ☒ No

If *Yes*, estimate the degree and likelihood of discomfort or distress entailed.

30. **Will information be given to the patient's General Practitioner (*especially* if a drug is to be given or an invasive procedure is undertaken)?**

☐ Yes ☒ No

If *Yes*, please enclose an information sheet for the GP.
If *No*, please justify.

If the study is on hospital patients, has the consent of all consultants whose patients are involved in this research been obtained?

☒ Yes ☐ No

If the study is in general practice, has the consent of all the partners been obtained?

☐ Yes ☐ No

Where available, please enclose an information sheet for consultants or GPs.

SECTION 7 Indemnity and confidentiality

Product liability and consumer protection legislation make the supplier and producer (manufacturer) or any person changing the nature of a substance, e.g. by dilution, strictly liable for any harm resulting from a consumer's (subject or patient) use of a product.

31. i) What arrangements have been made to provide indemnification and/or compensation in the event of a claim by, or on behalf of, a subject for negligent harm?

NA

I HAVE PROFESSIONAL LIABILITY INSURANCE ARRANGED THROUGH THE BRITISH PSYCHOLOGICAL SOCIETY.

ii) What arrangements been made to provide indemnification and/or compensation in the event of a claim by, or on behalf of, a subject for non-negligent harm?

NA

AS ABOVE.

If applicable, the arrangements involving a drug supplied by a company should conform to the most recent ABPI guidelines on patient indemnity or individual Trust documents.

iii) Will a medical student be involved directly in the project?

☐ Yes ☒ No

32. In cases of equipment or medical devices, have appropriate arrangements been made with the manufacturer?
(Please indicate NA if not applicable.)

☐ Yes ☐ No ☒ NA

If *Yes*, give details.

33. i) Will the study data be held on a computer? ☐ Yes ☒ No

ii) If *Yes*, has the relevant Data Protection Officer been notified? ☐ Yes ☒ No

Give name of Data Protection Officer: .....

iii) If *No*, give reasons

34. Will the patient's medical records be examined? ☐ Yes ☒ No

If *Yes*, will information relevant to this study **only** be extracted ☐ Yes ☐ No

If extra information is extracted, please justify.

What, if any, additional steps have been taken to safeguard confidentiality of personal records?

SEE ATTACHED SHEET

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35. Will the study include the use of any of the following?

Audio/video tape recording ☐ Yes ☒ No

Observation of patients ☐ Yes ☒ No

If *Yes* to either,

a) How are confidentiality and anonymity to be ensured?

b) What arrangements have been made to obtain consent?

c) What will happen to the tapes at the end of the study?

---

36. Will medical records be examined by research worker(s) outside the employment of the NHS?

☐ Yes ☒ No

If *Yes*, it is the responsibility of the principal investigator to ensure that research workers understand that they must:

i) undertake never to divulge information about patients or research subjects, recorded or otherwise, to anyone without the authority of the Consultant/GP under whose care the patient is;

ii) also understand that the names, addresses and places of work of patients or research subjects are confidential and must not be divulged.

Please ensure that you complete the check list on the front cover of the application form and enclose all relevant enclosures.

SOUTH AND WEST LOCAL RESEARCH
ETHICS COMMITTEE APPLICATION FORM

APPLICANT

Caroline Steere
Clinical Psychologist
Psychology Department
Cedar House
Blackberry Hill Hospital
Bristol
BS16 2EW

9. i) How was the size of the study determined?

Ideally, power calculations would have been used, based on an estimate of the effect size. In order to do this, however, it would have been necessary to make reference to a previous study. Since this is a pioneering study, it has not been possible to use specific power calculations.

In order to determine the size of the study then, the need for 5 data sets per cell for a parametric analysis of variance was taken into account. Statistical principles suggested that 10 sets of data per cell would ensure valid statistical analysis, giving a total of 40 data sets.

34. What, if any, additional steps have been taken to safeguard confidentiality of personal records?

The principal investigator is covered by a Trust contract. Any information divulged will be treated with strict confidentiality and the information will be destroyed at the end of the study. The principal investigator will be the only person to know how individuals responded on the questionnaires, (unless of course, participants indicated that a Trust employee had been abusive, in which case confidentiality would have to be breached).

With regards to inferences that might be drawn from comparing nurses' reports and clients' reports (regarding how an incident was handled and associated confidentiality issues), the following considerations apply: A situation could arise where a nurse and client reported the nurse's actions very differently. It will be made clear to nursing colleagues that each of the reports (the nurse's and the client's) will be attended to carefully and that each person's perception will be valued. Neither the nurse's nor the client's viewpoints will be dismissed.

Account will be taken of the fact that two apparently conflicting reports of an incident might be equally valid. Nurses need to be assured of confidentiality in order to promote accurate self-reporting. Findings from the research will be presented within the Trust, but no specific reference will be made to any individual nurse, and this will be made clear to staff participating in the study. This confidentiality would only be breached in extreme cases where a nurse's behaviour did not comply with the code of professional conduct of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

Nurses' management of repeated self-harm in an acute residential setting

Protocol

Nursing staff at Oakwood House will be requested to approach clients with client information/consent sheets and client questionnaires following an incident of self-harm on the unit. The nurses will be asked to use their clinical discretion regarding at what point to approach clients. The clients will be informed about the research and asked if they wish to participate. They will be informed that I can make contact with them personally should they require more information or help in completing the questionnaire. The nurse who dealt with each index incident will also be asked to complete a questionnaire describing their perspective on their management of the incident. No further direct contact with the client would be made but liaison would occur between the principle investigator and nursing staff to monitor further incidents of self-harm.

Caroline Steere
February 1999

North Bristol NHS

NHS Trust

Clinical Governance Directorate
Trust Headquarters, Frenchay Site
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Frenchay
Bristol BS16 1JE

Direct dial: (0117) (918)6517
Fax: (0117) 9563880
Our ref: re99.16

6 April 1999

Ms C Steere
Clinical Psychologist
Psychology Department
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds Bristol BS16 2EW

Dear Ms Steere

Project 99/16 **Nurses' management of repeated deliberate self-harm in an acute residential setting**

I am writing to confirm receipt of your application for approval of the above project by the Research Ethics Committee based at Frenchay and have forwarded it to the Committee Chairman. However, the Committee is recommending now that the consent forms should be printed on headed paper, as well as the patient information sheets, and both should bear the same project title. As you are now part of the new Avon and Western Wiltshire Mental Health Care NHS Trust, these will need to be on your new headed paper. Perhaps you would like to make these amendments and provide copies before your project is circulated to the other Committee members.

Please quote Project No. 99/16 in any correspondence in respect of this project so that it can be identified quickly.

Yours sincerely

K Matthews

Rec'd 22.4.99

Mrs K M Matthews
Research Ethics Administrator

cc Dr L Dow, Chairman REC

North Bristol NHS

NHS Trust

Clinical Governance Directorate
Trust Headquarters, Frenchay Site
Beckspool Road
Frenchay
Bristol BS16 1JE

Direct dial: (0117) 9186517
Fax: (0117) 9563880
Our ref: app99.16

4 May 1999

Ms C Steere
Clinical Psychologist
Psychology Department
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds Bristol BS16 2EW

Dear Ms Steere

Project 99/16 **Nurses' management of repeated deliberate self-harm in an acute residential setting**

I am writing to confirm that the Avon Health Authority, North Bristol NHS Trust (Frenchay) Research Ethics Committee has given approval to the above project, **in as far as ethics matters are concerned,** subject to the following conditions:

(i). a short information sheet being prepared for the nurses and copied to the Committee;
(ii). confirmation that you will be approaching the nurse managers and persuading them that your project is good, and acceptable;
(iii). the subject either being given a copy of the back-to-back information sheet and consent form or the two items being printed on separate sheets of paper;
(iv). the information sheet for the subjects is headed "Client's Information Sheet" but the consent form asks "Have you read the Patient Information Sheet?" Normally, an information sheet for subjects who are patients would be headed "Patient Information Sheet", Is there a particular reason why you have headed it "Client's Information Sheet"? If not, it should be amended to "Patient Information Sheet". Otherwise, the consent form should be amended to refer to "Client's Information Sheet" to match. Please provide a copy of the item that you amend;
(v). ratification by the Committee at a later meeting.

The approval will be put for ratification at the Committee's meeting on 14 May 1999 provided an acceptable response has been received to points (i). to (iv). Unless there are any further points raised then regarding your project, I shall not need to contact you again.

The Committee is required to monitor research it has approved in accordance with Good Clinical Practice Guidelines of the European Community and the standard operating procedures for Local Research Ethics Committees. Also, in accordance with the ICH Harmonised Guideline for Good Clinical Practice, an annual, as well as end-of-study report is required. Therefore, **it would be appreciated if you will report annually, and notify the Committee when the project is completed.** We will be grateful if you would complete and return the enclosed form with your project report at the end of the study or after each year from the beginning of the study if it is an ongoing study. Should the results be published, the Committee would like to receive a copy for information and for the benefit of any future research that may be undertaken in this field.

Please notify the appropriate Culyer Lead within your new Avon & Western Wiltshire Mental Health Care NHS Trust organisation of your project.

Data Protection Act 1984 : If the project involves computerising data about patients and/or healthy volunteers who come within "Frenchay's" area of responsibility, please contact the Data Protection Officer/Project Officer, Miss A J Cooke, Information Systems Department, Room 45, Administration Block, Frenchay Hospital, Frenchay Park Road, Bristol, BS16 1LE, telephone No. (0117) 9701212 on extension 2620.

May I just remind you that costs may be involved should you need a patient's medical records to be pulled in connection with your project. If you do need medical records to be pulled, you should speak to the appropriate Directorate General Manager and Miss R Wood, Senior Medical Records Manager to determine how these costs should be covered, whether or not you have made an application for funding which included this aspect.

Information from your application may need to be extracted by the Avon & Western Wiltshire Mental Health Care NHS Trust for its R&D Support Costs Funding and its submission to the National Research Registry. Unless I hear otherwise within two weeks of the date of this letter, it will be assumed that you have no objections.

Whenever contacting the Committee about this project, and/or any amendments or extensions which should be submitted for approval before initiating it will be appreciated if you quote "Project 99/16" as this will assist in identifying the project.

I look forward to receiving your response to points (i). to (iv). in the first paragraph of this letter.

Yours sincerely

Kathy Matthews

Mrs K M Matthews
Research Ethics Administrator
cc Dr L Dow, Chairman REC
Mr A Stainthorpe, RDSU

Clinical Psychology Services
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds
Bristol BS16 2EW
Telephone: (0117) 9754844 Fax No: (0117) 9754832

Avon and Western Wiltshire NHS
Mental Health Care NHS Trust

13th May 1999

Mrs.K.M.Matthews
Research Ethics Administrator
Clinical Governance Directorate
Trust Headquarters, Frenchay Site
Beckspool Road
Frenchay
Bristol BS16 1JE

Dear Mrs.Matthews,

Re:Project 99/16 Nurses' management of repeated deliberate self-harm in an acute residential setting.

Thank you for your letter of the 4th May. I respond to each of the Committee's conditions in turn:

i) I enclose the information sheet that I have prepared for the Nurses.

ii) I have already approached Vijay Jugmohum (Unit Manager at Oakwood House) and persuaded him that my project is good and acceptable. I will be meeting with the nursing staff as a group to discuss my proposals with them prior to embarking on data collection.

iii) Each participant will be given a Patient Information Sheet and a Patient Consent Form, printed on separate sheets of paper.

iv) I have amended the information sheet, so that it is now headed "Patient Information Sheet" and not "Client Information Sheet". It now matches the reference made to it in the consent form. (I enclose the amended version).

I trust that these responses satisfy your conditions, and look forward to hearing the Committee's decision.

Yours sincerely,

Caroline Steere
Clinical Psychologist

North Bristol NHS

NHS Trust

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Beckspool Road
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Bristol BS16 1JE

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Our ref: rat99.16

7 June 1999

Ms C Steere
Clinical Psychologist
Psychology Department
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds Bristol BS16 2EW

Dear Ms Steere

Project 99/16 **Nurses' management of repeated deliberate self-harm in an acute residential setting**

Thank you for your letter of 13 May 1999 in response to the conditions attached to the Avon Health Authority, North Bristol NHS Trust (Frenchay) Research Ethics Committee's approval of the above project. I am please to confirm that your response was accepted and approval was ratified at the meeting of the Committee held on 14 May 1999. However, the Committee still feels the nurses choice and time-pressures need to be considered - essentially being able to volunteer or not.

Yours sincerely

Kathy Matthews

Mrs K M Matthews
Research Ethics Administrator

cc Dr L Dow, Chairman REC

Appendix XII

Clinical Psychology Services
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds
Bristol
BS16 2EW
Tel (0117 9754844 Fax (0117 9754832

14th October 1999

Mrs Kathy Matthews
Research Ethics Administrator
Clinical Governance Directorate
Frenchay Site
Beckspool Road
Frenchay
Bristol BS16 1JE

Dear Mrs Matthews

Re: Project 99/16 Nurses' Management of repeated deliberate self-harm in an acute residential setting

Thank you for your letter of 7th June 1999 confirming that approval of my project was ratified at the meeting of the Committee in May.

I began data collection at Oakwood House in mid-June and hope to obtain information regarding 30 first incidents of self-harm during an admission. Since mid-June, however, there has only been one such incident at Oakwood House.

I therefore propose to broaden the scope of the study to encompass acute inpatient psychiatric facilities in the Bristol area, as well as in South Gloucestershire, namely Clifton, Weston and Mason Wards (on the Southmead Hospital site) and Brockley House, Dundry Villa and John Carey House (on the Barrow Hospital site). Blagdon Villa

I am writing to ask if, provided that I gain the support of the relevant Nursing staff, Nursing Managers, Consultant Psychiatrists and Clinical Directors, the Committee would sanction data being collected in these different areas. I propose setting up and implementing the study in exactly the same way that I have done at Oakwood House.

I look forward to hearing from you.

Your sincerely

Caroline Steere
Clinical Psychologist

Clinical Psychology Services
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds
Bristol BS16 2EW
Telephone: (0117) 9754844 Fax No: (0117) 9754832

Ref: CS.JB

27 October 1999

Dr P Woodhead
Chairman
Weston Ethics Research Committee
X-Ray Department
Weston General Hospital
Grange Road Uphill
Weston-super-Mare BS23 4TQ

Dear Dr Woodhead

Re: **Research into Nurses' Management of Repeated Deliberate Self-Harm in an Acute Residential Setting**

I am a Clinical Psychologist formerly employed by Frenchay Healthcare Trust, and now working within Avon and Western Wiltshire Mental Health Care NHS Trust.

I enclose a copy of my application to the South and West Local Research Ethics Committee, which meets at the North Bristol NHS Trust Headquarters on the Frenchay site. This committee ratified its approval for my study in May 1999, and I proceeded with data collection at Oakwood House (an acute psychiatric unit which used to be part of the Frenchay Healthcare Trust, but which is now part of the Avon and Western Wiltshire Mental Health Care NHS Trust).

Insufficient data, however, are forthcoming from Oakwood House. I therefore propose to broaden the scope of the study to encompass acute inpatient psychiatric facilities in the Bristol area, as well as in South Gloucestershire, namely Clifton, Weston and Mason Wards (on the Southmead Hospital site) and Brockley House, Dundry Villa, Blagdon Villa and John Carey House (on the Barrow Hospital site).

All of these units now form part of the Avon and Western Wiltshire Mental Health Care NHS Trust. I am not yet clear about which Ethics Committees I need to approach and look forward to hearing whether you will be processing this application or whether I need to re-apply elsewhere.

Thank you for giving this matter your attention.

Yours sincerely

Caroline Steere
Clinical Psychologist

c.c. Ms S Bowman, Research Ethics Administrator, Trust Headquarters, Ssouthmead Hospital, Bristol

Ms M Nathoo, Research Ethics Administrator, United Bristol Healthcare Trust Headquarters, Marlborough Street, Bristol

Similar letter sent to Ms S Bowman, Ms M Nathoo

WESTON LOCAL RESEARCH ETHICS COMMITTEE

Weston Area Health Trust
Weston General Hospital
Grange Road
Uphill
Weston-super-Mare
North Somerset
BS23 4TQ.

Direct Dial: 01934 647203
Internal Ext: 3343

DATE: 2nd November1999

TO: Caroline Steere
Clinical Psychologist
Clinical Psychology Services
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds
BS16 3EW

Dear Ms Steere

Re: E188 Research into Nurses' Management of Repeated Deliberate Self-Harm in an Acute Residential Setting

I am pleased to inform you that the above project was given approval by Chairman's Action although the approval will be put for ratification at the next meeting to be held on Tuesday 16th November 1999.

This Ethics Committee complies with the national guidelines for LRECs.

The Ethics Committee is responsible for giving ethical approval but approval for the study within the Trust must be given by the Chief Executive or Medical Director. We wish you to understand that approval of the investigation does not absolve you from total responsibility for the safety and well-being of the subjects.

The Committee will be contacting you to review the progress of your project.

I hope your project goes well.

Yours sincerely,

pp Dr P Woodhead
Chairman, Weston LREC

North Bristol NHS
NHS Trust

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Frenchay
Bristol BS16 1JE

Direct dial: (0117) 9186517
Fax: (0117) 9563880
Our ref: 2re99.16

29 November 1999

Ms C Steere
Clinical Psychologist
Clinical Psychology Serices
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds Bristol BS16 2EW

Dear Ms Steere

Project 99/16 **Nurses' management of repeated deliberate self-harm in an acute residential setting**

I am writing to confirm in writing for your records that, as advised to you by telephone on 25 October 1999, you need to contact the Research Ethics Committees based at Southmead Hospital and the UBHT for approval to extend the above project into their areas of responsibility as listed in your letter of 14 October 1999.

It would be helpful to these Cmmittees if you include a copy of our approval letter and ensure that you amend the application form and enclosures as appropriate.

Yours sincerely

Kathy Matthews

Mrs K M Matthews
Research Ethics Administrator

cc Dr L Dow, Chairman REC

North Bristol NHS

NHS Trust

1 December 1999

Trust Headquarters
Southmead Hospital
Westbury-on-Trym
Bristol BS10 5NB
Tel: (0117) 959 5207
Fax: (0117) 959 0902
e-mail: bowman_sue @hotmail.com

Dr C Steere
Clinical Psychology Services
Cedar House
BLACKBERRY HILL HOSPITAL

Dear Dr Steere

PROJECT 116/99: RESEARCH INTO NURSES' MANAGEMENT OF REPEATED DELIBERATE SELF-HARM IN AN ACUTE RESIDENTIAL SETTING

Thank you for your letter of 27 October 1999. I am pleased to inform you that Mr Gordon Bannister, Chairman of Southmead Local Research Ethics Committee, has given his approval to your request to extend the scope of your project to include acute inpatient psychiatric facilities on the Southmead Hospital site.

Approval is given on the understanding that:-

a) Any ethical problems arising in the course of the project will be reported to the Ethics Committee;

b) Any change in protocol will be reported to the Ethics Committee;

c) An annual progress report will be submitted and a brief final report on completion.

Yours sincerely

Sue Bowman

Mrs S B Bowman
Administrator
Southmead Local Research Ethics Committee

U B H T
TEACHING CARE

The United Bristol Healthcare NHS Trust

UBHT Headquarters
Marlborough Street
Bristol BS1 3NU
***Tel.** 0117 928 3613*
***Fax:** 0117 928 3724*
***Email:** Naaz.Nathoo@ubht.swest.nhs.uk*

12 November 1999

Ms Caroline Steere
Clinical Psychologist
Clinical Psychology Services
Cedar House
Blackberry Hill Hospital
Manor Road, Fishponds
Bristol BS16 2EW

Dear Caroline,

Re: Research into nurses' management of repeated deliberate self-harm in an acute residential setting

Thank you for your letter dated 27 October 1999.

I agree that there is some confusion about which Research Ethics Committees to consult from within the Trust of Avon & Western Wiltshire Mental Healthcare NHS Trust. The principle remains the same as before in that you should consult the REC of the areas from which the patients are recruited or those in which they are treated or investigated. Since the Mental Health Care NHS Trust does not have an ethics committee of its own, application must be made to up to five ethics committees. However, there is reciprocal whereby under the authority of the Avon Health, chairman's action can be taken where a study has already been approved by another REC within Avon.

Very small modifications need to be made to the patient information sheet which should not affect the validity of your study. The letterhead can remain the same, but it should be made clear that the subject will take part in a **research** study as the words 'study' and 'research' are not synonymous for everyone. It should suggest the time the subject should take time to decide whether to take part or not, but since the investigating tool is a self completion questionnaire, and the subject can return it at any time, this probably does not matter. It does not say how many subjects will take part, nor that the study will have no benefit on the patients' present care. I would think that insertion of a very few words will redress this. These factors are all required by the ICH Good Clinical Practice with which all REC are or should be compliant. If these stipulations are met, I can give Chairman's approval for this study to proceed on the Barrow Hospital site.

Yours sincerely,

N. Nathoo

J I Alexander
Chairman to the Research Ethics Committee

POSITIVE ABOUT DISABLED PEOPLE

Clinical Psychology Services
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds
Bristol BS16 2EW
Telephone: (0117) 9754844 Fax No: (0117) 9754832

Ref: CS.JB

19 November 1999

Dr J L Alexander
Chairman to the Research Ethics Committee
UBHT Headquarters
Marlborough Street
Bristol BS1 3NU

Dear Dr Alexander

Re: **Research into nurses' management of repeated deliberate self-harm in an acute residential setting**

Thank you for your letter of 12 November 1999 and for clarifying the issue regarding from which RECs I need approval.

I enclose a copy of my modified patient information sheet, and have highlighted the additions. I trust that they meet the conditions set out in your letter, and look forward to hearing whether you can now give Chairman's approval for me to proceed on the Barrow Hospital site.

Yours sincerely

Caroline Steere
Clinical Psychologist

PATIENT INFORMATION SHEET

Nurses' Management of Repeated Deliberate Self-Harm in an Acute Residential Setting

I am doing a research study to try and find out what kind of a response is helpful to people when they have harmed themselves. I need information from a total of 40 people in order to make the research meaningful. The findings of the study will be presented to mental health nurses in the Trust. The intention is to improve the quality of the care they provide, although the study will provide no benefit to your present care.

You do not have to take part in this study. You can refuse to participate without giving a reason, and it will have no effect on the care you receive in this unit.

If you do agree to take part, you are asked to fill in the attached consent form and the questionnaire, and to send them to me at Cedar House through the internal mail system. (If you have any difficulty with the questionnaire, telephone me and I will come and help you fill it in).

I will then liaise with the nursing staff for one month to find out if and when you have harmed yourself again.

If you do consent to take part in the study, you can withdraw at any time without having to give a reason, and without this affecting your treatment.

I will keep any information you give me strictly confidential and the information will be destroyed at the end of the study. I will be the only person to know how individuals responded on the questionnaire, unless you tell me that a nurse has been abusive, in which case I could not keep that to myself.

Please contact me if you would like further scientific background and explanation.

Yours sincerely

Caroline Steere
Clinical Psychologist

U B H T
TEACHING CARE

The United Bristol Healthcare NHS Trust

UBHT Headquarters
Marlborough Street
Bristol BS1 3NU
***Tel.** 0117 928 3613*
***Fax:** 0117 928 3724*
***Email:** Naaz.Nathoo@ubht.swest.nhs.uk*

29 November 1999

Ms C Steere
Clinical Psychologist
Psychology Department
Cedar House, Blackberry Hill Hospital
Manor Road, Fishponds
Bristol BS16 2EW

Dear Ms Steere

E4514 **Nurses' management of repeated deliberate self-harm in an acute residential setting**

I am pleased to advise that the above project was considered by the Research Ethics Committee at their meeting held on 26 November 1999.

If a satisfactory response to our letter dated 12 November 1999 is received, it may be possible to give delegated approval to this study before the next meeting on 28 January 2000.

We look forward to hearing from you.

Yours sincerely

J I Alexander
Chairman to the Research Ethics Committee

U B H T
TEACHING CARE

The United Bristol Healthcare NHS Trust

UBHT Headquarters
Marlborough Street
Bristol BS1 3NU
***Tel.** 0117 928 3613*
***Fax:** 0117 928 3724*
***Email:** Naaz.Nathoo@ubht.swest.nhs.uk*

09 December 1999

Ms C Steere
Clinical Psychologist
Psychology Department
Cedar House, Blackberry Hill Hospital
Manor Road, Fishponds
Bristol BS16 2EW

Dear Ms Steere

E4514 **Nurses' management of repeated deliberate self-harm in an acute residential setting**

Thank you for your letter dated 19 November 1999 along with enclosures, received by us on 2nd December 1999.

I am pleased to advise that delegated approval has been given to the above study.

In accordance with Good Clinical Practice Guidelines of the European Community and the standard operating procedures required by NHS(E), the LREC is required to monitor research. The International Conference on Harmonisation Tripartite Guideline requires an annual, as well as end-of-study report. Continued approval depends on the receipt of these reports.

Reminder: The short title will be published in national and Trust registers. It should not contain confidential information that you or any sponsors of this research would not wish published.

Yours sincerely

N. Nathoo

J I Alexander
Chairman to the Research Ethics Committee

Appendix XIII

FRENCHAY HEALTHCARE TRUST
Directorate of Mental Health
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds
Bristol
BS16 2EW

Telephone: (0117) 9754844 Fax No: (0117) 9754832

Ref: CS.JB

29 January 1999

Dr Darryl Watts
Consultant Psychiatrist
Blackberry Hill Hospital

Dear Darryl

Re: **Research into nurses' management of deliberate self harm at Oakwood House**

I am part way through a research study investigating the above issue. I began collecting data in Hull when I worked up there but now propose to complete the study based on the client group at Oakwood House. The study consists of a prospective group analysis design based on data collected from nursing staff and clients regarding the nurses' immediate response to an incident of self harm. The enclosed questionnaires seek to measure the response across 4 dimensions:

1. The content of what the nurse said to the client.

2. The length of time the nurse spent with the client.

3. The emotional tone of the response.

4. The strength of emotion expressed by the nurse.

I propose that data are collected pertaining to 25 consecutive incidents of self harm at Oakwood House. Clients who are acutely psychotic at the time of the self harm would be excluded. I would then monitor clients following index incidents of self harm in order to record the length of time that elapses before the client harms him or herself again. This time duration forms the dependent variable. I have discussed my proposals with Alan Hayward, and with Vijay Jughohum. I am also about to submit a proposal to the research ethics committee. I would be grateful if you would let me know whether you have any reservations about me commencing data collection, assuming that I gain ethical approval.

No reservation.

I look forward to hearing from you.

Yours sincerely

Caroline

Caroline Steere
Clinical Psychologist

c.c. Alan Hayward
Vijay Jugmohum

Similar letter sent to Dr Alan Moore and Dr John Owen

FRENCHAY HEALTHCARE TRUST
Directorate of Mental Health
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds
Bristol
BS16 2EW

Telephone: (0117) 9754844 **Fax No: (0117) 9754832**

Ref: CS.JB

29 January 1999

Dr Alan Moore
Consultant Psychiatrist
Blackberry Hill Hospital

Dear Alan

Re: **Research into nurses' management of deliberate self harm at Oakwood House**

I am part way through a research study investigating the above issue. I began collecting data in Hull when I worked up there but now propose to complete the study based on the client group at Oakwood House. The study consists of a prospective group analysis design based on data collected from nursing staff and clients regarding the nurses' immediate response to an incident of self harm. The enclosed questionnaires seek to measure the response across 4 dimensions:

1. The content of what the nurse said to the client.

2. The length of time the nurse spent with the client.

3. The emotional tone of the response.

4. The strength of emotion expressed by the nurse.

I propose that data are collected pertaining to 25 consecutive incidents of self harm at Oakwood House. Clients who are acutely psychotic at the time of the self harm would be excluded. I would then monitor clients following index incidents of self harm in order to record the length of time that elapses before the client harms him or herself again. This time duration forms the dependent variable. I have discussed my proposals with Alan Hayward, and with Vijay Jughohum. I am also about to submit a proposal to the research ethics committee. I would be grateful if you would let me know whether you have any reservations about me commencing data collection, assuming that I gain ethical approval.

I look forward to hearing from you.

Yours sincerely

Caroline

Caroline Steere
Clinical Psychologist

c.c. Alan Hayward
Vijay Jugmohum

Similar letter sent to Dr Darryl Watts and Dr John Owen

Sounds like an excellent piece of work
— my main comment is that wide
consultation with nurses at all levels
involved is vital in view of high
work levels of nurses, then perception of
not always being involved / informed in
work of this kind, and most importantly
involved in the eventual outcome / results.

The other point is that the ward is
about to undergo a re-vamp / Redecorate
in the next weeks. This would be a
good time to carry out the work

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Frenchay Healthcare Trust

Directorate of Mental Health Services, Cossham Hospital, Lodge Road,Kingswood,
Bristol BS15 1LF
Telephone: (0117) 967 1661 Fax: (0117) 975 8034

JO/jas

12 February, 1999

Caroline Steer
Clinical Psychologist
Cedar House
Blackberry Hill Hospital

Dear Caroline

Thank you for your letter of 29 January 1999 regarding a research project on deliberate self harm at Oakwood House. I have no objection to your proposals and look forward to hearing about your findings.

Best wishes

Dr John Owen
Consultant Psychiatrist

Clinical Psychology Services
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds
Bristol BS16 2EW
Telephone: (0117) 9754844 Fax No: (0117) 9754832

Avon and Western Wiltshire
Mental Health Care NHS Trust

Ref: CS.JB

27 October 1999

Dear

Re: **Research into Nurses' Management of Deliberate Self-Harm in Acute Inpatient Settings**

I am part way through a research study investigating the above issue. I began collecting data in Hull when I worked up there, but now propose to complete the study based on data collected in Bristol. The research is already up and running at Oakwood House, and I now propose to encompass Clifton, Weston and Mason Wards (on the Southmead Hospital site) and Brockley House, Dundry Villa, Blagdon Villa and John Carey house (on the Barrow Hospital site).

The study consists of a prospective group analysis design based on data collected from nursing staff and clients regarding the nurses' immediate response to an incident of self harm. The enclosed questionnaires seek to measure the response across 4 dimensions:

1. The content of what the nurse said to the client.

2. The length of time the nurse spent with the client.

3. The emotional tone of the response.

4. The strength of emotion expressed by the nurse.

I propose that data are collected pertaining to consecutive first incidents of self-harm during an admission, until I have 30 data sets. Clients who are acutely psychotic at the time of the self harm would be excluded. I would then monitor clients following index incidents of self harm in order to record the length of time that elapses before the client harms him or herself again. This time duration forms the dependent variable.

I have approval from the South and West Local Research Ethics Committee to collect data from Oakwood House, and am in the process of seeking approval to broaden the study to incorporate the Southmead and Barrow sites. I would be grateful if you would let me know whether you have any reservations about me commencing data collection, assuming that I gain ethical approval.

Please contact me should you have any questions, criticisms or comments.

I look forward to hearing from you.

Yours sincerely

Caroline Steere
Clinical Psychologist

Clifton Ward
Southmead Hospital

Trevor Innin, Ward Manager, Clifton Ward
Dr Jan Truscott, Clifton Ward
Dr David Whitwell, Donal Early House

Mason Ward
Southmead Hospital

Gina Long, Ward Manager, Mason Ward
Dr Robin Arnold, Mason Ward
Dr Steve Arnott, Gloucester House

Weston Ward
Southmead Hospital

David Price, Ward Manager, Weston Ward
Dr Sam Babiker, Weston Ward
Dr Rica Newbury, Weston Ward

Brockley House
Barrow Hospital

Jenny McDonald, Hospital Manager, Woodwise
Kerri Harris, Ward Manager, Brockley House
Dr Paul Birkett, Brockley House

Dundry Villa
Barrow Hospital

Kath Sayer, Ward Manager, Dundry Villa
Dr Peter Godfrey, Dundry Villa
Dr Simon Britten, Dundry Villa

Blagdon Villa
Barrow Hospital

Paul Tobias, Ward Manager, Blagdon Villa
Dr Smith, Blagdon Villa

John Carey House
Barrow Hospital

Roy Hussey, Ward Manager, John Carey House
Dr Jeremy Hyde, John Carey House

Also Dr Sue O'Connor, Clinical Director, AWW Mental Healthcare NHS Trust, Barrow Hospital

Avon and Western Wiltshire
Mental Health Care NHS Trust

MASON WARD
Mental Health Unit
Southmead Hospital
Bristol BS10 5NB
TEL: (0117) 9595882
FAX: (0117) 9595804

Our ref: RA/VSN/LET991108

8th November 1999

Caroline Steere
Clinical Psychologist
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds
Bristol

Dear Caroline,

RE: Research into Nurses' Management of Deliberate Self-harm in Acute Inpatient Settings

Thank you for your request on the research project. I have read the information you passed to me but could not answer the following questions from it. I wonder whether you could give me answers to:

1. What is the hypothesis and how will it be based?

2. Can you confirm how issues of consent will be dealt with in particular how it will be determined whether the patient is competent to consent?

3. I presume that confidentiality will be ensured but could not find this spelt out anywhere?

4. How will you decide when the patient is fit to respond to the questionnaire?

Yours sincerely,

Dr Robin Arnold
Consultant Psychiatrist

Clinical Psychology Services
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds
Bristol BS16 2EW
Telephone: (0117) 9754844 Fax No: (0117) 9754832

Ref: CS.JB

19 November 1999

Dr R Arnold
Consultant Psychiatrist
Mason Ward
Mental Health Unit
Southmead Hospital

Dear Dr Arnold

Re: **Research into nurses' management of deliberate self-harm in acute inpatient settings**

Thank you for your letter of 8 November, and for your constructive comments and questions. I shall address each in turn:

What is the hypothesis and how will it be tested?

The null hypothesis is that a nurse's immediate response to an incident of deliberate self-harm will have no effect on the time that elapses before a client self-harms again. The expectation is that certain features of this response, (the content of what the nurse says, the length of time the nurse spends with the client, the emotional tone of the response, and the strength of emotion expressed by the nurse), will have some bearing on how long it is before self-harm is repeated. A literature review has not provided empirical evidence to indicate the specific response characteristics which might be associated with good or bad outcome. The null hypothesis will be tested by measuring and defining nurses' responses (using the questionnaires). A one-way analysis of variance and a correlation analysis will then be applied to the data to determine whether there is a statistically significant relationship between certain features of the nurses' responses, and the time that elapses before self-harm is repeated.

How will issues of consent be dealt with? In particular, how will it be determined whether the patient is competent to consent?

When a client self-harms during an admission, the nurse who dealt with the incident will make an assessment of the client to decide if and when it would be appropriate to approach him/her with the Patient Information Sheet, Patient Consent Form and Client's Questionnaire.

Clients who are acutely psychotic at the time of self-harm, will be automatically excluded. The nurses will be briefed not to seek consent if their clinical impression indicates that clients would not be competent to give informed consent.

Confidentiality

Confidentiality for both clients and nurses will be ensured and this is made clear on the Patient Information Sheet and the Nurses' Information Sheet, which I enclose.

I trust that this answers your questions adequately. I look forward to hearing from you to know whether you have any further reservations, or whether you are happy for me to proceed.

Thank you for your time and attention.

Yours sincerely

Caroline Steere
Clinical Psychologist

Avon and Western Wiltshire
NHS
Mental Health Care NHS Trust
Barrow Hospital, Barrow Gurney, Bristol BS48 3SG
Tel: 0117 928 6608 Fax: 0117 928 6650

AS/AML
16 November 1999

Caroline Steere
Clinical Psychologist
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds
Bristol BS16 2EW

Dear Caroline

Re: Research into Nurses' Management of Deliberate Self-Harm in Acute Inpatient Settings

Thank you for your letter of 27 October 1999. I have no objection to you approaching any clients in my care.

Yours sincerely

Dr Andrew Smith
Consultant Psychiatrist

Avon and Western Wiltshire
NHS
Mental Health Care NHS Trust

Medical Director's Office
Bath NHS House
Newbridge Hill
Bath
BA1 3QE

Tel:(01225) 731731
Fax:(01225) 731732

Dr Caroline Steere
Clinical Psychologist
Cedar House
Blackberry Hill Hospital
Bristol
BS16 2EW

19 November, 1999

Dear Dr Steere

Re: Research into Nurses' Management of Deliberate Self-Harm in Acute Inpatient Settings

Thank you for your letter. I don't have any objection to you starting your data collection and note that you have contacted all the relevant individuals in the different clinical areas involved.

Yours sincerely

Dr Susan O'Connor
Medical Director

Copy: Dr Simon Britten

Avon and Western Wiltshire
Mental Health Care NHS Trust

Our Ref: FDW/MB

14 December 1999

DONAL EARLY HOUSE
Southmead Hospital
Westbury on Trym
Bristol BS10 5NB

Tel: (0117) 9595830
Fax: (0117) 9595804

Ms Caroline Steere
Clinical Psychologist
Cedar House
Blackberry Hill Hospital
Manor road
Fishponds
Bristol BS16 2EW

Dear Ms Steere

re: **Research into Nurses' Management of Deliberate Self Harm in Acute Inpatient Settings**

Thank you for sending me details of your research project. I think it sounds very interesting and I do not have any reservations about it.

Yours sincerely

Dr F D Whitwell
Consultant Psychiatrist

Avon and Western Wiltshire
Mental Health Care NHS Trust

Barrow Hospital, Barrow Gurney, North Somerset BS48 3SG
Direct Line telephone: 0117 928 6600 Fax: 0117 928 6650

PBB/JAS January 13, 2000

Ms Caroline Steer
Clinical Psychologist
Cedar House
Blackberry Hill Hospital
BRISTOL BS16 2EW

Dear Caroline

RESEARCH INTO NURSES MANAGEMENT OF DELIBERATE SELF HARM IN ACUTE INPATIENT SETTINGS

I have no objection to you commencing data collection for the above study, assuming you obtain the appropriate ethical approval.

Yours sincerely

Dr Paul Birkett
Consultant Psychiatrist

Avon and Western Wiltshire
Mental Health Care NHS Trust

Barrow Hospital, Barrow Gurney, Bristol BS48 3SG
Tel: 0117 928 6605 Fax: 0117 928 6650

SB/sjk

14 February 2000

Caroline Steere
Clinical Psychologist
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds
Bristol
BS16 2DD

Dear Caroline,

Thank you for your letter of 27 October 1999 which was sent to Dundry Villa. I wasn't aware that I had a letter drop on Dundry and I am sorry for the late reply.

I do not have any reservations about you commencing your data collection providing you get ethical approval.

Yours sincerely

Dr. Simon Britten
Consultant Psychiatrist &
Associate Medical Director

Cc: Kath Sayer, Ward Manager, Dundry Villa

NURSE'S QUESTIONNAIRE UNIT.....

Please complete this questionnaire following an incident of self-harm that takes place during an admission, provided that the client is not acutely psychotic at the time of self-harm.

A) INCIDENT IDENTIFICATION

Client's Initials:
Client's DOB :
Your Initials:
Time of Self-harm:
Date of Self-harm:
Form of Self-harm:

What do you think was the real reason for the for self-harm?

Please indicate with a single vertical line along the scale below, how serious you would gauge the self-harm to be in terms of risk of death.

Not at all serious _____ Extremely serious

B) THE CONTENT OF WHAT YOU SAID TO THE CLIENT

✓ Please tick all those boxes which apply.

* Please put an asterisk in the box describing what you spent most of the time saying to the client.

Apologising ☐
(eg; I'm sorry, but I have to ring for an ambulance, report it....).

Questioning regarding exact means and nature of self-harm. ☐
(eg: How many tablets? When? What did you use to cut yourself?)

Pointing out negative consequences of self harm. ☐
(eg:, You're scarring yourself, you could die).

Expressing disappointment ☐
(eg: You've let me down)

Joking(☐
eg: When I finish dressing the wounds on your feet, will you go to the shops for me?

Open questioning (other than regarding motivation), exploring feelings. ☐
(eg; Do you want to talk about it? How are you feeling?)

Informing regarding imminent events ☐
(eg: An ambulance will take you to A&E. I'll come with you).

Questioning regarding motivation ☐
(eg: Why did you do it? Did you want to avoid being discharged?)

Practical Issues regarding physical care. ☐
(eg;, Is that bandage too tight?)

Expressing Frustration
(eg:, I'm getting fed up with this) ☐

Explaining/justifying actions ☐
(eg: You should go to A&E because.....,
effect of paracetamol on liver).

Acknowledging and accepting the self-harm ☐
(eg: Here you are, use it like this, then you won't cut your fingers.
Here are the bandages for next time you cut yourself).

Offering Help ☐
(eg; Would you like me to help you?)

Attempts to prevent future self-harm ☐
(Including care planning, contracting, negotiating. eg; It would be nice if you could talk to us before you do it. What are the triggers/ Alternative coping strategies. You can come and ask for attention at any time).

Issues other than self-harm. ☐
(eg; weather, activities during the day, friends).

Other ☐
(Please detail)

None of the above ☐
(ie; disengaged totally)

C) HOW LONG YOU SPENT WITH THE CLIENT (Immediately after being made aware of the self-harm).

Please estimate number of minutes: ----------

D) YOUR ATTITUDE

Although it may be that none of these words describes your attitude exactly, please tick one box that is the best description.

fearful, inadequate		**hostile**, impatient, critical, hard, belittling, patronizing, harsh, intolerant, cynical, contemptuous, negative, unfeeling, uncaring, unsympathetic, abandoning.	
indifferent, distant, uninterested, dismissive, disinterested		**sympathetic**, non-judgemental, sensitive, friendly, compassionate, responsive, considerate, respectful, thoughtful, gentle, protective, mothering, nurturing, understanding, empathetic, supportive, caring, reassuring, interested.	

How would you describe your attitude in your own words?

E) STRENGTH OF EMOTION

How strongly did you express emotion of any kind? (eg, anger, warmth or sadness).

Please indicate with a single vertical line along the scale below, how emotional you were.

Not at all emotional _____ Extremely emotional

F) **Is there anything else you would like to mention?**

Thank you very much for you valuable time.

I will be providing feedback regarding this research in due course. Please return this questionnaire to me via internal mail.

Thanks

Caroline Steere
Clinical Psychologist - New Bridges

Appendix XV

CLIENT'S QUESTIONNAIRE UNIT.....

A) INCIDENT IDENTIFICATION

Client's Initials:
Client's DOB :
Your Initials:
Time of Self-harm:
Date of Self-harm:
Form of Self-harm:

Can you explain why you felt the need to harm yourself?

Do you think that you wanted to achieve anything through the self-harm? If so, what?

Please indicate with a single vertical line along the scale below, how serious you would gauge the self-harm to be in terms of risk of death.

Not at all serious _____ Extremely serious

B) THE CONTENT OF WHAT THE NURSE SAID TO YOU

✓ Please tick all those boxes which apply.

* Please put an asterisk in the box describing what the nurse spent most of the time saying to the you.

Apologising ☐
(eg; I'm sorry, but I have to ring for an ambulance, report it....).

Questioning regarding exact means and nature of self-harm. ☐
(eg: How many tablets? When? What did you use to cut yourself?)

Pointing out negative consequences of self harm. ☐
(eg:, You're scarring yourself, you could die).

Expressing disappointment ☐
(eg: You've let me down)

Joking ☐
(eg: When I finish dressing the wounds on your feet, will you go to the shops for me?

☐

Open questioning (other than regarding motivation), exploring feelings.
(eg; Do you want to talk about it? How are you feeling?)

Informing regarding imminent events ☐
(eg: An ambulance will take you to A&E. I'll come with you).

Questioning regarding motivation ☐
(eg: Why did you do it? Did you want to avoid being discharged?)

Practical Issues regarding physical care. ☐
(eg;, Is that bandage too tight?)

Expressing Frustration ☐
(eg:, I'm getting fed up with this)

Explaining/justifying actions ☐
(eg: You should go to A&E because.....,
effect of paracetamol on liver).

Acknowledging and accepting the self-harm ☐
(eg: Here you are, use it like this, then you won't cut your fingers.
Here are the bandages for next time you cut yourself).

Offering Help ☐
(eg; Would you like me to help you?)

Attempts to prevent future self-harm ☐
(Including care planning, contracting, negotiating. eg; It would be nice if you could talk to us before you do it. What are the triggers/ Alternative coping strategies. You can come and ask for attention at any time).

Issues other than self-harm. ☐
(eg; weather, activities during the day, friends).

Other ☐
(Please detail)

None of the above ☐
(ie; disengaged totally)

C) HOW LONG THE NURSE SPENT WITH YOU (Immediately after being made aware of the self-harm).

Please estimate number of minutes: ----------

D) THE NURSE'S ATTITUDE

Although it may be that none of these words describes the nurse's attitude exactly, please tick one box that is the best description.

fearful, inadequate		**hostile**,impatient, critical, hard, belittling, patronising, harsh, intolerant, cynical, contemptuous, negative, unfeeling, uncaring, unsympathetic, abandoning.	
indifferent, distant, uninterested, dismissive, disinterested		**sympathetic**, non-judgmental, sensitive, friendly, compassionate, responsive, considerate, respectful, thoughtful, gentle, protective, mothering, nurturing, understanding, empathetic, supportive, caring, reassuring, interested.	

How would you describe the nurse's attitude in your own words?

E) STRENGTH OF EMOTION

How strongly did the nurse express emotion of any kind? (eg, anger, warmth or sadness).

Please indicate with a single vertical line along the scale below, how emotional the nurse was.

Not at all emotional _____ Extremely emotional

F) **Is there anything else you would like to mention?**

Thank you very much for you valuable time.

I will be providing feedback regarding this research in due course. Please return this questionnaire to me via internal mail.

Thanks

Caroline Steere
Clinical Psychologist - New Bridges

Hull & Holderness
Community Health
NHS TRUST

CLIENT'S INFORMATION SHEET/CONSENT FORM

I am doing a study to try and find out what kind of a response is helpful to people when they have harmed themselves.

You do not have to take part in this study, and if you choose not to, it will have no effect on the care you receive in this unit.

If you do agree to take part, you are asked to fill in the tear off slip below and the questionnaire, and to send them to me at New Bridges through the internal mail system. (If you have any difficulty with the questionnaire, telephone me and I will come and help you fill it in).

I will then liaise with the nursing staff for one month to find out if and when you have harmed yourself again.

If you do not consent to take part in the study, you can withdraw at any time without this affecting your treatment.

I will keep any information you give me strictly confidential and the information will be destroyed at the end of the study. I will be the only person to know how individuals responded on the questionnaire, unless you tell me that a nurse has been abusive, in which case I could not keep that to myself.

Please contact me if you have any questions.

Yours sincerely

Caroline Steere
Clinical Psychologist

I consent to take part in the self-harm study.

NAME: .....

SIGNATURE .....

DATE: .....

If you do not want to take part, just ignore this form and questionnaire.

NEW BRIDGES
East Hull Community Mental Health Team/Acute Residential Unit
Birkdale Way Newbridge Road HULL HU9 2BH
☎ (01482) 321703 Fax: (01482) 321704/5

NHS

Clinical Psychology Services
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds
Bristol BS16 2EW
Telephone: (0117) 9754844 Fax No: (0117) 9754832

Avon and Western Wiltshire
Mental Health Care NHS Trust

March 2000

NURSES' INFORMATION SHEET

Dear Colleague

Research regarding the management of deliberate self-harm

I am part-way through some research which I began when I was working in Hull. It investigates what represents the most therapeutic response when patients self-harm, and whether the nurse response type affects the time that elapses before a repeated incident of self-harm.

I am aware that there can be confusion and conflict within staff groups regarding what represents the most therapeutic response when a patient self-harms, particularly when this happens repeatedly. Different nurses can apply models which are at variance with one another, on an ad hoc basis. For example, some schools of thought would indicate an empathic response which allows the patient time to talk, whilst other approaches suggest that a less reinforcing approach is appropriate. My research seeks to address the lack of empirical, systematic research in this area, and to bring some clarity to the question, in the hope that confusion and conflict might reduce.

I propose that data be collected regarding consecutive incidents of self-harm. This would involve both the patient and the nurse (who took the lead role in dealing with the incident of self-harm), completing a questionnaire describing how the incident was managed. I would then liaise with staff for one month following each index incident, to monitor any further incidents of self-harm. Patients who are acutely psychotic at the time of self-harm would be excluded. Nursing staff would approach patients with the Patient Information Sheet/Consent Form, and the Patient Questionnaire, and give them the option of consenting to take part in the study. In addition, potential participants can telephone me with any queries, and I can come to help with completion of the questionnaires if necessary. (Copies of the questionnaires and the Patient Information Sheet/Consent Form are enclosed).

There may well be good theoretical grounds for whatever approach you are currently taking, and it would help the research if you did not change from your usual practice.

Please be assured that should a situation arise where a nurse and a patient report the nurse's actions differently, each of the reports (the nurse's and the patient's) will be attended to carefully, and each person's perception will be valued. I will guard against either the nurse's or the patient's viewpoint being dismissed, and will be aware that two apparently conflicting reports of an incident might be equally valid. I also appreciate the need for confidentiality. I do intend to present the findings from my research within the Trust, but I will make no specific reference to any individual nurse. (This confidentiality would only be breached in extreme cases were a nurse's behaviour not to comply with the code of professional conduct of the United Kingdom Central council for Nursing, Midwifery and Health Visiting. I do not anticipate that such a situation would arise).

I will be coming to discuss my proposals with you, as well as a possible start date, and look forward to hearing any comments, criticisms or questions.

Yours sincerely

Caroline

Caroline Steere
Clinical Psychologist

Avon and Western Wiltshire
Mental Health Care NHS Trust

PATIENT INFORMATION SHEET

Nurses' Management of Repeated Deliberate Self-Harm in an Acute Residential Setting

I am doing a research study to try and find out what kind of a response is helpful to people when they have harmed themselves. I need information from a total of 40 people in order to make the research meaningful. The findings of the study will be presented to mental health nurses in the Trust. The intention is to improve the quality of the care they provide, although the study will provide no benefit to your present care.

You do not have to take part in this study. You can refuse to participate without giving a reason, and it will have no effect on the care you receive in this unit.

If you do agree to take part, you are asked to fill in the attached consent form and the questionnaire, and to send them to me at Cedar House through the internal mail system. (If you have any difficulty with the questionnaire, telephone me and I will come and help you fill it in).

I will then liaise with the nursing staff for one month to find out if and when you have harmed yourself again.

If you do consent to take part in the study, you can withdraw at any time without having to give a reason, and without this affecting your treatment.

I will keep any information you give me strictly confidential and the information will be destroyed at the end of the study. I will be the only person to know how individuals responded on the questionnaire, unless you tell me that a nurse has been abusive, in which case I could not keep that to myself.

Please contact me if you would like further scientific background and explanation.

Yours sincerely

Caroline Steere
Clinical Psychologist

Central Offices, Bath NHS House, Newbridge Hill, Bath, Somerset, BA1 3QE

Clinical Psychology Services
Cedar House
Blackberry Hill Hospital
Manor Road
Fishponds
Bristol BS16 2EW
Telephone: (0117) 9754844 Fax No: (0117) 9754832

Avon and Western Wiltshire
Mental Health Care NHS Trust

Patient Consent Form

Study Title: **Nurses' Management of Repeated Deliberate Self-Harm in an Acute Residential Setting**

Please complete the following:

Please cross out as necessary

Have you read the Patient Information Sheet? Yes/No

Have you had an opportunity to ask questions and discuss this study? Yes/No

Have you received satisfactory answers to all your questions? Yes/No

Have you received enough information about the study? Yes/No

To whom have you spoken? .....

Do you understand that you are free to withdraw from the study:

- At any time?
- Without having to give a reason for withdrawing?
- And without affecting your future medical care? Yes/No

Do you agree to take part in this study? Yes/No

Signed ..... Date .....

(Name in block letters) .....

Signed (Researchers): ..... Date .....

1) A 24 year old woman, with diagnoses of personality disorder and alcohol use. The nurse reported an attitude to the client falling in the 'indifferent' category, whilst the client regarded the nurse's attitude to have fallen in the 'sympathetic' category.

This client was matched with the only other client diagnosed with personality disorder and substance use (including alcohol), with no other diagnoses: a 39 year old man. The nurse who had managed his index incident described an attitude falling in the 'sympathetic' category. The client himself had not described the nurse's attitude.

2) A 27 year old woman, with diagnoses of personality disorder, bipolar affective disorder, and schizophrenia. The nurse in this incident reported an attitude falling in the 'sympathetic' category, whilst the client perceived her to have had an attitude falling in the 'hostile' category.

This woman could be matched with herself, since a few weeks prior to the incident outlined above, she had had an admission (to a different unit), when the index incident was met with a different response. In this instance, both the nurse and the client reported that the nurse's attitude had fallen in the 'sympathetic' category.

3) A 19 year old man, with diagnoses of personality disorder, and borderline learning disability, as well as a mention of voice-hearing. The nurse who managed his index incident reported an attitude to the client falling in the 'hostile' category. The client did not describe the nurse's attitude.

This client could be matched with a man with diagnoses of personality disorder, borderline learning disability, a mention of voice-hearing, and drug use. Although this man's age was not known, and he had a substance use problem as well, he was the only other person in the study with a borderline learning disability. The nurse who dealt with this index incident reported a response falling in the 'sympathetic' category. The client did not describe the nurse's attitude.

4) A 34 year old woman, with diagnoses of depressive illness and alcohol use. The nurse in this incident reported an attitude falling in the 'fearful' category. The client did not describe the nurse's attitude.

This woman was matched with a 49 year old woman, who was the only other client in the study with a diagnosis of depressive illness and alcohol use and nothing else in addition. In this incident, both the nurse and the client reported that the nurse's attitude had fallen in the 'sympathetic' category.

5) A 33 year old woman with a diagnosis of personality disorder. In this incident, the nurse reported an attitude falling in the 'indifferent' category. The client did not describe the nurse's attitude.

She was matched with a 34 year old woman because she was the person with a diagnosis of personality disorder (and nothing else in addition), who was closest in age. In this case, both the nurse and the client reported that the nurse's attitude had fallen in the 'sympathetic' category.

	PD	Substance Use	Psychosis	Eating Disorder	BLD	Trauma	Affective Disorder	Epilepsy
1	✓							
2			✓				✓	
3	✓			✓			✓	
4	✓							
5	✓			✓				
6			✓					
7	✓		✓			✓		✓
8							✓	
9	✓	✓						
10	✓	✓	✓		✓	✓		
11	✓		✓				✓	
12	✓	✓					✓	
13	✓							
14	✓		✓				✓	
15								
16	✓							
17		✓					✓	
18	✓		✓		✓			
19	✓							
20	✓	✓						
21	✓							
22	✓			✓			✓	
23				✓			✓	
24	✓						✓	
25	✓	✓	✓	✓				
26	✓							
27			✓			✓		
28		✓					✓	
29			✓			✓	✓	
30		✓	✓				✓	
31	✓		✓					
32	✓							
33							✓	
34	✓							
Total	24	8	13	4	2	4	12	1
%	67.7	23.5	38.2	11.8	5.9	11.8	35.3	2.9

PD = Personality Disorder BLD = Borderline Learning Disability

Table 2: Showing diagnoses that clients had been given.

Nurses' grade	Did not reply	Did reply
G	3	6
F	4	1
E	24	8
D	26	1
Nursing Assistants	36	5

Table 26: Response rate by nurses' grade

Given that the data were small, they had to be compressed in order to get numbers large enough for analysis.

Nurses' grade	Did not reply	Did reply
G	3	6 (67%)
E and F	28	9 (24%)
D and Nursing Assistants	62	6 (9%)

Table 27: Response rate by nurses' grade after categories had been compressed

There was a significantly greater return rate from the higher grade nurses (χ^2=18.97, df=2, p<.001).