THE UNIVERSITY OF HULL

Experiences of the relationship between hospital staff and people who self-harm

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Overview

The portfolio thesis consists of three parts: a systematic meta-synthesis, an empirical study, and appendices.

Part one is a meta-synthesis of hospital staffs' relationships with people who self-harm. The review aimed to gain an insight in to staffs' experiences of their interactions with people who self-harm, and how that may influence the delivery of care. Three main themes emerged from nine papers detailing experiences, and the influence of contextual factors on their interaction with people who self-harm. The themes were discussed in relation to theory, and the implications for clinical practice are described.

Part two is an empirical study exploring experiences of people who re-attend Accident and Emergency with self-harm. Six people were interviewed and the data was analysed through Interpretive Phenomenological Analysis. Three superordinate themes encompassed the experiences of peoples' relationships with A&E, but also of additional support networks in times of crisis. Implications on the delivery of care for people in crisis are discussed.

Part three is an appendix that provides additional information for the meta-synthesis and the empirical study, as well an epistemological, reflexive and reflective statement.

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Part one - Systematic Metasynthesis

Hospital staff experiences of their relationship with adults who self-harm: A qualitative synthesis.

Hospital staff experiences of their relationship with adults who self-harm: A qualitative synthesis.

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Abstract

Purpose. This review aimed to synthesise qualitative literature exploring inpatient hospital staffs' experiences of their interactions with people who self-harm, and identify what may impact and maintain existing interactions.

Methods. Nine studies were identified from a systematic search of five research databases. Papers included both the experiences of staff in Physical Health and staff working in Mental Health hospitals. The studies employed varied qualitative research methods and were appraised using an adapted quality assessment tool (Tong, Sainsbury, & Craig, 2007). Data was synthesised through traditional methods of qualitative research.

Results. The meta-synthesis produced 3 superordinate themes: *'protection'*, *'withstanding the relationship'*, and *'challenges of the system'*. A threat-focused relationship emerged from the data whereby staff use avoidance to cope, and engage in punitive methods of responding to risk, ultimately resulting in a sense of failure. A process-focused relationship highlighted the means by which a positive relationship is established, and how staff can respond in ways that are mutually beneficial for both staff and patients. Both of these types of relationship were influenced by the context of the system which forms an important basis for facilitating change. The threat-focused relationship involving *'protection'* occurred across both mental health and emergency settings despite differences in training, however *'withstanding the relationship'* primarily emerged from Mental Health staff experiences.

Conclusions. Staff's experience of their relationship with people who self-harm was highlighted to have an important impact on the delivery and outcome of care. Encouraging support for staff with a focus on distress tolerance, managing relational issues, and developing self-awareness within the relationship may lead to a more mutually beneficial experience of care.

Practitioner points:

- Working with people who self-harm can be emotionally challenging and the impact of emotion on the relationship can have important effects on outcome.
- Increasing the skills of staff in managing relational issues and tolerating distress, as well as providing support and reflective practice groups may be useful in managing emotional responses to working with people who self harm.

Introduction

Healthcare is under scrutiny as the demand for inpatient services increase, with reports of long waiting times in under funded and under resourced departments (Kings Fund, 2015). The increasing demands on hospital services have left staff reporting difficult working conditions and low morale, which is likely to be impacting on patient care (Kings Fund, 2014). The majority report positive experiences of hospital care (Care Quality Commission; CQC, 2015), however people who present with mental health problems tend to have more difficult experiences and require more support from staff (CQC, 2014).

Self-harm was one of the top 3 reasons for attendance to A&E over 2012 / 2013; presentations to A&E following self-harm are increasing (Health & Social Care Information Centre; H&SCIC, 2014), and significant proportions of people who present following self-harm attend on more than one occasion (H&SCIC, 2013; Vedsted, Fink, Sorensen, & Olesen, 2004). Re-attendance can be costly and places more demand on services that are limited in their ability to go beyond physical health care, potentially impacting on the extent and quality of care that people who self-harm receive (Eastwick & Grant, 2004; Saunders, Hawton, Fortune, & Farrell, 2012).

People who self-harm often have negative experiences of care (Bryce, 2010; Taylor, Hawton, Fortune & Kapur 2009), including punitive responses, judgemental comments, and having treatment withheld (National Institute of Health and Clinical Excellence; NICE, 2004; Taylor, *et al.,* 2009). Despite increased awareness and education, negative attitudes towards people who self-harm are reported to have remained consistent across countries and over time (Saunders *et al.,* 2012).

The attitudes of hospital staff often reflect those of people who self-harm; both describe feelings of frustration and powerlessness (Rees, Rapport, Thomas, John, & Snooks, 2014; Karman, Kool, Poslawsky, & Meijel, 2015; Taylor, *et al.,* 2009).

Research often recommends improving staff responses through training around self-harm. Unfortunately, the content and quality of such training can vary significantly and there is little research on the long-term benefits of training. Furthermore, although training claims to change negative attitudes, a change in attitude does not necessarily reflect behaviour change (Smith & Louis, 2009).

The staff/ patient relationship is argued to positively contribute to outcome and form a significant part of a person's experience of care (Kelley, Kraft-Todd, Schapira, Kossowsky, & Riess, 2014). A person's initial contact with hospital staff can play a major role in their perceptions of services and care which is likely to influence a person's subsequent recovery. It has been highlighted that people who present with self-harm often evoke negative responses from healthcare staff (Huband, & Tantam, 2000). It remains unclear as to what it is about this interaction that may lead to and maintain responses, and how this may impact on engagement and recovery.

The importance of exploring the interaction between staff and patients has been highlighted to provide an insight into how to improve experiences of care (Taylor, Marshall, Mann, & Goldberg, 2012; Department of Health, 2003). Reviewing staff perceptions could provide an understanding into whether people who self-harm evoke similar interactions with staff regardless of the demographic characteristics and contextual factors highlighted by previous reviews (Saunders, *et al.*, 2012; Rees, *et al.*, 2014; Karman *et al.*, 2015).

The present review aims to explore hospital staff experiences of their interaction with adults who self-harm. The review aims to gain a deeper insight into how staff responses may impact on and maintain current care practices for people who self-harm, and identify what support could be put in place for staff.

For the purposes of this review people who self-harm may be referred to as a 'patient' in line with the traditional experience of physical health hospital care.

Method

Article selection

A search of literature was carried out through CINALH Complete, Medline, PsycINFO, Web of Science and Scopus. These databases were chosen as they encompass both broad and narrow topic areas, from medicine to other multidisciplinary research. They also include a range of sources and boast to be some of the largest databases. This selection of databases allowed for breadth and depth of searching, as no singular database is all-inclusive. Initially titles and abstracts were searched to identify relevant articles related to the research aims. The exclusion and inclusion criteria were implemented upon a review of the full text of the remaining articles (Table 1.). Relevant papers were hand searched to identify any further studies (Figure 1.)

Search strategy

The terms *"self harm" OR "self injur*" OR "self poison*" OR overdose* were entered to identify articles that related to the experience of self-harm without suicidal intent. The terms *staff OR nurse OR doctor or clinic** and *A&E OR "accident and emergency" OR casualty OR "Emergency Department" OR Inpatient* OR Hospital OR Medic** were used to identify samples of staff working in inpatient settings. In addition, *relationship OR attitude* OR belief* OR view* OR perception* OR experience OR understanding* highlighted papers that focus on the perceptions and experiences of hospital staff. No limiters were applied to the searches to ensure that all relevant papers were reviewed. The search was completed in February 2015.
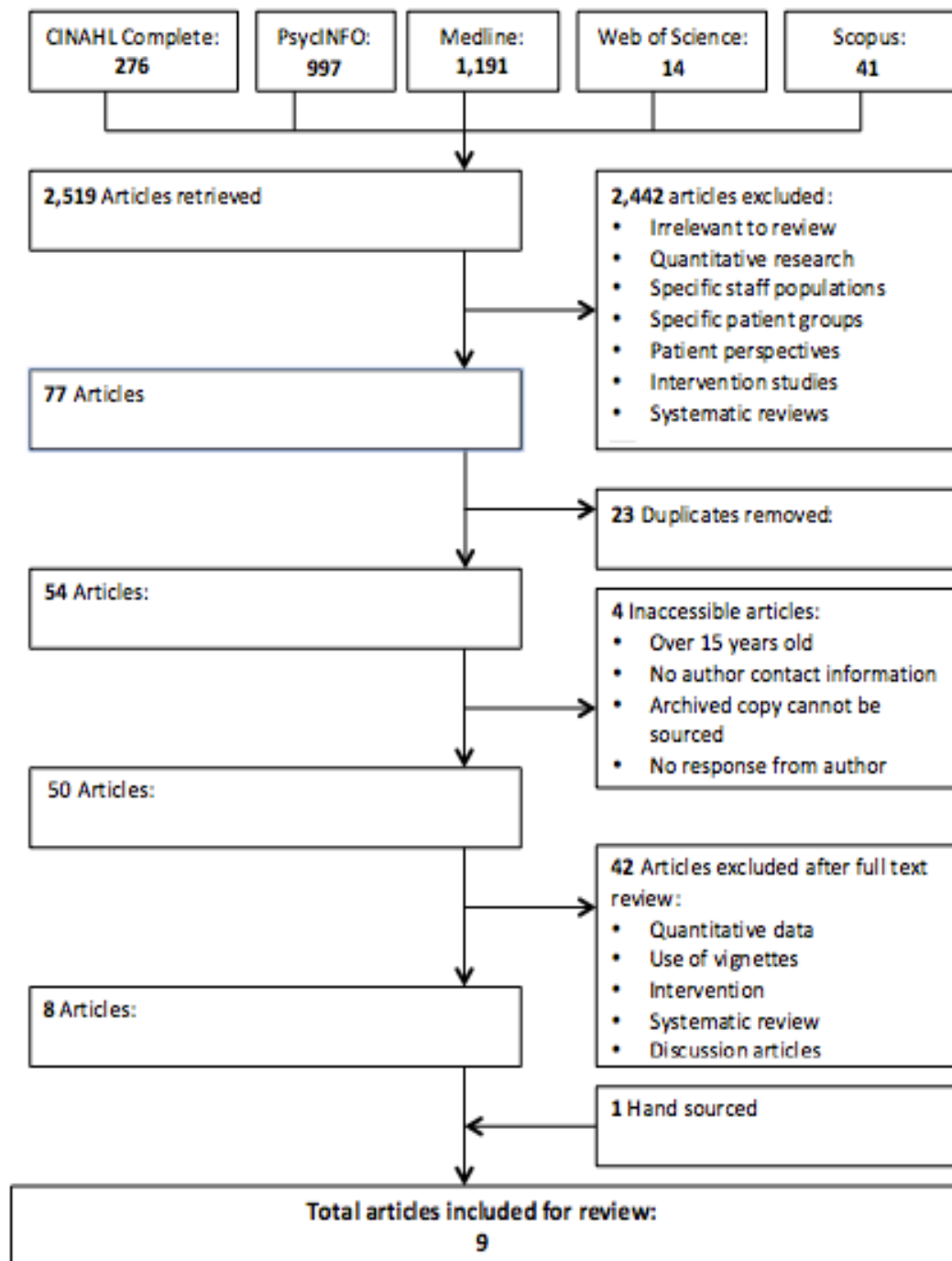
Figure 1. *Article selection process*

Table 1. *Inclusion criteria and rationale*

Inclusion criteria	Rationale
i. Studies that conceptualise self-harm as any act of harm to the self without suicidal intent	The perceived intent of self-harm is suggested to influence the attitudes of staff; staff are more likely to have more positive attitudes towards people who self-harm to end their life (Lilley, Owens, Horrocks, House, Noble, & Bergen, 2008). It is also reported that suicidal acts serve a different function to self-harm and therefore require a different response (Gratz, 2003). Focusing specifically on self-harm as far as possible would highlight staff experiences more in line with this specific phenomenon.
ii. Research that contains qualitative methodology	Qualitative methodology is required to complete the meta-synthesis in order to gain more in-depth data for interpretation.
iii. Research of inpatient general or mental health staff responses to adults who self-harm	Inpatient services have different responsibilities and a different working environment than community teams. In order to regain some consistency in the context of the relationship, only inpatient staff were included.
iv. Papers were included regardless of year of publication, or country of origin	A range of papers were included to capture all relevant staff experiences regardless of demographic or historical factors.

Table 2. *Exclusion criteria and rationale*

Exclusion criteria	Rationale
i. Investigations of staff working in specific settings (e.g. forensic), or research in to staff perceptions of specific populations of people (e.g. people with diagnoses)	The specific setting or patient group produces another layer of social construction upon staff attitudes, which may affect their experience of the relationship. In order to retain the focus on self-harm, these specific factors were excluded.
ii. Intervention or vignette based research	Intervention or vignette based research prompts certain responses which may take away from the actual experience of the staff in the relationship, and were therefore excluded.
iii. Research reporting only patient experiences	Gathering patient experiences would not be concordant with the aims of this review.
iv. Systematic review papers	Systematics reviews are often quantitative and/ or descriptive in nature and thus would not provide the richness of information required for the review. Reviews would also duplicate the information provided from the original sources, and would add another layer of interpretation that may take away from the original data set.
v. Papers not published in English	The review did not have a budget for the translation of papers.

Quality assessment

Quality was assessed using an adapted version of the Consolidated Criteria for Reporting Qualitative Research (CORE-Q; Tong, Sainsbury & Craig, 2007). The CORE-Q was selected due to its established use in qualitative research (see Appendix B). Sandelowski and Barroso (2003) present the argument that interpretations of quality of qualitative research are subjective, therefore the exclusion of papers on the basis of perceived quality should be minimised.

A sample of the included papers were rated by an independent reviewer (Appendix C), however agreement on quality did differ (65.6% agreement). Differences in ratings may have be due to two of the papers originating from larger studies, therefore not all the information was available to the independent reviewer; the researcher spent more time gathering information to contextualise the research and therefore rated more highly. The independent reviewer was also less familiar to qualitative research and therefore differences may have been partly in the subjective perceptions of quality. In the case of differing views, the papers were discussed until an agreement was reached; once further information was provided to the independent reviewer a more informed judgement of quality could be made. Quality ratings were used to establish the suitability of research for the purposes of this synthesis.

Studies were regarded as more suitable if the context surrounding the analysis and the participants' accounts were described, and if the findings were described independent of theory. As the focus of this review was inherently to explore staff experience of their interaction, factors that were deemed as less relevant included number of participants, the recruitment strategy, and descriptive characteristics of the researcher.

Table 3. *Characteristics of included studies with quality rating scores*

Author (Year) **Country**	Aims	Sampling	*n*	Participant characteristics	Data collection	Methodological and theoretical orientation	Quality (%)
Artis, Smith, & Scarff, (2012) **UK**	To explore: - Staff attitudes and behaviours - The impact on effective treatment, team identification and norms.	Voluntary sample.	10	- 3 male and 7 female participants; - 2 doctors, 1 manager, 4 senior nurses, 2 staff nurses, and 1 healthcare assistant.	Semi-structured interviews lasting between 20 to 60 minutes were conducted at the A&E.	- Thematic Analysis - Theory of group norms and identity.	77
Chapman & Martin (2014) **Australia**	To explore staff perceptions about caring for people who present to the emergency department following self-poisoning.	Voluntary sample recruited from 3 Emergency Departments	169	- 45% of staff participated - 133 nurses (11 male; 122 female); 53 doctors (35 male; 18 female) - Nurses age: m= 33 years; doctors, m= 39 years. - Length of experience in the Emergency Department: Nurses m= 4.7 years; Doctors, m=9 years	The Attitude towards Deliberate Self-harm Questionnaire (McAllister, Creedy, Moyle, & Farrugia, 2002) was sent to all staff and contained 2 open-ended questions.	No specific method stated. Reported to use qualitative data analysis of coding, categorising and clustering. (One of two papers; see Martin & Chapman, 2014)	61

Hadfield, Brown, Pembroke & Hayward (2009) **UK**	To explore: - The meaning that A&E doctors attribute to experiences of treating people who self-harm - How this relates to the treatment offered	Purposive sample recruited from 2 A&E departments	5	3 female and 2 male A&E doctors. Mean length of experience of treating people who self-harm was 7.1 years.	Interviews were audio recorded and lasted between 40 to 75 minutes.	Interpretive Phenomenological Analysis	66
Hopkins (2002) **UK**	To gain an understanding of what it means to nurses on medical admissions units to have patients who self-harm	Purposive sample	4	4 general nurses working in 2 Medical Admissions Units	Observations, field notes and semi-structured interviews. Interviews were audio recorded and lasted between 30 to 60 minutes.	Ethnography	63
Mattson & Binder (2012) **Norway**	To explore: - How healthcare workers think, feel and act when working with patients who self-harm	Sample recruited from a psychiatric ward	8	3 nurses, 2 "licenced practical nurses", 2 "social educators", and 1 clinical psychologist (Mattson & Binder, 2012, p. 274),	Semi-structured interviews were audio-recorded and conducted at the psychiatric ward. Interviews lasted on average for 45 minutes. The ward had experienced a reduction in self-harm; interviews focused on past experience and difference over time.	Interpretive Phenomenological Analysis	58

O'Donovan & Gijbels (2006) **Ireland**	To gain an understanding of the practices of nurses working with people whom self-harm without suicidal intent.	Convenience sample recruited from 2 psychiatric admissions units	8	6 female and 3 male psychiatric nurses aged between 25 to 55 years old. Length of experience in psychiatric units ranged from 6 months to 15 years.	Semi-structured interviews conducted	Content Analysis and thematic analysis (One of 2 papers; see O'Donovan, 2007)	48
Senarathna, Adams, De Silva, Buckley, & Dawson (2008) **Sri Lanka**	To explore the experiences and perceptions of primary care doctors in rural Sri Lanka towards the treatment of people who self-harm	Voluntary sample recruited from 13 hospitals with inpatient facilities	15	- 13 male and 2 female doctors - 10 participants - Aged range : 35 to 40 years - Length of experience range: 1 to 8 years - 13 participants had more than 2 years experience - 13 doctors consented but did not participate	Semi-structured interviews were conducted in Sinhalese and independently translated in to English. Interviews lasted between 20 to 30 minutes and were recorded.	Thematic Analysis and fieldwork.	66
Tofthagen, Talseth, & Fagerstrom (2014) **Norway**	To explore mental health nurses' experiences of caring for inpatients who self-harm	Purposive sample recruited through nursing managers	15	- 13 female and 2 male participants working across four psychiatric clinics. - 12 mental health nurses; 3 were general nurses with mental health experience. - Length of experience in psychiatric hospitals ranged from 1 to 14 years (m =5.1 years)	Semi-structured interviews lasting between 45 to 90 minutes were audio-recorded.	Content Analysis The study is within the context of the Tidal Model and a person centred approach	60
Wilstrand, Lindgren, Gilje, &	To gather nurses descriptions of their experiences	Purposive sample recruited	6	3 male and 3 female nurses working in 4 psychiatric units; 2 general nurses, and 4	Narrative interviews conducted and audiotaped at the	Content Analysis	65

Olofsson (2007) **Sweeden**	of caring for patients who self-harm	by nurse manager	psychiatric nurses with one trained in psychotherapy. Participants were aged between 27 and 53 years (m=40). Length of experience ranged from 1 to 18 years (m=9.4).	psychiatric clinics. Interviews lasted between 40 to 50 minutes.

Analysis

In total, 9 papers were included for review. Four papers explored mental health staff perceptions: Wilstrand, Lindgren, Gije & Olofsson (2007); O'Donovan and Gijbels (2006); Matson and Binder (2012); and Tofthagen, Talseth, and Fagerstrom (2014). Five papers investigated the perceptions of physical health hospital staff: Artis, Smith, & Scarff (2012); Hopkins (2002); Hadfield, Brown, Pembroke, and Hayward (2009); Chapman and Martin (2014); and Senarathna, Adams, De Silva, Buckley and Dawson (2008). The main characteristics of included studies can be found in Table 2.

Meta-Synthesis

'Meta-synthesis' captures a number of methods of combining qualitative research of various methodological and epistemological orientations (Paterson, Dubouloz, Chervrier, Ashe, King, & Moldoveanu, 2009; Paterson, Thorne, Canam, & Jillings, 2001; Walsh & Down, 2004). Metasyntheses aim to integrate qualitative research in order to develop further understandings and meaning surrounding a topic or phenomenon (Paterson, Thorne, Canam, & Jillings, 2001). Research has previously described staff perspectives of working with people who self-harm, but is yet to explore the meanings behind this experience. By synthesising and interpreting pre-existing literature it may be possible to go beyond the current 'truth' of the experience and explore why experiences of interactions may occur. An epistemological and reflexive statement can be located in appendices D and E.

The methods of meta-synthesis remain somewhat ambiguous in terms of a prescriptive procedure. Transparency about the method used is a key factor in grounding the research in its context (Walsh & Down, 2005). The present review synthesised research in line with first hand qualitative analysis. Themes emerged through coding, categorising and tabulating data. The original authors' interpretations,

alongside the original participants' quotes were included. Initial ideas and codes were compared within and between papers in order to establish common or contrasting ideas, as described by Noblit and Hare (1989). Maps of each articles key themes were kept at each stage to track the development of ideas and help relate the analysis to the primary source. This review included papers using thematic and content analysis, ethnography and Interpretive Phenomenological Analysis (IPA).

Findings

The meta-synthesis produced themes of 'protection', an inhibitory process in providing care, and 'withstanding the relationship', a facilitative process (see Table.3) 'Challenges of the context' also emerged as influencing the extent to which staff were able to provide care (see Appendix F for examples).

Table 4. *Themes identifying the staff experiences of people who self-harm*

Superordinate Theme	Subordinate theme
Protection	Fear and uncertainty
	Taking control
	Unable to protect
	Defeated
	Self-preservation
Withstand the relationship	Making sense of what's happening
	The process of recovery
Challenges of the system	

Protection

A need to protect developed out of staff's uncontained feelings of fear, leading to a preoccupation with managing risk. Significant attempts to manage risk were not always sustainable.

"She nearly succeeded in taking her life, the fear we felt... If I had been the one who found her and she had been dead. It's unfair to expose another person to that; it is very hard to think about"

(Wilstrand *et al.,* 2007; p. 75)

Strong uncertainty surrounded staff's understandings of a patient's level of risk, the functions of self-harm, and how to respond in incidents where harm had occurred (O'Dovovan & Gijbels 2006; Artis, *et al.,* 2012; Senarathna *et al.,* 2008; Chapman & Martin, 2014). Approaches to self-harm were inconsistent and ambiguous; staff perceived patients to be too different to establish consistent methods of managing self-harm (Artis, *et al.*, 2012; O'Dovovan & Gijbels 2006, Chapman & Martin, 2014). In times of uncertainty and perceived high risk, staff tended to act on an impulse:

"I think you can be a little too easy with this, actually that you too quickly give medication when we notice that we are unsure."

(Tofthagen *et al.,* 2014; p.6)

Both MH and PH staff described being hyper-vigilant, and developing a 'sixth-sense' to the risks that a person who self-harms may present (Tofthagen *et al.,* 2014, Hopkins, 2002, Wilstrand *et al.,* 2007). Understandings of the functions of the self-harm linked to perceived levels of risk; patients deemed 'manipulative' or 'attention seeking' (Wilstrand *et al.,* 2007; Hadfield *et al.,* 2009; Hopkins, 2002) were seen to pose less of a risk and evoked feelings of anger and frustration. It was believed that 'manipulative' behaviour should not be 'rewarded' (Matson & Binder, 2012; Wilstrand *et al.,* 2007; Hadfield *et al.,* 2009) resulting in acts of self-harm being ignored or avoided.

"They describe fearing the patient's manipulative actions that could deceive them and

report that they feel cheated."

(Wilstrand, 2007; P. 74)

The emotional impact of working with people who self-harm was more explicitly discussed in Hadfield *et al. (*2009). Staff fears included losing their own sanity and being unable to contain their strong emotional responses to people who self-harm.

"I guess in some senses it's for your own sanity as well because you don't want to hear

you know every day someone's awful, awful life, life story… So I suppose in some ways

it is some kind of self-preservation"

(Hadfield *et al.,* 2009; p. 761)

In times of fear and perceived threat, instinct took over in order to minimise harm. Both MH and PH staff experienced an overwhelming sense of responsibility; patients were perceived to be vulnerable and incapable of taking an active part in their care (Hopkins, 2002; Hadfield *et al.,* 2009; Tofthagen *et al.,* 2014).

"…Because of their mental health problems they don't have the insight to make a

rational decision some of the time, well actually, you know, we've got to do it for

them."

(Hadfield *et al,* 2009; p. 760)

The anxiety surrounding holding responsibility for patient welfare resulted in restrictive and coercive responses to risk. Methods of managing risk were often impulsive and included: close observation, isolation, withdrawal of leave and possessions, medication

and restraint (Tofthagen *et al.,* 2014; Matson & Binder, 2012; O'Dovovan & Gijbels 2006).

> *"... Before, if someone had a razor that they could [use to] hurt themselves… You were*
>
> *completely hysterical about what they might do... You were going to get it [the razor]*
>
> *at any cost."*
>
> (Matson, & Binder, 2012; p. 277)

Despite attempts at minimising or preventing risk behaviour, staff inevitably found that taking control was not sustainable; patients found new methods of self-harm, or presented challenges to staffs' interventions (Tofthagen *et al.,* 2014; Matson & Binder, 2012 Wilstrand *et al.,* 2007). The methods intended to protect actually resulted in adverse effects on the relationship and engagement.

Taking control in order to minimise risk could result in escalations of patient behaviour. PH staff reported the prevalence of violence and aggression from patients (Chapman & Martin, 2014; Hopkins, 2002). This was accompanied by a sense that staff welfare was not a priority for their employer, leaving staff feeling vulnerable and unprotected (O'Dovovan & Gijbels 2006; Hadfield *et al.,* 2009; Artis, *et al.,* 2012; Wilstrand *et al.,* 2007).

> *"I think you just have to [manage]... So to have that protocol there ensures the*
>
> *patient's safety really, more than ours. . ."*
>
> (Hadfield, *et al.,* 2009, p. 761)

Attempts at managing risk for both MH and PH staff were often unsustainable. Patients repeated self-harm or escalated behaviour led staff to experiencing a sense of defeat,

stuckness, inadequacy and hopelessness (Hadfield *et al.,* 2009; Artis, *et al.,* 2012; Wilstrand *et al.,* 2007; Chapman & Martin, 2014; Hopkins, 2002; Senarathna, *et al.,* 2008). This was associated with a decrease in empathy and engagement with patients (Chapman & Martin, 2014; Hadfield *et al.,* 2009; Hopkins, 2002). Feelings of inadequacy were more apparent for PH staff, whose orientation with the medical model led to a need to 'fix' people and see more immediate change (Artis, *et al.,* 2012; Hopkins, 2002; Hadfield *et al.,* 2009; Chapman & Martin, 2014). Attempts to help patients were experienced as hopeless as interventions were carried out "time and time again" (Hopkins, 2002; p. 151).

PH staff reported that working with people in mental distress was beyond their ability. Staff felt unable to talk with patient about their distress due to not having training in how to do so (Artis, *et al.,* 2012; Hopkins, 2002; Chapman & Martin, 2014)

"I feel like I'm not doing my job properly, because my job is to help people and I can't

help them."

(Artis, *et al.,* 2012: p.44.)

As efforts to protect the patient and manage risk were unsuccessful, staff also engaged in methods of protecting the self. Physical health staff attributed challenges in patient care as the responsibility of society, mental health services, and the individual (Artis, *et al.,* 2012; Hadfield *et al.,* 2009; Senarathna, *et al.,* 2008) in not promoting or allowing change. Staff's responses to patients depended on factors including perceived lethality and severity of the self-harm. This provided a sense of justification for their responses and patient outcome, reducing feelings of inadequacy (Senarathna, *et al.,* 2008; Hopkins, 2002; Chapman & Martin, 2014; Hadfield *et al.,* 2009). In most cases, the perception that self-harm was a reaction to social or situational circumstances led

staff to respond with more empathy than when self-harm was perceived to be related to mental health problems.

" I feel for someone who has felt overwhelmed by a situation and maybe self-poisoned on an impulse, which they either regret after doing so, or remain feeling so hopeless and depressed that they still wish to die. I feel exasperated and annoyed with a patient if I perceive them to have self-poisoned (especially if it was to a minor degree) then notified someone to help them. "

(Chapman & Martin, 2014; p. 141)

Avoidance was the most dominant coping strategy for MH and PH staff. Physical avoidance of patients, avoiding talking about distress, and emotional distancing were methods used to protect the self (Artis, *et al.,* 2012; Wilstrand *et al.,* 2007; Hadfield *et al.,* 2009; Tofthagen *et al.,* 2014; Hopkins, 2002). If avoidance was not enough to manage their emotion, staff engaged in punitive behaviours including humiliating patients, and trivialising or minimising patient distress.

"The participants noticed staff losing control of their emotions by shouting at the patient, grasping the patient's arm tightly, and humiliating patients."

(Wilstrand, *et al.,* 2007; p. 75)

Withstanding the relationship

In contrast to the process of 'protection', staff described a process of managing the relationship with people who self-harm that promoted recovery.

"…To persevere and withstand the relationship and bear hope regarding the patient's recovery when the patient him/herself is unable to envisage such occurring"

(Tofthagen *et al.,* 2014, p.4)

Understanding, acknowledging and identifying the role of self-harm for a patient, and the intention behind the behaviour provided staff with an ability to know the person and their indicators for distress. This allowed staff to more effectively tolerate and manage risk leading to more appropriate responses (Matson, & Binder, 2012; Tofthagen *et al.,* 2014; O'Dovovan & Gijbels 2006).

Reflection upon their own contribution to the caregiving relationship encouraged self-awareness and understanding of when their responses to a patient may trigger self-harm, or may contribute to the maintenance of distress. Understanding the self allowed staff to separate their feelings from those of the patients and implement clear boundaries. Staff were then able to provide containment and safety in times of distress, ensuring the relationship and associated responses were predictable and certain for patients.

" I am able to separate myself… from the patient's feelings, for example, to stop this projection storm."

(Tofthagen, *et al.* 2014; p.5)

Responding appropriately to patient need consisted of collaboration, acknowledgement, distraction, reflection and supporting patients to communicate verbally. Initially staff built an alliance with the patient based on trust and transparency, whereby both parties were jointly responsible for risk management. Collaboration increased motivation, and promoted autonomy and a sense of responsibility; staff's responses communicated belief in the patient's capability to learn to cope in alternative

ways (Matson, & Binder, 2012; Tofthagen *et al.,* 2014; Wilstrand *et al.,* 2007; Hadfield *et al.,* 2009)

If self-harm could not be prevented, staff acknowledged and attended to the physical injury. Once the physical need was met and distress had reduced, staff explored the reasons, feelings and triggers behind the self-harm, encouraging reflection and awareness. From this, staff supported the patient to problem solve alternative methods to delay the use of self-harm next time (Matson, & Binder, 2012; Tofthagen *et al.,* 2014; Wilstrand *et al.,* 2007; O'Dovovan & Gijbels 2006; Hadfield *et al.,* 2009).

"If you only ignore it, you're sending a signal that it doesn't matter to you. They can just keep doing it, hurt themselves as much as they want to, because you don't care ... It's more comprehensive than just a cry for attention ... there's a lot of pain under there."

(Matson & Binder, 2013; p. 279)

What was unique to MH staff was a sense of the bigger picture of self-harm; treatment and recovery was perceived as a process that occurs over time as a person gradually learns alternative ways of coping when presented with overwhelming situations (Tofthagen *et al.,* 2014; Matson, & Binder, 2012).

Challenges of the system

The system was described to have an inhibitory role on patient care. A lack of resources posed dilemmas regarding balancing the welfare of the patient verses the demands of the system (Senarathna, *et al.,* 2008; Artis, *et al.,* 2012). This was described as especially problematic in PH as people with mental health problems were perceived to be a significant drain on time and resources (Senarathna, *et al.,* 2008; Artis, *et al.,*

2012; Hadfield *et al.,* 2009; Chapman & Martin, 2014). PH staff spent time observing patients, chasing up mental health teams or being involved in risk management and de-escalation, evoking feelings of frustration. Staff described active avoidance of engaging with mental health care due to the significant demands staff perceived to be involved.

"I guess not knowing too much is good because they're not giving you so much

that then you feel duty bound to continue the conversation to try and work things

through with them because you just don't have the time to be able to do that… "

(Hadfield *et al.* 2009; p. 761)

The PH staff held the view that wards are not an appropriate for mental health patients (Hopkins, 2002; Artis, *et al.,* 2012; Hadfield *et al.,* 2009; Chapman & Martin, 2014). Staff described the nature of the wards as fast paced, busy and demanding leaving little time for meaningful patient contact. PH staff expressed the view that their role was to provide urgent physical health care; staff reported avoiding people who had self-harmed once they were deemed medically fit. The focus of care for MH staff however, began after physical health had been treated.

"In the ED the focus of care is on the emergency not the mental health/counselling. I

feel as if I 1) don't have time to explore MH [mental health] issues, 2) aren't

encouraged to explore MH issues, 3) don't feel as though the department is the right

place to explore this."

(Chapman & Martin, 2014; p. 143)

The need for more training was mainly described by PH staff as a solution to feeling unable to work with people who self-harm (Artis, *et al.,* 2012; Senarathna, *et al.,*

2008; Hadfield *et al.,* 2009; Chapman & Martin, 2014). Training was perceived to improve confidence and communication. In contrast, MH staff described a need for structure, support and consistency in approach (O'Dovovan & Gijbels 2006).

Discussion

In the synthesis of staff experiences of their relationship with people who self-harm, two processes emerged from the data within the context of the third theme 'challenges of the system'. In coping with the threat of risk to patients and to themselves, staff engaged in a protective process surrounding avoidance of the relationship. 'Withstanding the relationship' with people who self-harm was possible through working collaboratively with patients in understanding their self-harm and their process of recovery whilst remaining self-aware in the interaction.

The review identifies important considerations for improving patient experiences of care. Various studies have highlighted that difficult experiences for patients include having treatment withheld, being humiliated, and receiving punitive treatment and disrespectful comments by staff. It has also been suggested that negative experiences of care may be a result of the characteristics of the patient group in how they perceive care (National Institute of Health Research; NIHR, 2008). Although people's mental health and methods of coping may impact on the way care is perceived, this review also suggests that staff acknowledge unacceptable care and play a significant part in patient's negative experiences. Staffs' experiences of their relationships and how they cope with the processes in the interactions are likely to impact on their own perceptions of providing care to people who self harm. By observing the process of the interaction rather than the 'characteristics' of one part or the other, this can provide a more balanced perspective of the problem rather than attributing fault to one party, possibly leading back into the threat focused interaction.

The majority of literature into experiences for staff around their relationship with people who self-harm provides negative perspectives of the phenomenon; little of the research identifies or provides a focus on positive experiences and interactions. The negative approach to this area of research is perhaps a result of the increasingly critical stance taken by regulating bodies and the media. The critical stance aims to improve care but this focus only provides one part of a whole picture; learning may also occur from the positive experiences which could be maximised in order to improve care. In the present review, the emergence of a positive process for managing the relationship provided insights into aspects of coping for staff and working with people to promote meaningful recovery; a process that is often overlooked in the literature around staff experiences. Despite a lack of positive processes in regards to staff's relationship with patients who self-harm, there are patient reports of positive experiences of the relationship; the responses of others in times of distress can be critical to a person's ability to cope (Palmer, Blackwell, & Strevens, 2007). O'Connor and Glover (2015; in preparation) highlighted that small but meaningful efforts made by staff, such as 'checking-in' with the person or offering a drink, made a significant difference to the patients' perceptions of themselves and their care, impacting on their motivation to engage and recover. It appears that staff's interaction, especially in physical health settings, can be protective for patients. At present staff are unable to engage in these positive processes as a result of barriers such as avoidance due to uncertainty and fear. It may be that by recognising and maximising these protective elements of the interaction, rather than purely focusing on the difficult aspects of experience can provide more insight in to improving patient care, and reducing the anxiety and avoidance around staff's approach to people who self-harm.

The theme of 'protection' highlights the consequences of the emotional impact of working with people who self-harm. Both MH and PH staff described avoidance of patients, suggesting that regardless of training or expertise in mental health, managing the emotional impact of the work is an important factor in the relationship. The Experiential Avoidance Model of self-harm (Chapman, Gratz, & Brown, 2006) suggests that self-harm is a method of avoiding uncomfortable and distressing internal events such as feelings, thoughts and memories. This provides some short-term relief of the unmanageable feelings, but may lead to increased discomfort in the long term; people are not exposed to the distress and are unable to learn to tolerate the discomfort. In circumstances where avoidance of emotion is no longer possible, distress is likely to be elevated (Chapman, *et al.,* 2006). This process of experiential avoidance was also described in the present review; staff reported avoiding people who self-harm and the associated distress that this interaction brings, such as feelings of failure, frustration, and hopelessness. When avoidance was no longer sustainable staff's distress was expressed intensely, often towards patients. The level of emotional avoidance by both staff and patients may contribute to the maintenance of risk and hostile behavior; patients potentially receive the message that their emotion is unmanageable, and neither staff or patients can learn to tolerate distress or learn alternative methods of managing. Chapman, *et al.* (2006) also report that emotional avoidance may be more likely in individuals who engage in reward-based behavior and have higher levels of novelty seeking and/or impulsivity. People who work in A& E departments may chose the specific field as a result of its changing environment, adrenaline fuelled role, and ability to make an instant impact (Byrne & Heyman, 1997). Individuals are also reported to be more likely to engage in impulsive behaviour and respond with more urgency as a result of negative emotion (Chapman, *et al.,* 2006). People who work in highly demanding environments may be more prone to engaging in emotional avoidance, but may also be

more likely to respond on an impulse to emotionally demanding situations. This may be the case where staff described using methods of taking control in order to minimise risk.

People who self-harm are frequently perceived to be challenging to work with, evoking significant emotional reactions and often dividing staff teams (Huband & Tantam, 2000). Sheard, Evans, Cash, Hicks, King, and Morgan *et al.,* (2000) suggested that patients methods of coping with unmanageable feelings can evoke reactions such as avoidance, hostility or rescuing responses from staff, as well as inconsistent responses from different staff member. Sheard *et al.* (2000) described these responses as collusive interactions with patients' processes that can contribute to the maintenance of self-harm; patients' may experience rejection and frustration, increasing their unmanageable feelings and therefore the need to self-harm.

Taylor *et al.* (2012) found that people's attachment type linked to the frequency at which people accessed services, with people who were considered to have a 'preoccupied' adult attachment style most likely to re-present. Gratz (2003) also suggests that people who self-harm are more likely to have insecure attachment types, and the development of self-harm is associated with early emotional neglect (Linehan, 1993). The inconsistent and emotionally avoidant experiences of care reported by staff may be a replication of patients earlier experiences of attachment relationships. When a relationship is unpredictable and inconsistent, gaining a sense of control provides feelings of safety (Bowlby, 1973; Crittenden,1999) and for patients this may be in the form of self-harm or risk behaviour. However this may leave staff feeling 'unable to protect', despite their own attempts of taking control of the relationship in order to manage uncertainty; staff engaged restrictive care, and patients may increase risk behaviours to re-establish control. In contrast, the processes in 'withstanding the relationship' replicate aspects involved in building a secure attachment base. Staff identified, acknowledged and responded appropriately to patients' distress with clear

and consistent boundaries. This relationship provided comfort and protection for patients, as well as encouraging emotional development (Adshead, 1998).

The behaviour of the caregiver can impact on the containment of the patient; staff who lack support may be less able to contain their own emotion and engage in methods that promote a positive interaction with patients (Adshead, 1998). Some staff in the present review described feeling unsupported and not protected within their system, whereas staff who were able to engage in 'withstanding the relationship' described more structure, support and active management (Mattson & Binder, 2013). The challenges of the environmental context through managing demand and the culture of the workplace, as well as the difficulties in managing the emotional impact of working with people who self-harm, reduced staff's ability to provide compassionate care. Distress tolerance, empathy and motivation are factors that are required in order to be able to deliver compassionate care (Cole-King, & Gilbert, (2011) which can be inhibited by high levels of emotion, preoccupation and a lack of support. Compassionate care has been found to create better staff patient relationships (Thompson, & Ciechanowski, 2003), however the ability to be compassionate often begins with having a compassionate approach to the self, which may be challenging in difficult working environments.

The themes of 'protection' and 'withstanding the relationship' pose somewhat opposite approaches to responding to patients that may be reflective of the differences between MH and PH staff. For PH staff, the tendency to focus on physical care may be one method of managing the intensity of the work (Hadfield *et al*, 2009), especially in fast paced busy environments where support is often limited. In comparison, MH contexts are also demanding, but are more likely to have established support systems and focus on emotional wellbeing and self-care, leading to more MH staff reporting ways of 'withstanding the relationship'. In 'protection', the need to determine the

legitimacy of need depending on the patient story was described, however, this conflicts with the need to avoid the patient and their distress. The avoidance may lead to staff assuming the self-harm is not legitimate due to not enquiring about the story, or make assumptions on the basis of medical notes or colleague feedback. Whilst some mental health staff also determined legitimacy based on the perceived reasons for the self harm, mental health staff are perhaps more likely to know more about the patients background and historical function of self-harm. Furthermore, this contrasts with the reports in 'withstanding the relationship' whereby staff describe a need to explore the reasons behind the self-harm, and help the patient verbalise their experience. As staff describe difficulties in tolerating patient distress, this may inhibit their ability to support the patient to verbalise their experience, potentially reinforcing the need to communicate distress through self-harm. Larson and Yao (2005) found that people were more likely to discuss their distress with staff who were perceived to be more empathetic, suggesting that if staff are not perceived to be empathetic patients may be less likely to disclose, which in 'withstanding the relationship' is highlighted as important in promoting understanding and change.

Clinical Implications

Mental health settings have more appropriate resources than PH settings for people who self-harm, however both reported having little time for more meaningful patient interaction. Mental health issues were described to be time demanding, which appeared to be linked to challenges that patients present and the management of risk. Investing time to adapt methods of responding to people who self-harm can promote an interaction that progressively reduces the demand on resources; patients may experience less of a need to escalate their behaviour to seek care, or communicate through harm.

Staff training is a frequent recommendation by research that has explored staff attitudes (e.g. Rees, *et al.,* 2014). The present synthesis identified that both MH and PH

staff experienced the process of 'protection' despite training differences. Huband and Tantam (2000) found significant differences in attitudes towards people who self-harm between those who had received qualifications in therapeutic approaches than those who had not; they suggested that therapeutic training provides staff with skills in containing emotion. Training staff to manage the emotional impact of the work, such as through distress tolerance and managing relational issues, may be more beneficial for example, than training around descriptive and factual information on self-harm.

From this review it is apparent that staff require a forum by which they are able to think about, process, and learn from the emotional impact of their work on themselves and on patients. Improving staff wellbeing through increasing reflection, self-awareness and emotion regulation could encourage a healthy foundation on which to build an effective staff-patient interaction. This could be achieved through linking staff in acute hospital settings with staff trained in therapeutic approaches such as Psychologists, who can facilitate reflective practice, as well as formal and informal training around managing the relationship, distress tolerance and emotional regulation skills. Although in busier environments the ability to engage with patients on a more meaningful level is limited, the ability to contain ones own emotion through self-awareness skills and using support systems may protect against impulsive responding that tends to escalate risk. Managing the emotional impact of the work may be enough in it's self to begin to change the way in which staff relate to and provide care to people who self harm.

Facilitating changes in staff wellbeing and clinical skill requires management to encourage and prioritise time to staff development. Building staff development into pre-existing times of increased staff numbers, such as hand over periods, would allow for team members to be able to take part, without depriving the wards of staff. Promoting staff support and development as part of appraisals and continuing professional development may increase motivation for staff to attend.

The lack of consistency in procedures and protocols of working with people who self-harm leaves staff with little containment in a demanding context; a basic method of approach could provide a more concrete procedure that may help reduce initial anxieties and ensure safe protocols in risk situations. This should be created through service user involvement and be agreed with management. A basic approach may be informed by mental health practices and could include steps such as ensuring a supportive interaction on a regular basis, meeting basic physical health needs, or establishing how a person prefers to communicate and interact with staff.

Limitations

This synthesis includes a small number of research papers, within a limited scope of inpatient settings; the findings will not be applicable to all staff and settings. It is also acknowledged that as this a review of staff perspectives, which is only one part of an interaction, with any interpretations remaining tentative.

A number of contextual and demographic differences may contribute to the variation in the findings between MH and PH staff. Firstly, there are significant differences in the responsibilities and nature of care between PH and MH staff that may account for the contrast between staff responses. Patients also tend to spend longer in mental health hospitals and often have higher concentrations of people with complex presentations requiring different approaches to care. In addition, physical health environments can have high patient turnovers that can affect the depth of the relationship that a staff member can engage in.

This review has included papers that primarily investigated attitudes and perceptions of staff, which for the purposes of the present investigation has been translated in to representations of the relationship. Additionally, qualitative research and reviews involve a high level of interpretation; the methodology and ability to assess

quality can be very subjective. However the present synthesis has remained transparent regarding the methods, influences and assumptions of this research.

The papers included in the review varied in methods and in quality. Senarathna *et al.* (2008) displayed perhaps more cultural differences; staff highlighted the implications of the system to the care, rather than staff attitudes or relationship leading to more of a contribution to the 'challenges of the system' theme. Chapman and Martin (2014) and O'Dovovan and Gijbels (2006) were part of larger research studies where the primary aim was not necessarily on the experience. These papers scored the lowest in term of quality due to the lack of transparency around methodology, analysis, epistemology and reflexivity. Chapman and Martin (2014) did however have a significant number of research participants whose experiences were collected with more anonymity and therefore may be more reflective of the experiences. The research included by Artis, Smith, and Scarff (2012) was a doctoral thesis, which perhaps provided more information around the context of the research, and as a result was rated most highly in terms of quality. Research directed by theory or more specific aims (Artis, *et al.,* 2012; Tofthagen *et al.* 2014) restricted the interpretation of the review as themes tended to be discussed in context to the theory, which may be reflected in the findings.

Future research

The present metasynthesis sought to explore the relationship around the specific presentation of self-harm in hospital settings. Identifying the experience of the relationship of staff in wider settings, such as the community or less contained environments may provide further understanding in to interactions that may affect care, or be inhibitory or facilitative processes to recovery.

Limited research has been carried out on the interventions of improving the relationship between staff and patients around self-harm. An experimental research

project could be undertaken intervening with staff around implementing ways of 'withstanding the relationship'. This may help identify the validity of the interpretation in whether improving the interaction could improve outcome, effectiveness and sustainability. Additionally, an experimental project could be undertaken in to the impact of introducing more support structures in to PH environments.

Conclusions

The present review identified inhibitory and facilitative processes that may form part of hospital staff's interactions with people who self-harm. The identified processes support previous research in the need to understand patients' relationships with staff in order to improve care.

The emotional impact on staff of working with people who self-harm can be significant. This review places an emphasis on increasing access to staff support in order to improve distress tolerance, and develop staff awareness of the impact of their contribution on the relationship. Training programs for staff could include understanding and managing the relational issues, developing an awareness of the self in relation to the patient, managing emotional responses, and using support systems and reflective groups. Through improving the relationship with patients, it is likely that this will improve experiences of care for both staff and patients.

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Part Two - Empirical Paper

Re-attendance at Accident and Emergency with self-harm: Patient experiences of their relationships with services

Re-attendance at Accident and Emergency with self-harm: Patient experiences of their relationships with services

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Abstract

Objectives. During a time of increased pressures on services, more people are presenting to Accident & Emergency following self-harm, and of these people a number repeatedly attend. This study aimed to explore the experiences of people who re-attend following self-harm and their relationship with A&E services.

Design. Qualitative data was gathered through semi-structured interviews with 6 participants.

Methods. Interpretive Phenomenological Analysis was used to analyse and interpret data.

Results. The following themes emerged from the data: 'nothing's in control in your life'; 'you're not ill in that way'; and 'If they had just…'

Conclusions. People who re-attend A&E with self-harm experience an ambivalent relationship with services as a result of having little access to support during times of crisis, and feeling that little changes as a result of their attendance. The relationship with staff can impact people's perceptions of themselves, of care, and of recovery. Mental health crises are not met with urgency or appropriate care, especially within a physical health environment, which may have significant implications. People who re-attend with self-harm would benefit from consistent, compassionate and practical support during presentations to A&E, as at present there is not enough provision for emergency mental health care.

Practitioner Points:

- People who re-attend A&E often feel they have no alternative options in a crisis, but understand that staff in A&E are busy and cannot always provide emotional support.
- Spending small amounts of time providing practical care, keeping people up to date with what is happening, and providing consistency in care can make a significant different to peoples experiences.

Introduction

The National Health Service (NHS) is experiencing increasing pressure to deliver more for less. As funding cuts to community and inpatient services have reduced resources, presentations to A&E have been rising (Health and Social Care Information Centre; H&SCIC 2014). Whilst more appropriate services are suggested to be available to cater for public health needs, presentations to A&E remain high (Moore, Deehan, Seed, & Jones, 2009; Darzi, 2007). The role of A&E is changing to include emergency care for people with mental health problems, however the traditional physical health setting poses challenges to meeting the needs this population (Broadhurt & Gill, 2007).

A high proportion of people who present to A&E are people who attend following self-harm (HSCIC 2014), and over half of this population may already be involved with mental health services (HSCIC, 2013). There are significant financial costs attached to self-harm presentations to A&E (Sinclair, Gray, Rivero-Arias, Saunders, & Hawton, 2011). It was previously estimated that people who presented with antidepressant poisoning cost the NHS £5.1 billion per year (National Collaborating Centre for Mental Health, 2004).

A number of people who present to A&E attend on more than one occasion for the same problem (H&SCIC, 2013; Vedsted, Fink, Sorensen, & Olesen, 2004), and self-harm presentations can account for a significant contribution of overall re-attendance. The more times a person presents with self-harm, the less likely they may be to receive an assessment (Kapur, House, Creed, Feldman, Friedman, & Guthrie, 1999; Barr, Leitner, & Thomas, 2005). When an assessment or follow up is offered, up to 70% of people who re-attend A&E with self-harm either do not attend or drop out (NHS Centre for Reviews & Dissemination, 1998; Webster & Harrison, 2004).

Reviews of research into the experiences of people who re-attend hospital, and people who attend with self-harm reveal mixed results, however a significant proportion

of experiences can be negative (Taylor, Hawton, Fortune, & Kapur, 2009). The National Institute of Health and Clinical Excellence (NICE, 2004) suggests that negative experiences of care may have implications on a person's future perspectives and behaviour in regard to services. Despite this, other research implies that A&E serves different functions for people who attend with self-harm such as a daily resource for coping; impersonal, practical care; or can provide familiarity and a sense of belonging (Bryce, 2010; Beckett, D'Angelo, Pattison, & Walker, 2012).

The initial contact with A&E staff has been recognised as an important factor in people's engagement with services, potentially influencing whether they go on to repeat self-harm or commit suicide (Hemmings, 1999; Baillie, 2005, Taylor, *et al.,* 2009; Redley, 2010). It is suggested staff's interactions with patients may reflect the person's earlier life experiences and relationships and reinforce the person's difficult feelings (Harris, 2000; Van Loon, Koch, & Kralik, 2004) resulting in further self-harm.

This research project aimed to explore the relationship between people who self-harm and A&E services in order to gain insight into the motivations and maintenance factors that may contribute to re-attendance.

Method

Ethical review

This research was reviewed by National Research Ethics Service Committee and was granted approval on the 8th July 2014 (Appendix H).

Research context

Individuals who present to the local A&E with suicidal ideation or self-harm injuries are referred to a nursing led Liaison Team (LT) for assessment or triage. If the person presents out of hours, they are referred to the crisis team and have to wait at the hospital until a member of the team is available. If people do not wait to be seen and they are not under the care of a mental health team then a follow up contact is offered.

The research was completed at a time of a national 'A&E crisis', starting in December 2014 and continuing throughout 2015. A&E departments experienced increasing demand, long waiting times, low staff morale and difficult working conditions.

Participants

Participants were recruited through the LT through purposive sampling between August 2014 and April 2015.

Around 29 people meet the inclusion criteria (see Table. 4): 13 were unable to be contacted, 2 people declined, and 8 people did not attend. In total, 6 British females aged 18 to 29 (m=23) were interviewed. Involvement with services ranged from having no input or waiting for support, being involved with community or crisis services, and /or using voluntary services for support.

Table 5. *Inclusion and exclusion criteria*

Inclusion criteria	Exclusion criteria
• People aged 18 to 65	• Assessed by the LT to pose a risk to others, or significant risk of suicide
• Attendances to A&E following self-harm regardless of the intent or purpose (NICE, 2004).	• Assessed by the LT to be likely to have adverse affects of taking part in the research
• Attendances to A&E with self-harm on 4 or more occasions within a period of around 12 months (in line with previous research; Cook, Knight, Junkins, Mann, Dean, & Olson, 2004; Locker, Baston, Mason, & Nicholl, 2007; Fuda, K. &Immekus, R., 2006)	• Assessed by the LT to be likely to present under the influence of substances
	• Actually presenting under the influence
• People were included regardless of any diagnosis	• People who may not have the capacity to consent (e.g people detained under Section)
	• Not fluent in English
	• Declined to consent

Potential participants were provided information by the LT (Appendix I) through face-to-face or telephone contacts whereby interested participants gave written or verbal consent to be contacted (Appendix J). Further information was provided to participants upon telephone contact, and those who wished to take part were booked in for an interview. At interview, the researcher discussed the information sheet and issues including: the limits of confidentiality, anonymity, data protection, and the right to withdraw. Participant's who wished to take part were asked to provide written consent (Appendix K) and demographic information.

Prior to the research, people with lived experience of self-harm provided feedback through an online survey on: the potential distress that the interview may raise for participants, how participants could be supported, and opinions on the use of

terminology (see Appendix L). As the interview was indicated to potentially raise distress, the researcher monitored participant emotion level before, during and after the interview through a 10-point Likert scale.

Semi-structured Interviews

Open-ended interview questions were produced to provide points for conversation (see Table 4). In particular, a curious stance was taken in exploring the interaction between the service-user and staff (see Appendix M for full interview schedule). The interviews were audio-recorded and transcribed verbatim. A field journal was also kept to log the researches observations of the context and the interactive processes during recruitment and the interviews.

Table 6. *A summary of the interview topics with a rationale, and example questions*

Interview area	Example question	Rationale
General thoughts	Tell me about your visits to A&E?	Enquire about initial meaning of the experience of A&E
Pre-attendance	What is it like before you go to A&E? *Prompt* – Tell me about what might influence whether or not you go?	Gain an understanding of the processes which occur before a person attends
During attendance	Describe what it's like when you get to A&E? *Prompt* – Tell me about the staff, what are they like to you?	Explore what it is like to be in hospital and peoples relationship with staff
Post attendance	Tell me what it's like to leave A&E? *Prompt* – How do people respond to you when you leave A&E?	Understand the process of leaving hospital and how people experience this transition

The duration of the interviews ranged between 25 and 68 minutes and were held at the LT base.

Five interviews were conducted with the individual participant. One participant wished for an external member of staff to be present during the interview due to physical and mental health purposes. The external member of staff did not comment

throughout the interview and was not a part of A&E services; their presence would have been unlikely to inhibit the participant expressing their experiences. The presence of the member of staff may have resulted in the participant elaborating more on their present difficulties to highlight the care they needed, as well talking about their A&E experiences. This interview was not excluded as the external member of staff was not active in the interview, and the interview provided valuable information around the process of seeking care and attending to A&E as a result of this small difference.

Interpretive Phenomenological Analysis

Interpretive Phenomenological Analysis (IPA; Smith & Osborn, 2008; Smith, Flowers & Larkin, 2009) provides an idiographic method for exploring and co-constructing meaning from peoples' experiences through the researcher/ participant interaction. IPA gives an individual focus on lived experience in a way that the socially constructed underpinnings of Discourse Analysis or the contextual influence of Ethnography would be less able to explore.

Transcription, re-reading and referring back to transcripts throughout analysis provided familiarisation with the data (Smith, *et al.* 2009; Smith, Jarman, & Osborne, 1999; Biggerstaff & Thompson, 2008). Linguistic, descriptive, and conceptual aspects of interest were noted in one margin of the transcripts, and the development of codes was noted in the other (see Appendix N for examples). Codes established for each participant were explored through mapping out the relationship within and between codes, whilst referring back to the original transcripts in the production of themes. Themes were tabulated and cross-referenced with participant quotes to establish the consistency of themes. In order to enhance the quality and validity of the findings, theme production and exploration was discussed with and reviewed by an independent researcher.

Findings

In discussing their experiences of A&E, participants also described their relationships with crisis teams, paramedics, hospital staff, mental health teams and voluntary sectors. A&E is one part of a wider process of seeking care; themes primarily detail experiences of attending to hospital, but also reflect experiences of the wider system.

Table 7. *Participants' experiences of re-attending with self-harm*

Superordinate Themes	Theme
Nothing's in control in your life (P5)	Your body fights with you… you know in your head that it's the right thing to do (P3)
	You just want to get up and run away (P1)
You're not ill in that way (P3)	Why should they treat me, because that's sort of the impression I get (P1)
	It's just a different kind of emergency. (P3)
If they had just…	A little time makes a big difference

Nothing's in control in your life (P5)

Your body fights with you… You know in your head that it's the right thing to do (P3)

At the point of crisis, the decision to go to A&E is a difficult one. Participants described uncertainty around how they would be treated and what the outcome might be:

> *"Either you feel lonely or you don't feel more lonely, or you feel more suffocated or overwhelmed or something, or you feel the opposite" (P3)*

Experiences *"depended entirely on the staff"* (P1) who were impossible to predict.

"Sometimes the staff are like really, really nice to you and really reassuring and then other times they'll be really, sort of belittle you… they can be a bit like horrible" (P4)

Negative experiences significantly outweighed the positives in the decision of whether to seek care; uncertainty around the anticipated experience led participant's to assume that staff responses would be negative, and that the outcome would be difficult. Participant's described knowing what was going to happen, from how they were going to be treated to knowing that receiving help is unlikely.

"I know how they're going to be. I know that it's going to be a really long wait… and I know I'm just going to go home feeling rubbish" (P1)

The predictability of these experience in some ways provides containment and a sense of safety, however the anticipation of a negative experiences led to a need to avoid A&E. The ambivalence of whether or not to seek care resulted from having limited alternative options; either feel unsafe on your own, or have a difficult experience at A&E.

"Knowing I'm going to be waiting for ages… makes me feel worse, but I know that I'm safe because I know I'm not at home where I can harm myself." (P5)

"I always end up leaving most of the time, erm, just because I don't want to be there anyway" (P4)

Attending to A&E for help was perceived as a waste of time as their attempts at seeking help often produced little outcome, leaving participants *"in limbo"* (P5). Even if participants experienced a positive outcome, this soon became hopeless as staff "just made false promises" (P2).

"I just end up like still being real down and I've literally like had that and then 2 days later I was back in again because I didn't get any help" (P4)

The unreliable, inaccessible and uncertain nature of care, especially by mental health services led to frustration and helplessness.

"I can't seem to get any help. I just seem to be put on waiting lists and rejected, and then put on waiting lists again, and then rejected." (P2)

You just want to get up and run away (P1)

The process of seeking care is difficult to escape from. Participants often do not want to go to A&E at crisis point, and tend to be forced by friends, family or services.

"I've tried to refuse [to go to A&E] before, but then they just get the police to take me" (P4)

Having a lack of control over themselves or their care was particularly distressing, especially in cases of forced treatment:

"It's awful, the worst thing ever, and there's nurses all around me holding me down, and they were telling the doctor to stop and she didn't. I was just screaming". (P1)

Participants experienced a sense of powerlessness and helplessness; regardless of how hard they try to speak up or get help they felt unheard and unsupported.

"I've learnt to keep my mouth shut because I can say too much" (P6)

At times, some attempted to rebel, or mirror the attitudes of staff in response to negative or punitive interactions. Responding in such a way however, inhibits care leaving any attempt to express their distress and dissatisfaction hopeless.

"You feel like you want to make it harder for them because they're being like that with you." (P3)

The ambivalence around seeking care and the need to avoid A&E often led to a dependence on other services, friends and family. This dependence was met with feelings of guilt and frustration at others for looking after them:

"I feel guilty about sort of impacting on her because I don't want her to have to do that… but if she didn't do that I would never go… I shouldn't be letting it affect others"
(P1)

Being reliant on others around periods of crisis kept participants safe, but was also experienced at times as controlling and restrictive. Participant's reported trying to cope on their own, however when this became overwhelming they often felt unable to access support, subsequently leading to a crisis and re-attendance.

"They say distract yourself, but the thing is that when you've got all the thoughts going round in your head about wanting to self-harm, sometimes it just not possible." (P3)

You're not ill in that way (P3)

Why should they treat me, because that's sort of the impression I get (P1)

Participants explained that people who have not self-harmed or had mental health problems do not understand what that experience is like. As a result, the participants described feeling different from those whom they perceived to not understand. Despite this, participants understood themselves as being separate to the impact of their mental health:

"It's not me, I'm not a nasty person, and I'm not a rude person at all, and when I have been… I just don't know what I'm doing or what I'm saying." (P2)

Staff were perceived to have a limited view of participants and miss the bigger picture of their context and life. Staff see the crises, not the periods of recovery, and were felt to have a biased perception of who the participants were. Staff responses were experienced as trivialising self-harm as a life choice rather than a significant means of coping:

"That's not me…You treat me like I've just walked in from a flat up the road and this is like a hobby for me; its not" (P1)

"….As if you've just woke up one day and thought "well I'm going to have my breakfast… and then I'm going to self-harm"" (P3)

Being surrounded by people with physical health problems at A&E reinforced a sense of being different and prompted feelings of shame, guilt and being less worthy of care. Participants felt exposed and that others were passing judgement on them.

"Sometimes like you feel like everybody's looking at you like they know what you're here for… and then it just makes you question yourself what you're actually doing here" (P3)

Having to disclose mental health problems to staff without privacy, and overhearing staff's indiscrete conversations about them also contributed to a heightened sense of self-awareness or visibility.

"I hate it, surely they realise that you can hear them talking" (P6)

Participants anticipated social judgement as a result of being known as someone with mental health problems, which reinforced a need to hide evidence of mental distress to fit in with the norm.

"I just want to cry but I don't want to do it in front of everyone so it just makes me feel worse" (P5)

Lying about the injury and keeping attendances hidden from friends and family were some ways that participants prevented negative reactions.

"As soon as they see mental health, I mean the first couple of times I went I'd try and lie and say what ever had happened was accidental." (P1)

Attending with self-harm and mental health related distress was perceived to lead staff to the conclusion that the participants waste time and are less deserving of care.

"I think they're blaming me, its my fault [and I] shouldn't be like I am" (P6)

The mismatch between the needs of people who self-harm and what A&E staff can offer led to uncertainty around the participant's role in the relationship.

"When you're sort of there because you've broken your arm or dislocated your

shoulder they talk to you, because you're the patient aren't you" (P1)

In an attempt to establish their position in relation to staff, participants were conflicted; holding empathy and understanding for staff's responses, but at the same time feeling angry at not having their needs met. Participants also identified staffs' uncertainty in how to respond; staff were described to not know what to do or how to treat people who have self-harmed:

"They don't know what to do or what to say… they just tell you it'll be all right or

something… it wont be all right will it. (P3)

Participants also questioned their own viewpoints, acknowledging that they may be putting their thoughts on to staff.

"I get the feeling that they think I'm a time-waster but I don't know if that's just me

being paranoid" (P2)

Harsh, punitive and neglecting experiences of care led to participants experiencing feeling unworthy and rejected.

"I had one doctor, he said to me, he was like "you're just being stupid, you're just doing it for attention"… he just like left me there and didn't bother coming back." (P4)

"I shouldn't be in there; I shouldn't be wasting their time. I should be sensible" (P6)

Services were felt to be unable to handle the extent of participants' distress, leaving them feeling dismissed and invalidated.

"One of them hung up on me once because they said I was too hysterical, I mean it's a crisis team, what do they expect you to be like?" (P2)

It's just a different kind of emergency. (P3)

All participants discussed the importance of time in a mental health crisis. Levels of distress increased as a result of significant waiting times; physical health need is given priority.

"If I was having a heart attack I'd get seen to straight away… and you're sat around waiting… when it could be an hour, it could be 5 hours. (P3)

A&E was experienced to underappreciate the urgency involved for people in crisis and the potential fatal impact that delayed care could have. Participants reported

inappropriate levels of response to crises, especially when people try to prevent more serious acts of self-harm.

"She was like "oh she'll have to wait her turn", but mum was like "she's suicidal", and they're like "oh well she's here she'll have to wait her turn""" (P5)

A sense of hopelessness and abandonment was shared as participants describe little or no support during or after their attendance, leaving them to go back to an environment from which they were recently unable to cope in.

"I just took a major overdose and they were going to send me home on my own." (P2)

"I... just feel like I'm being left in the middle of the sea without any help, without a compass, boat or anything. I'm just left there" (P5)

The feeling of having nowhere to turn was associated with repeat self-harm and re-attendance.

"I've never seen [the follow up team]. I just went straight home… and did exactly the same thing again and did it a lot worse... I didn't know how to cope or what options I had" (P1)

The stigma attached to self-harm and mental health was felt to be permanent, leading to experiences of being treated differently from other patients.

"Cause if like someone came in with a broke leg and they were absolutely balling their eyes out, they'd sit and talk to them, and they'd calm them down, but they wouldn't do that for mental health patients I don't think." (P5)

Self-harm was perceived to impact all aspects of care, regardless of whether it was related to mental health or not.

Participants reported staff ignoring the reasons for their attendance, avoiding talking about the self-harm, being rude, and withholding treatment as a result of being perceived as a mental health patient. Participants expressed wanting to be treated the same as people with physical health problems, but also identified having different needs that required different treatment.

If they had just…

A little time makes a big difference

Taking a small amount of time to think about the reasons behind self-harm, or taking a moment to carry out minor tasks such as checking in with participants had a significant impact on patient experience; participants reported being more likely to engage with and comply with treatment.

"It was just that 2 minutes of time she took out so I felt I at least owed it to her to wait 10 hours" (P1)

"So just them little comments sometimes, even though it don't mean anything maybe to other people, but it does mean something when you feel like that… it makes me want to stay and wait, and it makes me want to feel better" (P3)

Participants recognised the limits of A&E staff's ability to provide deeper psychological support in times of crisis. It was more important for participants to have their basic needs met such as being offered a drink and being kept up to date on what was happening in their care. Recognising the person's context outside of their attendance such as periods of recovery was reported to impact on the participants motivation and engagement.

"Having one nurse say to you "well you haven't been in for 6 months and you're not doing the extremes of what you were doing before" and "well done" that would be enough to absolutely make my day" (P1)

Discussion

The present study supports the view that peoples' relationships with staff can shape engagement, perceptions of care and outcome (Hemmings, 1999; Baille, 2005; Taylor, *et al.,* 2009; Redley, 2010). Re-attendance at A&E has previously been understood as attachment-based care seeking (Taylor, *et al.,* 2012). Experiences at hospital may evoke patterns of relating to others based on a person's perception of the self and others, potentially formed from early attachment relationships (Bowlby, 1988; Harris, 2000; Van Loon, Koch, & Kralik, 2004).

The theme 'your body fights with you… (P3)' indicates participants' ambivalent relationship with A&E. Uncertain perceptions of care were conflicted with the idea that care is predictably unresponsive. Invalidation of emotional distress, emotional neglect and punitive experiences in early life are suggested to be a precursor to the development of self-harm (Linehan, 1993; Gratz, 2003). These experiences may be replicated at A&E; participants described the lack of emotional containment at times leading to more serious attempts of harm. Participants also experienced a sense of dependency upon others which led to experiences of abandonment upon discharge or when care was not available. This however conflicted with the frustration of being overly cared for; responses from perceived caregivers were experienced as inappropriate to the level of need. This conflict may perhaps be reflective of a need for independent exploration however the sense of insecurity and anxiety that this provokes, results in a need for proximity (Blatz, 1966; Ainsworth, 2010)

Similar to the concepts in Attachment Theory, Personal Construct Theory describes processes of making sense of the self in relation to others (Kelly, 1955). Participants may make sense of the world through making predictions and testing out their ideas. The unpredictable and uncertain nature of A&E leaves inconsistent confirmation of

ideas, leaving participants unsure about themselves or how to respond to staff (Stephan & Linder, 1985). Participants may have constructed themselves with the role of a 'helpless patient' in identifying as a mental health patient for whom nothing changes. This potential construction of the self may be based upon the physical care environment, whereby patients are often passive recipients of physical health care, but also from staff perceptions of participants as time wasters, unable to be helped, and undeserving of care. Participants recognised that staff construct people who self-harm based on their patient role; staff have little concept of the person as a whole and only see the crisis. Invalidation of the self-concept may occur as staff are unable to respond to the patient role as a result of the person perhaps having no physical injury or may no longer need physical care. Potential invalidation of the self-construct may lead to anxiety, hostility or guilt (Kelly, 1955).

In times of crisis and uncertainty, the inability to identify options and make decisions may lead to impulsive acts of self-harm in order to gain a sense of control, however the impulsivity can prevent gaining a sense of control and become repetitious (Dunnett, 1985). Participants may constrict their options to a dichotomous decision process of either 'independently struggle' or be 'dependently rescued', whereby either decision often results in an attendance to A&E. By anticipating hospital care as a 'waste of time' (P2) the participant may be validating their self-construct through perceiving and acting in ways that confirm and reinforce this idea; for example, not waiting to be seen, rebelling against care, or being a passive recipient of care, which may inhibit change and maintain a sense of helplessness. It may be suggested that change does not occur as 'nothing's in control' (P5) to direct change (Kelly, 1955). It may be that the participant's dominant self-construct as the 'helpless patient' leaves them a limited role from which to act; participants may struggle to find other ways of relating to the care

system as they have no other construction of themselves from which to make sense of interactions.

Rogers (1959; 1961) also suggested that people make sense of themselves through interactions with others within an environmental context. The internal sense of self is shaped by the regard that others provide, and exposure of this over time forms self-regard. When positive or negative regard is conditional, a person's sense of worth could also become conditional (Rogers, 1961). Participants mainly saw themselves as unworthy of care due to negative regard from staff, and described statements about themselves in line with responses they had received from others. A person is suggested by Rogers (1959) to adapt their perceptions of events to fit with the current understanding of the self and dismiss evidence that is inconsistent. The discrepancies in their perceptions of themselves may contribute to uncertainty in relating to others; participants were unsure as to whether they wanted the same or different treatment to others, or whether they wanted to seek care. The actual or perceived regard from staff appeared to maintain the sense of self as unworthy of care, which in turn affected participants' actions and perceptions and may as a result inhibit change.

Limitations

IPA is in itself interpretive and the findings are unlikely to reflect the experiences of all people who re-attend with self-harm. The sample of participants was limited due to challenges with recruitment, however the limited range of participants does provide homogeneity of the sample, which Smith, *et al.* (2009) recommends. The research also focuses on negative experiences of care that appeared to be more salient for participants, and from this any interpretations remain tentative.

Time limitations and experience of the researcher is also likely to have influenced the interpretation and analysis of the findings. The subjective nature of IPA could result in alternative interpretations at different points in time or between researchers.

Clinical implications

At present services are unable to sufficiently support the increasing numbers of people presenting at A&E with mental health problems. Emergency mental health care is not a priority in A&E departments and people in distress have little alternative option but to attend in crisis. The reactive nature of crisis care and the severity threshold in A&E for physical care leaves people who re-present at a loss with little chance of change. The findings indicate how the urgency and severity of mental health at crisis point can be underappreciated and could have fatal consequences. The findings of the present study highlight that little access to support at times of crisis leads people to attend to A&E, often after harm has occurred. Participants described a need for a physical space during the night to help prevent further harm, and reduce the risk of fatal consequences of having little access to support. A separate mental health space within A&E departments may provide people with this preventative support in times of crisis, and may reduce the current message people receive; participants experienced a sense of hopelessness and failure in their recovery if they re-attend which may reinforcing difficult feelings about themselves and about recovery.

Although the increasing awareness of mental health has begun to change societies perceptions of self-harm, it appears that physical health services such as A&E are not currently at a stage where they can be integrated with mental health. Equally, mental health services do not have the capacity or the physical health training to provide comprehensive care. It may be that increasing the focus on bridging mental health and

physical health care can reduce some of the barriers that staff experience in their relationship with patients. Placing mental health practitioners in the physical health environment, may allow for better fluidity between mental health and physical health care, and reduce the current dualism between mind and body in emergency care. The inclusion of mental health nurses on site is also likely to reduce the demand on general health staff through providing consultation in circumstances of risk and anxiety. Mental health nurse could also utilise their skills in treating minor physical health needs that might otherwise take up a significant amount of time for general health staff. As reflected in the participants' responses, the bridging of mental health and physical health care is likely to provide more timely and appropriate responses to people who self-harm. It may also reduce the barriers for people with mental health problems in terms of seeking help in what has traditionally been a physical health setting. The integration of care could also improve engagement as peoples' needs are met more effectively and may lead to a reduction in re-attendance over time.

Practically the findings highlight how small changes in practice can make significant differences in people's experience. Spending small amounts of time meeting basic needs may be enough to reduce levels of distress for people; participants recognised that staff are often unable to provide psychological support at that time. In their interactions, staff can however provide consistency, predictability and certainty in a person's experience, as well as work with the person to help them achieve a sense of containment and control.

Future research

The present study has focused purely on the individual experience of people who re-attend with self-harm. The impact of other people around those who attend with self-harm appeared significant in how they sought help and experienced time after their

attendance. Understanding the experiences of the family and friends of people who self-harm may provide more of an insight into how people cope in crisis and seek help, as would seeking to explore the experience of people who self-harm in relation to their informal support networks.

Both the NHS and voluntary sector services experience re-attendance with self-harm. Investigating the relationship between voluntary sector services and people who re-present with self-harm may provide more of an understanding in to how these relationships may be similar or different, and the patterns of when people use what service. This may provide more of an understanding around appropriate levels of support for people who re-attend both in crisis and those who seek support earlier.

Conclusions

Re-attendance to A&E is maintained due to insufficient crisis resources in the community, leaving people with limited alternative options. People are left without enough support before, during and after their attendances and this in turn inhibits recovery. Difficult interactions with staff at hospital leave people feeling worthless and hopeless, potentially placing them at a higher risk to themselves. The relationship with staff can impact significantly on a person's sense of themself, their recovery, and of care. Taking time to provide people with consistent, compassionate and practical support with information on their care, may provide a person with enough containment, encouragement and hope for recovery.

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Part Three - Appendices

Appendix A - Guidelines for Authors

Psychology and Psychotherapy: Theory, Research and Practice

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

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

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All articles submitted to PAPT must adhere to the stated word limit for the particular article type. The journal operates a policy of returning any papers that are over this word limit to the authors. The word limit does not include the abstract, reference list, figures and tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length (e.g., a new theory or a new method). The authors should contact the Editors first in such a case.
Word limits for specific article types are as follows:
- Research articles: 5000 words
- Qualitative papers: 6000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

3. Brief reports
These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

4. Submission and reviewing
All manuscripts must be submitted via http://www.editorialmanager.com/paptrap/. The Journal operates a policy of anonymous peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

5. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded here.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labeled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.
- All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professional practice.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.
- Manuscripts describing clinical trials must be submitted in accordance with the CONSORT statement on reporting randomised controlled trials (http://www.consort-statement.org).
- Manuscripts describing systematic reviews and meta-analyses must be submitted in accordance with the PRISMA statement on reporting systematic reviews and meta-analyses (http://www.prisma-statement.org).

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

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Authors considering submitting two or more linked submissions should discuss this with the Editors in the first instance.

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13. The Later Stages

The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site: http://www.adobe.com/products/acrobat/readstep2.html. This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.

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Further information about the process of peer review and production can be found in this document. What happens to my paper?

Appendix B – Qualitative research quality assessment tool

Quality Checklist

Adapted from the Consolidated Criteria for Reporting Qualitative Research (COREQ; Tong, Sainsbury, & Craig, 2007).

Reference:	

		Unknown (0)	No (0)	Somewhat (1)	Yes (2)	N/A (2)
Researcher Characteristics						
Occupation and qualifications	Does the paper state the researchers occupation and qualifications at the time of the study?					
Experience and training	Does the paper state the researchers experience and training in the topic area?					
Researcher biases	Are the researchers bias, assumptions, and interests in the research topic stated explicitly?					
Research orientation						
Aims/ Agenda	Is the agenda of the research and its aims clearly stated?					
Ontology, epistemology and theory	Does the paper describe the ontological and epistemological assumptions that underpin the study?					
	Does the paper describe its theoretical influences?					
	Are the findings reported without theoretical interpretation?					
Methodology						
Methodological orientation	Does the paper state and describe the methods chosen? E.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis					
Context	Does the paper describe the context of data collection? E.g. the circumstances under which data was collected, the setting of data collection.					
Methods of data	Are the questions and					

collection	prompts provided?		
	Was the method of data collection pilot tested?		
Audio/visual recording	Were audio or visual recordings used to collect the data?		
Field notes and reflections	Were field notes made along side data collection?		
Duration	Does the study state the duration of data collection? E.g. does it describe when data was collected to and from, does it describe length of interviews etc.		
Saturation	Is data saturation discussed?		
Participants			
Sample	Is the sampling strategy clearly defined and justified? e.g. purposive, convenience, consecutive, snowball		
	Does the paper describe the recruitment process?		
	Does the paper describe the sample size?		
	Does the paper describe non-participation and the reasons for this?		
	Does the paper describe important characteristics of the sample? E.g. demographic information, experience, etc.		
Participant's understanding	Does the paper describe the researchers relationship with the participants?		
Analysis			
Process of analysis	Does the paper describe the analytic process?		
Examples	Are examples provided of the analysis?		
Derivation of themes	Are themes derived from the data?		
Feedback	Did participants provide feedback on the findings?		
Reporting			
Use of quotations	Are participant quotations presented to illustrate the themes / findings?		

	Is each quotation identified? E.g. using participant numbers or pseudonyms		
	Is the context provided to enhance the meaning of the quotation?		
Consistency	Is there consistency between the examples presented and the findings?		
Clarity of themes	Are major themes clearly presented in the findings?		
	Is there a description of diverse cases or discussion of minor themes?		
TOTALS	Total score:		/62
	Percentage:		
Other comments			

Tong, A., Sainsbury, P., & Craig, J., (2007) Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*, 6, 349–357 DOI: http://dx.doi.org/10.1093/intqhc/mzm042

Appendix C – Quality assessment scores

Papers	Rater	Researcher characteristics	Research orientation	Methodology	Participants	Analysis	Reporting	Totals
		Areas of quality assessment						
Artis, Smith, & Scarff (2012)*	A	6	6	12	8	6	10	48
Chapman & Martin (2014)*	A	2	5	9	9	6	7	38
	B	1	3	7	7	5	7	30
Hadfield, Brown, Pembroke & Hayward (2009)*	A	6	8	10	4	4	9	41
Hopkins (2002)*	A	2	7	11	5	3	11	39
	B	4	4	10	0	4	8	30
Mattson & Binder (2012)	A	0	8	9	4	6	9	36
O'Donovan & Gijbels (2006)	A	1	4	4	5	7	9	30
	B	0	2	2	6	6	9	25
Senarathna, Adams, De Silva, Buckley, & Dawson (2008)*	A	0	5	12	9	4	11	41
Tofthagen, Talseth, & Fagerstrom (2014)	A	0	5	8	8	5	11	37
Wilstrand, Lindgren, Gilje, & Olofsson (2007)	A	2	4	10	8	6	10	40

Quality was assessed by the researcher (A), and an independent rater (B).

- studies that investigated PH staff perceptions

Appendix D – Epistemological Statements

A phenomenological approach was taken to the review and the empirical research as they both aimed to explore the experience of the relationship between people who self harm and hospital staff. The researcher's stance lay between post-positivist and constructivist positions. It was assumed that a person's experience of a phenomenon could be accessible through their interpretation of events, which are affected by social and contextual influences. The meaning of events are created in collaboration with and interpreted by the researcher; the true reality of the event cannot be separated from the subjective experiences and interpretations. Whist it was assumed that people hold unique realities, it was also acknowledged that through reflection and the interaction with multiple unique realities this may uncover a shared reality into the phenomenon of the relationship between people who self-harm and hospital staff. Whilst this stance may prevent the depth of exploring the unique experience, it enables a more comprehensive insight into a shared phenomenon that may lead to improvements in care.

The empirical research and the meta-synthesis are hermeneutic in nature. It is assumed that meaning is brought out through the interaction between the participant and the researcher. As a result the researcher cannot remain fully objective but can only be transparent about the influences that may have contributed to the meaning created (a reflexive statement is made in Appendix E). The meta-synthesis included 3 levels of interpretation; that of the participant, the original author, and the researcher. Although the layers of interpretation may reduce the accessibility or focus on the initial co-constructed reality, it does provide a forum for further meaning to be constructed, as aimed for through the methods of meta-syntheses. In order to reduce the influence of the researcher's bias and assumption's on participants' realities, analysis was independently

reviewed, reflective groups were held, and interpretations were related back to the data at various stages throughout the review and the empirical research.

Appendix E – Reflexive statement

Reflexivity in research is an important consideration especially in qualitative investigations; transparency in regards to the researchers' influences on the research provides a context from which the readers' interpretations of the findings are more informed (Finlay, 2002). Both the meta-synthesis and the empirical research are qualitative in nature and have followed traditional methods of analysis and interpretation around a very similar topic, therefore the influences on both will be discussed.

Through clinical training, my thinking has been shaped to seek to make sense of why experiences occur. Within this, I have developed an interest around social constructionism and the influences of context on experience, but also on the process by which experience occurs and how that is then interpreted. My assumptions in these investigations have been that 'one cannot exist without the other'; that patient's experiences wouldn't occur without the presence of staff or services, and vice versa. This assumption may have led me to neglect other aspects outside of the relationship which are unique to the person and independent of the interaction, however as the focus of the research and review has explicitly been on the relationship (as a result of the mass of research on these individual characteristics), these elements were perhaps less relevant in regards to the aims.

My orientation to seeking to make sense of processes underlying the surface characteristics of the relationship is likely to have led me to a deeper analysis informed by my training in regards to theory and approach. Whilst attempting to remain objective of theoretical influences and assumptions through independent reviewers, supervision and reflective groups, one cannot be completely separate from the research process. In the review, the various levels of interpretation (influenced by various factors including theories and models) by original authors and participants may have evoked more

psychological thinking to allow for deeper analyses and interpretation. In the empirical research, my social constructionist and relational ideologies led me to become familiar with the service and staff experience, leading me to become clearer in my understanding of the context of the phenomenon. The familiarity with context, as well as hearing participant experiences first hand, is likely to have led to a more grounded analysis and interpretation but perhaps this distracted from purely focusing on the underlying interaction. The influence of my involvement with both staff perspectives and patient perspectives is likely to have impacted my approach to the research process, providing a more balanced view, but also further insight in terms of exploration in interview, analysis and interpretation.

My assumptions around self-harm, such as understanding self-harm as a means of coping, and my experiences of working with people who self-harm was helpful in empathising with the participants and their experiences. My experiences of working with people and my clinical training also allowed me to remain self-aware in interviews which provided useful information for analysis and interpretation. In addition, my interpretations are likely to have been influenced by my clinical experiences of working in trauma and attachment-focused services at the time of the research. These experiences may have led me consider staff reactions as a response to threat and anxiety, and to considering patient experiences in relation to attachment processes.

In the completion of the review, the initial rationale was around difficult experiences of care by patients, and the majority of the literature reporting negative attitudes by staff towards people who self harm. The difficult experiences of both staff and patients prompted the review in an attempt to understand why this interaction can be difficult. In reviewing the literature I had expected that a negative interaction would occur as a result of the negative reports from staff. It may be that this expectation may have led to a negative bias in my analysis and interpretation, however a positive process

was also identified out of the analysis indicating that a negative bias did not dominate the research. This may also be argued for the empirical paper; the majority of literature reports difficult experiences of care, and although the findings of the study describe these experiences, positive interactions are also reported and identified as important within the relationship.

In the empirical research, the majority of participants were a similar demographic to myself which in part is useful in empathising and having insight in to the cultural context to inform analysis and interpretation. Similarities however can lead to assumptions around what people may experience, therefore grounding the analysis in the data and in the context helped to reduce assumptions. Additionally, being of a similar demographic to participants may have affected interviews in my reduced awareness of additional factors that may have been prevalent for people. However my experiences of shadowing assessments at A&E provided me with a deeper understanding of issues for a range of people who present to A&E with self-harm.

Being a researcher but also a practitioner allowed me to build a good relationship with staff and become familiar with the context of attending to A&E. I was able to hear staff's perspectives of the process of attending with self-harm, as well as their thoughts and about their roles. This helped inform my interviews in terms of understanding more about the context of the experience but also assisted analysis and interpretation of data by providing a more grounded approach to making sense of the process. Equally, hearing patient perspectives provided a more grounded approach in the interpretation and analysis of the review. However, aspects of having this conflicting role were unhelpful at times, especially around staff providing indicators of issues that may arise, which was helpful in maintaining an ethical approach to interviews, and responding appropriately. The limitations of these experiences are that

my approach to interview may have been affected by the anxieties around risk communicated by staff, however this process provided further information for interpretation around the interaction with people who self-harm for staff.

References:

Finlay, L. (2002) Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research, 2,* 209.

Appendix F – Themes and example data

Overarching concept	Concept	Subordinate concept	Data
Protection	Fear and uncertainty	Gut feelings and hyper-vigilance	"Several of the nurses described a 'sixth sense' about patients who they felt would wish to leave and the feelings of frustration which this aroused in them. Caring appeared to be submerged under the heavy burden of responsibility: "As soon as you see them you know"" (Hopkins, 2002) "The participants had to be on their guard at all times, constantly aware of the risk for self-harm that could be fatal" (Wilstrand, *et al.,* 2007) "Gut feeling comes very fast - a combination of knowledge, and experience in a way. You speak on and off about that you "smell" things then. You can, to be sure, capture [it] (i4)." (Tofthagen, *et al.,* 2014)
	Taking control	Feeling responsible as patients are vulnerable	"Patients who wish to leave the environs of the ward pose a problem for the nursing staff. They feel that they have a responsibility for all these patients who might potentially be at risk of further self-harm or suicide." (Hopkins, 2002) "It tends to be people who have serious mental illness that are very depressed and, or things like that and you think, okay, they don't really know what's, they do know what's going on but because of their mental health problems they don't have the insight to make a rational decision some of the time, well actually, you know, we've got to do it for them." (Hadfield, *et al.,* 2009)
		Methods of taking control	"The participants reported that serious self-harm that can lead to suicide is always stopped, whether through the use of seclusion or restraints or constant observation for shorter and longer periods of time." (Tofthagen, *et al.,* 2014) "Restraints, holding the patient, isolation, shielding (removing the patient from the common areas of the ward – usually to her own room) and forced medication were among the coercive strategies employed. Moreover, planned leave from the ward was withdrawn when the staff expressed concern that the patient might self-injure while on leave, and the patients' rooms were searched for tools with which they could hurt themselves." (Matson & Binder, 2012) Safety was maintained by removing sharp objects from a person's possession and requesting that

		protect	control and force the more she banged her head and it became very difficult (i8)." (Tofthagen, *et al.,* 2014) "She [patient] was lying under the blanket and used a razorblade to cut herself on the arm, despite being on close observation." (Wilstrand, *et al.,* 2007) "There was a war here at the ward. Of finding the tools they used to hurt themselves with. But we had to give up! The patients are so skilled at hiding tools that it's no use ... We can search, and search, and search, we won't find it. We can tear up the floorboards, we can tear up everything, she'll still manage to hide it away ... We had a struggle here for several years. But then we discovered that continuing this war was anti-therapeutic" (Matson & Binder, 2012)
		Not protected from the patients	"… I find it [caring for DSP patients] an extremely frustrating area of my work especially in that we are not backed up by management in protecting our safety... " (Chapman, & Martin, 2014) "I think you just have to [manage], or I just have to get on with it unfortunately. . . . So to have that protocol there ensures the patient's safety really, more than ours. . . . It ensures that you are giving best treatment and also it's good because by having a set protocol you're removing any emotional thoughts about the patient yourself . . . no matter what you think, you know what you have to do. It's probably the same way soldiers were." (Hadfield, *et al.,* 2009) "People who have self-harmed may become violent because of the toxic or intoxicating effects of the substances they have ingested. Sometimes they 'lash out' because they wish to avoid treatment. At these times they become highly visible – they are watched by the nurses, the other patients and also perhaps the security staff or the police. They become high-profile patients and have a significant effect on the functioning of the ward – they speed it up, slow it down, divert resources and require much attention to be focussed upon them to bring the system back into equilibrium." (Hopkins, 2002)
Withstand the relationship	Process of recovery	Helping the patient to manage	"Active diversion is an expression of care and creates a distance between patients and their suffering and simultaneously teaches patients alternative strategies to self-harm." (Tofthagen, *et al.,* 2014) "Attempts at preventing self-harm were made through the use of special observations, no-harm contracts, and distraction techniques. Additionally, individual participants reported engaging in a range of interventions such as stress management, assertiveness training, instillation of hope, development of problem-solving skills, mind mapping, and positive reinforcement with people who self-harm, suggesting very individualized approaches when working with people who self-harm rather than adopting a coordinated approach to care." (O'Donovan, & Gijbels, 2006) "Most participants described a similar set of events: doing something about the injury and taking care of the patient emotionally there and then, following up to determine what caused the patient to self-injure, and then discussing pre-emptory measures should the urge to self-injure arise the next time." (Matson & Binder, 2012)

| Challenges of the system | The emergency department is not for mental health | "Acute psychiatric admission units were described by the participants as demanding and busy places. The participants reported that due to the nature of their all-encompassing role, they did not have enough time to engage in therapeutic care with individuals who self-harm. They suggested that as they have to undertake other tasks that take up so much time, they do not have time to do anything else. They also indicated that the unpredictable nature of the acute environment made it difficult to plan anything." (O'Donovan, & Gijbels, 2006)

"Medical admissions units are busy, bustling places. To each patient and their family, being admitted is a unique trauma but, to the nurses, this uniqueness can become subsumed in the volume and pace of admissions. Only the very unusual is remembered in detail." (Hopkins, 2002)

"Further to this, limitations were seen as within the divide of the physical and psychological, such that the ED did not have the appropriate facilities, such as private rooms and increased patient supervision, and was seen as the place to treat the physical wounds, but not the psychological ones." (Artis, *et al.,* 2012)

"We in accident and emergency will just deal with their physical side whether that is external or internal. . . . If they've taken tricyclic antidepressants or heroin, whatever, they'll all be treated the same way medically. The psychiatric aspect of it doesn't come into the situation until you've treated them. . . . But similarly with the external harmers, you treat their cigarette burns, you remove the needles that they've placed in, or staples, and you stitch up their wounds, but, you know, we're not treating them psychiatrically" (Hadfield, *et al.,* 2009) |

Appendix G – Guidelines for Authors

British Journal of Clinical Psychology

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

The following types of paper are invited:
- Papers reporting original empirical investigations
- Theoretical papers, provided that these are sufficiently related to the empirical data
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
- Brief reports and comments

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

2. Length
The word limit for papers submitted for consideration to BJCP is 5000 words and any papers that are over this word limit will be returned to the authors. The word limit does not include the abstract, reference list, figures, or tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length. In such a case, the authors should contact the Editors before submission of the paper.

3. Submission and reviewing
All manuscripts must be submitted via http://www.editorialmanager.com/bjcp/. The Journal operates a policy of anonymous peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

4. Manuscript requirements
- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded from here.
- The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.
- Tables should be typed in double spacing, each on a separate page with a self-

explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.

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

- All papers must include a structured abstract of up to 250 words under the headings: Objectives, Methods, Results, Conclusions. Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

- All Articles must include Practitioner Points – these are 2–4 bullet points to detail the positive clinical implications of the work, with a further 2–4 bullet points outlining cautions or limitations of the study. They should be placed below the abstract, with the heading 'Practitioner Points'.

- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

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

- In normal circumstances, effect size should be incorporated.

- Authors are requested to avoid the use of sexist language.

- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

5. Brief reports and comments

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

6. Supporting Information

BJC is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at http://authorservices.wiley.com/bauthor/suppmat.asp

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9. Pre-submission English-language editing
Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found at http://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

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11. The Later Stages

The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site: http://www.adobe.com/products/acrobat/readstep2.html.
This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.

12. Early View
British Journal of Clinical Psychology is covered by the Early View service on Wiley Online Library. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Articles are therefore available as soon as they are ready, rather than having to wait for the next scheduled print issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have volume, issue or page numbers, so they cannot be cited in the traditional way. They are cited using their Digital Object Identifier (DOI) with no volume and issue or pagination information. E.g., Jones, A.B. (2010). Human rights Issues. *Human Rights Journal*. Advance online publication. doi:10.1111/j.1467-9299.2010.00300.x
Further information about the process of peer review and production can be found in this document: What happens to my paper?

Appendix H – Ethical Approval

[REMOVED FOR HARD BINDING]

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Appendix I – Information Sheet

PARTICIPANT INFORMATION SHEET

Title of the research: **Frequent attendance with self-harm:
An exploration of service users' relationships with
A&E services**

We would like to invite you to take part in a research project. The research aims to investigate the experiences of people who often go to A&E with self-injury or self-poisoning. The research is particularly interested in people's relationship with services.

Before you decide if you want to take part, we would like you to:
- Understand <u>why</u> this research is being done.
- Understand <u>what</u> participating would involve.
- Understand the potential <u>pros and cons</u> to participating.

You are welcome to discuss taking part with other people before you decide.
The researcher will be happy to answer any questions you may have.

<u>Why</u> are we conducting this research?
- A large number of people attend to A&E with self-injury or self-poisoning, and some people attend to A&E several times. By visiting A&E, it could be suggested that people who self-harm aren't getting enough support from other services. This research may help us understand what further support may be needed.

- People who go to A&E with self-harm are said to have a range of good and bad experiences. We wondered whether people's relationship with staff affected whether they come back to A&E.

- By asking people about their experiences of going to A&E with self-harm injuries, this may help services think about how their responses can affect how often people may go to A&E.

- The responses may help us to identify better ways of supporting people with self-harm injuries.

Why am I being invited?

This information has been given to you by a member of the A&E liaison team because you often use A&E services with injuries that may be considered self-harm. We are interested to hear about your experiences.

What will happen if I decide to take part?

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┌──────────┐     ┌──────────┐     ┌──────────┐     ┌──────────┐
│  Inform  │     │  Leave   │     │   The    │     │ Meet the │
│ staff you│ ──▶ │ contact  │ ──▶ │researcher│ ──▶ │researcher│
│ would like│    │details with│   │ will     │     │for around 2│
│ to take  │     │  staff   │     │contact you│    │  hours   │
│   part   │     │          │     │within a couple│ │          │
└──────────┘     └──────────┘     │of weeks to│     └──────────┘
                                  │ arrange a │
                                  │time/ date │
                                  └──────────┘
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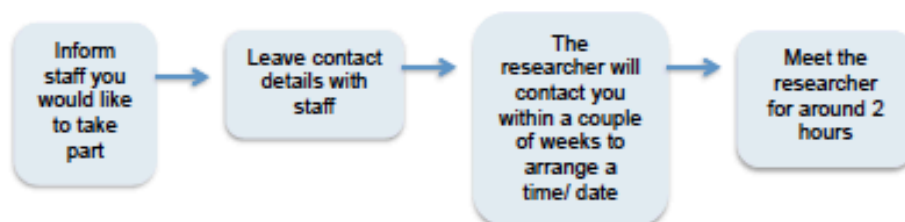
- When you meet the researcher, they will give you some more information about the research and you will have the opportunity to ask questions.
- The researcher will ask about your experiences of A&E and will audiotape the conversation.
- Talking about experiences may raise emotions for some people. The researcher will talk to you about using a scale to keep track of your distress.
- Once the conversation is over, the researcher will write up the conversation and will interview other people.
- A summary of the findings can be sent to you in approximately May 2015.
- If you will incur any travel costs to take part (i.e. car fuel, public transport, and/ or parking costs) you should let the researcher know when they contact you to discuss what you will be able to claim back. Reimbursements will be based on Humber NHS Foundation Trust Policy.

Do I have to take part?

No, participation is voluntary. If you decide to take part you will:
- Be asked to sign a consent form to indicate that you agree to take part.
- *If you decide you no longer wish to take part*, you are free to withdraw your participation and your data from the study up to the point where the data analysis is complete.
- You do not have to give a reason if you decide to withdraw.
- Your decision will not affect your healthcare or your legal rights.

What are the possible disadvantages of taking part?

✗ Participating in the study will require approximately 2 hours of your time, which may inconvenience you.
✗ Talking about self-harm and personal experience may raise emotions for some people. Distress will be carefully monitored throughout the conversation with the researcher. You will be reminded that it is ok to stop the interview if you would like. Staff will be on site to provide additional support if required.

What are the possible benefits of taking part?

We cannot promise that you will have any direct benefits from taking part in the study.
✓ Some people find participating in research a rewarding and valuable experience.
✓ The responses may provide information to the people who fund services about what further support people who attend A&E with self-harm may need.

2

✓ The results may help us to think about different ways that services can support people who often attend to A&E with self-harm injuries.

What if there is a problem?
If you have a concern about the research, you can contact the researcher who will do their best to answer your questions and resolve any problems. You can also contact Patient Advice and Liaison Service (PALS) for further information.

Will my taking part in this study be kept confidential?

- All the personal information that you provide will be kept strictly confidential.

- The only time that information cannot be kept confidential is if you disclose something that suggests that you or someone else is at risk of serious harm. If this happens during the conversation the researcher will need to contact appropriate staff or services to ensure that both you and any other people are safe. If the researcher was concerned about you, or another person's safety they will try to discuss this with you to inform you of any action that may be taken.

- Any information that could be used to identify you will not be used in the research. Your name and details will be changed to protect your identity.

- All recordings of the conversation will be kept on an encrypted memory stick and will be destroyed once the interview has been transcribed.

- The A&E liaison team will be aware of whether you take part, however the team will not have access to interview data. Identifiable interview data may only need to be disclosed if any concerns around risk to you or other people are raised in the interview.

- If you were to disclose information that raises serious questions about the quality of care, information would have to be passed on to the service manager. You would also be encouraged to contact PALS. The researcher would try to discuss this with you if any action needed to be taken or information needed to be passed on.

What will happen to the results of the study?
At the beginning of the research, you will have the opportunity to state whether you would like a written summary of the results once the research has been completed in late 2015. You will be able to contact the researcher who will be happy to discuss any questions you have about the research.

The results will be written-up and may be submitted for publication in an academic journal. Some direct quotes from the interview may be used in the write-up however; no personal details or any identifiable data be included.

Who is organising and funding the research?

3

This research is being undertaken as part of a doctoral research project in Clinical Psychology. The research is funded and regulated through the University of Hull. Responsible individuals from the University of Hull or from regulatory authorities may look at some of the information collected during the research to ensure that the researcher has followed appropriate guidance.

Who has reviewed the study?
This research has been reviewed by the Research Ethics Group at the University of Hull and has received a favourable review; they are happy for the research to proceed.

The research has also been reviewed by NRES Committee Yorkshire & The Humber – Leeds East and has been given a favourable review.

If you have any further questions, comments or queries, please don't hesitate to contact Sophie O'Connor (the researcher).

Further information and contact details

If you are interested in taking part in the study please leave your contact details on the sheet provided and give it to a member of staff. The researcher will contact you within a couple of weeks to arrange a meeting at a convenient date and time.

Thank you for taking the time to read this information.

Yours Sincerely,

Sophie O'Connor
Researcher

The Department of Clinical Psychology
Hertford Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Tel: 07514661003 (Research Mobile; Monday to Friday, 9am-5pm)
E-mail: S.E.O'Connor@2012.Hull.Ac.Uk

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Appendix J – Consent to contact

Date: 03-04-14
Version Number: 1.0

PARTICIPANT CONTACT INFORMATION

By providing your information below you consent to the researcher contacting you to discuss the research. (NB: You are not consenting to take part, just to discuss it)

Please tick your preferred method of contact.

	Tick
Name:	
Address:	☐

Telephone Number(s): ☐

Home: | | | | | | | | | | | |

Mobile: | | | | | | | | | | | | ☐

Would it be OK to leave answer phone messages?   YES / NO

When would be the best time of day to contact you?

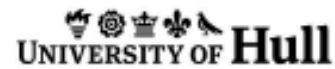Do you have any further comments or questions for the researcher to consider?

Signature:..   Date:..

1

Appendix K – Consent form

UNIVERSITY OF Hull

Centre Number: _____   Study Number: _____   Participant Identification: _____

CONSENT FORM

Title of Project: Frequent attendance with self-harm: An exploration of service users relationships with A&E services

Name of Researcher: Sophie O'Connor

Please write your initials in the boxes:

1. I confirm that I have read and understood the information sheet dated 01-07-2014 (Version 1.2) for the above research. I have had the opportunity to consider the information, ask questions and have had these answered sufficiently. ☐

2. I understand that my participation is voluntary and that I am free to withdraw my participation and data up until the data analysis is complete. I understand that I can withdraw without giving any reason, and without my care or legal rights being affected. ☐

3. I understand that any information collected from my interview or records will be anonymised. I understand that the anonymous information I provide access to as part of this research may be published in a research journal, including direct quotes. ☐

4. I consent to the audio taping of my responses. I understand that the tape will be deleted once the recording has been placed on an encrypted device. ☐

5. I understand that my information will be kept confidential unless I disclose information which suggests a potential risk to myself or others. ☐

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

Please tick whether you would like to be sent a written summary of the results. Results will be fed back to individual participants in approximately June 2015. You will be provided with contact details in case you change your mind or would like the opportunity to discuss any questions you have with the researcher.

☐ Please send me a written summary of the results (2015)

☐ No, please <u>do not</u> contact me to feed back the results.

_____   _____   _____
Print Name (Participant)   Date   Signature

_____   _____   _____
Print Name (Staff)   Date   Signature

Date: 01-07-2014   Version 1.2   1

Appendix L – Lived experience feedback

Re-attendance at A&E with self-harm: Lived experience feedback

The primary research study will investigate re-attendance at A&E with self-harm with a particular interest in the relationship between services users and A&E services. Individuals are often defined by services and have varied experiences with A&E, therefore gaining feedback on terminology and interview areas will provide useful information about conducting the research and will incorporate the views of those whom this research is aimed for.

Methods

A survey was designed using Survey Monkey to gather quantitative and qualitative feedback on the potential distress that participant may experience in the interviews, and feedback on the use of terminology.

Participants were provided with a summary of the topic areas and were asked to rate on a 9-point Likert scale how distressed they believed they might become if they were to be interviewed. Participants were also asked their thoughts on terminology and had space to provide further comments on the research.

The findings are presented as percentages and brief themes.

Participants

The survey was distributed through online social media where volunteers self selected to provide feedback. Overall 39 people completed the survey; 36 females (92.31%) and 3 males (7.69%). The majority of respondents were within the working age adult age range (97.44%) with 2.56% under 18 years. Participants gave an approximate number of their attendances to A&E with self-harm injuries, ranging from zero attendances to over 500 (see Figure 1.)
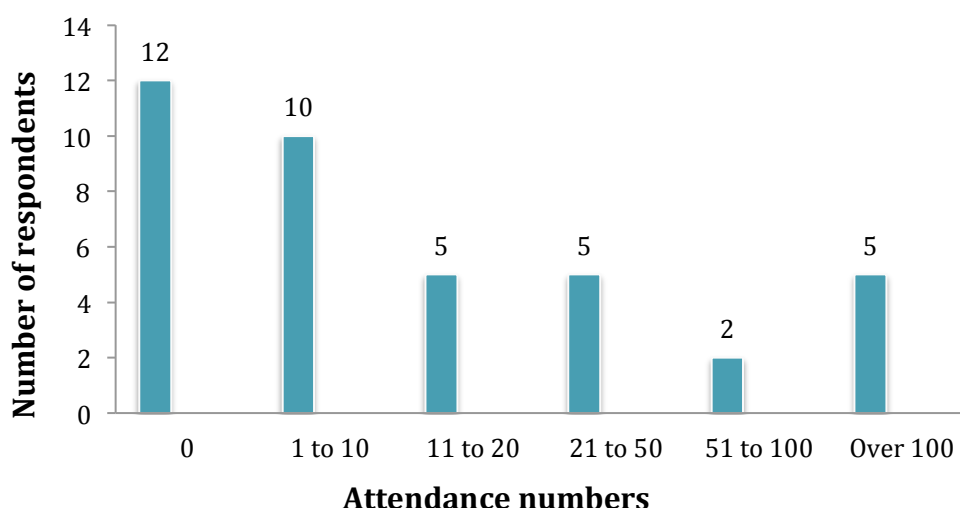

Figure 1: *Participants' self reported approximate number of attendances to A&E with self-harm*

Findings

All participant responses were included regardless of whether they had completed all the questions.

Thirty-two people provided feedback on what terminology should be used to refer to someone who has often attended to A&E with self-harm. The most preferred term was "re-attends" (37.50%), followed by "frequently attends" (34.38%), with the least preferred being "repeatedly attends" (9.38%). Eight respondents (25%) expressed that they would prefer not to be referred to as any term as the terms often have negative connotations:

"I'd prefer to be seen as a person not a category"

"…They all feel like I'm being a burden on A&E"

These respondents expressed that they would rather be viewed and referred to as a person:

" Someone who has needed to attend A&E often."

"Person who has uses A&E for self-harm treatment regularly…"

Thirty-four people rated how the interview topics may affect their distress. Respondents distress levels ranged from "not at all distressed" to "extremely distressed' on each interview area (see Table 1.) The majority of people rated their distress as a '6' out of 9 for talking about experiences before A&E, a '5' out of 9 for their experiences during A&E, and a '5' out of 9 for talking about their experiences after A&E.

Table 1: *Respondents' distress ratings of the interview areas*

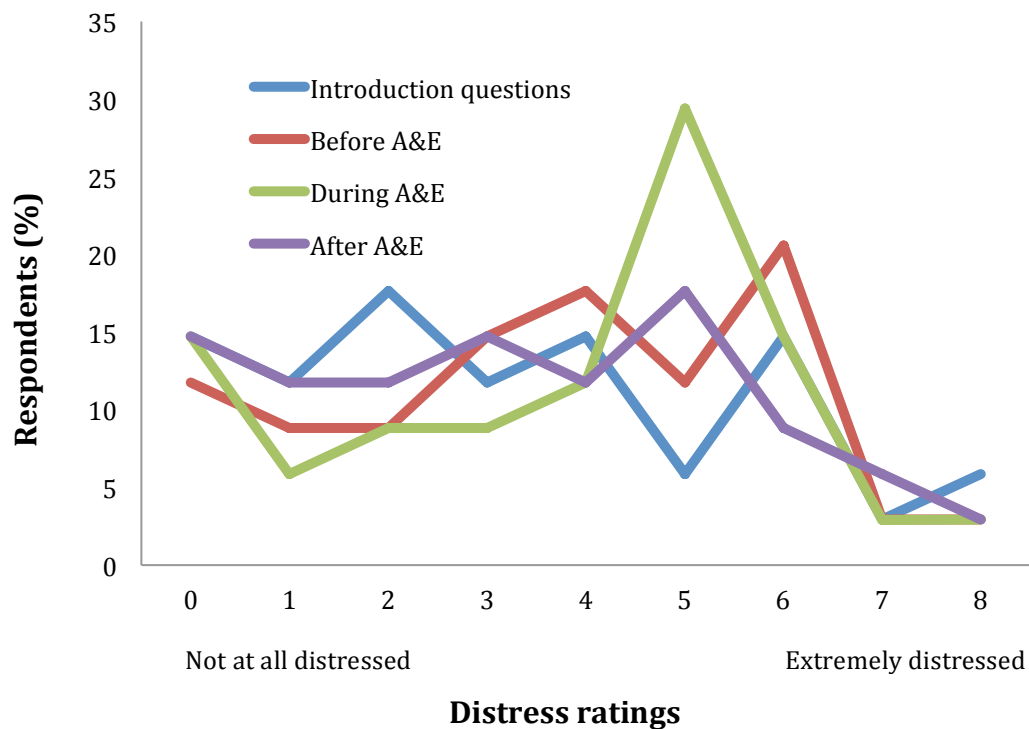| Topic Area	Distress ratings (% of respondents)									Average Distress rating
	Not at all distressed						Extremely distressed			
	0	1	2	3	4	5	6	7	8	
Intro	14.71	11.76	**17.65**	11.76	14.71	5.88	14.71	2.94	5.88	**3.26**
Before A&E	11.76	8.82	8.82	14.71	17.65	11.76	**20.59**	2.94	2.94	**4.68**
During A&E	14.71	5.88	8.82	8.82	11.76	**29.41**	14.71	2.91	2.94	**4.76**
After A&E	14.71	11.76	11.76	14.71	11.76	**17.65**	8.82	5.88	2.94	**4.32**

Figure 2: *Respondents (%) ratings of potential distress when talking about before, during and after their A&E attendance with self harm*

Nine respondents also provided qualitative feedback on what aspects might be most distressing and how their distress could be minimised. It was expressed that discussing personal topics with an unfamiliar person may raise anxiety or may be triggering.

Most commonly people expressed that discussing how they have been treated by others would be distressing; often people experience negative or hurtful comments when talking about their experience.

"Staff get the practical job completed without further thought or care which can leave people to feel hopeless."

"I had an awful experience with police being incredibly rude, condescending and patronising".

"Makes it feel hopeless asking for help as they don't care"

It was suggested that having mental health staff for support at the interview may actually cause more distress, and having alternative options for support would be preferred.

"What about family, friends, advocates etc? Mental health staff can cause more distress."

"e.g. plans to meet a friend to keep my mood up"

Respondents stated that the interviewer should show empathy and understanding, be non-judgmental and not overreact. The interviewer should give participants time to answer and to listen without asking too many questions.

Respondents detailed needing a safe space with tissues where they are given time to be upset, and to form their answers.

"Given time to talk about things, listen to what I'm saying without asking lots of questions. Don't overreact to things that sound bad."

A frequent theme was a need to be given time and support afterwards.

"They just treat cuts and kick you out"

"…Worried about triggering things and then being alone with them replaying in my head afterwards"

"Reminder of being abandoned and left with no hope…it would help spending time after the interview exploring how I could keep myself safe"

Additional comments were left by some respondents. One person suggested discussing language, sensitivity, and the use (or not) of anaesthesia. They also suggested exploring the way that people are discussed in A&E. Another respondent suggested being clearer about what is defined as self-harm in terms of what is included. People described the need for A&E to change the way it responds to individuals who attend with self-harm and the need for more support. Other responses highlighted the positives of the research.

"I truly believe A&E have to change the way they deal with people with self-harm"

"Personally I feel any research [into] how people are treated at A&E is positive. Hopefully my negative experience would help make it better for others"

"Thanks for asking 'how to ask' …and please include that you did this in your write up/flag it up as good practice"

Conclusions

Respondents often described processes that occur at A&E which cause distress. The suggestions to reduce distress themed on not replicating these processes; respondents described being abandoned, being judged, rushed, and not emotionally cared for. This is useful feedback to raise awareness of potential processes in order to minimise them and ensure participants are supported as far as possible.

The quantitative data reflects the difference and range in peoples experience and potential distress levels. The data does indicate that for most people the interview will be distressing, but not to the extent where a mental health professional would need to be involved. Additionally it is useful to have feedback that suggests that the current support procedures in place for participants are appropriate; individuals may require support from the mental health team. Both practical (e.g. tissues) and emotional (e.g. meeting a friend afterwards) support methods are suggested to help reduce distress. The feedback stresses the importance of participants, and other people who attend to A&E with self-harm to be seen as people.

Appendix M – Interview Schedule

Interview topics	Prompts
Introduction	
Tell me about your visits to A&E? • How often do you visit A&E? • For what reasons might you go to A&E? • What services, if any, do you also go to for [named reasons]?	• How often do you use these services? • What is it that makes you go to A&E over other services? • How do they respond to you?
Pre-attendance	
Tell me about what it's like before you go to A&E? • What might influence whether you go to A&E following self-harm? • What might be the reasons you wouldn't go to A&E following self-harm? • After you have self-injured, tell me about what its like up until the point you get to A&E?	• How do you feel? • How does [anyone involved] respond?
During attendance	
Describe what it is like when you get to A&E? • Tell me about any changes in your experience of A&E over time? • Tell me about how you feel when you go to A&E with self-harm? • Tell me about the staff, what are they like to you? • Describe a positive experience with A&E staff when you went to A&E with self-harm? • Describe a negative example?	• Why do you think that may/ may not be? • How do they make you feel [about your injuries]? • What do you think staff that think about you being there? • Tell me about how staff respond to your feelings? • How does that impact you? • How do you respond? • How do different staff members respond?
Post attendance	
Tell me what it is like to leave A&E? • What is it like to be discharged? • Tell me about the extent to which your expectations were met? • What happens in the days after you were discharged? • Tell me about your experience of the follow up? • How do other people in your life respond to your attendance?	• Tell me about why you drop out/ don't attend the follow up? • What impact does that have on you? • How do you feel able leaving?
General prompts	
• Why do you think that may/ may not be? • Can you give me an example? • How does it make you feel? • Tell me more about…? • What happens after that?	• How do you/ they respond? • What makes you say that? • What do you mean? • What thoughts go through your mind?

Handwritten left margin notes:
- Questioned intentions
- Ambivalence of being treated normally
- consequences of being exposed.
- impact of mental health stigma

26 P Erm, like I dislocated my shoulder... and had to go and

27 have it manipulated back, and I found myself getting

28 asked "have you taken anything?", you know... "did you

29 take an overdose?", "was this deliberate? Have you

30 deliberately dislocated your shoulder?" and I just sort

31 of wanted... normal... treatment

32 I Yeah

33 P Because I had just dislocated my shoulder *laughs* but

34 [Yeah]

35 P I found it quite... difficult when I went to the [hospital]

36 afterwards... I know this isn't A&E... but ... the...

37 consultant... was being absolutely lovely and fine to

38 me, and then I had to take my top off so he could test...

39 my range of movements, and I said it was still really

40 hurting... and he said "oh, well you obviously enjoy

41 pain" *laugh* ...referring to... marks on my arms...

42 which I found real upsetting, because I felt like I should

43 have been prescribed some pain relief considering I'd

44 dislocated my shoulder

45 [Yeah]

46 P I'm sure they would have [provided pain relief] for

47 anybody else... that didn't have... mental health all over

48 their records.

49 I Right, gosh, okay. So you talked a bit about dislocating

50 your shoulder, and sort of... them seeing the marks...

Handwritten right margin / interlinear notes:
- repetition → discovered? unexpected? sudden awareness of self
- Being questioned/accused
- self harm takes over other areas of care.
- others are preoccupied with self harm?
- ambivalence?
- wanting to be treated like everyone else.
- Theme of the situation – not believed.
- → disbelief at their reaction?
- → SH affects other areas of care
- visibility of self harm / knowledge of self harm changes reactions
- → exposure, visibility?
- distress dismissed
- → incongruent
- → hesitant in recalling difficult experiences
- Expectation of care not met
- Disadvantaged as a result of self harm exposure.
- treated differently
- mental health discrimination
- → all encompassing / contaminated?

77   she said "well.. I cant not do anything' and... she comes

→ *passive care seeking?*   no choice.

78   and takes me to A&E... and... I never want to go and I

79   get... really nervous in the car cause I know how

knowing what will happen   *knowing what to expect.*

80   they're going to treat me *laughs*

81 I   Yeah

→ *incongruent - covering distress?*

82 P   And... I've, you know, been there so many times that I

predictable experience

83   know that they'll... read the... thing and just think...

→ *unworthy of time? invalid?*

84   timewaster. I don't want to go to A&E... in the first

↳ *defined by time?*

no choice and no escape.   *not wanting to go vs having to go.*

85   place. And the when we start getting nearer and... they

86   put the central locking on cause they know I get so

no escape.

87   nervous before having to go in that I'll try like to jump

impulsive.

significant avoidance   *significant attempt to avoid care.*

88   out the car.

89 I   So you get... really nervous and you kind of dread it?

dependent on others

90 P   Yeah.. I couldn't go on my own, I'd be so panicky cause I

91   worry they'll ... sort of, lock me in a room, and never let

→ *dismiss self.*   *no escape, trapped powerless.*

92   me out.. silly things like that.

93 I   You're worried about what might happen?

94 P   Yeah *laugh*

95 I   Gosh, so what might influence whether you go to A&E

96   for self-harm?

97 P   Erm... ...[Attendance depends on] the time of day, and

avoidance of care regardless of need

98   the time in the week... regardless of how serious what

99   I'd done was... if it was a Friday or a Saturday at like..

staff responses dependent on time?

100   I'd do anything to avoid it, because they're so stressed

101   out and... running round after drunk people, that they

→ *don't want to burden?*   → *assumption?*

102   just, they don't want to deal with... some... Mental

importance of time

4

Handwritten annotations (left margin):

Having no control

impact of being known

Perceived as as waste of time.

Having no control/ not being heard

permenancy of self-harm

Handwritten annotations (right/inline):

→ reluctance.

→ shame.

I wish → wishing it could be different.

→ no control.

→ significance of being known?

no control powerless.

Questioning worthiness

→ treatment is futile.

↳ being heard forceful/resistance?

undeserving, unworthy, dismissed?

repetition – emphasis on her perspective. – being heard?

Present awareness vs past → rationale doesn't justify response. hindsight.

shame.

Permenancy of self-harm ↳ like a prison sentence.

↳ self-harm affects all care?

→ questioned

Transcript:

154 I I just feel embarrassed, I don't want to go with it

155   because it's .. its embarrassing... and I just think. I wish

156   I could have stopped myself before I did it, but then I

157   do it... and then its.. too late and then im having to have

158   surgery to have [self harm] removed. But I did that

159   twice and... it was the same... doctor who came back

160   the second time. I didn't want them out, I.. I wanted

161   them to stay in, it was only because I was.... in

162   [admission unit] that I was being forced to take them

163   out, and the doctor said "why should I waste my time

164   taking these out when you're just going to put them

165   back in again?", so I shouted out, "I don't want them

166   out". But that was her attitude to it, that, I should [sic],

167   "why should I waste my time and resources on you ....

168 I Hmmm

169 P Which I can, I didn't want them out, so, I didn't want

170   her to take them out, I was being... forced. I can see

171   now that they needed to come out... I couldn't walk

172   about with [self-harm], but..

173 I How did it make you feel?

174 P Just, mortified, just... humiliated, and I know these

175   things are going to be written down for life,.. so now if I

176   go in with any... complaint, they'll say, they'll look at my

177   thing and say, have you, "have you done that again"

178   *laughs*

179 I Right, ok

7

116

Appendix O – Reflective Statement

At the time, I felt I 'ended up' looking into re-attendance at A&E. Looking back, I think I was probably drawn to re-attendance to A&E with self-harm due to my voluntary experiences. Prior to the course I volunteered as a Listener, supporting people in times of crisis, often in the early hours of the morning, who felt they had no other option but to self-harm or attempt suicide. These stories were extremely powerful, and I often felt very saddened by the lack of support that people had in times of crisis. Whilst volunteering, I also experienced people who would repeatedly access the service, sometimes multiple times a shift, everyday, with the same story. I remember the sense of frustration and disbelief at the frequency and severity of the self-harm. It's possible that these experiences led me down the route of exploring both the perspectives of staff and services users around self-harm. In the early stages, I was presented with a research paper by a consultant in the team who was interested in the idea that people's attachment types could be linked to re-attendance. This formed the basis of exploring the relationship.

The process of the research up until ethics was relatively straightforward. There had been a mass of quantitative research in to re-attendance with self-harm but no one had qualitatively explored the phenomenon. I was keen to develop my qualitative research skills and using IPA presented this opportunity. I am greatly interested in the stories and experiences of other people, and have always tended to be a listener rather than a talker. For the review, it seemed natural to explore the other side of the relationship, and research in to staff attitudes had been qualitatively explored, but an interpretation of why attitudes remain negative appeared to be missing.

The ethics committee did pose some challenges, but not for the issues that I thought would be a problem. I did however surprise myself at being able to sit in front of a very large panel of professionals and talk about the ethical issues of the research. I actually quite enjoyed it and it gave me an insight in to the concerns for non-mental health professionals regarding people who self-harm. One requirement was that I had to take a personal alarm in to the interview room as the panel were concerned about my safety in interviewing people who self-harm. This was despite me explaining that the interview room has a large window in the door, is quite central to the team base, and participants were excluded if they were deemed to pose a risk.

Recruitment was by far the biggest challenge of the project. Initially, staff at the team experienced difficulties in recruiting; informing people about a research project understandably can be forgotten when people have presented in distress. As time went by, with little or no potential participants to be contacted we decided to change the recruitment process from face-to-face recruitment to telephone contact. Once granted ethical approval, again, further barriers to recruitment emerged; people were difficult to contact, and a high number of people did not attend interview despite opting for reminder messages. At this time I felt frustrated and hopeless; it seemed that once I thought things had began to get going it would reach a standstill. Interestingly, feeling stuck was also something the participants experienced. Recruitment remained a challenge until one member of the team made it her mission and recruited the majority of the participants, for which I will be eternally grateful. I think my biggest strength in the recruitment process was managing to remain patient and, as my supervisor says, 'trust the process'. If anything I have learnt from recruitment, it is to know more about the target population in order to predict with more certainty the likelihood of

recruitment. It has also made me appreciate that sometimes when there is a gap in the research, this may mean the population is hard to reach, and despite this being a challenge it also makes it more worthwhile. In hindsight, following from the ease of gaining feedback of people with lived experience (some of whom reported to re-attend A&E), and knowing the difficulties of engaging people who re-attend, that perhaps online methods of data collection could be an accessible option for future research.

Despite a lot of waiting around, often to be disappointed when a participant didn't show, I really enjoyed spending time with the team and shadowing their work. It gave me more of an insight into the process of the assessments following attendance with self-harm which was interesting and thought provoking. The experiences of the team were also useful to hear, such as the conflicts between physical and mental health staff on their perspectives of what was best for patients. Seeing what happens after people present provided me with a perspective beyond the experiences of the participants and perhaps grounded me more to the context of the relationship.

At times, the process posed some ethical challenges to me. During shadowing, I was shocked and disheartened to discover that people had little access to support after attempting to take their life, and were left to go back to the situation from which they were very recently unable to cope in. I could appreciate how it can be easy to fall into a 'rescuing' position, or alternatively supress or avoid the emotional conflict that this may bring up for staff who often enter caring professions to help people.

During the interview process I found it difficult to not step in to a clinical role, especially when monitoring participant distress. On reflection, if I was to interview again I would have a more thorough ending process for participants who felt slightly more distressed than when they started, perhaps a relaxation technique or a re-orientation activity. I think participants felt they had to leave because the interview had finished, despite being offered the space and or time if they wanted it.

I found data analysis for both IPA and the meta-synthesis consuming. The more I tried to be interpretive, the more concrete my mind became. At multiple points the data no longer made sense and I really struggled to see it for anything other than face value. Other times I found I was too interpretive and questioned all meaning. The time restrictions on my analysis I think inhibited the outcome, and I would have liked to have spent more time thinking about and making sense of the data.

The thesis portfolio has been a significant test of my patience and anxiety management skills. However, it has allowed me to develop new skills in qualitative research and has challenged my perceptions of what I thought I could achieve. I have learnt a lot about how services and services users interact, and will take my newly acquired experiences and understandings into my clinical work.

Choice of Journals

I initially wanted to submit the research and the review to journals aimed at emergency department health professionals, however I found that often these are medically orientated which either do not take qualitative research, or do not

provide a sufficient word count for a meaningful write up. Instead I have chosen to submit to the *British Journal of Clinical Psychology* for my empirical and *Psychology, and Psychotherapy: Theory, Research and Practice* for the meta-synthesis. These both distribute research to a wide audience and include both self-harm and qualitative research.